Supervised Practice Assessment

Chart Review & Chart Stimulated Recall

Introduction

Applicants have already demonstrated that they have the requisite medical knowledge, skills and attributes to practise as the most responsible physician on the Provisional Register as a result of successfully completing the preliminary clinical assessment component of a practice readiness assessment. Alternatively, CPSA may have waived the requirement for the preliminary clinical assessment, as it is believed that the applicant already possesses sufficient training and/or experience such that these conditions have been met. In either situation, the purpose of the supervised practice assessment is to assess whether an applicant is continuing to demonstrate good medical practice in his/her own practice setting in the role of the most responsible physician.

As opposed to the preliminary clinical assessment, direct observation is not the method of assessment for the supervised practice component. Assessment in this component is achieved through chart review, chart stimulated recall and interviews with an applicant's colleagues or staff. The Interim and Final assessment reports for the supervised practice assessment have already been provided for reference (see Appendix B in the PPAP Information Manual – Section 1). CPSA has also prepared the following additional tools for use while the supervisor performs each supervised practice visit: Chart Review Guide, Chart Stimulated Recall Interview Guide and the Chart Review and Chart Stimulated Recall Worksheet (attached).

The Chart Review Guide is intended to assist the supervisor in evaluating the applicant's competence as evidenced in the charts, while the Chart Stimulated Recall Interview Guide is intended to assist the supervisor in formulating questions to ask the applicant to gain information not readily apparent in the chart. The Chart Review and Chart Stimulated Recall Worksheet acts as a means to document the supervisor's findings following the chart review and the subsequent discussions with the applicant. The supervisor is asked to judge the quality and organization of the chart notes, and in doing so, to look for internal consistency (for example, are historical problems followed through with appropriate examinations and investigations?) and for discordances (for example, does the assessment align with the history and physical findings?). Finally, the supervisor is asked to engage in case-based discussions that probe the applicant's medical knowledge, and clinical decision-making and judgment.

Applicant – Supervisor Practice Visits

Supervisors are expected to meet regularly with the applicant over the course of the assessment. Prior to each visit or at the beginning of each visit, the supervisor should request between 5-10 charts be made available for his/her review to provide the basis for the chart stimulated recall. The chart reviews should involve a broad cross-section of medical conditions including chronic disease management and common presenting complaints.

Once the supervisor has reviewed the cases and completed the associated worksheets, he/she should arrange to meet with the applicant to conduct chart stimulated recall. The supervisor should begin the discussion with open-ended questions to reduce bias and to provide insight into the applicant's thought processes. The questions should be asked in a non-judgmental, non-biased approach, and the supervisor should be prepared to provide advice and feedback to the applicant throughout the supervised practice visit. Questions related to professionalism can be included in the discussion. Notes captured on the worksheets should be kept by the supervisor after each visit to assist with completion of either the Interim or Final Progress Report for submission to CPSA at the designated intervals. These notes will provide support to substantiate the associated evaluation results through concrete examples gathered from each of the supervised practice visits and can be valuable in the event that an assessment finding is ever challenged by an applicant.

Note: Any worksheets or notes completed over the course of the assessment relating to an applicant must be submitted to CPSA with the assessment reports following completion of the Supervised Practice Assessment.

Supervised Practice Assessment – Chart Simulated Recall Interview Guide

A. Individual Visit Questions

1. **General** – "Please tell me about this visit." [Alternative: "Please outline your approach to the presenting complaint and highlight the key points."]
2. **Clinical Assessment** – "What specific features led you to this diagnosis or clinical impression?" Were there any other conditions that you ruled out?"
3. **Investigations and Referrals** – "What specific features led you to the investigations/referrals you chose?" Were there any other investigations/ referrals that you thought about, deferred or ruled out?
4. **Treatment** – "What specific features led you to the management you chose?" "Were there any other treatments that you thought about, deferred or ruled out?" [Alternative: "I note that you ordered 'XYZ'. What factors influenced your choice?" "Were there any other medications you considered?"
5. **Follow-up** – "Do you recall if there was a decision about follow-up?" "What were the factors that influenced your decision?"
6. **Patient Factors** – "Patient characteristics sometimes influence decision-making. Was there anything special about this patient that influenced your decisions regarding management? (e.g., psychosocial issues, compliance, past medical history, current medications, support systems, employment)". "On reflection, is there anything about this patient you wish you knew more about?"
7. **Practice/System Factors** – "Is there anything special about your practice setting that influenced your management in this case? (e.g., a nurse educator, lack of access to laboratory or x-ray)". "On reflection, what changes would improve your ability to deliver care to this patient?"

B. Broader Practice Issue Questions

1. **Getting Timely Answers to Clinical Questions**

   Purpose: To determine the physician's awareness and processes to find reliable/ current clinical information.

   - When you don't know the answer to a clinical question, what do you do to get a timely answer?

- Do you use the Internet/reference books/journals to search for clinical information?
- Are those sources serving your needs?
- Tell me about a particularly challenging patient where you needed urgent knowledge and could not contact a colleague.
- What additional resources would help you to find timely answers to clinical questions?
- A strong response will indicate use of multiple sources (web-based; paper resources; colleague support); will indicate openness to new sources and methods; and is willing to adapt to available resources.

