

Peer & Practice Assessment Handbook

General Procedural Practice

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The General Procedural Peer Assessment Handbook is made publicly available to support transparency in the Peer and Practice Assessment Program of the College of Physicians and Surgeons of Ontario (CPSO). It is freely available for research purposes, informal self-assessment, and for individual use in developing quality improvement plans.

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1. Introduction to Peer Assessment

1.1 Purpose of Peer Assessment

Peer Assessments are conducted by the College of Physicians and Surgeons of Ontario (CPSO) as part of its mandate under the Regulated Health Professions Act (RHPA) (Schedule 2, Section 80). The purpose of Peer Assessment is to:

“Promote continuous quality improvement by providing physicians with feedback to validate appropriate care and show opportunities for practice improvement.”

Peer assessment is based on the premise that all practices have room for improvement, and is therefore intended to encourage continuous quality improvement for all physicians.

1.2 Development and Maintenance of Peer Assessment Tools

The peer assessment program has been operational since 1980 and thousands of physicians have been assessed. In 2012, the CPSO began an initiative to redesign its peer assessment program to better align the program with its primary purpose of encouraging continuous quality improvement for all physicians. Particular focus was given to supporting physicians in moving their practice from “good” to “excellent”. This initiative led to the creation of the tools found in this Peer Assessment Handbook.

The Peer Assessment Handbook was developed by the CPSO in collaboration with peer assessors. Assessors provided the discipline-specific content expertise for establishing the elements of quality and evaluation criteria found within this handbook. External consultations by practising physicians and physician bodies were conducted to validate the content with respect to how quality is defined, how it should be evaluated, and how it might be improved.

The CPSO’s Research and Evaluation Department provided measurement expertise and established a rigorous validity framework for the peer assessment program. Specifically, attention was paid to optimizing the validity, reliability, acceptability, and educational impact of the program. In order to continue to improve the effectiveness of the peer assessment program, these tools and procedures are periodically reviewed and updated to ensure their validity and relevance.

1.3 CanMEDS in Peer Assessment

[CanMEDS](#) is a national competency-based framework for medical education that describes the abilities physicians require to effectively meet the needs of the people they serve. It was developed by the Royal College of Physicians and Surgeons of Canada¹ in the 1990s and organizes physician abilities thematically under seven roles: Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional. It was updated most recently in 2015 and now includes key milestones to describe the development of physician abilities across the continuum of their career starting at entry to residency, following them throughout practice, and finally into the transition out of professional practice.

The latest edition of CanMEDS, often referred to as CanMEDS 2015, was developed collaboratively by 13 Canadian medical education organizations. In May 2015, the CPSO formally adopted it as an organizing framework for physician education and assessment. From a regulatory perspective, CanMEDS complements much of the work of the CPSO, particularly with respect to [The Practice Guide](#) and [CPSO policy](#). Furthermore, a key competency of the Professional Role identifies the responsibility of physicians to participate in physician-led regulation.



¹ Adapted from the CanMEDS Physician Competency Framework with permission of the Royal College of Physicians and Surgeons of Canada. Copyright © 2015

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<http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e>. Reproduced with permission.

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1.4 How to use the Peer and Practice Assessment Handbook

This handbook is designed to be a resource for both assessors and physicians undergoing a peer assessment. It describes the assessment process and evaluation criteria in order to guide assessors in consistently delivering structured peer assessments and to inform physicians who are anticipating a peer assessment about what to expect and how to prepare.

An electronic copy of this handbook, and the handbooks of other disciplines, can be found listed under “Scope Specific Assessment Tools” at:

<https://www.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Assessments/Peer-Assessment>

In addition to the information provided in this handbook, the CPSO’s webpage dedicated to the Peer and Practice Assessment Program can be consulted:

<https://www.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Assessments>

2. Peer Assessment Process

Peer Assessments are conducted in a structured way, as described below:

Phase 1 - Before the Assessment

A. Physician and Assessor Selection

- A physician is selected for assessment and his/her eligibility is confirmed. Physicians can be selected based on specific criteria (e.g., at 70 years of age)
- All physicians to be assessed complete a general Physician Questionnaire. This information is shared with the assessor to aid in providing a context for the assessment.
- A College Assessment Coordinator matches an assessor to the physician based on relevant practice details.

B. Pre-visit Telephone Discussion

- In advance of the site-visit, the assessor initiates a telephone discussion with the physician to be assessed.
- Relying on information from the Physician Questionnaire, the assessor may ask for further clarification about the physician's practice as well as respond to questions or concerns the physician may have.
- As part of the discussion, the assessor reviews the purpose and process of the on-site/virtual assessment and the physician's responsibility for preparing/selecting patient records that will be reviewed during the assessment.
- The time and date of the assessment visit is confirmed. After discussing the planned assessment process, it should be clear when the physician is expected to be available on the day of the assessment. The physician can choose to see patients during the assessment record review **but must be available at all times if questions arise**. The physician must also set aside time at the end of the visit for the Physician discussion. Some assessors prefer to conduct the record review in an interactive fashion with the physician throughout the duration of the visit; **this will be clearly communicated by the assessor to the physician prior to the assessment date**.

