

A Communication Skills Module:

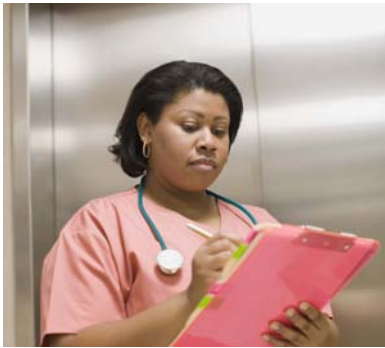
REPORTING & DOCUMENTING CLIENT CARE

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Developing Top-Notch CNAs, One Inservice at a Time



A Communication Skills Module:

REPORTING & DOCUMENTING CLIENT CARE

We hope you enjoy this inservice, prepared by registered nurses especially for nursing assistants like you!

Instructions for the Learner

If you are studying the inservice on your own, please do the following:

- Read through **all** the material. You may find it useful to have a highlighting marker nearby as you read. Highlight any information that is new to you or that you feel is especially important.
- If you have questions about anything you read, please ask _____.
- Take the quiz. Think about each statement and pick the best answer.
- Check with your supervisor for the right answers. You need **8 correct** to pass!
- Print your name, write in the date, and then sign your name.
- Keep the inservice information for yourself and turn in the quiz page to _____ no later than _____.
Show your Inservice Club Membership Card to _____ so that it can be initialed.
- Email In the Know at feedback@knowingmore.com with your comments and/or suggestions for improving this inservice.

After finishing this inservice, you will be able to:

Name at least three purposes of clinical documentation.



Describe the difference between objective and subjective observations.



Discuss the five rules of clinical documentation.

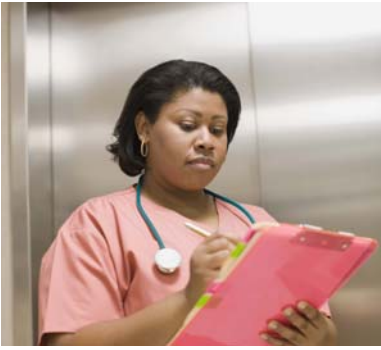


Describe the purpose of an incident report.



Complete your documentation according to the guidelines presented in this inservice and the policies of your workplace.

THANK YOU!



Developing Top-Notch CNAs, One Inservice at a Time

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A Communication Skills Module:

Reporting & Documenting Client Care

WHAT HAPPENED TO CAROLINE?

Caroline, a 76 year old woman arrived at the nursing home to recover from hip surgery that resulted from a fall at home. The routine surgery was done at the hospital without complications.

Upon arrival at the nursing home, an assessment was completed by the nurse, a care plan was written and the nursing assistant helped Caroline get settled in for her stay.

Orders were written for Caroline to:

- Ambulate to bathroom and in halls 3 to 4 times per day,
- Attend therapy sessions and perform hip exercises,
- Wear elastic stockings, and
- Continue to perform cough and deep breathing exercises.

After three days, Caroline was doing great. She was well on her way to regaining her independence. But, then something happened.

Caroline removed her elastic stockings for a shower before bed. After the shower, she felt some pain in her leg, but didn't report it and went to bed without the stockings.

That night, the chart indicated that Caroline was sleeping

comfortably, no swelling, redness or pain on the affected leg and *that the elastic stockings were on.*

In the morning, Caroline complained of feeling dizzy and was unable to get out of bed. Her vital signs indicated a rapid heart rate and rapid, shallow breathing.

The abnormal vitals were documented correctly, but the nurse was not given an oral report and didn't see the data until later that morning.

When the nurse arrived in the room she found Caroline. . . dead. Caroline had suffered a deep vein thrombosis or DVT (a blood clot in the leg). The DVT became dislodged and traveled to Caroline's lungs.

So, what went wrong? Could this tragedy have been avoided?

Keep reading to learn why accurate and timely documentation is so important. Find out what you can do to make sure something like this does not happen to your clients.



WHY IS DOCUMENTATION SO IMPORTANT?

Did you know that in long term care (home health and SNF)... the facility or agency *pays up front* for the care of each client.

- Then, the facility or agency is *reimbursed* for the *specific care* you provide *after* the care has already been provided and documented.

This is different from hospitals which are paid a single payment for each episode of care, regardless of how much care you provide.

- *So who decides how much your workplace will be reimbursed for the care you provide? **YOU DO!***

Every time you provide care for your client, the activity is **“scored”** according to the amount of intervention your client needs.

