4

Communication and Cultural Diversity

1. Define communication

Communication is the process of exchanging information with others. It is a process of sending and receiving messages. People communicate by using signs and symbols, such as words, drawings, and pictures. They also communicate through their behavior.

The simplest form of communication is a three-step process that takes place between two people (Fig. 4-1). In the first step, the sender (the person who communicates first) sends a message. In the second step, the receiver receives the message. The receiver and sender switch roles as they communicate. The third step involves providing feedback. The receiver repeats the message or responds to it to let the sender know that the message was received and understood. Feedback is especially important when working with the elderly. Home health aides (HHAs) must take time to make sure clients understand messages.

All three steps must occur before the communication process is complete. During a conversation, this process is repeated continuously.

Effective communication is a critical part of an HHA's job. A client's health depends on how well an HHA communicates observations and concerns to the supervisor. The HHA will also need to communicate clearly and respectfully in stressful or confusing situations.

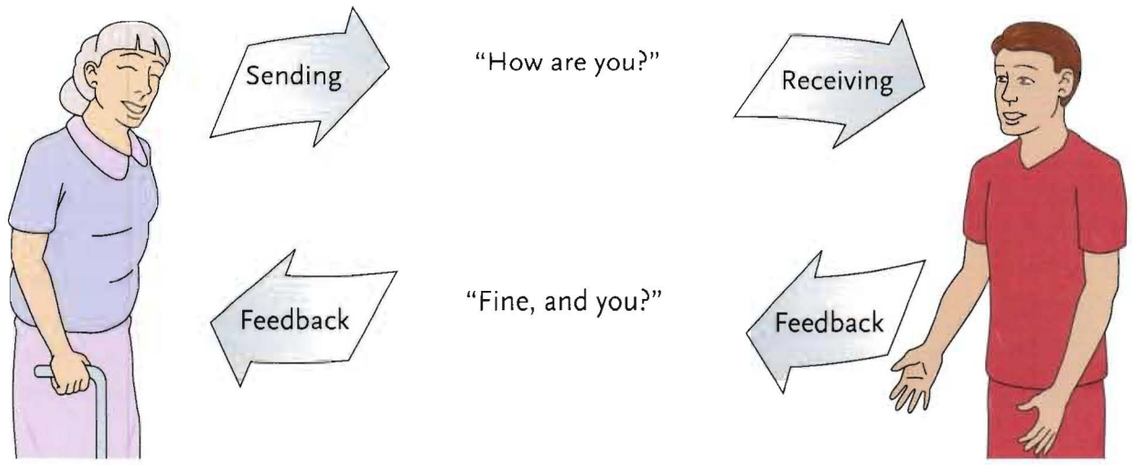

Fig. 4-1. *The communication process consists of sending a message, receiving a message, and providing feedback.*

2. Explain verbal and nonverbal communication

Verbal communication involves the use of words or sounds, spoken or written. Oral reports are an example of verbal communication. **Nonverbal communication** is communicating without using words. Examples include shaking one's head or shrugging one's shoulders. Nonverbal communication also includes how a person says something. For example, an HHA says cheerfully, "I'll be right there, Mr. Dodd." This communicates that the HHA is ready and willing to help. But saying the same phrase in a different tone or emphasizing different words can communicate frustration and annoyance: *"I'll be right there, Mr. Dodd!"*

Body language is another form of nonverbal communication. Body movements, facial expressions, and posture can express different attitudes or emotions. Just as with speaking, body language sends messages. Other people receive them and interpret them. For example, slouching in a chair and sitting up straight send two different messages (Fig. 4-2). Slouching says that a person is bored, tired, or hostile. Sitting up straight says that the person is interested and respectful. Other examples of positive nonverbal communication include smiling, nodding one's head, and looking at the person who is speaking.

Fig. 4-2. *Body language sends messages just as words do. Which of these people seems more interested in their conversation—the person on the right who is looking down with her arms crossed or the person on the left who is sitting up straight and smiling?*

Sometimes people send one message verbally and a very different message nonverbally. Nonverbal communication often illustrates how someone is feeling. This message may be quite different from what he is saying. For example, a client who says, "I'm feeling fine today," but does not want to get out of bed and winces in pain is sending two very different messages. Paying attention to nonverbal communication helps HHAs give better care. In this example, the HHA should communicate to her supervisor that the client is staying in bed and appears to be wincing in pain, despite what he says.

Home health aides must also be aware of their own verbal and nonverbal messages. If an HHA says, "It's nice to see you today, Mrs. Rodriguez," but does not smile or look her in the eye, the client may feel that the HHA is not really happy to see her.

When communication is confusing, the HHA should try to clarify it by asking for an explanation. She can say something like, "Mrs. Jones, you've just told me something that I don't understand. Would you explain it to me?" Or she can state what she has observed and ask if the observation is correct. For example, "Mrs. Jones, I see that you're smiling, but I hear by the sound of your voice that you may be sad. Are you sad?" Taking time to clarify communication can help avoid misunderstandings.

Cultural Sensitivity

Nonverbal communication may depend on personality or cultural background. A **culture** is a system of learned beliefs and behaviors that is practiced by a group of people. Often these beliefs and behaviors are passed on from one generation to the next. Each culture may have different knowledge, behaviors, beliefs, values, attitudes, religions, and customs.

Some people are more animated when they speak. They use lots of gestures and facial expressions. Other people speak quietly or calmly,

regardless of their moods. Depending on their cultural background, people may make motions with their hands when they talk. They may stand close to the person with whom they are speaking or touch the person.

People from some cultural groups stand farther apart when talking than people from other groups. When one person moves closer, the other person may view it as a threat.

The use of touch and eye contact also varies with cultural background and personality (Fig. 4-3). For some people, touching is welcome. It expresses caring and warmth. For others, it seems intrusive, threatening, or even harassing. In the United States, it is common to talk about "looking someone straight in the eye" or speaking "eye to eye." Eye contact is often viewed as a sign of honesty. However, in some cultures, looking someone in the eye may seem overly bold or disrespectful.

