College of Veterinarians of British Columbia

Guide to the Professional Practice Standard: Medical Records

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Introduction

The College's *Professional Practice Standard: Medical Records* establishes the expectations that are fundamental to achieving complete and comprehensive medical records. The *Professional Practice Standards: Companion Animal Medical Records; Equine Medical Records; and Production Herd/Flock Medical Records* serve to supplement the foundation established in the general *Professional Practice Standard: Medical Records.*

The medical record is the only resource that provides the necessary information to ensure continuity of care, to enable effective collaboration among the veterinary team, and to demonstrate the quality of a veterinarian's practice. Complete and comprehensive medical records are essential to the health and well-being of every patient.

Using a question and answer format, this Guide to the Professional Practice Standard addresses questions and offers suggestions on how to apply the Professional Practice Standard in situations that arise in veterinary practice.

Frequently Asked Questions about the Comprehensiveness of Medical Records

What documents should be included in a medical record?
A medical record includes, but is not limited to, the following documents:

- client information forms,
- emergency contact information forms,
- client communications,
- cumulative patient profile/master problem list,
- examination notes,
- progress notes,
- monitoring forms,
- protocols (if used),
- logs (surgery, anesthesia, hospitalization),
- laboratory reports,

- diagnostic images (such as radiographs and ultrasounds),
- prescriptions,
- invoices,
- insurance documents (applications, claim forms),
- consent forms,
- health certificates,
- certificates of rabies vaccination,
- referral letters to and from others,
- export documents,
- an audit trail of changes to the record if it is separate from the main record (usually in electronic records), and
- copies of records from previous veterinary facilities (if any).

Is there a preferred format for ensuring that records are comprehensive and complete while also enabling records to be compiled in an efficient manner?

Veterinarians have access to a wide variety of tools to ensure that records are complete and comprehensive. Subjective-Objective-Assessment-Plan (SOAP) or Data-Assessment-Plan (DAP) are generally-accepted formats to organize medical record information. In addition, use of tools such as master problem lists/cumulative patient profiles, protocols, templates, and checklists contribute to the efficient collection of information and a sufficiently-documented record.

A comprehensive medical record documents:

- the client's description of the presenting problem(s) and reason for the visit,
- the findings of the physical examination,
- the results and interpretation of any diagnostic or laboratory tests,
- problem lists and differential or definitive diagnoses,
- a description of any treatment administered and/or procedures undertaken,
- future treatment plans, and
- any advice provided to the client.

How much detail should be captured in a SOAP or DAP format to facilitate a complete record?

Minimum standards for a comprehensive and complete record would include, but are not limited to:

- The history documenting the presenting complaint and recent health status of the animal(s). A vaccination record is an important component of the history.
- An indication of which body systems were examined. Abbreviations such as PE-NAF or PE-NSF are not sufficient documentation unless a protocol detailing what is covered in the examination is referenced in the record.
- Information and reasoning on how the veterinarian arrived at a diagnosis should be recorded. Regular updates on differential diagnoses should be recorded until

a definitive diagnosis is determined.

- Sufficient information demonstrating that the veterinarian has reviewed and interpreted data from diagnostic tests to confirm a diagnosis.
- Treatment plans describing recommendations for tests, drugs, treatments, surgical or medical procedures, referrals for specialized care and a follow-up schedule.
- Client communication and professional advice provided.

Can protocols be used as a component of a medical record?

Yes. The use of protocols contributes to the delivery of safe and quality care and to efficient record-keeping. A library of all protocols should be maintained in the facility for reference purposes. Protocols, despite revisions, must be maintained for as long as any medical records that refer to it are kept.

Is it sufficient to only include test result reports in the medical record?

It is not sufficient to include only reports of test results. The record should reflect the veterinarian's interpretation of the test results.

How can a veterinarian ensure that ownership is clear in the medical records documentation?

The name, address, and contact information of the owner(s) should be documented. Contact information should be updated on a regular basis. The patient's name or ID number should be linked to the client identification record. In situations with multiple owners, each owner should be recorded (name, address, and contact information). A veterinarian should take care to ensure that his or her medical record files are clear with respect to who is and who is not an owner, co-owner, and/or agent to avoid potential disputes. An agent is a person who has received the authority to act on behalf of the owner and whose decisions bind the owner as though he or she were themselves making the decisions. It should be clear whether a particular individual listed is authorized to make decisions or not. Simply adding a name under "spouse" "other" or even "emergency contact" may cause confusion. It is also prudent to clarify whether an individual is an emergency contact for a specified time period, and whether an emergency contact is also an agent. The client identification sheet should document permission to leave messages by voicemail or e-mail.

