Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Health Centre Documentation Audit	STANDARDS	04-004-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 25, 2020 / July 2023	04-003-00, 01, 02	3
APPLIES TO:		
Community Health Nurses and Nurse Practitioners		

1. **BACKGROUND:**
   Documentation in patient charts provides evidence of care given. Not only is it essential to Quality Assurance activities, it informs each nurse's performance evaluation and provides an opportunity to address gaps and enhance practice.

2. **POLICY:**
   The Supervisor of Community Health Programs (SCHP) or delegate shall conduct documentation audits and record the findings on an approved Department of Health Documentation Audit Form. A total of three (3) audits are to be conducted each month.

3. **PRINCIPLES:**
   Conducting regular health record audits are essential Quality Assurance activities which support the monitoring of quality healthcare services. The process of auditing health records should be considered an opportunity to teach, learn and enhance nursing practices.

4. **GUIDELINE:**

Case Selection

4.1 Each month, the SCHP (or delegate) shall select three (3) separate documentation entries to audit. The selection criteria includes the following:
   a) All three documentation samples shall be entered by the same nurse (Community Health Nurse, Nurse Practitioner, or Public Health Nurse); and
   b) The three documentation samples shall include:
      i. A complex case
      ii. A focused visit
      iii. A pediatric visit

Conducting the Audit

4.2 The findings of the documentation audits shall be documented on the *Documentation Audit Form* (Appendix A).

4.3 The SHP shall review the health records for:
   a) **Subjective Information** – Chief complaint is clearly stated in client's own words.
      - ✓ The quantity and quality of information recorded is appropriate.
      - ✓ A well documented and concise history of presenting illness or evidence of an attempt by the Nurse to seek further subjective data.
      - ✓ Chronological order with pertinent positive and negative information documented.

b) **Objective Information** - The physical assessment is clearly, concisely and accurately documented.
   - ✓ Vital signs, as appropriate, are documented.
   - ✓ The physical assessment is consistent with the subjective information obtained.
   - ✓ The laboratory and other diagnostic tests are clearly recorded,justifiable and align with clinical practice guidelines and medical directives. For infants – a temperature [and route] is documented. The infant's weight is recorded within the SOAP note and on the gender-appropriate growth chart.

c) **Assessment** – Medical and/or nursing diagnoses are documented.
   - ✓ The diagnosis is consistent with the documented subjective and objective data findings.

d) **Plan and Evaluation** - Plan is appropriate to the *Assessment* documented.
   - ✓ Evidence that a Physician or Nurse Practitioner was consulted for complex cases or cases which are outside the scope of the nurse. The *Community Call Form* has been completed and included as part of the health record (where applicable).
   - ✓ Client education, health promotional activities, treatment and follow-up care is documented and based on sound clinical judgment, clinical practice guidelines and medical directives.
   - ✓ All medications are administered, dispensed and/or prescribed according to best practices and the Nunavut formulary.

e) **Referrals** – Referrals are consistent with the documented findings, assessment and care plan.
   - ✓ Documented evidence that referral was made and followed up.

f) **General** - Is the entry legible?
   - ✓ Does the entry follow SOAP format?
   - ✓ Is the entry clearly signed with designation?
   - ✓ Is there a date and time recorded?

Follow-up

4.4 The SCHP will meet with the specific nurse to review the findings of the audit and collaboratively formulate a remediation plan for the nurse as required
   - The Documentation audit serves to inform the performance review and includes a plan for remediation. A follow-up audit for each nurse should be done at 2-6 month intervals.
   - Note: Documentation audits are also encouraged for returning casual nurses and agency nurses at the discretion of the SCHP. The Documentation Audit findings are to be forwarded to the employing nursing agency as well.

4.5 The completed *Documentation Audit Form* is submitted to the Director of Health Programs each month. The Director will review the report, keep a copy on file, and work with the SCHP to support completion of any remediation plan in place.

AUDIT / MONITORING

A yearly regional review shall be conducted of all completed audits to examine nursing trends and any factors that influence quality nursing care.

5. RELATED POLICIES:

APPENDIX -DOCUMENTATION AUDIT TEMPLATE

DEPARTMENT OF HEALTH POLICY- (04-003-00) DOCUMENTATION POLICY

6. **REFERENCES:**

Registered Nurses Association of Northwest Territories and Nunavut (2015). *Documentation Guidelines*

Registered Nurses Association of Northwest Territories and Nunavut (2014). *Standards of Practice for Registered Nurses and Nurse Practitioners.*

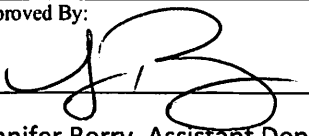
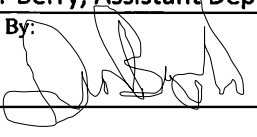
Approved By: 	Date: Dec 10, 2020
Jennifer Berry, Assistant Deputy Minister, Operations, Department of Health	
Approved By: 	Date: Dec 10, 2020
Jenifer Bujold, A/ Chief Nursing Officer	

Chart Audit Tool

Auditee:

Community:

Auditor: Jenifer Bujold

Audit Date:

Client Identifier (initials and DOB or HIN):

GENERAL

Paper: ☐ Meditech: ☐ Focused Assessment: ☐ Comprehensive Assessment: ☐

Each page is labeled with demographic information.	Select. Yes	Enter a comment
Documentation is legible in black or blue ink.	Select.	Enter a comment
Signature or signature page identifies nursing role (eg: CHN, PHN)	Select.	Enter a comment
Date and time for each entry. Late entries identified.	Select.	Enter a comment
Errors or additions are correctly noted.	Select.	Enter a comment

SUBJECTIVE

Factual and concise history of present illness including sufficient exploration of symptoms.	Select.	Enter a comment
Review of systems is noted.	Select.	Enter a comment
Past medical history, allergies and current medications present.	Select.	Enter a comment
Relevant social/family history present.	Select.	Enter a comment

OBJECTIVE

Vital signs, O2 saturation and weight. If infant-weight noted as naked or clothed. Documented in body of note (not margin)	Select.	Enter a comment
Head to toe assessment or focused assessment including system above and below area of concern.	Select.	Enter a comment
Lab and X-ray results noted if appropriate.	Select.	Enter a comment

ASSESSMENT

Differential diagnoses listed and appropriate to history. No evidence of diagnostic anchoring.	Select.	Enter a comment

PLAN

Appropriate interventions listed.	Select.	Enter a comment
Medication: Name, dose, amount dispensed.	Select.	Enter a comment
Consultation noted including name of consultant.	Select.	Enter a comment
Any orders from physician accurately listed.	Select.	Enter a comment

Referrals listed and noted as complete.	Select.	Enter a comment
Follow up noted within a specified time frame.	Select.	Enter a comment

Audit Review Summary: