CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH

Documentation, confidentiality, triage and telemedicine

The Meeting - Jim Oskineegish

Module 4 – AB

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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

Module 4 Objectives

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- 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?

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- 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 CARNA 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

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- 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

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- 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?

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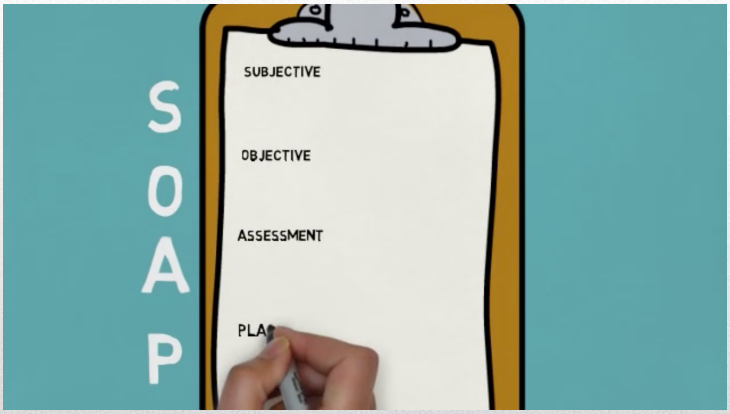

- https://youtu.be/9TZqTtbBVXc

SOAP Charting overview:

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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, Quality/Quantity, Radiation, Severity, Timing, Associative Symptoms, Aggravating Factors, Alleviating Factors
- **Past Medical History (PMHx):** Significant past medical illnesses, Surgeries, Hospitalizations, Major Trauma (MVA's), Childhood Illnesses, Immunization Status, Obstetrical History (GTPAL includes gravidity)
- **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? Health Habits, Nutrition, exercise, hobbies, Sexual activity.
- **Review of Systems (ROS)**: Head to toe symptom inquiry, reporting in the patient's own words.
  - General (Constitutional);
  - HEENT/ Neurological
  - Cardiovascular/Respiratory;
  - Gastrointestinal; Genitourinary/ Gynae/ Obstetrics;
  - Musculoskeletal; Skin;
  - Endocrine/ Hematology
  - Mental Health

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

Use words like:
•"Reports"
•"Denies"
•"Describes"

SOAP Charting: SUBJECTIVE

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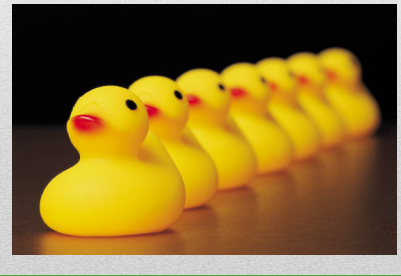
Videos:

- Dr. Jessica Nishikawa – Review of Systems
- Essentials of Medicine – Taking a history
- Essentials of Medicine – Review of Systems



SUBJECTIVE: Review of Systems

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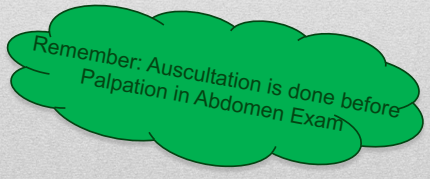
Objective: **A DESCRIPTION OF ASSESSMENT FINDINGS FROM <u>YOUR</u> PERSPECTIVE**

your "OBSERVATIONS"

- Vital signs (V/S): Temperature, Pulse, Respirations, Blood Pressure, SPO_2
- Point of Care 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)
- ALWAYS Document **IPPA**
  - Inspection
  - Percussion
  - Palpation
  - Auscultation



OBJECTIVE

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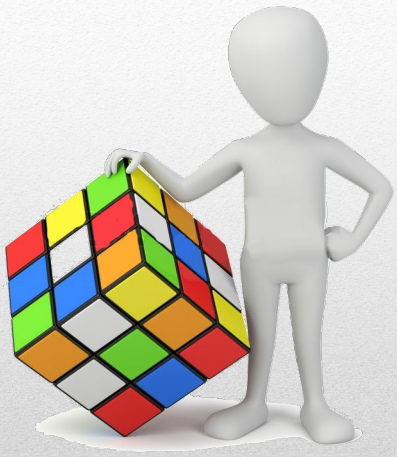
Assessment : **Your Primary Diagnosis statement, and differential diagnoses.**

Dx: What do you think is going on? (Primary)

