CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH

Documentation, confidentiality, triage and telemedicine

The Meeting - Jim Oskineegish

Module 4

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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.

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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 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

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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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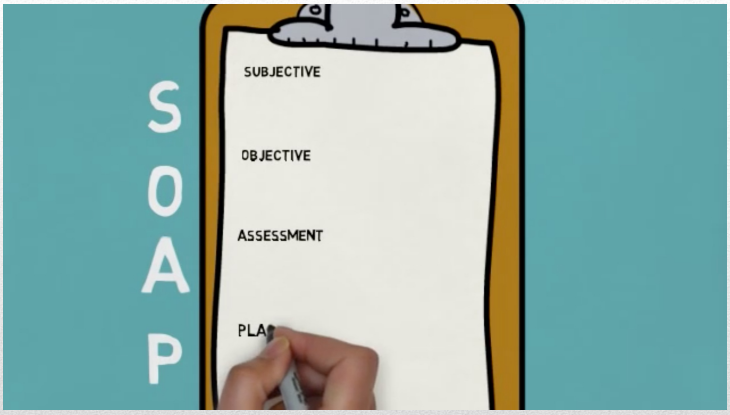

- https://youtu.be/9TZqTtbBVXc

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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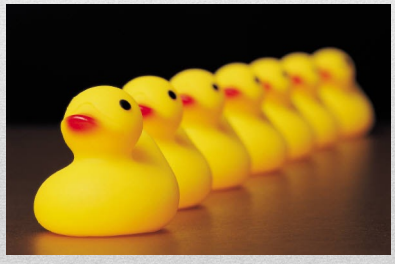
Videos:

- Dr. Jessica Nishikawa – Review of Systems
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

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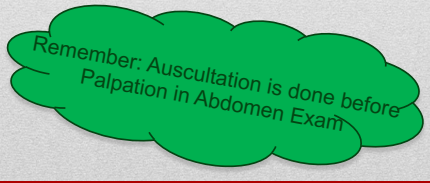
Objective: **A DESCRIPTION OF ASSESSMENT FINDINGS FROM YOUR PERSPECTIVE**

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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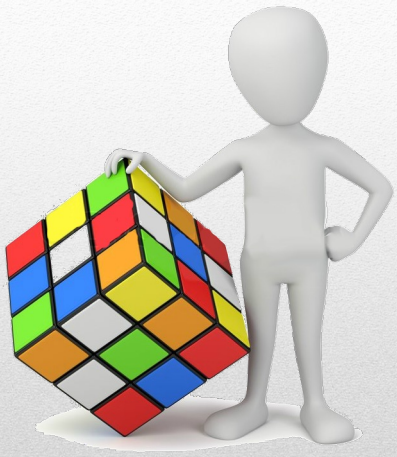
Assessment : **Your Primary problem statement, and list of alternatives.**

Dx: A list of problems in order of importance

- BRIEF STATEMENT listing the overall problems experienced by the patient, beginning with the reason for the encounter.



ASSESSMENT: List of problems

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

your "TREATMENTS and RECOMMENDATIONS" must include:

- Consultation/ Referral (name of MD/NP, time, method)
- Recommended additional Diagnostic Tests ordered by MD/NP (x-ray, u/s. bloods)
- Pharmacological Interventions with prescription fully written out (Drug, Dose, Route, Frequency, Mitte)
  - * includes name of prescriber, time of consultation
- 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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Non-Pharmacological intervention examples:

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

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

Also document:

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

PLAN: Therapeutic (Non-pharmacological)

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Pharmacological

- *Document complete prescription*

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).

As per Dr. Smith, or NP Jones, May 26, 2020 15:30.

Always use generic drug name

PLAN: Therapeutic (Pharmacological)

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- 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

