

---

## The Atlantic Provinces Medical Peer Review



<p><b>PEER ASSESSMENT REPORT SURGICAL SPECIALTIES</b></p>
---

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

(PLEASE USE BLACK INK)

**APMPR#** \_\_\_\_\_

**Physician's Field of Practice:** \_\_\_\_\_

**Date of Assessment:** \_\_\_\_\_

**Assessor Name:** \_\_\_\_\_

**Assessor Signature:** \_\_\_\_\_

## .1 Clinical Practice – New Consultations/Pre-Operative Management

Please assess, based on the records, and through your interview with the physician, whether the physician's response in dealing with new or known patients who present with a new complaint or condition is appropriate. Pre-operative examination, testing and treatment should be evaluated.

<b>New Consultations/Pre-Operative Management</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. Information regarding the complaint, the physical examination, and treatment (including presumptive diagnosis) obtained from the referring physician is...				
2. The chief complaint(s) is clearly stated, the symptoms are adequately described, the duration of symptoms noted and a functional inquiry is performed.				
3. The physical examination performed with positive/negative physical findings is...				
4. The family and past history (including significant negative observations) are maintained.				
5. The investigation of the complaint/condition is...				
6. Review of current medication(s) is...				
7. Prescribed medications in type, dose, and duration are...				
8. Requested lab tests, x-rays, and other diagnostic investigations are clinically indicated and...				
9. Consideration of a differential diagnosis is...				
10. The treatment plan is...				
11. Prior to the procedure, treatment alternatives, risk/benefits, potential complications, and side effects were discussed with the patient/substitute decision maker and documented.				
12. Requests for consultations (e.g., high risk patients are recognized) are...				
13. Follow-up of acute conditions is...				
14. Follow-up of abnormal test results is...				
15. Urgent problems are dealt with...				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>New Consultations/Pre-Operative Management</b>				

No concerns/suggestions:

**Comments:**

## .2 Clinical Practice – Operative Patient Management and Procedures

Please assess, based on the records, and through your interview with the physician, whether the physician's actions in dealing with patients who require surgical treatment is appropriate. Where possible, please evaluate the appropriateness of the indications for surgery, operative documentation, operative complications and the procedure selected.

<b>Operative Patient Management &amp; Procedures</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. Indications for procedures are...				
2. The surgical technique(s) used is...				
3. The operative report is dictated/completed within 48 hours of surgery.				
4. The content and comprehensiveness of the operative report is...				
5. When required, medications (e.g. antibiotics, anticoagulants) provided perioperatively are...				
6. Intraoperative unexpected findings and/or adverse events are dealt with.				
7. Management of high-risk situations (e.g. appropriate support team and pre-operative and intra-operative consultations present) is...				
8. The consistency of the pathology report with the preoperative diagnosis is...				
9. The discharge summary or comparable documentation is completed in a timely manner and is sent to the referring/consulting physician as necessary.				
10. Consistency of the discharge diagnosis with the preoperative diagnosis is...				

<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>Operative Patient Management &amp; Procedures</b>				

No concerns/suggestions:

**Comments:**

### .3 Clinical Practice – Post-Operative Management and Follow-up

Please assess, based on the records, and through your interview with the physician, whether the physician's post-operative patient management is appropriate. Follow-up of patients with conditions that may require long-term monitoring should also be considered where applicable.

<b>Post-Operative Management &amp; Follow-up</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. Post-operative follow-up is...				
2. Indication of patient status on post-operative documentation is...				
3. Incidents of post-operative complications (e.g. infections, haemorrhage, etc.) are documented.				
4. Rate of re-admission for post-operative complications is...				
5. Post-operative complications are treated and monitored.				
6. Medications prescribed in type, dose and duration are...				
7. When appropriate, use of social agencies (e.g. home care, nursing care, physiotherapy, etc.) is...				
8. Follow-up of patients suffering from chronic conditions is...				
9. Appropriate follow-up of abnormal test results is...				
10. Requests for consultations are...				
11. Communication with referring physician in order to facilitate continuity of patient care (e.g. notification sent to primary physician regarding new medications or changes to current medications) is...				
12. Post-operative blood transfusions are...				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>Post-Operative Management &amp; Follow-up</b>				

No concerns/suggestions:

**Comments:**

### 4 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



Patient Identifier	Date of Visit	Complaint/Problem	Comments or Suggestions

## .5 Required Medical Record Components

Required Medical Record Components	Appropriate	Appropriate with Suggestions	Concerns	N/A
1. The legibility of the record to the assessor is...				
2. Documentation of the patient's name, sex, telephone number, address and date of birth is...				
3. Documentation of the patient's Health Card number (if the patient has a Health card) is...				
4. For a consultation, documentation of the name of the primary care physician and of any health professional who referred the patient is...				
5. The date of each professional encounter with the patient is documented.				
6. The start and stop times for psychotherapy and counselling encounters are recorded.				
7. Patient histories are recorded.				
8. Functional inquiries are recorded.				
9. Diagnoses are recorded.				
10. Investigations are recorded.				
11. Results are recorded.				
12. Each treatment prescribed or administered by the physician (dose, duration, quantity) is recorded.				
13. Notation of professional advice given by the physician is recorded.				
14. Notation of particulars of any referral made by the physician is recorded.				
Section Recommendation	Appropriate	Appropriate with Suggestions	Concerns	N/A
<b>Required Medical Record Components</b>				

## .6 Record Keeping and Patient Management Tools

<b>Record Keeping and Patient Management Tools</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
1. The record system that allows for ready retrieval of an individual patient file is...				
2. The mechanism that notifies the physician when consultant reports and/or laboratory reports have been received is...				
3. The mechanism that ensures that all investigation, consultation and lab reports have been reviewed, with appropriate action taken is...				
4. The record is organized.				
5. Documentation of the consultation record to the referring doctor is...				
6. Patient Summary Sheet(s) (e.g. Cumulative Patient Profile) is/are...				
7. In the event that more than one physician is making entries in the patient chart, each physician is identified.				
8. Growth charts are...				
9. Antenatal Charts are...				
10. Allergies are identified.				
11. Immunization records are...				
12. Flow sheets for chronic conditions are...				
13. Flow sheets for health maintenance are...				
<b>Section Recommendation</b>	<b>Appropriate</b>	<b>Appropriate with Suggestions</b>	<b>Concerns</b>	<b>N/A</b>
<b>Record Keeping and Patient Management Tools</b>				

**.7 General Comments on This assessment**

A large, empty rectangular box with a thin black border, intended for providing general comments on the assessment. The box is currently blank.