Does a medical record have to document both verbal and written communication with clients?

A complete and accurate medical record includes documentation of all communications with the client. This includes face-to-face, telephone, electronic, and other means of communication with owners and/or alternate decision makers. Records should document advice provided, including diagnoses, treatment plans, required tests and interpretation of results, referrals, and discharge directions. They should also document discussions to obtain consent and, in situations when

treatment is refused, a notation of the rationale for refusing the recommendation, if provided. The language used by all staff members when writing in a medical record should be professional and objective and should avoid subjective and derogatory comments. A medical record is a permanent record and it is important to ensure that the tone is professional in nature. For example, if treatment is refused and a reason is not provided, it is not appropriate to document a subjective comment or a staff member's perception of what the reason is.

Are logs considered part of the medical records of a veterinary facility?
Yes. Requirements for logs are detailed in the CVBC Bylaws, Schedule D – Accreditation Standards:

Controlled Drug Log:
Standard 78, Guideline (c) requires veterinarians to maintain a log for controlled substances.

Radiology Log:
Standard 72 (a) states that "diagnostic images and their logs comprise part of the patient's medical records"; and
Standard 72 requires that "documentation in the form of logs must be kept for each piece of diagnostic imaging equipment using ionizing radiation.

Anesthesia/Surgery Log:
Standard 89 states that "the facility must have an anesthesia/surgery log on every procedure performed under general anesthesia within the facility."

What information must be captured on a controlled substances log?
A controlled substance log must indicate (but is not limited to) the following information:

- the date that a controlled substance is dispensed or administered,
- the name and address of the client,
- the patient's name or id,
- the drug's brand name or DIN,
- the strength/concentration and quantity of the controlled substance dispensed or administered, and
- the quantity of the controlled substance remaining in the registrant's inventory after the controlled substance is dispensed or administered.

In addition to recording information on all controlled substances, the log should document inventory of any compounded products that include controlled substances.

What information must be captured in a surgical-anesthetic log?
The surgical log must include (but is not limited to) the following information:

- date of the procedure,
- client and animal identification (including age, breed, sex, and weight, which can be estimated for large animals),
- the nature of the anesthesia (the name, dose, and route of pre-anesthetic agents, the name, dose, and route of anesthetic agents) and of any procedures performed (identify the procedure and the time required to perform the procedure)

What information must be captured in a radiology log?
The radiology log must include (but is not limited to) the following information:

- the date when the radiograph is taken,
- animal and client identification,
- the area of study,
- technique information (mA, kVp, and time),
- tissue depth,
- the operator's name,
- dosage of any contrast material used, and
- any applicable comments.

What financial information should be included in the medical record?
Invoices and estimates should be included in medical records to demonstrate the services provided. Fees for drugs should be itemized separately. Dispensing fees may be incorporated into drug costs or itemized separately. Fees should be easily cross- referenced with all treatments and procedures described in the medical record.

What strategy should be employed to ensure all components of the record are linked to the patient?
A unique identification number or code may be assigned to each animal, flock or herd, and each component of the record should include a reference to this identification number. Paper-based records should have the number written on both sides of every page. Electronic records should be capable of printing the identification number on each page.

As an alternative to an identification number system, the name of the client and the animal(s) or group of animals should be referenced on each component of the record.

Frequently Asked Questions about the Release of Medical Records

Is a veterinarian required to provide a copy of a medical record to a client?
Yes, a veterinarian is required to provide either a copy or a summary of the medical record containing the relevant medical information to a client upon request. While the physical copy of the medical record is the property of the practice and veterinarians are required to keep the originals of all records, the information contained in the record belongs to the client and the client has the right to access the content of his or her animal's medical record. When transmitting a copy of a medical record, it may be transmitted by any method that allows for appropriate privacy safeguards.

Is a veterinarian required to provide a copy of a medical record to another veterinarian who is treating the same animal or group of animals which are owned by the same owner(s)?
A client's authorization to disclose medical information may be verbal or written, and may be conveyed by an agent of the owner (including another veterinarian). If a veterinarian receives a request for a medical record – unless he or she has reason to suspect that the request is not being made under authorization of the client on file – he or she must respond to the request. A veterinarian is expected to respond in a timely manner to enable continuity of care. In urgent cases, such as an emergency, relevant information can be provided verbally, with a summary of the medical records or complete records to follow.

