NSVMA Medical Records Handbook

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Medical Records Handbook

Background

Council of the NSVMA has identified improving the quality of the medical records in veterinary practices as a priority. Members of the Hospital Accreditation Committee (HAC) and the Complaints Committee (CC) have expressed concerns over the quality of medical records reviewed in the course of their committee work. The HAC and the CC support the development of a NSVMA Medical Records Handbook, as an aide for practitioners to evaluate and improve the quality of their own records as needed.

Purpose and Objective of this Document

Professional enhancement is one of the primary responsibilities of the NSVMA. Professional enhancement is described as providing learning opportunities and tools that allow members to improve the quality of veterinary medical services delivered to the public in Nova Scotia. This directly benefits veterinarians, animal health technologists, veterinary practices and ultimately the public.

This handbook will:

- Clarify and provide guidance in the interpretation of the Practice Standards Bylaws regarding medical records.

- Assist the Hospital Accreditation Committee and Complaints Committee when medical records are reviewed.

- Describe the expectations of the veterinary profession to educational institutions that provide instruction to veterinarians and animal health technologists

- The intent is that members will gain a better understanding of acceptable standards for medical records and this will lead to a renewed appreciation for the important role that medical records play in optimizing care for veterinary patients, thereby improving the quality of medical records in Nova Scotia veterinary practices.

Why Create and Maintain Medical Records?

The primary objective of this handbook is to provide some guidance and clarity to the members so that they can enhance the quality of their medical records and ultimately enhance veterinary medical care.

1. Accurately Document Medical Care provided to the patient.

The primary reason for creating and maintaining a medical record is to facilitate provision of quality care to the patient. The medical record is necessary to document findings, diagnoses and treatments, so that any veterinary professional who subsequently assumes care of a patient may continue to provide quality care.

2. Members have a legislated responsibility to create and maintain medical records.

The Veterinary Medical Act is legislation that regulates the practice of veterinary medicine in Nova Scotia. Section 6(1) and Part IV of the Veterinary Medical Act provides that Council shall determine the standards of facility and service required from each category of veterinary practice. These standards are ratified at an AGM of the Association; they are the Annex to the By Laws. The Practice Standards bylaws stipulate that complete, accurate medical records are maintained and available for review. Maintenance of such records is to be by all veterinary practices and is subject to a Hospital Inspection every 3 years. A Hospital Inspection failed on the basis of inadequate medical records may lead to either non-accreditation of a veterinary practice or an appeal by the individual veterinarian, undertaken by the Accreditation Appeal Committee. The HAC will issue a practice accreditation certificate upon successful completion of a Hospital Inspection.

3. Medical Records facilitate professional communication.

Appropriate, accurate and complete medical records are the cornerstone of effective communication between practitioners, clients, animal health technologists, staff, other veterinarians and ultimately a court of law if required. An appropriate medical record is clear and concise, but contains sufficient detail to demonstrate the rationale for patient assessments and treatments performed as the case progresses. Practices with multiple veterinarians, or that employ a parttime or locum veterinarian, will often have

patients that are provided care by more than one veterinarian. Complete medical records (including history, physical exam findings, tentative and differential diagnoses, treatments, client communication and follow up instructions) will allow subsequent veterinary medical professionals and care givers to provide continuity and a consistent level of care for the patient, as well as improve client compliance and satisfaction. Referral and emergency centers benefit from complete medical records that accompany referrals and in many cases such information may prevent repetitive tests. Complete medical records ultimately provide the framework for ongoing professional relationships and open lines of communication with clients and colleagues.

4. Medical records are the basis for peer review of the adequacy of patient care.

An appropriate and complete medical record is the basis of a veterinarian's defense of their professional conduct. The adage 'if it isn't written down, then it didn't happen' holds true in professional conduct proceedings.