For example:

Activity	Scoring Criteria	Score
Bathing	Requires no assistance	0
	Requires stand-by assistance	2
	Requires full assistance	3
	Requires full assistance-two caregivers	4

The documentation you provide is reviewed and scored (as above) and sent to Medicare/Medicaid for reimbursement.

The total score determines the clients **“Assistance Level”** and also determines how much the company will be reimbursed for the care of that client.

The more **thorough** your documentation, the easier it will be for the nurse to score the assistance level of your client.

It’s important to note that payment will be made based on the **daily abilities of the client**. This means payments are based on estimates of the actual staff time it should take to perform the care required by your client.

- Daily abilities are usually assessed over a period of a few days. So, if your client ambulates unassisted one day, but needs help the next—you should report **exactly** what happens each day. The care will be reimbursed based on the *highest* level of care needed during the period.

Please Note: If you are providing care for clients without documenting thoroughly and carefully—your employer may not get reimbursed for your work.

In contrast, if you are documenting care that you did not perform, your employer may not get reimbursed, and **WILL POSSIBLY** be fined for the false records.

Both situations result in a financial loss. And, a loss for your employer is a loss for you, your clients and your co-workers!

So, this is why it is very important for you to always document:

- **Thoroughly,**
- **Accurately, and**
- **In a timely manner!**



WHAT'S NEW?

Grab your favorite highlighter! As you read through this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your supervisor and co-workers!



WHAT DO YOU DOCUMENT?

Whether you write it down or tell someone, your report should include:

Observations

- Observations are the facts and events that you notice as you go about your daily work. (See page three for more about making observations.)

Daily Measurements

- You may be ordered to record your client's:
 - Vital signs
 - Weight
 - Intake and Output
 - Blood sugar level

Safety Issues

- This includes measures you took to ensure a client's safety and any concerns you have about possible safety hazards in the client's environment.

Client Statements & Complaints

- Document—in their *exact* words—any pertinent statements your clients make about how they are feeling. This may include statements about pain, appetite or emotions.
- Be sure to report complaints. (Again, use the client's *exact* words.) Complaints help your workplace improve client care and/or find new ways to meet a client's needs.

Unusual Events

- Report anything out of the ordinary that happens while you are with a client. For example, be sure to document if a client refuses care or if the heat in the client's room doesn't work. (Notify your supervisor as soon as possible, too.)



Your workplace should have a list of “approved abbreviations” you are permitted to use in your documentation.

If you have not seen this list, ask your supervisor for it, today! Using unapproved abbreviations can be dangerous, confusing and a big time waster!

For example, these two abbreviations were found in actual medical records. Can you figure out what they mean?

1. **THBNCS** yesterday.
2. Patient may get up **AFAWG**.

ANSWERS: 1. There have been no get up As Far As Wire Goes. changes since yesterday. 2. Patient may

FUNNY QUOTES FROM REAL MEDICAL RECORDS!



MD orders:

“Walk patient in hell,” and
“Patient may shower with nurse.”

MAKING OBSERVATIONS

- When you observe your clients, you take note of *facts* and *events*. Observations may be *subjective* or *objective*.
 - If a client *tells* you something, it is subjective information and should be written inside quotation marks. (For example, Mrs. Smith states, “*I feel like I’m getting a cold.*”)
 - Objective observations include things you can see, hear, smell and feel.

WITH YOUR EYES, YOU CAN SEE A CLIENT’S:

- Daily activities such as eating, drinking, ambulating, dressing and toileting.
- Body posture.
- Skin color, bruising or swelling.
- Breathing pattern.
- Bowel movement (including the color, amount and consistency).
- Urine (including color, amount and frequency).
- Facial expressions (such as smiling, frowning, grimacing or crying).

WITH YOUR EARS, YOU CAN HEAR A CLIENT’S:

- Raspy breathing.
- Crying or moaning.
- Coughing.
- Blood pressure.
- Sneezing.

WITH YOUR NOSE, YOU CAN SMELL A CLIENT’S:

- Breath.
- Urine.
- Body odor.
- Bowel movement.
- Environment (such as an unusual chemical odor or gas leak).
- Vomit.

WITH YOUR FINGERS, YOU CAN FEEL A CLIENT’S:

- Skin temperature.
- Skin texture.
- Pulse.

REMEMBER: Making observations involves using four senses: **sight, hearing, smell and touch.** State **objective** observations as facts and write **subjective** observations as statements in quotation marks.



Years ago, charting about clients consisted of short (and rather meaningless) observations such as: “*The patient ate well.*” or “*The patient slept well.*”

No one expected to read anything of importance in notes written by nurses or nursing assistants.