Is a veterinarian expected to provide copies of radiographs as part of a request for a medical record?
Yes. Radiographs are part of the medical record. For digital radiographs, the digital image may be forwarded. For film radiographs, a veterinarian may forward the original radiograph(s) directly to the other veterinarian with a request for their return. If this is not practical, the client can be asked to transfer the radiograph(s) as long as a release is signed stating that the radiograph(s) will be returned or are to be permanently transferred directly to their primary care veterinarian. Alternatively, digital photos of film radiographs may be forwarded, as long as the quality of the image is preserved (difficult to achieve).

Are there any situations when a veterinarian may refuse to provide relevant information from the medical record to an owner?
No. In circumstances where a veterinarian has fees associated with transferring medical records and an owner refuses to pay the fees, **relevant** medical information can be provided verbally or in the form of a written summary rather than by a complete copy of the entire record. It is not acceptable to withhold the transfer of records and compromise animal care because of an outstanding balance, as this is a separate business issue that can be addressed by a facility's collection policy.

Can a veterinarian delay or refuse transmission of medical records to another veterinarian if he or she believes the client has not provided consent?

It is not the responsibility of the veterinarian receiving the request for a record to determine if the client provided consent to request the record. It is only when there are reasonable grounds to believe that the requesting veterinarian has not obtained at least implied consent, or where the client has withdrawn consent, that the responding veterinarian may refuse or delay transmission of information. The responding veterinarian should not raise unfounded concerns about consent. However, if a veterinarian has reason to believe in the circumstances of a particular case that consent from the client was not provided, or has explicitly been denied, confirmation can be sought from the client. Even here, the request for confirmation from the client should not amount to an attempt by the responding veterinarian to dissuade the client from exercising his/her right to consult with another veterinarian.

When is client consent not required to release a medical record?

A registrant must provide full access to client personal or medical information or provide a copy of a medical record to:

- Any party that has an urgent and compelling need for the information in order to ensure the well-being of an animal;
- Any party that has an urgent and compelling need for the information in order to ensure the health or safety of the general public or a particular person;
- The College for the purpose of administering the Act or Bylaws;
- A government agency or its designate, as required or authorized by law;
- A party on the basis of a court order or subpoena.

If a client requests the release of medical records relating to a time when their animal or group of animals was owned by a different owner, does a veterinarian require the consent of the previous owner to release the records?

Yes, the information in the medical records pertaining to the period of time when the animal was owned by the previous owner belongs to the previous owner (unless they have already authorized those records to be released to the new owner) and a veterinarian must obtain consent from the previous owner prior to releasing any information from those records.

Must requests for medical records be made in writing?

No. A request for a medical record may be made by telephone, facsimile, email, regular mail, personal contact or by other means (including through an agent).

Can a veterinarian charge a fee for providing copies of a medical record?

Yes. A veterinarian may decide to recover reasonable costs for producing copies of medical records. Factors that influence the cost include the number of pages, cost of staff time, courier or postage costs, and the cost of any other related items. The charge must not obstruct the efficient and timely release of information.

Frequently Asked Questions about Entries and Changes to Medical Records

How soon after an encounter should a medical record be updated?
A veterinarian must ensure that records are complete and up-to-date. Records should be created or updated immediately or as soon as possible after contact with the patient or client or new information is received. Timely recording of information minimizes the risk of incomplete records and ensures current information is available to all members of the veterinary team.

Can a veterinarian make a change to a medical record?
There are situations when it is necessary for a veterinarian to change a medical record to ensure that the correct information is recorded. A veterinarian must not delete or make the original information illegible when making a correction. Corrections should be documented with the date of the change, the initials/name of the person making the change, and a notation explaining the reason for the change. It is sufficient to strike a single line through incorrect information in paper-based records. Electronic records should establish an audit trail that documents the change and retains the original information.

What are the requirements for documenting changes within an electronic record?
For a veterinarian who maintains his or her medical records electronically, an audit trail is required that allows for an original record to be maintained and accessible when changes to the record have been made. A veterinarian must be familiar with the auditing capabilities of their software system. Some systems have an on/off feature for preserving the original content of records. Other systems have a time-out feature or locking feature – this feature can be set so the system will time-out after a period of inactivity. The veterinarian must then sign back into the system to make the next entry. If a correction to the record is needed, this can be documented as an addendum with the current date and with a reference to the entry being modified. While some systems maintain an audit trail external to the main record, it is still considered part of the record. When making copies of electronic records, the audit trail must be capable of being printed as well.

Can all staff members enter information in the record?
Any person (e.g., veterinarians, technicians, other staff) making an entry in the medical record should be authorized to have access to that record. 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.

