Northwest Territories Health and Social Services

NWT Clinical Practice Information Notice

UPON RECEIPT: (1) PLEASE FOLLOW THE DIRECTIONS BELOW
(2) FILE THIS NOTICE IN SECTION C, CLINICAL PRACTICE INFORMATION BINDER FOR FUTURE REFERENCE

The following clinical practice has been approved for use in the Northwest Territories Health and Social Services system, and has been distributed to:

☐ Hospitals ☒ Community Health Centers ☒ Public Health Units ☐ Doctors' Offices ☐ Social Services Offices ☐ Other: _____

The information contained in this document is a Departmental:

☐ Policy ☒ Standard ☐ Protocol ☒ Procedure ☐ Guidelines

Title: Audit Tools for Monitoring and Evaluating Community Health Nursing Programs

Effective Date: March 23rd, 2007

Statement of approved clinical practice:
The attached revised NWT Audit Tools for monitoring and evaluating community health nursing programs are recommended for use by the Department of Health and Social Services. The revised audits were produced in consultation with a subgroup of the NWT Nursing Leadership Network.

Please replace your current audit tools that do not have an NWT number nor date with the attached Audit Tools that are dated 12/06 and have a NWT number.

Attachments:

- Adult Health Audit Tool (Well Woman and Well Man Program) with Instruction Sheet
- Chart Audit Tool with Instruction Sheet
- Chronic Disease Audit Tool with Instruction Sheet
- Communicable Disease Audit Tool with Instruction Sheet
- Neonatal Audit Tool (Infant's Chart) with Postnatal/Neonatal Instruction Sheet
- Prenatal Audit Tool with Instruction Sheet
- Postnatal Audit Tool with Postnatal/Neonatal Instruction Sheet
- Well Child Audit Tool with Instruction Sheet

This clinical practice is approved. _____
(signature)

Assistant Deputy Minister ☒ **Chief Medical Officer of Health** ☐ **Director, Child & Family Services** ☐ **Director, Adoptions** ☐

ADULT HEALTH AUDIT TOOL

INSTRUCTION SHEET

1) Identification data on chart page includes patient's full name, date of birth, health care number, allergies.

2) Chart entry includes date and time of visit.

3) History or subjective findings include:

- health and psycho/social concerns
- sexual health history
- contraceptive use
- family history
- lifestyle (nutrition, tobacco use, caffeine use, substance abuse, medications, fitness. etc)

4) Objective findings include base line vital signs (B.P., P., Ht., Wt.,). Examination according to functional inquiry/client concerns.

5) Assessment/Diagnosis is appropriate given the history and physical findings.

6) Lab work as appropriate such as: PAP smear, chlamydia cervical swab for C & S, urinalysis and Haemoglobin (if not done in the past year). Results of lab work are recorded.

7) Screening as needed including vision, hearing, TB (as per NWT Protocol), Diabetes

8) Immunization is checked for tetanus, polio, diphtheria, pertussis and rubella (as appropriate).

9) If immunization is given, date, lot # and site of injection is recorded on the immunization card and chart.

10) Chronic Condition follow-up as appropriate

11) Health teaching and counselling such as Breast Self Exam, Testicular Self Exam, sexual health, contraception, nutrition and other topics as needed.

12) Referrals are noted as needed.

13) Follow-up required is summarized.

14) Entered in recall system.

15) Signature (initial, last name) and designation is recorded.

16) SOAP charting.

