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Practical Suggestions for Medical Record Keeping

The following practical suggestions for medical documentation (based on current standards and guidelines) were compiled by the Physician Practice Enhancement Program.

Cumulative patient profile

The **cumulative patient profile** (**CPP)** is a concise yet complete and current summary of important patient information. Ensure that you update the CPP regularly—after hospitalizations, consultants' reports, at the time of a complete exam (CPX) or any time you obtain information that pertains to your patient's management. It should be a complete database on your patient that is available "at a glance" to your colleagues and any residents whom you are mentoring. The CPP is also an important repository for information that should be included with your referral letters to consultants, emergency staff, hospitals, etc.

Components of a good CPP are:

- current medical problems
- current medication list
- past medical history
- past surgical history
- allergies and adverse effects of medications
- social history
- family history
- immunizations

Tips on creating a CPP

1. **Current medical problems** – Create a list of the active medical issues that your patient is dealing with (e.g. hypertension, diabetes mellitus (DM), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), atrial fibrillation, aortic stenosis, anemia, etc.). Include the name of any consultants who are involved and include any management advice that you are aware of (e.g. CHF with ejection fraction (EF) of 20%, next echocardiogram due…followed by…). Update this regularly. Include chronic kidney disease (CKD) when your patient's glomerular filtration rate (GFR) persists below normal values. Add any end organ changes that occur (e.g. DM with peripheral neuropathy (PN), retinopathy and nephropathy). Include the presence of implantable cardiac defibrillators (ICDs), pacemakers, and artificial valves. Avoid populating your list with redundant or general IC9 (International Classification of Diseases, Ninth Revision) categories that are too vague. The list should be clear and concise.

2. **Current medication list** – Create a list of all medications that your patient currently takes. Include important over-the-counter (OTC) medications such as ASA or nonsteroidal anti-inflammatory drugs (NSAIDs). Include all diabetic medications with type of insulin and dosing. Include all medications even if a specialist is seeing your patient and doing the primary prescribing of that medication. Review and update the medication list whenever there is a change of medication or dose, including after any hospitalizations. Avoid a medication list that is a cumulative list of all medications as they are prescribed. This type of list can become very long and unwieldy and makes it difficult to see what a patient is taking "at a glance." Ensure that medications are reviewed regularly in older patients to ensure they follow guidelines for age and renal function. Monitor for drug interactions. Avoid chronic use of opioid/benzodiazepine drugs in the elderly. Include any duplicate controlled prescriptions, as they may not appear on your patient's medication list unless you actively enter them.
3. **Past medical history** – Include previous medical issues which although not requiring active treatment need to be recorded, such as pneumonia, MIs, MVAs, fractures, etc.
4. **Past surgical history** – Include all previous surgery including nephrectomy, splenectomy, total hip and knee replacements (THR and TKR), GI and GU surgeries, etc. Include any information gleaned from consultation reports that you may not have recorded or known about.
5. **Allergies and adverse effects of medications** – These must be recorded for all patients. Include adverse effects (AEs) of medications such as angiotensin converting enzyme inhibitor (ACEI)– induced cough. Ensure that food allergies and anaphylactic reactions are clearly marked. Update allergies that are gleaned from consultation reports or recent hospitalizations, etc. Ensure that your EMR does not have a default to NKDA (no known drug allergies). Actively check and enter allergies consistently in the appropriate data box. Document when a history for allergies was last obtained even if no known allergies were reported.
6. **Social history** – Your knowledge about your patients is helpful for all colleagues to understand the context within which your patients are suffering. Include Information about drug and alcohol use. Include smoking pack years to help identify possible COPD. Include end-of-life directives when known, so that your patients' wishes are clearly identified in case of emergencies. Update these following any health changes or hospitalizations.
7. **Family history** – This is important to help identify patients who need targeted screening such as colonoscopy, appropriate imaging studies, etc. Include age of onset in the relative. Update data that becomes available from relevant consultations, pathology and imaging reports, etc.
8. **Immunizations** – These should be recorded in detail in the appropriate data box and may need to be actively entered. Include the vaccine date (rather than saying "up to date") so that the timing of next booster (if needed) is clear. Include vaccines recommended by Public Health (PH) such as TdaP, Zostavax, flu vaccine, pneumococcal conjugate vaccine 13 and pneumococcal polysaccharide vaccine 23, etc. Include pediatric vaccines that are given or indicate who is providing them. Include travel-related vaccines such as hepatitis and typhoid with details about lot number and when/where given. Include the dates of all booster shots given to complete immunization schedules (e.g. hepatitis A # 1 and # 2). Avoid embedding vaccine information in encounter notes, as these can be difficult to find later when patients ask for their vaccine records. Clear, concise immunization data is very useful.

