Many physicians already recognize that good medical records are indispensable. Records need to provide comprehensive and accurate documentation of all the features of assessment, diagnosis, treatment and follow-up to ensure the patient’s story is conveyed. Yet record-keeping remains the primary area identified by peer assessment as needing improvement. The Medical Records policy was recently updated and includes new requirements for physicians, recommendations as to the best means of record-keeping to assist in providing patients with quality medical care, and many new resources to help physicians in all aspects of record-keeping.

The following are the top five recommendations made by the Quality Assurance Committee to physicians to assist them in improving their records.

1. Implement and maintain Cumulative Patient Profile (CPP)

Under the updated policy, a CPP is required for each patient’s family practice chart, including charts in walk-in clinics. While not required for specialists’ charts, a CPP is highly recommended for specialists who see patients on an ongoing basis.

A comprehensive and current CPP provides a handy overview of the significant items in a patient’s medical history, thereby enabling information to be distilled from the medical record more easily. It saves the physician time by eliminating the need to rewrite information in the progress notes and is helpful to the physician and any colleague or staff member who refers to the record.

Many samples of CPPs exist, and physicians are encouraged to customize the CPP to meet their needs (see Appendix E of the Medical Records policy).

2. Keep medication list current

A current medication list is a key component of a patient’s medical record. A review of the list with the patient at every visit ensures patient compliance and enables the physician to make any necessary adjustments and avoid prescribing a drug that will interact negatively with another one that the patient is taking, whether previously prescribed or over-the-counter.

The most appropriate location in the record to place a medication list is directly on, or proximate to, the CPP. The Committee often reminds physicians of the importance of recording the type, dose and duration of the medication prescribed. It is not safe to assume that another physician who refers to the record will know the details of the course prescribed. Also, patients themselves are sometimes unaware of the medications they are taking.
3. Include Flow Sheets

Flow sheets, such as those for health maintenance or chronic conditions, can tremendously facilitate and enhance a physician's management of patients. They allow the physician to record important clinical information about the patient's management over a period of time, thereby enabling the physician to see trends, which, in turn, means that an appropriate course of action or treatment plan can be identified.

See Appendix F of the Medical Records policy for samples.

4. Use SOAP

A recurrent finding in medical records is the omission of sufficient detail to accurately describe the patient and the physician's encounters with them. Often, the Committee recommends that physicians provide more relevant detail with respect to medical history, functional inquiry, description of the symptoms (including the severity), and findings upon physical examination (significant negative and positive).

To assist physicians in meeting the challenge inherent in consistently recording enough detail, the Committee recommends the use of the Subjective Objective Assessment Plan format, commonly known as SOAP. There are many advantages to the SOAP format, not least of which is that it guides physicians to document the most relevant information about a patient encounter, thereby reducing unnecessary information and giving the note a recognizable structure. The updated policy provides guidance on information to be included in each element of SOAP.

5. Keep referring physicians in the loop

A recurrent finding in consulting physicians' medical records is the need for more detailed notes and better consultation reports to the referring health professional (or family physician) to ensure appropriate communication and a shared understanding of responsibilities for follow-up and treatment.

The updated policy features a new section on procedural medicine, which outlines requirements regarding consultants' records, consult notes for diagnostic and operative procedures, and discharge summaries. Physicians are encouraged to review this new section. Among the most significant changes is the requirement that consultants report to the referring health professional after completion of the initial assessment, with follow-up reports when there are new findings or changes made to the management plan. 

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