In the 1800’s, Florence Nightingale began to develop theories about nursing documentation and it began to take on more meaning.

More than 100 years later nurses began to develop their own documentation systems based on *nursing diagnoses*.

- **Today, nurses, doctors, therapists and insurance companies rely heavily on documentation you provide to make important decisions about your client!**

FUNNY QUOTES FROM REAL MEDICAL RECORDS!



“*On the second day the knee was better and on the third day it had completely disappeared.*”

THE RULES OF GOOD DOCUMENTATION

RULE #1: MAKE IT COMPLETE!

Complete documentation is thorough and follows your workplace policies. *In general, your documentation will be **complete** if you include:*

- The correct date and time.
- The client's correct name.
- The tasks you perform with each client and how the client responds to your care.
- Any changes you notice in a client's condition.
- Any care that was refused by the client.
- Any phone calls or oral reports you made about the client to a supervisor. (Include the supervisor's name.)
- Your signature and job title.
- Note: Check with your supervisor about how to complete the specific forms used in your workplace.

RULE # 2: KEEP IT CONSISTENT!

Documentation is consistent when it remains true to:

- The client's care plan.
- Physician and nursing orders.
- The observations that your coworkers have made about the same client.
- Your workplace policies.

*Your documentation will be **consistent** if you:*

- Use workplace-approved medical terms and abbreviations.
- Perform your care according to each client's care plan. If you are unable to follow the care plan on a particular day, document the reason why.
- Tell your supervisor right away if you notice changes in a client's condition so that your observations can be shared with other members of the health care team. This keeps your coworkers from documenting incorrect information. For example, you take your client's BP and it's suddenly very high. If you don't inform the nurse, she may document that the client's vital signs are normal. This can cause confusion and have a negative effect on client care.
- If you make home health visits, be sure your documentation matches the visit frequency ordered by the physician.



TALK about it!

Open the Discussion

Daytime television bombards us with ads from lawyers offering free consultations to look over medical records for errors. This has led to an increase in lawsuits and medical malpractice claims.

These claims are expensive and drive up healthcare costs for EVERYONE!

- Personal access to medical records is a right that cannot be denied.
- Should commercials for lawyers who file malpractice claims be regulated? What about their rights?
- What would you do if you or a loved one suffered an illness or injury as a result of a documentation error?

Share your thoughts with your co-workers and find out how they would solve the problem.

FUNNY QUOTES FROM REAL MEDICAL RECORDS!



"She has had no rigors or shaking chills, but her husband states she was very hot in bed last night."

THE RULES OF GOOD DOCUMENTATION - *continued*

RULE #3: KEEP IT LEGIBLE

Remember, the purpose of documentation is to communicate with other members of the health care team. *(If you are the only person who can read your handwriting, your documentation won't communicate anything to anybody!)*

- Use a black or blue ballpoint pen. (The ink from felt tip pens tends to "bleed".)
- Watch your handwriting . . . messy documentation could come back to haunt you in a lawsuit.
- Print with block letters. Cursive handwriting tends to be hard to read and should not be used in a medical chart.

Flow sheets are often used as a quick way to document vital signs, weights and other tasks. If you use flow sheets, make sure they are legible. Here are a couple of tips:

- Fill out the flow sheet properly. For example, do you circle numbers or words on the flow sheet? Or, are you supposed to make marks like X's or checkmarks?
- Don't try to cram long narrative documentation onto a flow sheet.

RULE #4: MAKE IT ACCURATE

Documentation is accurate when it is true. Your documentation will be **accurate** if you:

- Use appropriate medical terms and abbreviations that have been approved by your workplace.
- Use correct spelling and proper English.
- Double check that you've written down the correct client name (and ID number, if required).
- Handle errors correctly. (See page 10.)
- Record only the facts...*not* your opinions about those facts. For example, if your client seems dizzy and confused, don't write what you *guess* to be true, like "*Client acts like she's on drugs*". Instead, stick to the facts, like "*Client is unable to stand up without assistance and called me by her mother's name several times*".
- Record what a client tells you by quoting his exact words. For example: If your client says, "*I want my daughter to visit*", don't put what he said in your own words such as "*client misses his daughter*". That's not really what he said!



CONNECT It Now!

Apply what you know

THE ART OF ORAL REPORTS

If you are not comfortable giving oral reports . . . here's your chance to practice!

