Peer Review of Medical Records Assessment Questions

THE COLLEGE OF VETERINARIANS OF ONTARIO

Companion Animal

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Section 1: Patient Identification

Statement
The patient is clearly identified to prevent gaps in continuity of care.

Legislation
22(1)The records required in respect of each companion animal shall contain the following information:
1. Animal identification including species, breed, colour, age, sex.

Professional Practice Standards and College Policy
A patient is considered intact unless otherwise noted.
Age (recorded as date of birth).[1]

RECORD CONTENT
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

[1] Guide: Medical Records, page 8

Section 2: Client and Emergency Contact Information

Statement
The client contact information is clearly identified to ensure responsibility for care is clear. Emergency contact information is documented in the client record; and authorization is clearly noted for financial and care decision in the absence of the client.

Legislation
22(1)The records required in respect of each companion animal shall contain the following information:
2. The client's name, address and telephone numbers.
3. If the client is likely to be absent from his or her address while the animal is confined with the member, the name, address and telephone number of a person to be contacted in case of an emergency.

Professional Practice Standards and College Policy
It is advisable to secure as much client contact information as possible.
Client should also provide the name and contact information for individuals authorized to make decisions when an owner is not available including in emergency situations.[2]

RECORD CONTENT
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

[2] Guide: Medical Records, page 8

Section 3: Date

Statement
Content of the record accurately reflects when the service/treatment was provided.

Legislation
22(1)The records required in respect of each companion animal shall contain the following information:
4. Date of each time that the member sees the animal.

Professional Practice Standards and College Policy
N/A

RECORD CONTENT

1. All entries are dated

2. Consistent date format used throughout.

Section 4: History – Subjective Data

Statement
The history is clearly, completely, and adequately documented to support continuity of veterinary care.

Legislation
22(1) The records required in respect of each companion animal shall contain the following information:
5. A history of the animal's health, including a record of vaccinations.

Professional Practice Standards and College Policy
The history should document the presenting complaint and recent health status of the animal(s).[3]
A vaccination record is an important component of the history.[4]

RECORD CONTENT
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)

[3] Guide: Medical Records, page 2
[4] Guide: Medical Records, page 2

Section 5: Assessments – Objective Data

Statement
The patient's weight is recorded at each visit for determining any trend, issues of concern.
Objective data should be noted in the record including the findings on the examination of the patient and the diagnostic and laboratory tests results.

Legislation
22(1)The records required in respect of each companion animal shall contain the following information:
6. The animal's current weight.
7. Particulars of each assessment, including physical examination data and any diagnostic investigations, performed or ordered by the member and the results of each assessment.

Professional Practice Standards and College Policy
The veterinarian should indicate that all body systems are examined.[5]

RECORD CONTENT
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

[5] Guide: Medical Records, page 2.

Section 6: Assessment – Diagnosis

Statement
The records clearly articulate the differential and tentative/final diagnosis allowing a colleague to reach similar conclusions based on the information documented.

Legislation
22(1)The records required in respect of each companion animal shall contain the following information:
7. Particulars of each assessment, including physical examination data and any diagnostic investigations, performed or ordered by the member and the results of each assessment.
11. A final assessment of the animal.

Professional Practice Standards and College Policy
Information and reasoning to arrive at a diagnosis should be recorded. Regular updates on differential diagnosis should be recorded until a final diagnosis is determined.[6]
Records should provide sufficient information to document that the veterinarian has reviewed and interpreted data from diagnostic tests to confirm a diagnosis.[7]
It is not sufficient to include only reports of test results. The record should reflect the veterinarian's interpretation of the test results.[8]

RECORD CONTENT
1. Problem list
2. Differential diagnoses
3.Tentative or final diagnoses
4. Diagnostic test result interpretation is present.

[6] Guide: Medical Records, page 2
[7] Guide: Medical Records, page 2
[8] Guide: Medical Records, page 2

Section 7: Medical Treatment

Statement
Detailed information is documented for all drugs prescribed, dispensed and/or administered.

Legislation
22(1)The records required in respect of each companion animal shall contain the following information:
9. All medical or surgical treatments and procedures used, dispensed, prescribed or performed by or at the direction of the member, including the name, strength, dose and quantity of any drugs.

