Section 4: Standards

Policy Number	Policy Name
04-001-00 04-001-01	Standards for Nursing Administration Practice Standards of Practice for Nursing Administration
04-002-00 04-002-01	Standards for Monitoring & Evaluating Community Health Nursing Guidelines for Conducting a Community Visit
04-004-00	Health Centre Documentation Audit

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Standards for Nursing Administration Practice		Standards	04-001-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		7
APPLIES TO:			
Community Health Nurses			

POLICY:

Nursing administration staff will perform at the level of professional conduct expected of his/her role in administration. Nursing administration staff are accountable to uphold the Standards of Practice for Nursing Administration (Reference Sheet 04-001-01).

These standards have been adopted from the Registered Nurses Association of Northwest Territories and Nunavut (2006) *Standards of Nursing Practice for Registered Nurses* and the Canadian Nurses Association (1988) *The Role of the Nurse Administrator and Standards for Nursing Administration.*

DEFINITIONS:

Nursing Administrator refers to all three levels of administration:

- First Line Nurse Administrator
  Carries the title of: Supervisor of Health Programs; or Nurse Manager

- Middle Nurse Administrator
  Carries the title of: Director of Health Programs; Regional Director; or Territorial Manager

- Chief Executive Nurse Administrator
  Carries the title of Chief Nursing Officer

Standards:

- Articulate the expectations the public can have of a registered nurse in any practice setting, domain and/or role.
- Are expected and achievable levels of practice against which actual performance can be measured
- Serve as a legal reference to describe “reasonable and prudent” nursing practice
- Provide direction for the development of nursing programs
- Provide a basis for self-assessment and peer review
- Provides direction for professional development

Indicators:

- Illustrate how standards may be met
- Are not intended to be an exhaustive or prioritized list for any standard of practice and may be further refined or developed to specifically describe their application in a given context of practice.

PHILOSOPHY AND PRINCIPLES:

- the client is the central focus of the professional service nurses provide, and as a partner in the decision-making process, ultimately makes his or her own decisions;
- the goal of professional nursing service is the outcome desired by the client that poses no unnecessary exposure or risk of harm;
- continuing competence is a necessary component of practice, and the public interest is best served when nurses constantly improve their application of knowledge, skill, judgment and attitude;
- provision of competent and professional nursing service requires practice environments that have adequate support systems; and
- The public has entrusted the RNANT/NU to honour the privilege to practice nursing through the licensing and regulation of its members.

RELATED POLICIES, GUIDELINES, LEGISLATION:

Reference Sheet 04-001-01 Standards of Practice for Nursing Administration

REFERENCES:

Canadian Nurses Association (1988). *The Role of the Nurse Administrator and Standards for Nursing Administration.* Ottawa: Canadian Nurses Association

Registered Nurses Association of Northwest Territories and Nunavut (2006). *Standards of Nursing Practice for Registered Nurses*. Yellowknife: RNANTNU

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

REFERENCE SHEET 04-001-01

STANDARDS OF PRACTICE FOR NURSING ADMINISTRATION

LEADERSHIP	
Standard	The Nurse Administrator provides leadership that is viable and proactive
Indicators	➢ seeks out new options and approaches to problems despite possible risks; ➢ seeks out new opportunities to improve program quality and productivity; ➢ inspires others to cooperate in achievement of professional and organizational goals; ➢ provides staff with stimulating opportunities for their creativity; ➢ encourages initiative by giving responsibility, resources, and authority; ➢ rewards achievement and success appropriately; ➢ manages change effectively; ➢ identifies potential leaders and acts as a mentor to these individuals to further their career development; ➢ represents the nursing perspective within the Department and within the Government; ➢ participates in activities of the Registered Nurses Association of Northwest Territories and Nunavut; ➢ promotes nursing involvement in public policy-making bodies.
Standard	The Nurse Administrator evaluates the effectiveness and efficiency of nursing services.
Indicators	➢ implements a quality assurance program and ensures the program integrates into the overall Government of Nunavut's quality assurance program; ➢ uses systems to determine whether nursing services are effective and efficient; ➢ ensures that evaluation is consistent with a nursing code of ethics, standards of nursing practice; and other relevant documents; ➢ reports the evaluation results to the appropriate bodies; ➢ promotes a periodic review of the philosophy of the nursing department, objectives, standards of care, policies, and procedures.
PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY	
Standard	The Nurse Administrator plans for and implements effective and efficient delivery of nursing services.
Indicators	➢ Articulates a philosophy of nursing and standards of care which are based on a conceptual framework(s) of nursing; ➢ Assesses client, organizational, and community need for nursing services; ➢ Forecasts the type of nursing services needed based on changes in demographics, social values, technology, nursing and medical science; ➢ Determines the congruency between the identified need for nursing services and the department's mission and mandate; ➢ Plans in accordance with the acts and regulations which affect nursing and health care; ➢ Establishes program priorities and policies; ➢ Plans a well-defined structure and processes for the delivery of nursing services; ➢ Coordinates the delivery of nursing services with other departments and community agencies.

PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY	
Standard	The Nurse Administrator participates in the setting and carrying out of the Department of Health and Social Services goals, priorities, and strategies.
Indicators	➢ Participates in long range fiscal planning including resource allocation decisions; ➢ Participates in evaluating the congruency between the Department's mission and its programs; ➢ Interprets the potential impact of corporate activities on client care; ➢ Participates in and influences the conceptualization and design of new or revised client programs; ➢ Plans, in collaboration with colleagues, for adequate facilities which are appropriate to the delivery of client programs; ➢ Participates in the development of a quality assurance program; ➢ Identifies and manages issues which put the organization at risk;
Standard	The Nurse administrator is accountable to the public and responsible for ensuring that her or his practice and conduct meet the standards of the profession by providing competent, safe and ethical nursing practice.
Indicators	➢ Assumes primary responsibility for: ▪ Investing time, effort or other resources in maintaining evidence-based knowledge and skills for practice; ▪ Practicing within own level of competence; ▪ Maintaining current practicing registration with the RNANT/NU; ▪ Maintaining own physical, mental and emotional well-being. ➢ Practises in accordance with: ▪ the Nursing Profession Act and its regulations and bylaws; ▪ the RNANT/NU Standards for Nursing Practice; ▪ the CNA Code of Ethics; ▪ other relevant position statements, guidelines or documents, adopted by RNANT/NU and the Government of Nunavut; ▪ individual competence and ability to evaluate own practice ➢ Presents an informed view of the nursing profession and its relationship to the health care system, clients, colleagues, students, other professionals and the public. ➢ Acts as a resource and role model for student nurses, colleagues and others. ➢ Responds to and reports to appropriate person or body, situations which may be adverse for clients and/or health care providers, including incompetence, misconduct and incapacity of registered nurses and/or other health care providers. ➢ Participates in the development of health care policies and procedures that guide the practice of health care providers. ➢ Advocates for continuing quality improvement in all areas of professional practice. ➢ Maintains clear, timely and accurate records of pertinent data and communicates the information in a timely manner. ➢ Communicates and collaborates with clients, the nursing team, and members of the health care team for the delivery of safe, competent, and ethical care. ➢ Uses information to ensure the best use of human and other resources ➢ Provides the opportunity for staff and clients to have input into the decision-making process

PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY	
Standard	The Nurse Administrator provides for allocation, optimum use of and evaluation of resources such that the standards of nursing practice can be met.
Indicators	➢ Provides valid measures for determining the need for and type of nursing required; ➢ Uses systems for recruitment and retention of personnel; ➢ Uses criteria for employment of personnel ➢ Implements a system of appraisal for personnel performance and productivity according to the Human Resources Manual; ➢ Ensures that appropriate expertise is available for delivery of efficient nursing services; ➢ Ensures compliance with statutory, contractual, and regulatory requirements; ➢ Uses appropriate measures to determine material resources required; ➢ Ensures adequate space, facilities, equipment, and supplies to fulfill the need of the professional, educational and management functions of nursing services; ➢ Evaluates the relationship between changes in technology and human resources; ➢ Establishes and implements a budget, including methods for control of the budget.
Standard	The Nurse Administrator maintains information systems appropriate for planning, budgeting, implementing and monitoring the quality of nursing services.
Indicators	➢ Defines and maintains clear lines of communication; ➢ Seeks information from diverse internal and external sources in order to develop a complete understanding of the Department and its environment; ➢ Uses effective communication skills to receive and disseminate information; ➢ Determines a systematic method of collecting, retaining, and retrieving statistical data relevant to client and management information; ➢ Uses information systems in the preparation, management, and control of the nursing budget; ➢ Liaises with other government departments, community and professional organizations; ➢ Ensures that systems for confidentiality regarding clients and staff are maintained and are consistent with legislative requirements and organizational policy.
CONTINUING COMPETENCE	
Standard	The Nurse administrator demonstrates responsibility for maintaining competence, fitness to practice and acquiring new knowledge and skills in her/his own area of practice.
Indicators	➢ Demonstrates appropriate theoretical knowledge and competence in skills as needed in her/his own area of practice ➢ Justifies decisions with reference to knowledge or theory. ➢ Has the knowledge, skill, judgment, and attitude needed to practice in her or his own setting ➢ Strives to improve the knowledge, skill judgment, and attitudes needed to practice within a dynamic healthcare system. ➢ Promotes the acquisition of new knowledge ➢ Assists clients, colleagues, students, other professionals and the public to acquire new knowledge ➢ Assesses individual competence and assumes responsibility for his/her own professional development. ➢ Seeks out and uses feedback from others in assessing own practice and provides feedback to others to support their professional development. ➢ Develops, implements and evaluates a professional development plan ➢ Promotes an environment supportive of continuous professional development.

