In-Home Aides



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artners n uality are **Sept 2024**

## Learning Objectives:

1. **List the importance of documentation**
2. **Describe what it means to observe, record, and report (ORR)**
3. **Review tips for documentation**



**Documentation- Why It’s Important:**

Documentation is a record of the care you provided to the client and provides the basis for the agency to bill for the services provided. **It shows how your time was spent in the client’s home performing the tasks which are assigned on the Plan of Care/ assignment sheet.**

Agencies are held to strict documentation requirements by their ***state licensing agencies, accreditation agencies and their payer sources*** (examples are Medicaid, Medicare, VA, and private insurance).

**Your documentation should show how you provided care to the client as it was assigned on the client’s plan of care and your aide assignment sheet.** If your client refuses a task, this should be noted in the documentation and your supervisor notified. Also, if your client or client’s family asks you to perform tasks that are not on the plan of care (assignment sheet), you should check with your supervisor to determine if the plan of care can be changed to allow the task.

**Agencies can get in serious trouble with their licensing agency and payer sources if they do not have documentation that supports the care provided and if the service notes do not match what was assigned on the plan of care.** Your responsibility as part of your In-home aide profession is to document clearly and to ask for assistance when you are unclear about performing tasks or how to document according to your agency specific service notes. Different agencies will have different forms or flow sheets for documentation. Be sure to know your agency policies regarding documentation requirements such as your signature requirements, time in

/out, dates, documenting deviations, client signature, notifying your supervisor for changes and when your documentation is due back to the agency!

**Observe, Record, Report:**

#### In-home aides may spend more time with clients than any other health care worker. That makes them the *“eyes and ears”* of the care team.

* By noticing changes in the client’s condition that could signal increasing illness, a worsening of the client’s physical or mental condition and/or a change in the client’s disease process, the aide could even save the client’s life or prevent the client from going into the hospital.
* As an In-home aide you should keep notes of when you do the tasks that are listed on the care plan. **You should also note what you *observe* while doing those tasks and while spending time with the client according to your agency policies and procedures and as assigned by your supervisor.**

This important part of your job is called **“Observe, Record, and Report”** (ORR, for short).

### What should you observe?

* Changes in the client’s condition-physical, mental, emotional
* Changes in the environment, or setting, that could affect the client’s health
* Changes in relationships with family and friends that could affect the client’s health

### Changes in the client’s condition - look for:

* Signs of physical discomfort ◻ Changes in what the client can do ◻ Changes in behavior
* Changes in physical appearance



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**Observe, Record, Report- continued:**

**Changes in the client’s environment** - **look for:**

* Potential safety hazards ◻ Health hazards

**Changes in relationships with family and friends**-**look for:**

* Family or friends who use to visit regularly and don’t anymore
* Family or friends who suddenly start visiting regularly

**Remember, the client’s record is a legal document so all documentation must be in legible, clear and accurate language so that there is no misunderstanding of the meaning.**

## Accuracy in Documentation:

* + When documenting regarding a client, all information must be completely accurate and up-to-date. Do not copy previous information.
  + You must document observations and also what care was given. However, only document the care you provided, not what another team member may have completed. It is unethical and illegal to document things that you intend to do in the future, in other words, things that you have not completed yet.
  + Only document things that you personally witnessed or experienced, not what you think may have happened or what a client told you (unless you state it is what a client told you versus what you personally witnesses or experienced).
  + It is important to describe behavior, and not your personal judgment. For example, instead of writing, “Susan is very sick today,” write, “Susan expressed feeling tired and achy, and she also has a temperature of 101.1 degrees.” Stick to facts, observations, and quotes from the patient.
  + Documented reports must also be completed in a timely manner. Other people may need the information that you will provide, and memories are always the freshest right after an event

happens.

Observations

Observe, Record, Report- Key points:

* Observe- Watch carefully and attentively
* Record- Write what you observe using your agency’s form
* Report- Use the telephone or other reporting method per your agency policy to notify your supervisor about what you observed
* The word ***observe*** means to watch carefully and attentively. This is a way of gathering information about something.
* People communicate in various ways: verbal, nonverbal, and written.
* Just as communication is a continuous process, observation also must be a process that is constantly in use.
* During the first visit, you will be gathering new information about your client, the client’s family, and the home environment. Then, with each visit, you will build on this information by observing any changes in your client, the client’s family, and the home environment.

***Objective*-** The objective method of observation means that you are using one or more of the body senses to gather information (sight, sound, smell, touch)

***Subjective***- someone tells you information that you cannot observe (client tells you he/she has pain, client says he/she is dizzy, family member tells you the client has been depressed).



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Documentation Tips: (check with your agency policies on specific documentation requirements for your agency)

How do I “record” it?

Different agencies will have different forms that they want you to use for recording.

What should I write?

Be “objective.” That means, don’t try to figure out why something is happening - write only what you observe or what happens.

* Write only what you see
* Write only what you hear
* Write only what you do
* Date all of your observations
* Sign your name

Who do I “report” my observations to?

Each agency will have different guidelines. They will tell you whom to report to when you start working, be sure to obtain this information from your agency.



Other items to consider with documentation and communication of client’s status:

* Communication with co-workers and supervisors can be challenging for the home care aide, as most of the aide’s work is performed outside of the office, alone at a client’s home.
* Your agency should have guidelines regarding communication within the agency, including frequency of contact with the supervisor and/or office staff.
* Communication with the office and your supervisors can occur in many different ways. It can be face-to- face, by a telephone call or even written communication.
* If you have a concern about a client or if you feel like your question or concern requires immediate attention – don’t just write it down on your flowsheet – call the office or other guidelines as you are given.
* You should have a supervisor available to you at all times during work hours and he/she should be able to answer any questions that you may have.



General Documentation Tips to Remember (talk with your agency supervisor about your agency policies):

* Remember, the client’s record is a legal document that may be used as evidence in court. Therefore, it is important that your charting is accurate. Record what you did and what you observed. Do not record what you thought or guessed or how you felt about your work or observations
* Always record the correct date and time
* Do not erase, draw a line through your mistake; write “error” above it; place your initials and date next to the word error; and rewrite your entry Always use blue or black ink, do not use erasable or felt-tipped pens
* Write legibly, or print the entry
* Record telephone calls or other communication that occurred with your supervisor
* Record only the facts
* **Never falsify documentation or turn in false time sheets/ service notes to your agency!!**

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Sources: PROVIDING PERSONAL CARE SERVICES TO ELDERS AND PEOPLE WITH DISABILITIES, PHI national,

[http://phinational.org](http://phinational.org/) ; Module 2, accessed September 28, 2016. NC Personal and Home Care Aide State Training, phase