PHYSICIAN PRACTICE ENHANCEMENT PROGRAM

Assessment Standards

Unified Medical Record for the Family Physician/General Practitioner

July 28, 2020

Assessment Standards

Administrative

UNIFIED MEDICAL RECORD FOR THE FAMILY PHYSICIAN/GENERAL PRACTITIONER

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. Physicians are encouraged to review this assessment standard to help guide their day-to-day medical record keeping.

Components of a unified medical record include patient identification data, health insurance information, demographics, current and past complaints and symptoms, medical/family/social history, allergy information, current medication lists/ prescription information, disease screening, immunization history, physical examinations, laboratory and radiology results 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. a multi-physician practice where more than one physician may care for the same patient, patient follow-up with a specialist, or when care is transferred from a retiring physician to new physician).

Physicians are also required by the Canadian Medical Association's *Code of Ethics*, as well as by the College Bylaws made under the *Health Professions Act*, 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.

All family physicians/general practitioners whether in solo or group practice, walk-in or pre-booked appointment settings must:

1. Routinely contribute to a patient's unified medical record
2. Ensure that a patient who attends repeatedly is offered longitudinal care if this is has not already been established
3. Ensure every patient has a cumulative patient profile (CPP)

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.

The medical director maintains oversight of and responsibility for all operational and administrative components. In a clinical office where the care of patients is shared by a number of physicians (i.e. walk-in clinic, urgent care or multi-physician clinic), a single physician must be designated as the medical director. In a solo physician clinic, the physician is the medical director.

For detailed information on the roles and responsibilities of the medical director, refer to:

- College practice standard – *Primary Care Provision in Walk-in, Urgent Care, and Multi-physician Clinics*
- Physician Practice Enhancement Program assessment standard – *Medical Director/Solo-practice Physician*

HOW TO USE THIS DOCUMENT

This document identifies those standards that are required in a medical record. 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.

   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.

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 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 UNIFIED MEDICAL RECORD

The unified medical record (UMR) is the patient chart in its entirety. It includes all of the patient's medical encounters, past medical history, personal/family/social history, current issues, allergies, immunizations, tests, medications, investigations, consultations and referrals over an ongoing period of time.

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, by telephone, or electronically by email, etc.).	1, 2, 5
ADM 1.1.3	**M**	The unified medical record contains a complete, up-to-date problem list.	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.	1, 2, 3, 5
ADM 1.1.8	**M**	The unified medical record contains copies of referral letters/notes to other physicians. *Guidance: As per the College's* Telemedicine *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.	Standard Criterion		Reference
ADM 1.1.10	**M**	The unified 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 • operative reports • reports of treatments by other health-care professionals	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**	Investigations are selected appropriately, reviewed and there is documentation of action taken when indicated.	1, 2, 3, 5
ADM 1.2.3	**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 1.2.4	**M**	Evidence-based and/or standard pharmacological treatment with consideration of patient characteristics and current practice guidelines.	9, 11
ADM 1.2.5	**M**	Education regarding management plan, options, risks, benefits and potential side effects is documented.	3, 11
ADM 1.2.6	**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 1.2.7	**M**	Prescriptions are documented including date, dose, quantity and instructions and updated when indicated.	1, 2
ADM 1.2.8	**M**	Medication monitoring is undertaken, as appropriate, and documented.	12
ADM 1.2.9	**M**	There is documentation of the reconsideration of diagnosis and treatment plan when there is inadequate response.	1, 2
ADM 1.2.10	**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

No.	Standard Criterion	Reference
ADM 1.2.11	**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	

ADM 2.0 CUMULATIVE PATIENT PROFILE

The cumulative patient profile (CPP) is intended to be a simplified, easily accessible document that contains relevant background information on a patient regarding their past medical history, personal/family/social history, allergies, medications, and screening test results/immunizations. The CPP is a time-unlimited record that grows out of repeated physician-patient encounters over an ongoing period of time.

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.	6
ADM 2.1.2	**M**	Maintenance and use of the CPP form has been communicated to each physician upon hire.	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).	6
ADM 2.2.2	**M**	The CPP includes a list of current/ongoing health concerns/problems (including date of onset).	6
ADM 2.2.3	**M**	The CPP includes current medications and other significant treatments.	6
ADM 2.2.4	**M**	The CPP includes allergies (past and current) or "no allergies" are indicated.	6
ADM 2.2.5	**M**	The CPP includes significant past medical/surgical history including date of diagnosis or procedure.	6
ADM 2.2.6	**M**	The CPP includes personal/family/social history.	6
ADM 2.2.7	**M**	The CPP includes screening tests/disease surveillance appropriate for age.	6

No.	Standard Criterion		Reference
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.*	6

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11. College of Physicians and Surgeons of British Columbia. Professional guideline: prescribing practices, countersigning prescriptions and internet prescribing [Internet]. Vancouver: College of Physicians and Surgeons of British Columbia; 2002 Jun [revised 2009 Oct; cited 2020 Jul 24]; 2 p. Available from: https://www.cpsbc.ca/files/pdf/PSG-Prescribing-Practices-Countersigning-Prescriptions-Internet-Prescribing.pdf

OTHER RESOURCES

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