- **Prepare a "shift report" about a client you cared for today. Be sure to include any changes in condition, ongoing orders, new orders, incidents, and any events for which the next shift will need to be prepared.**

In addition to shift reports, you are required to report orally to the nurse in certain circumstances.

- **Make a list of at least 10 situations that require an immediate oral report in addition to your normal documentation.**

Share your shift report and your list of ten situations with your supervisor for feedback!

FUNNY QUOTES FROM REAL MEDICAL RECORDS!



"She slipped on the ice and apparently her legs went in separate directions in early December."

THE RULES OF GOOD DOCUMENTATION - *continued*

RULE #5: FINISH ON TIME!

Documenting on time means writing information down as it happens and turning in your paperwork when it is due. Your documentation will be **on time** if you:

- Write information down immediately. For example, if you take a client's vital signs, document them right away. Don't wait until you finish your care and leave the room. The longer you wait, the more likely you are to forget some of the details.
- Be sure you make note of exact times on your documentation. Don't guess at the time or put a general time frame like "Day Shift".
- Note the time of your arrival and your departure from each client's home (if you make home health visits).
- Use the proper time format according to your workplace policy. For example, some health care organizations use a twelve hour clock, noting whether it's AM or PM. Others use a twenty-four hour clock—also called military time. Using military time, 6:00PM is written as 1800.
- Most home health aides are required to document their care on visit notes. If you care for clients in their homes, be sure to complete your visit notes at the time of each home visit. Don't wait until the end of the day to fill out visit notes on all your clients. Be sure to meet the deadlines for turning in your visit notes at the office. (Remember: completing visit notes on time helps you and your workplace get paid!)



THINK about it!

HOW DO YOU HANDLE ERRORS?

1. **What would you do if you left out important information in your client's chart?** For example, while driving home from work, you suddenly recall something your completely forgot to chart!
2. **How do you correct a mistake?** For example, you charted your client's output as 2700mL instead of 270mL.
3. **What should you do if you notice someone else made a mistake in the chart?** For example, you notice the nurse documented that the client was NPO when the client was not.

Share your answers with your co-workers and find out how they would solve the problem.

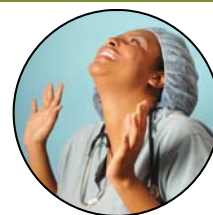
If you can't answer these questions, ask your supervisor for your official workplace policy on handling errors.

WHO CARES ABOUT YOUR DOCUMENTATION?

Your documentation may be read by a number of different people, including:

- Your coworkers and supervisors
- State and/or Joint Commission surveyors
- Researchers
- Quality improvement personnel
- Medicare and insurance company reviewers
- Lawyers and judges

FUNNY QUOTES FROM REAL MEDICAL RECORDS!



"The patient's past medical history has been remarkably insignificant with only a 40 pound weight gain in the past three days."

DOCUMENTATION IN DIFFERENT CLINICAL SETTINGS

ACUTE CARE:

- **Care plans** or **critical pathways** (used to outline the client's needs).
- **The Kardex** (used to chart activities, treatments and medications).
- **Progress notes** (for documenting changes in the client's condition).
- **Flow sheets** or **graphic forms** (for tracking vital signs and weights).

Special Tips For Acute Care Documentation:

- Patients in acute care settings tend to be quite sick. If you are ordered to document vital signs every four hours, it's important to take the vitals—and document the results—on time.
- Remember that sick patients can become sicker in a matter of minutes. And, as they get better, they can be discharged on short notice. It's very important to complete documentation on time.

HOME HEALTH CARE:

- **Plan of care** (may be known as a "486" which is a special Medicare/Medicaid care plan).
- **Home health aide care plan** (outline the assignment for each client).
- **Daily** or **weekly visit note** (for documenting care at each visit).

Special Tips For Home Health Documentation:

- Home health clients on Medicare must be homebound—and must need help with bathing—to receive the services of a home health aide. Your documentation should show that your client meets these requirements. However, if your client has already bathed when you arrive, document the reason and tell your supervisor right away.
- Take extra care to keep your documentation confidential—especially in the client's home (where friends or neighbors might see it) and in your car.

LONG TERM CARE:

- **Minimum Data Set or MDS** (used to evaluate the needs of clients).
- **ADL checklists** or **flow sheets** (tracks daily care given to each client).

Special Tips For LTC Documentation:

- Some LTC residents may need skilled care (which requires *more frequent* documentation). Others receive a lower level of care (which requires *less frequent* documentation).
- A resident's condition may change slowly over time. Always observe and document even slight physical and mental changes.
- Most LTC facilities are required to keep a record of visits and phone calls from family or friends. (The facility may even face a fine if it doesn't comply!) You may be asked to help keep track of your client's visitors and calls.



