CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH

# Documentation, confidentiality, triage and telemedicine

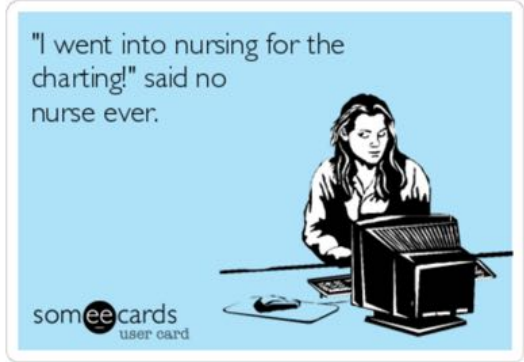
The Meeting - Jim Oskineegish

## Module 4



## Module 4 Objectives

1. Understand SOAP charting principles
2. Practice Scenarios and applying SOAP, IPPA and ROS
3. Read and Review concepts of Consent, and Confidentiality.
4. Understand Principles of Telemedicine Practice
5. Discuss the role and responsibilities of the triage nurse



- Purpose is to communicate the chronology/ continuity of care to other members of the team to ensure consistent and continuous client care
- Advantages:
  - Greater Safety of the client
  - Protection of you as the healthcare provider
  - Reduction of risk arising from possible negligence in the performance of duty of care.
- Documentation is evidence. Your documentation is your best defence.
  - Clear, legible, complete, organized and timely notes help everyone.
  - You are better able to recount your actions when you have a timely record of them.
  - Late charting is better than not charting

## Why is documentation so important?



- Negligence is the failure to exercise the care that a reasonably prudent person would exercise in like circumstances.
- Also referred to as “medical malpractice”.
  1. Duty of Care: Did you do the basic things that need to be done according to the CNO Practice Standards?
  2. Standard of Care: Did you do what your employer expected you to do?
  3. Plaintiff must suffer an injury or loss: must be proven for the negligence action to succeed. (physical or mental)
  4. Conduct must have been the cause of the injury.

## Negligence

- Provides evidence for the proceedings
- Considered proof that the standard of care was met or breached

Problematic Documentation:

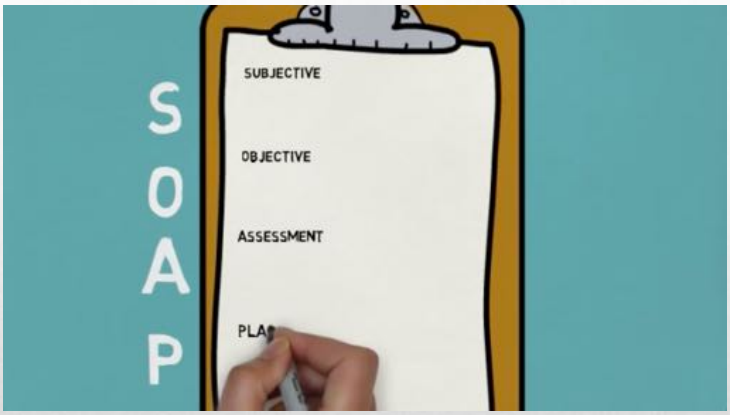
- Vague entries such as “everything is normal” could draw inferences and conclusions of sub standard practice.
- “Chippy Charting” – displays judgmental attitude about a patient. Eg: “This person is drunk” vs. “This person smells of alcohol”.

## How documentation is used in court



- Develop a standardized practice/ habit regarding your documentation (eg. SOAP charting)
- Present meaningful observations within your documentation, painting a picture for others in the future can help avoid problems
- Make sure that your practice respects the proper standards expected of your profession and employer
- Overall, the chart must show:
  1. What Happened
  2. To whom it happened
  3. By whom it happened
  4. When it happened
  5. Why it happened
  6. The result of what happened

## How can you improve your charting?




- https://youtu.be/9TZqTtbBVXc

## SOAP Charting overview:



Subjective: **A DESCRIPTION OF PRESENTATION FROM PATIENT'S PERSPECTIVE**

**The patient's "STORY"**

- Chief Complaint (CC): One brief statement in patient's own words
- History of Presenting Illness (HPI): Onset, progression, associated symptoms, alleviating factors
- Past Medical History (PMHx) : Any recent hospitalizations? Changes in your past medical Hx?
- Family History (FHx): Anyone ill at home? Any contributing factors from your family members health history?
- Social History (SHx): Work or school attendance? Do you use alcohol, cigarettes or drugs?
- Review of Systems (ROS): Head to toe symptom inquiry, reporting in the patient's own words.

