
PHYSICIAN PRACTICE ENHANCEMENT PROGRAM

# Assessment Standards

## Medical Record for the Internist in a Community-based Office Setting

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Administrative

# MEDICAL RECORD FOR THE INTERNIST IN A COMMUNITY-BASED OFFICE SETTING

All internists must routinely contribute to a patient's medical record.

The medical record is a powerful tool that allows a physician to track the patient's medical history and identify ongoing or recurrent problems or patterns. The primary purpose of a medical record is to enable physicians to provide quality health care to their patients. The quality of documentation should allow any clinician to review the chart and continue to provide care for a given patient. Physicians are encouraged to review this assessment standard to help guide their day-to-day medical record keeping.

The intent of this Physician Practice Enhancement Program (PPEP) **assessment standard** is to provide more detail on what is required for documentation and what a peer assessor will be looking for in a medical record, to increase transparency of the assessment process and facilitate consistency amongst peer assessors. The peer assessment is based on the premise that a peer can understand the care being provided for a patient from a review of the medical record.

This is **not** a College practice standard but a PPEP assessment standard designed to guide both the registrant and peer assessor on expectations for record keeping. Please also refer to the College's practice standards on *Medical Records Documentation* and *Medical Records Management*.

In a shared/collaborative multi-physician care practice, a single registrant must be designated as the medical director, and have a clearly identified alternate registrant to assume the above responsibilities when the medical director is unavailable. In a solo physician clinic, the physician is the medical director. The clinic's medical director has oversight of and responsibility for establishing administrative procedures to ensure standards of appropriate medical care are followed (see the College's *Primary Care Provision in Walk-in, Urgent Care, and Multi-physician Clinics* practice standard), including the medical record. The enduring access of a patient's medical record is critical when more than one provider may be involved in providing patient care (e.g. shared/collaborative care practice with family physicians, specialists, multidisciplinary settings, patient hospitalization, or when care is transferred from a retiring physician to new physician).

Regardless of setting, the use of technology (i.e. telemedicine or virtual care) does not alter the ethical, professional and legal requirements regarding appropriate medical care or records. In other words, medicine is medicine; the task of a physician does not vary by interface.

## HOW TO USE THIS DOCUMENT

This document identifies those standards that are best practices in a medical record for an internist in a community-based office setting. A physician undergoing a quality improvement assessment is strongly encouraged to review this document in advance and to ensure they are familiar with the mandatory requirements prior to their on-site assessment.

An assessment standard consists of three components:

1. **Standard** – a goal statement of achievable levels of performance. An assessment standard is identified by a first level whole number ending in ".0" such as 1.0, 2.0, 3.0 etc.
2. **Criterion** – activities or components of the standards that once implemented lead to the overall attainment of the standard. A criterion is identified by the first level number indicating the standard to which it is associated, and a second level number such as X.1, X.2, X.3, etc.
3. **Criterion descriptors** – specific actions for each criterion. Criterion descriptors are identified by the first level standards number, the second level criterion number and a third level criterion number such as X.Y.1, X.Y.2, etc.

   A criterion marked by an **M** indicates that the criterion is mandatory to the extent that it is relevant to the type of consultation being recorded. It is important to note the qualifying words within a criterion, such as **"as relevant"** or **"as indicated"**. A peer assessor's role is to assess how well they understand the care being provided to a patient, and whether the items relevant to that patient's presenting problem(s) are present.

   A criterion that is marked by an **O** indicates that criterion is optional but considered best practice. A registrant should use their best judgement to determine whether the unique circumstances of their practice necessitate meeting each **O** criteria.
4. **Guidance** – the medical record assessment standards have been created, where possible, to be equal across specialties. Guidance notes are offered as clarification of the item from the perspective of a particular specialty.

Components of a quality improvement assessment may include:

- An assessment of office procedures and processes
- A multi-source feedback assessment including feedback from physician colleagues, non-physician co-workers, and patients
- A review of a physician's prescribing practices
- An assessment of a physician's documentation conducted by a peer assessor
- A physician interview and discussion conducted by a peer assessor

**Guidance:** This assessment standard does not apply to independent medical examinations (IMEs). Physicians conducting IMEs must refer to the College of Physicians and Surgeons of British Columbia standard *Independent Medical Examinations*. When assessing IMEs, a peer assessor will

review the letter of instruction, IME report, notes, and fulfilment of the expert witness' duty to court. The report is expected to include the facts and assumptions made to substantiate the opinions rendered by the expert.

