Peer Review of Medical Records Self-Assessment Tool

Companion Animal

Table of Contents

HOW TO USE THE SELF-ASSESSMENT TOOL 2
SECTION 1: PATIENT IDENTIFICATION 3
SECTION 2: CLIENT AND EMERGENCY CONTACT INFORMATION 3
SECTION 3: DATE 3
SECTION 4: HISTORY – SUBJECTIVE DATA 4
SECTION 5: ASSESSMENTS – OBJECTIVE DATA 4
SECTION 6: ASSESSMENT – DIAGNOSIS 4
SECTION 7: MEDICAL TREATMENT 5
SECTION 8: SURGICAL TREATMENT AND ANESTHETIC NOTES/PROTOCOLS 5
SECTION 9: INFORMED CLIENT CONSENT 6
SECTION 10: ADVICE AND COMMUNICATION 6
SECTION 11: REPORTS, INVOICES 6
SECTION 12: RADIOGRAPHIC LOGS 7
SECTION 13: CONTROLLED DRUG LOGS 7
SECTION 14: ANESTHETIC AND SURGICAL LOGS 7
SECTION 15: GENERAL REQUIREMENTS 8
SECTION 16: ANNUAL RISK ISSUE: WRITTEN PRESCRIPTIONS 8
HOW TO CALCULATE AN OVERALL SCORE 9

How to Use the Self-Assessment Tool

This self-assessment tool uses a check-list format to assess your medical record records. The record content in the check-list matches the Peer Review of Medical Records (PRMR) Assessment Questions so that you will be checking the content that a peer reviewer is assessing in the PRMR process. This tool can help you to understand the expectations for record-keeping and to determine areas of your records requiring improvement.

One strategy to consider in self-evaluating your records is to choose a sample of records that reflect the scope of your practice. For example, if you work at a hospital that offers a full scope of services to the public, choose a surgical case, an acute medical case, a chronic medical case, and a routine wellness case. Make sure that you compile all relevant components for that case. Please refer to the **Information Package** for PRMR on the College's website for information on what components are needed depending on the case type. For example, a surgical case would also include surgical and anesthetic logs and controlled drug logs.

For each case record, use this check-list to indicate whether the record content listed is present (check Yes), not present (check No), or not applicable to this case type (check N/A).

When considering whether something is not applicable, consider the following example. A routine wellness case where the main reason for the visit is a consultation for administering vaccines would not have surgical treatment. Therefore, in Section 8: Surgical Treatment and Anesthetic Notes/Protocols, the record content would not be applicable to that case and you would check N/A for that content.

After filling out the tool for each case, **review what is going well and areas that require attention in your record-keeping. Implement changes in your record-keeping where needed to ensure that your records are meeting expectations.**

For resources on record-keeping expectations, you may wish to review the **College's Professional Practice Standard and Guide on Medical Records.** You can also access the College's **online learning module series: Foundations for Medical Record Keeping.**

Section 1: Patient Identification

RECORD CONTENT	Yes	No	N/A
1. Patient identifier (e.g. name, ID number, tattoo, microchip) specification			
2. Type of Species			
3. Type of Breed			
4. Sex of the animal			
5. If the patient is neutered/spayed			
6. Date of Birth or Age			
7. Colour and markings			
Total			

Section 2: Client and Emergency Contact Information

RECORD CONTENT	Yes	No	N/A
1. Client’s Name(s)			
2. Client’s Address(es)			
3. Client’s telephone number			
4. Client's alternative method of contact (e.g. email, cell phone number)			
5. Name of emergency contact person (other than the owner)			
6. Contact information for emergency contact person (other than the owner)			
7. Authority for financial and care decisions in emergency situations			
Total			

Section 3: Date

RECORD CONTENT	Yes	No	N/A
1. All entries are dated			
2. Consistent date format used throughout.			
Total			

Section 4: History – Subjective Data

RECORD CONTENT	Yes	No	N/A
1. Statement of presenting complaint or reason for visit			
2. Description of presenting complaint			
3. General/body systems review (in progress notes, template, or protocol)			
4. Vaccine record (in progress notes, cumulative patient profile, or summary view)			
Total			

Section 5: Assessments – Objective Data

RECORD CONTENT	Yes	No	N/A
1. Weight recorded at each visit			
2. The unit of measurement of the weight is clearly indicated			
3. Physical examination details (in progress notes, template, or protocol)			
4. Presence of diagnostic tests and laboratory results			
Total			

Section 6: Assessment – Diagnosis

RECORD CONTENT	Yes	No	N/A
1. Problem list			
2. Differential diagnoses			
3.Tentative or final diagnoses			
4. Diagnostic test result interpretation is present.			
Total			

Section 7: Medical Treatment			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Medical treatments and procedures are described in appropriate detail.			
2. Hospitalized patient care and monitoring is recorded in hospital flow sheet or detailed in progress notes.			
3. Time is noted for hospitalized care.			
4. (a) Type of fluid therapy			
4. (b) Route of fluid therapy			
4. (c) Rate of fluid therapy			
4. (d) Total amount of fluid therapy			
5. (a) Names and strengths of drugs administered			
5. (b) Doses of drugs administered			
5. (c) Routes of drugs administered			
6. (a) Types of vaccines administered			
6. (b) Sites of vaccines administered			
6. (c) Routes of vaccines administered			
6. (d) Details (manufacturer and serial numbers) of vaccines administered			
7. (a) Names and strengths of drugs dispensed or prescribed			
7. (b) Quantities of drugs dispensed or prescribed			
7. (c) Doses of drugs dispensed or prescribed			
7. (d) Directions for use of drugs dispensed or prescribed including route			
Total			