DDx: What else could it possibly be? (Differential)



- BRIEF STATEMENT listing the medical diagnosis & any pertinent differential diagnoses.
- Medical Diagnosis: the primary purpose of the medical visit on the given date of the note
- Differential diagnosis: a list of the other possible conditions that might produce a patient's signs and symptoms.
  - An important part of clinical reasoning.
  - It enables appropriate testing to rule out possibilities and confirm a final diagnosis.
  - Courts view the formulation and documentation of a differential diagnosis as evidence of a clinician's competence, prudence, and critical thinking.
- Tip: use the CPG's to find differentials

ASSESSMENT: Primary and Differential Diagnoses

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Plan: **A DESCRIPTION OF FURTHER ASSESSMENTS, and PLAN OF CARE FROM <u>YOUR</u> PERSPECTIVE**

your "TREATMENTS and RECOMMENDATIONS" must include:

- Consultation/ Referral (name of MD/NP, time, method)
- Recommended additional Diagnostic Tests (x-ray, u/s. bloods)
- Pharmacological Interventions with prescription fully written out (Drug, Dose, Route, Frequency, Mitte)
  - * includes CPG chapter (as of 2019)
- Non-pharmacological treatments (eg. Apply ice, drink ++fluids etc.)
- All Health Teaching provided to the client/ caregiver
- 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.
  - **IMPORTANT:** have a legible printed name if your signature if illegible; and sign the master signature sheet if one exists.

PLAN

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Pharmacological

- *Document complete prescription as per the Clinical Practice Guidelines.*

Example:

Penicillin VK 300 mg tablets:

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

Acetaminophen 325mg tablets:

1 to 2 tablets po q4h prn. (Mitte 20 tabs).

Always use generic drug name

Use your clinical judgement on severity of illness to decide how long to treat the patient.

PLAN: Therapeutic (Pharmacological)

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CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH
SOAP Note Quick Reference

SUBJECTIVE: *(Pt's story)*
CC: Chief Complaint (presenting problem)
HPI: History of Presenting Illness (explore CC)
OPQRST: Onset; Progression; Quality/ Quantity; Radiation; Severity; Timing; Relieving/ Aggravating factors; Associated Symptoms
PMHx: Past Medical History relevant to CC
Allergies
Immunizations
Current Meds: Rx; OTC; Herbal
FMHx: Family Hx HTN; DM; TB; etc
SHx: Social Hx ETOH; Smoking; Drugs; Living cond; Diet; Sleep; Work/ School
ROS: Review of Systems (pt's report) - HEENT; CardioResp; GI/GU; MSK; Neuro; Integ; Mental Health

OBJECTIVE: *(Your Physical Exam)*
General Observations
VS: Temp; HR; Resp; BP; SPO2
Measurements: Wt; Ht; BMI
POC Labs: Gluc; Hgb; UDip; HCG;
ROS: Review of Systems: HEENT; Resp; Cardiovasc; GI; GU; MSK; Neuro; Integ; Mental Health

ASSESSMENT:
Primary Diagnosis
Differential Diagnoses (List)

PLAN:
1. Consultation/ Referral
2. Additional Diagnostics
3. Pharmacological Interventions (incl. CPG chapt or consultant name)
4. Non-Pharmacological Interventions
5. Health Teaching
6. Follow up instructions
7. Confirm pt/ caregiver understands

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SOAP Note Quick Reference

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Documentation Summary

- 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.

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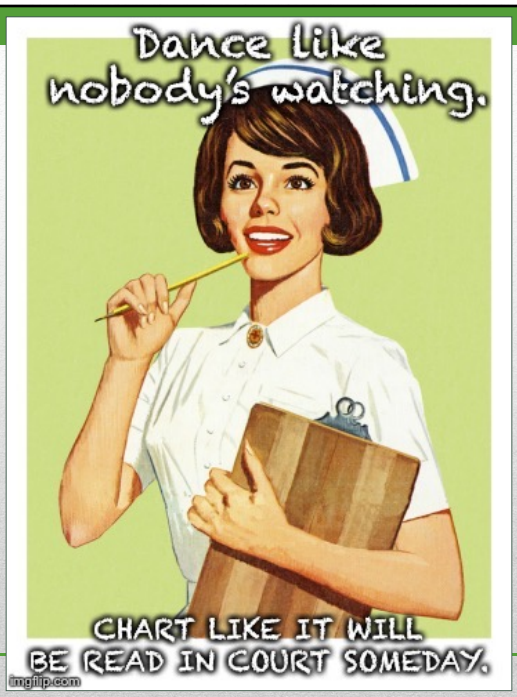