Phase 2 - During the Assessment

C. Initial Discussion

- The assessment site visit begins with a discussion between the assessor and physician to review the assessment process, orient the assessor to the practice, and familiarize the assessor with the patient records.
- The initial discussion and orientation may include a review of the EMR and how to access all elements of the patient record.

D. Patient Record Review

- The assessor reviews a sample of the physician's patient records that have been selected using a **patient record selection protocol** (section 3.2).
- The assessor records notes for each record using the **patient record summary**.

E. Physician Discussion

- In addition to reviewing patient records, the assessor discussion with the physician occurs in order to:
 - o Clarify issues which may have arisen during the record review.
 - o Gather further information which cannot be accessed through the record review.
 - o Provide feedback to validate appropriate care.
 - o Discuss opportunities for practice improvement (the **scoring rubrics** [section 4.2] can be used as informational tools during this time).
 - o Highlight opportunities for practice improvement including Continuing Professional Development.

Phase 3 - After the Assessment

F. Assessment Report

- The assessor reviews information collected through the patient record review and Physician discussion to complete the **peer assessment report** (see section 5.2). This is comprised of a brief description of the background of the physician's practice, overall ratings and narrative comments for each of the assessment domains, as well as an overall narrative summary. The narrative comments of the assessor are particularly important for providing the specific examples of

care and documentation that supported their decision making and suggestions for improvement to assessed physicians.

The scoring rubrics are intended to be broadly applicable across diverse patient care interactions and provide an extensive framework for evaluating care and documentation.

- The assessor submits the assessment report and the patient record summaries to the CPSO for review.
- The CPSO sends a copy of the assessment report and patient record summaries to the assessed physician, along with a letter outlining the Quality Assurance Committee's decision.

G. Role of the Quality Assurance Committee (QAC)

- The QAC is a CPSO committee comprised of physicians and elected public members. The QAC reviews assessment reports and provides additional feedback to assessed physicians, either recommending no further action or directing follow-up to ensure physicians are meeting the standard of practice in Ontario.
- Whereas the assessor is responsible for collecting information during the on-site assessment and providing immediate feedback to assessed physicians, the QAC is responsible for reviewing assessment reports and deciding the outcome of the assessment.
- If potential concerns are identified, the assessed physician is provided an opportunity to address those concerns prior to any further action being taken by the QAC (e.g. reassessment).
- For more information on the possible outcomes of QAC review, visit the CPSO Peer and Practice Assessment [webpage](#).

3. Assessment Tools and Protocols

3.1 Patient Record Selection Protocol

A structured, specific method is used for selecting and reviewing patient records. This method ensures that a representative sample of records is chosen (i.e., selection includes a variety of conditions over a sufficient time period), and that records are reviewed systematically (i.e., specific sections of the records are examined).

Patient Record Selection Protocol for General Procedural Practice:

Record Selection:

1. **In advance of the assessment:**
 - a. The **physician to be assessed** will:
 - Either need to liaise with the Medical Records department to ensure that the assessor will have access to all necessary resources in order to review entire patient records (i.e., EMR, paper notes, summaries) on the day of the assessment (note: a temporary EMR password will need to be set up in advance).
 - Retrieve 40-45 patient records reflecting a variety of diagnoses and patient management scenarios (e.g., initial management, referrals from other services, discharge) representing the scope of practice, in which the physician to be assessed has been responsible for the majority of patient care (i.e., most responsible physician for at least 80% of care)
 - b. The **assessor** will:
 - Liaise with the physician to be assessed **and** the relevant Medical Records personnel as necessary to ensure that all aspects of patient record selection process are prepared.
2. **On the day of the assessment:**
 - a. The **physician to be assessed** will:
 - Provide an overview of the patient record filing system to orient the assessor
 - Be prepared to retrieve additional patient records as needed
 - b. The **assessor** will:
 - Select a total of 15 patient records reflecting both consultations and follow-up assessments from the total number of patient records prepared by either the physician or medical records department.

Record Review:

Patient Record Content	Review Process
Initial Consultations	<ul style="list-style-type: none">• Initial consultations• Ancillary documentation (e.g., referral information)• Patient History
Assessments	<ul style="list-style-type: none">• Assessment• Corresponding initial consultation
Follow-up over multiple years	<ul style="list-style-type: none">• Initial consultation• Most recent visit• Intermediate visits that convey patient management

Patient Record Selection and Review for Reassessments

The CPSO Quality Assurance Committee may require a reassessment of a practice after completion of the initial assessment to assess whether recommended practice changes have been implemented.

Reassessments follow the same broad and comprehensive assessment process as outlined in this handbook; however, specific patient care or documentation issues will be identified from the initial assessment by way of the assessment report and/or decision letter (e.g., improvement is needed regarding medication prescribing, clarity of documentation, etc.,).

During the reassessment, the assessor will pay particular attention to the issues identified in the previous assessment in order to provide an informed impression of whether those concerns were ameliorated. The assessor will use their professional judgement to determine if specific types of records should be included during the reassessment to address any issue or area of concern (e.g., if there was a concern regarding presentation “X” in the previous assessment, the assessor will use their judgement to decide if extra records of that type must be reviewed in order to provide an informed impression in the reassessment report).

Timeframe for records selected during reassessment: Records of care may be chosen during any point between the initial assessment and reassessment. Overall, records should be reviewed across a timeframe that allows the assessor to assess improvements in practice since the previous assessment.