Northwest Territories

ADULT HEALTH AUDIT TOOL (Well Woman and Well Man Programs)

Health Centre:	Date of Audit (d/m/y):	Date of Last Audit (d/m/y):

Key:

D - Done
N - Needs to be reviewed
N/A - Not Applicable

Identification	Date & Time	History Noted	Physical Assessment Noted	Lab Work Noted	Screening Noted	Immunization Up to Date	Lot # Site Noted on Card & Chart	Chronic Condition f/u as Needed	Health Teaching & Counselling Noted	Referrals as Needed	Follow-up	Entered Into Recall System	Signature & Designation	Remarks* (including SOAP charting)

* **Dose, Route, Length of Rx, Amount Dispensed**

Audited By (Please Print):	X _____ Auditor's Signature / Date - d/m/y	**Discussed with NIC:** _____ Date - d/m/y

NWT8705/1206

CHART AUDIT TOOL

INSTRUCTION SHEET

1) Identification Data
   - date/allergies
   - to ensure that appropriate information is on the chart and on patient progress/treatment record
   - allergies on patient profile, and on patient file cover.

2) Date and Time
   - month should be spelled out, i.e. **APRIL**
   - 24 hour clock should be used

3) SOAP format is used consistently:

   SUBJECTIVE (S) - comments originate with the client and represent his/her perspective. Reflects information that the nurse solicited.

   OBJECTIVE (O) - records ACTUAL FINDINGS (i.e. what is smelt, felt, seen, heard) of physical assessment.

   ASSESSMENT (A) - records a conclusion or diagnosis that is appropriate given the subjective and objective findings.

   PLAN (P) - records medication prescribed, teaching done, lab tests required, follow-up to be done, referrals.

4) Chief complaint - elicited from client.

5) History - of present illness as well as pertinent past health/family history.

6) System Assessment - to include vital signs. Comprehensive enough to demonstrate that they have considered significant differentials and have attempted to eliminate them as potential diagnosis.

7) Significant negative findings are charted.

8) Diagnosis appropriate given physical and subjective findings. Could include description of the symptom if diagnosis not yet known e.g. Fever NYD. Only significant differentials are noted as appropriate.

9) Lab Work/X-ray
- appropriate for complaints
- results recorded.

10) Consult:
- M.D. named
- Closest, referral centre
- Other appropriate agencies, i.e. Social Services, R.C.M.P.

11) Medication Dose Route:
- medication appropriate for diagnosis
- length of treatment and amount of medication dispensed.

12) Treatment/management
- e.g. dressing change.

13) Patient Teaching
- to manage the problem/diagnosis

14) Follow-up:
- referrals - nurses, community, physician, specialists
- when to return to clinic (immediate vs. long-term)
- lab work follow-up.

15) Signature and designation:
- Signature - first initial and full last name
- Title - R.N., not B.Sc.N

Northwest Territories

CHART AUDIT TOOL

Health Centre:	Date of Audit (d/m/y):	Date of Last Audit (d/m/y):

Key:

D - Done
N - Needs to be reviewed
N/A - Not Applicable

Identification, Allergies	Date & Time	SOAP Format	Chief Complaint	History	System Assessment	Negative Findings	Diagnosis	Lab Work/ X-Ray	Consultation as Needed	Medication Information*	Treatment Noted	Patient Teaching	Follow-up	Signature & Designation	Remarks*

*** Dose, Route, Length of Rx, Amount Dispensed**

Audited By (Please Print)**:**	X _____ Auditor's Signature / Date - d/m/y	**Discussed with NIC:** _____ Date - d/m/y

NWT8703/1206

CHRONIC DISEASE AUDIT TOOL

INSTRUCTION SHEET

1) Identification data on chart page includes patient's full name, date of birth, health care number, allergies.

2) Chart entry includes date and time of visit.

3) Individualized care plan - indicates frequency of follow-up, practitioner, etc. May be on recall system, surveillance register and/or client chart. Should include teaching required.

4) Regular nursing follow-up as appropriate to disease/condition and client individual needs.

5) Immunization status up to date and appropriate, i.e. follow-up.

6) Regular M.D. follow-up as for # 4.

7) Lab and X-ray follow-up timely and appropriate.

8) Results of Lab and X-ray tests reviewed and documented.

9) Client entered into surveillance system as appropriate (e.g. register, card index, database, etc).

