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Common Physician Office Deficiencies

The Physician Practice Enhancement Program (PPEP) is a collegial program designed to proactively assess and educate physicians to ensure they meet high standards of practice throughout their professional lives. Each year, hundreds of British Columbia's physicians participate in the program. The peer practice assessments are conducted by peer assessors who themselves are practising physicians.

During a peer practice assessment, key areas of the physician's practice are evaluated. A report is generated and shared with the physician, including an overview of recommendations for improvements, directed actions and ongoing education as required.

The PPEP report is designed to identify opportunities for improvement and provides physicians with recommendations on how to achieve success.

PPEP has tabulated the most common deficiencies observed during peer assessments. These deficiencies are related to various aspects of the community-based physician office and have been summarized below.

A. Office Procedures

1. Emergency preparedness

a. Emergency kit is deficient in mandatory medications and/or equipment

Refer to the Emergency Preparedness assessment standard for detailed information on requirements including emergency kit medications and equipment.

2. Reprocessing of reusable medical devices

a. Requirements for reprocessing of reusable medical devices are not followed

Physician offices that use reusable medical devices must follow the requirements outlined in the BC Ministry of Health *Best Practice Guideline for Cleaning, Disinfection and Sterilization in Health Authorities* and the manufacturer's instructions for use. For semi-critical and critical reusable medical devices, a clinic must reprocess using a tabletop steam sterilizer (check manufacturer's instructions for use) and all provincial requirements; otherwise the option is to obtain the disposable equivalent. Additional resources are available on the College website. Non-critical reusable medical devices must be cleaned and undergo low level disinfection.

3. Prescription pads and repeat prescribing

a. Documentation of repeat prescriptions is lacking

Repeat prescriptions given via telephone to the pharmacy or repeated on the original prescription must be recorded in the patient's unified medical record. Include total amount and dosage for each medication.

b. Prescription pads left in rooms

Prescription pads must not be left in the examining rooms or other locations where patients have access to them.

4. Medication safety

a. Expired medication, supplies, and samples

Physician offices must have a process in place to routinely check for expired items.

b. Documenting opioid and controlled drugs administered to a patient

The administration of an opioid to a patient must always be documented. Document the administration in both the patient's medical record and the opioid/controlled drug log book. Refer to the Vaccine and Medication assessment standard.

c. Samples and drugs stored in examination room

Drug samples and other therapeutic agents must not be kept in the examination room since patients are commonly left unattended and could have access to these drugs. For more information refer to the Vaccine and Medication assessment standard.

5. Sharps safety

a. Sharps not disposed of safely

Sharps must be disposed of in an appropriate manner. There are specific requirements for a sharps disposal container based on WorkSafeBC recommendations. The requirements are described in the Sharps Safety assessment standard.

B. Medical records, documentation and referrals

1. Documentation in the patient unified medical record (UMR)

a. Encounter note is incomplete

The unified medical record is the patient chart in its entirety. For each patient encounter, the physician must document why the patient came, what was found, and what was done. Refer to the Unified Medical Record assessment standard for all requirements.

b. UMR is disorganized

Each patient must have his or her own UMR and this record must be organized accordingly so that all documents can be easily retrieved as required. Refer to the Unified Medical Record assessment standard for all requirements. Family charts are discouraged as charting errors are more likely to occur, documents may be placed in the wrong section of the chart, or confidential information regarding another family member may inadvertently be disclosed.

c. Cumulative patient profile (CPP)

Each patient chart must have a CPP at the front of the chart. The CPP summarizes the patient's current status, including current active problems and medications, allergies (or absence of allergies), salient past medical history, family and social histories. For all requirements for a patient's unified medical record, refer to the Unified Medical Record assessment standard.

d. Prescription information lacking in medical record

Prescriptions given to patients must always be recorded in the medical record. The details of the prescription includes: dose of the drug; the number of times it is to be taken per day; the total amount prescribed; and the number of repeats given. This again is important for future reference.

2. Legibility of medical records

If paper records are used, they must be written legibly.

3. Allergy flagging

Patient allergies (or absence of) must be clearly noted on their medical record. Allergies must be documented in the cumulative patient profile (CPP). Refer to the Unified Medical Record assessment standard for more information.

4. Recording of telephone advice

Medical advice given to a patient over the telephone must be documented in their medical record.

5. Sending patient's medical records to a new physician

The original copy of a patient's medical records must be kept in the originating physician's possession. If information needs to be shared with a new physician, the pertinent information must be summarized in a report and a copy sent.

6. Referral letters

When a referral is made to another physician, a note or letter should be sent explaining the reason for the referral. This is especially important in complex situations requiring detailed medical history including medications. Include a copy of the note or letter in the patient's chart for reference.