Advice to the Profession: Medical Records Documentation

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

The importance of good medical record-keeping

The medical record is a tool that supports each encounter patients have with the health professionals involved in their care. It allows physicians to track their patients' medical history and identify problems or patterns that may help determine the course of health care. The goal of the medical record is to "tell the story" of the patient's health care journey. Medical records can take the form of a paper or electronic record.

Medical records serve many roles in health care. Not only does good medical record-keeping contribute to quality patient care and continuity of care but medical records can also serve a number of other purposes. For instance:

- Optimizing the use of resources, (e.g., by reducing duplication of services);
- Providing essential information for a wide variety of purposes, including:
    - billing,
    - research,
    - investigations (by the Coroner's Office, or the College),
    - legal proceedings,
    - insurance claims; and
- Serving as a valuable tool for self-assessment by allowing physicians to reflect on and assess the care they have provided to patients (i.e., through patterns of care recorded in the electronic medical record (EMR)).

This document is a companion document to the College's *Medical Records Documentation* policy and provides guidance with respect to how to satisfy the expectations set out in the policy as well as best practices for documenting specific patient encounters.

Subjective Objective Assessment Plan (SOAP)

Is there a specific format I should use to document my patient encounters?

One of the most widely recommended methods for documenting a patient encounter is the Subjective Objective Assessment Plan (SOAP) format. The SOAP format is a structured method for documenting the patient encounter. While other documentation methods are acceptable,

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using this format will ensure the obligations set out in the *Medical Records Documentation* policy are satisfied. Considerations for aspects of care that would be captured by each element of SOAP are set out below.

Subjective Data: The subjective elements of the patient encounter are those which are expressed by the patient (e.g., patient reports of nausea, pain, tingling). This includes the following, where applicable:

- Presenting complaint and associated functional inquiry, including the severity and duration of symptoms;
- Whether this is a new concern or an ongoing/recurring problem;
- Changes in the patient's progress or health status since the last visit;
- Review of medications, if appropriate;
- Review of allergies, if applicable;
- Past medical history of the patient and their family, where relevant to the presenting problem;
- Patient risk factors, if appropriate;
- Salient negative responses.

Objective Data: Objective data are the measurable elements of the patient encounter and any relevant physical findings from the patient exam or tests previously conducted are documented in this section. This includes the following, where applicable:

- Physical examination appropriate to the presenting complaint;
- Positive physical findings;
- Significant negative physical findings as they relate to the problem;
- Relevant vital signs;
- Review of consultation reports, if available;
- Review of laboratory and procedure results, if available.

Assessment: The assessment is the physician's impression of the patient's health issue. This includes the following, where applicable:

- Diagnosis and/or differential diagnosis.

Plan: The physician's plan for managing the patient's condition includes the following, where applicable:

- Discussion of management options;
- Details of consent, in accordance with the College's *Consent to Treatment* policy;
- Tests or procedures ordered and explanation of significant complications, if relevant;

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- Consultation requests including the reason for the referral, if relevant;
- New medications ordered and/or prescription repeats including dosage, frequency, duration and an explanation of potentially serious adverse effects;
- Any other patient advice or patient education (e.g., diet or exercise instructions, contraceptive advice);
- Follow-up and future considerations;
- Specific concerns regarding the patient, including any decision by the patient not to follow the physician's recommendations.

Record-keeping for Specific Types of Encounters

The expectations set out in the *Medical Records Documentation* policy apply to all physicians, however the College recognizes that a physician's practice area and the nature of the physician-patient relationship (e.g., whether it is a sustained relationship) will influence the type of records and documentation maintained by each physician. As required by the *Medical Records Documentation* policy, documentation in a medical record must always support the treatment or procedure that takes place. Advice for documenting operative and procedural notes is set out below.

What should I include in an operative note?

In general, a typical operative note will include the following:

- Name of the patient and the appropriate identifiers such as birth date, OHIP number, address, and hospital identification number if applicable;
- Name of the family physician (and referring health professional if different from the family physician);
- Operative procedure performed;
- Details of consent, in accordance with the College's *Consent to Treatment* policy;
- Date and time on which the procedure took place;
- Name of the primary surgeon and assistants;
- Name of the anaesthetist (if applicable) and type of anaesthetic used (general, local, sedation);
- Pre-operative and post-operative diagnoses (if applicable); and
- A detailed outline of the procedure performed, including:
    - administration of any medications or antibiotics,
    - patient positioning,
    - intra-operative findings,
    - prostheses or drains left in at the close of the case,

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    - complications including blood loss or need for blood transfusion,
    - review of sponge and instrument count (i.e., a statement of its correctness at the conclusion of the case), and
    - patient status at the conclusion of the case (stable and sent to recovery room vs. remained intubated and transferred to ICU).
- Any required follow-up.

What should I include in a diagnostic or interventional procedural note?

In general, a typical diagnostic or interventional procedural note will include the following:

- Name of the patient and the appropriate identifiers such as birth date, OHIP number, address, and hospital identification number if applicable;
- Name of the family physician (and referring health professional if different from the family physician);
- Procedure performed;
- Details of consent, in accordance with the College's *Consent to Treatment* policy;
- Date and time on which the procedure took place;
- Name of the physician performing the procedure and assistants if applicable;
- Name of the anaesthetist if applicable and type of anaesthetic used (general, local, sedation); and
- A detailed outline of the procedure performed including:
    - administration of any medications,
    - complications,
    - findings, and
    - recommendations based on the findings if applicable; and
- Any required follow-up.

Physicians are required by the *Medical Records Documentation* policy to document their patient encounters in a timely manner. In keeping with this requirement, physicians are advised to dictate or transcribe operative and procedural notes on the day on which the procedure took place, or where this is not feasible, as soon as possible after the procedure.

How should I document chronic conditions? Are there additional tools that can help me with this documentation?

Flow sheets are a record-keeping tool that can assist physicians in documenting and tracking important clinical information over time. They are often used to track chronic conditions and deal only with one disease (e.g., diabetes mellitus). There are a number of benefits to the use of flow sheets and thus their use is considered a best practice for treating patients with chronic

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conditions. Flow sheets permit physicians to easily see trends, which enhances their ability to identify the appropriate treatment, easily retrieve information, and support continuity of care.

If I work in a walk-in clinic do I need to maintain a Cumulative Patient Profile[1] (CPP) for each patient?

The *Medical Records Documentation* policy requires primary care physicians to include an easily accessible, up to date CPP or an equivalent patient health summary in each patient medical record and requires all other physicians to use their professional judgement to determine whether to include one. The policy sets out considerations for determining whether a CPP is required. For example, the nature of the physician-patient relationship (e.g., whether it is a sustained physician-patient relationship), the nature of the care being provided, and whether the CPP or an equivalent summary would reasonably contribute to quality care.

Physicians who practise in walk-in clinics should evaluate whether a CPP is required for a given patient. For example, the more often or more complex care that is being provided, the more likely a CPP would be necessary to facilitate quality care.

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[1] A summary of essential information about a patient that includes critical elements of the patient's medical history and allows the treating physician, and other health care professionals using the medical record, to quickly get a picture of the patient's overall health.