***Use words like:***
- ***"Reports"***
- ***"Denies"***
- ***"Describes"***

## SOAP Charting: SUBJECTIVE

**History of Present Illness (HPI):** **OPQRST, AAA**

- Onset
- Progression
- Quality/Quantity
- Radiation
- Severity
- Timing
- Associative Symptoms
- Aggravating Factors
- Alleviating Factors

The HPI components are very important, and you may remember OPQRST as the way we take a history.

Onset, Progression and associated and alleviating factors, and of course the clients perception of the problem!!

Remember – this is the story from the patient's perspective!

**Past Medical History:**

- Significant past medical illnesses
- Surgeries
- Hospitalizations
- Major Trauma (MVA's)
- Childhood Illnesses
- Immunization Status
- Obstetrical History **TPAL**=**T**erm--**P**remature Births-**A**bortions-**L**iving Children
- GTPAL includes gravidity

## SOAP Charting: SUBJECTIVE



Family History:

- Pertinent positive and negative findings
- Acute history (anyone sick at home?)
- Chronic history (parents' medical hx)

Social History:

- Health Habits
- Nutrition, exercise, hobbies
- Smoking, alcohol, Rx & illicit drug use
- Sexual activity
- Education
- Occupation

## SOAP Charting: SUBECTIVE

Videos:

- Dr. Jessica Nishikawa – Review of Systems

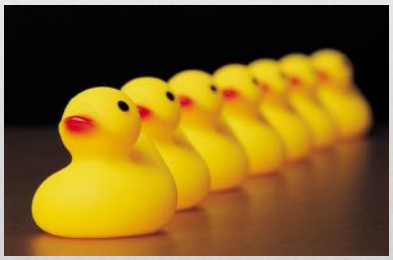
https://youtu.be/4h1tefA8JA0

- Essentials of Medicine – Taking a history

https://youtu.be/06Mi6OVE4A4

- Essentials of Medicine – Review of Systems

https://www.youtube.com/watch?v=mFHe4Z4pVFQ



## SUBJECTIVE: Review of Systems



**Review of Systems:**

- General (Constitutional)
- HEENT
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary/ Gyne/ Obstetrics
- Musculoskeletal/ Neurological
- Skin
- Endocrine/ Haematology
- Mental Health

This is the symptom checklist from the patient's perspective!

## SUBJECTIVE: Review of Systems

Objective: **A DESCRIPTION OF ASSESSMENT FINDINGS FROM YOUR PERSPECTIVE**

**your "OBSERVATIONS"**

- Vital signs (V/S): Temperature, Pulse, Respirations, Blood Pressure, $SPO_2$
- Laboratory data: Random Blood Glucose (RBG), Hemoglobin (Hgb),
  - Other Lab findings: urinalysis (uDip), Pregnancy test (BHCG), ECG, Radiology results etc.
- Measurements: Weight in kg (done at every pediatric visit), Height, BMI, Snellen Eye Exam etc.
- Systemic documentation of physical exam findings as listed in Review of Systems (ROS).
  - Normal findings documented as "no remarkable findings", or N)
- Document IPPA
  - Inspection
  - Percussion
  - Palpation
  - Auscultation

Remember: Auscultation is done before Palpation in Abdomen Exam

**OBJECTIVE**



Assessment : **Your Primary Diagnosis statement, and differential diagnoses.**

**What do you think is going on? (Primary)**

**What else could it possibly be? (Differential)**

- BRIEF STATEMENT listing medical diagnosis & pertinent differential diagnoses.
- Medical diagnosis for the purpose of the medical visit on the given date of the note

**ASSESSMENT: Primary and Differential Diagnoses**

Plan: **A DESCRIPTION OF FURTHER ASSESSMENTS, and PLAN OF CARE FROM YOUR PERSPECTIVE**

**your "TREATMENTS and RECOMMENDATIONS"**

- Recommended additional Diagnostic Tests (x-ray, u/s. bloods)
- Prescription fully written
- Non-pharmacological treatments
- Health Teaching
- Referral, Monitoring, Follow-Up and/or Re-evaluation instructions
- ALWAYS include Follow-Up guidance – "Return to Clinic in 24 hours" etc.
- Signature, Printed Name and Professional Designation.