It is important to clearly document the history and presenting complaint, physical examination findings, diagnostic testing results, differential diagnoses, treatments (including dose, route, frequency and duration), prognosis, all client communications and follow up instructions. Any tests, treatments, or referral options that are declined by the client at the time of presentation should be documented in the medical record. Inadequate communication is a common underlying factor in complaint cases. A summary of all client communication methods including in-person, electronic and telephone conversations (with veterinarians, animal health technologists and non-medical staff) must be recorded in the medical record. Failure to do so may lead to miscommunication, misunderstandings, errors and client dissatisfaction - all of which may lead to a complaint against a veterinarian. A properly maintained medical record may be the best defense against a complaint of unprofessional conduct or a civil lawsuit. On the other hand an incomplete or illegible medical record could be interpreted as an indication of professional incompetence and lead one to believe that medical care may have fallen below an acceptable standard. In the event a complaint of unprofessional conduct or unskilled practice is received regarding a member, an investigation into the matter is usually conducted. In all cases the member complained against is required to respond to the letter of complaint and submit relevant documents including medical records that pertain to the complaint. The Complaints Committee is charged with reviewing the complaint which customarily includes medical records. In the event there is an incomplete or no medical record to support the member's actions, a disciplinary finding is likely to result. Complaints Committee members are peers and understand the nuances of veterinary medicine. Veterinarians and animal health technologists recognize adequate care and can readily identify details that don't make sense. Strive to prepare every record as if it will be reviewed by your peers.

5. Complete medical records can help avoid medical errors.

The act of creating a complete medical record causes the practitioner to thoughtfully articulate the reasoning for the treatment or diagnostic plan. The exercise of systematically compiling the medical record will assist in preventing errors or omissions in a complex case.

It is important that all treatments (including dose, route, frequency and duration) are recorded in the medical record. Proper documentation is essential in helping to prevent potentially harmful drug interactions. It is also crucial that adverse side effects are documented in the medical record. If it is recorded that a patient reacted negatively to a medication in the past, repeated use can be avoided.

6. Good medical records lead to good patient care.

The ultimate justification for keeping appropriate medical records is the provision of quality care for the patient. There is ample evidence that good medical records lead to good patient care. Quality medical records and patient care with documentation of informed consent may increase owner compliance and as a result may increase the level of care provided.

7. Good medical records lead to good business

. A persuasive reason to create and maintain excellent medical records is that consistently good medical records correlate with enhanced medical care and this is good for business. An increase in the quality of patient care provided and the resultant increase in owner compliance with diagnostic tests, treatments and follow up examinations and consultations will increase net revenues for a practice. A direct benefit of accurate and timely completion of medical record is the avoidance of omissions and errors with billing.

8. Consistently poor medical records correlate with and actually can result in poor medical care.

The reverse of the above holds true in that incomplete records that lack detail can result in incomplete examinations, erroneous differential diagnoses, missed or incorrect treatments, recurrence of adverse reactions or lack of response to treatments and overall poor patient care.

The Complaints Committee, when reviewing a complaint, will assess the information provided by a medical record. The CC may determine that the medical record is deficient, but the overall medical care of the case is acceptable. Generally, in that case the CC will not refer the matter for a hearing based solely on the medical record deficiencies. However, if the medical record is reflective of a poor quality of medicine practiced, then the CC will proceed accordingly.

The Hospital Accreditation Committee will review the medical records of a practice as part of an Accreditation process. The Inspector will often find medical records that do not meet the standard. This is either a practice issue where all medical records and their management should be addressed or it is an individual member issue that is reflected in a practice inspection. The HA committee may address a deficiency in medical records at the practice level by requesting that corrective actions be taken and follow up Inspections are performed. The HA committee may identify medical records that suggest a deficiency in an individual member's ability to practice veterinary medicine.

9. Collect and Archive Data

An appropriate medical record and management system will provide a concise and logical means of retrieving information in a timely fashion that optimizes patient care. An archive of good medical records will help identify problems and patterns, advance medical knowledge and provide for health and disease surveillance.

10. Benefits the Integrity of the Profession

Maintaining complete and appropriate medical record upholds the integrity of the veterinary profession and distinguishes veterinarians and animal health technologists from those in the public who are encroaching into certain facets of veterinary medicine. This lends credence to our quest to maintain our professional independence and self-regulatory status.

What is Expected from Members?

Following are general statements regarding medical records that succinctly describe what is expected from veterinary health care professional with respect to creation and maintenance of medical records. These expectations are the standard that is established by members of the profession and applied by peer review groups that examine medical records. This is not a standard of perfection. It is established by reasonable veterinarians engaged in the similar practice of veterinary medicine. This standard is consistent with the Annex to the By Laws on medical records and upholds the mandate to protect both the public and the integrity of the veterinary profession.

- A practice must maintain records in such a way that any veterinary health care professional may proceed with continuity of care and treatment of any given case.

