Chapter 8

Client Care:
Planning, Processes,
Reporting, and Recording

Care Planning Process

- The care planning process (also known as nursing process) is the method nurses use to plan and deliver nursing care.
- The care planning process has five steps:
  - Assessment
  - Nursing diagnosis
  - Planning
  - Implementation
  - Evaluation

Care Planning Process (Cont’d)

- Assessment
  - Assessment involves collecting information about the client:
    - A health history is taken.
    - The family’s history is also important.
    - Information from the doctor is reviewed.
    - Test results and past medical records are reviewed.
    - An RN assesses the client’s body systems and mental status.
Care Planning Process (Cont’d)

- Assessment (cont’d)
  - Support workers play a key role in assessment.
    - You make many observations as you give care and talk to the client.
    - Objective data (signs) are seen, heard, felt, or smelled.
    - Subjective data (symptoms) are things a client tells you about that you cannot observe through your senses.
  - The assessment step never ends.

Care Planning Process (Cont’d)

- Nursing diagnosis
  - The RN uses assessment information to make a nursing diagnosis.
  - A nursing diagnosis describes a health problem that can be treated by nursing measures.
  - A client can have many nursing diagnoses.
    - They deal with the total person (physical, emotional, social, and spiritual needs).

Care Planning Process (Cont’d)

- Planning
  - Planning involves setting priorities and goals.
  - The needs are arranged in order of importance.
  - Goals are then set.
    - Goals are aimed at the client’s highest level of well-being and function.
  - Nursing interventions are chosen after goals are set.
    - A nursing intervention is an action or measure taken by the nursing team to help the client reach a goal.
Care Planning Process (Cont’d)

- Planning (cont’d)
  - The nursing care plan (care plan):
    - Is a written guide about the client’s care
    - Has the client’s nursing diagnoses and goals
    - Has the measures or actions for each goal
    - Is a communication tool
    - Is used by nursing staff to see what care to give
    - Helps ensure that the nursing team members give the same care
    - The care plan is not a finished document – it is continually reviewed and revised, depending on the client’s needs, condition, and progress.

Care Planning Process (Cont’d)

- Implementation
  - The implementation step is performing or carrying out nursing measures in the care plan.
    - Care is given during this step.
  - Nursing care ranges from simple to complex.
    - The nurse delegates nursing tasks that are within your legal limits and job description.
    - The nurse may ask you to assist with complex measures.

Care Planning Process (Cont’d)

- Support workers report the care given to the nurse.
  - In some agencies, you record the care given.
- Reporting and recording are done after giving care, not before.
- Report and record your observations.
  - Observing is part of assessment.
  - New observations may change the nursing diagnoses.
  - Changes in nursing diagnoses result in changes in the care plan.
Care Planning Process (Cont’d)

- The nurse uses an assignment sheet to communicate delegated measures and tasks to the support worker.
  - The assignment sheet tells you about:
    - Each client’s care
    - What measures and tasks need to be done
    - Which nursing tasks to do
- If an assignment is unclear:
  - Talk to the nurse.
  - Check the care plan and Kardex.

The Care Plan in a Community Setting

- Case managers co-ordinate and manage client care.
- Meetings take place in the client’s home.
- Family is very important to the assessment process, because serious illness greatly affects the family roles.

Community Planning

- Case manager establishes priorities, sets goals, and determines available resources.
- Plan includes services provided by family members, outside professionals, and agencies.
- Some clients choose to co-ordinate and manage their own care.
Community Implementation and Evaluation

- Unforeseen needs arise – support workers must be able to adapt to request and adjust the care to best meet the client’s needs.
- Evaluation is ongoing – case manager reviews care and services.

Care Planning Process (Cont’d)

- Evaluation
  - This step involves measuring if the goals in the planning step were met.
    - Progress is evaluated.
  - Assessment information is used for this step.
  - Changes in nursing diagnoses, goals, and the care plan may result.
  - Support workers provide valuable information towards this evaluation, which may result in changes being made to the care plan.

Support Worker Role

- The nurse uses support worker observations for nursing diagnoses and planning.
  - In the implementation step, support workers perform nursing actions and measures outlined in the care plan.
  - Your observations are used for the evaluation step.
Developing Observation Skills

- Observations – an active process of sensing and assimilating information.
- Use senses:
  - Sight, hearing, touch, smell
- Listening to the client breathe, noticing flushed or pale skin, noticing red swollen ankles, smelling unusual odours from urine/bowel movement

Data (Signs)

- Objective data – information observed about the client
  - Red swollen ankles
  - Coughing
  - Crying
  - Box 8-2: Basic Observations (p. 95)

- Subjective data – information reported by a client that is not directly observed
  - I feel faint.
  - The pain is worse.
  - I have a headache.

