Association of Professors of Dermatology

Chart Documentation Review

Resident: ______________________________ Derm Yr: ________

Evaluator: ______________________________ Date: __________

Encounter Complexity: ☐ Low ☐ Moderate ☐ High

Diagnosis Summary: ____

Focus: ☐ Data gathering ☐ Exam ☐ Assessment ☐ Management ☐ Quality Care

PC1 / ICS.3

1. Quality of Patient History (☐ Not observed)

Below Level 1	LEVEL 1	LEVEL 2	LEVEL 3	Ready for Unsupervised Practice	LEVEL 5
Missing basic history elements for basic disease	Documents some history but misses several expected associated ?s for routine derm conditions. Accurate in data recorded	Accurate targeted disease-specific hx of common dz, but needs assistance to complete. Appropriate template use	Independently obtains excellent hx from pt with common, even difficulty/subtle information. Readily probes to clarify. Concise reasoning documented.	Independently elicits excellent hx from pt with complex conditions. Clear, concise and organized document.	Independently obtains hx from pts with rare, atypical, or refractory condition

PC.1 / MK2 / ICS.3

2. Physical Examination Skills (☐ Not observed)

Below Level 1	LEVEL 1	LEVEL 2	LEVEL 3	Ready for Unsupervised Practice	LEVEL 5
Failed to perform key exam for routine skin condition. Key sizes inaccurate or missing	Performs basic exam of common chief complaint, but not associated areas. Defines morphology. Accurate measurements.	Accurate targeted exam. Requires assistance to complete exam for common conditions. Needs morphology assist	Independently performs A+ exam for common, Identifies some but not all difficult/subtle findings. Fluent morphology. Documents dermoscopy w assist	Documents excellent clear concise exam in complex conditions. Identifies subtle clinical patterns and examines all associated areas. Reliable, accurate dermoscopy interp.	Independently documents thorough exam in pts with rare, atypical, or refractory conditions. Includes wide range dermoscopy

PC.7 / ICS.3

3. Communicating Critical Thinking and Differential Diagnosis (☐ Not observed)

Below Level 1	LEVEL 1	LEVEL 2	LEVEL 3	Ready for Unsupervised Practice	LEVEL 5
No differential; Assessment or Plan is way off the mark for common.	Develops limited DDx for common presentations. Some premature closure. Vague. Not always clear.	Documents organized diagnostic and therapeutic reasoning Appropriate differential for common.	Appropriately weighted DDx for complex presentations. Concisely reports reasoning in document	Incorporates additional information to reach high-probability dx. Clear, concise and organized documentation	Documents alternative diagnostic considerations if current assessment incorrect.

PC.8 / ICS.3

4. Therapeutics Management Documentation (☐ Not observed)

Below Level 1	LEVEL 1	LEVEL 2	LEVEL 3	Ready for Unsupervised Practice	LEVEL 5
No documentation of vehicle, dosage, or frequency of prescribed therapy	Documentation requires significant edits to clarify accurate drug selection, dosing, vehicle, monitoring for common	Txs for common dz documented, with minor edits. SE counseling and monitoring documented, with some edits. Uses templates appropriately	Documents treatment response assessment, expectations, risk and benefits assessment. Requires editing to document an experienced adverse event. Monitoring accurately documented.	Explains Tx escalation. Documents appropriate therapeutic ladder climb for common and uncommon. Documents lab monitoring and adverse event management	Manages rare, complex disease based on emerging evidence. Evaluates emerging tx modalities or applications

PBL.1 / SBP.2

5. Documented Care that is Evidence-based and Patient-Centered (☐ Not observed)

Below Level 1	LEVEL 1	LEVEL 2	LEVEL 3	Ready for Unsupervised Practice	LEVEL 5
Insulting of patient in documentation. Unsupported recommendations.	Correct assessment and care for common. Little evidence in note that patient involved in decision making or plan. Requires guidance for care coordination.	Documents eliciting patient preferences. Applies evidence-based guidelines to treatment plan. Obtains needed consults in common.	Documents or references best available evidence integrated with patient preference to the care of complex patient. Coordinates care in complex situations.	References applied evidence in decision making in the face of uncertainty, tailored to individual patient. Document demonstrates leading effective coordination across multiple disciplines.	Clearly documents care decision rationale weighing both sides, when evidence-based care conflicts with patient centered decisions.

6. Overall Clinical Competence (☐ Not observed)

Below Expected 1st Yr	Beginning Resident Level	Junior Resident Level	Senior Resident Performance	Ready for Unsupervised Practice	Mastery Level
1	2 3	4 5	6 7	8	9 10

FEEDBACK AND COMMENTS TO HELP THE RESIDENT IMPROVE PERFORMANCE:

ASSOCIATION OF PROFESSORS OF DERMATOLOGY

Chart Documentation Evaluation Exercise

Instructions:

General principles

- This tool is designed to help assess the chart documentation and written communication skills of dermatology residents. It is appropriate for encounters in an outpatient or inpatient clinical setting. The evaluation can include assessment of procedure notes as well as clinical notes that do not involve procedures. This tool is appropriate to evaluate both New and Established patient notes.
- All or part of an encounter note can be observed. It is not required to assess the entire document, although the tool was designed to provide feedback from the assessment of the entire clinical note.
- Notes for assessment can be selected at random or can be targeted for degree of complexity. That decision is made by the faculty member selecting the charts for assessment.
- Not every document will have quality measures assessable.
- Provide direct, specific constructive feedback to the trainee after the encounter. Determine what are 'must' areas for improvement vs. 'the art of how I would have done it' areas for improvement (ie, corrections vs. advice).
- If a hard copy of the document is printed as part of the review, it is appropriate and possibly more clear to the learner to make some feedback notes directly on this document printout as opposed to referring to the issues on the evaluation form.
- If a hard copy of the document is created, care must be taken to remain HIPPA compliant.

Specific instructions

- **Encounter complexity** – Determined by the evaluator. Factors to consider include the diagnosis, clinical situation, patient interactions.
  - For example, a visit for a routine skin cancer check in a patient with a history of basal cell carcinoma with nothing new to see but a well-healed scar is likely low complexity. A visit for a routine skin cancer check in a patient with signs of recurrent skin cancer might be of moderate complexity. A visit for routine skin cancer check in a patient upset by the resulting scar made by a previous resident colleague could be moderate or high complexity.
- **Diagnosis / summary** – Describe the diagnosis and / or what occurred.
  - Ex: Suspect allergic contact hand dermatitis, discuss patch testing
- **Focus** – Check the focus or foci that are assessed. Several foci may be checked if several parts of the note were assessed (typical).
- **Skills** – Rate the trainee on the milestones scale for each skill. It is important to remember that trainees are not being compared relative to other trainees; they are being rated on a continuum; on a scale designed to assess progression of skills from novice to master. It is common for first year residents to score Level 1 out of 5 and still be great first year residents.
- If a particular written component is not reviewed, check the "Not observed" box.
- **Feedback and comments** – Note specific positives in the encounter and give constructive feedback on how the trainee could improve.