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Office of Integrated Health

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Documenting Changes in a Person's Status December 8, 2015

Your Observations Are Important

Remember at all times when assisting an individual with an intellectual or developmental disability that the individual may not be able to give you any information about discomfort or symptoms that he or she may be experiencing.

Often times the family and caregivers are the eyes and ears for the healthcare professional that must assess the medical status of the individual and make diagnostic and treatment decisions.

Know what is Normal for the People You Support

Knowing the people you support, their usual behaviors and normal activities is important because it helps you to recognize what is not normal for them.

You can get to know what is normal for the people you serve by maintaining a record such as a daily health review, which will serve as a reference when there is a change in the individual's status. This information may be valuable at a doctor's appointment or emergency room visit/hospitalization.

Know When to Document

When a person has a serious medical condition or a recurring medical condition it is important to document changes in the individual's condition. This applies to individual's behavior, mood and energy level too. Proper, clear, concise documentation will assure the best possible care. For example, if a person is given a new medication, it is important to document any physical, mental or behavioral changes that are noted after the person begins taking the medication.

Know How to Document

- □ When you are documenting, write legibly, if you have illegible handwriting, type your notes.
- \Box Document how the person is responding to changes in living conditions, diet, medication, therapy, etc.
- $\hfill\square$ Use terms that everyone can understand and use medical terms only when necessary.
- □ Document as soon as an event happens if possible before you forget important facts.

Documenting and communicating information is very important to care. It also confirms and validates the care provided and received. Good factual documentation is especially important in the event of a negative outcome or death.

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