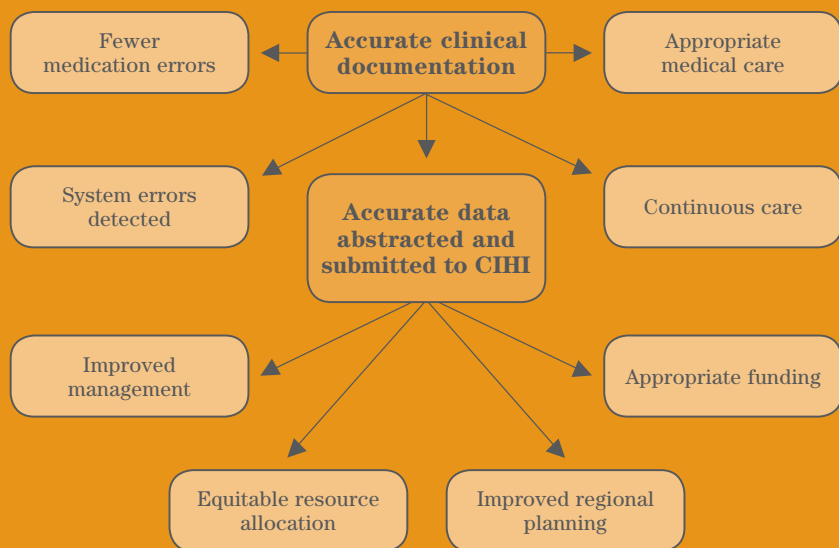


# Inpatient Record

ADMITTING PHYSICIAN	HOSP. NUMBER	ADMIT DATE	ADMIT TIME	ADMIT TYPE
ADMITTING DIAGNOSIS			HEALTH CARD NUMBER	NAME
MEMO <i>Lives depend on you fill out patient charts legibly complete and on time</i>			SURNAME ON HEALTH CARD	
			DATE OF BIRTH	SEX
FAMILY PHYSICIAN			AGE	ADDRESS
REFERRING PHYSICIAN			PHONE	BUS. PHONE
HCN			IN EMERGENCY NOTIFY	RELATIONSHIP
PRE ADMISSION COMORBIDITY			PHONE	RELIGION
				LANG
			ALTERNATE LEVEL OF C	
			KNOWN DRUG ALLERG	

What you should know about physician documentation

# The Benefits of Complete and Accurate Documentation in the Health Record



## Studies have shown:

- The risk of re-hospitalization decreased when patients were assessed for follow-up by a physician who received a discharge summary.
- Visits in the emergency department of a teaching hospital were 1.2 hours longer on average for patients with an information gap in their health records than for those without one.
- Only 11% of hospitals in Ontario have discharge summaries completed and signed within 48 hours.

# The Patient Health Record: *Why It's Important*

Good patient care and health outcomes are dependant on accurate, clear, complete and timely documentation of a patient's diagnosis, problems, treatment and progress in the health record.

**Quality physician documentation has been shown to improve patient care and outcomes.** For instance, when shared in a timely manner, the patient record can help avoid negative consequences, such as adverse medication events.

Concern over the quality of patient health records led to the creation of Ontario's first **Physician Documentation Expert Panel**.

In examining ways to improve the quality and usefulness of health records, the panel paid particular attention to the discharge summary, which is especially critical in ensuring optimal continuity of care. A family doctor treating a patient without the benefit of a discharge summary from an acute care physician is working at a disadvantage in a potentially life-threatening situation.

The panel has put together a **checklist** that physicians can follow to ensure that the discharge summary is as complete and accurate as it can be, so that important patient information is included and passed on in a timely and effective manner.

“As a physician, you are the key to providing the information that your patients, other physicians and the system needs.”

Ralph Z. Kern MD MHSc FRCP(C)  
Assistant Professor, Neurology Program Director,  
University of Toronto  
Chair, Physician Documentation Expert Panel

## Discharge Summary Checklist for Physicians

When completing the discharge summary, consider whether you have included the following:

- Admitting diagnosis
- Pertinent physical examination findings and laboratory results
- Procedures and comorbidities while in hospital
- Discharge diagnosis/diagnoses
- Discharge medications
- Active medical problems at discharge
- Arrangements for continuing care, i.e., follow-up

Additionally, the following information can help physicians to improve the quality of the discharge summary:

1. Details of medications prescribed at discharge, including reasons for giving or altering medications, frequency, dosage and proposed length of treatment.
2. Specific plans after discharge, including a list of follow-up appointments with consultants, further outpatient investigations, and outstanding tests and reports that need follow-up.
3. Information that was provided to the patient about diagnosis, management and expected outcome.
4. A summary of the case.

# A Guide for Physicians by Physicians

An expert panel of more than 20 physicians, representing a variety of disciplines, as well as organizations, including The College of Physicians and Surgeons of Ontario and the Ontario Medical Association, has devised ways to improve physician documentation primarily in acute and ambulatory care episodes.

The *Guide to Better Physician Documentation* reflects their collective input and recommendations. Produced for physicians by physicians, the guide includes:

- Facts about the importance and impact of the patient health record
- An overview of the current documentation environment
- A chart completion policy template
- Information about reporting requirements

The guide is available on the Ministry of Health and Long-Term Care's website at:

**[www.health.gov.on.ca/transformation/information/information\\_mn.html](http://www.health.gov.on.ca/transformation/information/information_mn.html)**

# Information Management

*A System We Can Count On*

For more information about the work of the Physician Documentation Expert Panel, write to the Ministry of Health and Long-Term Care at **Akeela.Jamal@moh.gov.on.ca** or call **416-326-7820**.