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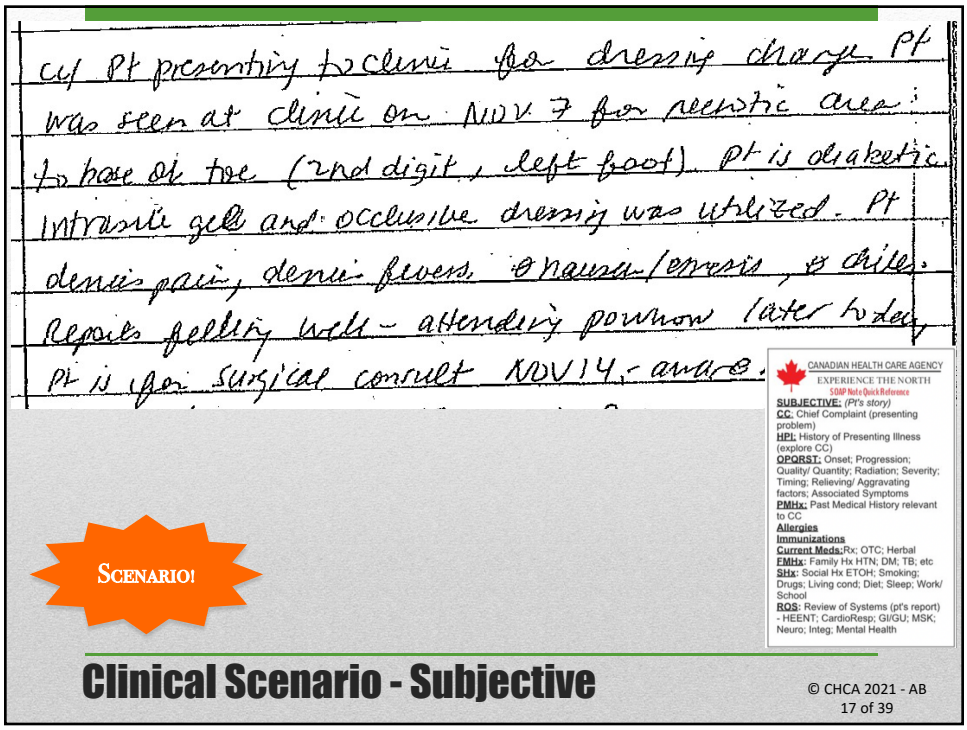
c/o Pt presenting to clinic for dressing change. Pt
was seen at clinic on NOV 7 for necrotic area
to base of toe (2nd digit, left foot). Pt is diabetic.
Intrasite gel and occlusive dressing was utilized. Pt
denies pain, denies fevers, & nausea/emesis, & chills.
Reports feeling well - attending pow wow later today.
Pt is for surgical consult NOV 14 - aware.
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SCENARIO!
Clinical Scenario - Subjective
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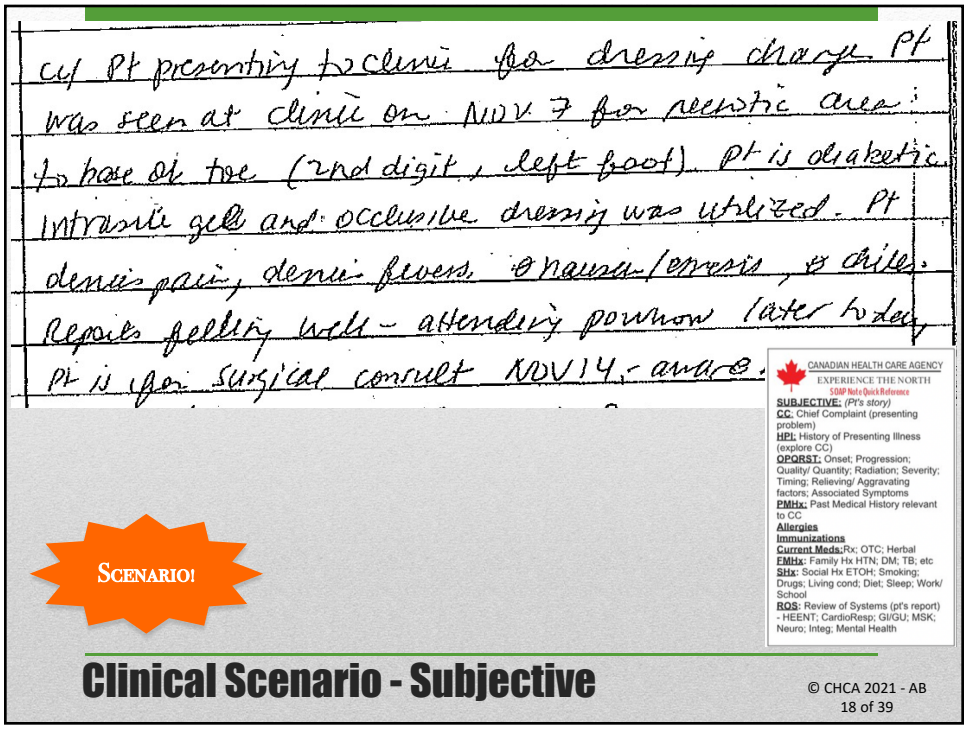
