Peer Assessment Committee
College of Physicians and Surgeons of New Brunswick

PEER ASSESSMENT REPORT - PSYCHIATRY

Please write legibly and forward completed form to the Peer Assessment Committee office as quickly as possible.

PAC # ______________________________

SOLO ______________________ **OTHER** ______________________

IS THIS A REASSESSMENT? ____________

ASSESSOR ______________________________

DATE OF ASSESSMENT ______________________________

SAMPLE

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Note: Please comment on those areas where specific deficiencies are noted. This information is invaluable in helping the Assessment Committee in their review of their report.

NOTE: If this practice is hospital-based, it is not necessary to complete Sections A & B. Go directly to Section C: Contents of the Medical File.
Please indicate hospital-based practice: Yes ______________ No ___________

A. PHYSICAL FACILITIES & EQUIPMENT:

Take a few moments to review the facilities information submitted by the physician on the Physician Questionnaire, page 8. Please comment below on any areas which do not appear to be satisfactory:

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B. SECRETARIAL AND PARAMEDICAL PERSONNEL

1. Is the staffing adequate to:

a) Support physician so (s)he can concentrate on patient care?

YES ________ **NO** __________

b) Provide patient support and comfort while in the office?
YES ________ **NO** __________

c) Does the patient have the opportunity for a chaperone?
YES __________ **NO** __________

OVERALL COMMENT ON STAFFING: ____

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C. CONTENTS OF THE MEDICAL FILE (RECORDS)

1. **Total number of files reviewed:** ______________________________

2. **Date(s) (within the last three months) chosen as representative of practice for files selected:** ______________________________

3. **Are the files individual or family?** ______________________________

4. **Are the records maintained chronologically?** ______________________________

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Definitions (for the purpose of this records review)

A Always" means ninety percent of files reviewed.

U "Usually" means from fifty to ninety per cent of files reviewed.

S "Sometimes" means between ten to fifty percent of files reviewed.

N "Never" means less than ten percent of files reviewed.

SAMPLE

RECORDS STRUCTURE	N/A	A	U	S	N
1. A record system is in place which allows for ready retrieval of an individual patient file.					
2. The record is legible.					
3. The patient's identity is clearly evident on each component of the file.					
4. Each patient file clearly shows full name, address, date of birth and sex.					
5. The date of each visit or consultation is recorded.					
6. The family history, functional inquiry, past history (including significant negative observations) is recorded and maintained.					
7. Allergies are clearly documented.					
8. Copies of consultation reports for each consultation are in the file.					
9. Consultation reports are sent to the family physician after each consult.					
10. Copies of final notes are sent to the family physician.					
11. Hospital discharge summaries are retained.					
12. There is a system in place to clearly show that abnormal test results come to the attention of the physician (are reports initialled?)					
13. There is evidence that the physician periodically reviews the list of medications taken by patients with chronic or multiple conditions.					
14. Are patients referred by this physician directly to other physicians?	YES __ NO ___				

SAMPLE

COMMENTS ON RECORDS STRUCTURE:____

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SUBJECTIVE, OBJECTIVE, ASSESSMENT, PLAN (SOAP)	N/A	A	U	S	N
1. The chief complaint is clearly stated.					
2. An adequate description of symptoms is present.					
3. The duration of symptoms is noted.					
4. Positive physical findings are recorded.					
5. Significant negative physical findings are recorded.					
6. A diagnosis or provisional diagnosis is recorded.					
7. Requests for lab tests, X-rays and/or other investigations are documented.					
8. Requests for consultations are adequately documented.					
9. The treatment plan and/or treatment is noted.					
10. The dosage of prescribed medications is recorded.					
11. The duration of prescribed medications is recorded.					
12. There is documented evidence that appropriate follow-up has taken place following the receipt of abnormal test results.					
13. Progress notes relating to the office management of patients suffering from chronic conditions are recorded.					

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COMMENTS ON SOAP:____________________________________

OVERALL COMMENTS ON RECORDS: ____________________________

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PATIENT CARE

Patient care is to be rated in three categories:

E - Excellent

S - Satisfactory

D - Deficient (i.e. unable to tell because of legibility or other problems or inadequate care)

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	PATIENT CARE	N/A	E	S	D
1.	The documented investigation is appropriate to the complaint/condition.				
2.	The documented chief complaint, history, physical findings and investigation reports lead to the making of an appropriate diagnosis.				
3.	The management plan (excluding prescribed medication) is appropriate to the condition being treated.				
4.	The medication prescribed is appropriate to the condition being treated.				
5.	The follow-up of patients suffering from acute conditions is appropriate.				
6.	The follow-up of patients suffering from chronic conditions is appropriate.				
7.	Counselling sessions are appropriately documented and indicated.				
8.	Psychotherapeutic sessions are indicated and appropriately documented so as to include the main themes, patient progress, relevant new information and major interventions made by the physician.				
9.	The records indicate that the physician is aware of and utilizes the various supportive social agencies in his/her community (e.g. public health nurse, home care, meals on wheels, etc.)				
10.	The records indicate that emergency problems are dealt with promptly and effectively.				
11.	There are appropriate arrangements in place for the physician's patients to be taken care of in his/her absence.				

SAMPLE

COMMENTS ON PATIENT CARE:____

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.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:

Patient Identifier	Date of Visit	Complaint/Problem	Comments or Suggestions

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Patient Identifier	Date of Visit	Complaint/Problem	Comments or Suggestions

SAMPLE

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If there are specific patient files where concern exists, please note your comments below:

PATIENT'S INITIALS	DATE OF VISIT	COMMENTS

Is any group of drugs being used inappropriately? **YES** ________ **NO** __________

If yes, please explain: ____

____

____

____

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.6 Recommendation and Comments about this Assessment

Category 1 ☐
Satisfactory

Category 2 ☐
Reassessment

Category 3 ☐
Interview

General Comments about this Assessment

Please include clarification of documentation, questions on diagnosis, investigations, management of patients, and any other areas of concern which were discussed during the interview.)

Assessor Signature **Date**

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