## PLAN



## Diagnostic Recommendations

- Recommended additional Diagnostic Tests (x-ray, u/s bloodwork)
- Consultation with Physician/ Nurse Practitioner (name, date, time)
  - MD/ NP Orders written out in detail

## PLAN: Therapeutic (Non-pharmacological)

## Non-Pharmacological intervention examples:

- Bed rest
- Increase fluid intake
- Salt water gargles
- Hand hygiene
- Fever management (cool baths, cool clothing)

- **Any health teaching provided to patient or parent/ guardian.**

## Also document:

- Monitoring, Follow-Up and/or re-evaluation
- **ALWAYS include Follow-Up guidance – "Return to Clinic in 24 hours" etc.**

## PLAN: Therapeutic (Non-pharmacological)



## Pharmacological

- *Document complete prescription from Clinical Practice Guidelines.*

Example:

Penicillin VK 300 mg tablets:

1 tablet po tid X 10 days (mitte: 30 tabs)

Tylenol 325mg tablets: 1 to 2 tablets po q4h prn. (Mitte 20 tabs).

## Med Bottle Example:

- Label Bottle, indicating:
  - Name of Patient, Date of dispensing.
  - Drug name and concentration
  - DIN (Drug Identification Number)
  - Administration instructions
  - Amount dispensed (mitte).
  - Your Name

September 14, 2012
John Smith
Penicillin VK 300mg tablets
Take 1 tablet by mouth, three times a day for ten days.
DIN: 00642215
M= 30 tabs Jane Nurse, RN

## PLAN: Therapeutic (Pharmacological)

- Look at everything you write from the perspective of how the reader (colleague, College, employer) might receive it.
- Perceived bias is easy to read. There is an expectation that you did something wrong, even if you did nothing wrong.
- Can't be found negligent for an error in judgement, but can be found negligent if you didn't meet the standard of care
- Correcting Errors: cross out, but do not alter.
- **NO WHITE OUT!!**
- Think about how your message could be perceived
- Your writing is your ambassador: show your reader you are clear, logical, thorough and informed.
- Chart even when an error is made. How you manage the situation will speak more than hiding behind it. Stick to the facts and avoid accusations.

## Documentation Summary



- Monday morning, and you are a CHN assessing an infant during general clinic.
- The grandmother (GM) - who speaks only Oji-Cree has brought her 7 month old grandson to the nursing station because the baby has been fussy for the last 2 days, tugging on his R ear on and off since Friday.
- The infant has felt warm and has been clingy since yesterday. She believes he has had a fever but does not have a thermometer at home.
- Denies any ear discharge, no vomiting or rash. This infant had an ear infection to the same ear over a month ago and is late for his 6 month vaccinations. Otherwise, vaccine status is up-to-date for the 2 and 4 month series and the infant has had no other illnesses.
- There is smoking in the home and the infant had a cold a week ago. There are 2 older siblings at home who both have a history of acute otitis media (AOM) during early childhood.
- GM states previous the baby is taking age appropriate formula (stage 2) and had one 6 ounce bottle today, as well as pureed fruits, which is less than normal. Normal daily intake also includes infant cereal and country meats.
- The infant had 2 wet diapers this morning, and 7 wet diapers yesterday. Last bowel movement (BM) yesterday was brown and soft.
- Tylenol was given early this morning and infant was less fussy.
- The grandmother has no other concerns.
- Mary Beaver, Community Health Resource Worker (CHR) translates throughout visit. The chart indicates the child has a history of RSV last winter. When asked, the grandmother reports no known allergies. The child is not currently taking any medications.

- *Suggested Redbook References:* Section A for child health assessment. Section I for Immunization catch up schedule, Section D for Drug formulary.
- FNIHB Pediatric Guidelines EENT section.

