SUBJECT: WELLNESS POLICY
APPROVED BY: VP Acute & Long Term Care & COO(South) _____
EFFECTIVE DATE: 2007
REVIEW/REVISED DATE: May 2009, January 2011

Purpose:

To provide clear direction when completing wellness health checks on men and women in community clinics.

To outline a format so that documentation is clearly, consistently and effectively communicated to all care providers.

To increase accessibility for all clients seeking preventative health.

To increase the numbers of pap smears completed annually.

Policy/Standard:

Nurses are responsible to ensure forms are utilized when performing well man/well women examinations.

Nurses must follow the standard as set out by the Breast Screening Program for Newfoundland and Labrador.

PSA and Prostate examination must be done in collaboration with the appropriate physician.

All orders must be accompanied with a telephone advice log.

Regional nurses must review and follow guidelines as set out by Best Practices in the Provision of Women's Wellness Clinics: Recommendation for Service Delivery Province of Newfoundland and Labrador. Provincial Women's Wellness Working Group – February 25, 2009.

Department audits will be completed annually (see attached appendix A).

Materials Required:

Well Man Form (Blue, Appendix B)
Well Women Exam Form (Pink, Appendix C)

Related Policies:

Nil

Procedure:

1. Provide a thirty (30) minute appointment for clients seeking appointments for wellness check.
2. Complete demographics section for each form, ensure its completed in blue/black pen and secured in chronological order.
3. Ask the client to complete the health questionnaire prior to the exam.
4. Review the completed health questionnaire and complete the physical exam.
5. Document finding and nurse's signature.
6. Document in the OPD Nursing notes in SOAP format.

References:

Best Practices in the Provision of Women's Wellness Clinics: Recommendation for Service Delivery Province of Newfoundland & Labrador. Provincial Women's Wellness Working Group – February 25, 2009.

Breast Screening Program for Newfoundland and Labrador.

http://www.sogc.org/guidelines/public/125e%2Dps%2Dmarch2003.pdf

Appendix A

COMMUNITY CLINICS
Quality Assurance Audit
WELLNESS

Date:_____
Clinic:_____
Auditor:_____

Select 3 Charts

Chart Numbers							
	Yes	No	Yes	No	Yes	No	**COMMENTS**
Was an entry made in SOAP format?							
Was the appropriate wellness form completed?							
Was the appropriate follow up action taken?							
COMMENTS:							

Review Date:
1998 09 (O),
2001 03 01 (r),
2007 03 29 (R)
2011 03 03 (R)

Appendix B

Well Man Exam

Clinic _____

<table>
<tr><td>Name</td><td>MCP
DOB</td></tr>
<tr><td>Last Eye exam
Hearing Aid
Dentures</td><td>Penile Discharge / Urinary Symptoms</td></tr>
<tr><td>PMH:

Surgeries--- Vasectomy, Orchiectomy, TURP

Erectile Dysfunction-
Last Prostate Exam-</td><td>Medication-

Immunization: Td, influenza, pneumonia
Allergies:
Type of reaction?</td></tr>
<tr><td>Personal Health
<table>
<tr><th></th><th>Yes</th><th>No</th></tr>
<tr><td>Smoker (PPD)</td><td></td><td></td></tr>
<tr><td>Etoh use</td><td></td><td></td></tr>
<tr><td>Drug Use</td><td></td><td></td></tr>
<tr><td>Diet</td><td></td><td></td></tr>
<tr><td>Exercise</td><td></td><td></td></tr>
<tr><td>STI</td><td></td><td></td></tr>
<tr><td>TSE</td><td></td><td></td></tr>
<tr><td>Previous urine infections</td><td></td><td></td></tr>
</table></td><td>Past Family History
<table>
<tr><th></th><th>Yes</th><th>No</th><th>Other</th></tr>
<tr><td>Thyroid</td><td></td><td></td><td></td></tr>
<tr><td>Hypertension</td><td></td><td></td><td></td></tr>
<tr><td>Diabetes</td><td></td><td></td><td></td></tr>
<tr><td>Testicular cancer</td><td></td><td></td><td></td></tr>
<tr><td>Colon Cancer</td><td></td><td></td><td></td></tr>
<tr><td>Cardiac history</td><td></td><td></td><td></td></tr>
</table>Other:</td></tr>
<tr><td>Review of Systems</td><td>Continue</td></tr>
</table>

