State-approved Curriculum

NURSE AIDE I TRAINING PROGRAM

July 2019

Module L

North Carolina Department of Health and Human Services

Division of Health Service Regulation

Health Care Personnel Education and Credentialing Section

Module L – Communicating with the Health Care Team
Teaching Guide

Objectives

- Describe components of communication with the health care team
- Discuss the importance of reporting and recording accurately
- Define Health Insurance Portability and Accountability Act (HIPAA) and its impact on communication
- Explain conventional and military time
- Explore the NA's role in reporting and recording objective and subjective data

Instructional Resources

- Examples of blank forms/documentation from health care facilities in your area commonly used by nurse aides, and for students to use in class or lab activities

Advance Preparation – In General

- Review curriculum and presentation materials
- Add examples or comments in Notes Section
- Set up computer/projector
- Research health care facilities to determine if documentation is done electronically. Inquire how nurse aides and nurse aide students are allowed to document. Incorporate findings into the notes section of the curriculum.
- Arrange for students to observe electronic documentation during clinical, if applicable

Advance Preparation – Teaching Tips

- **#4L Web site:** Familiarize self with the following Web sites:

  https://www.visnos.com/demos/clock
  Instructions/information is shown in the right-hand corner:
  - o  View instruction videos
  - o  View information about the activity
  - o  Close the activity

  https://www.mathsisfun.com/definitions/analog-clock-or-watch.html

  https://www.mathsisfun.com/time-clocks.html

Module L – Communicating with the Health Care Team
Definition List

Communication with the Health Care Team – the exchange of information, either verbally or in written form, between and among members of the health care team

HIPAA (Health Insurance Portability and Accountability Act) – law that protects the privacy and security of a person's health information

Medical Record – a legal document that organizes all the information about care of a single resident in one document and allows each discipline involved in the care to know what all disciplines are doing

Objective Data – observations using the senses

Recording – the written/electronic documentation of care and observations by the health care team

Reporting – the oral account of care done and observations noted; informing other members of the health care team

Subjective Data – information collected through communication; what is said

Module L – Communicating with the Health Care Team	
(S-1) Title Slide **(S-2) Objectives** 1. Describe components of communication with the health care team. 2. Discuss the importance of reporting and recording accurately. 3. Define Health Insurance Portability and Accountability Act (HIPAA) and its impact on communication. 4. Explain conventional and military time and how to convert times. 5. Explore the NA's role in reporting and recording objective and subjective data.	
Content	**Notes**
(S-3) Communicating with the Health Care Team • The exchange of information, either verbal or written, between and among members of the health care team	
(S-4) Reporting • Is the verbal account of care provided and observations noted by the health care team • Is initiated immediately when there is a change in the resident's condition • Is communicated regardless of time, circumstances or schedules and prior to the end-of-shift	
(S-5) Recording • Is the written/electronic documentation of care and observations by the health care team • Medical Record o Legal document o Collection of documentation regarding a resident's condition and response to treatment and care o Is used to keep all team members updated about the resident's care	
(S-6) HIPAA • Health Insurance Portability and Accountability Act • Law that protects the privacy and security of a person's health information o Maintains that electronic transmission of documentation, photos, videos or other identifiable means is securely protected o Protects the person's identity; his/her past, present or future health conditions/concerns; phone number; social security number; and other identifiable information • Only people involved with direct resident care or processing records are allowed access to information	
TEACHING TIP #1L: Examples of HIPAA Breaches Provide examples of breaches in HIPAA, such as reading a	