SCENARIO!

## Clinical Presentation # 1

**Objective:**

- **GENERAL:** No apparent distress (NAD), alert, intermittently fussy but consolable, appears mildly ill,
- **V/S** 38.1 (R), 124 HR, 30 RR, Naked weight (no diaper) = 9.0 kg
- **HEENT** - ant font flat/open, no lymphadenopathy, R TM intact, reddened, bulging, light reflex visualized, slight nasal congestion bilat nares, clear discharge, MMM, Throat: no erythema or exudate, no enlarged tonsils palpated.
- **Resp** - no in drawing/accessory muscle use, clear with good AE to bases
- **CVS** - S1S2 , no S3S4 or murmurs noted
- **Abd** - BSX4, soft, no other masses/ organomegaly
- **Skin** - skin turgor WNL, cap refill brisk, no pallor, rashes or cyanosis noted
- **MSK**- good CWCM noted (colour, warmth, circulation, movement

## Clinical Presentation #1 - On Exam

**Question: What is your diagnosis for 7 month old infant?**

TIP: Use your Pediatric Clinical Practice Guidelines

**Clinical Presentation - Assessment & Plan**



**Question: What is your diagnosis for 7 month old infant?**

TIP: Use your Pediatric Clinical Practice Guidelines

**A***:* Right Acute Otitis Media

**Clinical Presentation Assessment & Plan**

***Unless care is provided on an emergency and life threatening basis, medical treatment should be provided under informed consent.***

Health care providers should disclose the following information to the client, in order for the client to make a decision for/against treatment:

- The **reason** for treatment
- Seriousness & **risks of the specific treatment**
- The **risks of refusing** the treatment
- Possible **alternative treatments**
- The **answers to any questions** the client may have

*Note: **For valid consent** – Client must be knowledgeable about the treatment and be free to decide to consent.*

Justice Dept. Handout on Consent - LMS

## Consent to Medical Treatment



**REFUSAL OR WITHDRAWAL OF CONSENT**

- At any time, client is allowed to refuse treatment or withdraw their consent.

**AGE OF CONSENT TO MEDICAL TREATMENT**

- The Client need not reach the age of majority to give consent to treatment. The determining factor in a child's ability to provide or refuse consent is whether the young person's physical, mental, and emotional development allows for a full appreciation of the nature and consequences of the proposed treatment or lack of treatment.

***Minor Majority Rule***

- If a minor does not have the legal and/or metal capacity to consent for treatment, a parent or legal guardian will have to provide consent on behalf of the minor.

**WHEN CONSENT IS IMPOSSIBLE OR IMPRACTICAL TO OBTAIN**

In an emergency situation, when the client's life or health is threatened and the client has not refused treatment, and it is impossible to obtain consent of their closest relative, the nurse should proceed with the **most appropriate** treatment and document the care given in the client's chart.

## Consent to Medical Treatment

*Health records (manual & electronic), personal information, and personal health information regarding medical and psychosocial interventions, must maintain confidentiality consistent with the federal Privacy Act, Policies regarding the Treasury Board Policy on Government Security, and Privacy Laws.*

- Disclosure of Personal Information With Consent Of Client
- Disclosure of Personal Information In A **"Circle of Care"**
- Disclosure For An Emergency Situation
- Disclosure To A Third Party
- Disclosure On A Proactive Basis

## Privacy and Access Issues



Many health concerns and treatments are sensitive subjects to tackle, and breaching confidentiality may affect the patient's desire to seek the help needed.

*It is important to maintain client confidentiality, unless the client discloses information about high-risk activity or thoughts (ex. Suicide, homicide, child abuse, etc.)*

***As a Health Canada employee and/or contractor, the violation of patient confidentiality is subject to disciplinary action, and possibly including dismissal***

## Confidentiality

The College of Nurses defines nursing telepractice as the delivery, management and coordination of care and services provided via information and telecommunication technologies.