This assessment standard was created in consultation with subject matter experts and input from the field, in addition to the references provided. Items are cross-referenced where applicable.

| No. | Standard<br>Criterion | | Reference |
|---|---|---|---|
| **ADM 1.0** | **THE MEDICAL RECORD** | | |
| | The medical record is the patient chart in its entirety. Registrants must ensure that the content of a patient's medical record meets the requirements as set out in section 3-5 of the Bylaws. The medical record must contain comprehensive documentation of the clinical care provided to the patient, including the following. | | |
| **ADM 1.1** | **The medical record contains essential, appropriate and relevant information about the patient.** | | |
| ADM 1.1.1 | **M** | The medical record is written in readable English and well organized. | 1, 2 |
| ADM 1.1.2 | **M** | The medical record contains detailed description of **all** medical patient encounters, with dates (including those made in person or by virtual care.<br>*Guidance: Virtual care is defined as any interaction between patients and registrants, occurring remotely, using any mode of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care. See https://www.cpsbc.ca/files/pdf/PSG-Virtual-Care.pdf.* | 1, 2, 5, 10 |
| ADM 1.1.3 | **M** | The medical record contains a complete, up-to-date problem list (list of active diagnoses). | 1, 2, 3 |
| ADM 1.1.4 | **M** | The medical record contains a complete, up-to-date medication list. | 1, 2, 3 |
| ADM 1.1.5 | **M** | The medical record contains a current record of allergies (or lack thereof). | 1, 2, 3 |
| ADM 1.1.6 | **M** | The medical record contains results of investigations ordered by, requested by, or copied to the physician. | 1, 2, 3, 5 |
| ADM 1.1.7 | **M** | The medical record contains copies of all initiated referral letters/notes to other physicians. | 7, 10 |
| ADM 1.1.8 | **M** | The medical record contains health insurance information (e.g. Medical Services Plan of BC). | 1, 2 |

| No. | Standard<br>Criterion | | Reference |
|---|---|---|---|
| ADM 1.1.9 | **M** | The medical record contains all written communications received by you **from** other physicians and health-care providers relevant to the patient's medical care.<br>Examples:<br>• consultation letters<br>• records of visits to other clinics or emergency rooms<br>• discharge summaries<br>• operative reports<br>• reports of treatments by other health-care professionals | 2, 7 |
| **ADM 1.2** | **A written consultation report is required for appropriate and timely communication with the referring physician.** | | |
| ADM 1.2.1 | **M** | The consultant should provide a prompt and informative response to the referring physician either accepting or not accepting the referral.<br>*Guidance: Two weeks is considered prompt as per the College's Referral-Consultation Process professional guideline.* | 7 |
| ADM 1.2.2 | **M** | The consultant should provide the referring physician with a timely written report.<br>*Guidance: As per the College's Referral-Consultation Process professional guideline, the expectation is that the report be provided within two weeks of the date of service, except in exceptional circumstances. In situations where multiple visits are required to obtain the information for a full consultation, it is acceptable to provide the written report two weeks from the date of the last visit.* | 5, 7 |
| ADM 1.2.3 | **M** | An internal medicine consultation report should include relevant items from the following list as appropriate for the condition being treated:<br>• patient demographics<br>• if known, the identity of the patient's primary care physician (if other than the referring physician)<br>• chief complaint/reason for referral<br>• history of presenting illness with evidence (pertinent positive and negatives)<br>• relevant past medical and surgical history<br>• allergies (or lack thereof)<br>• relevant family history<br>• current medications and doses<br>*Guidance: Note that doses are mandatory for medications that you have prescribed. If it is not possible to confirm the doses of other relevant medications, at a minimum, the name(s) must be listed.*<br>• substance use history and current use (or lack thereof), as relevant<br>• relevant personal and social history<br>• diagnostic conclusions (definitive/provisional; differential diagnosis where appropriate) | 5, 7 |

| No. | Standard<br>Criterion | | Reference |
|---|---|---|---|
| | | • treatments or interventions initiated, including medications prescribed or diagnostics ordered<br>• advice or next steps provided to the patient<br>• recommendations for follow-up by the referring physicians<br>• recommendations for continuing care by the consultant<br>• recommendations for referral to other consultants and indication of who will be responsible for arranging the referral–the internist or the referring physician<br>*Guidance: All of these elements (as relevant) must be documented in the full consultation report contained in the patient's medical record. The consulting physician may choose to send a more concise letter to the referring physician if deemed appropriate.* | |
| **ADM 1.3** | **An encounter note contains essential, appropriate and relevant information about the patient visit.** | | |
| ADM 1.3.1 | **M** | Developments and symptoms since previous visit (i.e. severity and duration), pertinent positives and negatives and, as indicated, a functional inquiry and a review of response to treatment interventions used are documented. | 1, 2, 3, 5 |
| ADM 1.3.2 | **M** | Physical examination findings and validated rating scales/ risk assessment calculations are documented, as relevant. | 5 |
| ADM 1.3.3 | **M** | Investigations are selected appropriately, reviewed and there is documentation of action taken when indicated. | 1, 2, 3, 5 |
| ADM 1.3.4 | **M** | Preferred and provisional diagnoses are clearly documented, consider co-morbidities and differential diagnoses, and are supported by the history, examinations and investigations in the medical record. | 1, 2, 3, 5 |
| ADM 1.3.5 | **M** | Evidence-based and/or standard pharmacological treatment with consideration of patient characteristics, interactions, and current practice guidelines.<br>*Guidance: If any therapies, other than those that are labelled or off-label but commonly used are employed (including alternative or complementary therapies), the details of the informed consent process including rationale must be documented in the medical record. Physicians who choose to practice complementary or alternative therapies in combination with conventional medicine do so in accordance with their professional, ethical and legal obligations. See the College standard, Complementary and Alternative Therapies.* | 8, 9, 11 |
| ADM 1.3.6 | **M** | Education regarding management plan, options, risks, benefits and potential side effects to enable informed consent is documented. | 3, 11 |
| ADM 1.3.7 | **M** | Family or other persons involvement in the consent process, where indicated, is documented.<br>*Guidance: The process of obtaining consent from a minor or persons with cognitive impairment/intellectual disability may need others to be present and involved in the consent discussion.* | 3 |
| ADM 1.3.8 | **M** | Prescriptions are documented including date, dose, quantity and instructions and updated when indicated. | 1, 2 |

