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PURPOSE OF THE MEDICAL RECORD

The medical record is the who, what, where, when, and how of patient care. Medical records are the tangible evidence of what the hospital is accomplishing. It must be maintained to serve the patient, the health care providers, and the institution in accordance with legal, accrediting, and regulatory agency requirements. Therefore, it is imperative that accurate, timely documentation be provided for each patient on each contact with a health care provider. An adequate medical record shall be maintained for every patient evaluated or treated by the facility on an inpatient, outpatient, or field service basis.

The quality of the medical record depends on information entered by those professionals authorized to provide care and responsible for documenting that care. The Associate Dean and Director of Veterinary Medical Services will grant hospital privileges to a clinical provider after they have completed their hospital orientation meetings and checklist.

It is the responsibility of the senior faculty clinician to ensure the completion of the medical record upon the discharge of the patient. This also includes the care rendered by a house officer (resident, intern) who may be the primary service provider. When a house officer is in charge of a service, a backup senior faculty member is ultimately responsible for case management and for ensuring compliance with the medical records completion policies and procedures.

THE MEDICAL RECORD FORMAT

The medical record (either paper or electronic) is a compilation of pertinent facts and health data of a patient’s birth, vaccination records, life, and health history, including past and present illness(es) and treatment(s) and death, documented by authorized healthcare professional/provider/caregiver etc. It must be compiled in a timely manner and contain sufficient data to identify the patient, support the diagnosis or reason for health care encounter, justify the treatment, and accurately document the results. Health data must also be kept in order that quality reviews may evaluate the adequacy and appropriateness of care:

- Goods and services are appropriately charged for and billed (fiscal accountability)
- Education and research to provide actual case studies and data to expand the existing knowledge
- Public health to protect the environment, food sources, and humans from disease and contamination
- Legal purposes to provide data and protect the legal interests of the patient, clinician, and facility
- Marketing and planning data to assist administrators in the selection and promotion of technological health care enhancements and services.

The Veterinary Teaching Hospital utilizes the POMR (Problem Oriented Medical Record) format. Originally developed by Dr. Lawrence Weed, this method of record keeping is chronologically ordered according to each problem that has been identified. The focal point of this system is such that all information is linked to specific problems.
The main components are: the defined data base, the complete problem list, plans, and progress notes. The defined data base includes the chief complaint, patient profile, history, physical examination, laboratory and radiology findings. The plans are written for further diagnostic procedures, therapy, and client education. The progress notes are written in the SOAP (Subjective, Objective, Assessment, Plan) format:

Subjective:
This information includes the past history, the presenting complaint, and the information regarding how and where the animal spends its day.

Objective:
This information is derived from the physical examination and diagnostic test reports, laboratory reports, radiology reports, histopathology reports, and necropsy findings.

Assessment:
The provisional diagnosis, results of consultations, and the final diagnosis are listed under assessment.

Plan:
This information is comprised of further diagnostic studies, assessment, the differential rule-outs, and for treatment and surgery. Plans are also made for client education.

This type of record keeping may require more time; however, it is worthwhile because the structured record makes the data and the information much easier to retrieve and it gives the clinician an organized base for reaching a diagnosis. This format gives everyone using the record a standard format to follow and includes a place and method for including data. It also facilitates the continuity of care. If the senior clinician is not available, then any other clinician who takes over the care would be able to follow the course and plan of treatment because the logic and format of the writing is preserved. It is this element that supports a thorough approach to patient care.
DOCUMENTATION REQUIREMENTS FOR THE MEDICAL RECORD

The following items have been identified as necessary elements to be documented in the patient’s medical record:

- **Owner Information** - each screen/page should contain demographic data; name, address, telephone number(s), email address, FAX, cell phone, and / or beeper etc.

- **Patient Information** - name, species, sex, age/date of birth, description / brand / tattoo etc.

- **Chief Complaint** - client’s explanation as to why they are bringing in their pet to the Veterinary Teaching Hospital.

- **History** - presenting, past, environmental are required elements for all visits.

- **Physical examination** - required on all new visits and recheck visits for the same problem within twelve (12) months.

- **Revisit Form / Case Summary** - includes history and physical findings; abnormal findings; summary and final diagnosis, procedures performed, prognosis for severe or life-threatening cases, discharge status, (alive, died, euthanasia, necropsy etc.) and signature of the attending clinician.

