CMPA.
Empowering
better healthcare

Documentation Matters – Family Medicine

Why does documentation matter?

Continuity of safe care

"Intellectual footprint"

Billing audits

A 5-year review of CMPA regulatory authority (College) complaints and legal actions identified documentation as being one of the issues for family physicians.

The top problems in order of frequency are:

1. deficient (poor quality) documentation
2. illegible records
3. improper alteration of records
4. delayed completion of reports or forms.

The following tips for improving the quality of documentation are based on the College and peer expert opinions from these CMPA cases:

- A contemporaneous, clear, accurate and legible note for each patient visit
- Notes in chronological order using a standardized format (e.g. SOAP)
- Pertinent positive and negative findings on history and physical examination
- Sufficient information in order to support the clinical diagnosis (or differential diagnosis) and care plan

Medical History

- Subjective reporting of symptoms by patient
- Prior medical + surgical history
- Co-morbidities/risk factors
- Pertinent family history

Physical Examination

- Vital signs, weight
- Focused exam findings
- Developmental milestones (in children)
- Mental / cognitive status
- Neurologic findings

Management Plan

- Recommended tests, treatments, referrals + follow-up visits
- Rationale to initiate, continue or discontinue treatment
- Provide sufficient detail on requisitions or referrals

Procedural Notes

- Detailed description (consider standardized templates or diagrams)
- Post-procedure status
- Discharge instructions

Patient Discussions

- Review of test results
- Treatment options and preventative measures
- Informed consent – including alternatives and patient concerns

EMR

- Unique to each patient + encounter
- Beware copy-paste and overuse of templates

Efficient and Secure Management and Handling of Medical Records

- Proper storage and staff training to safeguard the physical integrity and confidentiality of records
- Processes to ensure the timely completion of required forms or notices e.g. third party reports or patient notification letters when ending a physician-patient relationship (keep copies in the patient's record)
- Processes to ensure lab or consult reports are viewed, signed off and followed up

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