| No. | Standard<br>Criterion | | Reference |
|---|---|---|---|
| ADM 1.3.9 | **M** | Medication monitoring is undertaken, as appropriate, and documented.<br>*Guidance: This applies to the medications prescribed by the consulting physician. Monitoring may include, but is not limited to, adverse effects, justification of use of medications, adherence, baseline and follow-up laboratory testing as appropriate to the condition and treatments.* | 1, 2 |
| ADM 1.3.10 | **M** | There is documentation of the reconsideration of diagnosis and treatment plan when there is inadequate response. | 1, 2 |
| ADM 1.3.11 | **M** | Ongoing goals for treatment and regularly noted progress related to these goals including, when possible, the endpoint for treatment, are documented. | 1, 2 |
| ADM 1.3.12 | **O** | SOAP-like format charting is recommended.<br>*Guidance: SOAP is the established format for problem-based record keeping. It enhances an understanding of the concerns and needs of the patient and improves communication among health care professionals. As not all specialist encounters may fit in a SOAP-like format, the format of the progress note is left to the discretion of the physician. Regardless of the charting format used, the content of ADM 1.3.1. to 1.3.11* ***must*** *be documented in the encounter notes.* | 1, 2, 3, 12 |
| ADM 1.3.13 | **M** | For virtual care encounters, ensure that the identities of all other participants involved in the virtual care encounter are disclosed to and approved by the patient, and documented in the patient record. | 10 |
| ADM 1.3.14 | **M** | For virtual care encounters, explain the appropriateness, limitations, and privacy risks related to virtual care to the patient in plain language during the initial virtual care visit, and document their consent. | 10 |
| **ADM 1.4** | **Communication with patients and with referring physicians is a foundational component of patient-centred care.** | | |
| ADM 1.4.1 | **M** | Need for continuing specialist care is communicated to the referring physician in a written update (see ADM 1.4.2). | 7 |
| ADM 1.4.2 | **M** | Referring physicians should receive written updates of the patient's condition and care from the consultant as appropriate, such as when there is a change in condition or management plan, or at least every six months if seen more frequently.<br>*Guidance: The written update should include a succinct summary of diagnoses, treatment plan/goals, and current medications.* | 5 |
| ADM 1.4.3 | **M** | Termination or transfer of care information back to the referring physician includes relevant details of<br>• diagnosis,<br>• treatments provided and patient response,<br>• new medications and/or medication changes, and<br>• recommendations for continued and future management. | 7 |

| No. | Standard<br>Criterion | | Reference |
|---|---|---|---|

## ADM 2.0 CUMULATIVE PATIENT PROFILE

The cumulative patient profile (CPP) is intended to be a simplified, easily accessible document that contains relevant background and current information on a patient. The CPP is a time-unlimited record that grows out of repeated physician-patient encounters over time. The CPP is an **optional** but recommended component of an internist's medical record. Internists should use their professional judgement to determine whether to include a CPP or an equivalent patient health summary in each patient medical record, considering a variety of factors, such as the nature of the physician-patient relationship (e.g. whether it is a sustained physician-patient relationship), the nature of the care being provided, and whether the CPP or equivalent summary would reasonably contribute to quality care.

| | | | |
|---|---|---|---|
| **ADM 2.1** | **The CPP includes appropriate and relevant information on a patient.** | | |
| ADM 2.1.1 | **O** | The CPP includes patient identification and demographic information (age, gender, date of birth, personal health number [PHN], address). | 2, 6 |
| ADM 2.1.2 | **O** | The CPP includes a list of current/ongoing health concerns/problems including date of onset. | 2, 6 |
| ADM 2.1.3 | **O** | The CPP includes current medications and other significant treatments. | 2, 6 |
| ADM 2.1.4 | **O** | The CPP includes allergies (past and current) or "no allergies" are indicated. | 2, 6 |
| ADM 2.1.5 | **O** | The CPP includes significant past medical/surgical history including date of diagnosis or procedure. | 2, 6 |
| ADM 2.1.6 | **O** | The CPP includes past psychiatric/family/social/substance use history (or notation if negative). | 2, 6 |

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