COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

Physician Practice Enhancement Program

ASSESSMENT STANDARDS

Unified Medical Record for the Family Practitioner

Introduction

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

The unified medical record is a powerful tool that allows the physician to track the patient's medical history and identify ongoing or recurrent problems or patterns. The primary purpose of the unified 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.

Understanding the assessment standard

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.

   Criterion that is not marked by an M is based on best practices using current provincial, national and international standards and guidelines. A non-M criterion should be met, but is not required. A registrant should use their best judgement to determine whether or not the unique circumstances of their practice necessitate meeting each non-M 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 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.

Standards

No.		Description	Reference
ADM 1.0		**THE UNIFIED MEDICAL RECORD** The unified medical record (UMR) 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 unified medical record contains essential, appropriate and relevant information about the patient.**	
ADM 1.1.1	**M**	The unified medical record is written in readable English and well organized.	1, 2
ADM 1.1.2	**M**	The unified medical record contains detailed description of all medical patient encounters, with dates (including those made in person or by virtual care. *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 unified medical record contains a complete, up-to-date problem list (list of active diagnoses).	1, 2, 3
ADM 1.1.4	**M**	The unified medical record contains a complete, up-to-date medication list.	1, 2, 3
ADM 1.1.5	**M**	The unified medical record contains a current record of allergies (or lack thereof).	1, 2, 3
ADM 1.1.6	**M**	The unified medical record contains current (when possible) immunization records (including adult immunizations such as tetanus-diphtheria, influenza and pneumococcal vaccines, as clinically indicated).	1, 2, 3
ADM 1.1.7	**M**	The unified medical record contains results of investigations ordered by, requested by, or copied to the physician.	1, 2, 3, 5
ADM 1.1.8	**M**	The unified medical record contains copies of all initiated referral letters/notes to other physicians. *Guidance: As per the College's Virtual Care practice standard, ensure patients referred to specialists are adequately investigated and treated before referral; if a primary care assessment of the patient presentation would normally include a physical examination before referral, the referring physician should ensure that one is done, and the medical record should reflect that.*	7, 10
ADM 1.1.9	**M**	The unified medical record contains health insurance information (e.g. Medical Services Plan of BC).	1, 2

No.	Description		Reference
ADM 1.1.10	**M**	The unified medical record contains all written communications received by you 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 • operative reports • reports of treatments by other health-care professionals	2, 7
ADM 1.2	**An encounter note contains essential, appropriate and relevant information about the patient visit.**		
ADM 1.2.1	**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 1.2.2	**M**	Physical examination findings and validated rating scales/risk assessment calculations are documented, as relevant.	5
ADM 1.2.3	**M**	Investigations are selected appropriately, reviewed and there is documentation of action taken when indicated.	1, 2, 3, 5
ADM 1.2.4	**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 1.2.5	**M**	Evidence-based and/or standard pharmacological treatment with consideration of patient characteristics, interactions, and current practice guidelines. 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 practise 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*.	8, 9, 11
ADM 1.2.6	**M**	Education regarding management plan, options, risks, benefits and potential side effects to enable informed consent is documented.	3, 11
ADM 1.2.7	**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 1.2.8	**M**	Prescriptions are documented including date, dose, quantity and instructions and updated when indicated.	1, 2

No.	Description		Reference
ADM 1.2.9	**M**	Medication monitoring is undertaken, as appropriate, and documented.	1, 2
ADM 1.2.10	**M**	There is documentation of the reconsideration of diagnosis and treatment plan when there is inadequate response.	1, 2
ADM 1.2.11	**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 1.2.12	**M**	**SOAP-like format charting should be used:** **S** The **subjective** details (including the presenting concern, severity and duration, pertinent positives and negatives and, as indicated, a functional inquiry and a review of past/family/social history) **O** The **objective** finding from physical examination and review of consultation and laboratory reports (including relevant positive and negative findings) **A** The physician's **assessment** (including a diagnosis and/or differential diagnosis) **P** The **plan** including discussion of management options, investigations, consultation requests, patient education, medications and discussion of potential side effects, follow-up plans and whether the patient is declining any of the recommendations	3
ADM 1.2.13	**M**	For virtual care encounters, ensure that the identities of all other participants involved in a virtual care encounter are disclosed to and approved by the patient, and documented in the patient record.	10
ADM 1.2.14	**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 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. A CPP must be documented by all family practitioners.

ADM 2.1	**Physicians complete the CPP for each patient.**		
ADM 2.1.1	**M**	A standardized CPP form has been developed for use in the clinical office and is used by each physician who works in that setting.	2, 6
ADM 2.1.2	**M**	Maintenance and use of the CPP form has been communicated to each physician upon hire.	2, 6
ADM 2.2	**The CPP includes appropriate and relevant information on a patient.**		
ADM 2.2.1	**M**	*The CPP includes patient identification and demographic information (age, gender, date of birth, provincial heath number [PHN], address).*	2, 6

No.	Description		Reference
ADM 2.2.2	**M**	*The CPP includes a list of current/ongoing health concerns/problems including date of onset.*	2, 6
ADM 2.2.3	**M**	The CPP includes current medications and other significant treatments.	2, 6
ADM 2.2.4	**M**	The CPP includes allergies (past and current) or "no allergies" are indicated.	2, 6
ADM 2.2.5	**M**	The CPP includes significant past medical/surgical history, including date of diagnosis or procedure.	2, 6
ADM 2.2.6	**M**	The CPP includes past psychiatric//family/social/substance use history (or notation if negative).	2, 6
ADM 2.2.7	**M**	The CPP includes screening tests/disease surveillance appropriate for age.	2, 6
ADM 2.2.8	**M**	The CPP includes immunizations appropriate for age and health, or a notation that immunizations were declined (it should be apparent that an immunization history has been taken). *Guidance: As patients commonly received immunizations from public health or elsewhere, the patient/guardian will often have the most current information on their immunizations.*	2, 6

References

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