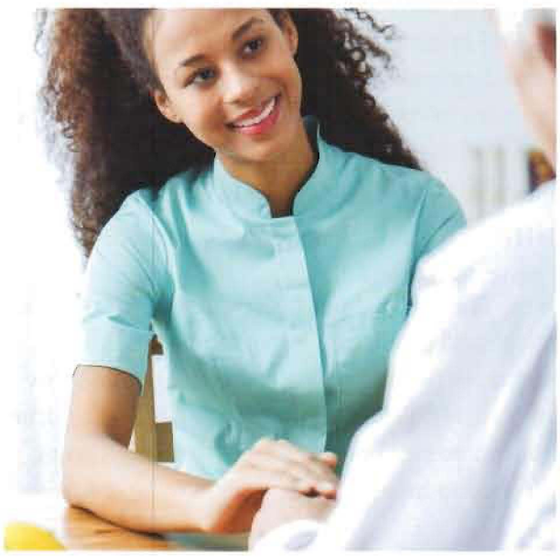

Fig. 4-3. *How a person perceives touch may depend on his cultural background.*

It is important for HHAs to be sensitive to each client's needs. This is key to providing professional, person-centered care. Learning each client's behavior and preferences can be a challenge, but it is an important part of communication. It is especially vital in a multicultural society (a society made up of many cultures), such as the United States. Being aware of all the messages sent and received and listening and observing carefully will help an HHA better understand clients' needs and feelings.

3. Identify barriers to communication

Communication can be blocked or disrupted in many ways (Fig. 4-4). Following are some communication barriers and ways for home health aides to avoid them:

Client does not hear HHA, does not hear correctly, or does not understand. The HHA should stand directly facing the client. He should speak slowly and clearly. He should not shout, whisper, or mumble. The HHA should speak in a low voice, using a pleasant, professional tone. If the client wears a hearing aid, he should check that it is on and is working properly.

Client is difficult to understand. The HHA should be patient and take time to listen. He can ask the client to repeat or explain the message, and then state the message in his own words to make sure he has understood.

HHA, client, or others use words that are not understood. An HHA should not use medical terminology with clients or their families. He should speak in simple, everyday words and ask what a word means if he is not sure.

HHA uses slang or profanity. The HHA should avoid using slang words and expressions. They are unprofessional and may not be understood. He should not use profanity, even if the client does.

HHA uses clichés. **Clichés** (*klee-SHAYS*) are phrases that are used over and over again and do not really mean anything. For example, "Everything will be fine" is a cliché. Instead of using a cliché, the HHA should listen to what the client is really saying and respond with a meaningful message. For example, if a client is afraid of having a bath, the HHA can say, "I understand that

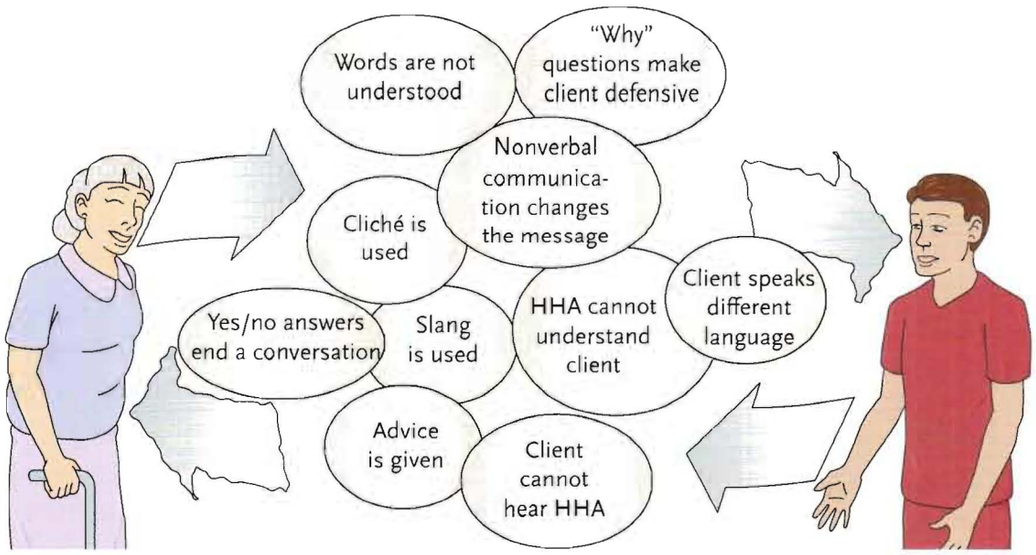

Fig. 4-4. Barriers to communication.

it seems scary to you. What can I do to make you feel more at ease?" instead of saying, "Oh, it'll be over before you know it."

HHA responds with "Why?" The HHA should avoid asking "Why?" when a client makes a statement. "Why" questions make people feel defensive. For example, a client may say she does not want to go for a walk today. If the HHA asks "Why not?" he may receive an angry response. Instead, he can ask, "Are you too tired to take a walk? Is there something else you want to do?" The client may then be willing to discuss the issue.

HHA gives advice. The HHA should not offer his opinion or give advice. Giving medical advice is not within an HHA's scope of practice. It could be dangerous. Giving advice about running the household can seem pushy and intrusive.

HHA asks questions that only require yes/no answers. The HHA should ask open-ended questions that need more than a "yes" or "no" answer. Yes and no answers end conversation. For example, if an HHA wants to know what a client likes to eat, he should not ask, "Do you like vegetables?" Instead, he should ask, "Which vegetables do you like best?"

Client speaks a different language. If a client speaks a different language than the HHA does, the HHA should speak slowly and clearly. He should keep his messages short and simple. He should be alert for words the client understands as well as signs that the client is only pretending to understand. He may need to use pictures or gestures to communicate. The HHA can ask the client's family who speak the client's language for help. He should be patient and calm.

HHA or client uses nonverbal communication. Nonverbal communication can change a message. The HHA should be aware of his body language and gestures. He can look for nonverbal messages from clients and clarify them. For example, "Mr. Feldman, you say you're feeling fine but you seem to be in pain. Is that true? What can I do to help?"

4. List ways to make communication accurate and explain how to develop effective interpersonal relationships

In addition to avoiding the barriers above, using the following techniques will help HHAs send and receive clear, complete messages:

Be a good listener. The HHA should allow the client to express her ideas completely. He should

concentrate on what the client is saying and not interrupt. The HHA should not finish the client's sentences even if he knows what she is going to say. When the client is finished, the HHA should restate the message in his own words to make sure he has understood.

Provide feedback. Active listening means focusing on the person sending the message and giving feedback. Feedback might be an acknowledgment, a question, or repeating the sender's message. The HHA should offer general but leading responses, such as "Oh?" or "Go on," or "Hmm." By doing this, he is actively listening, providing feedback, and encouraging the sender to expand the message.

Bring up topics of concern. If the HHA knows of a topic that might concern a client, he can raise the issue in a general, nonthreatening way. This lets the client decide whether or not to discuss it. For example, if the HHA observes that a client is unusually quiet, he could say, "Mrs. Jones, you seem so quiet today." Or he may notice a certain emotion. He might say, "Mrs. Jones, you seemed upset earlier. Would you like to talk about it?"