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Clinical Scenario - Subjective
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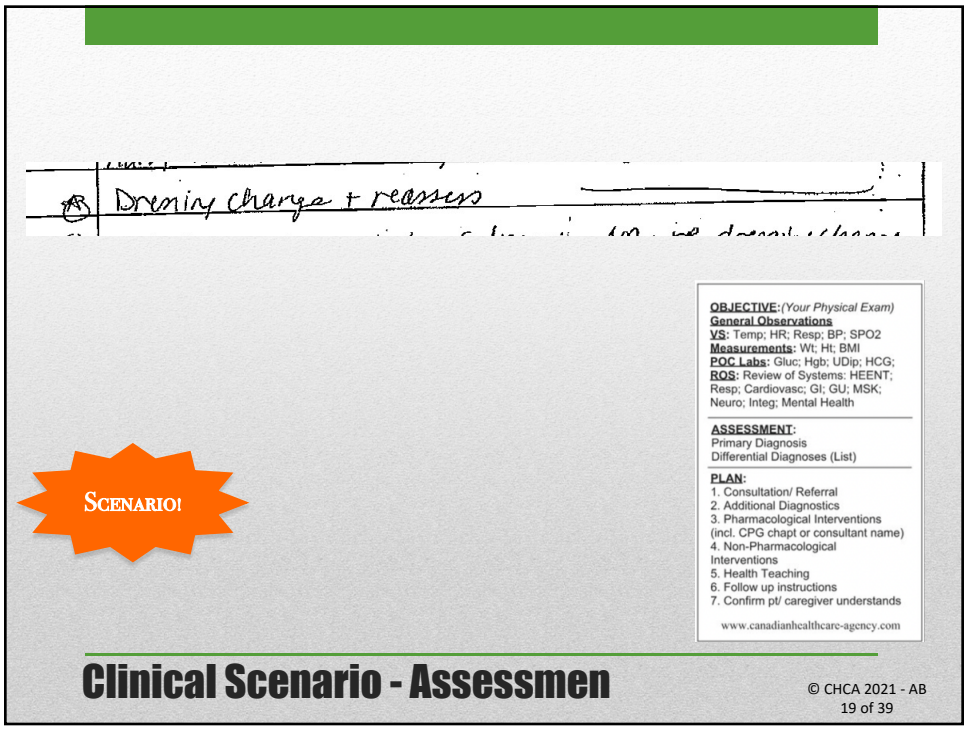
Draining charge + reassess
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SCENARIO!
Clinical Scenario - Assessmen
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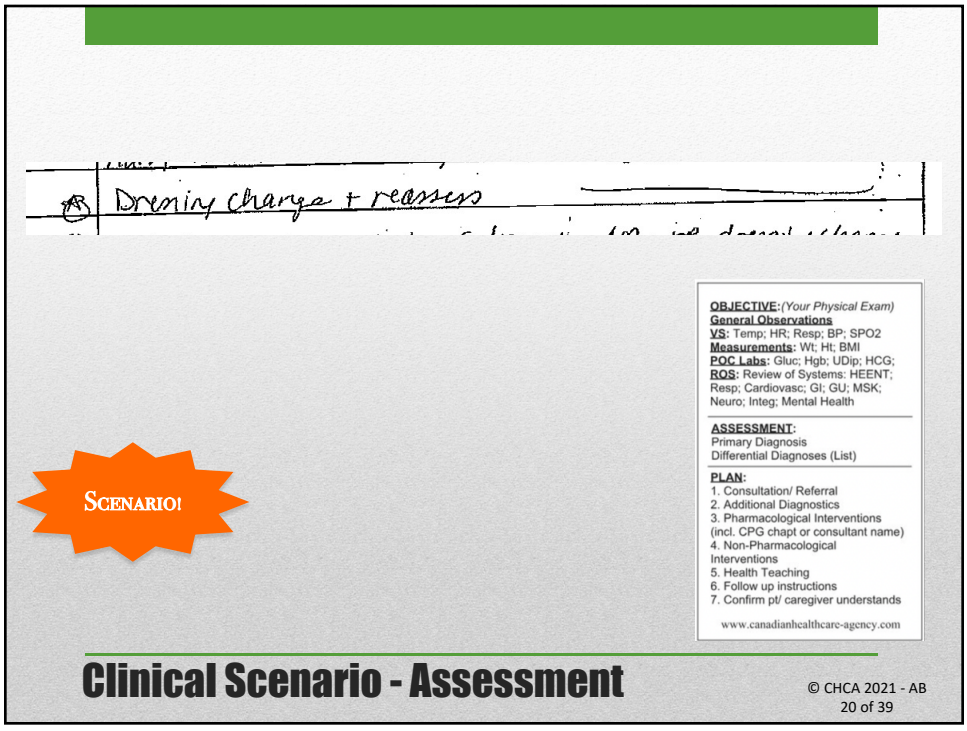
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SCENARIO!
Clinical Scenario - Assessment
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Unless care is provided on an emergency and life threatening basis, medical treatment should be provided under informed consent.