- **Discharge Summary on ALL patients, with final diagnosis and signature of attending clinician and owner/agent/representative. The signed original copy will be retained in the patient’s record.**

- **The Master Problem List will remain open and will be updated by the attending clinician whenever the patient has a newly identified problem or one is resolved and / or the patient dies.**

- **Clinician Orders must be signed by the ordering/senior clinician. They should also be charged against the client account; include the route, dose, frequency, duration, dispensed, lot numbers etc. and any adverse reactions noted with appropriate labels affixed to the file. The electronic patient index will also be updated with the patient alerts. Narcotic and controlled substances must be documented on the Clinician Order Form / ICU Flowsheet / TPR sheet with administration and wastage documented directly in UVIS. Treatment records will be authenticated by the authorized caregivers’ initials and or signatures/credentials.**

- **Progress Notes will be documented in SOAP format; patient demographic data via label or electronic template format; dated and signed daily. The attending clinician must sign/pin the last note documented.**

- **Laboratory Reports - all ancillary preliminary and final reports will contain the provisional and or final diagnosis and signature/electronic pin of the senior
interpreting clinician. (Histopathology / Necropsy, Surgical Pathology, Clinical Pathology, Clinical Pharmacology, Clinical Microbiology, etc.)

- Radiology Reports will identify the procedure(s) performed, final diagnosis and signature/pin by senior interpreting clinician.

- The Anesthesia record will be completed and signed by the anesthesiologist.

- A Surgery Report will be completed when general anesthesia is used. The report will identify the procedure performed, date of procedure, notation of tissue submitted, surgical complications and post-operative recovery.

- The Euthanasia/Donation/Cremation/Necropsy/Discharge Against Medical Advice/ Extra Label Drug Use and special Consent forms must be completed and signed by the authorized CVM Representative or caregiver(s).

- The Communication Log is maintained electronically but is considered an essential part of the medical record as it documents all communications between VTH clinicians and students with the patient’s owners as well as the primary and or referring veterinarian. Case reviews are maintained separately and should not be entered into the Communication Log. This log is printed to accompany the copy of the paper medical record whenever a record copy is requested.

See Exhibit A for sample medical record forms.

REQUIRED CHARACTERISTICS OF ENTRIES IN MEDICAL RECORDS

It is essential that accurate, timely documentation be provided for each patient on each contact / visit (inpatient / outpatient) with a health care provider.

Appropriate Documentation
The quality of the medical record depends on the information entered by the health care providers authorized to provide care. The medical record shall contain the originals of all reports. Fact, and not opinion, documents the patient’s encounter at this facility. Paper records should be documented with either blue or black ballpoint pen ink. Computerized entries should be time and date stamped and or authenticated after each entry and should be made by only those authorized health care providers.

Authentication
The health care providers who provide care during the course of a patient’s stay at this facility must document the care provided and date and sign the entry. This process is known as ‘authorship.’ Any person who wishes to utilize a rubber signature stamp and or imaged computer key must have a letter on file stating that the individual and only that individual has the exclusive use of that stamp to authenticate his/her entries. Unauthorized use will result in disciplinary action. Authentication may include signatures, written initials, or computer entry.

The senior or attending clinician is to sign entries made to the history, physical exam, and discharge summary. Any additional areas specifically documented as ‘directed by the
senior clinician’ must be co-signed by the senior clinician. i.e. medication or procedure orders.

**Abbreviations**

Only approved abbreviations may be used when they have been approved by Hospital Board and there is an explanatory legend and each abbreviation and symbol has only one (1) meaning. Only those individuals who are authorized to use and interpret these should document these in the record and interpret them. See Exhibit B for current approved list.

**Timeliness**

Due to the frailty of human memory, all patient related entries are be made as close as possible to the time of occurrence of the event(s) being documented. Current records (history, physical examination, and pertinent laboratory and radiology data) are those which are typically completed within 24-48 hours of admission as an inpatient to the facility. Upon discharge of the patient, a discharge summary will be given to the client / agent / representative. The original will be retained in the medical record. A copy will be faxed to the referring veterinarian within 24 hours unless otherwise designated by the legal and authorized owner / agent / representative.

The remainder of the record must be completed within fifteen (15) working days and not exceed thirty (30) days. Medical records will conduct a chart assembly and analysis on the record, indicating those areas that are deficient and still require completion and / or signatures or pending reports. A completion form will be included in the record. Completeness implies that the required forms are assembled and authenticated; all final diagnoses are recorded without the use of abbreviations; and any other reports are produced in their final, edited, and authenticated version and inserted in the record for permanent filing.