- Telephones, trail radios, satellite phone
- Smartphones/ mobile devices
- Faxes
- Internet; (Facebook)
- Video and audio conferencing
- Tele-radiology
- Computer information systems

## What is Nursing Telemedicine/Telepractice?



- Telephone triage
- Providing health information and/or answering client questions that promote client self-care
- Answering questions about laboratory tests
- Providing disease-specific information, education, counselling and/or linking to resources (e.g. hotline services, Motherisk, Poison Control Centres, or help lines for teenagers or mental health crisis intervention)

## Examples of nursing tele-practice

Telephone consultation is within the scope of registered nursing practice, however it requires specialized nursing competence.

Such indicators as:

- Advanced assessment skills
- **Knowledge of the client** population and current community resources
- **Effective communication** and crisis intervention skills
- An attitude of **sensitivity and respect**
- Judgment which includes **critical thinking** ability. And the ability to decipher ambiguous information.

## Telephone consultation/ triage



- The therapeutic nurse-client relationship
- Providing and documenting care
- Roles and responsibilities
- Consent, privacy and confidentiality
- Ethical and legal considerations
- Competencies

## Principles of Nursing Telepractice

*When a nurse provides care to a client using information and telecommunication technologies, a therapeutic nurse-client relationship is formed.*

- The CHN has to provide her name and her professional designation, she is accountable for establishing and maintaining the therapeutic nurse-client relationship.

## Principles of Nursing Telepractice



As with all therapeutic nurse-client relationships, nurses use a caring and systematic approach while identifying care needs and providing care during nursing telepractice encounters..

It is expected that clients can be assured of confidentiality; however, as in face-to-face encounters, there may be times when nurses become aware of information they are required to report (e.g., suspected child abuse or neglect.)

## Confidentiality

- Listening effectively
- Assisting clients to identify and prioritize their needs
- Knowledge of available resources
- Sharing information with clients
- Making safe, effective and appropriate recommendations
- limited interaction
- Contracting and making referrals.

## A telephone consultation involves:



- Ask open-ended questions to elicit sufficient data to assist with decision-making
- Ask questions in a logical sequence with attention and sensitivity to the client's acuity level;
- Find solutions to communication, and language or cultural barriers
- Avoid medical or technical jargon
- Avoid premature conclusions regarding the client's situations or problems; listen for emotional and behavioural cues that can convey important client information (tone of voice, background noise)

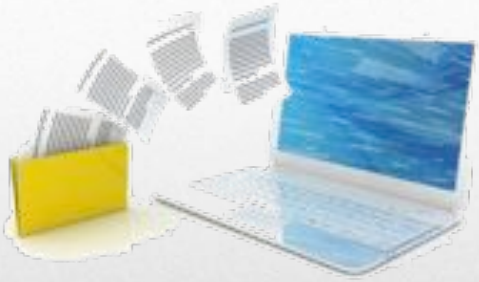
## Reducing the risk of missing important information.

- explore the client's self-diagnosis ( a client with chest pain says it's just indigestion but, on further questioning, the nurse finds that other symptoms and the client's medical history suggest a heart attack)

- consult with and refer to appropriate health care professionals when a client's needs exceed the nurse's knowledge, skill and judgment. (second on call)
- When conducting assessments tele practice, nurses may use standardized interview tools, computer-based protocols, algorithms or other decision support tools.

**Reducing the risk of missing important information.**





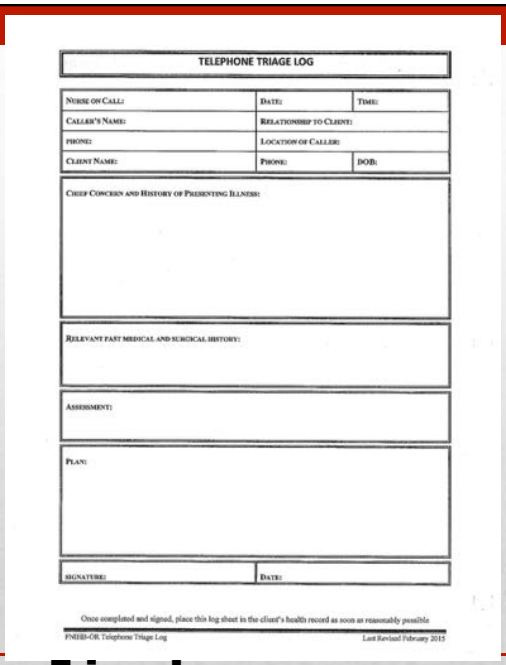
- All nurses who provide care, including those in tele practice, are required to document interactions with clients according to the CNO Practice Standard: Documentation.