Electronic Medical Records (EMR)

There are many types of EMR with different ways that your data need to be entered or captured. Ensure that you become familiar with your EMR and learn how and where data are entered so that you easily and consistently have access to information when you need it, and where colleagues can find it. Actively update your database after office visits, every time you do a periodic health review and/or complete examination, pre-anesthetic exam, driver's medical exam, etc., and when you are reviewing any lab/imaging results or discharge/consultation reports. Referral notes can be populated with a full database from your EMR and this will ensure that any other physicians seeing your patients have access to complete information prior to surgery, procedures, or initiation of new medications or treatment. A good CPP record demonstrates to all who read your notes that you are able to organize, record and update patient clinical information in a way that enables you to manage their acute, active and long-term medical issues.

Organizing Encounter Notes

Encounter notes should be organized into a SOAP-type format that gives structure to the patient visit, and enables colleagues to follow your intellectual footprint.

SOAP **"Subjective"** is the reason for the visit that day and should record the history of the present or recent illness (HPI) with all relevant symptoms of the clinical issues being assessed. Make sure your information is clinical. Include symptom duration with pertinent negatives and positives. With a complete physical exam (CPX), also obtain a full review of systems (ROS) or functional inquiry (FI) from your patient.

S**O**AP **"Objective"** is your recording of what you examined and noted about your patient. Include details about height, weight, vital signs, oxygen saturations, affect, etc., to show what you saw and did for the patient. A blood pressure reading should always be recorded when renewing antihypertensive medication or oral contraceptives. Avoid templates with check boxes that give almost no clinical information. Be specific. What did you examine? Avoid writing "neuro N" or "WNL" (within normal limits). Include pertinent negative and positive findings. Give specific details about any procedures you do and include site and medications used. Do consider use of accepted questionnaires such as MMSE, GAD-7, PHQ-9, CAGE, etc., to objectify your assessments of the cognitive and mental status of your patients. Pediatric patients should be screened using the comprehensive Rourke questionnaires, together with your own short assessment.

SO**A**P **"Assessment"** is your diagnosis (Dx) with differential diagnoses (DDx) and should reflect your history and examination findings. Summarize current medical issues and show you are aware of current guidelines of care. A DDx shows your ability to think laterally and avoid premature closure and/or missed diagnoses.

SOA**P "Plan"** is how you are going to manage your patient. List the labs and imaging you will need to check your diagnosis and/or monitor your patient's condition. List referrals and what advice you gave. When is the next appointment? What circumstances would prompt earlier reassessment? Write out full details of the **prescriptions** that are being written that day, including amounts prescribed, dosing and duration. Include duplicate prescriptions and OTC recommendations. Document that the patient was informed about significant potential side effects of the medication and what to do should they occur.

Overall your SOAP notes should be succinct, organized, and demonstrate your clinical thinking to others. Avoid phrases that are too colloquial such as "doing well," "looking good," and "seems OK." Replace them with a more clinical description. If you obtain important clinical information about your patient (e.g. immunization dates, details about family and social history, or drug and alcohol use), it should also

be added to the CPP, and not simply left embedded only in encounter notes where it would be difficult to retrieve. Sign off your notes. Whenever possible, complete your notes on the day that you saw the patient. You should not go back and change or alter your notes. If an error needs to be corrected, this must be clearly documented with an additional note, date and signature. All residents and students should have a clear sign-off by their mentoring physician.

Screening

Familiarize yourself with the sections of your EMR that contain prompts regarding age-appropriate and risk-related screening of your patients. Incorporate the required family history, risk factors and "red flags" into your SOAP subjective notes. Ensure that you include physical exam details for screening procedures such as Pap tests. Describe discussions that you had with patients about recommended and/or controversial screening tests. For example, this should include the pros and cons of screening with PSA. Use your EMR's full capability for recalls and screening whenever possible.