**Legibility**

The value of the information contained and documented in the medical record and the quality of the patient care delivered is contingent upon the ability of the recorded entries to be understood and legible and / or upon computer entry.

**AMENDING OR CORRECTING THE MEDICAL RECORD**

Mistakes can and do occur in the course of entering data in the medical record. If an error has been made, the proper method of correcting it is for the author to draw a single line through the incorrect information without obliterating it, and to record the correct information above, below, or beside it. The date of the correction should always be recorded, as well as the name of the person making the correction. Minimally, the first initial and full last name and credential should be included as the authenticating author. The reason for the incorrect entry should also be included.

For computerized entries, an additional comment may be added to correct or amend the original entry. It should NOT be deleted. Additionally, an addendum may be entered from the viewing screens. The entry should include an explanation of the omission, error and the reason that the entry is appearing out of sequence and the electronic pin of the individual making the entry.
If the clinician has forgotten to make an entry or if additional information about the patient has been processed and received, or if the client wishes to correct an entry in the medical record; it should ALWAYS be done as an amendment to the original entry, without changing the original. The amendment should be clearly identified as an additional document or amendment to the original which has been done at the direction of the client/clinician. Once the amendment has been completed, the information is then considered a part of the record and released along with other information when a proper release is authorized.

A request for amendment or correction form should be completed whenever possible and included in the medical record.

CONFIDENTIALITY

Medical confidentiality is concerned with the restrictive use of medical information from and about a patient/client relationship. There is no such thing as absolute medical confidentiality. Information about the patient must be shared between AUTHORIZED care givers in order for the patient to be treated. It is the ethical AND legal requirements that control the re-disclosure of medical information. Therefore, there are procedures in place that restrict and authorize the disclosure of medical information about the patient/client.

Distinctions Between Non-confidential and Confidential Medical Record information:

NONCONFIDENTIAL information is that which is generally considered to be general or common knowledge and there is no specific request by the patient/client to restrict disclosure, i.e. name of patient; verification of hospitalization and dates of service.

CONFIDENTIAL information is ANY information that results from a clinical relationship between patients and healthcare providers. Typically, confidential information includes; but, is not limited to all clinical data and the patient’s address on discharge.

In order to release information about a patient/client, an authorization for release of information must be obtained. Requests for additional information may be forwarded to the Health Information Management section.

Breeches of confidentiality will be addressed through the University’s Human Resources Department in accordance with disciplinary guidelines.
RECORD REVIEW & CHECK-OUT

Medical Records will remain in the designated departmental area for review.

Medical Records may NOT be kept locked in personal faculty offices or house officer work areas. If a patient presents to the Veterinary Teaching Hospital and it is discovered that the record has been checked out and is in such a place; VTH staff will notify Housekeeping or Campus Police to unlock the office or locker so that staff may retrieve the record.

Medical Records may be checked out for a period of thirty (30) days. After that time, the record(s) must be returned to the department for renewal or simply returned.

Records requested for a study must be submitted on a request form in designated format and the requesting party must identify the funding source for payment if the records are stored off site.

Only those individuals have active VTH privileges and / or a Recognition of Presence Form may check out medical records for research purposes.

ROUTING OF MEDICAL RECORD AT THE TIME OF DISCHARGE

Upon the patient’s discharge, the medical record will be turned in to the medical records department by 9am on the next business day after discharge.

Chart assembly and analysis will be performed by medical records staff.

Chart will be forwarded to clinician for review and completion. The Incomplete Record Form will be in the record to indicate those areas requiring completion, signature(s) and / or if reports are pending.

After a clinician has completed a record; it should be placed on the return shelf.

The record will be coded in accordance to SNOMED nomenclature and filed in permanent filing.
RELEASE OF INFORMATION FROM THE MEDICAL RECORD

The original medical record, reports, tracings, radiographic images, recordings etc. are the property of the NC STATE Veterinary Teaching Hospital and may not be released without proper authorization i.e. signed authorization for release of information from the medical record by the client/owner/duly authorized agent/representative. Original records may be released with a valid subpoena duces tecum and a copy retained for hospital records.

- Copies of medical records and images may be provided to clients or third parties (insurance agencies, attorneys) at their request provided a Release of Information Consent form has been completed and signed by the owner or duly authorized agent/representative.

- Request for copies of the medical record will not be refused to an owner who has failed to pay their bill.

- Information concerning reportable diseases will be released as specified to regulatory agencies.

