The College of Naturopaths of Ontario

PEER AND PRACTICE ASSESSMENT PROGRAM

Patient Files Review Worksheet

Please select 5 patient files (no more than a year old) that best represent the scope and breadth of your practice. If you perform IVIT procedures and/or prescribe, please be sure to select at least one file that includes these controlled acts.

Complete this form as you review each file according to the requirements in the Standard of Practice for Record Keeping, using the legend below. You may include comments providing additional information about requirements that have not been met (attached additional pages if needed). The information you provide on this form will be provided to your assessor prior to your peer and practice assessment. During the peer and practice assessment, your assessor will go over your comments with you to discuss what has been done well and what areas need improvement.

The assessor will also complete a review of one of your patient files and compare their review with yours. A complete patient file includes the chart, appointment, and financial record. Please be sure to submit all components of the patient file to the College for the assessor to review.

Please indicate the patient's initials for the chart that you have submitted to the College to be used by the assessor when doing their chart review and the chart stimulated recall.

Patient's initials _____

Legend: Y = yes N = no NA = does not apply to the chart reviewed

Registrant's name:					
File number:	**1**	**2**	**3**	**4**	**5**
Patient's initials:					
DAILY APPOINTMENT RECORD					
1. Registrant maintains an appointment record that clearly and legibly identifies:					
a) Registrant's name, clinic name, address, and telephone number					
b) Date and time of appointment					
c) Name of patient (minimum of last name and first initial)					
d) Duration of appointment					
e) Corresponds with visits in the patient chart					

Registrant's Comments

PATIENT FINANCIAL RECORDS						
2. Registrant ensures that financial records clearly and legibly record:						
a) Registrant's name, clinic name, address, telephone number						
b) Patient's name, address, telephone number						
c) Date of service						
d) Services billed						
e) Substances, drugs, or devices dispensed						
f) Payment amount and method of payment						
g) Balance of account						
Registrant's Comments						

3. Registrant ensures that:						
a) Patient financial records are clearly itemized						
b) Fees for naturopathic consultation are separated from all other fees						
c) Fees for supplements, injectable substances, devices, special testing, etc., are individually listed						
d) Receipts are issued for all payments and copies are maintained in the patient financial record.						
Registrant's Comments						

PATIENT CHARTS						
4. In the patient chart, the Registrant ensures that:						
a) All written entries are made in permanent ink						
b) The patient name or patient number is recorded on each page						
c) All entries are made in either English or French. Other languages may be used provided that English or French are also used						
d) There is no highlighter used over writing						
e) All written records are clearly legible						
f) There are no blank spaces between entries						
g) All pages are in chronological order, consecutively numbered and dated						
h) A consistent format is used for recording the date						
i) When other than generally medical abbreviations are used, a legend of abbreviations or codes is available						
Registrant's Comments						
5. The Registrant ensures that all records contain:						
a) Subjective information, including patient's health history and family history, provided by the patient or their authorized representative						
b) Relevant objective findings						
c) Results of any naturopathic examinations						
d) An assessment of the information and any diagnosis						
e) Proposed treatment plan, including prescriptions and recommendations						
f) Relevant communications with the patient						
g) Relevant information obtained from re-assessment						
h) Indication of who made each entry and when the entry was made						
Registrant's Comments						

6. The Registrant records the following information related to the delivery of treatment:						
a) Name and strength of all drugs and/or substances administered						
b) Dosage and frequency						
c) Date of administration						
d) Method of administration						
e) How treatment was tolerated						
Registrant's Comments						
7. Treatment Plan						
a) Has a treatment plan been articulated and recorded in the chart?						
b) Is there a record of the discussion held with the patient regarding the treatment plan including the assessment, diagnosis, risks and benefits?						
c) Is there a record of the patient providing informed consent to the treatment plan?						
Registrant's Comments						
8. Lab Tests/Reports						
a) Requisitioned by ND						
b) Requisitioned by others						
c) Laboratory tests are dated and readily available in chart						
Registrant's Comments						

9. General Documentation						
a) Was all documentation in SOAP format?						
b) Was there evidence in the patient file that this patient was re-assessed periodically to justify ongoing care?						
Registrant's Comments						
AMENDMENTS TO PATIENT CHARTS						
10. The Registrant ensures that:						
a) Any amendment to a written chart is initialed, dated and indicates the change that was made						
b) All previous written entries remain legible						
c) Amendments are only to be in the form of additions and not erasure or overwriting						
d) The original entry is available and legible						
Registrant's Comments						

For sections 11 (Electronic Records) and 12 (Inventory Record Keeping) please indicate with a Y (yes) or N (no) regarding the listed criteria.	
11. ELECTRONIC RECORDS	
When patient records are maintained in an electronic system, the following criteria are met.	
a) The system provides a visual display of the recorded information	
b) The system provides a means of accessing the record of each patient by the patient's name or other unique identifier	
c) The system is capable of printing promptly the recorded information in chronological order for each patient	
d) The system maintains an audit trail that:	
i) Records the date and time of each entry for each patient	
ii) Preserves the original content of the record if changed or updated	

iii) Identifies the person making each entry or amendment	
iv) Is capable of printing each patient record separately	
e) The system provides reasonable protection against unauthorized or inappropriate access	
f) The system is backed up at least each practice day and allows for the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to and inaccessibility of records	
g) Backed-up files are stored in a physically separate and secure area	
h) Files are encrypted if they are transferred or transported outside of the facility	
i) Ensures, if other practitioners also see the same patient, that the Registrant's electronic records can be individually retrieved	
Registrant's Comments	
12. INVENTORY RECORD KEEPING	
When the practice includes a dispensary, the following criteria are met.	
a) An inventory of drugs and substances purchased or received is maintained, including the date of receipt.	
b) The date drugs and substances are dispensed and/or sold is recorded.	
c) The name of the person to whom the drugs and substances were dispensed and/or sold is recorded.	
d) A log containing a record of distribution of each drug or substance dispensed is maintained to enable the Registrant to issue a recall of any dispensed drug or substance.	
e) A record of any product recalls or alerts provided by the manufacturer or Health Canada is maintained.	
Registrant's Comments	