Chart Review

As the Assessor, you will have 30 charts to review. The candidate will send you their rosters 30 days before the start of their Summative Assessment. You will have 1 week to select 30 charts and notify the candidate of your specific chart selection. For each of these 30 chart reviews, complete a Chart Review Form (provided within this package). The candidate is not to provide you with any part of the chart, just the patient rosters.

Out of the 30 charts, you will select only 10 to discuss in detail with the candidate and complete a Chart Stimulated Recall Form. Complete a log of each review in the Patient Chart Summary located on page 10. The chart review is not to be done in advance but during the Summative Assessment at the candidate's locations of practice.

FAMILY MEDICINE

For Family Medicine assessments, the candidate is required to provide you with 14 days of general patient visits. You will review 15 charts from the patient rosters provided to you by the candidate. In addition, review 15 of the 26 additional mandatory patient charts (see next page for details on these mandatory charts).

SPECIALIST

For Specialist assessments, the candidate is required to provide you with 30 days of patient visits from the applicable clinic/hospital/ER/LTC rosters. Of these, you will select 30 to review.

CHARTS SHOULD INCLUDE, AS APPLICABLE:

- referral letter, initial consultation or emergency room report and/or admission report
- your progress notes, your consultationrequest(s) to others and results
- your reports to other physicians andyour discharge summary

Identify any assessments that were performed by other physicians before you took over the patient's care.

CHARTS SHOULD NOT INCLUDE:

- nurses' notes,
- other doctors' notes, or
- material prepared by other people except as noted above.

Mandatory Chart Review
(Family Medicine Assessors only)

For Family Medicine assessments, select and review the number listed under each category:

- ☐ Preventative care charts
  - 2 male
  - 2 female
- ☐ Antenatal/Prenatal care charts
  - at least 3
- ☐ Well baby check chart
  - at least 2, including an 18-month check if possible
- ☐ Chronic health conditions charts
  - at least 2 hypertension
  - at least 2 diabetes
  - at least 2 complex care (i.e., patient with multiple co-morbidities)
- ☐ Psychosocial/mental health charts
  - at least 2 depression
  - at least 2 anxiety
  - at least 2 other (may include domestic violence or non-prescription substance abuse)
- ☐ At least 2 chronic non-cancer pain management chart (with or without opioids)
- ☐ Acute care management charts
  - at least 3, including 1 respiratory tract infection

Additional info:

Complete a Chart Review Form for every chart you review and log each review in the patient chart summary.

Chart Review Reference

Score Guide: All scoring criteria is based on CPSA standards of practice.

Met	Most elements of the standard for care are evident and deficiencies, if any, are minor.
Partially met	Some elements of the standard for care are lacking, but the likelihood of adverse patient outcomes is low.
Not met	Many elements of the standard for care are lacking or patient outcomes could be adversely affected.

General Scoring Criteria	Standard for Care
The presenting complaint is clearly documented (why the patient came in).	The patient's complaint and/or reasons for visiting are clearly recorded.
The history is complete, reasonable and accurate, and is clearly documented.	A standard history of the presenting complaint is documented, including relevant details of: • onset and evolution • symptom description and duration • aggravating and relieving factors • pertinent positives and negatives • medications history and results • functional inquiry when appropriate and function status (activities of daily living)
Based on the presenting complaint and the history, there are no missing items from the physical exam.	The physical examination was completed and documented based on the presenting complaint. Documentation may include: • pertinent positive and negative finding • physical measurements and vital signs • relevant descriptive information • illustrations of condition, if appropriate

A working diagnosis is stated.	The diagnosis the candidate will be treating is clearly documented.
The working diagnosis is reasonable.	The documented diagnosis shows the candidate considered other possible causes, co-morbidities and presenting symptoms. The diagnosis notes relevant acuity and/or severity.
Any appropriate differential diagnoses are listed.	There is appropriate exploration and documentation of relevant differential diagnoses.
Diagnostic Imaging, lab tests and/or other investigations are recorded in the chart.	All investigations are recorded.
Investigation of the problem is appropriate.	The candidate's rationale for ordering or not ordering tests to help confirm the diagnosis is documented. Tests ordered must be necessary and reasonable as indicated by: • rationale • consideration of differential diagnoses • review of previous investigation and relevant findings • urgency • consideration of judicious use of resources
Prescribed medications are appropriate and recorded.	Documentation of prescribed medications includes: • patient characteristics • goals of pharmacological treatment • drug name • dose and quantity/repeats • route • duration • any required education or monitoring The patient medication list is updated with changes and rationale.

