Essential Communication – Incident and Complaint Reporting

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

Home health aides spend more time with our patints 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 or any concerns or complaints the patient may have.

Incident Reporting…

There are **5 methods of observation** 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. **Hearing** – 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 patient. 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 the patient's urine or the way a client's breath smells
5. **Touch** – Skin that feels hot, clammy, cold, dry or wet

WHAT to report:

1. Any change in condition that affects the patient's ability to communicate such as not being able to speak or slurring words
2. Any changes in the patient's ability to ambulate (ability to walk)
3. 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 rise and fall or placing your hand on the lower part of the rib cage. Respirations less than 10 per minute 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.
4. Changes in a patient's color
   A. Blue or grayish lips and/or nail beds can be indicative of lack of oxygen
   B. Flushed or ruddy color can be sign of a fever or infection
   C. Pale skin can be signs of poor circulation or anemia
5. Changes in output
   A. Urine

1. Increased need to urinate can be symptom of a urinary tract infection. Decrease in urine can mean the patient may be dehydrated or have a kidney infection.
2. Change in color of urine
    a. Red, brown, orangish, or very light yellow
3. Changes in smell; a strong smell can indicate dehydration or maybe an infection

B. Bowel movements
1. Changes in frequency. If a patient 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.
2. Changes in consistency i.e., runny (could be an infection like C-Diff) hard (could be signs of dehydration)
3. Changes in color, dark, or tarry could indicate bleeding, yellow, or light tannish could be indicative of liver problems.

6. 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 areas feeling hot or cold
7. Changes in the ability to rate pain
8. Signs of pain such as grimacing, moaning or guarding
9. Changes in ability to move arms or legs
    A. Decrease in range of motion
    B. Pain when moving arms or legs or turning head
10. **ANY** seizure activity
11. Changes in mental status such as crying, confusion, memory loss
12. Shaking, trembling
13. Complaints of numbness or tingling
14. Changes in hearing or vision
15. Changes in eating patterns or fluid intact
16. Difficulty swallowing
17. Combative or violent behavior. Increase agitation
18. Decreased ability to perform or help perform ADLs
19. Accidents or injuries (such as falls)
20. If your client or family notifies you that the client is going to the hospital
21. 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. Make sure your report is verbally reported. Remember to chart "report issue to office" on your visit note.

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. Always report observations and concerns 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 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 patient's "code status".

If your patient/patient's family has a complaint…

Complaints or dissatisfaction with any of our services are as important to us as a patient's change in condition. Our goal is to have happy and healthy patients and if you hear anything while with a patient, please report it to the nursing supervisor or Administrator immediately so we can resolve the issue. If it is of a sensitive nature or something the patient says they "don't want to get anyone in trouble," it still needs reported. We can absolutely investigate and help any situation without making the patient feel like they got someone in trouble. Please help us ensure good customer service and quality care that our patient's deserve by reporting any complaints to management as soon as you hear them.