

SAHTU HEALTH AND SOCIAL SERVICE AUTHORITY
Policy

**Documentation Policy for
Sahtu Community Health
Nurses and Nurse Practitioners**

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POLICY:

Community Health Nurses (CHN's) are responsible for maintaining the clinical record of each patient they see in a current, complete, and comprehensive manner, using the format and procedures outlined in this policy.

PURPOSE:

1. To ensure accurate documentation of assessment and treatment
2. To provide a mechanism for communication, planning, and continuity of care
3. To protect patient confidentiality
4. To comply with Professional Standards of Practice.
5. To protect the legal interests of the patient, practitioner, and the Authority.

FORMAT:

1. All charting is completed immediately after each visit and includes:
 - The date and time of visit (i.e. Jan 10/04 at 1310 hours).
 - S.O.A.P. documentation as follows:
 - S. = Subjective data. Verbalization of the client; (i.e. How does the client feel?)
 - O. = Objective data. Measured and observed; (i.e. What are the results of the physical exam, values, vital signs)
 - A. = Assessments and diagnosis. Diagnosis based on data; (i.e. What is the current situation)
 - P. = Plan. Treatment, diagnostics, medications, physicians' orders; (i.e. What the caregiver plans to do)
 - Signature and Professional designation.

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- Factual, accurate, and concise documentation
- No space left between entries

FORMAT CONT...

- The use of “approved” abbreviations and symbols only.
- Circumstances of refusal of treatment and discharge against advice are documented on the Progress and Treatment Record.
- All documentation is done in blue ink. Errors are NOT erased or obliterated with “White Out” or markers. Draw a single line through the incorrect entry and indicate “error”.

PROCEDURE:

1. Documentation must be recorded when services are rendered
2. Master signature sheet must be signed
3. Document diagnosis and treatment plan on the Progress and Treatment Record, including: medication, dose, frequency, duration, amount dispensed, teaching done, and follow up recommended
4. Process Physician’s orders, indicating actions, initials and designation and date it was processed.
5. Transcribe medication orders onto the Medication Administration Record (MAR)
6. All staff documenting on the patient’s chart must sign the Master signature sheet located in each patient chart.
7. All charts are completed and filed securely by the end of the workday **by the clerk.**

REFERENCES

1. Canadian Nurses Protective Society, Documentation
2. Records Format GNWT Policy 605
3. SOAP documentation Guidelines GNWT Policy 605A
4. Core Documentation Standards GNWT Policy 601A
5. Quality Documentation GNWT Policy 601

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Approved by: 
Chad Fehr, CEO