10) Entered into the recall system - (e.g. tickler file, appointment book, etc).

11) Drug profile up to date and easily accessible on chart.

12) Disease profile up to date and easily accessible on chart.

13) S.O.A.P. charting.

Northwest Territories

CHRONIC DISEASE AUDIT TOOL

Key:

D - Done
N - Needs to be reviewed
N/A - Not Applicable

Health Centre:	Date of Audit (d/m/y):	Date of Last Audit (d/m/y):

Identification	Date & Time	Individual Care Plan	Regular Nursing Follow-up	Immunization Status up to Date	Regular MD Follow-up	Appropriate Lab/X-Ray Screening	Results Reviewed & Documented	Surveillance System (register, card index, etc.)	Entered Into Recall System	Drug Profile on Chart	Disease Profile on Chart	Signature & Designation	Remarks* (including SOAP charting)

*** Dose, Route, Length of Rx, Amount Dispensed**

Audited By (Please Print)**:**	X _____ Auditor's Signature / Date - d/m/y	**Discussed with NIC:** _____ Date - d/m/y

NWT8704/1206

COMMUNICABLE DISEASE AUDIT TOOL

INSTRUCTION SHEET

1) Identification data on chart page includes patient's full name, date of birth, health care number, allergies.

2) Chart entry includes date and time of visit.

3) SOAP format of charting is used consistently.

4) Treatment appropriate for disease diagnosis.

5) NWT Communicable Disease / STD Report is completed

6) Disease reported to appropriate authorities within legal time frames, i.e. Health Protection Unit, NIC, Nurse Manager. Appropriate medical consultation documented.

7) Lab tests appropriate to disease diagnosis

8) Lab results reviewed and documented

9) Contracts followed up or referred as appropriate

10) Disease teaching documented, i.e. handwashing, AIDS, etc.

11) Disease follow-up, i.e. follow-up lab work done, H.V.'s, regular check-up during disease process, etc.

12) Signature - includes initial and last name
Designation - R.N. not B.Sc. N

Northwest Territories

COMMUNICABLE DISEASE AUDIT TOOL

Health Centre:	Date of Audit (d/m/y):	Date of Last Audit (d/m/y):

Key:

D - Done
N - Needs to be reviewed
N/A - Not Applicable

Identification	Date & Time	SOAP Format	Appropriate Treatment	Communicable Disease/STD Report Completed	Reported Within Time Frame	Lab Tests Appropriate	Lab Results Documented	Contacts Followed Up	Disease Teaching	Disease Follow-up	Signature & Designation	Remarks*

*** Dose, Route, Length of Rx, Amount Dispensed**

Audited By (Please Print)**:**	X Auditor's Signature / Date - d/m/y	**Discussed with NIC:** Date - d/m/y

NWT8702/1206

POSTNATAL / NEONATAL AUDIT TOOL

INSTRUCTION SHEET

1) Identification data completed on mother & infant charts.

2) Copy of delivery notes and newborn records on file.

3) First home visit made within one week of returning home from hospital.

4) Second home visit made within one month of returning home from hospital.

5) Infant seen a 3rd time at home or in the health centre between 4-6weeks.

6) Physical assessment of child includes skin, head, eyes, ENT, chest, abdomen, genitalia, height, weight, H.C.

7) Physical, Psycho - Social Assessment of mother includes appearance, weight, nutrition, lochia, perineum, fundus, breasts, nipples, elimination, rest and activity, social support systems.

8) Infant teaching/discussion includes: feeding, elimination, crib safety, immunization, sleep activity, crying, cord & skin care.

9) Mother seen at six weeks postpartum. Check up complete including physical assessment, pap, vaginal swabs, B.S.E., teaching and birth control counselling.

10) Child entered in Well Child recall system.

11) Mother entered in Well Woman recall system.

12) Signature (initial, last name) and designation of caregiver entered for each entry.

