Appendix 2B

# Health Form 2 Direct Observation

**BACKGROUND:** Establishing a set of routine/preventive health care recommendations is only one step in assuring that individuals receive quality health care. The ability of a health care provider to do quality assessments, diagnosis and treatment, in large part, rests on the quality of the history and information that he/she receives. In the general population, information regarding health care status is usually communicated by the patient or a family member. While many people with mental retardation may be able to share information with a health care provider, others are largely dependent upon the observations of direct support professionals to record and report information. It is critical, therefore, that MRDDA providers have a consistent manner in which to gather information regarding health issues and changes to better inform the primary health care provider. Without this critical information, it is doubtful that a full review can be successfully accomplished. The Direct Observation form helps to provide consistent, relevant and thorough health status information to the treating provider at the time of the medical encounter.

**PURPOSE:** The Direct Observation form is generally completed by direct support professionals. The tool asks direct support professionals who interact most directly with individuals on a day-to-day basis to respond to questions about easily observable indicators of health or illness. It does not require that staff make any clinical judgments, only that they observe and record what they see.

The Direct Observation form is required to be used in preparation for the Health Care Management Plan and is recommended for any visit to the individual’s primary care provider. It is not required for use in preparation for specialty visits, unless the provider feels such use would be helpful. This checklist can also be used at regular intervals to monitor specific conditions or to note changes in health status.

While the checklist was developed primarily with the direct support professional in mind it can also be used by family members or other provider staff to help prepare for a consultation or visit with a health care provider. Consistent use of this form by direct support professionals can also assist staff to be more attuned to issues of concern and help them to become better observers of potential signs and symptoms of illness It can also serve as historical information for new staff to have a better understanding of an individual’s previous health status.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Status Indicators**  \*\*Highlight or circle changes in health status. Any “Yes”, “Don’t know” or “Recent Change” may indicate a need for monitoring. | Yes | | No | Don’t  know | | Check if  recent change | |
| **HABITS:** Does this person:  1. Smoke or use tobacco products?  2. Drink alcohol?  3. Avoid regular exercise?  4. Engage in sex?  5. Engage in substance abuse? | |  |  | |  | |  |
| **SLEEP:** Does this person:  1. Have problems sleeping at night?  2. Get up 2 or more times during the night to go to the bathroom?  3. Fall asleep during the day? | |  |  | |  | |  |
| **EATING/WEIGHT:** Has this person:  1. Gained or lost more than 10 pounds in the past year?  2. Ever choked while eating?  3. Had trouble chewing or swallowing?  4. Cough or had a change in their breathing during or after eating or drinking?  5. Ever been reluctant to eat or drink?  6. Needed to change the texture of their food or drink? | |  |  | |  | |  |
| **CARDIAC:** Does this person:  1. Ever complain of chest, jaw or left arm pain?  2. Have swollen feet or ankles?  3. Ever have blue lips or nails? | |  |  | |  | |  |
| **RESPIRATORY:** Does this person:  1. Frequently cough or wheeze?  2. Have shortness of breath when at rest?  3. Have shortness of breath while exercising?  4. Have frequent colds, pneumonia, sinus infections or bronchitis? | |  |  | |  | |  |
| **GASTROINTESTINAL**: Does this person:  1. Complain of or appear to have heartburn: rub chest, or burp frequently?  2. Vomit 2 or more times per week?  3. Complain of or appear to have abdominal pain?  4. Have a bowel movement less than 3 times per week?  5. Frequently have 3 or more bowel movements per day?  6. Seem to have difficulty moving their bowels?  7. Ever have blood in their bowel movements? | |  |  | |  | |  |
| **NEUROLOGICAL:** Does this person:  1. Have a seizure disorder?  2. Complain of headaches, loss of consciousness, or dizziness?  3. Fall a lot or have difficulty with balance?  4. Walk differently lately?  5. Show a change in what their seizures look like? | |  |  | |  | |  |

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| --- | --- | --- | --- | --- |
|  | Yes | No | Don’t  Know | Check if  recent change |
| **SKIN & NAILS:** Does this person:  1. Have dry skin?  2. Have any rashes, redness or open sores on their skin?  3. Have any unusual lumps or bumps on or under the skin?  4. Have any unusual marks or moles on the skin?  5. Have problems with fingernails or toenails?  6. Have any blisters or calluses on their feet? |  |  |  |  |
| **MOUTH:** Does this person:  1. Have gums that bleed while brushing their teeth?  2. Have any sores in their mouth?  3. Grind their teeth?  4. Have bad breath?  5. Have swollen gums? |  |  |  |  |
| **VISION/ HEARING:** Does this person:  1. Ever have redness or drainage from their eyes?  2. Rub their eyes?  3. Squint?  4. Ever have drainage from their ears or earwax problems?  5. Respond to sound differently lately?  6. Wear a hearing aid or glasses? |  |  |  |  |
| **MOBILITY:** Does this person:  1. Have trouble using stairs?  2. Have trouble getting around the house?  3. Have difficulty standing, sitting, or bending? |  |  |  |  |
| **MUSCULOSKELETAL:** Does this person:  1. Complain of or appear to have joint or muscle pain or stiffness?  2. Have a history of broken bones or osteoporosis (brittle bones)?  3. Have any deformities of the feet?  4. Wear special shoes? |  |  |  |  |
| **GENITOURINARY:** Does this person:  1. Have trouble starting to urinate?  2. Complain of pain or burning during or after urinating?  3. Have urine that has an unusual color or bad odor?  4. Have frequent bladder or kidney infections?  5. Menstruate (have a period)?  6. Experience pain or other behavior changes during their period (menstruation)?  7. Report a change in their menstrual cycle?  8. Ever have any unusual vaginal bleeding or discharge?  9. Ever bleed or have unusual discharge from their penis?  10. Have any lumps or report pain in their groin? |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | Don’t  Know | Check if  recent change |
| **BEHAVIOR:** Currently, does this person ever:  1. Hurt him/her or others?  2. Damage property?  3. Appear unusually sad or depressed?  4. Withdraw from others?  5. Display moodiness or irritability?  6. Eat nonfood items?  7. Complain of pain?  8. Have any recent history of personal losses or major life stressors?  9. Display sexually inappropriate behavior?  10. Run or wander away?  11. Appear anxious (nervous, agitated, restless)?  12. Appear forgetful?  13. Repeat words and/or actions again and again? |  |  |  |  |

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