Medication choices are appropriately monitored and reviewed.	Documents show: • The candidate is monitoring and recording medication side-effects at appropriate intervals. • The candidate is reviewing ongoing treatments every year with the patient. • The candidate and patient have discussed the pros and cons of medications as health and age changes. • When necessary, the candidate has identified a responsible person to monitor the patient's medications. • When necessary, the candidate has addressed substance use issues and/or uses an opioid treatment agreement.
Non-drug therapies are recorded (e.g., physiotherapy, occupation therapy, diet, exercise, counselling).	The candidate's recommendations for any non-drug therapies are documented.
Any management plan is appropriate and documented, including drug and non-drug therapies and next steps.	Documented management plans are consistent with: • the patient's history, examinations and results of investigations • pre-treatment screening for contraindications or cautions • consideration of co-morbidities in treatment plans • consideration of acuity of the patient's presenting complaint and any accompanying safety issues • relevance of ordered/conducted tests, procedures, and referrals and assessments • employment of patient safety and infection control measures as warranted • consideration of judicious use of resources • consideration of patient circumstances and costs • documentation of outstanding preventative health topics to be addressed at future appointments

A clear and concise follow-up plan is documented and used.	The patient chart shows the candidate documents and implements: • follow-up plans with the patient • recommendations for return appointments Patients with a higher risk of receiving a significant clinical result are followed up with more closely, sometimes including: • follow-up after canceled or missed appointments • follow-up when an investigation has been completed without a report received • flagging abnormal results in investigations
The patient EMR chart is a fulsome representation of the patient's health status.	The physician has completed the following sections of the patient chart; they are up-to-date and readily accessible and the physician is able to pinpoint problem information: • Allergy section, including reactions to specific medications or 'No Known Allergies' (NKA) • Active problem list, including chronic illnesses and risk factors • Past medical history • Social/Occupational history, including occupation, habits, life events, living arrangements • Family history • Lifestyle, including smoking alcohol intake or recreational drug use • Consultant's report

Case-Specific Scoring Criteria	Standard for Care
Age-appropriate preventative strategies are documented.	The candidate has documented the following age-appropriate screening strategies: • For children < 2 years old: inquiry/performance of primary vaccines (may be done by public health) • For adults: inquiry about smoking • For adults > 40: recorded blood pressure • For adult women: periodic well-women, in accordance with the current guidelines. • Opportunist inquiries at unrelated visits are acceptable (e.g., asking a relatively young, otherwise healthy person about smoking) Documents also show the candidate makes efforts to ensure that appropriate scanning is completed (e.g., cancer, BP, immunizations)
The history is complete, reasonable and accurate, and is clearly documented.	A standard history of the presenting complaint is documented, including relevant details of: • onset and evolution • symptom description and duration • aggravating and relieving factors • pertinent positives and negatives • medications history and results • functional inquiry when appropriate and function status (activities of daily living)
Pediatric monitoring is documented on an appropriate pediatric form.	The candidate documents patient height, weight, nutrition, milestones, reference to growth charts and immunizations. The candidate uses: • pediatric growth charts for all children under the age of 2 • the Grieg Health Record for children/adolescents aged 6 to 17 • the Rourke Baby Record for newborns to 5 year old

<table>
<tr><td>Antenatal monitoring is documented appropriately.</td><td>The candidate completes and keeps Alberta prenatal/antenatal forms in the patient's chart depending on the number of weeks of antenatal care provided by the candidate: Documents from the first antenatal visit includes at minimum:
• medical history
• present medications
• last menstrual period
• menstrual cycles
• estimated due date
• lifestyle issues
• past obstetrical history
• family history
• height and weight years prior
• blood pressure