13) SOAP charting.

Northwest Territories

NEONATAL AUDIT TOOL (Infant's Chart)

Health Centre:	Date of Audit (d/m/y):	Date of Last Audit (d/m/y):

Key:

D - Done
N - Needs to be reviewed
N/A - Not Applicable

Identification	Newborn Record on File	1st Home Visit Within 1 Week of Returning Home	Physical Assessment During 1st Home Visit	2nd Home Visit Within 1 Month	3rd Visit (home or clinic) at 4 - 6 Weeks	Parent-Child-Family Interactions Noted	Assessments Recorded in Chart & on Personal Health Record	Health Teaching Noted	BCG & Hep B Immunization at Birth	Entered Into Well Child Recall System	Signature & Designation	Remarks* (including SOAP charting)

*** Dose, Route, Length of Rx, Amount Dispensed**

Audited By (Please Print):	X _____ Auditor's Signature / Date - d/m/y	**Discussed with NIC:** _____ Date - d/m/y

NWT8701/1206

Prenatal Audit Tool
Instruction Sheet

PRENATAL RECORD

Page 1

1) Identification
   - Client's surname entered
   - Client's given name entered
   - DOB entered correctly (i.e. D/M/Y)
   - Healthcare number entered
   - Client's address entered
   - Planned birthplace entered
   - Referring clinic/hosp/hc entered
   - Primary care giver name entered
   - Physician/Midwife's name entered
   - Client's Age entered at EDD
   - Client's ethnic origin entered
   - Contact number(s) entered
   - Father's name entered
   - Father's age entered
   - Ethnic origin of newborn's father entered
   - Support of father during pregnancy entered

2) Informed Consent
   - Client's signature entered
   - Witness's signature entered
   - Date entered

3) Allergies/Medications
   - Allergies entered
   - Medications entered

4) Previous Pregnancies, including Abortions
   - All preg./abor/ectopics entered COMPARE AGAINST MEDICAL RECORD
   - Year entered and correct
   - Community of birth, entered and correct
   - Weeks of gestation at birth
   - Length of labour entered and correct
   - Type of delivery entered and correct
   - Sex entered and correct
   - Birth wt. entered and correct
   - Infant's current health and correct
   - Complications entered and COMPREHENSIVE

5) Health History
   - CHECK the CHART. If any "yes" scores, comments are included.

6) Social History
   - If any yes scores, comments and referenced to page 4

7) Family/Genetic History
   - If any "yes" scores, comments are included

8) Present Pregnancy
   - If any "yes" scores, comments are included

9) Clinical Dating
   - Date of positive pregnancy test entered
   - LNMP entered
   - Certainty of LNMP checked off
   - Menses cycle entered
   - Contraception type entered
   - Date of discontinuance of contraception entered
   - EDD by LNMP entered
   - EDD by U/S entered

10) Revised/confirmed EDD entered

11) Initial Physical Examination
   - Date of initial examination (D/M/Y) entered
   - Height entered
   - Pre-pregnancy weight entered
   - BMI entered
   - Present weight entered
   - BP entered
   - Normal parameters entered
   - Details of abnormal findings entered
   - Name of initial assessor entered

Prenatal Audit Tool
Instruction Sheet

Page 2

12) Identification
- Client's surname entered
- Client's given name entered
- DOB entered correctly (i.e. D/M/Y)
- Healthcare number entered

13) Laboratory (Results and Dates)
- ABO & RH Type entered (should be performed at the first prenatal visit)
- Antibody screen results entered
- If, RH negative, this info is entered, with dates Rhogam given
- If indicated, maternal serum screen results entered
- If indicated Amnio/CVS results entered
- GDM –GCT results entered (to be done between 24-28 weeks)
- If indicated, GTT result(s) entered

