THE COLLEGE OF VETERINARIANS OF ONTARIO

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 medical record is the primary source 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

1. 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, progress notes, monitoring forms, protocols, logs, laboratory reports, diagnostic images (such as radiographs and ultrasounds), invoices, insurance documents, consent forms, health certificates, insurance applications, 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).

2. 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 profile, protocols, templates, and checklists contribute to the efficient collection of information and a sufficiently documented record. Examples can be found on the College's website at https://cvo.org/Resources/Templates-Protocols.aspx.

A comprehensive 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.

3. 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. This includes the recording of problem lists, differential diagnoses and regular updates as more information is gathered.
- 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.

4. 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, inclusive of the date of each version, should be maintained in the facility for reference purposes. A protocol, despite revisions, must be maintained for as long as any medical records that refer to it are kept.

5. 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.

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

The name, address and contact information, including preferred methods of communication, of the owner should be documented and updated on a regular basis. In situations with multiple owners, each owner's information should be recorded and updated accordingly. The patient ID number should be linked to the client identification record.

A veterinarian should ensure that their medical record file is clear with respect to who is and who is not an owner to avoid potential disputes. An owner has the ability to name an individual as an agent who has 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 any individual listed is an owner or an agent with or without decision-making power. Simply adding a name under "spouse", "other" or even "emergency contact" may cause confusion.

It is important to note that any significant changes to the client identification records requires the consent of all listed owners. This includes instances in which one owner requests the removal of another owner from the medical record.

7. 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 mechanisms to communicate 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. 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. 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 and legal record and it is important to ensure that the tone is professional in nature.

8. Are logs considered part of the medical records of a veterinary facility?

Yes. Regulation 1093 requires veterinarians to maintain a log for controlled substances. In addition, the *Minimum Standards for Veterinary Facilities in Ontario* requires veterinarians to maintain logs for surgical procedures, administration of anesthetics, and radiographs. Anesthetic and surgical logs may be maintained separately or in combination. A veterinarian who performs laboratory tests in-house is also advised to maintain logs of laboratory tests to enable accurate and timely recording and follow-up of test results.

9. What information must be captured on a controlled substances log?

A controlled substance log must indicate the date that a controlled substance is dispensed or administered, the name and address of the client or client identification, 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. It is also advised that the log include identification of animal(s) for which controlled substances are dispensed or administered and the signature or initials of the member who dispensed or administered the controlled substances. In addition to recording information on all controlled substances, the log should document inventory of any compounded products that include controlled substances.

10. What information must be captured in a surgical-anesthetic log?

The surgical log must include the following: date of the procedure, client and animal identification (including age, breed, sex, and weight, which can be estimated for large animals), the name of the surgeon, the nature of the procedures performed, pre- and post-procedure condition of the animal, the name, dose, and route of pre-anesthetic agents, the name, dose, and route of anesthetic agents, and the time required to perform the procedure/administer the anesthetic.

11. What information must be captured in a radiology log?

The radiology log 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.

12. What financial information should be included in the medical record?

Invoices and estimates should be included in medical records to demonstrate the services provided. They should contain the name of both the associated facility and professional corporation, if applicable. 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.

13. What strategy should be employed to ensure all components of the record are linked to the patient?

A unique number or code may 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. Electronic records should be capable of printing the identification number on each page. Alternatively, it is appropriate to include the name of the client and the animal(s) or group of animals.

Frequently Asked Questions about the Release of Medical Records

14. Who owns an animal's medical record?

While the physical copy of the medical record is the property of the practice and a veterinarian is required to keep the originals of all records, the information contained in the record belongs to the owner and the owner has the right to access the content of their animal's medical record.

15. When can a veterinarian provide a copy or part of a copy of an animal's medical record?

A veterinarian can provide a copy or part of a copy of an animal's medical record when:

- Requested or consented to by the owner of the animal(s);
- Requested or consented to by a previous owner of the animal(s) for the part of the record that was created during the period of that specific ownership;
- Requested by another veterinarian to facilitate and coordinate patient care in cases where the record relates to the same owner;
- Required or authorized to do so by law, such as when there is a court order or when reporting suspected abuse or neglect to the Ontario Society for the Prevention of Cruelty to Animals;
- Helping to prevent or assisting in the treatment of a person with a disease or physical injury, such as reporting any knowledge of any animal bite, or a contact that may result in rabies in persons to a local Medical Officer of Health. (For more information please refer to: http://cvo.org/getmedia/7b76602e-d513-4315-b0f2-52f581cbb20e/LegOverviewRabies.aspx);
- Identifying, locating, or notifying the apparent owner of the animal, protecting the rights of the apparent owner, or enforcing applicable laws with respect of the animal, where it appears that the animal is not owned by the person who has presented it for treatment; or
- Requested by the College of Veterinarians of Ontario.

