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**NC Department of
Health and Human Services
NC Nurse Aide I Curriculum**

**Module L
Communication with the
Health Care Team**

July 2024

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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

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Communicating with the Health Care Team

The exchange of information, either verbal or written, between and among members of the health care team




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Reporting

- The verbal account of care provided to the resident
- Initiated immediately when there is a change in the resident's condition
- Is communicated regardless of time, circumstances or schedules, and at change-of-shift





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Recording

- Written or electronic documentation about the care and observations of the resident that becomes part of the medical record
- Allows all health care team members to be updated about the resident





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HIPAA

Health Insurance Portability and Accountability Act

- A law that protects the privacy and security of a person's health information
- Information is available to health providers on a "need to know" basis



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Importance of Communication

- The nurse aide is a vital link in communicating observations to the health care team
- Allows the health care team to make sound decisions about the resident's care
- Results in documentation that becomes part of the resident's legal records



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Recording


- Make notes and always keep with you, but do not record protected information that identifies the resident
- Check that you are documenting on correct resident's record
- Record information accurately and in detail
- State facts, not opinions in simple descriptive words
- Use facility specific forms or electronic templates
- Never remove pages from a paper record or delete entries from an electronic record

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Recording

- Observe and document the resident's use of senses
 - Sight (facial expressions, skin condition and color, ambulation, body language)
 - Hearing (breathing, speaking)
 - Smell (odor of breath, urine, body)
 - Touch (skin temperature, change in pulse)




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Reporting

- Document observations regarding:
 - Personal care given to the resident
 - Treatments and how the resident reacted
 - Measurements such as vital signs, intake and output
 - Activities the resident performed or participated in
 - Mental and emotional status




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Written Recording

- Use a pen, not a pencil
- Sign your name legibly and write your title (NA) or per facility policy
- Follow facility policy for correcting errors
- Do not use white out
- Keep medical documentation in a secure place **ALWAYS**




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Electronic Recording

- Record information and sign electronically as per facility policy
- Follow facility policy for correcting errors
- Do not misuse electronic devices or share passwords or protected information
- Always maintain confidentiality



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Reporting

- Report immediately and accurately, as changes occur
- Change-of-shift reporting is communicating verbal information about residents from one shift to the next
 - Care given
 - Care to be given during other shifts
 - Resident's current condition
- State facts, not opinions
- Report observations and activities to facility employees as per policy

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Objective Versus Subjective Reporting



- 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

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What to Report

- Comments or concerns voiced by the resident regarding treatment and activities
- Unusual actions or behaviors that deviate from the normal or from previous actions



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What to Report


- Resident complains of sudden or severe pain
- Change in resident's ability to respond
- Change in resident's mobility
- Changes in vision, breathing, or swallowing
- Change in facial responses or appearance
- Complaints of numbness anywhere in body
- Vomiting, bleeding, or unusual odors
- Change in vital signs or skin color

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Recording Time

- Document the date and exact time for each entry
- Use standard or military time (24-hour time)



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Standard Time

- Uses numbers 1 through 12
- Has either 3 or 4 digits
 - First one or two numbers are hours
 - Remaining two numbers are minutes
- Uses a colon (:) to separate hours from minutes
- To specify morning, use a.m.
- To specify afternoon and evening, use p.m.


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Military Time

- Has 4 digits
 - First two numbers are hours
 - Remaining two numbers are minutes
- Do not use a.m. and p.m.
- Examples:
 - 0100 hours is 1:00 a.m. (in the morning)
 - 1200 hours is 12:00 p.m. (noon)
 - 2100 hours is 9:00 p.m. (in the evening)
 - 2400 hours is (midnight) – also written 0000



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Converting Standard to Military Time for A.M.

- Time containing 3 digits:
 - Add a 0 in front of such as 5:30 a.m.
 - Remove the colon (:) and a.m.
 - 5:30 a.m. is 0530 hours (0 was added in front)
- Time containing 4 digits:
 - Do not add a 0 in front of such as 10:00 a.m.
 - Remove the colon (:) and a.m.
 - 10:00 a.m. is 1000 hours (0 was not added)

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Converting Standard to Military Time for P.M.

- Beginning at 1:00 p.m., add 12 to the “hour”
- Remove the colon (:) and p.m.
 - 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)
- 12 is only added to the “hour” 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)

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Converting Military to Standard Time


- To convert military to standard time, reverse the process
- For a.m. remove the 0 in front of the hours, and add the colon (:) and a.m.
 - 0530 hours is 5:30 a.m.
 - 0422 hours is 4:22 a.m.
- For p.m. subtract 12 from the hours only, not the minutes, then 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)

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Points to Remember

- HIPAA is a law that protects the resident's privacy
- 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



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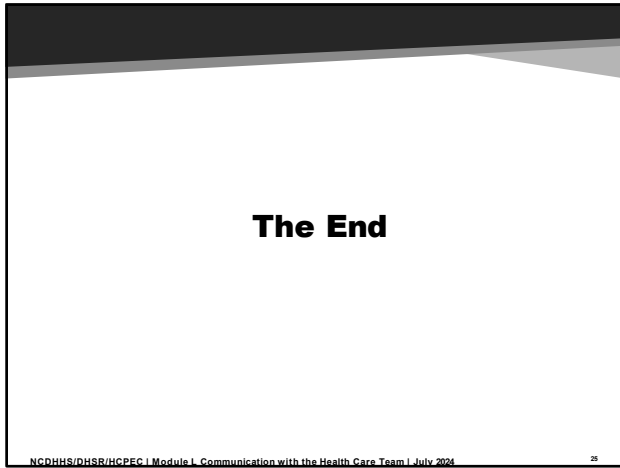
Points to Remember

- Document using the established standard or military time
- Ensure information remains confidential
- Do not misuse electronic devices or share passwords or protected information
- Report using objective and subjective data appropriately
- When in doubt, always ask for clarification

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