Infection Screening
- Serology results entered for VDRL, HepB, HepC , Rubella, Varicella, and HIV (should be performed at the first prenatal visit). History of Chicken Pox is entered if serological evidence not required.
- Postpartum immunization(s) need entered
- Pap Smear (date and result) entered (should be performed at the first prenatal visit)
- Cervical results entered for Gonorrhea and Chlamydia (should be performed at the first prenatal visit)
- Vaginal results entered for Trichomonas, Bacterial Vaginosis and past Herpes/HSV
- MSU results entered
- Group B Strep results entered from 36 week visit
- Abnormal results, treatments and dates entered
-

14) Ultrasound Studies
- Ultrasound dates and results entered (one ultrasound is recommended between 16-20wks.
- F/u scans are not routine)

15) Confirmed Gestational Dating
- Confirmed gestational dating is entered (revised EDD should reflect LNMP, clinical exam and ultrasound results)

16) Clinical Visits
- Date entered for each visit using d/m/y
- Gest. age (wks) entered for each visit
- SFH entered (pg 2) and graphed (pg 3) for each visit (from 16wks onward)
- BP entered for each visit
- Wt entered
- Urine gluc/prot entered for each visit
- Hb dates and results entered (should be done minimum once each trimester)
- Fetal position entered for each visit (from 16wks onward)
- Movement (fetal activity) entered for each visit (from 16wks onward)
- FHR entered for each visit (from 16wks onward)
- Examiner's initials entered
- Comments entered as appropriate
- Return dates using d/m/y, as appropriate, entered for each visit

17) Risk Factors/Concerns to be Anticipated in Pregnancy (based on history, physical and scores of pg 3)
- Pregnancy scores entered. Is this assessment correct given the present pregnancy and family history.
- Delivery scores entered. Is this assessment correct given the history
- Newborn scores entered. Is this assessment correct given the history
- Total score entered at initial visit, at 36 wks and at L&D (pg 3)

18) Referral Plan
- Appropriate referral entered

Prenatal Audit Tool
Instruction Sheet

Page 3 & 4

19) Identification
- Client's surname entered
- Client's given name entered
- DOB entered correctly (i.e. D/M/Y)
- Healthcare number entered

20) Part A, B, and C (Risk Assessment)
- Risk assessment for Parts A, B, and C are entered, including subtotal and total score

21) SFH Graph
- SHF measurements (pg2) are entered for each visit as appropriate

22) 24 Hour Food Recall
- completed during initial visit. Used to identify women who are at risk for nutritional deficiencies.

23) T-ACE Questionnaire
- completed during initial visit. Used to identify women who are at risk for alcohol abuse in pregnancy.

24) Health Promotion Topics
- Completed APPROPRIATELY for the stage of pregnancy.

25) Information on extra pages of page 5 and page 6 are entered correctly.

Client's Chart

- Notation of pregnancy is on treatment record i.e. pt. profile and indication on clinic notes as prenatal record.
- Lab results filed by category and chronologically on client's chart.
- All prenatal correspondence i.e. specialist reports filed on client's chart.

Northwest Territories

PRENATAL AUDIT TOOL

Health Centre:	Date of Audit (d/m/y):	Date of Last Audit (d/m/y):

Key:

D - Done
N - Needs to be reviewed
N/A - Not Applicable

Page 1 as per NWT Prenatal Record

Identification	Consent	Previous Pregnancies	Health History	Family/ Genetic History	Social History	Present Pregnancy	Clinical Dating	Revised/ Confirmed EDD	Initial Physical Exam	Medications*	Allergies	Signature & Date	Notation in Chart

***** **Dose, Route, Length of Rx, Amount Dispensed**

Audited By (Please Print)**:**	X _____ Auditor's Signature / Date - d/m/y	**Discussed with NIC:** _____ Date - d/m/y

NWT8699/1206

PRENATAL AUDIT TOOL

Northwest Territories

Health Centre:	Date of Audit (d/m/y):	Date of Last Audit (d/m/y):