16. Does a request for an animal's medical record have to be in writing?

No. A request for an animal's medical record may be made by telephone, facsimile, email, regular mail, in-person contact, or by any other means.

17. Can a veterinarian charge a fee for providing a copy or part of a copy of an animal's medical record?

Yes. A veterinarian may decide to recover reasonable costs for producing a copy or a part of a copy of an animal's medical record. 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. It is not acceptable to withhold the transfer of records and compromise animal care because of any outstanding balance, as this is a separate business issue that can be addressed by a facility's collection policy.

18. How quickly does a veterinarian need to respond to a request for a copy or part of a copy of an animal's medical record?

A veterinarian is expected to respond to a records request in a timely manner to enable continuity of care. Requests to transfer a complete copy of records should be completed within two (2) business days. In urgent cases, such as an emergency, relevant information can be provided verbally, with a copy or part of a copy of an animal's medical record to follow.

19. Does a veterinarian always have to provide an animal's full medical record?

No. A veterinarian is required to provide relevant historical (i.e. medical) information when requested. This may involve providing the entire medical record but can also include medical summaries or a portion of the medical record based upon the request being made.

For example, if the treating veterinarian is providing a second opinion about a specific condition, they may only require information that pertains to that condition. Another example is a referral to a specialist. This may only require that certain aspects of the medical history be provided.

If in doubt, a conversation between the veterinarians and/or client will assist with ensuring that the information that is required is available to coordinate care for the animal(s). The individual making the request can also be specific about what information

is required. This can help to ensure that the information they need is provided in a timely fashion, which is also critical to prevent any delay in providing care to the animal.

It is important to note, however, that there will be times when the client and/or veterinarian requesting the information determines that the full record is needed to coordinate care. The client also maintains the right to request a full copy of an animal's medical record for any reason. In these circumstances, the responding veterinarian must provide the animal's full record.

20. Is a veterinarian expected to provide copies of radiographs as part of a request for an animal's medical record?

If it is determined to be relevant to the request, a veterinarian is required to provide radiographs as 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 client or other veterinarian with a request for its return. If this is not practical, then 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 to be permanently transferred to the primary care veterinarian. Alternatively, digital photos of film radiographs may be forwarded, as long as the quality of the image is preserved.

21. A new client has an animal that they have continuously owned that has previously received care from a different veterinarian. What are the treating veterinarian's obligations to ensure continuity of care as they related to medical records.

When treating an animal that has previously received treatment from another veterinarian, a veterinarian is required to notify the previous veterinarian and obtain relevant historical (i.e. medical) information as soon as practicable. After receiving the request, the previous veterinarian is required to provide information that is relevant to the request.

Example: Dr. X sees a new client and patient at their hospital to examine an unresolved lameness issue. Dr. X contacts Dr. Y who previously treated the patient to request relevant historical (i.e. medical) information. Based on the reason for the visit, Dr. X determines that it is necessary to review any visits to Dr. Y that relate to the lameness issue, any tests that were performed, treatments that were done (including any drugs prescribed, dispensed or administered), and the patient's vaccine history. Dr. X contacts Dr. Y to request this information. Dr. Y has their staff prepare the relevant records and sends them to Dr. X within two business days.

22. A new client has booked an initial appointment for an animal(s) that they have continuously owned that has previously received care from another veterinarian, can the treating veterinarian and/or staff contact the previous veterinarian to request relevant historical (i.e. medical) information prior to the appointment occurring?

When a new client makes an appointment with a veterinarian, there is the intent to establish a veterinarian-client-patient relationship (VCPR). During the contact with a new client, the veterinarian and/or staff can inform the client that they will need to contact their previous veterinarian and obtain relevant historical (i.e. medical) information on their animal. The reason for this is care coordination. Alternatively, they can ask the client to bring their animal's medical record with them to the appointment or to provide it before the appointment.

There may be circumstances where a new client refuses to have further communication with the previous veterinarian, including requesting their animal's previous record. They may also indicate that they do not wish for the new veterinarian to contact their previous veterinarian. In these circumstances, the new veterinarian is obligated to inform the client that uncoordinated care put their animal at risk. If the client still refuses, the veterinarian can still proceed with seeing the patient if they choose to do so. The veterinarian must not break confidentiality or privacy by seeking the information when the client has withdrawn their consent.