What procedures should be in place to protect patient and client confidentiality?
Appropriate steps must be taken to protect patient and client confidentiality regardless of whether records are paper-based or electronic. Physical and visual access to records should be limited to veterinarians and authorized staff.

Procedures must be in place to protect client and patient information from unauthorized access, loss or damage. Paper-based records should be stored in secure, fire-proof cabinets that are locked when not in use. Electronic records should be encrypted and back-ups made and stored off-site (any off-site server/cloud database should be based in Canada). Passwords need to be secure and changed on a regular basis. Paper records and electronic equipment (e.g., laptops, USBs, etc) must be securely stored when in transport.

Frequently Asked Questions about Retention of and Access to Medical Records

How long must a veterinarian retain records?
Medical records must be retained for a period of at least seven years after the date of the last entry in the record or until seven years after the member ceases to practise veterinary medicine, whichever occurs first.

When a practice is closed, what steps must be taken to enable access to records?
Veterinarians who retire or close a facility must arrange for records to be stored for up to seven years after the practice closes. Clients and the CVBC should be notified about how to access records (through submission of a completed Medical Record Location Form to the Office of the Registrar). "Closed Practice Record Retention Guidelines" can be found on the CVBC website, under Resources/Practice Facilities/Closing a Practice Facility.

Can a veterinarian purge medical records if a client gives consent?
No. A veterinarian is required to retain a complete copy of the medical record for at least seven years after the date of the last entry in the record or until seven years after the member ceases to practise veterinary medicine, whichever occurs first.

What procedure must be followed when scanning documents for a medical record?
Scanned paper documents should be converted to read-only electronic formats. Once scanned, the original copy may be destroyed.

Frequently Asked Questions regarding Exemptions to Medical Records Requirements

Are there any circumstances in which a veterinarian is exempt from the full medical records requirements?
Yes. The medical records must contain only as much information as can reasonably be obtained in the circumstances when a veterinarian is:

- Providing services that are permitted or required under the *Prevention of Cruelty to Animals Act* or any other act, except for the *Veterinarians Act*, or
- Retained or employed by a person other than an animal's owner to conduct an

independent examination of the animal and report on the animal's health to that person.

However, the records must be:

- legibly written or typed,
- kept in a systematic manner,
- identified after each entry with the initials or code of the veterinarian responsible for the procedure (in practices of more than one practitioner or in practices that employ locums), and
- retained for a period of at least seven years after the date of the last entry in the record.

In addition, the records must adhere to the normal requirements regarding updating records, and recording and maintaining electronic records.

Companion Animals: Frequently Asked Questions about Medical Records

What information needs to be documented to describe a companion animal to ensure the record is for the correct animal and client?
The medical record should include the animal's:

- species,
- breed,
- colour,
- age (recorded as date of birth or estimate of),
- weight, and
- sex (including spay/neuter if relevant)

In addition, the following should be included, if applicable:

- name of the animal,
- any unique colourings or markings, and
- tattoo or microchip

Assigning of unique identification numbers for each patient file facilitate accurate record keeping.

Can a single record be established for a client who owns multiple companion animals?
No. Each companion animal must have an individual medical record.

Production Herds & Flocks, and Equine: Frequently Asked Questions about Medical Records

Can a record be established for either a herd or an individual animal?
Yes. Records for production herds/flocks or horses can be for individual animals or for the group. In situations where an individual animal is treated within a herd or flock, a separate record should be documented within the herd record.

What information needs to be documented to describe a production animal or horse to ensure the record is for the correct animal/herd and client?
The breed and sex should be clearly identified within the medical record. Herds or groups of animals should also be identified by location (i.e., barn, pen). The geographic location (address) of the herd/animal should be noted if different from that of the owner.

When advice or care is given to an individual animal, the animal's name, tattoo or ear tag number or the animal's colour, markings or distinguishing features should be documented.

What information needs to be documented for a bird or flock to ensure the record is for the correct flock and client?
In addition to species and type, a flock identification that clearly refers to a specific group of birds (i.e. entire flock, bird of specific age group, or other designation) should be documented. The geographic location of the bird/flock should be noted if different from that of the owner. When advice or care is given to an individual bird, the bird's name or other identifying information (colour, markings or distinguishing features) should be documented.

What information should be documented about withdrawal times?
Withdrawal times of any drug that is prescribed, dispensed or administered by a veterinarian must be documented. Records should document that the veterinarian advised the client of the withdrawal time for any drug(s) prescribed, dispensed, or administered for use in food-producing animals, which should be at least as long as the withdrawal time recommended by the manufacturer.

Acknowledgement

Adapted with permission from the CVO's "Professional Practice Standard Medical Records".