Reassessment reporting: As with initial assessments, the assessor provides their impression in the assessment report regarding the quality of care and documentation observed during the reassessment. The assessor should also make a succinct statement in the reassessment report, as required, to make clear whether the standard of practice appears to be met for issues/concerns identified in the initial assessment (e.g., “The concerns related to “X” identified in the previous assessment were ameliorated”).

3.2 Physician Discussion Guide

Purpose

The *physician Discussion* fulfills two essential components of the peer assessment:

1. *Gathering of information about the physician's practice*

As an information gathering technique, the Physician discussion allows the assessor to explore topics which cannot be determined from reviewing patient records or to clarify issues that arose during the patient record review. This exchange is critical as the physician may provide an explanation which helps the assessor reach conclusions, particularly around determining where quality improvement may be required; e.g., "Is the problem one of inadequate record- keeping or is there an area where the process of care should be improved?"

2. *Provision of feedback to the physician to validate appropriate care and discuss opportunities for improvement*

As a feedback technique, the Physician discussion provides the assessed physician with specific information about their practice from a peer. Assessors review areas of appropriate care, discuss any issues identified through the record review, and provide specific recommendations for improvement. Assessors may provide educational materials or quality improvement strategies to address identified issues and may recommend relevant Continuing Professional Development (CPD) opportunities. The [CPD/Practice Improvement Resources](#) section of the CPSO's CPD webpages may also be shared for additional educational resources:

www.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Continuing-Professional-Development/.

Continuing Professional Development (CPD) is a [requirement](#) for all physicians. Prior to the assessment, the physician completes a questionnaire that provides the assessor with information about how the physician identifies and meets ongoing CPD needs. This topic may be further explored in the Physician discussion with respect to issues identified in the assessment. The assessor may also assist the physician in developing a self-directed CPD or quality improvement plan that is stimulated by feedback from the peer assessment.

Structure: Although information gathering starts from the first telephone call between the assessor and the physician, the Physician discussion refers specifically to the discussion conducted during the last approximately 60 to 90 minutes of the peer visit. Depending on assessor preference, there may be other one-on-one time requested (e.g., after the first few patient records are reviewed to address any questions about navigating the record or to

provide clarification). The Physician discussion is semi-structured; some discussion themes are routinely explored and others develop naturally given the particular circumstances of the assessed physician.

4. Assessment Framework and Scoring Rubric

4.1 Peer Assessment Framework

The *Peer Assessment Framework* provides a structure for the assessment report and evaluation criteria. The General Procedural framework consists of seven assessment domains organized into three broad categories (see table below). Details of how these domains align with the CanMEDS framework can be found in **Appendix B**.

E _{valuation}	P _{eriodic} operative/I _{ntervention}	C _{ontinuing} Care
1. Patient Assessment	4. Pre-procedure	7. Continuing Care
2. Decision Making	5. Procedure	
3. Communication	6. Post-procedure	

The *Scoring Rubrics* (listed in section 4.2) support consistency, specificity, and transparency in the assessment process. For each domain, high quality care is defined and specific evaluation criteria are provided to guide assessor evaluation. A working group of peer assessors developed the criteria and sought feedback from practising physicians/surgeons and specified physician/surgeon specialty organizations to ensure the relevance and appropriateness of the tools. The criteria in the rubric are periodically reviewed to ensure they are up-to-date.

Assessors use the scoring rubric to assist in their decision making when completing the assessment report. The rubrics are NOT intended to be used in “scoring” individual patient records, but rather to describe the overall trend in care, considering all information gathered during the patient records review and the physician/proceduralist discussion. The **global rating scores** for each of the 7 domains are expressed with a 3-point scale (see below). Narrative detail provided in the assessment report for each of the domains provides the critical information regarding validation of appropriate care and opportunities for improvement.

Global Rating Scores:

1 — Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor

2 — Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low

3 — Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected

General Procedural Peer Assessment Framework with Summary of Elements of Quality for each Domain

E valuation	P eriodic/ I ntervention	C ontinuing Care
<p><u>1/ Patient Assessment:</u></p> <p>HISTORY</p> <ul style="list-style-type: none"> • Problem • Past Medical History (PMHx), Functional Inquiry (FI), Family History (FHx) • Meds/Allergies <p>PHYSICAL EXAM</p> <p>REVIEW OF INFO</p> <ul style="list-style-type: none"> • Blood work • Imaging • Consults <p>SETTING</p> <p>TIMELINESS</p> <p><u>2/ Decision Making:</u></p> <ul style="list-style-type: none"> • Tests/consultations • Conclusions/ diagnosis • Treatments/ procedures • Management /follow-up • Triage <p><u>3/Communication:</u></p> <ul style="list-style-type: none"> • Discussion/ documentation • Diagnoses • Next steps • Info given to patient and other care providers • Consent discussion • Timely, legible, secure 	<p><u>4/ Pre-procedure</u></p> <p>Appropriate:</p> <ul style="list-style-type: none"> • Instructions / processes • Evaluation / consultations • Consent • Postponement / cancellation • Preoperative orders <p><u>5/ Procedure</u></p> <p>Appropriate:</p> <ul style="list-style-type: none"> • Setting (Location, equipment, personnel) • Surgical Safety Checklist • Meds (antibiotics, etc.) • Analgesia / sedation • Procedure / technique • Operative report <p><u>6/ Post-procedure</u></p> <p>Appropriate:</p> <ul style="list-style-type: none"> • Handoff • Early monitoring / assessments • Analgesia • Management of complications • Discharge processes • Follow-up of patient / all results (including pathology) 	<p><u>7/ Continuing Care:</u></p> <p>Appropriate:</p> <ul style="list-style-type: none"> • Follow-up plan, screening, management, and referrals • Hand-offs • Availability and coverage during absences/after-hours • Supervision of trainees