- Medical records must be legible on hard copy or maintained electronically with appropriate safeguards to ensure permanency and inability to alter after an entry is made.

- The medical record must demonstrate an appropriate level of medical care is provided to the patient/herd.

- Medical records must ensure sufficient information has been entered into the history and exam portions to justify a tentative diagnosis, problem list and treatment plan.

- Medical records must clearly indicate the author of the medical record, and this must be permanently and uniquely identified in a manner that is understood by anyone examining such records. Each entry in the medical record must be dated and signed, or initialed.

- Medical records must be complete, concise, timely and contemporaneous.

- The medical record is permanent; that is, nothing in the medical record should be erased, covered with correction fluid or in any way obliterated. A single line may be drawn through errors, then date and sign. Addendums and corrections must be clear.

- Medical records may include standard abbreviations that are unambiguous, and medical terminology for improved accuracy and efficiency. A list of all non-standard abbreviations used should be approved and maintained by the hospital.

Food Animal Medical Records

- Food animal medical records must meet the Practice Standards bylaws. It is acknowledged that the structure and content of the food animal medical record will differ from conventional individual animal medical records.

- Food animal medical records may identify groups of animals and/or individual animals. Food animal medical records may document individual animal examinations, procedures and treatments and/or producer consultations, herd health programs, laboratory reports, and animal health protocols.

- Food animal medical records must achieve the same objectives of appropriate creation and maintenance of medical records, which is to document findings, diagnoses and treatments, so that any veterinary professional who subsequently assumes care of a patient may continue to provide quality care.

- The importance an appropriate medical record may be increased when the veterinarian deals with large production facilities or large numbers of animals, as there will be increased liability. Food animal medical records may be subject to increased scrutiny given societal concern of food safety.

What is the Medical Record?

Any document or information relevant to veterinary medical service delivery may be considered part of the medical record. The medical record is often thought of as the paper chart or file and its contents, which is the paper based folder or computer equivalent containing:

x Client information

x Patient information

x Patient history

x Problem List

x Exam Findings

x Results of client consultations and recommendations

x Progress/Medical notes x Surgery/Procedures reports

x Anesthesia monitoring record x Laboratory reports

x Reports from consultants

In fact, the medical record is comprised of all documents and items with information regarding the care of a patient, which not only includes the medical chart, but also includes:

x Health certificates

x Appointment schedules

x Invoices and statements

x Letters, phone logs, records of client communications

x Consent forms

x Discharge Instructions

x Photographs

x Digital and electronic data

x Radiographs and interpretations

x Surgery, Anesthesia and Radiology logs

x Controlled Drug Logs

x Diagnostic Imaging (e.g. Ultrasound/CT images) and interpretations

Medical Record Formats

Records need to be organized, logical and self-explanatory. To accomplish this, a format may be used to provide structure and consistency. This format also allows a ready transfer of files between facilities and practitioners, and helps ensure all relevant information is properly recorded. The use of a standardized medical record format is important in computerized medical records as well. There are several different formats of medical records that may be employed by veterinary medical practitioners. The format of the medical record used in a practice is the discretion of the veterinary medical practitioner. The Problem Oriented Medical Record (POMR) may be regarded as the gold standard for creating and maintaining medical records.

1. Problem Oriented Medical Record (POMR)

A POMR enhances the medical process by improving documentation of the medical logic. It organizes information in the record by problem. Additional diagnostics and treatments are based on refinement of the problems and the diagnosis. This format requires discipline of thought , extra effort and is well suited to complex cases. A pattern or underlying cause may become evident when reviewing the problem list. The problem list is limited to current knowledge and understanding of the case.

POMR includes:

1. Date

2. Presenting complaint by client or alternate caregiver

3. Pertinent history

4. Patient evaluation, exam findings

5. Problem(s) listed

6. Assessment of the complaints, the history and the problems in order to come up with a tentative diagnosis or rule outs

7. Refine the problem list, develop a plan of action, implement the plan and re-evaluate

8. Diagnostic and therapeutic plans

9. Medications prescribed or administered with amount, dosage, frequency and duration as indicated on prescription label.

10. Prognosis in complex or serious cases

2. SOAP Charting

True SOAP charting calls for conducting a Subjective-Objective-Assessment-Plan (SOAP) on each problem identified. This is an excellent teaching tool, however it may be impractical in a veterinary practice setting. A SOAP charting format where the patient rather than each problem is SOAPed, is acceptable.

