CANADIAN HEALTH CARE AGENCY LTD

EXPERIENCE THE NORTH

Health records are legal documents and must be consistent with the standards of the College of Nurses of Ontario and First Nations and Inuit Health Branch.

SOAPIE (Subjective, Objective, Assessment, Plan, Implementation, Evaluation) format must be used.

Date of Audit: _____ Nurse: _____

Community: _____ Evaluator: _____

N/A = not applicable

Client ID number:			
Criteria for Audit	Yes	No	Comment
Overall Content Standards			
Complete, clear, concise recording			
Recording relevant to client care			
Legibile and comprehensive recording			
Recording in black or blue ink			
All entries must include: • Date and time of entry • Location of service (Clinic, Telephone consult etc.) • Proper legible signature, or printed name underneath • Professional designation/ title • Chronological recording of events			
Documentation shows evidence of objective, non-judgmental statements			
Late entries recorded appropriately (entry indicating “late entry”)			
No blank spaces between entries			
Appropriate correction of errors (no erasure, covering or completely scratching out erroneous entries)			
Correct Spelling and Grammar, no colloquialisms, appropriate use of abbreviations			
Charting succinctly written, organized and factual.			
SUBJECTIVE: (includes all information relevant to client care)			
Chief Complaint • Brief, one line statement in client’s words, in quotes			
History of Presenting Illness • Chronological (onset, location, PQRST, SAMPLE)			
Current Health • Medications: OTC, Rx, traditional, herbal, recreational			
Past Medical History • Immunizations • Allergies • Screening Tests			
Family History • Recent History • Extended History			
Personal Social History • Environment • Sleep • Exercise • Smoking, • ETOH • Diet			
Review of Systems (ok if noted in HPI)			

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OBJECTIVE: (Organized in Head-to-Toe format)			
Vital Signs • T, HR, RR, BP, O_2 Sat) • Measurements (wt, ht, BMI, head circumference)			
Point-of-Care Results • Urine Dip • Random Blood Glucose • Haemoglobin • Rapid Strep			
Baseline assessment pertinent to client's chief complaint			
Review of systems: Physical Examination Findings • IPPA approach evident in documentation			
ASSESSMENT: (Must include)			
• Differential and • Working diagnoses			

PLAN, IMPLEMENTATION and EVALUATION:			
Laboratory and Diagnostic Imaging Investigations (non point-of-care)			
Written plan of care • Specific, measurable and related to the definitive diagnoses			
Acknowledgement of abnormal test/ imaging results • Point of Care • Previous Results			
Treatments • Non-pharmacological interventions • Pharmacological Interventions (within scope of practice)			
Evidence of Client and/or Family Health Teaching			
Evidence of Client and/or Family's input into plan of care			
Clear documentation of verbal/ telephone order consultations • MD/ NP/ Other provider Name • Method of consultation (Verbal/ Phone/ Fax/ Other) • Full order transcribed			
Evidence of care evaluation			
TECHNICAL STANDARDS			
SOAPIE format evident in documentation			
Client Data on every record page includes: • Client name • Date of birth • Gender • Health Card Number • Band number • List of Allergies • Health facility name			
CRITERIA FOR CHART AUDIT			
List of medical diagnoses (problem list)			
Medication profile (chronic)			
Next of kin or guardian			
Current address and phone number			