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

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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

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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

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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 an Indigenous Services Canada employee and/or contractor, the violation of patient confidentiality is subject to disciplinary action, and possibly including dismissal

Confidentiality

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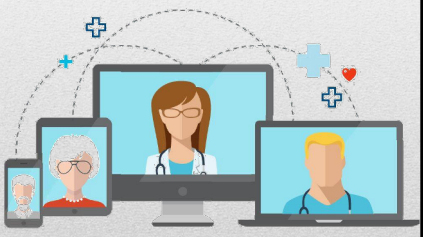
CARNA defines nursing telehealth nursing practice as the delivery, management and coordination of care and services provided via information and telecommunication technologies.

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



https://nurses.ab.ca/practice-and-learning/nursing-practice-information/telehealth-nursing-practice

What is Telehealth Nursing Practice?

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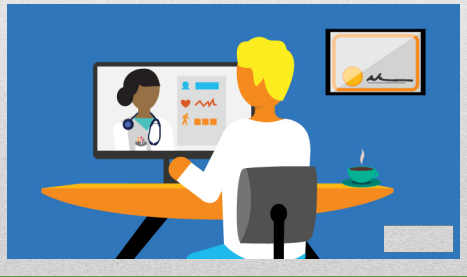
- Telephone triage
- Providing health information and/or answering client questions that promote client self-care
- Answering questions about laboratory tests
- Providing disease-specific information, education, counselling and/or linking to resources (e.g. hotline services, Motherisk, Poison Control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



Examples of Telehealth Nursing practice

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Telephone consultation/ triage

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.

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Principles of Nursing Telepractice

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

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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 his/her name and his/her professional designation, she is accountable for establishing and maintaining the therapeutic nurse-client relationship.

Principles of Telehealth Nursing Practice

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

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- 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:

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- 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.

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- 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)

- When conducting assessments tele practice, nurses may use standardized interview tools, checklists, or consult with a colleague (2nd on call nurse)

Reducing the risk of missing important information.

