## 

**Performance assessment tool:**

**MAJOR PROCEDURALISTS RECORDS REVIEW TOOL**

## This tool is the property of the Medical Council of New Zealand, and may be used only with the permission of the Council.

## Objective

## The objective of this module is to assess the standard of the doctor’s record keeping in regard to:

## summary of patient health information

## details of encounters

## record systems.

If the records are the responsibility of a team of doctors and allied health professionals, rather than mainly the doctor being assessed, then this tool may not be appropriate. If so, please discuss the use of the tool with the Council’s Medical Adviser.

In some disciplines, review of referral letters, operation notes, outpatient or inpatient records, or other records, may be necessary.

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5. **Instructions**

Familiarise yourself in advance with the tool by reading the scoring guidelines carefully. Try the tool on a selection of your own patient records to be sure you are comfortable with it.

**Selection of records**

In a private practice, ask the doctor to have ready the appointment book or computerised appointment system. Select the last 20 records of cases seen by the doctor.

If the doctor does not have an appointment system, select records as randomly as possible from the files.

For doctors who are working in the public system and are mainly proceduralists the outpatient clinic letters and operative records will be important to review as the day-to-day clinical record maybe limited in its value. Arrange with the doctor in advance to have ready 40 records of consecutive consultations (of these 20 will be randomly selected by the reviewers) he or she has carried out in an outpatients clinic in the last 2 months or 40 consecutive hospital admissions. Ensure that the doctor has complied with the rules of their institution about access to medical records (contact the relevant Council staff member if there are any difficulties).

**Preparing for the review**

Each medical assessor should review 10 records where possible.

Use the list of principles “Summary of patient health information” and “Pre-operative assessment” to complete the notes review. There may be other criteria you wish to add; please discuss these with the Council’s medical adviser.

The “Record systems review”section only applies if the medical practitioner being assessed has responsibility for the record systems used, as in private practice.

The assessors should observe the facilities and interview the doctor and staff about the systems used. If receptionist and nursing staff are present ask the doctor for permission to interview them.

If you have found, after reviewing 10 patient records, that they are clearly acceptable, there is no need to complete the other 10. If, on the other hand, review of the first 10 suggests record keeping is unacceptable or borderline, please complete the whole 20. (This may mean only one assessor views patient records – should be minimum of five per assessor - see also under CBO).

1. **Notes review template**

Directions: Use this form to compile a summary of the records that have been reviewed. For each case, place either an: A, B, or C in each row related to that case.

*A = adequate; B=borderline, some cause of concern; C=concerns identified, follow up needed.*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Case** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** |
| Score A - C |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Principles:**

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| --- | --- |
| **Summary of patient health information:** | **Pre-operative assessment:** |
| * patient identity data – Name, address, Ph (or no ph), DOB | * investigations |
| * past medical/surgical history | * management Plan |
| * family history | * patient Consent |
| * smoking | * operative Notes |
| * alcohol | * indications |
| * occupation | * findings |
| * summary problem list | * operative details |
| * list of current medications | * post Operative Care |
| * immunisations | * notes. |
| * cervical smears |  |
| * drug allergies recorded |  |
| * legibility. |  |

**It is important to look at the structure of history, physical examination, investigations, diagnosis, management and follow up as a general principle.**

**Comments on ‘B’ borderline cases or ‘C’ cases of concern (include case number and NHI as identifier). Any chart review scoring a ‘C’ needs to be addressed with the doctor by the end of the assessment.**

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| **Case number/NHI** | **Nature of concern** | **Suggested follow up** |
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1. **Record *systems* review**

If the doctor has no responsibility for the records systems in place (eg locum/assistant, but not partner in practice), omit this section.

|  |  |
| --- | --- |
| **ASPECT OF SYSTEM** | **Y/ N/ n/a** |
| Patient records and documents (paper or computer) are stored or filed safely and securely. Open/legible Patient records and documents are not visible in public areas.Open records/documents are not visible in currently occupied consulting rooms.Non-lockable files are in staff areas only.Computer files are password protected. |  |
| Patient reports, letter and results are checked, actioned and filed. There is a process for ensuring all information is seen and actioned by appropriate medical staff.There is a system for checking whether significant results have arrived and have been actioned.There is a system for notifying patients of all important results (positive or negative). |  |
| Patient records are accessible, identifiable and complete. *All appropriate members of the medical team are able to access patient records.*Significant telephone consultations are recorded.Individual contributions are identifiable, dated, legible.Clinical management decisions made outside the consultation are recorded. |  |
| Transfer of medical records is done only with patient consent, and a record kept of where they were sent. |  |
| There is a system for keeping the patient’s regular GP informed of the patient’s progress. |  |
| The practice has a regularly updated age/sex register. |  |

1. **Record review summary**

## 4.1 Strengths of current record keeping

## 4.2 Any aspects which give cause for concern, and suggestions for improvement

**4.3 Clearly unacceptable aspects of record keeping. The criterion is “If another doctor were required to take over care of this patient, would the record give ready access to all the information required for adequate continuing management?”**