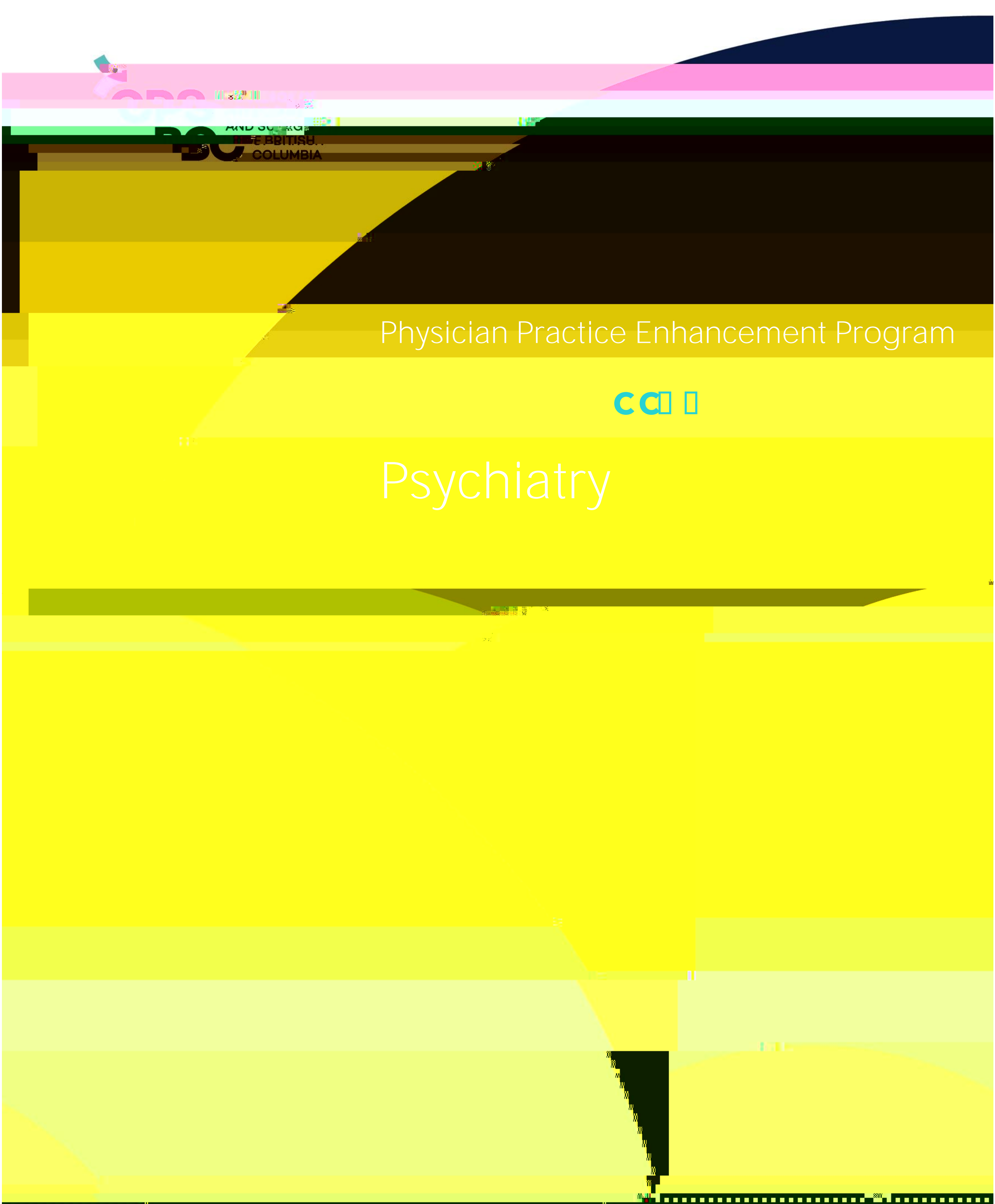

Physician Practice Enhancement Program

Psychiatry

The Physician Practice Enhancement Program (PPEP) is a collegial program that proactively assesses and educates physicians to ensure they meet appropriate and current standards of practice throughout their professional lives. Our vision is to promote a culture of quality improvement among BC's physicians.

We seek to support the success of continuous quality improvement in community-based physicians' m / A ú { q n ú

C Y OYW W

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Psychiatry
March 2022

SYWOS S Y RS Y

OY	Y WSS Y SV Y V W
1	**S YWYSV Y V W** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: chief complaints were not always clearly identified histories contained required information, but were disorganized allergies were not always documented
2	**Y SV Y V W** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: histories lacks sufficient details to confirm diagnoses and differential diagnoses biological medical histories were incomplete
3	**SOWSSO WSV Y V W** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: biological factors, such as medical conditions and current prescribed medications which may pose contraindications with plan and management, were not inquired about in one or more records significant co-morbidities that may affect treatment (i.e., history of manic symptoms in a presenting complaint of depression, substance use, history of suicide attempts) were not included in one or more records suicidal and/or homicidal ideation were not probed about or documented sufficiently in one or more records

SYWOS S Y V SW SYW

OY	

S QWY S

OS SYW

The identification of a possible disease, disorder, or injury in a patient.