Section 8: Surgical Treatment and Anesthetic Notes/Protocols			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. (a) Surgical treatment details are recorded (in progress notes or a protocol) and include the approach used, findings and type of repair.			
1. (b) The suture materials used and the closing technique			
2. The anesthetic monitoring notes contain the name, strength, dose, and route of the pre-anesthetic agent.			
3. The anesthetic monitoring notes contain the name, strength, dose, and route of the induction agent.			
4. The anesthetic monitoring notes contain the name, dose or concentration, and delivery method of the maintenance agent.			
5. The anesthetic notes include the ET size and whether it is cuffed or non-cuffed (where applicable).			

6. The anesthetic notes contain a time-based record of the heart rate, respirations, and perfusion/blood pressure at minimum.			
7. The anesthetic monitoring notes contain a record of when the anesthetic started and finished.			
Total			

Section 9: Informed Client Consent

RECORD CONTENT	Yes	No	N/A
1. Written consent for surgery			
2. Documentation of consent (written or verbal) for non-surgical procedures			
3. Refusal of treatment documented			
4. Estimates for procedures are documented (on consent form, in progress notes, or itemized estimate).			
Total			

Section 10: Advice and Communication

RECORD CONTENT	Yes	No	N/A
1. Description of the advice given			
2. To whom the advice was provided (e.g. owner, other)			
3. Mode of communication (e.g. in-person, phone, email, voicemail)			
Total			

Section 11: Reports, Invoices

RECORD CONTENT	Yes	No	N/A
1. Copies of any non-diagnostic/ non-laboratory reports			
2. Invoices note the itemized list of drugs and services provided.			
3. The invoices reflect the recommendation(s) and/or care or services provided.			
Total			

Section 12: Radiographic Logs			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. The date each radiograph is taken			
2. The identification of the animal and the client			
3. The area of the body exposed to the radiograph			
4. The number of radiographic views			
5. Radiographic setting			
Total			

Section 13: Controlled Drug Logs			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. The date the controlled substance is dispensed or administered			
2. The name and address of the client			
3. The name, strength and quantity of the controlled substance dispensed or administered			
4. The quantity of the controlled substance remaining in the member's inventory after the controlled substance is dispensed or administered			
Total			

Section 14: Anesthetic and Surgical Logs			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. The date of induction/procedure			
2. The name of the client			
3. The breed, age, sex, weight and identity of the anesthetized animal/animals upon which the procedure is performed			
4. The pre-anesthetic condition/pre-operative condition of the animal			
5. The name, dose, and route of administration of any pre-anesthetic agents			
6. The name, dose, and route of administration of the anesthetic agents			
7. Nature of the procedures performed under the anesthetic			
8. Post-anesthetic condition/post-operative condition of the animal			
9. The name of the surgeon			
10. The length of the time of the surgery/procedure			
Total			

Section 15: General Requirements			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Master problem list or cumulative patient profile is maintained and up-to-date.			
2. The components of the record are organized in a logical manner and are easy to find (e.g. uses SOAP or DAP).			
3. The record content is legible.			
4. Patient and client identifications are clearly marked on each page of the file.			
5. Each entry is identified by a signature or initials.			
6. Changes are noted so the original entry is still legible (even if records are electronic).			
7. Abbreviation or acronyms used are commonly known or explained (e.g. abbreviation list).			
Total			

Section 16: Annual Risk Issue: Written Prescriptions			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Veterinarian's name and address			
2. Date the prescription is issued (includes day/month/year)			
3. Client's name and address			
4. Identity of the animal for which the drug is prescribed			
5. Weight of the animal if dispensing veterinarian is different than prescribing veterinarian			
6. Name, strength and quantity of drug			
7. Prescribed directions for use (dose, route of administration, frequency, duration)			
8. Number of refills permitted if any			
9. Veterinarian's license number and signature			

How to Calculate an Overall Score

1. Put the total number of “Yes” and “No” marked in each section in the chart below. (Note that Section 16 is not included in the overall score.)
2. In the last column, add the numbers in the “Yes” and “No” columns to calculate the total number of times there was an opportunity for a requirement to be met in that section.
3. At the bottom, tally the grand total numbers in each column.
4. Divide the grand total in the “Yes” column by the grand total in the last column.
5. This provides you with a percentage that is the Overall Score. To be successful in meeting the requirements, the goal is to achieve a score > 83%.

SECTIONS	Yes	No	Total of Yes + No
Section 1			
Section 2			
Section 3			
Section 4			
Section 5			
Section 6			
Section 7			
Section 8			
Section 9			
Section 10			
Section 11			
Section 12			
Section 13			
Section 14			
Section 15			
Grand Total			

Overall Score = (Grand Total “Yes”/ Grand Total of Last Column) x 100		
Grand Total “Yes”	**Grand Total of Yes + No**	**Overall Score**