4.2 Scoring Rubric

IMPORTANT NOTE: The elements of quality listed below are intended to be extensive in order to apply to a diverse range of possible patient presentations and a diverse range of medical specialties. It is acknowledged that not every element of quality will be relevant for every medical record or patient visit nor for every medicine specialty. By following the caveat statements (“including relevant details of”, “as required”, etc.), the assessor will use medical expertise and professional judgement to determine which elements of quality are relevant for a given patient interaction.

CPSO POLICIES: Many elements of quality are linked to specific College policies (e.g., Medical Record Management, Prescribing Drugs, etc.). Relevant College policies can be opened by clicking links in the header of each rubric. Where a perceived difference exists between the present content and CPSO policy, the relevant CPSO policy will take precedent.

PATIENT ASSESSMENT	
Assessment of new patients including history, physical examination, and review of tests/information in a defined setting with documentation.	
Key CPSO Policies : Medical Records Documentation Protecting Personal Health Information Managing Tests	
ELEMENTS OF QUALITY	
<ul style="list-style-type: none">a. History – as appropriate for problem and reason for consultation, including, as appropriate: History of Present Illness (HPI), Past Medical History (PMHx), Prior procedures, Medications, Allergies, relevant Social/Family History, Review of Systems, Functional Inquiryb. Physical Exam – appropriate for problem and reason for consultationc. Review of Information – reference to review of relevant data, information for diagnosisd. Setting (office, clinic, emergency room [ER], other) – clean, safe, private, accessible, adequate equipment/supplies/personnele. Timeliness – of initial assessment, investigations, interventions, and follow-up	
EVALUATION CRITERIA:	
Score	Opportunities for Improvement
1	<p>Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include:</p> <ul style="list-style-type: none">• Generally comprehensive patient assessments with only occasional missing documentation of elements of quality (e.g., history, physical exam, review of information)
2	<p>Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include:</p> <ul style="list-style-type: none">• History often missing some components such as Social History/Family History/Medications/Functional Inquiry <i>when inclusion appropriate</i>• Pertinent positives and negatives were often not noted <i>when appropriate to do so</i>• Documentation of physical exam often lacks some relevant data (such as important positives/negatives or specifics such as size, location)

	<ul style="list-style-type: none"> References to abnormal results or consultants' opinions often missing when appropriate
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> History frequently missing key components such as relevant symptoms, signs, risk factors (particularly for malignancies), past medical history, medications, allergies, functional inquiry (particularly for high risk patients or procedures) Absent or inadequate physical examinations, including absence of pertinent vital signs <i>when appropriate</i> Absent or inadequate investigations, consultations (e.g., lack of anesthesiology or medicine consults for high risk patients, multi-disciplinary input for certain cancers, etc.)
DECISION MAKING Conclusions and recommendations based on interpretation of tests and patient evaluations. Key CPSO Policies : Medical Records Documentation Managing Tests	
ELEMENTS OF QUALITY <ol style="list-style-type: none"> Appropriate interpretation of symptoms/ signs and test results as demonstrated by concordance with subsequent diagnosis/test/imaging and pathology results Appropriate ordering of further investigations and/or referrals/consultations or transfers particularly in frail patients and those with significant comorbidities or needs that exceed local resources Appropriate differential diagnosis and/or clearly stated diagnosis based on symptoms/signs/investigations Appropriate recommendations for management and follow-up Consideration of co-morbidities in treatment plans Appropriate triaging (e.g., life-threatening or time sensitive problems prioritized) 	
EVALUATION CRITERIA:	
Score	Opportunities for Improvement
1	<p>Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include:</p> <ul style="list-style-type: none"> Occasional ordering of inappropriate/unnecessary, but low risk, tests Occasional minor deficiencies in documentation of rationale
2	<p>Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include:</p> <ul style="list-style-type: none"> Repeated pattern of ordering inappropriate/unnecessary, but low risk, tests (e.g., repeated pattern of ordering fecal occult blood test [FOBT] despite patient having undergone recent colonoscopy) Differential diagnoses were often not listed when appropriate Patient risk factors (e.g., workplace exposures/ family history/ past radiation) were often not adequately considered in and/or choice of procedure Multidisciplinary input was often not sought when appropriate (e.g., no tumour board) Evidence-based/consensus guidelines were often not followed Rationale for assessment/management decisions was often poorly documented or seldom provided
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> Frequent ordering of inappropriate/unnecessary, but low risk, tests OR ordering of an inappropriate/unnecessary higher risk test that may compromise patient outcomes

	<ul style="list-style-type: none"> • Diagnoses were often inappropriate based on documentation/ results/ outcomes • Appropriate tests based on histories and physical examinations and/or differential diagnosis were often not ordered/performed • Management recommendations and/or treatment plans were often inappropriate given histories, examinations, results of investigations, and diagnosis • Management recommendations and/or treatment plans did not consistently take into consideration the acuity or severity of the patients' illnesses (e.g., septic or hemorrhagic shock not managed emergently; no follow-up for worrisome results/incidental findings)
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COMMUNICATION

Written and verbal communications with the patient, primary care physician, consultant physicians/surgeons, and other members of the multidisciplinary health care team that identify the diagnosis or problems, diagnostic and management plans, details of any consent discussions, and patient instructions.

