

# State-approved Curriculum Nurse Aide I Training Program

## MODULE L Communication with the Health Care Team

### Student Manual 2024 Version 2.0



## NC DEPARTMENT OF **HEALTH AND HUMAN SERVICES**

Division of Health Service Regulation



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**HEALTH AND  
HUMAN SERVICES**



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 – 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	
<p><b>(S-1) Title Slide</b></p> <p><b>(S-2) Objectives</b></p> <ol style="list-style-type: none"> <li>1. Describe components of communication with the health care team</li> <li>2. Discuss the importance of reporting and recording accurately</li> <li>3. Define Health Insurance Portability and Accountability Act (HIPAA) and its impact on communication</li> <li>4. Explore the nurse aide's (NA) role in reporting and recording objective and subjective data</li> <li>5. Explain conventional and military time and how to convert times</li> </ol>	
Content	Notes
<p><b>(S-3) Communicating with the Health Care Team</b></p> <p>The exchange of information, either verbal or written, between and among members of the health care team</p>	
<p><b>(S-4) Reporting</b></p> <ul style="list-style-type: none"> <li>• Is the verbal account of care provided and observations noted by the health care team</li> <li>• Is initiated <u>immediately</u> when there is a change in the resident's condition</li> <li>• Is communicated regardless of time, circumstances, or schedules, and at change-of-shift</li> </ul>	
<p><b>(S-5) Recording</b></p> <ul style="list-style-type: none"> <li>• Is the written/electronic documentation of care and observations by the health care team</li> <li>• Becomes part of the medical record <ul style="list-style-type: none"> <li>– Legal document</li> <li>– Collection of information regarding a resident's condition and response to treatment and care that is organized in one document.</li> </ul> </li> <li>• It allows all team members involved to be updated about the resident's care</li> </ul>	
<p><b>(S-6) HIPAA</b></p> <p>Health Insurance Portability and Accountability Act</p> <ul style="list-style-type: none"> <li>• Law that protects the privacy and security of a person's health information <ul style="list-style-type: none"> <li>– Maintains that electronic transmission of documentation, photos, videos, or other identifiable means is securely protected</li> <li>– Protects the person's identity; their past, present or future health conditions/concerns; phone number; social security number; and other identifiable information</li> </ul> </li> <li>• Only people involved with direct resident care or processing records are allowed access to information</li> </ul>	
<b>(S-7) Importance of Communication</b>	

<b>Module L – Communicating with the Health Care Team</b>	
<ul style="list-style-type: none"> <li>• Observations and communication from the nurse aide are of vital importance to the health care team</li> <li>• Allows health members to make sound decisions about care and treatment plans</li> <li>• Documentation from the nurse aide becomes part of legal records</li> <li>• Must be reported and recorded accurately and in detail</li> </ul>	
<p><b>(S-8) Recording – Nurse Aide’s Role</b></p> <ul style="list-style-type: none"> <li>• Carry a small notebook/worksheet to make notations. (Do not record protected information in case the notebook or worksheet is misplaced/lost)</li> <li>• Keep written information with you at all times</li> <li>• Validate first that you are documenting on the correct resident’s record</li> <li>• Information must be recorded in a responsible manner</li> <li>• Must be based on facts, not opinions</li> <li>• Use simple, descriptive terms, but avoid words such as normal, good, or adequate</li> <li>• Documents often used: <ul style="list-style-type: none"> <li>– Check sheets</li> <li>– Flow sheet</li> <li>– Graphs</li> <li>– Incident reports</li> <li>– Facility specific forms</li> </ul> </li> <li>• Never remove pages from a paper record or delete entries from an electronic record</li> </ul>	
<p><b>(S-9) Recording – NA’s Role (2)</b></p> <ul style="list-style-type: none"> <li>• Observe and document the resident’s use of senses <ul style="list-style-type: none"> <li>– Sight (facial expressions, rashes, skin color, bruising, ambulation, body language)</li> <li>– Hearing (breathing, speaking, moaning)</li> <li>– Smell (odor of breath, urine, body)</li> <li>– Touch (lumps, skin temperature, change in pulse)</li> </ul> </li> </ul>	
<p><b>(S-10) Recording – NA’s Role (3)</b></p> <ul style="list-style-type: none"> <li>• For all the following, document care or treatment given, the time, and resident’s response</li> <li>• Document observations regarding: <ul style="list-style-type: none"> <li>– Personal care – oral, bathing, perineal, catheter, skin, turning/positioning</li> <li>– Treatments – hot/cold applications, soaks, or wound care (as per facility policy)</li> <li>– Measurements – vital signs, intake/output, elimination</li> <li>– Activities – eating, sitting, ambulating, talking, sleeping, socializing, participation in activities or events</li> </ul> </li> </ul>	