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

Tele Practice Documentation

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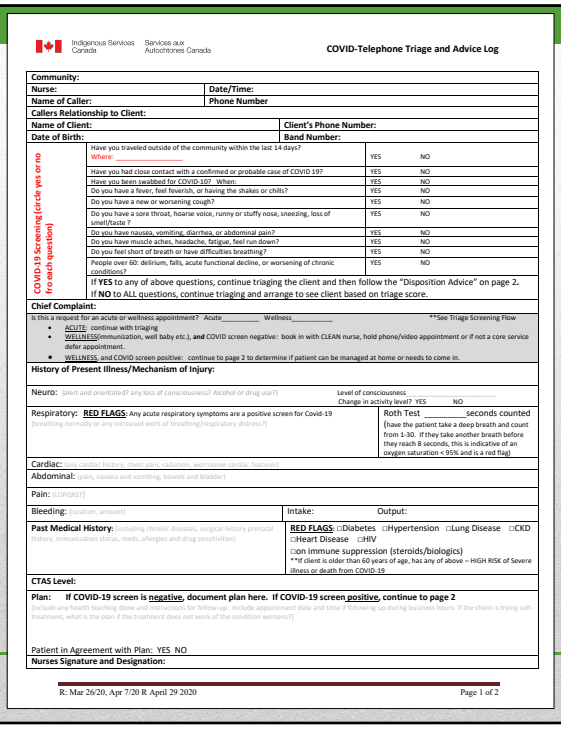
COVID-19 Telephone Triage Log



Indigenous Services Canada / Services aux Autochtones Canada

COVID-Telephone Triage and Advice Log

Community:	
Nurse:	**Date/Time:**
Name of Caller:	**Phone Number**
Callers Relationship to Client:	
Name of Client:	**Client's Phone Number:**
Date of Birth:	**Band Number:**

COVID-19 Screening (circle yes or no fro each question)

Have you traveled outside of the community within the last 14 days? Where: _____	YES	NO
Have you had close contact with a confirmed or probable case of COVID 19?	YES	NO
Have you been swabbed for COVID-10? When:	YES	NO
Do you have a fever, feel feverish, or having the shakes or chills?	YES	NO
Do you have a new or worsening cough?	YES	NO
Do you have a sore throat, hoarse voice, runny or stuffy nose, sneezing, loss of smell/taste ?	YES	NO
Do you have nausea, vomiting, diarrhea, or abdominal pain?	YES	NO
Do you have muscle aches, headache, fatigue, feel run down?	YES	NO
Do you feel short of breath or have difficulties breathing?	YES	NO
People over 60: delirium, falls, acute functional decline, or worsening of chronic conditions?	YES	NO

If **YES** to any of above questions, continue triaging the client and then follow the "Disposition Advice" on page 2.
If **NO** to ALL questions, continue triaging and arrange to see client based on triage score.

Chief Complaint:

Is this a request for an acute or wellness appointment? Acute_____ Wellness_____ **See Triage Screening Flow

- ACUTE: continue with triaging
- WELLNESS(immunization, well baby etc.), **and** COVID screen negative: book in with CLEAN nurse, hold phone/video appointment or if not a core service defer appointment.
- WELLNESS, and COVID screen positive: continue to page 2 to determine if patient can be managed at home or needs to come in.

History of Present Illness/Mechanism of Injury:

Neuro: (alert and orientated? any loss of consciousness? Alcohol or drug use?) Level of consciousness _____ Change in activity level? YES NO

Respiratory: **RED FLAGS:** Any acute respiratory symptoms are a positive screen for Covid-19 (breathing normally or any increased work of breathing/respiratory distress?)

Roth Test _____seconds counted (have the patient take a deep breath and count from 1-30. If they take another breath before they reach 8 seconds, this is indicative of an oxygen saturation < 95% and is a red flag)

Cardiac: (any cardiac history, chest pain, radiation, worrisome cardiac features)

Abdominal: (pain, nausea and vomiting, bowels and bladder)

Pain: (LOPQRST)

Bleeding: (location, amount) Intake: Output:

Past Medical History: (including chronic diseases, surgical history prenatal history, immunization status, meds, allergies and drug sensitivities)

RED FLAGS: □Diabetes □Hypertension □Lung Disease □CKD □Heart Disease □HIV
□on immune suppression (steroids/biologics)
**If client is older than 60 years of age, has any of above – HIGH RISK of Severe illness or death from COVID-19

CTAS Level:

Plan: **If COVID-19 screen is negative, document plan here. If COVID-19 screen positive, continue to page 2**
(include any health teaching done and instructions for follow up. Include appointment date and time if booking or during business hours. If the client is trying self treatment, what is the plan if the treatment does not work of the condition worsens?)