- Vaccination history / status is the only type of record information that may be released via the telephone without a signed authorization for the release of medical information.

Methods of Releasing Information

There are four (4) basic methods of releasing properly authorized information from medical records: direct access, abstracting information, verbal release, or photocopying all or portions of a record.

- Direct Access: This form of releasing information may be directly by the patient or representative of the patient. Identification of the individual should be required prior to allowing access. A departmental representative should review the contents of the paper/hard copy record with the reviewer to assure that the information is not altered; nor, the contents removed or defaced etc.

- Abstracting Access: This form of releasing information may be performed by a properly trained departmental employee so that only the essential and stipulated information on the authorization for release of information form is abstracted and that errors of interpretation do not occur.

- Verbal Access: This form of releasing information may be performed under limited circumstances when other methods of release cannot be used, such as an emergency situation. The identity of the caller should be verified by returning the call. Only that information required to satisfy the emergency should be released verbally. The information should be related and released by a trained employee of the department. A record should be made of the verbal release.
Photocopying & Fax Access: This form of releasing information may be performed after the appropriate and designated authorization for release of information has been completed. Only that information specified by the release should be photocopied. The record should be reviewed to assure that highly sensitive data is not inadvertently disclosed.

Information that is urgently needed may be faxed; however, fax machines are not perfectly secure means of transmitting confidential information. It is possible that the information may be misdirected or mishandled at the receiving end. The faxing of information should only be done when using the original or mailing photocopies of the original will not meet the immediate needs for patient care. Complete medical records are not faxed. A single report may be faxed when an emergent need arises that directly impacts the needs for patient care.

SECURITY OF MEDICAL RECORDS

Due to the ease of data transmittal in computerized systems, the ability to produce multiple printouts of confidential data; the content and release of information contained therein is subject to the procedures of handling and accessing confidential medical patient/client information and the release thereof.

COMPUTER RECORDS

User accounts, identification access, and passwords will be processed and granted by the CVM IT System Administrator with the presentation of a valid Recognition of Privilege Form, Hospital Privileges Application (Completed and Approved by the Associate Dean for Medical Services), or written exception request by an authorizing supervisor.

The IT System Administrator will assign the level of access as authorized and the security will be ‘terminated’ upon exit notification by the immediate supervisor, Hospital Administrator, Hospital Director, or designee.

PAPER RECORDS

Paper records will be stored centrally in the Medical Records Department and will be housed in permanent storage via mobile density file unit. Authorized personnel will have access to this area after 5:00 p.m. for emergency record retrievals/admissions. Records housed in the incomplete area of medical records and the special studies area will be available after-hours; however, must remain in the Medical Records Department.

When patient records are in the nursing areas they must be kept in the designated areas and not left lying about. They should be secure and NOT available to unauthorized users. Records that are particularly sensitive will be maintained by the Medical Records Administrator or Hospital Administrator under separate lock and key.

If the record is used for internal use and while the patient is hospitalized, the original record(s) may be used. When photocopies or printouts are necessary, they are subject to the same controls for use and access and should be returned to the Medical Record Department for destruction.
INCOMPLETE AND DELINQUENT MEDICAL RECORDS
The medical record will be considered delinquent fifteen (30) days post discharge date. Please refer to SOP #39 Incomplete / Delinquent Medical Records for detailed procedures on handling delinquent records.

SPECIAL CONSENTS
A special consent or authorization form is required for any non-routine diagnostic or therapeutic procedures performed on a patient. This form provides written evidence that the patient agrees to the procedure(s) listed on the form. In order for the consent to be considered valid, the clinician must discuss the procedure(s) named, the risks, alternative procedures, and likely outcomes with the client/owner/agent/representative. The patient’s demographic data are be verified during this process.

These consents would be used in special considerations to and including: euthanasia, donation, necropsy, cremation, and discharge against medical advice.

In the event of an emergency, an attempt will be made to secure verbal consent via telephone, fax, email etc. from the duly authorized owner/client/agent/representative for surgical lifesaving procedure(s). This consent will be documented in the record and a properly executed consent form should be in the patient’s medical record prior to surgery.

NECROPSY REPORTS
When a patient dies in the hospital, the medical record (paper) will accompany the patient to necropsy. The record may remain with the pathologist at the time of the necropsy procedure and will be returned directly to medical records within twenty four hours (24) of the completion of the procedure. A final necropsy report is generated within fifteen (15) working days following the submission of a completed electronic UVIS Necropsy Request. Final completed reports may be viewed via UVIS. Histopathology will forward a final completed hard copy to the medical records department for inclusion into the patient record.

