PHYSICIAN PRACTICE ENHANCEMENT PROGRAM

Assessment Standards

Medical Record for the Psychiatrist in an Outpatient Setting

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Administrative

MEDICAL RECORD FOR THE PSYCHIATRIST IN AN OUTPATIENT SETTING

All psychiatrists 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 the medical record is to enable physicians to provide quality health care to their patients. Physicians are encouraged to review this assessment standard to help guide their day-to-day medical record keeping.

Components of a medical record include patient identification data, health insurance information, demographics, consultation reports, progress notes, medical/psychiatric/family/social/substance/risk assessment, allergy information, current medication lists/prescription information, investigations, update letters, collateral reports, and initiated referrals.

The College's *Medical Records, Data Stewardship and Confidentiality of Personal Health Information* practice standard describes physicians as having "an ethical, professional and legal obligation to ensure that before they create a medical record they comprehensively address the issues of ownership, custody, confidentiality and enduring access of the record for themselves and their patients." 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, multidisciplinary settings, patient hospitalization, or when care is transferred from a retiring physician to new physician).

In a solo psychiatric practice, the psychiatrist is responsible for maintaining this standard. In a shared/collaborative care practice, the clinic's medical director has oversight of and responsibility for all operational and administrative components of the medical record. 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.

Physicians are also required by the Canadian Medical Association's *Code of Ethics*, and under the College Bylaws pursuant to the *Health Professions Act*, RSBC 1996, c.183. to create a complete and legible record of the medical care they provide to their patients, whether in paper or electronic format. Other agencies and organizations (e.g. the Medical Services Plan, Canadian Medical Protective Association) also require a record of care.

HOW TO USE THIS DOCUMENT

This document identifies those standards that are required in a medical record for a psychiatrist in an outpatient setting. A physician undergoing a quality improvement assessment is strongly encouraged to review this document in advance and to ensure all mandatory requirements have been fulfilled 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 and must be met. If the registrant is assessed by PPEP, the expectation is that the registrant has met this criterion.

   A criterion that is marked by an **O** is based on best practices using current provincial, national and international standards and guidelines. An **O** criterion is optional. A registrant should use their best judgement to determine whether the unique circumstances of their practice necessitate meeting each **O** criteria.

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 for independent medical examinations (IMEs). Physicians conducting IMEs must refer to the College of Physicians and Surgeons of British Columbia practice 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 Criterion		Reference
ADM 1.0	**THE MEDICAL RECORD** The medical record is the patient chart in its entirety. It includes all the patient's consultation reports, progress notes, past medical/psychiatric/family/social/substance/forensic history, allergy information, medications, investigations, update letters, collateral reports, and referrals over an ongoing period of time.		
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, by telephone, or electronically by email, etc.).	1, 2, 5
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) if providing publicly funded services.	1, 2
ADM 1.1.9	**M**	The medical record contains all written communications received **from** other physicians and health-care providers relevant to the patient's medical care. Examples: • consultation letters • records of visits to other clinics or emergency rooms • discharge summaries • 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. *Guidance: Two weeks is considered prompt.*	7

No.	Standard Criterion		Reference
ADM 1.2.2	**M**	The consultant should provide the referring physician with a timely written report. *Guidance: MSP expects 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**	A full psychiatric consultation report (versus a limited consultation) should include:
		• patient demographics
		• chief complaint/reason for referral
		• history of presenting illness with evidence (pertinent positive and negatives) to determine DSM-5 diagnosis(es)
		• current medications and doses
		    ○ *Guidance: Doses are mandatory for current psychiatric medications. If it is not possible to confirm the doses of non-psychiatric medications, at a minimum, the name(s) must be listed.*
		• allergies (or lack thereof)
		• past medical history (past surgical history, as appropriate)
		• family history
		• past psychiatric history, including suicidal and/or homicidal risk assessment if applicable
		• personal and social history
		• substance use history and current use (or lack thereof)
		• risk assessment
		    ○ *Guidance: This includes harm to self, harm to others, and violence risk. This may include a legal history. In forensic assessments, it is not intended for patients to self-incriminate.*
		• mental status examination (MSE)
		• DSM-5 preferred diagnosis(es) and differential diagnosis
		    ○ *Guidance: Some electronic health record systems use alternative frameworks such as ICD or DSM-IV. This is acceptable as long as diagnoses can be matched to a recognized classification system.*
		• psychodynamic formulation, if applicable
		    ○ *Guidance: This is applicable only for consultations for psychodynamic psychiatry.*
		• initial biopsychosocial treatment plan (including the goals of treatment)
		Guidance: All of these elements 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.
			5, 7

ADM 1.3	**An encounter note contains essential, appropriate and relevant information about the patient visit.**		