S.O.A.P

a) Subjective

Data from secondary sources, such as history from the owner This data may not be qualified or verifiable

b) Objective

Data from direct examination and from verifiable sources

c) Assessment

Documentation of the understanding of the data Differential diagnosis list

d) Plan

Treatment, additional diagnostics other decisions

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3. Other Medical Record Formats and Charting Methods

Charting by Exception

This is a medical record format where only the abnormal findings are recorded. Veterinarians may be using charting by exception and not realize it. This format does not hold up well to scrutiny, and does not provide information that something did or did not happen. If no record is made, the assumption is that the condition was monitored and all was normal. Inconsistencies in the medical record will undermine the value of the record.

Charting by exception is not an acceptable standard for medical records.

Source Oriented Medical Record

This is a chronological narrative that is organized only by the source of the information. Source oriented medical records are a fast way to complete handwritten records, but lack a logical structure. Review of source oriented medical records is challenging as information is not systematically documented and is often limited.

The creation of this record does not force a systematic or logic based review of the case, as in a SOAP format. This medical record format generally does not meet the minimum standard and does not stand up to peer review.

Medical Record Content

The following objectives for medical records content and maintenance should be regarded as a minimum standard with a goal of advancement at every opportunity.

The NSVMA requires a medical record system that includes the following:

1. Client Identification

Client, and patient or herd information that is complete, contemporaneous, clear, legible, clinically oriented, and is retrievable on an individual, corporate or herd (flock) basis.

It is advisable to collect as much client contact information as possible. Use of a separate client information sheet and/or a new client registration form is recommended.

Client Information minimum data:

x Name Mailing address, home address if different

x Phone numbers – residence, business and cell phone

x Email address

x Alternate caregivers

If the client will be absent while the patient is being cared for, the name address and phone number of the person to contact in the event decisions regarding patient care are required

2. Patient / Herd / Group Identification

The patient in most cases is easily identified as an individual animal. In Food Animal Practice, the patient may be a herd, a sub-group defined by age or sex, a pen, or entire production facility. The patient is defined to the level that is appropriate.

Patient Information minimum data (where appropriate):

x Name

x I.D. Number (if applicable)

x Species x Breed (where appropriate)

x Age or Date of Birth Age is best indicated by birth date so that age can be calculated at any time.

x Sex/altered Gender should be clearly stated and not inferred from other information. A patient is considered intact unless otherwise noted.

x Weight Current weight and unit of measure (kg or lb) is clearly indicated, or is estimated in the case of large animals.

x Color/markings, including scars, horns, antlers etc.

x Microchip/tattoo if available x Immunization records

x CCIA (Canadian Cattle Identification Association) Tag #

x Pen or Lot # x Other Tag# (Rabies)

x Brands, (freeze or hot iron)

x A clear description of where the animals are normally housed, in addition to where they were treated – street address (legal/land description), directions, GPS, etc.

x Maintain a current list that summarizes the patient or herd problems.

x Maintain a current list of long-term medications/ therapy.

3. Initial Differential Diagnosis

The medical record contains, at minimum, sufficient information entered into the history and exam findings of the medical record to justify a tentative or differential diagnoses, diagnostic plan and treatment plan.

x History of previous and present illness, medical treatments, and responses, vaccination status and parasite control measures.

x A Master Problem List is used to allow rapid access to a patient's history including vaccination, chronic conditions, long term medications and resolved or recurrent problems, routine medical tests, allergy warnings.

x Physical examination findings are recorded in detail.

- Templates may be used – see discussion below.

- Recording "PE-NAF" is not appropriate unless accompanied by a protocol detailing what is included in the abbreviation.

- Observations of groups of animals may be appropriate.

x Each problem is defined at the current level of understanding of the case. The medical record is continually updated as further information is acquired, the understanding is refined and new assessments are made.

x Prognosis is recorded and continually updated as understanding of the case is refined, and the medical record contains a final or up-to-date assessment of the patient. Medical Record Content

4. Progress of Care / Medical Notes

Information is documented and continually updated as the case progresses including:

- Current information is entered contemporaneously (at the time of treatment or service) every time the animal is "seen."

The assessment of the patient is critical; documentation of procedures performed without an assessment of the patient is not a complete medical record.