Let some pauses happen. Using silence for a few moments at a time encourages the client to gather her thoughts and compose messages.

Tune in to other cultures. The HHA should learn the words and expressions of a client's culture. This shows respect and interest and promotes person-centered care. It will help the HHA to understand the resident more fully. He should be careful about using new words and terms, though, because some may have a different meaning than what he thinks. The focus should be on understanding words and expressions when others use them. The HHA should not be judgmental; he should accept people who are different from him.

Accept a client's religion or lack of religion. Religious differences also affect communication. Religion can be very important in people's lives, particularly when they are ill or dying. Other people are not religious and may feel strongly about that. The HHA should respect clients' religious beliefs, practices, or lack of beliefs, especially if they are different from his own. He should not question clients' beliefs or discuss his beliefs with them.

Understand the importance of touch. Softly patting clients' hands or shoulders or holding their hands may communicate caring. Some people's backgrounds may make them less comfortable being touched. The HHA should ask permission before touching clients and should be sensitive to their feelings. HHAs must touch clients in order to do their jobs. However, they should recognize that some clients feel more comfortable when there is little physical contact. The HHA should learn about his clients and adjust care to their needs.

Ask for more. When clients report symptoms, events, or feelings, the HHA should have them repeat what they have said and ask them for more information.

Make sure communication aids are clean and in proper working order (Fig. 4-5). These include hearing aids, eyeglasses, dentures, and wrist or hand braces. The HHA should inform his supervisor if they do not work properly or are dirty or damaged.

Fig. 4-5. *Eyeglasses must fit well, be clean, and be in good condition. The supervisor should be informed if communication aids are not working properly.*

Developing good relationships with clients, their family members, and the care team will help HHAs provide excellent care. Although an HHA should not try to be friends with clients, she

should try to develop a warm professional relationship with them that is based on trust. In addition to the strategies already discussed, these suggestions can promote effective communication and develop good relationships:

Avoid changing the subject when a client is discussing something. This is true even if the subject makes the HHA feel uncomfortable or helpless. For example, a client might say, "I'm having so much pain today." The HHA should not try to avoid the topic by asking the client if he wants to watch television. This makes the client feel that the HHA is not interested in him or what he is talking about.

Do not ignore a client's request. Ignoring a request is considered negligent behavior. The HHA should honor the request if he can. Otherwise, he can explain why the request cannot be fulfilled. These requests should always be reported to the supervisor.

Do not talk down to an elderly or disabled client or a child. An HHA should talk to clients and their families as he would talk to any person. He can make adjustments if someone is hearing impaired or visually impaired.

Sit or stand near the client who has started a conversation. Sitting or standing near the client shows that the HHA finds what she is saying important and worth listening to (Fig. 4-6).

Fig. 4-6. *Sitting near a person and looking at her while she talks shows that the HHA is interested in the conversation.*

Lean forward in the chair when a client is speaking. Leaning forward communicates interest. The HHA should pay attention to his nonverbal communication. If he folds his arms in front of his body, he sends the negative message that he wishes to distance himself from the speaker.

Talk directly to the client. The HHA should not talk to the client's family members or friends or anyone else while helping clients. He should not gossip about other staff members or clients.

Approach the client. Even if the HHA is in another room, he should approach the client. This tells the client he is interested in what the client has to say.

Be empathetic. The HHA should try to understand and identify with what the client is going through. This is called empathy. He can ask himself how he would feel if he were confined to bed or needed help to go to the bathroom. The HHA should not tell clients he knows how they feel, because he does not know exactly how they feel. He can say things like, "I can imagine this must be difficult for you."

Have time for clients' families and friends. The HHA should not discuss a client's care with friends or family members, but he can listen if they want to talk. The HHA should be respectful and pleasant and give privacy for visits. He should not interfere with private family business.

5. Describe the difference between facts and opinions

A fact is something that is definitely true. "Mr. Garcia lost four pounds this month," for example, is a fact. This fact has evidence to back it up: weighing Mr. Garcia and comparing his current weight to his weight last month. An opinion is something someone believes to be true, but is not definitely true or cannot be proven. "Mr. Garcia looks thinner," is an opinion. So is "Mr. Garcia has lost weight because he doesn't like

what I cook." These statements might be true, but they cannot be backed up with evidence. It is important to be able to separate facts from opinions.

Separating facts from opinions promotes better communication. When a person gives an opinion, he risks being wrong. If an HHA says, "Mrs. Myers, drinking coffee is going to keep you awake tonight," he may make his client mad. He might also be wrong. Perhaps Mrs. Myers always drinks coffee, and it does not affect her sleep. Or maybe she does not sleep well because of medication, not because of the coffee.

Using facts instead of opinions is a more professional and effective way to communicate. "Mrs. Myers, many people find that the caffeine (*kaf-EEN*) in coffee keeps them awake at night. Would you like to try skipping your coffee today to see if you might sleep better?" Now Mrs. Myers has no reason to get mad. The HHA is not wrong because it is a fact that caffeine keeps many people awake.

When communicating with the care team, distinguishing between facts and opinions is important. For example, "Mr. Morgan is acting like he had a stroke" is an opinion and could very well be wrong. Instead, the HHA should report the facts: "Mr. Morgan has lost strength on his right side and his speech is slurred." When reporting opinions, the HHA can introduce them with, "I think...". Then it is clear that he is offering his opinion and not a fact he has observed.

6. Describe basic medical terminology and approved abbreviations

Throughout an HHA's training, he will learn medical terms for specific conditions. For example, the medical term for a runny nose is nasal discharge; skin that is blue or gray is called **cyanotic** (*sye-a-NOT-ik*).

Medical terms are made up of roots, prefixes, and suffixes. A root is a part of a word that contains its basic meaning or definition. The prefix is the word part that precedes the root to help form a new word. The suffix is the word part added to the end of a root that helps form a new word. Prefixes and suffixes are called *affixes* because they are attached, or affixed, to a root. Here are some examples:

- The root *derm* or *derma* means skin. The suffix *itis* means inflammation. Dermatitis is an inflammation of the skin.
- The prefix *brady* means slow. The root *cardia* means heart. Bradycardia is slow heartbeat or pulse.
- The suffix *pathy* means disease. The root *neuro* means of the nerve or nervous system. Neuropathy is a nerve disease or disease of the nervous system.

When speaking with clients and their families, HHAs should use simple, nonmedical terms. Medical terms should not be used because they may not be understood. But when speaking with the care team, using medical terminology will help give more complete information.