RENDERING AN OPINION ON MEDICAL CARE
Faculty, house officers, students, and staff will NOT volunteer an opinion on the medical care provided at other facilities or by other veterinarians. Opinions should only be provided as a formal expert witness in court. Volunteering an opinion may be considered unethical and an individual can be held personally accountable and liable for any opinions volunteered.

Faculty may be asked to provide an expert opinion (become an expert witness) on veterinary medical or animal care. NC State University and the CVM discourages faculty from acting as expert witnesses against veterinarians in North Carolina and surrounding referral areas. Acting as an expert witness must be performed as a private consultant (not as a faculty duty) and requires completion of annual conflict of interest and notice of intent to engage in external activity for pay filings.

A faculty or house office may also be compelled or subpoenaed to testify as a “fact” (not opinion) witness about treatment you helped provide, observations you made on a
patient’s condition, or records you made. Faculty or house officers who receive a subpoena should immediately notify the Associate Dean and Director of Veterinary Medical Services.

CHANGE OF OWNERSHIP
When an animal is sold or the original owner changes, a CHANGE OF OWNERSHIP form is used to document the event. A bill of sale or contract or registration papers may be used as ‘proof’ of ownership in the event that the new owner comes in with the animal and presents for treatment. Identifying features as tattoos, brands, bands, etc. may also be used as verification assists. Information may not be released to the new owner until this process has been completed.

PERMANENT FILE CHART ORDER
LEFT SIDE OF FOLDER
Mass Topography Form for Chemo/Radiation Patients
Chemotherapy Schedule
Radiation Forms
Rabies Contact Log
Dental Films and Adhesive Pocket for Films
Special Studies (Protocols, Consent Forms, etc.)
Dermatology/Allergy Schedule
FDA Drug Usage Forms (Experimental, Extra Label Drug Use)

RIGHT SIDE OF FOLDER
Incomplete Record Routing Slip
Labels
Master Problem List
Release of Information
Change of Ownership
Telephone Communication Forms - Green/Pink/Yellow
Cover Sheet
Drop Off Patient Questionnaire
Admissions Information
Case Summary-Revisit Form
Avian Case Summary Update Form
Necropsy/Euthanasia Consent
Necropsy Report-Final Report
Consent Forms/Emergency Treatment Authorization Form
Orthopedic Coding Sheet/General Surgery Coding Sheet
Discharge Summary
History
Patient Information (Large Animal, Ophthalmology, Dermatology, Specialty History Forms)
Referral Veterinarian Information
Referral Communication Record
Physical Exam Form
Specialty Exam Forms (Neurology, Ophthalmology, Dermatology-Intradermal Skin Test and Health Certificate)
Emergency Case Transfer/Service Transfer
Progress Notes-Reverse Chronological Order
Intensive Care Flow Sheet/Large Animal Intensive Care Sheet
Laboratory Flow Sheet
Caloric Calculation/Nutrition Worksheet
Tumor Description Form, Radiation Oncology Treatment Plan, Summary, Radiation Treatment-Anesthesia Log
Clinician Order Forms/Daily Treatment Record
Orange Controlled Drug Tracking Log Form
Pharmacy/Outpatient Prescription Printouts
Clinical Pharmacology Request/Report
Lab Request/Report Forms:
  Blood Transfusion Request/Report
  Clinical Immunology
  TEG-Thromboelectrograph
  Clinical Pathology (CBC, Chemistry, Hematology, Urinalysis, Cytology)
  Microbiology
  Parasitology
  Virology
  Send Outs
Radiology Reports/Ultrasound Reports/Equine Outpatient Imaging Service
Ophthalmology Pre-surgical Checklist
Pre-Anesthesia Checklist
Yellow Anesthesia Worksheet
Anesthesia Record/Radiation Anesthesia Records
Surgical Procedure Report
Surgical Pathology Report
LA Equine Incisional Study Form
Consultation Request/Report:
  Cardiology Consultation Report, EKG, EEG
  M-Mode Echocardiographic Report
  Holter Monitor
  CMG-UPP Report
  Electromyographic Report
  Evoked Potential Report
  Canine Dentistry Examination
  Feline Dentistry Examination
  Ophthalmic Ultrasound
White Patient Transfer/estimate
Financial Adjustment Communication Form (Lilac)
Financial Estimate Agreement/Informed Consent