Key [CPSO Policies: Medical Records Documentation Protecting Personal Health Information Consent to Treatment Prescribing Drugs](#)

ELEMENTS OF QUALITY

- a. **Timeliness, legibility, organization, secure storage, and secure transmission**
- b. Appropriate **information given** to all key stakeholders, as relevant/indicated (e.g., family physician, consultant[s], other stakeholders)
- c. Appropriate attention given to **informed consent process** (including when substitute decision maker and/or translation assistance are necessarily involved)
- d. **Avoidance of abbreviations and/or jargon** that may be misunderstood
- e. **Documentation/discussion** includes, as appropriate:
 1. Information supportive of diagnosis/differential
 2. Diagnosis and/or differential
 3. Specifics of planned investigations, treatments, procedures, and follow-up (i.e., who/when, including clear follow-up for pathology results)
 4. Materials/prescriptions/ resources given to patient including any patient instructions
 5. Anticipated recovery time, postoperative patient limitations
 6. Details of consent discussion including risks/benefits of the proposed treatment and alternatives
 7. if using a Substitute Decision Maker (SDM) – documentation of patient's lack of capacity and name/relationship to the patient of the SDM
 8. Details of any patient handoffs
 9. Contact information provided for patient and key stakeholders, as appropriate, for any questions/concerns
- f. **Templates** used require sufficient clinical information in addition to patient identifiers to make the resulting document both accurate and specific for each unique patient encounter

EVALUATION CRITERIA:	
Score	Opportunities for Improvement
1	<p>Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include:</p> <ul style="list-style-type: none"> • Medical records were mostly legible (some words were unreadable but charts could be understood by a clinician) • Abbreviations and/or jargon were occasionally inappropriate (i.e., occasional potential for misunderstanding by patient/other healthcare providers) • Inadequate documentation regarding reason(s) for patient's lack of capacity when consents done by SDM • Occasional lack of documentation limited to elements with no substantive impact on patient management and outcome
2	<p>Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include:</p> <ul style="list-style-type: none"> • Medical records were somewhat illegible (many words were unreadable; meaning of charts was sometimes unclear) • Abbreviations and/or jargon were repeatedly inappropriate (i.e., more than occasional potential for misunderstanding by patient/other healthcare providers) • Investigations, while done, were often not documented • Advice given to patients (such as wound care or activity/diet restrictions) was often not documented • Physician-patient encounters, including telephone contact, were sometimes not documented and/or sometimes not dated, and/or, in the case of shared records, sometimes it was not clear who made the entry • Follow-up plans were often not clearly stated
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> • Medical records were often illegible (most words unreadable; meaning of charts was generally unclear) • Abbreviations and/or jargon were consistently inappropriate (i.e., frequent potential for misunderstanding by patient/other healthcare providers) and/or had the potential to adversely affect patient outcomes (via misunderstanding by patient/other healthcare providers) • Physician-patient encounters, including telephone contact, were often not documented and/or often not dated, and/or, in the case of shared records, often it was not clear who made the entry • Consent discussion details such as risks/benefits and alternatives were often not documented • Overall, clinical notes often do not tell the story of patient's health care in a way that would allow other healthcare providers to understand or seamlessly assume care of the patient

PRE-PROCEDURE

Evaluation and confirmation of consent, as well as pre-procedure instructions and processes.

Key [CPSO Policies: Medical Records Documentation Consent to Treatment](#)

ELEMENTS OF QUALITY

- a. Appropriate pre-procedure instructions/processes such as:
 1. Nil by mouth (NPO)
 2. Antibiotic prophylaxis
 3. Deep Vein Thrombosis (DVT) prophylaxis
 4. Marking of surgical site
 5. Adequate review by anesthesiologist if indicated
 6. Appropriate postoperative monitoring arranged (e.g., Intensive Care Unit [ICU])
- b. Confirmation of/or appropriate preoperative assessment and informed consent
- c. Confirmation that patient remains optimized (e.g., anticoagulants held as appropriate, no recent significant events such as myocardial infarction, or no current serious infection) and that any patient concerns are addressed
- d. Postponement or cancellation of procedure if appropriate (e.g., if further tests needed, procedure no longer indicated, lack of required resources, etc.)
- e. Appropriate preoperative orders (e.g., insulin and dextrose solutions for patients with labile (brittle) diabetes; fluid/ blood resuscitation for hypovolemia/bleeding; antibiotics for patients with sepsis; adequate monitoring, particularly in frail or seriously ill patients)

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include:</p> <ul style="list-style-type: none"> • Appropriate care delivered by surgeon based on all documentation and review of processes, with some minor documentation deficiencies • Provided an opportunity to address patient questions/concerns although documentation of such may be lacking
2	<p>Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include any of the following:</p> <ul style="list-style-type: none"> • Although discussion supports adequate pre-procedure processes being followed, there is no documentation that the surgeon performing procedure: <ol style="list-style-type: none"> a. reviewed pre-operative patient evaluation/relevant consultants' reports or b. confirmed adequate consent or c. confirmed that any significant preoperative instructions (such as holding anticoagulants) were followed
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> • Inadequate or improper preoperative processes • Surgeon never/rarely reviews preoperative patient evaluations/consultation notes (including review of history and physical exam) or whether patient followed preoperative instructions (particularly when patient has never been met before) • No, or inadequate, opportunity for patient to discuss concerns/questions prior to procedure • Inappropriate preoperative care (e.g., failure to resuscitate or monitor when indicated)

PROCEDURE

Procedures done using accepted techniques in a defined setting, with documentation.