Key College practice standard: *Medical Records Documentation*

Key PPEP assessment standard: *Medical Record for the Psychiatrist in an Outpatient Setting*

V W Y S

a) **S QWY SOOYWD SYW** were appropriate, as demonstrated by:

consideration of information provided by the patient/collateral sources/reports

psychiatrist's clinical observations and MSE

formulation of patient presentation reflecting biological, psychological, social, spiritual, and cultural factors, when relevant

b) **S QWY W S V V S** were appropriate, as demonstrated by:

assessment of risk (e.g., neglect of self-care or neglect of care of dependents (including postpartum), self-harm, suicidality, harm to others (postpartum harm to baby, driving, elder abuse))

medical conditions significant to differential diagnosis of psychiatric conditions were ruled out (e.g. in cases of depression - iron deficiency, thyroid conditions and chronic diseases have been considered)

preferred and provisional diagnoses consistent with current version of DSM or ICD (considering co-morbidities and differential diagnoses)

outlining of key factors in development of patient's current presentation (i.e. biological, psychological, socia.g. in cases of de2 792 reW* nBT/F1 11.04 TfETQt

WQ V W W

OS SYW

A plan of care tailored to the patient's needs that includes objectives, interventions, time frame for accomplishment and evaluation.

Key College practice standard: *Medical Records Documentation*

Key PPEP assessment standard: *Medical Record for the Psychiatrist in an Outpatient Setting*

V W Y S

1. **WQ V W W** were **Y** appropriately, as demonstrated by:

   a) **W WSYW OSYW**

      alignment of treatment plans with histories, examinations, and results of investigations

      consideration of treatment of the "whole person" (preference, goals, values, desire for confidentiality), i.e., mental and physical health from a biopsychosocial perspective including consideration of socio-economic factors, as appropriate

      spiritual/cultural/social determinants of health considered (e.g. indigenous population, symptom expression, religious background)

      evidence-based psychological treatments were chosen consistent with diagnosis and patient characteristics including: intellectual capacity, insight and motivation for treatment

      selection of optimal treatment modalities, short-term vs. long-term or referral to another clinician: outlined with justification

when different types of psychological therapy were considered, these therapy alternatives were discussed with patients (e.g., availability and accessibility)

instances where resources are lacking to provide optimal care were discussed with patients

name of substitute decision maker (if applicable)

d)

e) **SO SYWV YWSY SWQ** was appropriate, as demonstrated by

ongoing tests, examinations, and investigations

medication list updated with changes and rationale for changes

medication side effects monitored at appropriate intervals.00000912 0 612 792 reW* nBT/F8 11.04 T

SYWOS S Y V SO SYW

OY	Y WSS Y SV Y V W
1	**S YWYSV Y V W** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: records sometimes did not specify when medications were used off-label (e.g., antidepressants in child psychiatry or antipsychotics for sleep) patient-oriented education materials were not provided to patients and/or care givers when relevant medication flow charts were not used consistently informed consent documentation does not effectively summarize consent process
2	**Y SV Y V W** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: elements of informed consent process were not reviewed with patients medication side effects were not consistently monitored or documented but the likelihood of adverse outcomes is low incomplete monitoring of patients on atypical antipsychotic medications discussion regarding risks and benefits of medication and/or medication side effects (both common and serious) were often not documented
3	**SOWSSO WSV Y V W** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: medication type or dose was incorrect for the condition in one or more records medications with dangerous interactions or contraindications were given to one or more patients essential monitou 3 I nI A

SYWOS S Y Y W VYWSY SWQ

OY	Y WSS Y SV Y V W
1	**S YWYSV Y V W** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: patients' support systems were not always assessed or documented summaries of psychotherapy (i.e., patient input, therapist input, and patient response to intervention/therapy) could be more detailed
2	**Y SV Y V W** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: records did not include periodic review of the treatment plans or consideration of alternatives when progress was not being made rationale for changes in management plans or medications was not always clearly documented psyc iatrist's intervention/input was often not doc mented records did not clearly indicate details of ongoing follow-up plans (i.e., relevant conditions, treatment goals, timelines) and/or which physicians were responsible for follow up ongoing indicators of improvement (e.g., response to treatment) were not consistently documented
3	**SQWSSO WSV Y V W** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: ongoing risk assessments and interventions, when relevant, were not documented in one or more records (e.g., there were no discussions of suicidal behaviours or MSEs completed after an attempt)

YO V W SYWY OYWSWS Y O

OS SYW

Documentation in the patient record/chart as well as other written communications, intended to share information with care providers or referring sources to ensure effective continuity of care.