CONTINUING COMPETENCE	
Standard	The Nurse Administrator promotes the advancement of nursing knowledge and promotes the utilization of research findings.
Indicators	➢ Encourages innovative approaches to nursing practice; ➢ Provides opportunities for professional growth and development of staff; ➢ Collaborates with educational institutions for the provision of education, practice, and research opportunities for nursing students and faculty; ➢ Provides for comprehensive resources within the Department to support educational activities; ➢ Promotes and facilitates the conduct of nursing research; ➢ Initiates and participates in research relevant to nursing; ➢ Promotes utilization of research findings; ➢ Monitors the impact of research activities on client, staff, and nursing practice; ➢ Collaborates with nurse researchers and researchers from other health-related disciplines on research projects.
APPLICATION OF KNOWLEDGE	
Standard	The Registered Nurse bases his/her practice on the application of current knowledge and demonstrates competencies relevant to his/her area of nursing practice.
Indicators	➢ Uses current literature/research to support and direct practice. ➢ Uses nursing and other theoretical frameworks to assess, plan, implement and evaluate care, and revises plan as needed. ➢ Analyses and evaluates knowledge and modifies practice accordingly. ➢ Performs planned interventions in accordance with policies, procedures and care standards. ➢ Demonstrates critical thinking and sound clinical judgement. ➢ Establishes and maintains communication systems to support delivery of quality health care. ➢ Demonstrates knowledge of management and organizational theory by creating an environment that fosters cooperation in the provision of health care.
ETHICS	
Standard	The Nurse Administrator understands, upholds and promotes the ethical standards of the profession.
Indicators	➢ Bases nurse-client relationships on mutual respect, shared objectives, and the right to self-determination. ➢ Ensures that the client=s rights are respected in the development and implementation of policies. ➢ Establishes, maintains and concludes appropriate & therapeutic nurse-client relationship(s). ➢ Advocates for a client's right to autonomy, respect, privacy, confidentiality, dignity, access to appropriate information, and choice. ➢ Protects confidential information obtained in the course of professional practice, in accordance with legislation and/or client consent. ➢ Promotes practice environments that have the organizational and human support systems and the resource allocation necessary for safe, competent and ethical nursing care ➢ Applies and promotes principles of equity and fairness to assist clients in receiving unbiased treatment services and resources proportionate to their needs. ➢ Establishes a system whereby ethical issues/concerns can be addressed.

REFERENCES:

Canadian Nurses Association (1988). *The Role of the Nurse Administrator and Standards for Nursing Administration.* Ottawa: Canadian Nurses Association

Registered Nurses Association of Northwest Territories and Nunavut (2006). *Standards of Nursing Practice for Registered Nurses*. Yellowknife: RNANTNU

Approved by:	Effective Date:
11 FEB 2011	
Chief Nursing Officer **Date**	April 1, 2011
February 11, 2011	
Deputy Minister of Health and Social Services **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Standards for Monitoring & Evaluating Community Health Nursing		Standards	04-002-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4
APPLIES TO:			
Community Health Nurses			

POLICY

The Department of Health and Social Services ensures there is a system in place for continuous monitoring and evaluation of the quality of care delivered through the Community Health Nursing Program.

Each community shall be visited by the Director of Health Program (or designate) at least once a year as part of the Community Health Nursing evaluation.

PRINCIPLES

- Prompt action will be taken to work with the health centre staff to eliminate potential or actual problems/concerns.
- Ongoing monitoring of activities will ensure program and departmental goals and objectives have been successfully achieved.

RELATED POLICIES, GUIDELINES, LEGISLATION:

Guideline 04-002-01	Guidelines for Conducting a Community Visit by Nursing Administration
Policy 04-003-00	Health Centre Chart Audit
Guideline 04-003-01	Conducting a Health Centre Chart Audit
Reference Sheet 04-003-02	Chart Audit Template

GUIDELINES 04-002-01

The Director of Health Programs (or designate) shall conduct community visits at a least once per year.

PREPARATION ACTIVITIES

Contact the Supervisor of Health Programs (SHP) in advanced to:

- Arrange a mutually agreeable date for the community visit
- Identify specific agenda items to review during the visit
- Allow the SHP an opportunity to plan his/her time and that of his/her staff during the visit

Community visits require two to four days on site, depending on:

- The size of the community;
- The date of the last community visit; and
- The overall frequency of community visits.