Patient in Agreement with Plan: YES NO

Nurses Signature and Designation:

R: Mar 26/20, Apr 7/20 R April 29 2020 Page 1 of 2

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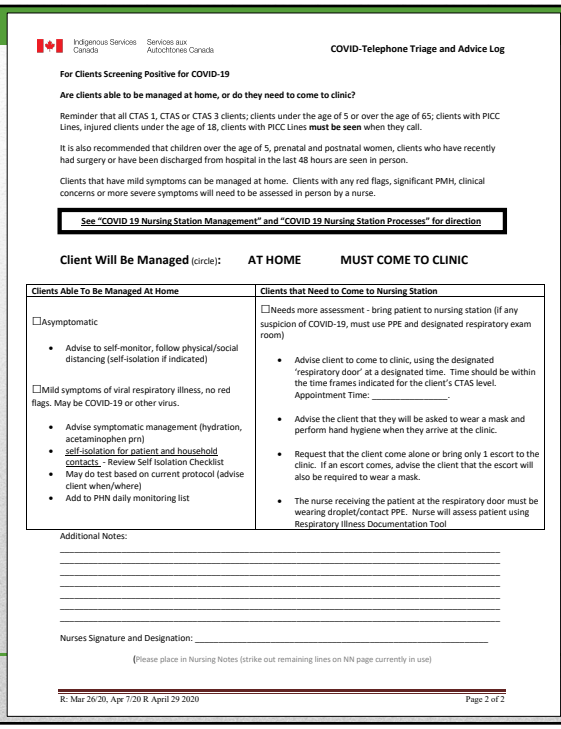
COVID-19 Telephone Triage Log



Indigenous Services Canada / Services aux Autochtones Canada

COVID-Telephone Triage and Advice Log

For Clients Screening Positive for COVID-19

Are clients able to be managed at home, or do they need to come to clinic?

Reminder that all CTAS 1, CTAS or CTAS 3 clients; clients under the age of 5 or over the age of 65; clients with PICC Lines, injured clients under the age of 18, clients with PICC Lines **must be seen** when they call.

It is also recommended that children over the age of 5, prenatal and postnatal women, clients who have recently had surgery or have been discharged from hospital in the last 48 hours are seen in person.

Clients that have mild symptoms can be managed at home. Clients with any red flags, significant PMH, clinical concerns or more severe symptoms will need to be assessed in person by a nurse.

See "COVID 19 Nursing Station Management" and "COVID 19 Nursing Station Processes" for direction

Client Will Be Managed (circle)**:** **AT HOME** **MUST COME TO CLINIC**

Clients Able To Be Managed At Home	Clients that Need to Come to Nursing Station
☐Asymptomatic • Advise to self-monitor, follow physical/social distancing (self-isolation if indicated) ☐Mild symptoms of viral respiratory illness, no red flags. May be COVID-19 or other virus. • Advise symptomatic management (hydration, acetaminophen prn) • self-isolation for patient and household contacts - Review Self Isolation Checklist • May do test based on current protocol (advise client when/where) • Add to PHN daily monitoring list	☐Needs more assessment - bring patient to nursing station (if any suspicion of COVID-19, must use PPE and designated respiratory exam room) • Advise client to come to clinic, using the designated 'respiratory door' at a designated time. Time should be within the time frames indicated for the client's CTAS level. Appointment Time: _____. • Advise the client that they will be asked to wear a mask and perform hand hygiene when they arrive at the clinic. • Request that the client come alone or bring only 1 escort to the clinic. If an escort comes, advise the client that the escort will also be required to wear a mask. • The nurse receiving the patient at the respiratory door must be wearing droplet/contact PPE. Nurse will assess patient using Respiratory Illness Documentation Tool

Additional Notes:
_____
_____
_____
_____
_____
_____
_____

Nurses Signature and Designation: _____

(Please place in Nursing Notes (strike out remaining lines on NN page currently in use)

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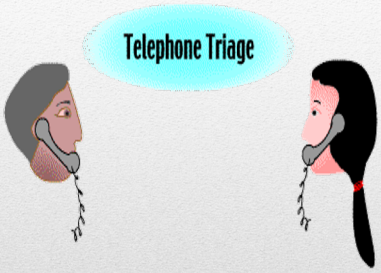
- Nurse's fatigue , deep sleep
- Language barrier
- Third person calls
- New to the community
- Rude caller



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

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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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PRESENTATION FINISHED
...ANY QUESTIONS?
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Questions?
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