No.	Standard Criterion		Reference
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—biological or psychotherapeutic—are documented. *Guidance: Examples of cognitive behavioural therapy (CBT) interventions include homework and exposure hierarchy. Examples of psychodynamic psychotherapy content include patient and therapist input, themes explored, transference, countertransference, interpretations.*	1, 2, 3, 5
ADM 1.3.2	**M**	Mental Status Examinations (MSEs), including relevant details, are completed and documented. *Guidance: The constituent elements of MSEs are determined by the needs of the patient and nature of care provided (e.g. initial consultation versus subsequent visit for established patient). It is acceptable to document only pertinent MSE changes for follow-up visits.*	
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 documented are consistent with the current version of DSM or ICD (considering co-morbidities and differential diagnoses) and are supported by the history, MSEs, and investigations in the medical record.	1, 2, 3
ADM 1.3.5	**M**	Assessment and management of risk is documented as appropriate. *Guidance: Examples of risk include but are not limited to neglect of self-care or neglect of care of dependents, self-harm, suicidality, harm to others (postpartum harm to baby, driving, elder abuse).*	
ADM 1.3.6	**M**	Evidence-based and/or standard pharmacological treatment with consideration of patient characteristics and current practice guidelines. *Guidance: If non-standard off-label, alternative, or complementary therapies are used, 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 practice standard* Complementary and Alternative Therapies.	9, 11
ADM 1.3.7	**M**	Education regarding management plan, options, risks, benefits and potential side effects to enable informed consent is documented.	3, 11
ADM 1.3.8	**M**	Family or other persons involvement in the consent process, where indicated, is documented. *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 1.3.9	**M**	Prescriptions are documented including date, dose, quantity and instructions and updated when indicated.	1, 2

No.	Standard Criterion		Reference
ADM 1.3.10	**M**	Medication monitoring is undertaken, as appropriate, and documented. *Guidance: This applies to medications prescribed by the physician. Monitoring includes, but is not limited to, adverse effects, serum levels, justification of use of medications, adherence.* *Guidance: Physical exam components may include blood pressure, BMI, waist circumference, and description of extrapyramidal symptoms. Validated rating scales may include AIMS, Simpson Angus Scale, and Extrapyramidal Symptoms Rating Scale.* *Guidance: The completion of physical exam components and validated rating scales may be delegated to another physician provided there is a system in place for ensuring these assessments are undertaken and confirmation of completion is noted in the psychiatrist's records.*	12
ADM 1.3.11	**M**	There is documentation of the reconsideration of diagnosis and treatment plan when there is inadequate response.	1, 2
ADM 1.3.12	**M**	Ongoing goals for treatment and regularly noted progress related to these goals including, when possible, the end point for treatment, are documented.	1, 2
ADM 1.3.13	**O**	SOAP-like format charting is recommended. *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 psychiatric 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 1.3.12 must be documented in the encounter notes.*	1, 2, 12
ADM 1.4	**Communication with patients and with referring physicians is a foundational component of patient-centered 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 at least every 6 months from the consultant, until the responsibility for this aspect of the patient's care is returned to the referring physician. *Guidance: A separate written update is not required if the referring physician receives copies of notes or letters from the specialist after follow-up visits. The intention is for communication to occur at least once every 6 months; more frequent communication is acceptable, particularly if there are changes to a patient's treatment or status.*	5
ADM 1.4.3	**O**	The written update (ADM 1.4.2) should include a summary of treatment, current medications, risk status (i.e. harm to self or others), diagnoses, treatment plan and goals for the next 6 months.	

No.	Standard Criterion		Reference
ADM 1.4.4	**M**	Termination or transfer information back to the referring physician includes relevant details of: • diagnosis, • treatments provided and patient response, • risks or concerns about the patient (specifically harm to self and/or others), • new medications and/or medication changes, and • recommendations for continued and future management	7

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 a period of time. The CPP is an **optional** component of a specialist's medical record.

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 (sex, gender, date of birth, provincial health number [PHN], contact information).	6
ADM 2.1.2	**O**	The CPP includes a list of current/ongoing health concerns/problems.	6
ADM 2.1.3	**O**	The CPP includes current medications and other significant treatments.	6
ADM 2.1.4	**O**	The CPP includes allergies (past and current) or "no allergies" are indicated.	6
ADM 2.1.5	**O**	The CPP includes significant past medical/surgical history.	6
ADM 2.1.6	**O**	The CPP includes past psychiatric/family/social/substance/forensic history (or notation if negative).	6

REFERENCES

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OTHER RESOURCES

PPEP Performance Review and Action Plan sample document: https://www.cpsbc.ca/files/pdf/PPEP-PS-PRAP-Sample.pdf