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.

Monitoring Report - Chart Audit Tool

- Section 1 – chart by chart
- Visit date – for the purposes of supervision, you may want to look at more than one visit (when available) to follow progression/continuity of care
- You must record concerns but can also record specific positive comments here if you wish

Section 1 – Chart by Chart

- Auditor Guideline – has been developed to bring uniformity to chart audits
- Reminder of salient point to remember when reviewing charts
- Lists different categories of information to keep in mind for chart review

Section 2 – Overview of Charts

- After doing chart by chart review, analyze the overall picture of record keeping and safety of care provision across all charts.

Overall Assessment

- The bottom line question – is this safe care?
- Comments may be positive or negative.
- "No" answer must be accompanied by comments outlining examples and rationale for rating as not meeting standard of care.
- Practice improvement recommendations – suggestions for supervised physician. May be things that will be followed up on at future visits.

Next step…

- Time to practice!