27(1) A member who dispenses a drug shall make a written record showing,

(a) the name and address of the owner of the animal or group of animals for which the drug is prescribed;
(b) the name, strength and quantity of the prescribed drug;
(c) the directions for use if they are different than the directions for use on the manufacturer's label or if the manufacturer's label does not specify the directions for use;
(d) the date on which the drug is dispensed; and
(e) the price charged.

Professional Practice Standards and College Policy
N/A

RECORD CONTENT
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

Section 8: Surgical Treatment and Anesthetic Notes/Protocols

Statement
The surgical notes detail the treatment and care provided during surgery and post-operatively.

Legislation
22(1)The records required in respect of each companion animal shall contain the following information:
9. All medical or surgical treatments and procedures used, dispensed, prescribed or performed by or at the direction of the member, including the name, strength, dose and quantity of any drug.

The *Minimum Standards for Veterinary Facilities in Ontario* requires veterinarians in companion animal facilities to maintain an anesthetic monitoring chart.

Professional Practice Standards and College Policy
N/A

RECORD CONTENT
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, dose, and route of the pre-anesthetic agent.
3. The anesthetic monitoring notes contain the name, 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.

Section 9: Informed Client Consent

Statement
Informed client consent obtained is recorded, dated and maintained as part of the client record.

Legislation
22(1)The records required in respect of each companion animal shall contain the following information:
9.1 One of the following with respect to each surgical treatment:

i. The written consent to the surgical treatment signed by or on behalf of the owner of the animal.
ii. A note that the owner of the animal or a person on the owner's behalf consented orally to the surgical treatment, and the reason why the consent was not in writing.
iii. A note that neither the owner of the animal nor anyone on the owner's behalf was available to consent to the surgical treatment, and the reason why, in the member's opinion, it was medically advisable to conduct the surgical treatment.

Professional Practice Standards and College Policy
Under Regulation 1093, companion animal veterinarians are required to obtain written consent for surgical procedures.[9]
In general, written consent should be obtained when a procedure or treatment presents significant risks. Complex cases and higher risk procedures warrant greater detail in documenting the process of obtaining informed client consent.[10]
A veterinarian should document that consent was obtained, whether it was written or verbal, and if not in writing, whether it was implied or explicit.[11]
A veterinarian should fully explain to the client the consequences of taking no action and document, in writing, the fact that this information was provided, as well as the client's refusal.[12]
Discussions to obtain consent and, in situations when treatment is refused, a notation of the rational for refusing the recommendation.[13]
It is advisable to provide a range of total costs that might be involved in a particular procedure or treatment. Written cost estimates assist in ensuring that the client understand the financial implications of the proposed intervention.[14]

RECORD CONTENT
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).

[9] Guide: Informed Client Consent, page 3.
[10] Guide: Informed Client Consent, page 3.
[11] Guide: Informed Client Consent, page 3.
[12] Guide: Informed Client Consent, page 2.
[13] Guide: Medical Records, page 2.
[14] Guide: Informed Client Consent, page 2.

Section 10: Advice and Communication

Statement
The record notes all professional advice given and indicates when and to whom such advice was provided.

Legislation
22(1)The records required in respect of each companion animal shall contain the following information:
8. A note of any professional advice given regarding the animal and an indication of when and to whom such advice was given if other than to the client.

Professional Practice Standards and College Policy
Records should document advice provided including diagnoses, treatment plans, required tests and interpretation of results, referrals, and discharge directions.[15]
A complete and accurate record includes documentation of all communications with the client. This includes face to face, telephone, electronic and other mechanisms to communicate with owners and/or alternate decision makers.[16]

RECORD CONTENT
1. Description of the advice given
2. To whom the advice was provided (e.g. owner, other)
3. Mode of communication (e.g. phone, email, voicemail)

[15] Guide: Medical Records, page 2.
[16] Guide: Medical Records, page 2.

Section 11: Reports, Invoices

Statement
All relevant reports, invoices and other documents related to patient care is maintained as part of the health record.
The records reflect the fees charged to the client including an itemized break-down of fees for drugs.

Legislation
22(1)The records required in respect of each companion animal shall contain the following information:
10. A copy of all reports prepared by the member in respect of the animal.