Example: Dr. X is seeing a new client and patient. Dr. X's staff have requested that the new client bring the patient's previous medical history to the appointment. The client brings invoices and vaccine certificates from the previous veterinarian that they kept at home. Dr. X informs the client that they also need to see previous lab tests that were performed, including x-rays and bloodwork. Dr. X informs the client that they can contact the previous veterinarian for this information. The client indicates that they do not want Dr. X to contact the previous veterinarian. Dr. X informs the client about the importance of having this information to coordinate care and prevent duplication of tests. The client still refuses. Dr. X asks the client if they are willing to proceed with the appointment which involves taking a complete history and performing a complete examination of the patient and that this may indicate that lab tests are needed to determine further care. The client agrees to continue with the examination.

23.*Can a veterinarian delay or refuse transmission of an animal's medical record 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. 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 been explicitly 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 their right to consult with another veterinarian.

Example: Dr. X recently had a client request a transfer of their animal's medical record to another veterinarian, Dr. Y. Dr. X calls Dr. Y and requests that they provide a copy of the records from the visit with the client to add to their own file on the animal. Dr. Y asks Dr. X if the client has an appointment with their clinic. Dr. X tells Dr. Y that there is no appointment but that they are still a client. Dr. Y informs Dr. X that the client indicated that they did not wish to return to Dr. X's practice. Therefore, Dr. X is not entitled to a copy of the records since Dr. X will not be treating the patient. If in the future the client makes an appointment to see Dr. X again, then Dr. X can request relevant historical (i.e. medical) information from Dr. Y.

In the above situation, Dr. X can assume that the VCPR with the client has ended. When the client has transferred care of their animal to another veterinarian, it also transfers the obligation of the record to the new veterinarian. Dr. X's obligation is to then retain the record for regulatory purposes. This requires Dr. X to retain the records on the patient for five (5) years after the date of the last entry in the record. Once the period has lapsed, Dr. X can purge the records.

24. ***If a client requests the release of an animal's medical records relating to a time when their animal(s) were owned by a different owner, does a veterinarian require the consent of the previous owner to release the records?***

Yes. The information in the animal's medical record pertaining to the period of time when the animal(s) were owned by the previous owner belongs to the previous owner and a veterinarian must obtain consent from the previous owner prior to releasing any information from those records.

Frequently Asked Questions about Entries and Changes to Medical Records

24. 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.

25. 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 line through incorrect information in paper based records. Electronic records should establish an audit trail that documents the change and retains the original information.

26. What are the requirements for documenting changes within an electronic record?

For a veterinarian who maintains their 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 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.

27. Can all staff members enter information in the record?

Any person (e.g., veterinarians, technicians, other staff) who makes an entry in the medical record should be authorized to have access to the 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.

28. 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. 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

29. How long must a veterinarian retain records?

Medical records, including all diagnostic results, x-rays, logs, etc., must be 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.

30. 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 two years after the practice closes. Clients and the College of Veterinarians of Ontario should be notified about how to access records.

31. Can a veterinarian purge medical records if a client requests it and/or gives consent?

No. A veterinarian is required to retain a complete copy of the medical record for 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.

32. 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. Radiographs must be kept in their original format.

Frequently Asked Questions asked about Exemptions to Medical Records Requirements

33. Are there any circumstances in which a veterinarian is exempt from the full medical records requirements?

Yes, a veterinarian who provides veterinary services in a temporary facility is not required to adhere to the full medical records requirements in respect of animals receiving services at the temporary facility.

In addition, for a veterinarian providing services that are permitted or required under the *Dog Owners' Liability Act*, the *Animals for Research Act*, the *Ontario Society for the Prevention of Cruelty to Animals Act*, the *Animal Health Act* or under any other Act except for the *Veterinarians Act* or for a veterinarian who is 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, the medical record must contain only as much information as can reasonably be obtained in the circumstances. 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 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. In addition, the records must adhere to the normal requirements regarding updating records and recording and maintaining electronic records.

Food Producing Animals, Equine and Poultry: Frequently Asked Questions about Medical Records

39. 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.

Legislative Authority

R.R.O. 1990, Reg. 1093: General, s. 17, 22-28 (*Veterinarians Act*)

Other References

The following can be found on the College's website at www.cvo.org,

Professional Practice Standard: Medical Records
Professional Practice Standard: Informed Client Consent
Guide to the Professional Practice Standard: Informed Client Consent

Resources

A variety of resources (e.g., samples, forms) can be found on the College's website at www.cvo.org.