- 'Seen' in this context refers to any procedure, client communication, assessment, observation, progress note and dispensation of products or pharmaceuticals. All entries must be dated and signed or initialed.

- Updates or changes in therapy / treatment plan, including those recommended over the phone, are all documented.

- Documentation of all phone conversations and electronic communications with the client are essential components of the medical record.
- Documentation of all drugs administered including dose, route, frequency and time of administration.
- Procedures performed with accurate descriptions are recorded in chronological order.
- Documentation of the response to the care or treatment provided.
- A comprehensive view of the patient with good communication of medical logic.

5. Prescribing/Dispensing Activities

- In every instance where a prescription is issued, the medical record should support the existence of a VCPR.
- The medical record must document that medical need is established for the prescribed treatment by the prescribing veterinarian.
- The medical record will document required elements of a prescription including (taken from NSVMA Annex to the By Laws)

x Prescribing practitioner and contact information

x Patient owner/agent

x Date of prescription

x Patient

x Name of drug prescribed and concentration

x Quantity of drug

x Direction for use, including dose, route of administration, frequency and duration

x Substitution (yes/no) of same drug (different brand name)

x Number of refills (repeats, zero if not indicated or refill expiry date)

x DIN

x Expiry date

x Withdrawal time

x Signature of veterinarian or electronic ID of Veterinarian

x Warnings or side effects

- The prescription does not necessarily need to appear in the medical record, as it would appear on a stand alone prescription issued to a client to be filled elsewhere. However, all of the elements of the prescription must be contained in the medical record.

- A prescription may refer to a treatment protocol that exists as part of a herd health program.

- A second copy of the prescription label may be included in the medical record as an efficient way to document this information.

- Medical records will document appropriate dispensing activities including:

x Maintaining an appropriate medical record for each client/patient.

x Maintaining the original prescription that is being filled.

x Indicate when refills are dispensed and a descending balance of refills still available or the expiry date of refills..

- The medical record should document the identity of the compounding pharmacy for any compounded drugs dispensed.

6. Anesthesia

- A record of the anesthetic protocol, including names of drugs, time of administration, dosages and route of administration of induction agent, as well as the concentration of the maintenance agent and any changes made to doses or concentration.

A record of the anesthetic monitoring is required.

- A time based record of the patient's heart rate and respiratory rate is required. Current Annex to the bylaws require a minimum anesthetic monitoring of cardiac and respiratory rates, which may be accomplished by a registered animal health technologist or by electronic monitoring.

- In addition, a record of additional monitoring employed, including capillary refill time, pulse oximetry, blood pressure, end tidal capnography, Doppler, depth of anesthetic, anesthetic risk score, pain score, etc. is recommended. It is suggested that the medical record include all relevant information regarding the anesthetic protocol and the physiologic parameters in the event of an adverse reaction or death.

- If a patient is intubated, the size of the tube, and the presence or absence of a cuff and inflation of the cuff, should be recorded.

7. Surgery

The medical record contains a written record of all surgical procedures including details of approach, findings, type of repair, suture material used, any material implanted, the closure technique used, duration of surgery and identity of surgeon.

- Reference may be made to a specific text, author and page, or standard operating procedures (SOP) manual, for elective and repetitive procedures. (e.g. cruciate surgery; ovariohysterectomy/neuter).

- **Any procedure described in a record as being "routine" shall have a corresponding Standard Operating Procedure (SOP).** For example, "Routine Castration" may be written in a record provided that a complete description of the procedure for each veterinarian on a given species is on file and available for reference.

8. Documentation of Client Communication

The best way to avoid a complaint is through proper communication. The medical record needs to include an account of all communication with the client. Maintaining a record of communication will help to protect the veterinarian and/or animal health technologist in the event of a complaint. The medical record is not a transcription of the conversation but contains enough information to know what was discussed and eventually consented to or declined by the client.

- The medical record will document all client communications by all staff members including , if relevant, unsuccessful attempts to reach client.

- Descriptions of all advice given must be clearly documented, including diagnostic, surgical and treatment options and their implications. Computer software can greatly simplify standard descriptions of procedures, risks, costs, etc.]

- In person and telephone communication with clients or alternate caregivers should be documented in the record by date. Voicemail box phone messages should be documented, including the number called, time and date.

- Include all communication with alternate caregivers.