12. The fees and charges, showing separately those for drugs and those for advice or other services

Professional Practice Standards and College Policy
A medical record includes… health certificates, insurance applications, certificates of rabies vaccination, referral letters to and from others and export documents.[17]
Invoices… are included in medical records to demonstrate the advice and services provided. Fees for drugs and vaccines are itemized separately. Dispensing fees may be incorporated into drug costs or itemized separately.[18]
Fees should be easily cross referenced with all treatments and procedures described in the medical record.[19]

RECORD CONTENT

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.

[17] Guide: Medical Records, page 3.
[18] Guide: Medical Records, page 3.
[19] Guide: Medical Records, page 3.

Section 12: Radiographic Logs

Statement
A radiographic log is complete and provides required details.

Legislation
The *Minimum Standards for Veterinary Facilities in Ontario* requires veterinarians in companion animal facilities to maintain logs for… radiographs.[20]

Professional Practice Standards and College Policy
The radiology must include: the date when the radiograph is taken, animal and client identification, the area of the body exposed to the radiograph, the number of views, and the radiographic setting.[21]

RECORD CONTENT
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

[20] Guide: Medical Records, page 3.
[21] Guide: Medical Records, page 9.

Section 13: Controlled Drug Logs

Statement
A member who dispenses controlled substance shall keep a controlled substance register to ensure proper tracking.

Legislation
28. (1) A member who dispenses a controlled substance shall keep a controlled substance register and shall enter the following information in it,
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.

Professional Practice Standards and College Policy
A controlled dug log must indicate the date that a controlled substance is dispensed or administered, the name and address of the client, the name, strength, and quantity of the controlled substance dispensed or administered, and the quantity of the controlled substance remaining in the member's inventory after the controlled substance is dispensed or administered.[22]

RECORD CONTENT
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

[22] Guide: Medical Records, page 3.

Section 14: Anesthetic and Surgical Logs

Statement
It is an expectation that surgical and anesthetic logs are complete.

Legislation
The *Minimum Standards for Veterinary Facilities in Ontario* requires veterinarians in companion animal facilities to maintain logs for surgical procedures [and] administration of anesthetics… Anesthetic and surgical logs may be maintained separately or in combination.[23]

Professional Practice Standards and College Policy
The surgical log must include the following: date of the procedure, client and animal identification, the nature of the procedures performed, pre- and post-procedure condition of the animal, the anesthetic protocol and the time required to perform the procedure/administer the anesthetic.[24]

RECORD CONTENT
1. The date of induction/procedure
2. The name of the client
3. The breed, age, sex, weight and identity of the anesthetized animal/animal 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

[23] Guide: Medical Records, page 3.
[24] Guide: Medical Records, page 9.

Section 15: General Requirements

Statement
The records present a chronology of care and are legible, understandable and are prepared and maintained in a timely and systematic manner.

Legislation
22(5) The records required under this section shall be,
- (a) Legibly written or typewritten;
- (b) Kept in a systematic manner;
- (b.1) In practices of more than one practitioner or practices that employ locums, identified after each entry with the initials or code of the veterinarian responsible for the procedure; and
- (c) Retained for a period of at least five years after the date of the last entry in the record or until two years after the member ceases to practise veterinary medicine, whichever occurs first.

Professional Practice Standards and College Policy
Use of tools such as master problem lists… contribute to the efficient collection of information and a sufficiently documented record.[25]
Formats such as Subjective-Objective-Assessment-Plan (SOAP) or Data-Assessment-Plan (DAP) are generally accepted practice.[26]
A unique number or code should be assigned to each animal, flock or herd. Each component of the record should include the identification number. Paper based records should have the number on both sides of every page.[27]
Whenever information is entered into the record, the entry should be documented with the initials of the person making the entry and the date the entry was made. For electronic records, the software should have the capacity to track and record who enters information and when it is recorded.[28]
Each time a record is updated, a veterinarian must ensure that the update or change to the record is dated and documented in a clearly identifiable manner and that the content of the record before each change or update is preserved.[29]

RECORD CONTENT
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).

[25] Guide: Medical Records, page 1.
[26] Guide: Medical Records, page 1.
[27] Guide: Medical Records, page 3.
[28] Guide: Medical Records, page 5.
[29] Guide: Medical Records, page 5.