Canadian Language Benchmarks/ Essential Skills | Niveaux de compétence linguistique canadiens/ Compétences essentielles

Lesson Plans

Lesson Plan:

Sector: Health Care	**Occupation: Visiting Homemaker (NOC 6471)**
Theme: Documenting/recording client information	**Occupational Task:** Complete a client progress report following documentation guidelines.

Essential Skills (ES) developed during the learning activities:

Reading Text: Read simpler text to locate multiple pieces of information. Make low level inferences. (ES 2)
Choose and integrate information from various sources (i.e. the patient, the family, the healthcare provider etc), make low level inferences, identify relevant and irrelevant information.

Document Use: Document is simple, multiple pieces of information. Enter several pieces of information on reports or charts. (ES 2)

Writing: Longer or shorter pieces of writing intended to inform. Writing task has an established format, more formal style a friendly, respectful tone appropriate for the occasion. (ES 2/3)

Oral Communication: Obtain information by questioning, follow and give directions, reassure and comfort, deal with minor conflict and complaints, present and discuss simple options. (ES 2)

Thinking Skills: Make inferences about the importance of information and decide on appropriate vocabulary and tone. (ES 2/3)

Continuous Learning: Use more complex documents, for example, incident and accident reports. (ES 2/3)

Canadian Language Benchmarks (CLB) competencies developed during the learning activities:

Speaking: Ask relevant questions and provide information related to routine activities. (CLB 7)

Listening: Identify factual details and inferred meanings in discussion of likes/dislikes and preferences. Demonstrate comprehension of factual details and some inferred meanings in simple advice and suggestions. Identify emotional state of speaker from tone and

intonation. (CLB 7/8)

Reading: Identify specific facts and key information in verbal text and charts. Identify type and purpose of text. (CLB 6/7)

Writing: Write a report providing accurate descriptions or an account of events. Demonstrate appropriate vocabulary for topic. (CLB 8)

Language and culture focus for the learning activities:

Grammar

- Use quotation marks when reporting direct speech; for example the information the client has given in answer to a question for the health care report.
- Use simple concise sentences.
- Use tenses, especially past tense, appropriately.

Vocabulary

Related to Personal Care: treatment and task, activity and limitations, and homemaking

- Positive and objective words. For instance, 1) *He seemed upset with his family. / He was mad at his family. 2) I asked him to put his fork down and get ready for dessert. / I told him if he didn't stop hitting the dinner tray with his fork, I wouldn't let him have his dessert.*
- Words of respect and dignity i.e., void, stool, toilet, personal hygiene.
- Seem, appear, smell, feel and hear when writing objective data (Words which indicate that the observations have been made using the senses.)
- Common abbreviations. Such as, BP-blood pressure, BRP-bathroom privileges, q-every, qd-every day, etc.(see inside back cover of *Mosby's Textbook for Nursing Assistants*)

Culture

- Documentation, reporting, and recording are the primary means of communicating in the Health Care field.
- The information in a report or record is confidential and can be used as a legal document.
- Visiting homemakers are usually subsidized by the government and administered through a social agency like the Red Cross, or Victorian Order of Nurses.
- Seniors and people with disabilities who want to live independently in a community and/or in their own homes can receive support and care from visiting homemakers. They can receive assistance with personal care, meals and light household duties.
- It is common in the North American culture to have Seniors and people with disabilities looked after by Health Care professionals either in their homes or in a Residential Institution. This is a practice that has been growing since WW II with the advent of the double-income family and changes in the family structure.

Suggested teacher resources and classroom materials needed:

1. Sorrentino, Sheila A. *Mosby's Textbook for Nursing Assistant (* St Louis, Missour: Mosby Inc. Fifth Edition 2000) pages 68, and 83
2. "Basic Observation Checklist". Sorrentino, Sheila A. *Mosby's Textbook for Nursing*

Assistant (St Louis, Missour: Mosby Inc. Fifth Edition 2000) page 69

3. Documentation Excerpts (attached)
4. Guidelines to Documentation (attached)
5. Home Care Plan for Marie Thistle (attached)
6. Situational Script for Marie Thistle (attached)
7. Case study (attached)
8. Support and Care Planning Documentation Exercise (attached)

Estimated time for the learning activities: 3 hours

The learners will document client care in a progress report.