Regular assessment (every 4 weeks until 28 weeks) includes at minimum:
• weight
• BP
• fundal height</td></tr>
<tr><td>Psychosocial: Appropriate assessment was done for risk of suicide or self-harm.</td><td>Documentation indicates the candidate reviewed the patient's:
• mental status
• risk of harm to self or others
• appearance
• attitude
• behaviour
• speech
• thought processes and content
• insight
• judgement</td></tr>
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Depression and/or anxiety: Appropriate assessment was done to establish diagnosis and severity.	Documentation indicates the candidate considered: • current signs and symptoms • recreational drug or alcohol use • social context • past history and co-morbid conditions • family history • past medications • a review of systems
Chronic disease: Management follows standard guidelines and protocols.	Documentation shows the candidate's management approach is organized and proactive. The candidate uses flow sheets or equivalent EMR tools for diabetes mellitus, hypertension, COPD and heart failure.

Patient Chart Summary

List every chart you review below, whether or not you have a concern with it. Use a Chart Review Form (at the end of this package) to record your detailed findings for each chart. If you're not sure about the scoring criteria, the Chart Review Reference outlines detailed expectations.

#	Chart Number	Patient Initials	DOB	Presenting Complaint
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Summative Assessment Chart Review Form

Chart #: ____________________ Date of visit: __________________________

DOB: _______________________ Gender: _______________________________

Brief summary of this visit:

Scoring guide:

Met	Most elements of the standard for care re evident and deficiencies, if any, are minor.
Partially met	Some elements of the standard for care are lacking, but the likelihood of adverse patient outcomes is low.
Not met	Many elements of the standard for care are lacking or patient outcomes could be adversely affected.

General scoring criteria	**Met**	**Partially met**	**Not met**	**N/A**
The presenting complaint is clearly documented (why the patient came in).				
The history is complete, reasonable and accurate, and is clearly documented.				
The biopsychosocial history is recorded in the chart.				
Where a cognitive assessment was indicated, the results are documented in the chart.				
Where a physical examination was clinically indicated, the findings are documented in a standard fashion.				
Based on the presenting complaint and the history, there are no missing items in the physical exam.				
The working diagnosis is stated.				

General scoring criteria	Met	Partially met	Not met	N/A
A working diagnosis is reasonable.				
An appropriate diagnosis based on DSM-V criteria is provided.				
Any appropriate differential diagnoses are listed.				
Diagnostic Imaging, lab tests and/or other investigations are recorded in the chart.				
Investigation of the problem is appropriate.				
Prescribed medications are appropriate and recorded (e.g., drug name, dose, and duration).				
Medication choices are appropriately monitored and reviewed.				
Non-drug therapies are recorded (e.g., physical treatments and psychotherapy).				
Any management plan is appropriate and documented, including drug and non-drug therapies, and next steps.				
A clear and concise follow-up plan is documented.				

Case-specific scoring criteria (Family medicine only)	Met	Partially met	Not met	N/A
Age-appropriate preventative strategies are documented (e.g., screening, weight control, immunizations).				
Pediatric monitoring is documented on an appropriate pediatric form (e.g., immunizations, growth monitoring and developmental milestones).				
Antenatal monitoring is appropriately documented on the Alberta pre-natal/antenatal.				
Psychosocial: appropriate assessment was done for risk of suicide or self-harm.				
Depression and/or anxiety: appropriate assessment was done to establish diagnosis and severity.				
Chronic disease: management follows standard guidelines and protocols.				

Select the statement that best describes this patient's care:

Both clinical performance and documentation were good/adequate.	
Both clinical performance and documentation were inadequate/lacking. Please explain in the space provided below.	
Clinical performance was good/adequate, but documentation was insufficient/lacking. Please explain in the space provided below, with rationale for assessing adequate clinical performance.	
Documentation was good/adequate, but clinical performance was inadequate/lacking. Please explain in the space provided below.	

If you have any concerns about the candidate's chart documentation or clinical performance, please explain: