BCC Standard of Practice - Physician Documentation

Policy

Admission to BCC

Since most patients seen at BCC centres are out-patients, the definition of an admission to BCC applies to the first time that the patient is being referred and seen at BCC by an oncologist who assumes the Most Responsible Physician role. This does not apply to consultation or screening services provided by BCC such as screening mammography program, pathology review, etc.

Documentation required for new admissions:

- Notes to be dictated within 2 working days of seeing the patient
- Admission note to contain elements of –
  - History as obtained directly from the patient / family and records sent by referring physicians
  - Current performance status
  - Other co-morbidities and previous illnesses
  - Current medications (list)
  - Allergy and Alert status
  - Family history
  - Physical examination – general and specific to the diagnosis
  - Stage of cancer – as known at the time of admission
  - Discussion and recommendation of next step of management
  - Consent if treatment at BCC is being recommended. This will comprise specifically the rationale of recommended treatment, options of alternate management and potential consequence, potential toxicities of

recommended treatment, patient's understanding of recommendation and patient's consent (or not) of the recommended treatment.
    - Disposition – e.g. Patient to call, patient to be notified for treatment appointment, discharge, patient to return after investigations completed, etc.
- Complete paper chart documentation per PIM policies:
    - Allergy & Alert form
    - Staging diagram
    - Signature record
    - Doctor's order and/or Pre print order and associated requisitions

Admission to hospital unit at Vancouver Centre

Documentation required for each admission:

- If this is also a new admission to BCC, admission note is to be dictated within 24 hours and transcribed urgently
- For communication purposes, hand written note is to be done at the time of admission. This should include the elements of:
    - Reason for hospital admission
    - Brief summary of history
    - Allergy and alert status
    - Medication (list)
    - Pertinent physical examination
    - Plan of management
    - Doctor's order

Consultation notes

If this is a new admission to BCC, all elements of a new admission note apply.

If this is not a new BCC admission, and the patient is being seen by an oncologist who does not provide ongoing oncology care, and the patient is being seen at the request of another physician or the patient, the consultation documentation is to be dictated within 2 working days of seeing the patient.
The elements of the dictated note include

- Summary of pertinent history including referral physician and reason of referral
- Allergy and alert status
- Medication (list)
- Physical examination (Exception: Consultation by Telehealth)
- Status of cancer diagnosis
- Discussion and recommendation of next step of management
- Consent if treatment is recommended, including all elements of consent
- Disposition

Progress Notes

This refers to the ongoing care of a patient. This is to be dictated within 2 working days of seeing the patient.
The elements of the dictated note include

- Reason that patient is being seen
- Pertinent physical examination
- Discussion and recommendation of next step of management
- Consent if treatment is recommended, including all elements of consent
- Disposition

Procedure / OR Notes

This is to be dictated within 24 hours of the procedure.

Completion of Radiation Therapy Notes (TCN)

This is to be dictated within 10 days of notification from the radiation department that the patient's TCN is to be done.

Action List completion:

Any blanks left by transcriptionists should be filled in prior to sign off.

There should be no items > 3 weeks in the Action List on a chronic

basis with the understanding that investigative reports are dealt with within 14 days.

Physicians should attempt to review Action Lists on a daily basis.

Please refer to *h:Everyone/MRP help//Implementation Summary/Presentation and Updates* to see updated processes to follow when a physician is away.

Appendix A
Standard Documentation

REQUIRED DOCUMENTS/ INFORMATION	Fully Admitted	Conference	Colposcopy	Dentistry	Not Referred Study	Prothesis	Drug Registration	Special Procedure	Visitor (Out-of-Province)
PATIENT TYPE CODE	**A**	**B**	**C**	**M**	**N**	**P**	**D**	**S**	**V**
HISTORY AND PHYSICAL									
ONCOLOGICAL CONSULTATION		**Conference Notes**							**Progress Note** ●
ESSENTIAL REPORT LIST									
PATHOLOGY REVIEW									
REFERRAL FORM									
CONSENT FORM (Release)									
CONSENT FORM (General)								● ●	
Most Responsible Physician									
FACE SHEET									

● **Out-of-providence hyperbaric oxygen patients require an Onocological Consultation only.**
● ● **General Consent require unless Consent to Surgical/ Special Procedure applies**