Describing Observations

- Communication
  - Communication is the exchange of information.
  - For good communication:
    - Use words that mean the same thing to you and the receiver of the message.
    - Use familiar words.
    - Be brief and concise.
    - Give information in a logical and orderly manner.
    - Give facts and be specific; do not interpret or make assumptions.
Verbal Reporting

- When reporting, follow these rules:
  - Be prompt, thorough, and accurate.
  - Give the person's name, room/bed number.
  - Give the time when your observations were made or the care was given.
  - Report only what you observed or did yourself.
  - Report care measures that you expect the person to need.

Verbal Reporting (Cont'd)

- Give reports as often as the client's condition requires.
- Give reports when the nurse asks you to.
- Report any changes from normal or changes in the client's condition.
  - Report these changes at once.
- Use your written notes to give a specific, concise, and clear report.
- Box 8-4: When to Contact Your Supervisor (p. 97)

Documentation

- A written account of a client's condition, illness, and responses to care.
- It is a permanent, legal record that provides communication for health care teams.
- Legal document
Documentation (Cont’d)

- Provides currency as the care plans change; as client’s needs change
- Provides accountability – signed/dated
- Education – view of client and illness

Documentation (Cont’d)

- Provides continuity of care because it provides information about past health problems and may help to detect patterns and changes in the client’s health.

Documentation (Cont’d)

- Statistics – can help an agency anticipate and plan for people’s future needs.
  - Keeps track of births & deaths.
  - Funding
    - In some provinces, the amount of funding long-term care facilities receive is based on review of each client’s chart.
Types of Charts

- Data forms
  - Details about physical, emotional, social, and intellectual health, plus interests and medication
- Assessment forms
  - Assist with identifying a problem area
- Care plans
  - Contain goals and interventions

Types of Charts (Cont'd)

- Progress notes
  - Vary; describe progress of the client
- ADL checklists and flow sheets
  - Describe daily care
- Task sheets (log notes)
  - Used by agencies in community setting to record provided care and services

Types of Charts (Cont'd)

- Graphic sheets or flow sheets
  - Record measurements and observations made every shift or three or four times a day; include measurements for temperature, pulse, respirations, weight
- Summary reports
  - Monthly summary
- Incident reports
  - Unusual occurrences
- Kardex
  - A card file that summarizes information
Charting

- The record (chart) has many forms.
  - These are organized into sections for easy use.
  - Each page is stamped with the client’s name, room and bed number, and other identifying information.
  - Health team members record information on the forms for their departments.
- Agency policies about medical records address:
  - Who records, when to record
  - Terminology, abbreviations, correcting errors
  - Ink colour, signing entries
  - Box 8-6: Guidelines for Recording (p. 107)

Recording

- Chart all observations in relation to behaviour, skin, pressure areas, etc.
- Chart all vital signs, weight.
- A data sheet can be made up to make it easier to collect information (e.g., leg size).

Narrative Charting

- Telling a story
- All details to be included
- Begin with date, time
- Include
  - What you did and when
  - Whom you reported to
  - The client’s response
  - Any results or problems
Methods of Charting

- SOAP:
  - Subjective data
  - Objective data
  - Assessment
  - Plan
- PIE:
  - Problem
  - Intervention
  - Evaluation
- DAR:
  - Data
  - Action
  - Response

Box 8-8: Examples of Progress Notes Written in Different Formats (p. 109)

SOAP: Subjective/Objective
Place an "S" or "O" in the Blank

- Sleepy
- Shivering
- Pain when urinating
- Chest pain
- Skin cool
- Productive cough
- Bruises
- Rapid breathing
- Nauseated
- Vomiting
- Sore throat
- Difficulty swallowing
- Rapid breathing
- Difficult
- Crying
- Toothache
- Sore toe
- Drooling
- Coughing
- Headache
- Itchy
- Aching joints
- Blurred vision

Questions

- What are the four senses you use to obtain information about a client?
  1.
  2.
  3.
  4.
24-Hour Clock

- Uses four-digit number for time
  - First two digits are for the hour
  - Last two digits are the minutes
- For am: add 0 in front of the time
- For pm: add 12 to the first two digits of the clock

24-Hour Clock (Cont’d)

- Recording time
  - Figure 8-9: The 24-hour clock

Next to each of the following, write the times using the 24-hour clock.

- 11:00 AM ______
- 8:00 AM ______
- 4:00 PM ______
- 7:30 AM ______
- 6:45 PM ______
- 12 NOON ______
- 3:00 AM ______
- 4:50 AM ______
- 5:30 PM ______
- 10:45 PM ______
- 11:55 PM ______
- 9:15 PM ______
Access to Client Charts

- A client chart is confidential, and you are ethically and legally bound to keep client information confidential.
- Only health care team members involved in the client’s care have access to confidential information.
- Client has a right to see chart if he/she requests it – usually doctor will review chart with client or family.

Using Computers and Other Electronic Devices

- Computer systems and some personal digital assistants (PDAs) collect, send, record, and store information.
  - Information is sent with greater speed and accuracy.
- You must follow your employer’s policies when using computers and other electronic devices.
  - The right to privacy and confidentiality must be protected at all times.