

SELF-ASSESSMENT of MEDICAL RECORDS in COMPANION ANIMAL PRACTICES

A tool to help you and/or your team to evaluate your *own* record-keeping practices

INTRODUCTION:

This tool is provided for members to use in order to assess the quality of their own medical records. Using this tool would be helpful before your facility undergoes an Accreditation Inspection and/or before you volunteer to submit records for a Peer Review. The Self-Assessment can be completed by an individual veterinarian or by the entire veterinary team as a group exercise.

This self-review approach is as useful for records that are computerized as for paper-based systems. Remember that all legislated requirements and generally accepted standards of practice must be present in computerized records, too—including all client instructions, communications, logs, 24-hour care sheet, lab results and test interpretations.

The Self-Assessment forms are based on the minimum legislated requirements for medical record keeping, as stipulated in Regulation 1093 (section 22) under the *Veterinarians Act* and in the *Minimum Standards for Veterinary Facilities in Ontario*, and also on College publications that set out generally accepted standards of practice—especially the CVO Guidelines on Medical Records for Companion Animal. (<http://www.cvo.org/uploadattachments/CAMedicalrecords.pdf>). You may wish to review the Guideline document before you begin the Self-Assessment.

INSTRUCTIONS:

1. **Use one form per case** for which you are reviewing your records. The case types that you might consider include: Wellness/Vaccine; Elective Surgery (ex: ovario-hysterectomy, orchectomy, onychectomy, dental prophylaxis); Other Surgery; Acute Medical; Chronic Medical; Referral Case.
2. **Answer Y** for “Yes” or **N** for “No” in the columns for each component of the medical record that you are reviewing. If not applicable, answer “NA.”
3. **Review the number of N’s** you have recorded, and identify consequent concerns you have about any element of the record by making a comment and/or placing a check mark in the final column to indicate “this aspect/component could be improved.”
4. **Develop a plan** as to how you will improve the identified elements of your records (for example: if you need to improve documentation of patient weights, your plan might be to implement a Cumulative Patient Profile form or a process at Reception whereby all patients are weighed when clients check in with your staff).
5. **Give yourself credit.** The Self-Assessment exercise “counts” as Continuing Professional Development (CPD) hours for veterinarians in Ontario, so record the time taken to conduct this self-assessment on your CPD Activity Log and include it on your CPD Summary Sheet at the end of the current CPD Cycle (Nov 1-Oct 31).
6. **Tell us what you think!** Was this exercise useful? Could the forms be improved? Send an email to ksmythe@cvo.org with your thoughts and suggestions.

SELF-ASSESSMENT of COMPANION ANIMAL MEDICAL RECORDS

Case Type: _____

File Identifier: _____

Date of Specific Visit(s) under Review: _____

Name of Individual/Team Completing this Self-Assessment: _____

Date of Self-Assessment: _____

COMPONENT	Present? Y / N or NA	Complete? Y / N or NA	Easy to find? Y / N or NA	Comments? Could be Improved <input checked="" type="checkbox"/>
Identification				
1. Patient a) Name/Species/Date of Birth/Sex/Breed/Colour is on file b) patient name or ID # is on every page of the record				<input type="checkbox"/>
2. Client(s) a) Name/Address/Phone/Alternate methods of contact for each b) Name or ID# is clearly marked on each page of the file				<input type="checkbox"/>
3. Emergency Contact when animal is confined with member. Name, address, and phone numbers of an emergency contact authorized to act as an agent for the owner is on file.				<input type="checkbox"/>
Dates				
1. Each entry in the medical record is dated, regardless of whether or not the animal is literally seen				<input type="checkbox"/>
History				
1. Description of presenting complaint is captured				<input type="checkbox"/>
2. Description of overall health is noted				<input type="checkbox"/>
3. Cumulative Patient Profile or Master Problem List is included <u>and</u> updated				<input type="checkbox"/>
4. Vaccination History (a) vaccination type (killed, live, lot, serial#, manufacturer, diseases)				<input type="checkbox"/>
(b) Site and Route of vaccination (in record or via protocol in the clinic)				<input type="checkbox"/>
Assessment				
1. Physical Exam Findings (a) Written out, or via check-list template, or contained in protocol on site (<u>more than</u> NSF or NAF is recorded)				<input type="checkbox"/>
(b) Animal's weight is recorded at each visit				<input type="checkbox"/>