Key [CPSO Policies: Medical Records Documentation](#)

ELEMENTS OF QUALITY

Appropriate:

- a. Setting (location, equipment, personnel)
- b. Analgesia and/or sedation
- c. Aseptic technique
- d. Surgical Safety Checklist (SSCL) as per Canadian Patient Safety Institute:
 1. **Briefing phase** (before introduction of anaesthesia) including verification of identity of patient, confirmation of planned procedure, site, and consent; review of important information, imaging, equipment, plan
 2. **Time-out phase** (before the first incision) including confirmation of procedure, antibiotics, any concerns prior to starting
 3. **Debriefing phase** (before the patient leaves the operating room [OR]) including procedure, key events, surgical count, specimens adequately labelled and managed, patient disposition)
- a. Appropriate procedure/technique and intraoperative management of findings/complications (e.g., unless included in consent, non-emergent additional procedures not required as part of the planned operation are not undertaken)
- b. Operative reports detail personnel, procedure(s), findings including aberrant anatomy and abnormalities, rationale for decisions, estimated blood loss, complications, and all specimens or implants

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include:</p> <ul style="list-style-type: none"> Minor deficiencies in Operative Report where missing information is present and readily apparent in other documentation Unanticipated intraoperative findings that result in deviation from planned procedure
2	<p>Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include:</p> <ul style="list-style-type: none"> Surgical Safety Checklist often not completed Preliminary operative report is often illegible and/or often lacks multiple elements Final Operative Report often missing relevant elements or specifics (such as size of implants, length of remaining bowel, location and number of bowel repairs, etc.) Some procedures done with inadequate analgesia
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> Operative reports consistently lack multiple required elements and lack sufficient detail to understand what exactly was found and done Inappropriate procedures or procedures using inappropriate techniques are frequently done Inappropriate equipment is used (e.g., not approved by Health Canada/regulator, or potentially contaminated/defective) Failure to use the Surgical Safety Checklist when indicated

POST-PROCEDURE

Post-procedure care, analgesia, and documentation including assessments, discharge instructions, initial follow-up and prescriptions.

Key [CPSO Policies](#): [Medical Records Documentation](#) [Prescribing Drugs](#) [Managing Tests](#)

ELEMENTS OF QUALITY

- a. Appropriate:
 1. Handoff to postoperative care unit/ ward team/ family doctor including communication of critical intra-operative events, concerns
 2. Postoperative orders
 3. Monitoring/inpatient assessments and documentation
 4. Assessment/management of pain and analgesia
 5. Management/disclosure of adverse events
 6. Discharge summaries/instructions/prescriptions/referral to social agencies (e.g., home care)
- b. An effective patient/result management process that ensures follow-up and review of all results, with highrisk patients and clinically significant test results flagged for timely review

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include:</p> <ul style="list-style-type: none">• Discussion confirms appropriate handoffs and follow-up of all patients/results although documentation is occasionally lacking.
2	<p>Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include:</p> <ul style="list-style-type: none">• Formal handoffs to postoperative care unit/receiving team (e.g., ICU) infrequent when appropriate to do so and/or missing many elements of quality• Infrequent and/or inadequate documentation of postoperative inpatient assessments• Postoperative orders often incomplete or missing key elements• Discharge instructions often missing or inadequately documented (e.g., missing information regarding when to seek medical attention; limitations to physical activity and/or eating; medication changes; home care; etc.)• Insufficient or excessive narcotics sometimes prescribed• Specifics of follow-up (with whom, when, where) sometimes not documented
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none">• No or inadequate advice given to patients regarding the circumstances under which they should seek urgent/follow-up care and with whom• Inappropriate or contraindicated medications, doses, or quantities of medication, which could result in harm, given to one or more patients (e.g., large quantities of narcotics)• Insufficient or excessive narcotics often prescribed• Specifics of follow-up (with whom, when, where) often not documented• Lack of an effective test results management system (e.g., test results often not reviewed and/or potentially clinically significant abnormal test results were not followed up)• Patients frequently discharged without appropriate follow-up

CONTINUING CARE

Longer term follow-up, screening, and/or management of patients with chronic conditions; also encompasses surgeon availability and handoffs/transfers of care/supervision of trainees

Key [CPSO Policies](#): [Medical Records Documentation](#) [Continuity of Care](#)

ELEMENTS OF QUALITY

Appropriate:

