PHYSICIAN PRACTICE ENHANCEMENT PROGRAM

Assessment Standards

Administrative: Unified Medical Record

May 5, 2017
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.

In addition, a critical part of quality patient care is enduring access of a patient’s unified medical record when more than one physician may be involved in their 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).

Components of a unified medical record include patient identification data and demographics, current and past complaints and symptoms, medical/family/social history, medications and allergies, disease screening, immunization history, physical examinations, laboratory and radiology results and health insurance information.

The College’s Medical Records 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.”

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

**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.
### 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.

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Criterion</th>
<th>Reference</th>
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</thead>
</table>
| ADM 1.1 | The unified medical record contains essential, appropriate and relevant information about the patient. | M |ADM 1.1.1 The unified medical record is written in readable English.  
ADM 1.1.2 The unified medical record contains detailed description of all medical patient encounters (including those made in person, by telephone, or electronically by email, etc.).  
ADM 1.1.3 M The unified medical record contains a complete, up-to-date problem list.  
ADM 1.1.4 M The unified medical record contains a complete, up-to-date medication list.  
ADM 1.1.5 M The unified medical record contains a current record of allergies (or lack thereof).  
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).  
ADM 1.1.7 M The unified medical record contains results of investigations.  
ADM 1.1.8 M The unified medical record contains copies of referral letters/notes to other physicians.  
ADM 1.1.9 M The unified medical record contains health insurance information (e.g. Medical Services Plan of BC).  
ADM 1.2.0 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 |

|ADM 1.2 | An encounter note contains essential, appropriate and relevant information about the patient visit. | M |ADM 1.2.1 An encounter note contains reason for the visit.  
ADM 1.2.2 M An encounter note contains what was found during the visit. |
### ADM 1.2.3

**M** An encounter note contains what was done during the visit.

### ADM 1.2.4

**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.**

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<thead>
<tr>
<th>No.</th>
<th>Standard Description</th>
<th>Reference</th>
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<tbody>
<tr>
<td>ADM 2.1.1</td>
<td>A standardized CPP form has been developed for use in the clinical office and is used by each physician who works in that setting.</td>
<td>M</td>
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<tr>
<td>AAA 2.1.2</td>
<td>Maintenance and use of the CPP form has been communicated to each physician upon hire.</td>
<td>M</td>
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### AAA 2.2

**The CPP includes appropriate and relevant information on a patient.**

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<thead>
<tr>
<th>No.</th>
<th>Standard Description</th>
<th>Reference</th>
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<tbody>
<tr>
<td>ADM 2.2.1</td>
<td>The CPP includes patient identification and demographic information (age, gender, date of birth, provincial health number [PHN], address).</td>
<td>M</td>
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<tr>
<td>ADM 2.2.2</td>
<td>The CPP includes a list of current/ongoing health concerns/problems (including date of onset).</td>
<td>M</td>
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<tr>
<td>ADM 2.2.3</td>
<td>The CPP includes current medications and other significant treatments.</td>
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<td>ADM 2.2.4</td>
<td>The CPP includes allergies (past and current) or “no allergies” are indicated.</td>
<td>M</td>
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<tr>
<td>ADM 2.2.5</td>
<td>The CPP includes significant past medical/surgical history including date of diagnosis or procedure.</td>
<td>M</td>
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<tr>
<td>ADM 2.2.6</td>
<td>The CPP includes personal/Family/Social history.</td>
<td>M</td>
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<tr>
<td>No.</td>
<td>Standard Criterion</td>
<td>Reference</td>
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<tr>
<td>ADM 2.2.7</td>
<td>M The CPP includes screening tests/disease surveillance appropriate for age.</td>
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<tr>
<td>ADM 2.2.8</td>
<td>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). <strong>Note:</strong> As patients commonly received immunizations from public health or elsewhere, the patient/guardian will often have the most current information on their immunizations.</td>
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REFERENCES