Key:

D - Done
N - Needs to be reviewed
N/A - Not Applicable

Page 2 as per NWT Prenatal Record

ID	Lab Results & Dates	Infection Screening	PP imm	U/S Studies	Confirm EDD	Clinical Visits	Risk Factors to Anticipate	Referr Plan	Init/ RTC Date

Pages 3 and 4 as per NWT Prenatal Record

ID	Risk Eval. Pre-Preg. (Part A)	Risk Eval. OBS Hx (Part B)	Risk Eval. Curr. Preg. (Part C)	Total Risk Scores (Part A+B+C)	Graph Com-plete	24 Hr Food Recall	T-ACE	Health Promo Topics	Remarks*

***** **Dose, Route, Length of Rx, Amount Dispensed**

Audited By (Please Print)**:**	X _____ Auditor's Signature / Date - d/m/y	**Discussed with NIC:** _____ Date - d/m/y

Northwest Territories

POSTNATAL AUDIT TOOL (Mother's Chart)

Health Centre:	Date of Audit (d/m/y):	Date of Last Audit (d/m/y):

Key:

D - Done
N - Needs to be reviewed
N/A - Not Applicable

Identification	Delivery Notes on File	1st Home Visit Within 1 Week of Returning Home	Physical Assessment During 1st Home Visit	2nd Home Visit Within 1 Month	Physical Assessment at 6 Weeks (6 week check-up)	Psycho-Social Assessment Noted	Pap & Vaginal Swabs Noted	Hgb Done	Birth Control Counsel Noted	Entered Into Well Woman Recall System	Signature & Designation	Remarks* (including SOAP charting)

***** **Dose, Route, Length of Rx, Amount Dispensed**

Audited By (Please Print)**:**	X Auditor's Signature / Date - d/m/y	**Discussed with NIC:** Date - d/m/y

NWT8706/1206

WELL CHILD AUDIT TOOL

INSTRUCTION SHEET

1) Identification data on Immunization card, progress notes, personal health history - includes full name as recorded on chart, health care number, date of birth, home community, guardian.

2) Chart entry includes date and time of visit.

3) Physical assessment done to rule out acute illness. Chronic health problems, allergies noted.

4) Consent signed for appropriate immunization, dated and witnessed.

5) Immunization up to date for age.

6) Lot number of vaccine and site of injection recorded. Trade name of vaccine recorded if appropriate.

7) Dietary counselling appropriate for age and findings of assessment.

8) Nipissing Developmental Screening done as per schedule (see Community Health Manual).

9) Health teaching done re: growth, development, safety, dental, immunization side effects, use of Acetaminophen, etc.

10) Height, weight, head circumference (if appropriate for age) charted on growth curves.

11) Growth parameters summarized and any abnormalities charted.

12) Follow-up summarized.

13) Entered in recall system.

14) Signature (initial, last name) and designation of caregiver entered for each entry.

15) SOAP charting.

Northwest Territories

WELL CHILD AUDIT TOOL

Health Centre:	Date of Audit (d/m/y):	Date of Last Audit (d/m/y):

Key:

D - Done
N - Needs to be reviewed
N/A - Not Applicable

Date & Time	ID & Allergies	Obstetric Record on Chart	Personal Health Record	Physical Assessment	Consent Signed & on Chart	Immunization Up to Date for Age	Vaccine Lot # Recorded on Card & Chart	Immunization Site Noted on Card & Chart	Dietary Counsel	Nipissing Screening	HGB	Health Teaching	Growth Chart	Growth Parameters Summarized in Chart	Follow-up	Entered Into Recall System	Signature & Title	Remarks* (including SOAP charting)

* **Dose, Route, Length of Rx, Amount Dispensed**

Audited By (Please Print):	X _____ Auditor's Signature / Date - d/m/y	**Discussed with NIC:** _____ Date - d/m/y

NWT8700/1206