State-approved Curriculum
Nurse Aide I Training Program

MODULE L
Communication with the Health Care Team

Teaching Guide
2024 Version 1.1

North Carolina Department of Health and Human Services
Division of Health Service Regulation
North Carolina Education and Credentialing Section
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Module L – Communication with the Health Care Team
Teaching Guide

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. Explore the nurse aide's NA's role in reporting and recording objective and subjective data
5. Explain conventional and military time

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 or written. 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.

Supplies – Optional

Handouts – Optional

Instructional Resources/Guest Speakers
- 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 – Teaching Tips
- **#L6 Examples of HIPAA Breaches:** Provide examples of breaches in HIPAA, such as reading a 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
- **#L8 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.
- **#L11 Corrections of Written Documentation Errors:** Demonstrate how to correct a documentation error. Show examples of how not to correct an error. Encourage students to ask questions
- **#L14-1 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.
- **#L14-2 Facts Versus Opinions:** Give examples of facts and examples of opinions. Ask students to share examples of facts and examples of opinions. Encourage discussion.

- **#L16 Examples of Reporting:** Share some examples of what a nurse aide may need to report, such as the resident having difficulty swallowing or the resident complains of pain. Allow time for class discussion.
- **#L22 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

Advance Preparation – Activities: Optional

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. Explore the nurse aide's (NA) role in reporting and recording objective and subjective data
5. Explain conventional and military time and how to convert times

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 <u>immediately</u> when there is a change in the resident's condition • Is communicated regardless of time, circumstances, or schedules, and at change-of-shift	

(S-5) Recording
• Is the written/electronic documentation of care and observations by the health care team
• Becomes part of the medical record
  — Legal document
  — Collection of information regarding a resident's condition and response to treatment and care that is organized in one document.
• It allows all team members involved to be 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
  — Maintains that electronic transmission of documentation, photos, videos, or other identifiable means is securely protected
  — Protects the person's identity; their 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 #L6: Examples of HIPAA Breaches	

Module L – Communicating with the Health Care Team	
Provide examples of breaches in HIPAA, such as reading a 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 • Documentation from the nurse aide becomes part of legal records • Must be reported and recorded accurately and in detail	

(S-8) Recording – Nurse Aide's Role
• 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
• Validate first that you are documenting on the correct resident's record
• Information must be recorded in a responsible manner
• Must be based on facts, not opinions
• Use simple, descriptive terms, but avoid words such as normal, good, or adequate
• Documents often used:
  — Check sheets
  — Flow sheet
  — Graphs
  — Incident reports
  — Facility specific forms
• Never remove pages from a paper record or delete entries from an electronic record	

TEACHING TIP #L8: 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 and document the resident's use of senses
  — Sight (facial expressions, rashes, skin color, bruising, ambulation, body language)
  — Hearing (breathing, speaking, moaning)
  — Smell (odor of breath, urine, body)	

Module L – Communicating with the Health Care Team	
— Touch (lumps, skin temperature, change in pulse)	

(S-10) Recording – NA's Role (3)
• For all the following, document care or treatment given, the time, and resident's response
• Document observations regarding:
  — Personal care – oral, bathing, perineal, catheter, skin, turning/positioning
  — Treatments – hot/cold applications, soaks, or wound care (as per facility policy)
  — Measurements – vital signs, intake/output, elimination
  — Activities – eating, sitting, ambulating, talking, sleeping, socializing, participation in activities or events
  — Mental/emotional status – subtle or drastic changes	

(S-11) Written Recording – NA's Role • 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 • Write clearly – remember this is a legal document • Sign full name and title (NA), or per facility policy • Follow facility policy for correcting errors. Do not draw multiple lines through a writing error or use white out. • Keep medical records in secure location ALWAYS, per facility policy	
TEACHING TIP #L11 Corrections of Written 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) Electronic Recording – NA's Role • Record information and sign electronically as per facility policy • Follow facility policy for correcting errors • Do not share passwords or protected information • Always maintain confidentiality	
(S-13) Reporting – NA's Role • Immediately and accurately as changes occur • Report at change-of-shift so information can be passed to the next shift; usually done 15-20 minutes prior to end of shift	

Module L – Communicating with the Health Care Team	
• Report: care given, care to be given during other shifts and resident's current condition • Must be based on facts, not opinions • Report as per facility policy (to designated employee)	

(S-14) Reporting – Objective Versus Subjective Reporting
• Use reminder notes from notebook or worksheet to report observations and activities
• Understand difference between objective and subjective data
  — Objective data – observations using the senses; based on facts
  — Subjective data – information you are told that you cannot observe through your senses; based on feelings or opinions	

