Essential Communication

What (to report), **When** (to report) **and Who** (to report to)

In 2016 a study was done that looked at malpractice and medical errors. The study reviewed 7,000 cases of which **1,744 patients died due to communication failures**. In another study, more then 25% of hospital readmission occur due to lack of communication. Communication affects every aspect of healthcare. These failures are not just linked to **patient safety**, but also include **patient satisfaction**, **harm to healthcare workers** and **management of resources**.

Home health aides spend more time with home clients than any other member of the home health care team. That is why they are the eyes and ears of the team and why is it so important for home health aides to observe and **report** changes in the client's condition or abilities.

There are **5 methods of observation techniques** that a home health aide must practice every day.

1. **Sight** – Think about what you see and what it means. Is it new or unusual?
2. H**earing** – Listen to a sound and try to understand what it means. Do you hear a new cough or wheeze? Some changes like pain, nausea, dizziness, tingling, or numbness can only be felt and described by the client. LISTEN to what your client says.
3. **Questions** such as
   - Where is your pain?
   - How long have you had pain?
   - How long does it last? Is it constant?
   - What does it feel like? Is it sharp or dull?
   - Have you taken any pain medications? Did it help?
4. **Smell** – The odor of a wound or the way a clients breath smell.
5. **Touch** – Skin that feels hot, clammy, or cold, dry, or wet.

WHAT to report:

- Any change in condition that affects the client's ability to communicate such as not being able to speech or slurring words.
- Any changes in the client's ability to ambulate (ability to walk)
- Changes in temperature, pulse, or respirations.
    a. To take a pulse, put 3 fingers over the inside of the wrist, below the thumb, and count for 60 seconds. In an adult, if the pulse is less than 60 beats per minute or greater than 100 beats per minute, it should be reported.
    b. To take a patient's respiratory rate, watch the inhale and exhale by watching the chest raise and fall or placing your hand on the lower part of the rib cage. Respiration less than 10 per minutes or greater than 18 (resting) should be reported.
    c. A temperature may be taken with a digital thermometer or a manual thermometer by placing it under the tongue and waiting a minute. An ear thermometer or forehead thermometer may also be used. If the temperature is less then 97.5 or more than 100, you should recheck it. If taking a temperature orally, make sure the client has not had anything cold or hot to eat or drink for at least 5 minutes.

- Changes in a patient's/client's color
    a. Blue or grayish lips, nail beds can be indicative of lack of oxygen.
    b. Flushed or ruddy color can be signed of a fever or infection.
    c. Pale skin can be signs of poor circulation or anemia.
- Changes in output
    a. Urine
        i. Increased need to urinate (can be symptom of a urinary tract infection). Decrease in urine can mean the client may be dehydrated or have an infection.
        ii. Change in color of urine.
        iii. Red, brown, orangish, or very light yellow
        iv. Changes in smell, a strong smell can indicate dehydration or maybe an infection.
    b. Bowel movements.
        i. Changes in frequency. If a client has **not had a BM for 3 days**, that must be reported. The longer a person does not have a BM, the higher the likelihood of a bowel obstruction.
        ii. Changes in consistency i.e., runny (could be an infection like C-Diff) hard (could be signs of dehydration)
        iii. Changes in color, dark or tarry could indicate bleeding, yellow or light tannish could be indicative of liver problems.
- New skin or wound breakdown
    a. Skin tears, blisters, rashes, open areas, reddened areas, scabs, drainage from existing wounds, boils, sores, abrasions, bleeding, bruising, swelling or any changes in a current wound such as an increase in size.
    b. Reddened area's feeling hot or cold.
- Changes in the ability to rate pain.
- Signs of pain such as grimacing, moaning or guarding.
- Changes in ability to move arms or legs.
    a. Decrease in range of motion.
    b. Pain when moving arms or legs or turning head.
- **ANY seizure** activity
- Changes in mental status such as crying, confusion, memory loss.
- Shaking, trembling.
- Complaints of numbness or tingling.
- Changes in hearing or vision.
- Changes in eating patterns or fluid intact.
- Difficulty swallowing.
- Combative or violent behavior. Increase agitation.
- Decreased ability to perform or help perform ADLs.
- Accidents or injuries (such as falls).
- If your client or family notifies you that the client is going to the hospital.
- Any signs or symptoms of abuse (REMEMBER, these do not necessarily mean abuse has happened)
    a. Physical (bruising, reddened areas around wrist, dried BM, weight loss)
    b. Mental (crying, withdrawn, fearful)
    c. Financial (money or things missing)
    d. Sexual (withdrawn, guarding peri area, bleeding from vaginal or rectal areas)

WHEN to report:

Always report **as soon as you can!** Of course, you never should leave the client in an unsafe position to call in a report (like if the patient is in the shower), but soon as the client is in a safe place, then do the report. Remember to do the report in person over the phone. DO NOT put the report in your written chart only. Make sure it is verbally reported.

WHO to report to:

You should always try to call the RN case manager. When you get oriented to the client, if you are not told who the RN case manager is, then ask! However, at times, that RN case manager may be with other clients, so it is perfectly OK to call the office and ask for nursing. DO NOT report a patient's condition to scheduling, HR, the receptionist or anyone other than nursing. When the office is closed, there is a nurse that is on call 7 days a week.

Guidelines for Reporting Observations:

1. When in doubt, always report observations to your nursing supervisor (Director of Nursing) or RN Case manager.
2. Do not make judgements or try to diagnose.
3. NEVER call the client's physician or any state or federal agency. You are to report to the client's nurse or the nursing supervisor or the on-call nurse and they will determine if the physician or any other agencies need to be notified.
4. Always think things over before you call to report, give your name, the name of the client, any abnormal signs, symptoms and how long the client has had the problem.
5. If it is an emergency (for example your client fainted, or is unresponsive or cannot breathe) call 911, stay with the client and call us after EMS gets there. Know your clients "code status".