- The medical record documents discharge instructions, or references the standardized discharge instructions, given to client especially in complex cases.

9. Documentation of Informed Consent

The duty of the healthcare provider is to inform the client of all material facts needed to determine whether or not to consent to treatment. The act of consent when a client has all the facts, is informed consent to treatment.

. x Material facts are set forth in a language that a legally competent person can reasonably be expected to understand.

x The definition of material facts is the facts to which a reasonably prudent person will attach significance, in deciding to agree to a treatment or procedure.

- The requirement is to document, by way of signature, that the informed consent was received for a specific prescribed treatment, procedure or diagnostic test on a case by case basis. This includes:

x Nature and character of the treatment or procedure proposed

x Anticipated results

x Recognized possible alternative forms of treatment and non-treatment

x Possible material risks or complications

x Potential treatment benefits

x Estimated cost of care

x A generic statement on the consent form informing the owner that students may be involved in treatment of their animals, if applicable

- If consent is not documented in writing with a signature, the medical record should reflect that verbal consent has been received and contain an explanation why written consent with signature was not obtained.

- Recommendations and estimates, including those for surgical or medical treatment, diagnostic testing or referral should be documented in a treatment plan.

- Specific treatments, procedures and/or diagnostic tests that are declined by the owner/client, including the reasons given by the client must be documented in the medical record. Details of the ensuing discussion regarding risks of not pursuing treatment are also documented.

- Documentation of specific treatments, procedures or diagnostic tests that are cancelled by the client, including the reasons given for cancellation

- Consider obtaining a written release when client is not following recommendations.

- Euthanasia consent must be documented, including declaration by owner or agent that the animal has not bitten anyone in the previous 10 days.

- Documentation of authority to provide consent that has been granted by the client to an alternate caregiver.

10. Radiographs

- Radiographs, ultrasound files and all digital imaging are considered part of the medical record, and are maintained accordingly.

- The medical record should document the results of any diagnostic imaging investigations or studies, with the specific images available to accompany the medical record if necessary.

- Radiographs should meet the requirements with respect to identification and labeling of radiographs and maintenance of the radiology log.

11. Consultation Reports

The medical record includes:

- Documentation of all consultation(s) with specialists or referral to other veterinarians including names, dates, procedures and recommendations. This information may be provided by referral letter or documented phone conversation.

- Laboratory reports and interpretations, and reports and assessments of diagnostic procedures performed. Includes pathology, radiology, histopathology, cardiograms, etc. as applicable. The veterinary practice entity (VPE) should consider implementing a system that tracks both in-house and send out laboratory samples. This system may document where and when each sample is sent and when the results are received, including the interpretation discussed with the client.

12. Hospitalized Patients / Critical Care Flowsheets

- The medical record will include a 'Hospitalized Patient' medical record which is separate and distinct from 'Out Patient' records that clearly shows:

x Name(s) and dosage of all medications(s) given,

x Time(s) of all medication administered,

x Date and frequency of medication administered,

x Dosage and rate of fluids, total volume of fluids administered,

x Duration of all treatments,

x I.D. of those who administer treatment.

IV Fluids

- Include the type of fluids administered, rate of administration, changes to rate of administration, when the change occurred, all drugs added to the fluids and the total amount of fluids administered.

Medical Record Management

Medical Record Management refers to the clerical creation and maintenance of the medical records as opposed to the information that is contained in them.

1. Entries

- An appropriate medical record shall be legibly written, typed or computer generated. Members must ensure that records can be read and interpreted to avoid misunderstandings which are detrimental to the patient.

- Changes to typewritten or medical records should be designated with a single line through the text or other suitable technique that preserves the original entry. All changes should be dated and initialed.

- An entry is defined as any notation regarding a procedure, client consultation or communication, assessment, observation, progress note, and dispensing products or pharmaceuticals.

- There is a date and signature, or initial for each entry. Time stamp of computer entries is preferred.

- Entries made by non-veterinary medical staff must be initialed by the staff member but do not need to be initialed by a veterinarian or AHT. Alterations to the Medical Record Under no circumstance is any information to be permanently deleted from a medical record. This includes owner information such as owner's name, phone numbers, addresses and all information entered in the medical record. All entries are to be made as of the date and time that the entry is actually made in the medical record. If information becomes available or information is recalled after a period of time, this information is entered, signed and dated as of when the entry is actually made. New information may contradict information that exists in the medical record, but the old information must remain in the record.