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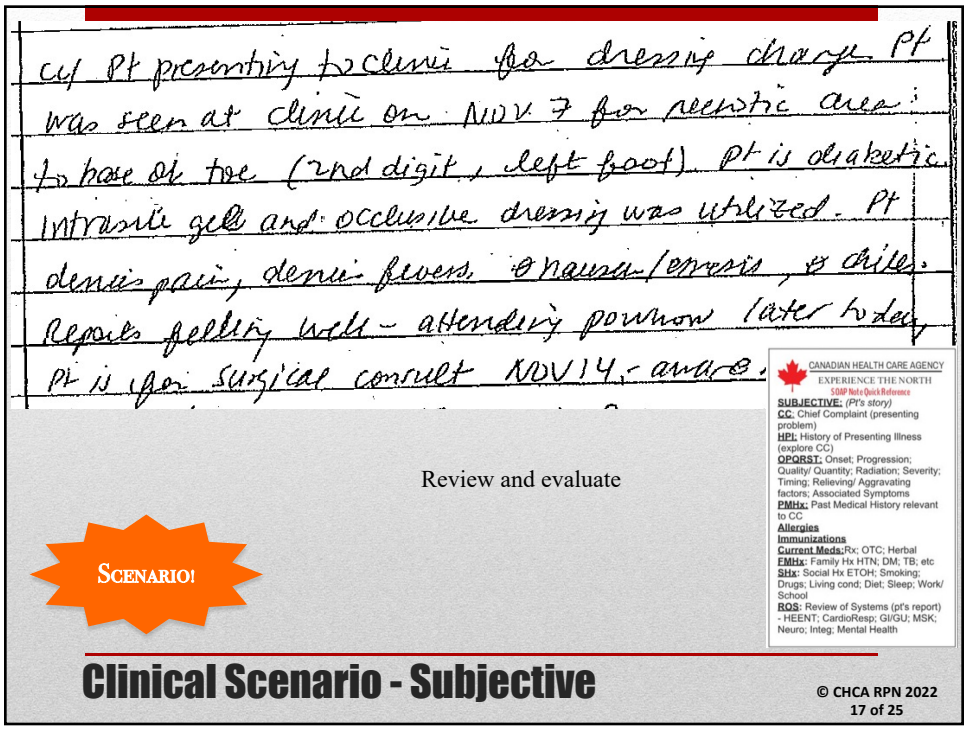
c/c Pt presenting to clinic for dressing change. Pt was seen at clinic on NOV 7 for necrotic area to base of toe (2nd digit, left foot). Pt is diabetic. Intrasite gel and occlusive dressing was utilized. Pt denies pain, denies fevers, & nausea/emesis, & chills. Reports feeling well - attending pow wow later today. Pt is for surgical consult NOV 14 - aware.
Review and evaluate
SCENARIO!
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
Clinical Scenario - Subjective
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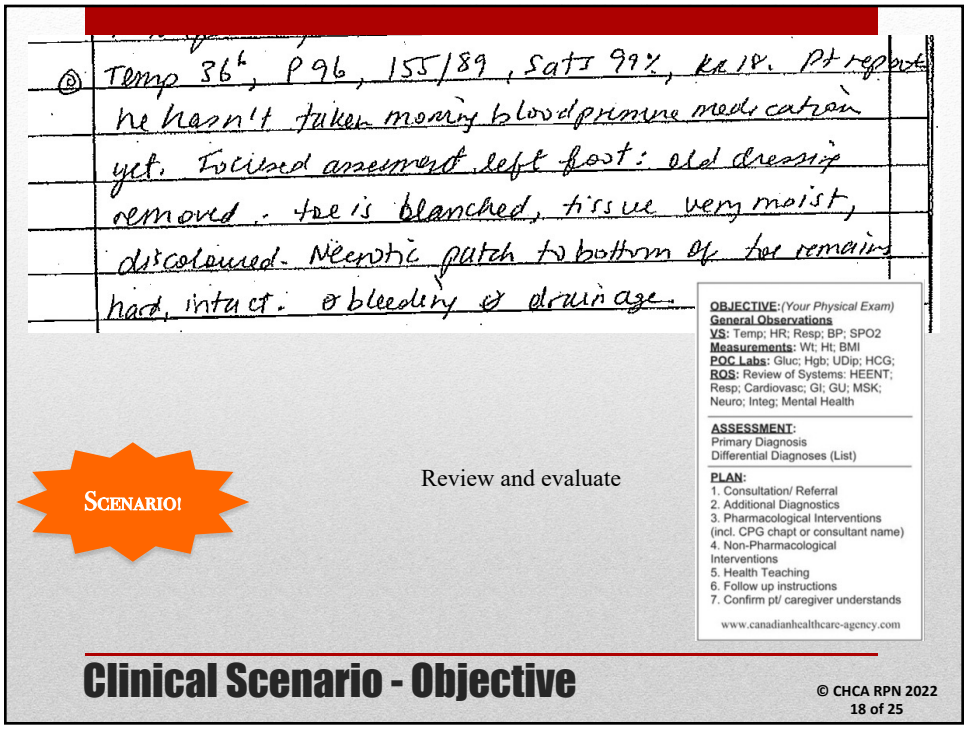
O: Temp 36.4, P 96, 155/89, Sat 99%, RR 18. Pt reports he hasn't taken morning blood pressure medication yet. Focused assessment left foot: old dressing removed. toe is blanched, tissue very moist, discoloured. Necrotic patch to bottom of toe remains hard, intact. ø bleeding & drainage.
Review and evaluate
SCENARIO!
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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Clinical Scenario - Objective
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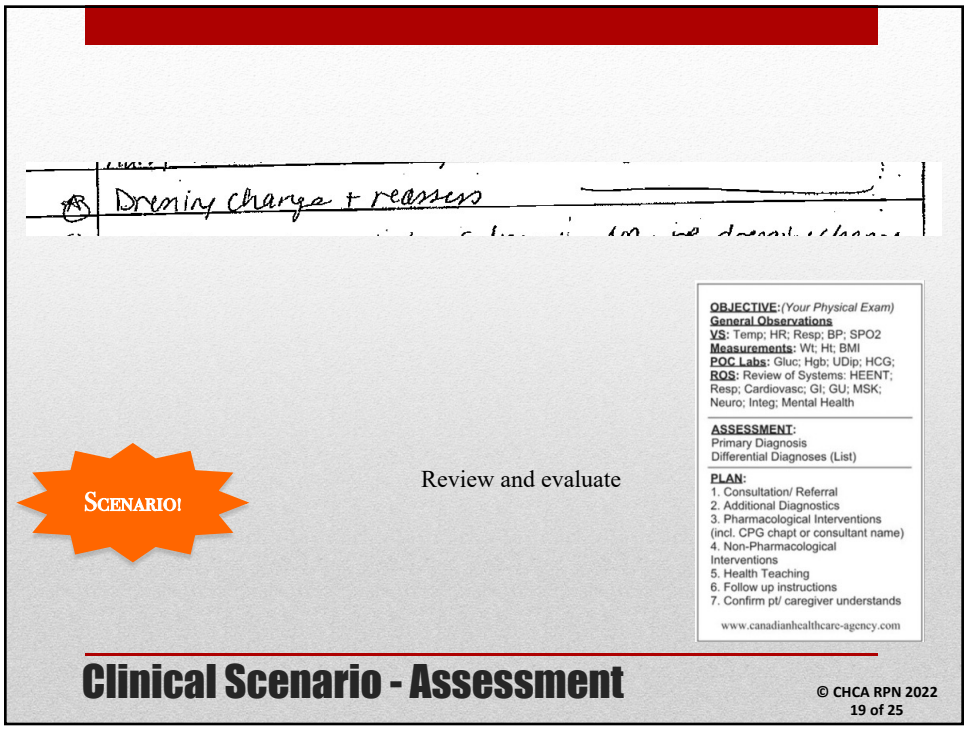
Dressing change + reassess
SCENARIO!
Review and evaluate
OBJECTIVE: (Your Physical Exam)
General Observations
VS: Temp; HR; Resp; BP; SPO2
Measurements: Wt; Ht; BMI
POC Labs: Gluc; Hgb; UDip; HCG;