Abbreviations are another way to communicate more efficiently with other caregivers. For example, the abbreviation *prn* means *as necessary*. Home health aides should learn the standard medical abbreviations their agency uses. They can use them to report information briefly and accurately. They may also need to know these abbreviations in order to read client assignments or care plans.

A brief list of abbreviations follows, and more are located in the instructor's guide. There may be other terms in use at an agency, so it is important for HHAs to follow agency policy.

Common Abbreviations

a̅	before
abd	abdomen
ac, a.c.	before meals
ad lib	as desired

ADLs	activities of daily living
amb	ambulate, ambulatory
b.i.d., bid	two times a day
BM	bowel movement
BP, B/P	blood pressure
c̄	with
C	Celsius
c/o	complains of
CHF	congestive heart failure
CPR	cardiopulmonary resuscitation
DNR	do not resuscitate
DX, dx	diagnosis
F	Fahrenheit
FBS	fasting blood sugar
f/u, F/U	follow-up
FWB	full weight-bearing
GI	gastrointestinal
H_2O	water
h, hr, hr.	hour
hs, HS	hours of sleep
inc	incontinent
I&O	intake and output
mL	milliliter
NKDA	no known drug allergies
NPO	nothing by mouth
NWB	non-weight-bearing
O_2	oxygen
OOB	out of bed
p̄	after
pc, p.c.	after meals
PO	by mouth
prn, PRN	as necessary
PWB	partial weight-bearing
q̄	every
ROM	range of motion
s̄	without
SOB	shortness of breath
stat, STAT	at once, immediately
t.i.d., tid	three times a day
TPR	temperature, pulse, respiration
vs, VS	vital signs
w/c, W/C	wheelchair

7. Explain how to give and receive an accurate oral report of a client's status

Home health aides must make brief and accurate oral and written reports to clients and staff. Careful observations are used to make these reports and are very important to the health and well-being of all clients. Signs and symptoms that should be reported will be discussed throughout this textbook. In addition, anything that endangers clients should be reported immediately, including the following:

- Falls
- Chest pain
- Severe headache
- Difficulty breathing
- Abnormal pulse, respiration, or blood pressure (Chapter 14)
- Change in mental status
- Sudden weakness or loss of mobility
- Fever
- Loss of consciousness
- Change in level of consciousness
- Bleeding
- Swelling of a body part
- Change in client's condition
- Bruises, abrasions, or other possible signs of abuse (Chapter 3)

Home health aides use oral reports to discuss experiences with clients or family members and observations of clients' conditions. Facts, not opinions, should be used for oral reports. It is a good idea for HHAs to write notes so that important details are not forgotten. Following an oral report, HHAs must document when, why, about what, and to whom an oral report was given. Documentation should always occur after the report is given, not before.

Sometimes a supervisor or another member of the care team will give a brief oral report on a client. The HHA should listen carefully and take

notes (Fig. 4-7). She should ask about anything that she does not understand. At the end of the report, the HHA can restate what she has been told to make sure she understands. An oral report from another home health aide who knows the client can be very helpful as well.

Fig. 4-7. *Taking notes helps home health aides remember facts and report accurately.*

Misunderstandings can occur when giving or receiving oral reports. If an oral report seems to require a change in the assignment sheet, the HHA should request that the change be made.

When making reports about clients, HHAs must remember that all client information is confidential. Information should only be shared with members of the care team.

8. Explain objective and subjective information and describe how to observe and report accurately

When making any kind of report, the right kind of information must be collected before documenting it. Facts, not opinions, are most useful to the supervisor and the care team. Two kinds of factual information are needed in reporting. **Objective information** is based on what a person sees, hears, touches, or smells. Objective information is collected by using the senses. It is also called *signs*. **Subjective information** is something a person cannot or did not observe. It is based on something that the client reported that may or may not be true. It is also called *symptoms*.

An example of objective information is "The client is holding his head and rubbing his temples." A subjective report of the same situation might be "Client says he has a headache." The supervisor and the care team need factual information in order to make decisions about care and treatment. Both objective and subjective reports are valuable.

The information reported should also be **pertinent** (*PER-ti-nent*). Pertinent means significant or useful. For example, "Mrs. Lee had rice for lunch" is factual information. However, it may not be pertinent unless carbohydrates are restricted in her diet. "Mrs. Lee refused to eat lunch" is objective and pertinent information.

In any report, what is observed (signs) and what the client reports (symptoms) need to be clearly noted. "Ms. Scott reports pain in left shoulder" is an example of clear reporting. Home health aides are not expected to make diagnoses based on signs and symptoms observed. This is beyond their scope of practice. Their observations, however, can alert the care team to possible problems.

In order to report accurately, an HHA must observe clients, their families, and their homes accurately. To observe accurately, as many senses as possible should be used to gather information (Fig. 4-8).

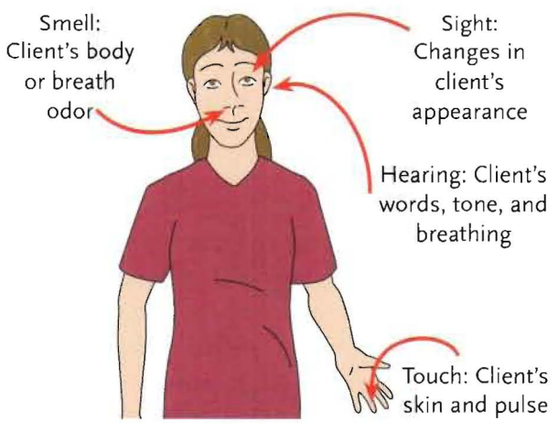

Fig. 4-8. *Observing a client accurately means using more than one sense.*

Sight: The HHA should look for changes in the client's appearance. These include rashes,

redness, paleness, swelling, discharge, weakness, sunken eyes, and posture or gait (walking) changes. The HHA should look for changes in the home. Does the home appear disorganized or dirty? Is food needed? Do safety hazards exist?

Hearing: The HHA should listen to what the client says about his condition, family, or needs. Is the client speaking clearly and making sense? Does he show emotions such as anger, frustration, or sadness? Is his breathing normal? Does he wheeze, gasp, or cough? Is the area calm and quiet enough for him to rest as needed?

Touch: Does the client's skin feel hot or cool, moist or dry? Is the pulse rate normal? The HHA can use his sense of touch to test bath water and the home's heating or cooling system.

Smell: Are there any odors coming from the client's body? Odors could suggest poor bathing, infections, or incontinence. **Incontinence** (*in-KON-ti-nens*) is the inability to control the bladder or bowels. Breath odor could suggest use of alcohol or tobacco, indigestion, or poor mouth care. Odors in the home may suggest housecleaning is needed. Food odors could indicate spoilage.

