The Art of Writing Medical Records©2022

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Most Common Mistakes Made:

- Elements are Missing - incomplete or too brief
- Illegible - cannot read them
- Confusion - DOB vs age at the time
- Inadequate description of PC or PE findings
- No assessment +/- No Rule-Outs
- Client Info is not updated - cannot contact
- No Treatment Plan to follow
- No Summary Diagnoses
- Inconsistent Dates
- Inconsistency between Veterinarians
- Documents missing or Out of Order
- Test Results NOT Interpreted so mistakes are made
- If it was written, it wasn't done

Ideally Medical Records Would Include:

1. Patient Information
2. Client Information - up to date
3. Emergency Contacts & Authority
4. Date of every visit
5. History (Previous & Current)
6. Current weight - every time
7. Complete Physical Exam Data
8. Assessments & Differentials (Rule-outs)
9. Any Professional Advice given
10. Medical Treatments (Fluids, Drugs, Therapies, Nursing Care)
11. Surgical Treatment (Prep, Surgery, Post-op Care, Assessment of Recovery)
12. Adverse Events – Visits, Drugs, Reaction
13. Reports - Labs, Referrals, Anesthetic Monitoring
14. Final Summary Diagnoses/Conclusion
15. Fees & Charges
16. All Logs, X-rays, Ultrasound, Photos, Consent Forms
17. Insurance Forms, Communication Logs, Declined Care, Estimates
18. Initials of all Participants
19. Identifier and time stamp at top of each page
20. Everything you & your team do, deserves credit! Record it!

Use SOAP or DAP

1. HEAR
2. SEE
3. THINK
4. PLAN

<u>GOOD</u> Medical Records Support <u>YOU</u>, Your Clients, Your Patients & Your Practice !

- Financially
- Legally
- Medically
- Quality
- Accurately
- Scientifically
- Efficiently
- Successfully
- Emotionally
- Professionally

Self -Assessment Tool - Medical Records Workshop

RECORD KEEPING SKILLS	Always	Needs Improvement	Missing	N/A
1. Our record keeping system allows for quick and easy retrieval of a COMPLETE patient file				
2. Our records are legible to anyone, not just our staff				
3. Patient Info is clearly visible on EVERY component of the file (including back of pages)				
4. A master Problem List or Cumulative Profile is present AND maintained				
5. The date of each visit or contact is reported (not just the exam dates)				
6. The presenting complaint is CLEAR at the top of each entry				
7. History is detailed enough that an outsider could clearly determine all the factors (present & past)				
8. The duration of the sign(s) is noted as well as whether it's better or worse				
9. There is a detailed description of the sign (s)				
10. Physical examination findings are recorded (both normal and abnormals)				
11. An assessment of the patient is recorded				
12. A diagnosis present (Tentative & Final)				
13. Lab tests, x-rays & all diagnostics are recorded and interpreted/assessed				
14. These test interpretations are discussed with clients and all advice/info is recorded				
15. The treatment PLAN is recorded, and the treatments performed are recorded with detail				
16. Doses, durations, methods of admin, timing and response to prescribed meds are noted				
17. Copies of Client education, discussions, hand-outs provided, and discharge instructions are kept in the file				
18. Surgical notes contain location, size, colour, tissue texture, procedure, suture, and result				
19. Anesthetic monitoring forms contain all required details & pets are monitored through recovery until discharge				
20. Logs are maintained for surgery/anesthesia, radiology & controlled substances				
21. Drug log audits are performed q 1-2 weeks				
22. Consent forms are detailed, reviewed, signed and show informed consent				
23. Entries are ALL signed by both staff & vets				
24. Changes to records are addendums in real time, or crossed & initialed				
25. We protect the PRIVACY of personal information				
26. We have internal protocols for records security (backups, the cloud)				
27. Our team provides medical information to other Veterinarians or to the client with speed, ethics, accuracy and professionalism.				