THE NEXT STEP!

WRITING AN INCIDENT REPORT

An incident is an unexpected event that often involves an accident or an injury. The injured person may be an employee, a family member, a client or yourself.

An incident report should include:

- The date and time of the incident.
- The mental and physical condition of the person involved.
- The result of the incident (scratch, broken bone, back injury).
- Actions taken to help the person involved.
- Suggestions for change so the incident does not occur again.

Only include the facts in an incident report. For example, if Mr. H. reports being hit by Mr. G., but you did not see it happen . . . you would not report "Mr. G. hit Mr. H." You would report "Mr. G. reported being hit by another client."

FUNNY QUOTES FROM REAL MEDICAL RECORDS!



"Bleeding started in the rectal area and continued all the way to Los Angeles."

LEGAL ISSUES

Poor documentation can cause a number of legal problems—especially if a client’s chart ends up in the hands of a lawyer.

- It may look like you gave *poor care*. For example, let’s say you remember turning your client every two hours as ordered, but you didn’t write it down *every time*. A lawyer might say that it’s *your fault* the client developed an infected bed sore.
- It may also look like you neglected specific orders. For example, if you are ordered to take a client’s pulse, but you forgot to write it down, you could be accused of neglecting an order and causing harm to the client.

Poor documentation can cause your workplace to be denied payment for the services you provided to your clients.

- For example, let’s say you made a home health visit but failed to turn in your visit note. Your workplace could be accused of fraud—even though you made the visit!

Regulations regarding how to properly document client care come from:

- State Boards of Nursing
- The American Nurses Association
- Joint Commission
- CMS (Medicare and Medicaid)
- Workplace policies and procedures.

A WORD ABOUT FALSE DOCUMENTATION

Medical records are legal documents intended as a means to communicate between caregivers. When records are false, great harm and even death may come to the client.

In addition, including false information in a medical record is grounds for a malpractice claim which could cost you and your employer countless hours and a lot of money to defend.

Examples of false documentation include:

- **Charting before you provide care.** *If you get busy and never perform the care you charted . . . you falsely documented it.*
- **Charting that you provided care that you did not do.**
- **Copycat charting.** *This is charting what the previous shift charted without actually assessing the client or performing the care on the client.*



5 KEY POINTS

1. Documentation is not just pointless busy work. It is a **legal representation of the care your client receives.**
2. Documentation should include both **objective** and **subjective** observations you make about the client and the environment while providing care.
3. Always strive to make your documentation **complete, accurate, legible, consistent** and **on time!**
4. Poor or inaccurate documentation can not only result in legal and *financial trouble* for your employer—but it can result in *harm or death* of a client and cost you *your job*.
5. Be sure to document EVERYTHING you do—even if you also gave an oral report . . . because, ***if it isn’t documented—it didn’t happen!***

FUNNY QUOTES FROM REAL MEDICAL RECORDS!



“She stated that she had been constipated for most of her life until 1989 when she got a divorce.”

HOW TO HANDLE ERRORS

- If you left out important information, call your supervisor as soon as possible. Follow your workplace policy for charting late information.
- Never correct someone else's charting error. Instead, tell that person that you noticed a mistake in their documentation.
- Never try to *erase* an error in your documentation. Using "White-Out" is also against the rules.
- Follow your workplace policy for correcting an error in your charting. Usually, this involves drawing one line through the error and initialing it. Write "*mistaken entry*" and your initials next to it. (Note: Documenting "*mistaken entry*" is better than writing "error" since someone might think you made an error in *care*—not just in documentation.)

Making up your own abbreviations can lead to serious errors. For example, these two abbreviations were found in actual medical records. Can you figure out what they mean?

1. **THBNCS** yesterday.
2. The client drank 6 ounces **PWISOTF**.

1. *There have been no changes since yesterday.* 2. *The client drank 6 ounces plus what I spilled on the floor.*

REPORTING CLIENT CARE

- You may be responsible for giving an oral report about a client to your coworkers. This report may be one-on-one with another person or in a group setting such as a team meeting or client care conference.
- Some health care organizations use tape recorders or voice mail systems for reporting client care.
- Oral reports should be given in a professional manner according to your workplace policy. For example, it's not appropriate to tell your supervisor about a client's problem while she's on the phone or is dashing off to eat lunch. She might forget what you told her—and client care could suffer.