Using all of the senses will allow an HHA to make the most complete report of a client's situation.

9. Explain why documentation is important and describe how to document visit records and incident reports

Home health aides may see many clients in the course of a day. They cannot remember everything that each client ate, did, or said, or every observation they made. Documentation gives an up-to-date record of each client's care. HHAs must learn to document accurately. They must always take the time to observe and record carefully. Because documentation is so important, it should be recorded immediately and not be put off until later.

A medical chart is a legal document. What is included in the chart is considered in court to be what actually happened. If an HHA worked in a client's home for four hours but never documented it, he could not necessarily prove that he actually visited the client. In general, if something does not appear in a client's chart, it did not legally happen. Failing to document visits with clients could cause very serious legal problems for home health aides and their employers. It could also harm clients. It is important to remember that if it was not documented, it was not done.

Medical charts are confidential. As discussed in Chapter 3, it is illegal for home health aides to discuss information about clients with anyone who is not part of the care team. It is important for HHAs to be aware of the legal implications of documentation and to record all activities completely.

Maintaining current documentation means keeping a record of everything done and observed during a client visit. Careful, accurate documentation is important for these reasons:

- It is the only way to guarantee clear and complete communication between all the members of the care team.
- Documentation is a legal record of every part of a client's treatment. Medical charts can be used in court as legal evidence.
- Documentation helps protect home health aides and their employers from liability by proving what they did during every visit with clients.
- Documentation provides an up-to-date record of the status and care of each client.

Employers have specific guidelines for completing reports that HHAs must follow. These reports may be handwritten or entered on a computer. Below are guidelines for completing two types of reports that most employers require: visit records or notes, and incident reports. **Visit records**, progress notes, or clinical notes, are the

notes HHAs make each time they visit a client. These notes serve as a record of the visit and the care provided. Visit records also document observations of the client's condition, changes, or progress (improvement).

Guidelines: Completing Visit Records

- Document care immediately after the visit. This makes details easier to remember. Always wait to document until after care has been completed. **Do not record any care before it has been done.**
- Think about what you want to say before documenting. Be as brief and as clear as possible.
- Use facts, not opinions. For example, "Client has lost 2 lbs. Did not finish lunch" reports facts about the client's condition. It is more useful than "Client is thin and won't eat." When reporting something a client or family member told you, put the words in quotation marks (" "). Document the tasks that you performed, assisted with, or observed the client performing.
- Use black ink when documenting by hand. Write as neatly as you can.
- If you make a mistake, draw one line through it and write the correct information. Put your initials and the date (Fig. 4-9). Do not erase what you have written. Do not use correction fluid. Documentation done on a computer is time-stamped; it can only be changed by entering another notation.

0930 Changed bed linens, picked up bedroom
0945 VS ~~BP 190/110~~ BP 150/70 SA 08-25-2022

2 ½ hours — Total Visit Time
Susan Alvarez, HHA — Signature & Title

Fig. 4-9. One example of how to correct a mistake.

- Sign your full name and title (Home Health Aide, Aide, or HHA). Write the correct date after each day's visit notes.
- Document as specified in the care plan. Some agencies have a check-off sheet for documenting care. It is also called an *ADL (activities of daily living) sheet.*
- Documentation may need to be done using the 24-hour clock, or military time (Fig. 4-10). Regular time uses the numbers 1 to 12 to show each of the 24 hours in a day. In military time, the hours are numbered from 00 to 23. Midnight is expressed as 0000 (or 2400), 1:00 a.m. is 0100, 1:00 p.m. is 1300, and so on.

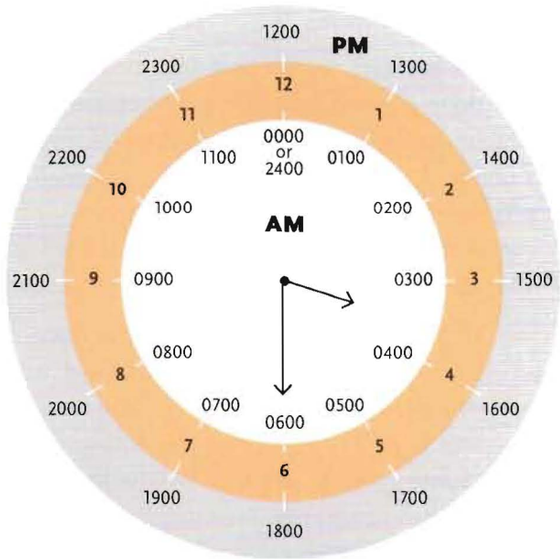

Fig. 4-10. Divisions in the 24-hour clock.

Both regular and military time list minutes and seconds the same way. The minutes and seconds do not change when converting from regular to military time. The abbreviations a.m. and p.m. are used in regular time to show what time of day it is. However, these are not used in military time, since specific numbers show each hour of the day. For example, to change 4:22 p.m. to military time, add 4 + 12. The minutes do not change. The time is expressed as 1622 (sixteen twenty-two) hours.

To change the hours between 1:00 p.m. and 11:59 p.m. to military time, add 12 to the regular time. For example, to change 4:00 p.m.

to military time, add 4 + 12. The time is expressed as 1600 (sixteen hundred) hours.

Midnight is the only time that differs. It can be written as 0000, or it can be written as 2400. This follows the rule of adding 12 to the regular time. Follow your agency's policy on how to express midnight.

To change from military time to regular time, subtract 12. The minutes do not change. For example, to change 2200 hours to standard time, subtract 12 from 22. The answer is 10:00 p.m.

G Some agencies require that documentation be done electronically, using a computer or tablet. Computers record and store information that can be retrieved when it is needed. This is faster and more accurate than writing information by hand. Some general guidelines for computer documentation are listed below:

- If your agency uses computers for documentation, you will be trained to use them. Always ask questions if you do not know or understand something. Some agencies use both handwritten and electronic records. Even when agencies require electronic/computer documentation, training often includes how to document by hand in case there is a system failure.
- Legal documentation rules apply to both electronic and paper medical charts.
- HIPAA privacy guidelines apply to electronic documentation. Make sure nobody can see protected health information on your computer screen. Do not share your log-in information with anyone.
- Do not have someone else enter information for you, even if it is more convenient.
- Make sure you are logged in to the correct client's chart before beginning to document. Log out and/or exit a client's chart when finished with documentation.
- Some computer software automatically fills in certain fields with information that has been entered before (autofill). Be sure that you are documenting correctly and that any autofill entries are accurate. Check your entries before exiting a client's chart.
- Treat computers carefully.
- Do not use the agency's computers or tablets to browse the internet or access any personal accounts.