Chronic Disease Management

See the following link for current guidelines pertaining to the care of patients with chronic disease: http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

Physicians using paper charts should be familiar with the chronic disease flow sheets that are available and downloadable from this site (e.g. DM, hypertension, CHF, CKD, COPD).

Physicians using EMR must become familiar with a means of chronic disease charting that is compatible with their system or create one that meets their needs.

It is useful to record:

- duration of condition
- comorbidities
- current medications used for that condition
- pertinent parameters (e.g. BP, BNP, INRs, weight, PFTs, etc.)
- monitoring of end-organ damage – renal function, echoes, visual checks, sensory checks, labs
- vaccinations (e.g. flu and pneumococcal vaccines)
- action plans
- end-of-life directives/DNR status
- functional status
- regular visits with sufficient documentation
- your clinical impression of how your patient is currently doing

Multi-physician Settings

Even though patients may be using walk-in clinics (WICs) for convenience to renew prescriptions or for more acute medical issues, physicians practising in such clinics are required to contribute to monitoring of chronic disease. There must be a system in place to record the monitoring and management of chronic disease. This often requires active entry of information into both the encounter note and the CPP. Office notes must show that a physician who treats a patient, in any clinic, has also collected and

entered information, when appropriate, into an accessible CPP. All patient medical records must identify the primary health-care provider or family physician, if there is one, and whether that health-care provider or physician is at the clinic or at another location. The clinic must provide a copy or summary of the patient-physician interaction (including copies of ordered tests) to the primary care provider identified by the patient, unless the patient explicitly directs it not to.

Encounter Notes

SOAP encounter notes should not only capture details of acute medical problems, but should show that you are aware and following the important aspects of longitudinal care for chronic disease according to current guidelines. Chronic disease flow sheets require succinct data. Update and complete these. Enter data consistently in the appropriate areas of the EMR. Show your intellectual footprint. Regardless of the system being used, show how you are tracking the patient's course including details of recent illness, consultations, hospitalizations, symptoms and signs (including weight, blood pressure, pulse), pertinent lab values and imaging results, current medications and follow-up concerns. Give some clinical context so that a colleague can pick up the care needs of that patient "at a glance."

The notes you make on every patient should reflect your optimal contribution to their overall care. If you are renewing prescriptions for a patient's convenience, your notes must contain an adequate database for that patient. Some examples:

- If renewing antihypertensive medication, record the BP, consider renal function and electrolyte status.
- If renewing warfarin, who is responsible for monitoring the patient's anticoagulation status and INR testing?
- If diabetic, are they stable? Are they having any episodes of hypoglycemia? When was their last HgbA1C and eGFR?
- If they have an acute exacerbation of their COPD, are they using appropriate puffers? Do they have an action plan? When and what was the last antibiotic used?
- If you are renewing oral contraceptives, ensure you document information about BP, risk factors and screening details including who is doing Pap tests and screening for sexually transmitted infections when appropriate.
- If you are seeing children, ensure there is detail about who is doing regular developmental screening and immunizations.

Final Tips

- Create a CPP on all patient charts.
- Augment the CPP with relevant clinical status notes (e.g. "end stage renal failure, does not want dialysis")
- Check PharmaNet to ensure you know what medications a patient is taking. Document that this has been done.
- Avoid templates with yes or no check boxes. Add your own clinical details about the patient.
- Update chronic care flow sheets regularly.
- Complex care notes should be updated regularly and they should reflect the time allotted for the periodic health review to monitor the patient's status and care.

- Include the names of pertinent specialists who are also involved with the patient's care.
- INR flow sheets should include the indication for anticoagulation, the INR target range, serial INR results, dosing instructions and recommended timing for the next INR test. Confirm that INR is in the therapeutic range at least 65% of the time.
- Show that you are checking relevant parameters for chronic disease monitoring.
- Patients receiving opioid therapy should be managed using current guidelines. Clarify the diagnosis. Ensure there is documentation of every discussion about weaning and alternative therapeutic options, use of pain treatment agreements, PharmaNet profiles as well as random pill counts and/or random urine testing.
- Document special visits (that involve counselling) with sufficient detail, using SOAP format and screening questionnaires (e.g. PHQ-9, GAD-7) to objectify your assessment.

Your medical records should be organized, comprehensive and clear so that all relevant medical information is present and accessible (or transferable) to every physician involved in the care of your patients.