Comments

Appendix B

PHYSICAL EXAM

B/P ____ HR_____T ____ RR __ Hgt _____ Wgt _____ BMI _____ Waist _____ Hip _____ W/H ratio ____	HEENT: Thyroid:
Respiratory: Cardiac:	Abdomen: Urine dipstick:
Musculoskeletal	Integument
Reproductive Exam Breasts **Prostate	**Reproductive Exam** Testicular: Penis:
Blood Work CBC _____ TSH _____ Glucose _____ Lytes _____ KFT _____ Cholesterol _____ **PSA_____ **Swabs** C & S _____ Chlamydia _____ GC _____ Urinalysis _____	**Teaching** Active Living Diet/Healthy Weight Mental Health/Stress Smoking Cessation Alcohol/Drugs STIs
Comments:	Date: _____ Time: _____ Signature:_____

Refer to community clinic services policy and procedure manual policy # C-11

Form # _____

NAME:
DOB:
NOK / RELATIONSHIP::
ADDRESS:
TEL:
MCP:

Appendix C

Health History

Age started having periods: _____ When was your first day of your last period? _____

How long does your period usually last? _____ How often do you have a period? _____

How many times have you been pregnant?(including stillbirths) _____

How many babies did you have? _____

Do you have any concerns about your periods that you would like to discuss? □ Yes □ No

Do you have a history of ovarian cancer? □ Yes □ No

Have you had a Clinical Breast Examination? □ Yes □ No, if yes when? _____

Have you had a Mammogram? □ Yes □ No, if yes, when? _____

Have you ever had Breast Cancer? □ Yes □ No, if yes, how long ago? _____

Have you had surgery for your breast cancer? □ Yes □ No

When was your last PAP test? _____ Was your Pap normal? □ Yes □ No
If no, what was the problem? _____

Family History

Has anyone in your family had any of the following cancers?

Breast: □ Yes □ No if yes, whom? _____

Ovary: □ Yes □ No if yes, whom? _____

Medications

Please list any medications you are taking, including hormones and birth control pills.

_____
_____

Additional Comments:_____

NAME:
DOB:
NOK / RELATIONSHIP:
ADDRESS:
TEL:
MCP:

WELL WOMAN EXAM FORM
Community Clinic Services

Blood Pressure: _____

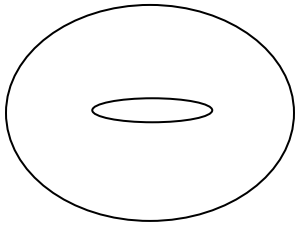
Cervical Screening:

Pap test completed: □ Yes □ No, if no why not? _____

Cervix _____

Vulva _____

Vagina _____



Vagina Discharge/Bleeding noted □ Yes □ No _____

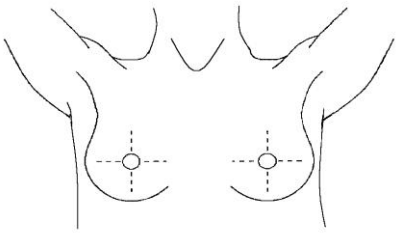
Swabs sent Chlamydia? □ Yes □ No C & S? □ Yes □ No

Breast Health Documentation

Clinical Breast Examination Completed? □ Yes □ No, if no, why not?

_____

Breast Health Awareness Reviewed? □ Yes □ No



Legend

- ● Firm Mass
- ○ Soft mass

^^^ Thickening
\+ Erythema
ttt Scar
x Nipple inv/retraction
* Mole/skin tag/raised growth
//// Nodular/granular
v Dimpling

Clinical Breast Exam Results

Handouts Provided: _____
_____

Referrals/Follow up: _____
_____

Examiner: _____ Date: _____

Telephone Number: _____ Ok to leave a message? □ Yes □ No

Adapted January 2013

Refer to community clinic services policy and procedure manual policy # C-11
Form #