2. Use of Optimal Office Systems

Purpose: To determine the physician's awareness of the impact of office processes on patient care and provider satisfaction.

- What frustrates you about your office practice?
- Which systems in your office for management of people, paper and patients work well? Which don't?
    - How well is intra-office communication working?
    - How well is inter-office communication working?
    - How up-to-date and readily available are your medical records?
    - How are third party requests for reports being handled? How can they be handled better?
    - How are phone calls managed (to front desk/ to physician)? What works and what isn't?
- How is follow-up of lab results/ notification of patients handled? How well is that working?
- What are the barriers to improving office functioning?
- What problems/barriers are office issues versus health system issues?

A strong response will indicate awareness of the strengths and weakness in the office; will acknowledge responsibility for it; and will have processes to adjust as problems are identified.

3. Utilizing Illness Prevention Strategies

Purpose: To determine the physician's capacity and commitment to health promotion / risk reduction strategies.

- How do you see your role in promoting healthy lifestyles?
- What health promotion / risk reduction strategies do you use in your practice?
- How do you / how often do you encourage lifestyle modification?
- How do you / how often do you address smoking, weight management, exercise, alcohol and other risk factors in disease management?
- What screening tests do you recommend for (disease: e.g. diabetes) (age- and sex-specific populations)?

A strong response will indicate responsibility for promoting healthy living among patients; will demonstrate (document in the record) a routine implementation of established preventive interventions (preferably in a flow sheet or summary page) and have reminder systems in place; will demonstrate routine questioning about risk factors; will have written material for patients; and will identify frequently used resources in the community to assist patients with these factors.

4. Empowering Patients in Self-Care

Purpose: To determine the physician's commitment to promoting and facilitating patients' active participation in their care.

- How do you encourage patients to take responsibility for their care?
- How do you facilitate their active participation in care plans?
- What written information do you provide to your patients?
- Do you help your patients set targets/goals for improvement?
- Do you use homework assignments for patients?
- Do you refer patients to community resources to assist in reaching goals?

A strong response will indicate commitment to achieving a partnership with the patient in a treatment plan; will provide written material or refer to resources available; will offer treatment choices to patients; will assign homework and will assist the patient to set goals; will measure successes.

(Evidence of Care Provided)

Items	
A	Do the recorded history and physical findings support the problem or diagnosis? Yes, if: there is evidence of any elaboration of the presenting complaint and evidence of examination, when appropriate, of: the offending part, an organ system, including features to distinguish the seriousness of the problem, and vital signs. Yes, if: I, as a colleague, could take over care of this patient safely without having to talk to the doctor. Comment if important history is not evident (e.g. the features of a chest pain; the cause of an injury; suicidal ideation in a case of depression; the features that distinguish among important diagnoses.)
B	Are problems or diagnoses recorded in the chart? Yes, if: problem labels (e.g., hip pain) or diagnoses (e.g., osteoarthritis) are recorded. Comment if patients' undifferentiated complaints are simply restated without evidence of being defined by the physician (e.g. chest pain without history or physical examination or apparent attempt to characterize the pain). Comment if major medical problems are overlooked.
C	Do x-rays and laboratory tests support the problem or diagnosis? Yes, if: investigations ordered reflect modern choices for laboratory and imaging studies AND are sufficient in each case to assess a problem or diagnosis. They may or may not be noted in the visit record.
D	Are abnormal findings or results properly followed-up? Yes, if: appropriate action is taken on abnormal findings on laboratory and imaging studies (e.g., advice, further investigation, treatment)
E	Are the names, dosages and quantities of prescribed medications recorded? Self-explanatory.
F	Are treatments, referrals and other interventions recorded and appropriate? Yes, if: advice or management strategy is recorded.
G	Are plans for follow-up recorded when follow-up is important? Yes, if: there is evidence of responsibility being taken for monitoring the course of an injury or illness, or the effect of advice or treatment.

cpsa
COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Supervised Practice Assessment

Chart Review & Chart Stimulated Recall

Please copy this form as many times as needed

Applicant Name: _____ Aplicant CPSA Registration #:_____

Examples where the clinical record raises questions about: responses to abnormal findings; evidence for diagnoses; choices of investigations or treatments; or diligence of follow-up. Record either chart ID #, or the combination of patient initials and date of birth and recent date of visit. **Do not record patients' names.**

Chart ID ***or*** Patient Initials: _____ Date of visit:_____

DOB:_____

		Yes	No	N/A
A	Do the recorded history and physical findings support the problem or diagnosis?	☐	☐	☐
B	Are problems or diagnoses recorded in the chart?	☐	☐	☐
C	Do x-rays and laboratory tests support the problem or diagnosis?	☐	☐	☐
D	Are abnormal findings or results properly followed-up?	☐	☐	☐
E	Are the names, dosages and quantities of prescribed medications recorded?	☐	☐	☐
F	Are treatments, referrals and other interventions recorded and appropriate?	☐	☐	☐
G	Are plans for follow-up recorded when follow-up is important?	☐	☐	☐

Field Notes & Chart Stimulated Recall (CSR)
Impressions

_____ _____ _____

Physician signature Supervisor signature Date

Submit completed form to registrationassessments@cpsa.ab.ca