An incident is an accident, problem, or unexpected event during the course of care. It is something that is not part of the normal routine. State and federal guidelines require that incidents be recorded in an incident report. An **incident report** (also called an *occurrence, accident, accident/incident,* or *event report*) is a report that documents the incident and the response to it. The information in an incident report is confidential. It is intended for internal use to help prevent future incidents. Incident reports should be filed when any of the following occur:

- A client falls (all falls must be reported, even if the client says he is fine)
- A home health aide or a client breaks or damages something
- A home health aide makes a mistake in care
- A client or his family member makes a request that is outside the home health aide's scope of practice
- A client or his family member makes sexual advances or remarks
- Anything happens that makes a home health aide feel uncomfortable, threatened, or unsafe
- A home health aide gets injured on the job
- A home health aide is exposed to blood or body fluids

Reporting and documenting incidents is done to protect everyone involved. This includes the

client, the home health aide, and the home health agency. For example, if a client drops and breaks a vase and forgets what happened, she might blame her home health aide. The report provides a record of anything that happens and describes the HHA's part in it.

When an incident occurs, the HHA should report it to her supervisor as soon as possible, before leaving the client's home. She should complete the incident report, following the agency's policies and procedures.

10. Demonstrate the ability to use verbal and written information to assist with the care plan

Home health aides spend more time with clients than other members of the care team. Because of this, they may observe things about clients that the nurses or doctor have not noticed. HHAs do not make diagnoses or decide on treatment. However, their observations are valuable information about clients that will help in care planning.

When attending care planning meetings, the HHA should not be afraid to speak up (Fig. 4-11). She should share her observations of clients. If she is not sure what is important to mention, she can talk to her supervisor before the meeting to find out.

Fig. 4-11. *During care planning meetings, information and ideas are shared to develop or change the client's care plan.*

Accurate documentation is an important contribution to care planning. A thorough record lets an HHA share her observations with others and helps her remember details about each client.

11. Demonstrate effective communication on the telephone

A home health aide may need to answer her client's phone or call her supervisor while at the client's home. When making a call, the HHA should follow these steps:

- Always ask for permission before using the client's phone to contact the supervisor.
- Identify herself before asking to speak to someone, and not ask, "Who is this?" when someone answers the call.
- After identifying herself, ask for the person with whom she needs to speak.
- If the person she is calling is available, identify herself again, and state why she is calling. Planning a call beforehand is more efficient.
- If the person is not available, ask to leave a message. Always leaving a brief message shows that the HHA was trying to reach someone.
- Leave a brief and clear message without giving more information than necessary. A basic message includes a name, the phone number to call, and a brief description of the reason for the call.
- Thank the person who takes the message. An HHA should always be polite over the telephone, just as she would be in person.

When answering calls for clients, the HHA should always identify herself and her position first. She should be sensitive to clients' privacy and not ask for more information than the client needs to return the call: a name and phone number is enough. The HHA can ask for proper spellings of names if needed. A client's information should not be shared. The HHA can simply say, "Mr. Schmidt is not available right now. May

I take a message?" After writing down the message, she should tell the client about the call.

Sample Phone Conversation

An HHA's side of a phone conversation with a supervisor might sound like this:

—This is Ella Ferguson. I am at Mrs. Lee's house. She has a question about her medication, and I need to know what to tell her.

—Her question is this: She forgot to take her pill this morning when she had breakfast. She wants to know if she should take two now with lunch.

—She should take one now and one with a snack around 3 p.m.? Okay, I'll tell her. I'll document in my visit notes that you told me to tell her to take one now, and one again with a snack at 3. I'll still be here then so I can help her remember.

—Thank you for your help, Ms. Crier. Goodbye.

If she could not reach Ms. Crier, her side of the conversation might go like this:

—Hello, this is Ella Ferguson calling. Is Ms. Crier there, please?

—Could you take a message for me, please?

—My name is Ella Ferguson. I'm an aide, and I am at Mrs. Lee's house. My number is 873-9042. I will be here until 4:30 this afternoon. I'm calling because Mrs. Lee has a question about her medication, and I need to know how to answer it.

—Thank you very much. Goodbye.

12. Describe cultural diversity and religious differences

The term **cultural diversity** refers to different groups of people with varied backgrounds and experiences living together in the world. Positive responses to cultural diversity include knowledge and acceptance, not **bias**, or prejudice.

Home health aides will take care of clients with backgrounds and traditions different from their own. It is important that HHAs respect and value each person as an individual. They should respond to differences and new experiences with acceptance.

There are so many different cultures that they cannot all be listed here. One might talk about American culture being different from Japanese culture. But within American culture there are thousands of different groups with their own cultures: Japanese-Americans, African-Americans, and Native Americans are just a few. Even people from a particular region, state, or city can be said to have a different culture (Fig. 4-12). The culture of the South is not the same as the culture of New York City.