2. Templates

- Templates can make record keeping more efficient. A template is a diagram, chart or checklist utilized to document information for quick recording and documentation.

- Lesions may be drawn on a diagram to indicate size and location, e.g. eye, dental and dermatological examinations.

- There is benefit to taking some time to compose an appropriate medical record in terms of giving due thought and consideration to the medical management of the case. In this respect, there is a limitation to the extent that templates should be used.

Members are cautioned regarding the use of a template consisting of check boxes, as this may place the member at greater risk in a civil court or professional misconduct hearing if no notes on the actual finding accompany the template.

- Members should not use default normal descriptions of body systems when using a computerized medical records program.

The medical record should not have a detailed description of a body system if the system was not examined, or if the description does not accurately reflect what is found.

- The medical record entry should have an accurate description of the actual findings of the system or body part examined.

3. Standard Operating Procedures (SOP) / Protocols

A medical record can make reference to a standard operating procedure (SOP). An SOP is a detailed description of a 'routine' procedure including a surgery and outlines in detail a particular way that the procedure, assessment or surgery is performed by a specific practitioner in the majority of cases.

- All current and archived SOPs are maintained in the VPE and accessible to and referenced by all staff.
- All SOPs are dated with a commencement and, if applicable, a termination date.
- Any variances from the SOP are recorded in the medical record with enough detail to explain the variance

4. Abbreviations

- Standard abbreviations and accepted medical terminology are used in medical records.
- A complete list of VPE approved abbreviations is maintained and available for reference.

5. Storage of Medical Records

- All components of the medical records are kept in a systematic matter. A systematic approach to medical record storage can help ensure timely retrieval and that no relevant information is overlooked or misplaced.

- The VPE will have a consistent and dependable method of client and patient or herd identification that permits dependable identification and retrieval of medical records, for example by colored file tabs or identification numbers for each patient.

- All components of the medical record are linked by a unique identifier relating to the patient. When files or reports are maintained in different locations (within the VPE or between locations), there exists a cross indexing system which allows for prompt retrieval and intra or inter-facility use.

- Medical records are kept current, and must be completed in a timely manner.

- A quality assurance system exists that ensures records are not filed before medical records are completed and signed.

6. Maintenance and Retention of Medical Records

Every VPE has an obligation to retain medical records.

- Dead animal files are maintained for 7 years.

- Records (including radiographs) are maintained for 7 years after the last patient visit.

- The client owns the information in the medical record and must be granted access to that information upon request. This is best accomplished by providing a copy of the medical record.

- Medical records are available to the public during regular business hours.

- Clients may request that the medical record be transferred to another veterinary practice entity. The medical record must be transferred in it's entirety to the requesting veterinarian or veterinary practice upon receipt of the request and client consent.

- A VPE may charge a reasonable fee for copying or faxing a medical record.

Large Animal / Food Animal Specific

- Records are created and maintained of all visits to production sites.

- If appropriate, A herd consultation report is provided to the client following visitation to the production site.

Referral Emergency Records

A VPE that provides referral emergency treatment must provide discharge forms in triplicate - one copy each for:

x the medical record

x client

x primary Care Veterinarian (mailed if necessary)

7. Disposition of Medical Records Upon Ceasing Practice

Any member who ceases to practice, for any reason, or upon death, their Executor shall:

a) Retain all medical records for 7 years; or

b) Transfer all medical records to a member who assumes responsibility for the practice, including the medical records; or

c) Transfer all medical records to:

i. Another member practicing in that locality, or

ii. A secure storage area with a person designated to allow all veterinarians reasonable access to the records; and

d) Publish a notice in the local or area newspaper indicating where the records can be accessed.

Log Books

The following logs are maintained in hard copy or are immediately retrievable from a computer system, and contain the identified information. These log books are totaled or reconciled by month and year. There must be a date and signature or initial for each entry. A time stamp is preferred.

1. Narcotic, Controlled and Targeted drugs logs:

x Use Log – an entry is made for any and all usage of a controlled substance including dispensing, use in clinic or compounded in clinic

. - Product, strength and quantity of drug used or dispensed

- Client/Patient the drug was dispensed for

- how and when drug is used or dispensed

- declining drug balance

x Separate narcotic, controlled and targeted drug log is maintained for each narcotic, controlled or targeted substance, including products compounded in a VPE, e.g. premedication mixes of BAG.

x Narcotic, controlled and targeted drug log is reconciled weekly and monthly.

x Narcotics log is signed or initialed by the prescribing or dispensing veterinarian.