TEACHING TIP #L14-1: 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 #L14-2: 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-15) What to Report – NA's Role (2) • Observations – what is normal and what appears to be abnormal; noticeable changes • Conversations with resident during treatment and activities that cause concern or appear to be out of the ordinary • Unusual actions/behaviors that deviate (differ) from the normal or from previous actions	
(S-16) What to Report - NA's Role (3) • 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	

Module L – Communicating with the Health Care Team	
• Change in facial responses/appearance, drooping eyelid, crooked smile, drooling • Complaints of numbness in lips, arms, other areas • Vomiting • Bleeding • Bloody stools, change in bowels, or urine • Unusual odors • Vital signs that are outside of normal range • Changes in skin color (for example, a new reddened area or change in current reddened area)	
TEACHING TIP #L16: Examples of Reporting Share some examples of what a nurse aide may need to report, such as the resident having difficulty swallowing or the resident complains of pain. Allow time for class discussion.	
(S-17) Recording 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) per facility policy	
(S-18) Standard Time • Uses numbers 1 through 12 to show each of the 24-hours of the day • Has either 3 or 4 digits - the first one or two digits are hours and the remaining two are minutes • A colon (:) separates the hours from the minutes • a.m. is used to specify morning – beginning at 12:00 a.m. • p.m. is used to specify afternoon/evening – beginning at 12:00 p.m. (noon)	

(S-19) Military Time
• Has 4 digits – the first two numbers are hours and the remaining two are minutes
  — a.m. and p.m. are not used
• Examples:
  — 0100 hours is 1:00 a.m. (in the morning)
  — 0800 hours is 8:00 a.m. (in the morning)
  — 1200 hours is 12:00 p.m. (noon)
  — 1500 hours is 3:00 p.m. (in the afternoon)
  — 2100 hours is 9:00 p.m. (in the evening)
  — 2400 hours is (midnight)
• Midnight may be documented as 2400 hours or 0000 hours (as per facility policy)	

Module L – Communicating with the Health Care Team	

(S-20) Converting Standard to Military Time for A.M.
• To convert standard time containing 3 digits to military time, add a 0 in front of the hour number and remove the colon (:) and a.m.
  — 5:30 a.m. is 0530 hours (0 was added in front)
  — 9:59 a.m. is 0959 hours (0 was added in front)
• To convert standard time containing 4 digits to military time, do not add a 0 and remove the colon and a.m.
  — 10:00 a.m. is 1000 hours (0 was not added)
  — 11:31 a.m. is 1131 hours (0 was not added)	

(S-21) Converting Standard to Military Time for P.M.
• To convert standard time to military time for the p.m., beginning at 1:00 p.m. (in the afternoon), add 12 to the "hour" 1 and remove the colon (:) and p.m.
• Examples:
  — 1:00 p.m. is 1300 hours (1+12=13 hours, 00 minutes)
  — 4:00 p.m. is 1600 hours (4+12=16 hours, 00 minutes)
  — 8:00 p.m. is 2000 hours (8+12=20 hours, 00 minutes)
  — 12:00 a.m. (midnight) is 2400 hours or 0000 hours
• 12 is only added to the "hour(s)" and not the minutes
  — 1:45 p.m. is 1345 hours (1+12=13 hours, 45 minutes)
  — 6:30 p.m. is 1830 hours (6+12=18 hours, 30 minutes)
  — 9:45 p.m. is 2145 hours (9+12=21 hours, 45 minutes)
  — 11:20 p.m. is 2320 hours (11+12=23 hours, 20 minutes)	

(S-22) Converting Military to Standard Time
• To convert military to standard time, reverse the process
• For a.m. simply remove the 0 in front of the hours, add the colon and a.m.
  — 0530 is 5:30 a.m.
  — 0422 is 4:22 a.m.
• For p.m. simply subtract 12 from the hours, add the colon and p.m.
  — 1300 hours is 1:00 p.m. (13-12=1)
  — 2238 hours is 10:38 p.m. (22-12=10)	

TEACHING TIP #L22: Web site Navigate to one of the following Web sites to demonstrate the difference between standard and military time: • https://www.visnos.com/demos/clock • https://www.mathsisfun.com/definitions/analog-clock-or-watch.html — An analogue clock has moving hands representing minutes and seconds.	

Module L – Communicating with the Health Care Team	
• https://www.mathsisfun.com/time-clocks.html — Scroll down to **Practice using Time Worksheets**	
(S-23) Points to 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) Points to Remember (2) • Document according to established facility policy using the established standard 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	