In a previous lesson, the learners studied the guidelines to documentation, a basic observation checklist and a home care plan.

Learner Profile:

All of the learners are foreign trained professionals in medicine, health care, social work or teaching. They know how to report and record data for a multidiscipline health team. They have studied "Words of Dignity", i.e. void, bowel movement, urinary infection, genitals, etc. and are familiar with common abbreviations.

Learning Objectives:

- The learner will be able to write a clear and thorough client care report including objective and subjective data.
- The learner will include what he observed, what he did and how the person responded in the documentation.
- The learner will demonstrate his ability to follow the guidelines for documentation.

Learning activities:

- In large group, the learners look at two sentences on the board:
  1) *"Henry was delighted with the flowers he thought his daughter sent. However, he does not have a daughter only a son."*
  2) *"Mr. Everingham seemed happy today with the flowers in his room. He seemed confused (about) who sent them.*

Elicit which sentence is the most appropriate and why. (10min)

- In pairs, the learners re-write 4 excerpts from health care reports. (see attachment Documentation Excerpts) (20 min)

- In large group, each pair discusses their corrected versions and the reasons for the changes. On the blackboard, develop a list focusing on relevant information, the objective and subjective data, sentence structure, grammar, spelling and vocabulary. (20 min)

- In large group, learners review the handout "Home Care Plan for Marie Thistle" (see the

attachment) written by the Supervising Nurse, and discuss the care the homemaker is to provide. (20 min)

- Class watches a role-play of a visiting homemaker with the client. (See attached Situational Script). The teacher will demonstrate with a learner. Discuss the vocabulary and what happened. In groups of three the learners practice 2 people role-play, the 3rd makes notes on what he/she observes. Repeat the process twice more. Discuss the information to be included in the progress report. (30 min)

- In large group, develop a point-form list of the information that the small groups thought were relevant in the role play. Ask how the information could be written in a report. Write the sentences exactly as they are given. Learners refer to their copies of the guidelines for documentation and check the answers on the board. Make the suggested changes. Review the guidelines to ensure complete comprehension (30 min)

- In groups of three learners review and discuss one case study, decide what information would need to be documented and complete a progress report. (See attached Case Study) (25 min)

- In large group, discuss the progress reports and have the learners explain the reasons they wrote what they did. Reinforce the importance of being concise and accurate. (25 min)

- Each learner will complete a documentation exercise following the guidelines and format for documentation. This will be assigned for homework.(See attached Support and Care Planning Documentation Exercise)

Additional and/or extension learning activities:

1. Job shadow a Visiting Homemaker or a Personal Support Worker and write some observations.
2. Watch a movie and practice observation skills of a scene with a caregiver and patient. Discuss as a class and write independent reports.
3. Study the format and guidelines of an incident report. Complete a report based on a role-play or a case study
4. Review the different health care forms that are used by Personal Support Workers, and Nurses' Aides.

Evaluation:

The learners will submit a client health care report. It will be evaluated, by the instructor, for objective and subjective data and adherence to the "Guidelines for Documentation. Spelling, punctuation and grammar will be marked.

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VISITING HOMEMAKER

Case Study

You are assisting Mr. Davidson, a 45 year old man who has a cast on his right leg from foot to groin. You assist him with a bed bath and change his pyjamas. He independently cares for his hair, teeth, shaving and grooming. You notice that he has a red broken area in the groin at the edge of the cast. He says that it doesn't hurt. The cast is moist and appears to smell of urine. During the bath, Mr. Davidson says he is depressed and complains of "tightness" in his right ankle.

Document relevant procedures that you would have carried out and the observations you would have made.

VISITING HOMEMAKER

Guidelines for Documentation

1. Use concise and clear language when writing information.
   - Use short, descriptive sentences.
   - Do not write a full page if you can record all pertinent information in a paragraph.

2. Record all pertinent facts and information. Provide specific and objective information.
   - Ensure that you have recorded all the important information that is required for the report.
   - Record specific details that are based on facts or your observation.
   - Do not include information which is subjective (your opinion or your emotional response). Record what you see and do not label it.

