Peer Assessment Committee
College of Physicians and Surgeons of New Brunswick

What The Assessors Look For

Assessors from the Peer Assessment Committee (PAC) are committed to making the review process a pleasant and positive one, with physicians being assessed having full knowledge beforehand of what will be reviewed. Both onsite and offsite assessments follow an established protocol, and a review of a standardized list of items. Below is an outline of the areas of practice which will be reviewed and assessed for an office-based practice. It is recognized that physicians working in a hospital environment may not have control over their surroundings, equipment provided or record-keeping practices in that facility. Assessors may note areas of concern which are systemic in nature; often these comments help physicians to facilitate their being corrected.

.1 **Office Facilities & Procedures (Reviewed Onsite by Assessor – Offsite Reported on Supplemental Information for Assessment)**

Is the office space adequate in size, clean, well-lit and with an adequate number of accessible washrooms? Are the rooms appropriate for their use; is there provision for patient privacy? Are medical instruments and investigative equipment suitable for the type of practice? Are facilities for refrigeration and storage adequate and are sterilization procedures appropriate?

Are controlled drugs and narcotics secure? Are expiry dates being checked and respected? Are there adequate emergency equipment and supplies available, such as oxygen, adrenalin, an airway and an Ambu-bag? How long before emergency teams could get to the office?

Is surgery carried out in the office? If so, are the facilities and instrumentation appropriate? Is there an established procedure for the disposal of biomedical waste such as needles, gloves and dressings?

Is the staffing adequate to make patients feel comfortable in the office? Is the staffing suitable to provide the physician with proper legal protection? Is there convenient access to lab or other investigative tests such as haemoglobin, blood glucose, or urinalysis?

.2 **Medical Records (15 – 20 records reviewed onsite; five charts sent for offsite)**

In an onsite review, the assessor will identify and select a number of patient files at random. In an offsite assessment, the charts submitted are chosen by the physician. Charts to be reviewed will be selected with specific disease entities in mind which are relevant to the practice. For example, Family Physicians will be asked to provide charts for patients with Chronic Pain, Hypertension or Type II Diabetes. For Paediatricians, the list would include Autism, Asthma and Seizure Management

The assessor will first review the documentation, and will determine whether certain items are:

"Appropriate"
"Appropriate with Suggestions"
"Concerns"
"N/A" (not applicable)

The assessor is checking to see if there is a record system which allows for easy retrieval of an individual patient's file. Is the patient clearly identified, so he can not be confused with others? Is every component of the file identified, so there is no doubt to which patient it belongs? Is the record legible and the date recorded?

Are things like family history, functional inquiry and past history recorded? Are allergies, drug sensitivities and immunizations noted? Is there a "cumulative patient profile?" Is there a single sheet or space in the record which provides a "snapshot" of the patient's significant health problems, allergies and medications being taken? Is this sheet kept up to date?

Regarding the patient's visit to the office, the assessor will be reviewing the record to answer three questions: Why did the patient come? What was found? What was done? In other words, Subjective information, Objective information, Assessment and Plan - SOAP. It is the information locum tenens would need, and the information that would be required in any court proceeding.

The assessor will also be looking at whether reports are retained: pathology, discharge summaries, and operative notes. Is there a system in place to ensure that the physician does not miss abnormal test results? Does appropriate follow-up always take place? Where there is a sharing of practice, is there a system to ensure that the primary physician knows what the others did? Are provincially standardized forms (such as ante-natal forms) utilized? Is there documented evidence that the physician periodically reviews the patient's health problems and medications?

3. **Patient Care**

The records review, carried out with the assistance of clinical practice guidelines for specific disease entities, allows the assessor to examine patient care over a significant period of time. Assessing care as 'Excellent', "Satisfactory" or "Deficient," the assessor determines if the chart answers the following questions:

- Is investigation appropriate to the complaint or condition?
- Is the diagnosis supported by the history, physical findings and investigation?
- Is the management plan suitable to the condition?
- Is medication prescribed appropriate to the condition?
- If surgery is advised, are the indications reasonable?
- Is follow-up on acute conditions appropriate?
- Is follow-up on chronic conditions appropriate?
- Is there suitable documentation of counselling sessions?
- Are psychotherapy sessions indicated and suitably documented?
- Are other community resources used appropriately?
- Are referrals to other physicians appropriate?
- Are emergency problems dealt with promptly and effectively?
- Are there suitable arrangements for care of the patients in the physician's absence?

PAC assessors are physicians in the same field of medicine as that of the physician being assessed, and have proven quality patient care. Throughout the review, assessors ask themselves, "could I take over the practice without difficulty, and would I be willing to continue with it without radical change?" If the answer is "yes", the assessment is satisfactory.