You've probably heard this old saying:

**If you didn't write it down,
you didn't do it!**

This is especially true for health care workers. When medical records are reviewed—by supervisors, surveyors and/or attorneys—the only information that counts is what is written in the chart. It's too late to say, "*Oh, I forgot to write that down...but I did it!*" The only acceptable proof that you performed your client care as ordered is to document it as it is done. Oral reports are not a substitute for writing information down.

FINAL DO'S AND DON'TS OF DOCUMENTATION

DO THIS:

- Stick to the facts—because facts speak for themselves. (No one can argue with the facts, but they *can* argue with your opinions!)
- Remain brief and to the point. You don't need to write a "book" about your clients!
- Be specific! For example, it's not very helpful to write "*client ate well*". Writing something like "*client ate 75% of lunch tray*" is much better.
- Avoid documenting the same information about a client day after day. Observe each client carefully and document even small changes.
- If you document directly in your clients' charts, make sure you have the right one before you begin to write!
- Include each client's full name in your documentation since there may be two clients with the same last name.
- If you document a change in a client's condition, be sure to write what you did about it. For example, if you document "*Mr. Johnson gained 4 pounds since yesterday*", you should also document that you notified your supervisor. You might write "*Called Jane Doe, RN about weight gain. She said she will talk to doctor.*"



DON'T DO THIS:

- Criticize the care given by any of your coworkers. Avoid writing about workplace problems like staffing shortages, too.
- Chart for someone else or write down what someone else tells you about a client.
- Document a task that you did not do!
- Write with a pencil...always use ink.
- Use two different colors of ink for the same entry. Someone might think you came back later to correct your initial charting.
- Use language that sounds like you have negative feelings about a client. For example, instead of writing "*client is drunk*", stick to the facts by writing "*client's breath smells of alcohol and he is slurring his words*".
- Remove pages from a client's medical record. Each page is a permanent, legal document.
 - Mention the name of one client in another client's chart.
 - Document your client care ahead of time—even if it never seems to change from day to day.



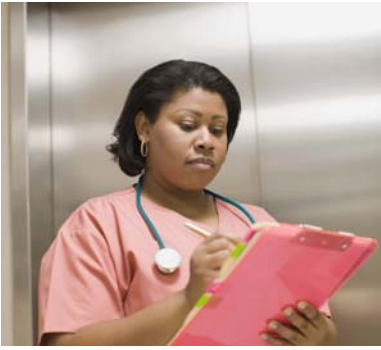
WHAT I KNOW NOW!

Now that you've read this inservice on documenting client care, take a moment to jot down a couple of things you learned that you didn't know before.

FUNNY QUOTES FROM REAL MEDICAL RECORDS!



"The patient had waffles for breakfast and anorexia for lunch."



Developing Top-Notch CNAs, One Inservice at a Time

A Communication Skills Module:

Reporting & Documenting Client Care

Are you "In the Know" about reporting and documenting client care? Circle the best choice. Then check your answers with your supervisor!

EMPLOYEE NAME
(Please print):

DATE: _____

- ***I understand the information presented in this inservice.***
- ***I have completed this inservice and answered at least eight of the test questions correctly.***

EMPLOYEE SIGNATURE:

SUPERVISOR SIGNATURE:

Inservice Credit:

<input type="checkbox"/> Self Study	1 hour
<input type="checkbox"/> Group Study	1 hour

File completed test in employee's personnel file.

1. True or False

It's best to perform all your care on all your clients first, then sit down to document everything all at once.

2. True or False

You can use any abbreviation you like as long as it is neatly written.

3. True or False

If your client refuses care, you should not document anything in the chart.

4. True or False

After making an oral report, you should document the name and title of the person you reported to (if documentation is part of your job description).

5. Your client tells you, "I'm sick of living in pain like this," you should report:

- A. "Client is suicidal."
- B. "Client needs pain medication but the nurse is not available."
- C. "Client reports, 'I'm sick of living in pain like this.'"
- D. "Client reports feeling sick from all the pain."

6. True or False

If you accidentally chart on the wrong client, you should use "white-out" to cover the documentation, then immediately chart in the right chart.

7. True or False

An example of an objective observation is: "Temp. 99.6, pulse 74, resp. 16."

8. True or False

Keeping documentation confidential in a Home Health setting is not as important as other settings because most people in the home are family or friends.

9. True or False

It is never okay to document care before you give it, even if you do the same thing every day.

10. Fill in the Blanks

A report that describes and unexpected event that involves an accident or injury is called an _____ report.