**Tele-Practice Documentation**

Nurses' documentation of client or consultant interactions is expected to include:

- date and time of the interaction
- name of the client/providers involved
- name of the client being discussed (when applicable)
- reason for the interaction
- information provided/received
- client information provided/ received
- advice or information given/ received
- any follow-up required/provided
- any agreement/consensus about the plan of care
- the documenting nurse's signature and designation.





TELEPHONE TRIAGE LOG

| | | |
|---|---|---|
| NURSE ON CALL: | DATE: | TIME: |
| CALLER'S NAME: | RELATIONSHIP TO CLIENT: | |
| PHONE: | LOCATION OF CALLER: | |
| CLIENT NAME: | PHONE: | DOB: |
| CHIEF CONCERN AND HISTORY OF PRESENTING ILLNESS: | | |
| RELEVANT PAST MEDICAL AND SURGICAL HISTORY: | | |
| ASSESSMENT: | | |
| PLAN: | | |
| SIGNATURE: | DATE: | |

Once completed and signed, place this log sheet in the client's health record as soon as reasonably possible

FNIHB-OR Telephone Triage Log — Last Revised February 2015

## Telephone Triage Log

- Nurse's fatigue , deep sleep
- Language barrier
- Third person calls
- New to the community
- Rude caller


Be on the safe side

- See infants, elders
- Anyone who, once you hang up, you start doubting yourself, maybe...I should have seen them…
- Always advise the caller to contact you if any changes or concerns.

**After Hours Telephone Triage Challenges**



When a client or community is unknown to the nurse, she/he can not draw on her/his knowledge of the disease process and previous treatment provided to design individualized assessments and give advice and will often have to do a face-to-face assessment.

**After Hours Telephone Triage Challenges**

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- Found in some larger nursing stations (Sandy Lake, Pikangikum, Kashechewan)
- Nurse in Triage Role generally does not see regularly scheduled patients – 4 areas of responsibility

1. Calls:

- Take any calls directed to on-call nurse, patient inquiries, clinic directed inquiries.
- Ensure a telephone encounter form is completed for every patient that is triaged.
- Triage patients according to CTAS (telephone/ walk-in)
- If CTAS 1 or 2: may need to pull extra RN's to assist

## Triage Nurse Role



2. Assist in Clinic Flow

- Booking patients in schedule,
- Assessing a patient if clinic is backed up
- Keeping those waiting informed.
- Rebooking patients if clinic is dealing with an emergency

3. Review and processing On-site MD notes / orders

- Review completed MD charts, note with initials or signature and date that orders have been reviewed.
- Fax Prescriptions, imaging requisitions, specialist referrals, then sign/date the document before inserting into chart
- Enter lab work orders into the lab book
- **all chart notes should be signed and dated by RN, even if there are no orders present.

## Triage Nurse Role

4. Paperwork/ Administration

- Review and handle incoming faxes (document, document, document!!)
- Priority 1: in the AM – review all faxes, sort by urgency
  - Positive or abnormal lab results should be given to the RN who conducted the test.
- Priority 2: Non-urgent faxes – divided amongst the staff.
  - Travel documents to travel clerk
  - Letters sent directly to Nursing Station should be copied to Sioux Lookout for inclusion in the patient's EMR.
  - Sign and date each document, and what was done with it (eg. Rec'd Jun 2, 2016 - Handed over to Erin. )

## Triage Nurse Role



4. Paperwork/ Administration (con't)

- Priority 2: Non-urgent faxes:
  - Review labs and MD orders – note any actions required (e.g. Add lab work to lab binder, book patient for follow up etc.)
  - Any MD note requiring a response – write on note and fax back
  - STI lab results to Public Health RN
  - Any labs results done by RN Medical Directive – given to RN who ordered it.

## Triage Nurse Role


PRESENTATION FINISHED
...ANY QUESTIONS?
Questions?