Key College practice standards and professional guidelines: *Medical Records Documentation*; *Primary Care Provision in Walk-in, Urgent Care, and Multi-physician Clinics*; *Virtual Care*; *Referral-Consultation Process*; *Complementary and Alternative Therapies*

Key PPEP assessment standard: *Medical Record for the Psychiatrist in an Outpatient Setting*

V W Y S

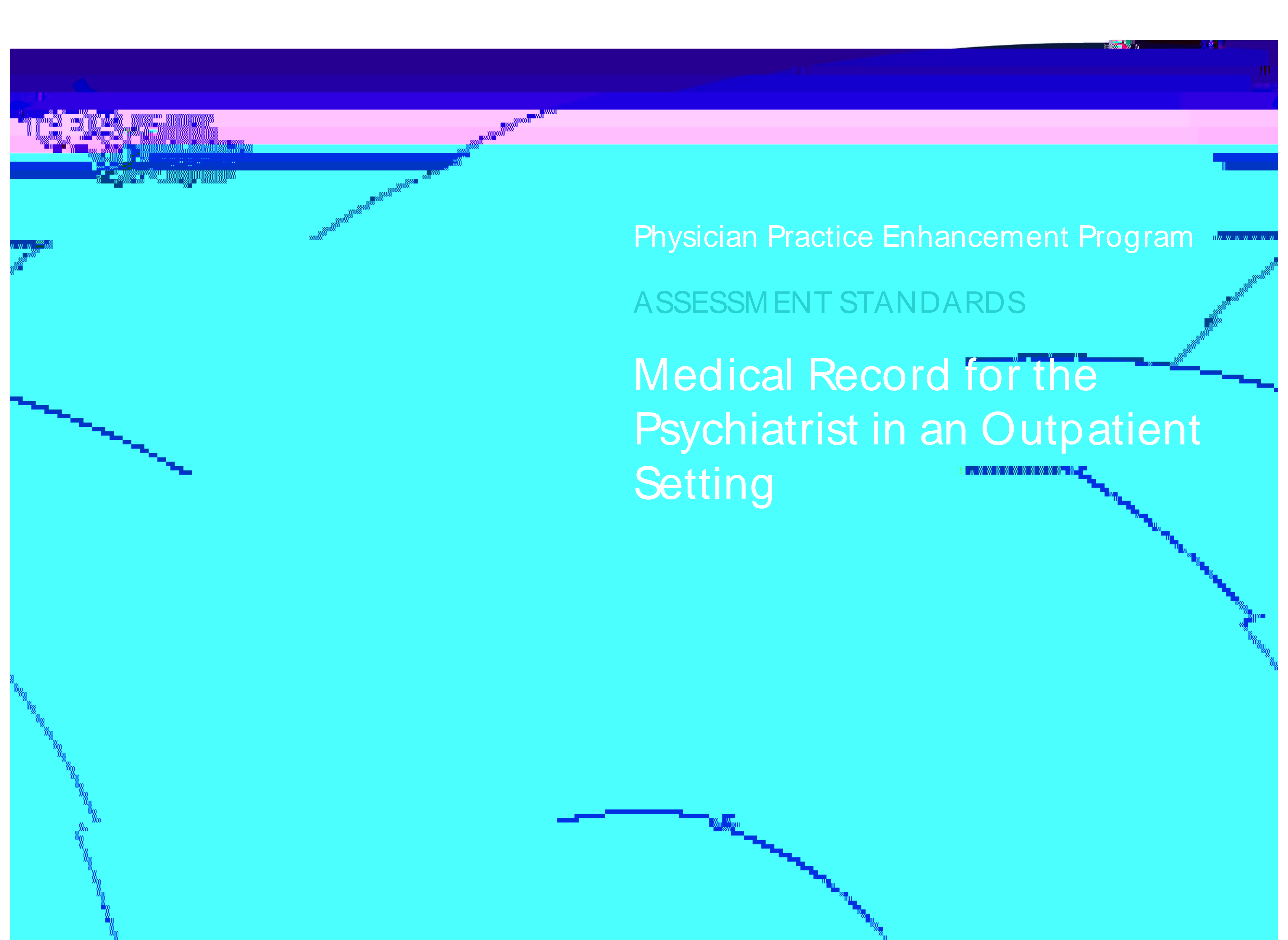
Documentation adhered to the record keeping requirements specified by the *Medical Record for the Psychiatrist in an Outpatient Setting* assessment standard; *Medical Records Documentation* practice standard; and best practices.