3. Complete each report or documentation according to the information needed.
   - Ensure that you understand what information is needed.
   - Look at examples of other similar reports.

4. Documentation should include positive and objective words. Do not use negative words or phrases.
   - Use words that are professional, polite and objective.
   - Example:
     -He was angry at his mother because she told him not to come over for a visit. *(He appeared to be upset as he could not go to see his mother.)*

VISITING HOMEMAKER

HOME CARE PLAN

Client: Marie Thistle Date: 01/01/06

PERSONAL CARE	TOTAL	ASSIST
Bath: 0 shower **Y** tub 0 partial bed bath 0 complete bed bath **Y** frequency *once a week*		>
Oral Hygiene: **Y** total mouth care **Y** dentures *upper and lower partial plates*		**>**
Hair: **Y** comb & brush Y shampoo -frequency *once a week*		**>**
Shave: 0 face 0 underarms 0 legs		
Skin Care: Y lotion 0 powder Y massage		>
Nail Care: **Y** clean & file **Y** fingers **Y** toes *once a week*		**>**
Dressing: **Y** street clothes: 0 pyjamas		>
Elimination: *Y* toilet 0 commode 0 urinal 0 bedpan 0 incontinent		>
TREATMENTS & **TASKS**		
Hot and Cold Applications: 0 heating pad 0 ice pack		
Medications: 0 admin. by family **Y** admin. by client 0 pre-poured		
Dressing Changes: 0 frequency location_____		
Empty Catheter/ Ostomy Bag: 0 empty 0 record observations		
Bowel Function: 0 monitor 0 enema - type_____		
Catheter Care: 0 type_____		
Urine glucose testing: Y record — frequency <u>before meals and at bedtime</u>	>	
ROM Exercises: Y active 0 passive		>
Fluids: **Y** encourage 0 limit		>
Vital Signs: Y frequency <u>od at 1000</u>	**>**	
ACTIVITY & LIMITATIONS		
O bed rest 0 BRP 0 position & turn — hrs 0 transfer to bed		>
O transfer to chair 0 hoyer lift **Y** walk 0 crutches 0 cane 0 w/c 0 wheelchair		
HOMEMAKING		
Y linen change 0 laundry Y light housekeeping Y meal preparation 0 shopping		>
Y diet regular diabetic		

Environmental Hazards: *<u>be aware of obstacles in client's path</u>* Rugs *<u>none</u>* Stairs <u>6</u>

<u>Other Needs: very particular about personal care, naps for one hour in the p.m., does own blood glucose testing four times daily, needs help with set-up.</u>

Y- is to be done **0**- not to be done

Susan Green R.N. *01/01/2006*

Signature of Nurse *Date*

VISITING HOMEMAKER

Optimal Support and Care Planning
Documentation Exercise

1. You needed to coax Mrs. Lo from Room 109 to get out of bed in the morning to come for breakfast. She stated that she slept poorly and was awake several times during the night. She ate a few bites of breakfast. Her daughter visited from 10:00 to 11:15 and brought in homemade cookies and some new socks, which she asked you to have labelled with her mother's name. You take them to the laundry room to be labelled. When you assisted her to the toilet at that time, you noticed a reddened area on her coccyx. At lunch, Mrs. Lo ate her sandwich, but refused to eat her soup. She went to play bridge after lunch as per her usual schedule, but came back early because she was tired. At 1315, you assisted her to the toilet and noticed that her coccyx was still red. You give her the call bell and leave the room to go tell your supervisor about the reddened coccyx.

What information do you need to document/record? Write a progress note.

2. Mr. Hill from Room 105 got up in the morning and swore at you during a.m. care when you were trying to help him wash. He ate his whole breakfast. At 09:30, he tried to hit another staff member. He attended the walking program as per his usual schedule, then went back to his room and watched the birds outside his window until it was time for lunch. You reported the behaviour to the nurse. Mr. Hill ate his whole lunch. After lunch, he told you stories about the weather when he was a boy while you put away his clean laundry. He then had a nap until 14:30 as per his usual schedule. When you assisted him to the toilet at that time, his urine was streaked with blood. You use the call bell to call the nurse to his room.

What information do you need to document/record? Write a progress note.