DR. X OFF-SITE CHART REVIEW FORM
Reviewer: Dr. Y
DATE: 17 November 2023

PREAMBLE: Initial Quality Improvement Program chart review.

CHARTS REVIEWED:

PHIN #	Patient Initials	Year of Birth	Gender	Start/End Date of Visits
Diagnosis:	Cardiac arrest			

Comments:
Adequate documentation.
56-year-old male with history of rectal cancer and recent rectal sigmoid resection on chemotherapy who presented with a history of suspected PE. He seemed hemodynamically unstable on arrival to the ER and subsequently coded shortly after. Resuscitative efforts including CPR, IO and central lines was carried out. Norepi was also started. Intubation was withheld as the patient seemed to improve with the initial interventions.

Before Dr. X could consult the medical ICU, the patient coded again with an asystole rhythm.
Labs were consistent with severe metabolic acidosis. The code lasted for 20 minutes before it was called off. Dr. X broke the news to the wife in an appropriate manner.

PHIN #	Patient Initials	Year of Birth	Gender	Start/End Date of Visits
Diagnosis:	CRAO (central retina artery occlusion)			

Comments:
The patient presented with loss of vision in her in both eyes, which initially started in her right eye as per triage note. There is a CXR and bloodwork on file.

There is no physician documentation regarding the assessment and care of this patient on file.

PHIN #	Patient Initials	Year of Birth	Gender	Start/End Date of Visits
Diagnosis:	Ascites			

Comments:
50-year-old male with ascites secondary to liver cirrhosis, presented to the ER with increased abdominal pressure as per triage history. His last paracentesis was 3 weeks prior to presentation. CBC, Lytes, U and Cr, PT/INR ordered. A consent form is also on file.

There are no physician notes, procedural notes, or discharge instructions on file.

PHIN #	Patient Initials	Year of Birth	Gender	Start/End Date of Visits
Diagnosis:	MVA with Left Elbow dislocation +distal radius fracture			

Comments:
56-year-old male involved in MVA and sustained left elbow dislocation and distal radius fracture. There was a triage history note and bloodwork, CT imaging of brain, chest, C-spine, abdomen ordered.

There is no physician documentation regarding this patient's polytrauma history or physical examination neither is there any note regarding his elbow reduction.

PHIN #	Patient Initials	Year of Birth	Gender	Start/End Date of Visits
Diagnosis:	Paroxsymal Afib/flutter, gluteal abscess, FTC			

Comments:
Acceptable patient management. A typed well-documented note was found in Part/volume 7 of patient chart.

65-year-old male who presented with A. Flutter RVR, gluteal ulcer and FTC. He was initially rate controlled with Diltiazem and then electrical cardioverted when he became hemodynamically unstable. Cardiology was consulted early. IV antibiotics was also started.

PHIN #	Patient Initials	Year of Birth	Gender	Start/End Date of Visits
Diagnosis:	Vaginal bleeding in 2nd trimester pregnancy			

Comments:
There is no physician history or physical examination documentation of this 22-year-old G4P1 female. I only had the triage history note to assess the history. The triage notes state the patient's GA as 13 weeks (which means she is still in 1st trimester). The only note on the emergency record note states "Vaginal bleeding in 2nd term pregnancy".

CBC reveals hgb of 108 and a quantitative BHCG done as well as U/A.

There is no documentation regarding the patient's rhesus status or ultrasound imaging. No consult to obstetrics on file.

OVERVIEW OF CHARTS Please complete this section taking into account all charts reviewed. See legend below for definition of categories.	No/Minimal Concerns Reasonable care provided	Opportunities for Improvement	Required changes - Patient safety concern
Medical Record Keeping	☐	☐	☒
Comments: Some of the charts did not have any physician notes, I had to rely on the triage notes. Please see the comments on the previous page for full details.			
Medical Management	☐	☐	☒
Comments: This is difficult to assess as the pertinent information to assess from Dr.'s notes on most of the patients is absent.			

Level of Concern	Definition
No/Minimal Concerns Reasonable care provided	No/minimal concerns, care provided is reasonable and adequate.
Opportunities for Improvement	Suggested changes or improvements to practice for self-directed implementation.
Required changes – Patient safety concern	Patient safety concerns or major practice changes needed and CPSM follow-up required.

OVERALL ASSESSMENT
Strengths
Comments: See below.
Opportunities for Improvement
Comments: See below.

PRACTICE IMPROVEMENT RECOMMENDATIONS

Required Changes - Patient Safety Concerns

Comments:

Documentation is a huge concern. It is difficult to assess if the patients Dr. X attended to received appropriate care in the absence of his notes.