CR *SO OY Y R ORS S SW W S W SWQ V W W W S* **V R V W Y S Y RS YV SW**

SYWOS S Y YOV W SYWY OYWSWS Y O

OY	**Y WSS Y SV Y V W**
1	**S YWYSV Y V W** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: psychotherapy notes were poorly formatted documentation was difficult to follow, though understandable with effort patients' comfort or concerns with transfer of care or termination was not always indicated
2	**Y SV Y V W** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: psychotherapy notes were disorganized referral sources and/or primary care providers were not always notified of material changes in patients' status periodic progress reports were missing or incomplete for long term therapy patients family doctors or specialists were not always communicated with regarding pertinent recommendations and updates (e.g., for patients with medical issues, sleep apnea, etc.) treatment updates were not provided or done less frequently (more than every six months) to referral sources and/or primary care providers details relating to future management were not consistently documented information (i.e., letters, copies of assessments, notice of changes in patients' status, discharge summaries) was not consistently provided to referral source and/or primary care providers email and/or telephone communication was often not recorded

3	**SQWSSO WSV Y V W** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: - documentation was illegible - documentation was not chronological - physicians responsible for essential aspects of care during or following psychiatry treatment were not identified for patients and/or referral sources - medications were often not logged properly - mandatory reporting procedures were often not considered/followed - discussions relating to termination plan were not documented when applicable - recommendations regarding ongoing mental health care were not consistently provided to patients upon transfer of care or termination



Physician Practice Enhancement Program

ASSESSMENT STANDARDS

Medical Record for the Psychiatrist in an Outpatient Setting

Introduction

The medical record is a powerful tool that allows a physician to track the patient's medical history and identify ongoing or recurrent problems or patterns. The primary purpose of the medical record is to enable physicians to provide quality health care to their patients. The quality of documentation should allow any clinician to review the chart and continue to provide care for a given patient. Physicians are encouraged to review this assessment standard to help guide their day-to-day medical record keeping.

The intent of this Physician Practice Enhancement Program (PPEP) assessment standard is to provide more detail on what is required for documentation and what a peer assessor will be looking for in a medical record, to increase transparency of the

Guidance: This assessment standard does not apply to independent medical examinations (IMEs). Physicians conducting IMEs must refer to the College of Physicians and Surgeons of British Columbia practice standard *Independent Medical Examinations*. When assessing IMEs, a peer assessor will review the letter of instruction, IME report, notes, and fulfilment of the expert witnes Duty to Court. The report is expected to include the facts and assumptions made to substantiate the opinions rendered by the expert.

This asseansOutpatient Setting

Standards

No.		Description	Reference
ADM 1.0		**THE MEDICAL RECORD** The medical record is the patient chart in its entirety. meets the requirements as set out in section 3-5 of the Bylaws. The medical record must contain comprehensive documentation of the clinical care provided to the patient, including the following.	
ADM 1.1		The medical record contains essential, appropriate and relevant information about the patient.	
ADM 1.1.1	M	The medical record is written in readable English and well organized.	1, 2
ADM 1.1.2	M	The medical record contains detailed description of all medical patient encounters, with dates (including those made in person or by virtual care. *Guidance: Virtual care is defined as any interaction between patients and registrants, occurring remotely, using any mode of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care. See*	

No.		Description	Reference
ADM 1.3.6	M	Evidence-based and/or standard pharmacological treatment with consideration of patient characteristics, interactions, and current practice guidelines. *Guidance: If any therapies, used are employed (including alternative or complementary therapies), the details of the informed consent process including rationale must be documented in the medical record. Physicians who choose to practice complementary or alternative therapies in combination with conventional medicine do so in accordance with their professional, ethical and legal obligations. See the College practice standard* Complementary and Alternative Therapies.	8, 9, 11
ADM 1.3.7	M	Education regarding management	

No.		Description	Reference
ADM 1.3.14	M	For virtual care encounters, ensure that the identities of all other participants involved in a virtual care encounter are disclosed to and approved by the patient, and documented in the patient record.	10
ADM 1.3.15	M	For virtual care encounters, explain the appropriateness, limitations, and privacy risks related to virtual care to the patient in plain language during the initial virtual care visit, and document their consent.	10
ADM 1.4	Communication with patients and with referring physicians is a foundational component of patient-centred care		
ADM 1.4.1	M	*Need for continuing specialist care is communicated to the referring physician in a written update D>BDC ,36:*	

No.	Description	Reference

2002 Jun 1 [revised 2021 Apr 7; cited 2021 Oct 28]; 2 p. Available from: https://www.cpsbc.ca/files/pdf/PSG-Prescribing-Practices-Countersigning-Prescriptions-Internet-Prescribing.pdf

11. Cameron S, Turtle Song I. Learning to write case notes using the SOAP format. J Couns Dev. 2002; 80(3):286-92.