Chart Audit

A Brief Primer

Conflict of Interest

• I have no conflict of interest to disclose.

Objectives

- By the end of this session, participants should be able to:
 - identify the basic elements of good charting
 - review a chart and identify strengths of the record and areas for improvement

First step

- Basic demographics full name, current address, PHIN, date of birth, telephone number(s), next of kin
- All pages of a paper chart should be labelled
- Paper chart is it legible?
- Cumulative patient profile, with problem list, medication list, allergies, past history, family and social history is highly recommended
 - · Always there in EMR, but not always completed
 - Paper formats available

Second step

- Visit notes should include
 - Adequate history presenting complaint, associated features, pertinent positives and negatives
 - Pertinent past history (previous episodes), social history, family history
 - Recording of examination (pertinent negatives)
 - Assessment/diagnosis/differential diagnosis
 - Plan investigations, treatment (Rx and non-Rx), referrals (specialist and ancillary providers), follow up recommendations

Second step

- Notes should be objective as possible avoid wording that might be offensive to patients
- SOAP format preferable, but okay if it's not strictly that format
- What is the mechanism for review of results/consults?

Bottom line...

• If the physician won the Lotto Max (or were hit by a bus), could someone step into the practice, pick up the chart, and keep going with the management of the patient? Or would they have to start from scratch?

Standard of Care

Another bottom line

 The level at which the average, prudent provider in a given community would practice.
It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.

Safe care is the objective.

Next step...

• Time to practice!