- a. Ongoing follow-up for questions/surgical concerns or referral to colleagues
- b. Availability to address questions/concerns from patients or members of their healthcare team
- c. Coverage during absences and for emergencies
- d. Processes that identify the most responsible surgeon for episodic care
- e. Hand-offs for all transfers of care (particularly for episodic care such as weekly rotations or after-hours locum coverage)
- f. Cancer screening/follow-ups as per guidelines
- g. Supervision of trainees performing procedures/assessing patients with timely correction of inaccurate documentation

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include:</p> <ul style="list-style-type: none">• Discussion confirms processes are always in place that allow patients/healthcare providers to quickly identify/contact the current Most Responsible Physician/Surgeon (MRP)• Discussion confirms appropriate/consistent patient hand-offs, although documentation is occasionally lacking for hand-offs for transfers of care
2	<p>Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include:</p> <ul style="list-style-type: none">• Occasional lack of adequate processes for quickly identifying/contacting the current Most Responsible Physician/Surgeon or the covering physician/surgeon• General lack of documentation for transfers of care, but discussion confirms appropriate/consistent patient handoffs• Unavailability or lack of processes to address recent patients' questions/concerns in a timely fashion• Inconsistent follow-up of post-procedural complications• Infrequent evidence of supervision of trainees (e.g., their documentation errors are sometimes left uncorrected)
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none">• No or inadequate processes for quickly identifying/contacting the current Most Responsible Physician/Surgeon or the covering physician/surgeon• No or inadequate handoffs done for transfers of care (as applicable and appropriate)• No or inadequate coverage arranged for absences or after-hours emergencies• No or inappropriate screening or follow-up of cancer patients

5. Assessment Templates

5.1 Patient Record Summary

The Patient Record Summaries are records of each chart reviewed during the assessment. The templates provide a structure for the assessor's "field notes" so that pertinent issues can be noted and referred to during the Physician discussion. When the physician/proceduralist provides additional information about issues discussed, the assessor will note this in the summary. Patient record summaries will inform the Peer Assessment Report and be attached to the final report submitted to the College. This package will be reviewed by the Quality Assurance Committee and will be provided to the assessed physician/proceduralist.

Instructions to Assessors for completing the Patient Record Summaries:

The Patient Record Summaries are completed during the record review and updated, if necessary, after the Physician discussion. One summary should be completed for each chart reviewed. **Note:** If issues are identified early in the patient record review (i.e., documentation appears to be missing), you should clarify this with the physician/proceduralist before proceeding to ensure that pertinent information is not stored in a different section of the chart / EMR.

How to complete the summaries

1. *Patient Identifier:* Patient initials or record number. Do not use full patient names.
2. *Date of Birth:* Patient's date of birth.
3. *Date of Visit / Date Range of Record Reviewed:* The range of dates that were reviewed within the chart. If only a specific visit/interaction was reviewed, that date should be entered.
4. *Presenting Problem of Patient/Clinical Issue:* The reason for the patient's visit.
5. *Comments/Concerns/Recommendations:* This section, which is divided into the seven assessment domains, is where pertinent information about the chart should be recorded. Comments do not need to be made for every assessment domain; only relevant details regarding quality of care and record keeping need to be included. If concerns are noted, the nature and the extent of the concern should be clearly articulated.
6. *Key Positives/Concerns and Clarification from Discussion with Physician (if relevant):* A brief statement about whether or not concerns were found in the record. Exemplary documentation and care can be recognized here (as appropriate). When follow-up

discussion with the physician clarifies issues or concerns noted in a patient record summary, relevant clarifying information should be added.

PATIENT RECORD SUMMARY TEMPLATE

Chart #1

Selector of patient record ☐ Assessed Surgeon ☐ Assessor

Patient Identifier (Initials/Chart Number):

--

Date of Birth (dd/mm/yyyy):

Gender:

--	--

Date of Visit (dd/mm/yyyy):

--

Presenting Problem of Patient/Clinical Issue:

--

Comments / Concerns / Recommendations:

Patient Assessment

Decision Making

Communication

Pre-procedure

Procedure

Post-procedure

Continuing Care

Specific Concerns:

Clarification from Discussion (if relevant):

5.2 Peer Assessment Report

The *Peer Assessment Report* provides an overall summary of the assessment. This report template guides the format of the report, which includes relevant background information about the physician's practice, areas of appropriate care, areas for improvement, and overall comments. The completed Peer Assessment Report (including the accompanying Patient Record Summaries) will be submitted to the CPSO. The report will be reviewed by the Quality Assurance Committee, who will use it to make a decision regarding the assessment; the Committee's decision along with the report is then provided to the assessed physician.

Instructions to Assessors for completing the Peer Assessment Report:

The Peer Assessment Report is completed after all the patient records have been reviewed and the discussion with the assessed physician has taken place. The report provides a global summary of the assessed physician's practice taking into account all sources of information (i.e., the patient records and Physician discussion).

How to complete the report

1. *Physician Demographic & Practice Information:* The assessed physician's name, CPSO number, and scope of practice that was assessed. The assessed physician's initials are inserted in the footer at the bottom left of the page (this will automatically be copied onto all subsequent pages).
2. *Assessment Information:* The assessor's name, the date of the assessment, and the address of the assessment (where the visit took place). In the boxes at the bottom right corner, the amount of time spent completing the patient record review and the amount of time spent in discussion with the physician. The assessor signs the form when completed.
3. *Relevant Background Information:* A brief description of pertinent contextual information about the physician's practice (e.g., clinical environment, relevant training and experience, type and scope of practice, key patient population characteristics, recent and/or planned changes to practice). Information already included in the Physician Questionnaire need not be repeated unless it provides context for the assessment findings.

4. *Ratings & Comments:* For each assessment domain, a rating (1, 2, or 3) is given based on the assessor's overall assessment of the physician's practice. The scoring rubrics guide assessors' decisions about ratings. Ratings are supported by narrative comments and specific examples. The space for narrative detail for each assessment domain is divided into two sections:
- i. *Areas of Quality Care and Suggestions for Quality Improvement:* A brief summary of the positive aspects of the physician's practice, as they relate to the elements of quality in the scoring rubrics, in order to validate and encourage continued effort in these areas. Optional suggestions for practice improvement and professional development are also included.
 - ii. *Specific Concerns Requiring Attention and Recommendations for Practice Change:* If a score of "2" (moderate improvement needed) or "3" (significant improvement needed) is assigned, the specific concerns that resulted in that score should be described here. When outlining concerns, include both the nature and extent of the concerns, as well as specific recommendations for improvement in this area. When relevant, reference should be made to instances of the concern found in specific patient record summaries. Clear and concise narrative details regarding a concern assist the Quality Assurance Committee in understanding the issues in order to make valid decisions and recommendations.
5. *Summative Comments:* A brief summary of the assessor's overall assessment of the physician's practice across all seven domains including aspects of quality care and any areas of concern. Assessors will provide a summary of all recommendations requiring attention. General comments about the assessment, the Physician discussion, or perceptions regarding the physician's responsiveness to feedback and potential for self-directed improvement should be included here. If pervasive record keeping issues was a hindrance to evaluating quality of care, this can be noted here.

PEER ASSESSMENT REPORT TEMPLATE

Relevant Background Information:

Ratings and Comments

1 - Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor.

2 - Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low.

3 - Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected.

Patient Assessment: Assessment of new patients including history, physical examination, and review of tests/information in a defined setting with documentation.

Rating:

1 ☐

2 ☐

3 ☐

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns Requiring Attention and Recommendations for Remediation:

Decision Making: Conclusions and recommendations based on interpretation of tests and patient evaluations.

Rating:

1 ☐

2 ☐

3 ☐

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns Requiring Attention and Recommendations for Remediation:

Communication: Written and verbal communications with the patient, primary care physician, consultant physicians/surgeons, and other members of the multidisciplinary health care team that identify the diagnosis or problems, diagnostic and management plans, details of any consent discussions, and patient instructions.			
Rating:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<p>Areas of Quality Care and Suggestions for Quality Improvement:</p> <p>Specific Concerns Requiring Attention and Recommendations for Remediation:</p> 			
Pre-procedure: Evaluation and confirmation of consent, as well as pre-procedure instructions and processes.			
Rating:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<p>Areas of Quality Care and Suggestions for Quality Improvement:</p> <p>Specific Concerns Requiring Attention and Recommendations for Remediation:</p> 			
Procedure: Procedures done using accepted techniques in a defined setting, with documentation.			
Rating:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<p>Areas of Quality Care and Suggestions for Quality Improvement:</p> <p>Specific Concerns Requiring Attention and Recommendations for Remediation:</p> 			

Appendix A – CanMEDS in Peer Assessment

The *Peer Assessment* addresses a range of CanMEDS roles across the seven domains and other assessment components as outlined in the table below.

		CanMEDS ROLES						
		Medical Expert	Communicator	Collaborator	Leader	Health Advocate	Scholar	Professional
PEER ASSESSMENT DOMAINS	1. Patient Assessment	✓	✓					
	2. Decision Making	✓	✓	✓	✓			
	3. Communication	✓	✓	✓				
	4. Pre-procedure	✓	✓	✓				
	5. Procedure	✓	✓	✓	✓			
	6. Post-procedure	✓	✓	✓	✓	✓		
	7. Continuing Care	✓	✓	✓	✓	✓		
ASSESSMENT COMPONENTS	Pre-visit Questionnaire*				✓		✓	✓
	Physician Discussion*				✓		✓	✓

* *Leader, Scholar and Professional are addressed to varying degrees in the Pre-visit Questionnaire and Physician Discussion.*

CanMEDS and Continuing Professional Development

CanMEDS is widely incorporated into Continuing Professional Development (CPD) activities that are accredited by the Royal College of Physicians and Surgeons of Canada and the CFPC. CanMEDS 2015 also includes a [Competence Continuum](#) that describes the development of physician/surgeon abilities across the continuum of their career, including CPD (maintenance of competence and advanced expertise).

Furthermore, Key Competency 1 of the Scholar Role is fundamental in espousing the principles of lifelong learning and engagement that motivated the CPSO to make participation in CPD a [regulatory requirement](#) for physicians/surgeons in Ontario: “Physicians are able to engage in the continuous enhancement of their professional activities through ongoing learning.” CPSO members are required to participate in CPD that meets the requirements set by the RCPSC, the CFPC, or an approved third pathway.

The peer assessor may explore CPD with the physician/surgeon, asking about the physician’s/surgeon’s current CPD needs and provide specific recommendations about CPD or quality improvement initiatives that relate to the assessment findings.