<b>Module L – Communicating with the Health Care Team</b>	
— Mental/emotional status – subtle or drastic changes	
<b>(S-11) Written Recording – NA’s Role</b> <ul style="list-style-type: none"> <li>• Ask for assistance to understand various forms</li> <li>• Clarify what and where the NA is allowed to document information</li> <li>• Use a pen, with blue or black ink, or per facility policy</li> <li>• Do <u>not</u> use a pencil or ink that can be erased</li> <li>• Write clearly – remember this is a legal document</li> <li>• Sign full name and title (NA), or per facility policy</li> <li>• Follow facility policy for correcting errors. Do not draw multiple lines through a writing error or use white out.</li> <li>• Keep medical records in secure location ALWAYS, per facility policy</li> </ul>	
<b>(S-12) Electronic Recording – NA’s Role</b> <ul style="list-style-type: none"> <li>• Record information and sign electronically as per facility policy</li> <li>• Follow facility policy for correcting errors</li> <li>• Do not share passwords or protected information</li> <li>• Always maintain confidentiality</li> </ul>	
<b>(S-13) Reporting – NA’s Role</b> <ul style="list-style-type: none"> <li>• Immediately and accurately as changes occur</li> <li>• Report at change-of-shift so information can be passed to the next shift; usually done 15-20 minutes prior to end of shift</li> <li>• Report: care given, care to be given during other shifts and resident’s current condition</li> <li>• Must be based on facts, not opinions</li> <li>• Report as per facility policy (to designated employee)</li> </ul>	
<b>(S-14) Reporting – Objective Versus Subjective Reporting</b> <ul style="list-style-type: none"> <li>• Use reminder notes from notebook or worksheet to report observations and activities</li> <li>• Understand difference between objective and subjective data <ul style="list-style-type: none"> <li>— Objective data – observations using the senses; based on facts</li> <li>— Subjective data – information you are told that you cannot observe through your senses; based on feelings or opinions</li> </ul> </li> </ul>	
<b>(S-15) What to Report – NA’s Role (2)</b> <ul style="list-style-type: none"> <li>• Observations – what is normal and what appears to be abnormal; noticeable changes</li> </ul>	

<b>Module L – Communicating with the Health Care Team</b>	
<ul style="list-style-type: none"> <li>• Conversations with resident during treatment and activities that cause concern or appear to be out of the ordinary</li> <li>• Unusual actions/behaviors that deviate (differ) from the normal or from previous actions</li> </ul>	
<p><b>(S-16) What to Report - NA's Role (3)</b></p> <ul style="list-style-type: none"> <li>• Observations must be reported to nurse IMMEDIATELY</li> <li>• Resident complains of sudden or severe pain</li> <li>• Change in resident's ability to respond – a responsive resident no longer responds, or a non-responsive resident who now responds</li> <li>• Change in resident's mobility – inability to move a body part, or improved ability to move a body part</li> <li>• Change in vision; pain or difficulty breathing; difficulty swallowing</li> <li>• Change in facial responses/appearance, drooping eyelid, crooked smile, drooling</li> <li>• Complaints of numbness in lips, arms, other areas</li> <li>• Vomiting</li> <li>• Bleeding</li> <li>• Bloody stools, change in bowels, or urine</li> <li>• Unusual odors</li> <li>• Vital signs that are outside of normal range</li> <li>• Changes in skin color (for example, a new reddened area or change in current reddened area)</li> </ul>	
<p><b>(S-17) Recording Time</b></p> <ul style="list-style-type: none"> <li>• Include the date and exact time, each time information is recorded</li> <li>• 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</li> </ul>	
<p><b>(S-18) Standard Time</b></p> <ul style="list-style-type: none"> <li>• Uses numbers 1 through 12 to show each of the 24-hours of the day</li> <li>• Has either 3 or 4 digits - the first one or two digits are hours and the remaining two are minutes</li> <li>• A colon (:) separates the hours from the minutes</li> <li>• a.m. is used to specify morning – beginning at 12:00 a.m.</li> <li>• p.m. is used to specify afternoon/evening – beginning at 12:00 p.m. (noon)</li> </ul>	
<p><b>(S-19) Military Time</b></p> <ul style="list-style-type: none"> <li>• Has 4 digits – the first two numbers are hours and the remaining two are minutes <ul style="list-style-type: none"> <li>– a.m. and p.m. are not used</li> </ul> </li> </ul>	