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neighbor's/friend's medical record, talking about a resident in a public location, texting or videoing, or answering questions about a resident's medical condition over the phone or in a public location.	
(S-7) Importance of Communication • Observations and communication from the nurse aide are of vital importance to the health care team • Allows health members to make sound decisions about care and treatment plans • Accurate documentation from nurse aide becomes part of legal records • Must be reported and recorded accurately and in detail	
(S-8) Recording – NA's Role (1) • Information must be recorded in a responsible manner • Must be based on facts, not opinions, as per facility policy • Documents often used: o Check sheets o Flow sheet o Graphs o Incident reports o Facility specific forms	
TEACHING TIP #2L: Examples of Documentation Ask students to think about what and how they document. Discuss how medical documentation differs from personal documentation. Describe some examples of correct and incorrect documentation.	
(S-9) Recording – NA's Role (2) • Observe the resident, using senses o Sight (facial expressions, rashes, skin color, bruising, ambulation, body language) o Hearing (breathing, speaking, moaning) o Smell (odor of breath, urine, body) o Touch (lumps, skin temperature, change in pulse)	
(S-10) Recording – NA's Role (3) • Document observations regarding: o Personal care – oral, bathing, perineal, catheter, skin, turning/positioning o Treatments – hot/cold applications, soaks or wound care (as per facility policy) o Measurements – vital signs, intake/output, elimination o Activities – eating, sitting, ambulating, talking, sleeping, socializing, participation in activities or	

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events o Mental/emotional status – subtle or drastic changes	
(S-11) Recording – NA's Role (4) • Document per facility procedures • Ask for assistance to understand various forms • Clarify what and where the NA is allowed to document information • Use a pen, with blue or black ink, or per facility policy • Do <u>not</u> use a pencil or ink that can be erased • Carry a small notebook/worksheet to make notations • Do not record protected information, in case the notebook or worksheet is misplaced/lost • Keep written information with you at all times • Write clearly – remember this is a legal document • Do not draw multiple lines through a writing error or use white out • Sign full name and title (NA), or per facility policy • Keep medical records in secure location ALWAYS, per facility policy • Always maintain confidentiality	
TEACHING TIP #3L Corrections of Documentation Errors • Demonstrate how to correct a documentation error • Show examples of how <u>not</u> to correct an error • Encourage students to ask questions	
(S-12) Time • Include the date and exact time, each time information is recorded • Health care facilities choose to use conventional (also called civilian or standard) time or choose to use military time (also called the 24-hour clock)	
(S-13) Conventional Time • **Uses numbers 1 through 12** to show each of the 24-hours of the day • **<u>Has either 3 or 4 digits</u> -** the <u>first one or two digits are hours</u> and the remaining <u>two are minutes</u> • A colon (:) separates the hours from the minutes • a.m. is used to specify <u>morning</u> – beginning at 12:00 a.m. • p.m. is used to specify <u>afternoon/evening</u> – beginning at 12:00 p.m. (noon)	
(S-14) Military Time • **<u>Has 4 digits</u>** – the <u>first two numbers are hours</u> and the remaining t<u>wo are minutes</u> o a.m. and p.m. are not used	

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• Examples: o 0100 hours is 1:00 a.m. (in the morning) o 0800 hours is 8:00 a.m. (in the morning) o 1200 hours is 12:00 p.m. (noon) o 1500 hours is 3:00 p.m. (in the afternoon) o 2100 hours is 9:00 p.m. (in the evening) o 2400 hours is (midnight) • **Midnight may be documented as 2400 hours or 0000 hours**	
(S-15) Convert Conventional to Military Time (1) • To convert conventional time **containing 3 digits** to military time**, add a 0 in front of the hour number** and remove the colon and a.m. o 5:30 a.m. is 0530 hours (0 was added in front) o 9:59 a.m. is 0959 hours (0 was added in front) • To convert conventional time **containing 4 digits** to military time, **do not add a 0** and remove the colon and a.m. o 10:00 a.m. is 1000 hours (0 was not added) o 11:30 a.m. is 1130 hours (0 was not added)	
(S-16) Convert Conventional to Military Time (2) • To convert conventional time to military time for the p.m., beginning at 1:00 p.m. (in the afternoon), **add 12 to the "hour" 1** and <u>remove the colon and p.m.</u> • Examples: o 1:00 p.m. is 1300 hours (1+12=13 hours, 00 minutes) o 4:00 p.m. is 1600 hours (4+12=16 hours, 00 minutes) o 8:00 p.m. is 2000 hours (8+12=20 hours, 00 minutes) o 12:00 a.m. (midnight) is 2400 hours or 0000 hours • **12 is only added to the "hour(s)" and not the minutes** o 1:45 p.m. is 1345 hours (1+12=13 hours, 45 minutes) o 6:30 p.m. is 1830 hours (6+12=18 hours, 30 minutes) o 9:45 p.m. is 2145 hours (9+12=21 hours, 45 minutes) o 11:20 p.m. is 2320 hours (11+12=23 hours, 20 minutes)	
(S-17) Convert Military to Conventional Time • To convert military to conventional time, **reverse the processes** • For a.m. simply **remove the 0** in front of the hours, add the colon and a.m. • For p.m. simply **subtract 12** from the hours, add the colon and p.m.	
TEACHING TIP #4L: Web site Navigate to one of the following Web sites to demonstrate	

