



Oversight and Assessment Report

Registrant Name: _____

Licence #: _____ Discipline: _____

Practice Location: _____

Report Assessment Period: _____

SECTION 1. CHART REVIEW TRACKING TABLE

Having reviewed a minimum of **five (5)** medical records, please record your general opinion of the information in the medical records. Complete additional tracking table(s) as necessary.

Medical Record	Patient Initials	DOB	Diagnosis	Concerns (Complete Comment Sheet For Yes)
#1				
#2				
#3				
#4				
#5				
#6				
#7				
#8				
#9				
#10				

SECTION 2. ASSESSMENT

Please complete this section, taking into account all charts reviewed.

Level of Concern	Definition
No/Minimal Concerns Reasonable care provided	No/minimal concerns, care provided is reasonable and adequate.
Opportunities for Improvement	Suggested changes or improvements to practice for self-directed implementation.
Further CPSNL Action Required (Attach Comment Sheet(s) with details)	Major practice changes needed due to patient safety concerns or serious deviations from College standards; CPSNL follow-up required.

STANDARD OF CARE

Component	No/Minimal Concerns Reasonable care provided	Opportunities for Improvement	Further CPSNL Action Required
Medical Record Keeping			
Chronic Disease Management			
Acute Disease Management			
In-Hospital Care (if applicable)			

CHART STIMULATED RECALL

Component	No/Minimal Concerns Reasonable care provided	Opportunities for Improvement	Further CPSNL Action Required
Clinical Assessment			
Investigations/Referrals			
Treatment			
Health Promotion/Prevention			
Context of Care (Patient and System)			

OVERALL ASSESSMENT

	Yes/No	Comments
Meets standard of care?		
Meets CPSNL Standards of Practice?		
Patient safety concerns?		
Concerns with team interactions?		
Concerns with professional behaviours?		
Strengths		
Comments:		
Opportunities for Improvement		
Comments:		
Changes Required – Further CPSNL Action		
Comments:		

SECTION 3. SIGNATURES

ASSESSOR:

_____	_____	_____
Name (Print)	Signature	Date

REGISTRANT:

_____	_____	_____
Name (Print)	Signature	Date

Ensure all relevant fields have been completed.
 Email your completed report to abixby@cpsnl.ca and kim.adams@nlhealthservices.ca.