DOCUMENTATION

Narrative summary reports are completed for each community visit and placed in the community file. Community visit findings and recommendations shall be shared verbally with the staff, followed by a written report. The summary report should be sent within two weeks of the visit.

VISIT ACTIVITIES

Administration Review:

- Staff moral
- SHP administrative duties
- Rapport of the health centre within the community
- Review administrative files, including birth and death record system
- Review month-end reports
- Community health information reports and other program information, including the after-hours calls log book
- Evaluation of the percentage of time spent on treatment vs. health promotion activities
- Transient accommodation

Personnel Review:

- Staff performance appraisals
- Workload
- Leave and attendance
- Certifications (as required)
- Other personnel concerns (consider consultation with Human Resources, if appropriate)

Narcotic Count and Audit:

- Count as per current *Nunavut Controlled Substances Policy and Procedures*
- Review entries in the Narcotic and Controlled Drugs Registers and findings on the *Nunavut Controlled Substances Audit* form.
- Review any drug loss/discrepancy reports and authorizations for destruction.
- Random chart audit on narcotics and controlled drugs given, on a minimum of five charts as per *the Nunavut Controlled Substances Policy and Procedures*.
-

Client Chart Audit:

- 10 files audited at random using the territorial audit tool
- Involve the SHP and other nurses with these audits, as appropriate
- Care delivered, including diagnostic testing, diagnosis and treatment plans
- Evidence of relevant health teaching
- S.O.A.P. charting requirements
- Legal charting requirements (e.g. RN designation after signature)
- Client file is set up as per the regional format requirements
- Process for referrals

Facility Tour:

- Tour facility
- Identify deficiencies in set-up and space
- Advise and discuss areas for improvement to enhance client care and health promotion activities

Workplace Health and Safety:

- Health Centre Fire evacuation plan
- Cleanliness of workplace
- Vehicle maintenance logs
- Environmental concerns
- Workplace Health and Safety Committee
- HSS Emergency Preparedness Plan
- Community Emergency Preparedness Plan / Health

Stores Review:

- Review stock supplies and ordering system
- Review protocol for requisitioning of supplies and justification for any recent requests for equipment
- Review quality control checks for emergency medical equipment

Treatment Clinics Review:

- Execution of treatment clinics and how health promotion activity is integrated into treatment clinics
- Identification of any staff learning needs in relation to providing treatment services
- Identification of ongoing health trends (e.g. rising incidence of hypertension and obesity in the community) and the risk reduction strategies (e.g. health promotion activities, screening) employed by the health centre staff to address these conditions
- Review the after-hour call backs
- M.D. appointment list
- Review client travel – scheduled and medivac
- Implementation of in-patient and home visiting protocols

Program Review:

- Complete a full audit of at least three core programs
- Review, at minimum, the following components of the other core programs:
    - Well child and immunization cards
    - Chronic disease follow-up and surveillance system (register, card index, database, etc.)
    - School health and immunization record
    - Adult immunizations
    - Prenatal charts and prenatal diagnostic screening criteria
    - Adult health services (e.g. well woman, well man)
    - Communicable disease surveillance (e.g. TB, STD, Hep B&C)

Staff Interviews:

- Spend time individually with both nursing and support staff and encourage them to discuss any matter/concern
- Review job descriptions
- Discuss any problem areas identified prior to the community visit
- Provide feedback on findings of visit to individual staff as required

Staff Meetings:

- General discussion with all staff (i.e. what is happening in the community, new initiatives, conferences, workshops, etc.)
- Provide feedback on findings of visit relative to team functioning and health centre operation

Community Development for Health:

- Program planning – current and future plans
- Number and type of community meetings attended as a committee member
- Type of support and expert guidance given to community groups
- Community health promotional activities
- Local healthy public policy
- Meetings with key community members and stakeholders
- Community Health Representative's involvement in the community
- Meetings with Hamlet Health Committee

RELATED POLICIES, GUIDELINES, LEGISLATION:

Policy 04-002-00	Standards for Monitoring and Evaluating Community Health Nursing Programs
Policy 04-003-00	Health Centre Chart Audit
Guideline 04-003-01	Conducting a Health Centre Chart Audit
Template 04-003-02	Chart Audit Template
Community Health Nursing Standards and Protocols	
Nunavut Controlled Substances Policy and Procedures	

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

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.*

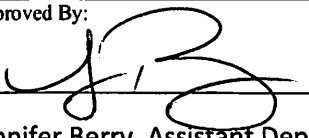
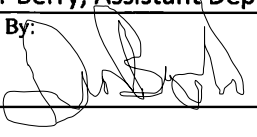
Approved By: 	Date: Dec 10, 2020
Jennifer Berry, Assistant Deputy Minister, Operations, Department of Health	
Approved By: 	Date: Dec 10, 2020
Jenifer Bujold, A/ Chief Nursing Officer	

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: