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DEPARTMENT OF HUMAN SERVICES

Standard Medication Administration Training Course

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Lesson 3: Report Changes

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Title Slide
(no narration)
Welcome
Slide 1 – This is Lesson 3 of the Commonwealth of Pennsylvania Medication Administration Training Course, "Report Changes"
Lesson Objectives
Slide 2 – By the end of this lesson, you will be able to: • Describe your responsibilities for reporting • Explain who to report to, what to report, when to report, and where to report. • Identify best practices for documentation and reporting.
Medication Cycle
Slide 3 – In a previous lesson, you learned about the Medication Cycle beginning with observation. Report Changes follows observation and is the information that you communicate about what you observed.
What Do You Report?
Slide 4 – As the staff member who spends the most time with the individual, you are often the first one to notice a change. Without your observations, small changes like the ones that may happen because of medication side effects or medication interactions may be missed. You have a responsibility to report what you observe. It is important to report everything that you observe even if you think that it might not be significant.
Slide 5 – Let's talk about the ways that information is reported. Both verbal and written reporting is necessary. You should tell someone about what happened to share information about the event quickly. Later you can write about it to record the little details that you might forget over time. Remember that the purpose of observation and reporting is to get the needed care and treatment for the individual for whom you provide services.
Who do you report information to?
Slide 6 – Many people will need to know the information that you have regarding what happens with an individual. Who you report information to will depend on their role in the individual's care. For example, if an individual is sick, then you may report your observations to the nurse or your supervisor shortly after you make the observation. In addition, there may be other people who need to know the information, including family members, other agency staff, the health care practitioner, and others. It is particularly important to share this information with the staff persons working with the individual when your shift ends. Your agency should have established policies and procedures for the notification and documentation of such observations that follow the rules of the regulatory requirements for your agency. Be sure that you are familiar with these.
What do you report?
Slide 7 – As direct care staff you should report what you actually observe. Do not add your interpretation or what you think. You may add historical information such as "the last time that this happened, we did this, and it worked." You may also report what a family member or some other staff person observed. Be sure to document who made the observation.
Slide 8 – When sharing this information remember the difference between objective and subjective information. Be sure to make it clear which information came from the individual and which information you observed first hand. Let's take a moment to review your understanding of **objective** and **subjective** information.

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• Objective information
  o is factual.
  o can be measured.
  o is directly observable (you observed it).
  o is based on any one or combination of **four** of the five senses: vision, hearing, touch, or smell.
• Subjective information:
  o is what an individual tells you about how they feel.

Slides 9 – You have been introduced to the concept that you should report your observations. You have completed a review of the meaning of objective and subjective information. Please complete the following exercise. You will write a note about your observations of Melissa. Melissa takes Mysoline twice a day for a seizure disorder. She has had vomiting for the last two days, and this morning she had a seizure. Her last seizure was four months ago. You are writing your report related to what occurred today. Select which information **you would not include in your note** and then click continue or Check. a) Melissa has had vomiting today b) Melissa had a seizure this morning c) Melissa complained of a headache this morning d) Melissa took her dose of Mysoline this morning e) Melissa's dose of medication needs to be changed
Slide 10 – The answer is: e) "Melissa's dose of medication needs to be changed" would not be included in your note. You should not add your interpretation or what you think to the report.
When do you report?
Slide 11 – The timing of reporting observations is just as important as what you report. You may report observations in different time frames depending on the nature of the observation. Depending on whether you see something serious or mild can change how quickly you report observations and obtain additional help. Some situations require immediate responses while other situations may be saved and added to what you need to share with the individual's health care practitioner at their next visit. Let's talk about some ways to think about reporting time frames. The nature of the situation will define the required time frame for reporting. There are some situations that are emergencies, some that are urgent, and others that are routine. Sometimes reporting must occur at a certain time determined by the health care practitioner. We'll next look at each of these types of situations.
When do you report? – Emergency (Emergent)
Slide 12 – A health emergency (an emergent situation) is an illness or injury that is acute and puts the individual's life or health at immediate risk of harm. Emergencies require immediate intervention. Emergencies include situations such as: difficulty breathing, loss of consciousness, chest pain or pressure, uncontrolled bleeding, coughing or vomiting blood, sudden severe pain, poisoning, major injuries, such as broken bones, as well as sudden facial drooping, weakness in an arm or leg, or other signs of stroke. The first step in reporting should be to alert the emergency system by calling 9-1-1. Emergencies must be dealt with immediately as they are life-threatening. You must know your agency's policy for handling an