<b>Module L – Communicating with the Health Care Team</b>	
<ul style="list-style-type: none"> <li>Examples: <ul style="list-style-type: none"> <li>0100 hours is 1:00 a.m. (in the morning)</li> <li>0800 hours is 8:00 a.m. (in the morning)</li> <li>1200 hours is 12:00 p.m. (noon)</li> <li>1500 hours is 3:00 p.m. (in the afternoon)</li> <li>2100 hours is 9:00 p.m. (in the evening)</li> <li>2400 hours is (midnight)</li> </ul> </li> <li>Midnight may be documented as 2400 hours or 0000 hours (as per facility policy)</li> </ul>	
<p><b>(S-20) Converting Standard to Military Time for A.M.</b></p> <ul style="list-style-type: none"> <li>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. <ul style="list-style-type: none"> <li>5:30 a.m. is 0530 hours (0 was added in front)</li> <li>9:59 a.m. is 0959 hours (0 was added in front)</li> </ul> </li> <li>To convert standard time containing 4 digits to military time, do not add a 0 and remove the colon and a.m. <ul style="list-style-type: none"> <li>10:00 a.m. is 1000 hours (0 was not added)</li> <li>11:31 a.m. is 1131 hours (0 was not added)</li> </ul> </li> </ul>	
<p><b>(S-21) Converting Standard to Military Time for P.M.</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>Examples: <ul style="list-style-type: none"> <li>1:00 p.m. is 1300 hours (1+12=13 hours, 00 minutes)</li> <li>4:00 p.m. is 1600 hours (4+12=16 hours, 00 minutes)</li> <li>8:00 p.m. is 2000 hours (8+12=20 hours, 00 minutes)</li> <li>12:00 a.m. (midnight) is 2400 hours or 0000 hours</li> </ul> </li> <li>12 is only added to the “hour(s)” and not the minutes <ul style="list-style-type: none"> <li>1:45 p.m. is 1345 hours (1+12=13 hours, 45 minutes)</li> <li>6:30 p.m. is 1830 hours (6+12=18 hours, 30 minutes)</li> <li>9:45 p.m. is 2145 hours (9+12=21 hours, 45 minutes)</li> <li>11:20 p.m. is 2320 hours (11+12=23 hours, 20 minutes)</li> </ul> </li> </ul>	
<p><b>(S-22) Converting Military to Standard Time</b></p> <ul style="list-style-type: none"> <li>To convert military to standard time, reverse the process</li> <li>For a.m. simply remove the 0 in front of the hours, add the colon and a.m. <ul style="list-style-type: none"> <li>0530 is 5:30 a.m.</li> <li>0422 is 4:22 a.m.</li> </ul> </li> <li>For p.m. simply subtract 12 from the hours, add the colon and p.m. <ul style="list-style-type: none"> <li>1300 hours is 1:00 p.m. (13-12=1)</li> <li>2238 hours is 10:38 p.m. (22-12=10)</li> </ul> </li> </ul>	
<p><b>(S-23) Points to Remember (1)</b></p>	

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<ul style="list-style-type: none"> <li>• HIPAA is a law that protects the resident's privacy; it is a legal document</li> <li>• Maintain confidentiality at all times</li> <li>• Report observations immediately and accurately</li> <li>• Report and record facts, not opinions</li> <li>• Relay information in specific terms not vague general terms</li> </ul>	
<p><b>(S-24) Points to Remember (2)</b></p> <ul style="list-style-type: none"> <li>• Document according to established facility policy using the established standard or military time</li> <li>• Ensure information remains confidential</li> <li>• Do not use electronic devices/computers/kiosks for anything other than the intended purpose</li> <li>• Do not share passwords or other information</li> <li>• Understand the difference between objective and subjective data and use it appropriately</li> <li>• When in doubt, always ask for clarification</li> </ul>	