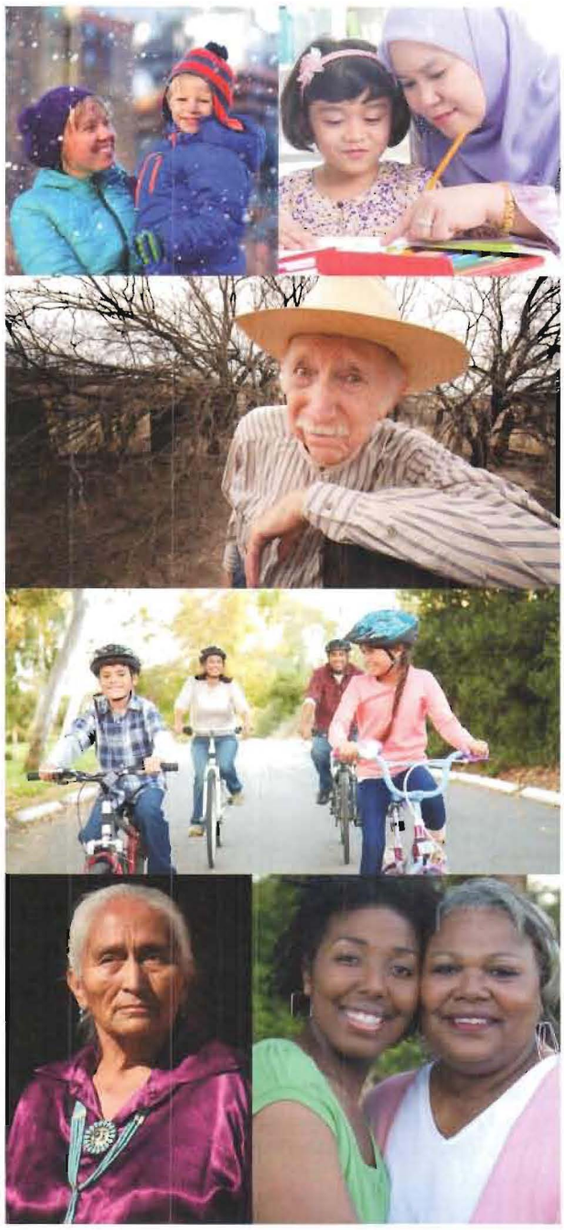

Fig. 4-12. *There are many different cultures in the United States.*

Cultural background affects how friendly people are to strangers. It can affect how they feel about having HHAs in their houses, or how close they want a person to stand when talking to them. It can affect how they feel about HHAs performing care for them or discussing their health with them. Home health aides should be sensitive to clients' backgrounds. They may have to adjust their behavior around some clients. Regardless of their backgrounds, all clients must be treated with respect and professionalism. HHAs should expect to be treated respectfully as well.

A client's primary language may be different from the home health aide's. If the client speaks a different language, an interpreter may be necessary. It can be helpful if staff learn a few common phrases in a client's native language. Picture cards and flash cards can assist with communication.

Religious differences also influence the way people behave. Religion may be very important in people's lives, particularly when they are ill or dying. Some people belong to a religious group but do not practice everything that religion teaches. Some people consider themselves spiritual but not religious. Others do not believe in any religion or God, and do not consider themselves spiritual. Home health aides must respect the religious beliefs and practices of clients, even if they are different from their own. Understanding a little bit about common religious groups may be useful. Common religions, listed alphabetically, follow:

Buddhism: Buddhism (*BOO-dism*) started in Asia but has many followers in other parts of the world. Buddhism is based on the teachings of Siddhartha Gautama, called Buddha. Buddhists believe that life is filled with suffering that is caused by desire, and that suffering ends when desire ends. Buddhism emphasizes meditation. Proper conduct and wisdom release a person from desire, suffering, and a repeating sequence of births and deaths (reincarnation). Nirvana is the highest spiritual plane a person can reach. It is the state of peace and freedom from worry and pain. There are many Buddhist texts. The Tipitaka, also called the Pali Canon, is the standard scripture collection. The Dalai Lama is considered to be the highest spiritual leader.

Christianity: Christians generally believe in a single God made up of the Father, Son (Jesus Christ), and Holy Spirit, and believe that they receive forgiveness of their sins through a relationship with God. They believe that Jesus Christ was the son of God and that he rose from the dead after being crucified. Christians believe in an eternal life. There are many subgroups or denominations, such as Baptist, Church of Jesus Christ of Latter-day Saints, Episcopalian, Evangelical, Lutheran, Methodist, Orthodox, Presbyterian, and Roman Catholic. Many Christians participate in rituals they consider holy, like baptism or communion. The Christian Bible is the sacred text and is divided into the Old Testament and the New Testament. Religious leaders may be called priests, ministers, pastors, or preachers.

Hinduism: Hinduism (*HIN-doo-ism*) is the dominant faith of India, but it is practiced in other places as well. According to Hindu beliefs, there are four purposes of life: acting morally and ethically (Dharma), pursuing prosperity (Artha), enjoying life (Kama), and accomplishing enlightenment (Moksha). People move through birth, life, death, and rebirth. How a person moves toward enlightenment is determined by karma. Karma is the result of actions in past lives, and actions in this life can determine one's destiny in future lives. Hindus advocate respect for all life, and some Hindus are vegetarians. Hindus who do eat meat almost always refrain from eating beef. Hindus follow the teachings of ancient scriptures like the Vedas and Upanishads, as well as other major scriptures. Holy men are called Sadhus.

Islam (*IS-lahm*): Muslims, or followers of Mohammed, believe that Allah (the Arabic term for God) wants people to follow the teachings of

the prophet Mohammed. Many Muslims pray five times a day facing Mecca, the holy city for their religion. Muslims also fast during the month called Ramadan. Muslims worship at mosques (*mosks*) and do not drink alcohol or eat pork. There are other dietary restrictions, too. The Qur'an (Koran, *koh-RAN*) is the sacred text of Islam. Islamic religious leaders may be called ayatollah, caliph, imam, mufti, or mullah, among other titles.

Judaism: Judaism is divided into Reform, Conservative, and Orthodox movements. Jewish people believe that God gave them laws through Moses in the form of the Torah (the sacred text), and that these laws should order their lives. Jewish services are held in synagogues or temples on Friday evenings and sometimes on Saturdays. Some Jewish men wear a **yarmulke** (*YAR-mul-ke*), or small skullcap, as a sign of their faith. Some Jewish people observe dietary restrictions. They may not do certain things, such as work or drive, on the Sabbath day (called Shabbat), which lasts from Friday sundown to Saturday sundown. Religious leaders are called rabbis (*RAB-eyes*).

Spirituality concerns a person's beliefs about the spirit or the soul. It may center on how a person relates to his community, to nature, or to the divine. It may involve reflection and contemplation and a search for inner peace. It may relate to a person's beliefs about the meaning of life. Spiritual practices can include meditation or prayer, but spirituality does not have to encompass religious beliefs. Some people consider themselves to be spiritual but not religious.

Many Native Americans (Indigenous Americans) follow many different spiritual traditions and practices. An emphasis is placed on the personal and the communal, rather than the institutional, and there is a deep connection with nature. There are many varied practices and rituals.

As mentioned earlier, people have varying beliefs about religion, spirituality, and God. Some people may not believe in God or a higher power and identify themselves as agnostic. **Agnostics** believe that they do not know or cannot know if God exists. They do not deny that God might exist, but they feel there is no true knowledge of God's existence.

Atheists are people who believe that there is no God. This is different from what agnostics believe. Atheists actively deny the existence of any deity (higher power). For many atheists, this belief is as strongly held as any religious belief.

Respect for clients' beliefs regarding religion and spirituality is an essential way in which HHAs provide person-centered care. HHAs should not discuss their own beliefs with clients.

13. List examples of cultural and religious differences

Some specific cultural and religious practices affect a home health aide's work. Many religious beliefs include **dietary restrictions**. These are rules about what and when followers can eat and drink. Some examples are listed below.