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the difference between standard and military time: • https://www.visnos.com/demos/clock • https://www.mathsisfun.com/definitions/analog-clock-or-watch.html o An analogue clock has moving hands representing minutes and seconds. • https://www.mathsisfun.com/time-clocks.html o Scroll down to **Practice using Time Worksheets**	
(S-18) Electronic Recording – NA's Role • Document as per facility policy • Use the mouse and drop-down boxes or touch-screen • Sign electronically as per facility policy • Always maintain confidentiality	
TEACHING TIPS #5L – #8L: Computer Usage #5L: Inform students which type of electronic devices (computers/kiosks) are being used at approved clinical sites. Discuss facility policies regarding the use of computers by nurse aide students and nurse aide employees #6L: Survey students about computer experience #7L: Encourage students to share information and become familiar with different types of computers #8L: Incorporate computer usage into the clinical experience	
(S-19) Reporting – NA's Role (1) • Report as per facility policy • Report accurately in a respectable manner • State facts, not opinions • Emphasize that facilities may choose to not allow students to document directly on a form or in a medical document • Explain that nurse aide students may be allowed to report observations and activities to facility employees • Remind students that they are guests in a facility and area required to adhere to facility policies	
(S-20) Reporting – NA's Role (2) • Use reminder notes from notebook or worksheet to report observations and activities	

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• Report immediately and accurately to the designated employee
• Reports facts, not opinions
• Understand difference between objective and subjective data
  o Objective data – observations using the senses
  o Subjective data – information you are told that you cannot observe through your senses
• Report changes as they occur
• Report before end-of-shift so information can be passed to the next shift	

(S-21) What to Report – NA's Role • Care or treatment given, the time, and resident's response • Observations – what is normal and what appears to be abnormal; noticeable changes • Conversations with resident during treatment/activities that cause concern or appear to be out of the ordinary • Unusual actions/behaviors that deviate from the normal or from previous actions	
TEACHING TIP #9L: Objective Versus Subjective Data Give examples of objective and subjective data. Ask students to share examples of objective and subjective data. Allow time for discussion. **TEACHING TIP #10L: Facts Versus Opinions** Give examples of facts and examples of opinions. Ask students to share examples of facts and examples of opinions. Encourage discussion.	
(S-22) What to Report - NA's Role • Observations must be reported to nurse IMMEDIATELY • Resident complains of sudden or severe pain • Change in resident's ability to respond – a responsive resident no longer responds, or a non-responsive resident who now responds • Change in resident's mobility – inability to move a body part, or improved ability to move a body part • Change in vision; pain or difficulty breathing; difficulty swallowing • Change in facial responses/appearance, drooping eyelid, crooked smile, drooling • Complaints of numbness in lips, arms, other areas	

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• Vomiting • Bleeding • Bloody stools, change in bowels or urine • Unusual odors • Vital signs that are outside the resident's normal range or differ from normal ranges that were taught • Change in skin color, sore or reddened area	
TEACHING TIP #11L: Examples of Reporting Share some examples of what a nurse aide may need to report, such as the resident has difficulty swallowing or the resident complains of pain. Allow time for class discussion.	
(S-23) Remember (1) • HIPAA is a law that protects the resident's privacy; it is a legal document • Maintain confidentiality at all times • Report observations immediately and accurately • Report and record facts, not opinions • Relay information in specific terms not vague general terms	
(S-24) Remember (2) • Document according to established facility policy using the established conventional or military time • Ensure information remains confidential • Do not use electronic devices/computers/kiosks for anything other than the intended purpose • Do no share passwords or other information • Understand the difference between objective and subjective data and use it appropriately • When in doubt, always ask for clarification	