2. Radiology Log

Members must include the following information in the Radiology Log.

x owner and patient identification x exposure technique (kVp, mA, time)

x body part thickness

x includes dental images

x. Information may be tracked electronically for digital systems.

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3. Mortality Log

The Mortality Log is used to record all unexpected or unanticipated deaths occurring in the Facility. The Mortality Log must include:

X Date of Death

X Client/Patient identification

X Procedure or detail history of the death

X Request and for outside autopsy and agreement (or not)

X Results of outside autopsy

Computerized Log Books/Medical Records

Many Nova Scotia veterinary practices create and maintain computerized medical records. The Hospital Accreditation Committee has been reviewing the requirements for hard copies of individual logs.

- Narcotics Log: The Narcotics Control Branch (Federal Government) requests that a hard copy be maintained for a minimum of two years, after which time a computerized (disc or hard drive) log may be kept. Computerized logs must be easily retrievable and appropriately backed up to ensure against information loss.

- Radiology Log: may be kept entirely on computer if they are easily retrievable and appropriately backed up to ensure against information loss.

- Computerized medical records shall be in compliance with NSVMA Annex to the Bylaws

- Computerized medical records must meet the same criteria as non-computerized records as stated in the NSVMA bylaws.

- The records may be created and maintained in an electronic computer system providing:

x the system provides a visual display of recorded information;

x the system is capable of printing the information promptly;

x the system retrieves information by owner and/or patient name;

x the system is password protected or otherwise provides reasonable protection against unauthorized access. Passwords are made available to authorized personnel to provide for continuity of access;

x the system backs up files and allows recovery of backed up files or otherwise protects against loss of, damage to, and unauthorized access to information;

x the system is capable of displaying the recorded information of each patient in chronological order; x the system records the date and time for each entry of information for each patient;

x the system indicates any changes in recorded information as changed, and preserves the original content of the recorded information when changed or updated.

Limitations of Paper Records

Conventional paper records or charts are ubiquitous in veterinary profession. Paper records comply with current NSVMA bylaws, though there are some limitations to the paper medical records. The conventional file system is a single use, at a single location view of the data in the medical record.

- The paper record entries are generally verbose open ended narratives. Finding and comparing data is difficult.
- Drawing a conclusion that the data does not exist requires examination of the entire record.
- Finding inconsistencies requires keeping the entire record in memory.

Privacy of Information

Provincial and Federal Legislation apply regarding the collection of personal information.

The Privacy Act covers the personal information handling practices of the federal government. The Personal Information Protection and Electronic Documents Act or PIPEDA covers the provincial privacy laws for the private sector in Nova Scotia.

Personal information is described as including any factual or subjective information, recorded or not, about an identifiable individual. This information can include information such as name, gender, ethnic origin, blood type, family status, health history, conditions, views, opinions, comments, disciplinary actions, employee information, etc.

Personal information contained in medical records and veterinary practices must comply with PIPEDA.

Each VPE should implement a privacy policy and procedure system. This provides you with the opportunity to review and revise your organization's practices should there be the need. Documentation and exceptional medical record management are key and few adjustments should need to be made. Implement a privacy policy that works for your particular practice or situation. There are some simple steps to help get you started. They are summarized as:

1) Appoint an Information Officer to oversee and implement the system.
2) Review your policies and practices for collecting, using, and disclosing personal information.
3) Implement safeguards to protect personal information. Confidentiality is a must.
4) Ensure individuals have the right to access and correct any personal information that is incorrect.
5) Implement a retention and destruction policy.
6) Get consent from your clients for the collection, use and disclosure of private information.

The information collected regarding a client and the patient belongs to the client. They have the right to access that information and view or take a copy of the medical record.

The practice is required to maintain the medical record in a secure fashion and safeguard from unauthorized viewing or access.

Medical Records Officer

It can be beneficial for a medical record management system to be properly documented and maintained by a designated individual.

- Veterinary practices should designate a “Medical Records Officer” within the practice who is responsible for implementing the policy

. • Consider written protocols for the practice that details the medical record management