

**Peer Assessment Committee  
College of Physicians and Surgeons of New Brunswick**

**PEER ASSESSMENT REPORT  
HOSPITALISTS**

*Please write legibly and forward completed form to the Peer Assessment Committee office as quickly as possible. (PLEASE USE BLACK INK)*

**PAC#** \_\_\_\_\_

**Type of Practice:** \_\_\_\_\_

**Group:** \_\_\_\_\_ **Solo:** \_\_\_\_\_

**Is this a reassessment?** \_\_\_\_\_

**Date of Assessment:** \_\_\_\_\_

**Assessor Name:** \_\_\_\_\_

**Assessor Signature:** \_\_\_\_\_

## 1 Clinical Practice – New Consultations/Pre-Operative Management

Please assess, based on the records, and through your interview with the physician, whether the physician's response in dealing with new or known patients who present with a new complaint or condition is appropriate. Pre-operative examination, testing and treatment should be evaluated.

<b>New Consultations/Pre-Operative Management</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. Information regarding the complaint, the physical examination, and treatment (including presumptive diagnosis) obtained from the referring physician is...				
2. The chief complaint(s) is clearly stated, the symptoms are adequately described, the duration of symptoms noted and a functional inquiry is performed.				
3. The physical examination performed with positive/negative physical findings is...				
4. The family and past history (including significant negative observations) are maintained.				
5. The investigation of the complaint/condition is...				
6. Review of current medication(s) is...				
7. Prescribed medications in type, dose, and duration are...				
8. Requested lab tests, x-rays, and other diagnostic investigations are clinically indicated and...				
9. Consideration of a differential diagnosis is...				
10. The treatment plan is...				
11. Prior to the procedure, treatment alternatives, risk/benefits, potential complications, and side effects were discussed with the patient/substitute decision maker and documented.				
12. Requests for consultations (e.g., high risk patients are recognized) are...				
13. Follow-up of acute conditions is...				
14. Follow-up of abnormal test results is...				
15. Urgent problems are dealt with...				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>New Consultations/Pre-Operative Management</b>				

No concerns/suggestions:

**Comments:**

## .2 Clinical Practice – Management of Patients with Ongoing/Chronic Conditions

Please consider the evidence found in the records and, through your interview with the physician, the appropriateness of the physician's actions in dealing with patients with chronic conditions. Conditions will usually require long-term monitoring.

Management of Patients with Ongoing/Chronic Conditions	Appropriate	Appropriate with Suggestions	Concerns	N/A
1. The patient history is				
2. Physical examinations performed with positive/negative physical findings are				
3. Requested lab tests, x-rays and other investigations are clinically indicated and				
4. Co-morbidities are evaluated and considered in the treatment plan.				
5. Management/treatment plans are periodically reviewed and				
6. Long-term medications in type, dose and duration are				
7. All medications are periodically reviewed and monitored.				
8. Discussions regarding medication side-effects are				
9. Follow-up of patients suffering from chronic conditions is				
10. Follow-up of abnormal test results is				
11. Requests for referrals are				
12. Narcotic addiction screening is				
13. Narcotic addiction monitoring is				
14. Medication diversion (i.e., distribution of medications to other individuals) monitoring is				
15. Narcotic prescribing is				

Section Recommendation	Appropriate	Appropriate with Suggestions	Concerns	N/A
Management of Patients with Ongoing/Chronic Conditions				

**Comments:**

### .3 CLINICAL PRACTICE – PSYCHOSOCIAL CARE

#### INSTRUCTIONS

Please consider the evidence found in the records and, through your interview with the physician, the appropriateness of the physician's actions in counselling their patients. This includes patient visits for general counselling, psychotherapy sessions, and patient support in reference to specific clinical situations. You should also consider the appropriateness of referrals to social services (e.g. public health nurse, home care, CCAC, Meals on Wheels), as well as to patient support groups and services that are available in the community (e.g. AA, Alzheimer's Society of Ontario).