ROS: Review of Systems: HEENT; Resp; Cardiovasc; GI; GU; MSK; Neuro; Integ; Mental Health
ASSESSMENT:
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4. Non-Pharmacological Interventions
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6. Follow up instructions
7. Confirm pt/ caregiver understands
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Clinical Scenario - Assessment
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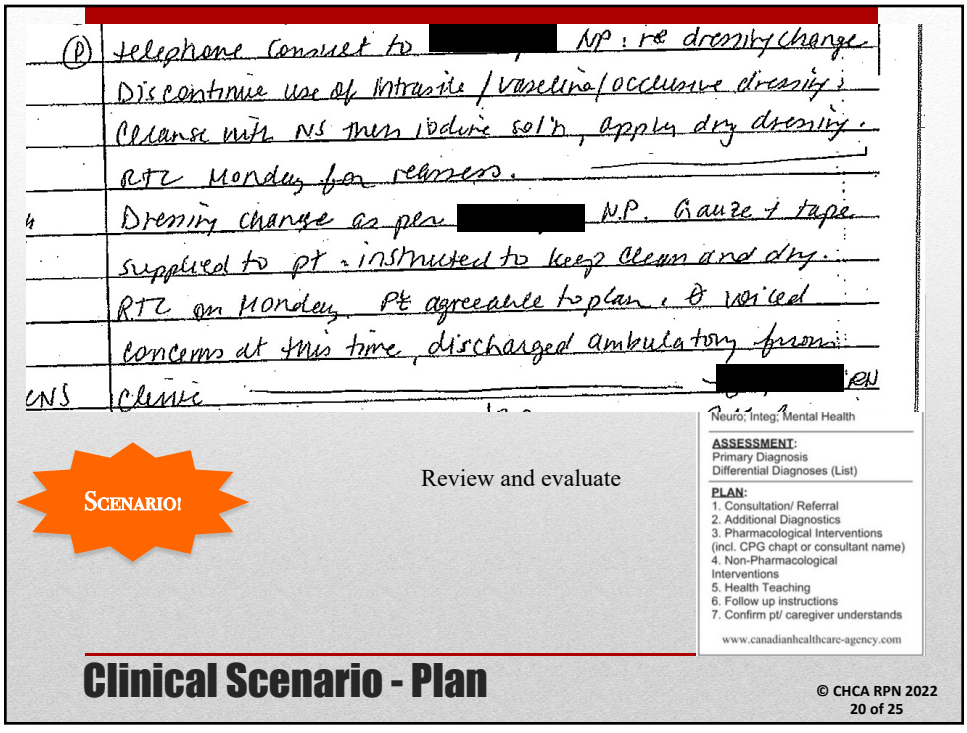
(P) Telephone Consult to [redacted] NP: re dressing change
Discontinue use of Intrasite / Vaseline / occlusive dressing;
Cleanse with NS then Iodine soln, Apply dry dressing.
RTC Monday for reassess.
Dressing change as per [redacted] N.P. Gauze + tape.
supplied to pt - instructed to keep clean and dry.
RTC on Monday. Pt agreeable to plan & voiced
concerns at this time, discharged ambulatory from
CNS clinic [redacted] RN
SCENARIO!
Review and evaluate
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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Clinical Scenario - Plan
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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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PRESENTATION FINISHED
...ANY QUESTIONS?
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Questions?
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