COMPONENT	Present? Y / N or NA	Complete? Y / N or NA	Easy to find? Y / N or NA	Comments? Could be Improved <input checked="" type="checkbox"/>
(c) Differential diagnoses are listed				<input type="checkbox"/>
(d) Provisional/final diagnosis included				<input type="checkbox"/>
(e) Diagnostics: Record of diagnostic plans to clarify assessment; results retained in record; results interpreted and interpretation noted				<input type="checkbox"/>
Treatment Plans				
1. Plan of action, including follow-up plans, recorded				<input type="checkbox"/>
2. Drug treatments: Name of drug/strength/dose/quantity/directions for use; repeats/warnings are all included				<input type="checkbox"/>
3. Detailed surgical notes or protocols are present				<input type="checkbox"/>
4. Anesthetic / analgesic notes or monitoring forms are present				<input type="checkbox"/>
5. In-hospital monitoring notes are present				<input type="checkbox"/>
6. Fluid therapy: type/rate/route/amount received/medications added are detailed				<input type="checkbox"/>
Client Communications and Professional Advice				
1. There are signed consent forms for procedures (not just surgical consent forms).				<input type="checkbox"/>
2. Cost estimates are used for all diagnostic tests or procedures (not just surgical procedures).				<input type="checkbox"/>
3. There is an indication that discussion took place and informed consent was obtained				<input type="checkbox"/>
4. Declined diagnostic investigations and treatment plans are recorded				<input type="checkbox"/>
5. Ongoing communications documented for hospitalized patients				<input type="checkbox"/>
6. Homecare or Discharge Instructions were provided and documented in the record (copy in the record or reference to a template).				<input type="checkbox"/>
7. Client Education information/forms were provided and are Documented (either by copy or reference to a template).				<input type="checkbox"/>
8. Personal and telephone / FAX / email communication with /messages for clients are included and documented by date.				<input type="checkbox"/>
9. Referral letters/ reports are included in the record, and follow-up communication with owner is documented				<input type="checkbox"/>
Reports				
A copy of all reports prepared with regard to the patient (vaccination certificates, referral letters, etc)				<input type="checkbox"/>

COMPONENT	Present? Y / N or NA	Complete? Y / N or NA	Easy to find? Y / N or NA	Comments? Could be Improved <input checked="" type="checkbox"/>
Fees and Charges				
Fees and charges are noted in file, with those for drugs listed separately from those for advice or other services.				<input type="checkbox"/>
Radiographs				
Radiographs are permanently identified with: name of veterinarian or facility; patient ID; date; indication of L or R side of the animal; indication of time for sequential studies				<input type="checkbox"/>
Logs				
Appropriate logs/registers are maintained for: anesthetic/surgery/radiology/controlled drugs/ketamine/targeted drugs				<input type="checkbox"/>

RECORDS MANAGEMENT	Y	N	N/A	Comments? Could be improved <input checked="" type="checkbox"/>
Medical records are legible.				<input type="checkbox"/>
Records are kept in a systematic manner.				<input type="checkbox"/>
Changes in records are clearly indicated as changes.				<input type="checkbox"/>
Entries in the record are initialed.				<input type="checkbox"/>
Records are retained for 5 years after the date of the last entry.				<input type="checkbox"/>
A Records Security protocol is in place and staff is trained.				<input type="checkbox"/>
A policy on Privacy/Personal Information Protection is visible to clients and understood by staff.				<input type="checkbox"/>
A procedure is in place for the transfer of medical information.				<input type="checkbox"/>

ASSESSMENT OUTCOME

As a result of this exercise, I / we have discovered or decided the following:

Areas for improvement in record keeping	Plans to address these areas
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.