PSYCHOSOCIAL CARE	APPROPRIATE(LY)	APPROPRIATE(LY) WITH SUGGESTIONS	CONCERNS	N/A
1. Counselling sessions are (i.e. include the physician's input and also information regarding the patient's response and future care plans)...				
2. In reference to specific clinical situations, patients are referred to support groups...				
3. Recognition and management of family violence or abuse is...				
4. Utilization of local social services/agencies in the community is...				
5. Patient education materials and resources are available to patients...				
6. Psychotherapy sessions (i.e. include documentation of critical interventions, the physician's input, the patient's response, future care plans, frequency of sessions, etc.) are...				
7. Diagnostic assessments – formulations are...				
8. Multi-axial DSM-IV classifications are...				
9. Mental status examinations are...				
10. Management of suicidality is...				
11. Management of homicidal risk is...				
12. Management of doctor-patient relationships (i.e., boundaries, transference, counter-transference, etc.) is...				
13. Termination planning is...				
14. The use of psychotropic medication(s) is...				

SECTION RECOMMENDATION:	APPROPRIATE	APPROPRIATE WITH SUGGESTIONS	CONCERNS
PSYCHOSOCIAL CARE			

**INSTRUCTIONS**

Please consider the evidence found in the records and, through your interview with the physician, the appropriateness of the physician's actions in counselling their patients. This includes patient visits for general counselling, psychotherapy sessions, and patient support in reference to specific clinical situations. You should also consider the appropriateness of referrals to social services (e.g. public health nurse, home care, CCAC, Meals on Wheels), as well as to patient support groups and services that are available in the community (e.g. AA, Alzheimer's Society of Ontario).

No concerns/suggestions

**DETAILS/COMMENTS:**

SAMPLE

#### .4 Medical Records – Record Keeping & Patient Management Tools

<b>Record Keeping &amp; Patient Management Tools</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. The record system that allows for ready retrieval of an individual patient file is				
2. The mechanism that notifies the physician when consultant reports and/or laboratory reports have been received is				
3. The mechanism that ensures that all investigation, consultation and laboratory reports have been reviewed, with appropriate action taken (if required), is				
4. The record is organized.				
5. Documentation of the consultation record to the referring doctor is				
6. Patient Summary Sheet(s) (e.g. Cumulative Patient Profile) is/are				
7. In the event that more than one physician is making entries in the patient chart, each physician is identified.				
8. Growth charts are				
9. Antenatal Charts are				
10. Psychiatric forms are used.				
11. Allergies are clearly identified.				
12. Immunization records are				
13. Flow sheets for chronic conditions are				
14. Flow sheets for health maintenance are				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>Record Keeping &amp; Patient Management Tools</b>				



**.4(a) Medical Records – Required Components of the Medical Record**

<b>Required Components of the Medical Record</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. The legibility of the record to the assessor is				
2. Documentation of the patient's name, sex, telephone number, address and date of birth is				
3. Documentation of the patient's Health Card number (if the patient has a Health card) is				
4. For a consultation, documentation of the name of the primary care physician and of any health professional who referred the patient is				
5. The date of each professional encounter with the patient is documented.				
6. The start and stop times for psychotherapy and counselling encounters are recorded.				
7. Patient histories are recorded.				
8. Functional inquiries are recorded.				
9. Diagnoses are recorded.				
10. Investigations are recorded.				
11. Results are recorded.				
12. Each treatment prescribed or administered by the physician (dose, duration, quantity) is recorded.				
13. Notation of professional advice given by the physician is recorded.				
14. Notation of particulars of any referral made by the physician is recorded.				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>Required Components of the Medical Record</b>				

**.4(b) Medical Records – Required Electronic Medical Records Components (if used)**

<b>Required Components of the Electronic Medical Record</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. The system provides a visual display of the recorded information.				
2. The system provides a means of access to the record of each patient by the patient's name and, if the patient has a health number, by the health number.				
3. The system is capable of printing the recorded information promptly and is				
4. The system is capable of visually displaying and printing the recorded information for each patient in chronological order.				
5. Confidentiality is maintained.				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>Required Components of the Electronic Medical Record</b>				

No concerns/suggestions about medical records:

**Comments:**

**Comments (cont.):**

## **.5 Patient Record Summary**

On the following page, please record the patient charts reviewed. Each note should include a patient identifier, such as initials or chart number and date of birth, **(please - no full names)**; the date of visit, the presenting problem and your comments. Include each chart, whether or not there are concerns or suggestions. If care is appropriate or exemplary, please ensure this is indicated in the "comments" section.

**Between 15 and 25 charts should be reviewed.** If this is **not possible**, please comment below:



