Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**

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APPLIES TO:
All regulated and unregulated Healthcare Providers

1. **BACKGROUND:**
   - **1.1.** Healthcare providers (HCP) are legally required to document the care they have provided to a client in the client's health record. The documentation is utilized to communicate between health professionals and to ensure quality and continuity of care. Standard formatting of documentation ensures a complete, accurate, comprehensive, timely and consistent method of recording client information. The Department of Health endorses SOAP charting as the format to be used in health centres in Nunavut.

2. **POLICY:**
   - **2.1.** HCPs working in community health centres will employ the principles of SOAP charting with each clinical encounter unless a Government of Nunavut approved form is available or the clinical situation is not conducive to this format (e.g., charting during an emergency).

3. **PRINCIPLES:**
   - **3.1.** HCP documentation reflects the client's perspective, identifies the HCP and promotes continuity of care by allowing other partners in care to access the information. It ensures HCPs are providing safe, effective, ethical care by showing accountability for professional practice.
   - **3.2.** Quality documentation is a nurse's best defense in a legal proceeding.

4. **DEFINITIONS:**
   - **4.1.** **Regulated and unregulated healthcare providers** refer to: Community Health Nurses (CHNs), Nurse Practitioners (NPs), Licensed Practical Nurses (LPNs), Supervisors of Community Health Programs (SHPs), Public Health Nurses (PHNs), Home Care Nurses (HCNs), Mental Health Nurses (MHNs), Mental Health Consultant (MHC), Registered Midwife (RMs), Acute Care Paramedics (ACPs) and Primary Care Paramedics (PCPs) who are authorized to document in the client's electronic or paper health record
   - 4.2 **SOAP charting**: Problem focused documentation using the headings Subjective, Objective, Assessment and Plan. Provides a framework for clinical reasoning and evaluation.

5. **GUIDELINE: SOAP CHARTING**

   SOAP charting is the standard format to be used by all HCPs working in a Community Health Centre.

   - **5.1. S – Subjective**

     This includes information provided by the client, what they stated or information obtained

from the health record. The section details the presenting concern (preferably in the client's own words); history of the presenting concern (events leading up to the appointment); review of systems; any allergies; current medications; past medical history; surgical history; family history; social history; and immunizations.

5.2. O – Objective

These are the observations made by the HCP during the examination or interaction with the client/family. Information may include vital signs, general appearance, physical assessment, any current and relevant laboratory test results, imaging results and consults.

5.3. A – Assessment

This is an appraisal statement of the client's current condition and includes any medical/nursing diagnoses as well as differential diagnoses. Differential diagnoses should be supported by evidence in either the subjective or objective areas.

5.4. P – Plan

The plan of care for the client is generally documented as:

- Care and treatment provided during the clinic visit along with the response to treatment if relevant
- Medications prescribed and/or dispensed
- Education and counselling provided to client/family
- Follow-up plans and referrals.

Evaluation of the plan should occur during subsequent visits, even if the client does not immediately return. Did the plan work? Were any changes required?

6. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards

7. REFERENCES:

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