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emergency situation. Once emergency measures have been implemented you must complete additional agency notification procedures.
When do you report? – Urgent
Slide 13 – An urgent situation is an unexpected illness, injury or change in the individual that requires prompt attention, but is not life-threatening. As soon as an urgent situations is observed, it should be reported to the individual listed in your agency policy to give direction and make sure that correct care is obtained. These situations may require treatment or more close observation. If an urgent situation is not attended to appropriately, it may develop in to an emergency situation.
Slide 14 – Examples of urgent situations include fever, changes in appetite, change in activitiy level, increased agitation, receiving the wrong medication, or seizure activity in an individual with a known seizure disorder. The health care practitioner will give additional instructions about the individual, such as having the individual seen in the emergency room or for an office visit. If you ever are not sure about whether a situation is an emergency versus an urgent situation, call **9-1-1** right away.
When do you report? – Routine
Slide 15 – Routine reporting is documenting regular or usual activity and course of action. These are observations that should be entered into daily notes. Some examples of information that are included in routine reporting are: • Graphic data, such as pulses, blood pressure, temperature, and blood sugar measurments • Home visits or community trips • Health care practitioner visit • Appetite • Activity level • Mood
When do you report? – Certain Time
Slide 16 – There will be times that health observations will need to be reported at a certain time established by the health care practitioner, a nurse or agency policy. This type of reporting is sometimes referred to as “certain time” reporting. Examples of a health observation that would be reported to the health care practitioner at a certain time include: blood sugar levels, blood pressure, heart rate or pulse, and oxygen saturation level.
Slide 17 – Many individuals with congestive heart failure take digoxin to help their heartbeat stronger. Digoxin also affects the individual’s heart rate and so a measurement of the heart rate is required to be done prior to administering medication. The health care practitioner will tell you the range of heart rates for which you will <u>not</u> administer the medication. The heart rate for a particular individual may need to be above 60 beats per minute in order for it to be safe to administer the digoxin. If the heart rate, also called the pulse, was 72, then you would document the heart rate in the record and administer the medication. If the heart rate was 56, then you would document it, but not administer the medication and follow the additional instructions provided by the health care practitioner. This might include contacting the health care practitioner with the heart rate level to get further instructions.

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Slide 18 – In the example the heart rate is 72. You would document the heart rate in the medication record and then administer the medication because it is above 60. The health care practitioner will schedule the individual to come back within a specific time frame like two weeks. You would bring a copy of the medication record and the pulse documentation with the individual to this visit as an example of "certain time" reporting.
Slide 19 – You have seen the relationship between the two parts of the cycle. You must observe the individual and their reactions to medication. The reaction then determines how to report and when to report the reaction. Please complete the next few exercises to check your ability to identify the types of reporting needed in each scenario.
Slide 20 – Select the type of reporting you would use if you observe: Sally has a good appetite this morning. a) Certain Time b) Emergency c) Routine d) Urgent Once you make your selection, click Check.
Slide 21 – The Answer is c) Routine. Routine reporting is documenting regular activities.
Slide 22 – Select the type of reporting you would use if you observe: A rash that appears to be getting worse. a) Routine b) Urgent c) Emergency d) Certain Time Once you make your selection, click Check.
Slide 23 – The Answer is b) Urgent An urgent situation may require treatment or more close observation.
Slide 24 – Select the type of reporting you would use if you observe: An individual with a minor cold that develops trouble breathing. a) Emergency b) Urgent c) Certain Time d) Routine Once you make your selection, click Check.
Slide 25 – The answer is a) Emergency. An emergency situation is one where there is an illness or injury that is acute and puts the individual's life or health at immediate risk of harm.

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Where do you report? – Reporting Best Practices
Slide 26 – Different types of reporting may be reported in different places. Verbal reports may occur over the phone or when transferring care from one staff to another. Written reports may have more variety and may be handwritten or electronic. Some examples of types of documents include the individual's record, the medication record, graphic charts, seizure and bowel movement records, incident reports, daily logs, or health care practitioner examination forms. Agencies use various forms and methods for documentation and you must be familiar with your agency's policies and procedures around reporting and documentation.
Slides 27 – There are some best practices when completing a written form, filling out a report, and documenting your observation: • Write clearly so others can read it. • Use blue or black ink. • Follow your agency-specific instructions for correcting an error. This usually involves drawing a single line through the error so that what is underneath is still readable. The correction should also include the date and time of the correction as well as the name of the individual correcting it.
Slides 28 – • "White Out" or other products that mask or completely cover the error must not be used. • Sign your name or initial the document so that people know who completed it. Use your agency's standard forms to help you remember to document important information.
Summary
Slide 29 – This lesson about reporting covered key points that included: • Observations should be reported to the appropriate people. • You should report what you observe or what the individual tells you. • Timelines for reporting observations will vary for emergency, urgent, and routine situations. • Certain Time reporting will be done at the time indicated by the health care practitioner, the nurse, or agency policy. Following best practices when completing a form helps to maintain consistency for reporting.
Next Step
Slide 30 – Now that you have completed the lesson, it is time to take the quiz. Please click on the link below to access the quiz.