- Many Buddhists are vegetarians, though some include fish in their diet.
- Some Christians, particularly Roman Catholics, do not eat meat on Fridays during Lent. Many Orthodox Christians do not eat meat, meat by-products, poultry, eggs, fish, and dairy products on Wednesdays and Fridays, as well as during Lent.
- Many Jewish people eat kosher foods, do not eat pork, and do not eat lobster, shrimp, and clams (shellfish). Kosher food is food prepared in accordance with Jewish dietary laws. Kosher and non-kosher foods cannot come into contact with the same plates. Jewish people who observe dietary laws may not eat meat products at the same meal with dairy products. When working in a Jewish client's home, the HHA may be asked to separate meat and dairy products. This

can include using separate basins to wash dishes, separate pans for cooking, separate utensils for eating, and separate areas in refrigerators.

- Members of the Church of Jesus Christ of Latter-day Saints may not drink alcohol, coffee, or tea. They may not use tobacco in any form.
- Muslims do not eat pork and may avoid eating certain birds. They may not drink alcohol. Muslims may fast from dawn to sunset during the holy month of Ramadan. **Fasting** means not eating food or eating very little food.
- Some people are vegetarians and do not eat any meat for religious, ethical, or health reasons.
- Some people are vegans. **Vegans** do not eat any animals or animal products, such as eggs or dairy products. Vegans may also not use or wear any animal products, including wool and leather.

The HHA should be aware of any dietary restrictions and honor them. The client's practices should be respected and followed.

14. List ways of coping with combative behavior

Clients may sometimes display **combative** (*kom-BA-tiv*), meaning violent or hostile, behavior. Such behavior may include hitting, pushing, kicking, or verbal attacks. This behavior may be the result of disease affecting the brain. It may be an expression of frustration, or it may just be part of someone's personality. In general, combative behavior is not a reaction to the caregiver and should not be taken personally.

Home health aides should always report and document combative behavior. Even if an HHA does not find the behavior upsetting, the care team needs to be aware of it.

Guidelines: Combative Behavior

- Block physical blows or step out of the way, but never hit back (Fig. 4-13). No matter how much a client hurts you, or how angry or afraid you are, never hit or threaten a client.

Fig. 4-13. *When dealing with combative clients, step out of the way, but never hit back.*

- Allow the client time to calm down before the next interaction.
- Ensure the client is safe and give her space. When possible, stand at least an arm's length away.
- Remain calm. Lower the tone of your voice.
- Be flexible and patient.
- Stay neutral. Do not respond to verbal attacks. Do not argue or accuse the client of wrongdoing. If you must respond, say something like, "I understand that you're angry and frustrated. How can I make things better?"
- Do not use gestures that could frighten or startle the client. Try to keep your hands open and in front of you.
- Be reassuring and supportive.
- Consider what provoked the client. Sometimes something as simple as a change in caregiver or routine can be very upsetting to a client. Do not blame yourself. Try to learn from the situation and avoid it in the future.

15. List ways of coping with inappropriate behavior

Inappropriate behavior from a client includes trying to establish a personal, rather than a professional, relationship. Examples include asking personal questions or revealing personal information, requesting visits on personal time, asking for or doing favors, giving tips or gifts, and lending or borrowing money. It is also inappropriate for a client to ask a home health aide to perform tasks that would not be in the care plan, like scrubbing floors or cleaning the garage. Inappropriate behavior includes making sexual advances and comments. Sexual advances include any sexual words, comments, or behavior that makes the HHA feel uncomfortable.

When clients or their family behave inappropriately, the HHA should report this behavior to the supervisor, even if she thinks the behavior was harmless. Reporting is the only way to protect the HHA, and it does not violate the client's privacy.

Guidelines: Inappropriate Behavior

- If you think a light approach will work, say something like, "I'm sorry, I'm not allowed to do that."
- Address the behavior directly, saying something like, "That makes me very uncomfortable. Please stop." If the client persists, call your supervisor immediately.
- Respond to personal questions by saying, "I really can't talk about my personal life on the job." If the client is sharing thoughts or feelings that make you uncomfortable, say, "That's not something I can help you with. If you'd like to speak with a social worker I can let the nurse know."
- Firmly refuse gifts, tips, and favors. Say, "I really can't accept that. It's against the agency's rules."
- Always report inappropriate behavior to your supervisor.

While working in people's homes, a home health aide may see family interactions that make her feel uncomfortable. Not all families behave in the same way. It is important for the HHA to remain professional. However, if fighting or abusive behavior is observed, the HHA should report it to her supervisor.

Chapter Review

1. Write a short sample conversation an HHA might have with a client. Use the three basic steps of communication.
2. Figure 4-2 shows an example of positive and negative nonverbal communication. Describe one different example of positive nonverbal communication and negative nonverbal communication.
3. List three ways that cultural background may affect nonverbal communication.
4. What is one way to provide feedback while listening?
5. What can silence or pauses help a client do?
6. Why should an HHA sit near a client who has started a conversation with her?
7. For each statement, decide whether it is an example of a fact or an opinion. Write *F* for fact and *O* for opinion.

   ___ Mrs. Connelly does not eat enough.

   ___ Mr. Moore looked terrible today.

   ___ Mr. Gaston had a fever of 100.7°F.

   ___ Ms. Martino needs to make some friends.

   ___ Mr. Klein has not had a visitor since last Tuesday.

   ___ The doctor says Mrs. Storey has to walk once a day.

8. What does the abbreviation *NPO* stand for?
9. With whom should HHAs use medical terminology—care team members or clients and their families?
10. After an HHA gives an oral report, what should be documented?
11. For each statement, decide whether it is an objective observation or a subjective observation. Write *O* for objective and *S* for subjective.

    ___ Client says he is depressed.

    ___ There is a patch of red skin on client's hip.

    ___ Client has a fever of 101°F.

    ___ Client has noisy breathing.

    ___ Client complains of chest pain.

    ___ Client says she has a toothache.
12. When should care be documented—before or after it is done?
13. If an HHA forgets to document an entire visit, did the visit legally happen?
14. Should an HHA use facts or opinions when writing visit notes?
15. Convert 10:00 p.m. to military time.
16. Convert 1400 hours to regular time.
17. Which care team member generally spends the most time with clients?
18. What should an HHA do before using a client's phone?
19. What does the term *cultural diversity* mean?
20. Pick three religions listed in Learning Objective 12 and briefly describe them. Feel free to add information that is not included in the Learning Objective.
21. If a client tries to strike an HHA, what should the HHA do?
22. How would an HHA respond to a client who asks about her personal life?
23. What should an HHA always do after a client behaves inappropriately?