Peer Review of Medical Records Self-Assessment Tool

Food Producing Animal, Equine, and Poultry

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How to Use the Self-Assessment Tool

This self-assessment tool uses a check-list format to assess your medical record records. The record content in the check-list matches the Peer Review of Medical Records (PRMR) Assessment Questions so that you will be checking the content that a peer reviewer is assessing in the PRMR process. This tool can help you to understand the expectations for record-keeping and to determine areas of your records requiring improvement.

One strategy to consider in self-evaluating your records is to choose a sample of records that reflect the scope of your practice. For example, if you work at a hospital that offers a full scope of services to the public, choose a surgical case, an acute medical case, a chronic medical case, and a routine wellness case. Make sure that you compile all relevant components for that case. Please refer to the **Information Package** for PRMR on the College's website for information on what components are needed depending on the case type. For example, a surgical case would also include surgical and anesthetic logs and controlled drug logs.

For each case record, use this check-list to indicate whether the record content listed is present (check Yes), not present (check No), or not applicable to this case type (check N/A).

When considering whether something is not applicable, consider the following example. A routine wellness case where the main reason for the visit is a consultation for administering vaccines would not have surgical treatment. Therefore, in Section 8: Surgical Treatment and Anesthetic Notes/Protocols, the record content would not be applicable to that case and you would check N/A for that content.

After filling out the tool for each case, **review what is going well and areas that require attention in your record-keeping. Implement changes in your record-keeping where needed to ensure that your records are meeting expectations.**

For resources on record-keeping expectations, you may wish to review the **College's Professional Practice Standard and Guide on Medical Records.** You can also access the College's **online learning module series: Foundations for Medical Record Keeping.**

Section 1: Patient Identification			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. (a) Individual identification (e.g. name, tattoo, ear-tag number, or patient's colour, markings, or distinguishing physical features)			
1. (b) Group identification (identified by location if applicable, e.g. barn, pen)			
2. Type of breed			
3. Sex of the animal (food producing animal and equine only)			
4. Type of species (required for poultry)			
Total			

Section 2: Client and Emergency Contact Information			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Client's Name(s)			
2. Client's Address(es)			
3. Client's telephone number(s)			
4. Address/location of patient(s) if different from address of client			
5. Name of alternate contact person (other than client)			
6. Phone number(s) of alternate contact person (other than client)			
7. Authority for financial and care decisions in the absence of the client			
Total			

Section 3: Date			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. All entries are dated			
2. Consistent date format used throughout, so the chronology of care is clear and easy to follow.			
Total			

Section 4: History – Subjective Data			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Statement of presenting complaint or reason for visit			
2. Description of presenting complaint			
3. History of recent health status (in progress notes, template, or protocol)			
4. Vaccine record (in progress notes, cumulative patient profile, or summary view)			
Total			

Section 5: Assessments – Objective Data			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Physical examination details (in progress notes, template, or protocol)			
2. Presence of diagnostic tests and laboratory results			
Total			

Section 6: Assessment – Diagnosis			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Problem list			
2. Differential diagnoses			
3.Tentative or final diagnoses			
4. Diagnostic test result interpretation is present.			
Total			

Section 7a: Medical Treatment			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. (a) Type of fluid therapy			
1. (b) Route of fluid therapy			
1. (c) Rate of fluid therapy			
1. (d) Total amount of fluid therapy			
2. (a) Types of vaccines administered			
2. (b) Routes of vaccines administered			
2. (c) Details (manufacturer and serial numbers) of vaccines administered			
3. Other medical treatments or procedures are described in adequate detail.			
Total			

Section 7b: Medical Treatment – Annual Risk Issue – Drug Documentation			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. (a) Names of drugs administered (excludes anesthetic drugs, see Section 8)			
1. (b) Strengths of drugs administered (excludes anesthetic drugs, see Section 8)			
1. (c) Doses of drugs administered (excludes anesthetic drugs, see Section 8)			
1. (d) Routes of drugs administered (excludes anesthetic drugs, see Section 8)			
2. (a) Names of drugs prescribed and dispensed at facility			
2. (b) Strengths of drugs prescribed and dispensed at facility			
2. (c) Quantity of drugs prescribed and dispensed at facility			
2. (d) Dose of drugs prescribed and dispensed at facility			
2. (e) Directions for use of drugs prescribed and dispensed at facility including route			
3. (a) Names of drugs prescribed to be dispensed at a pharmacy or feed mill			
3. (b) Strengths of drugs prescribed to be dispensed at a pharmacy or feed mill			
3. (c) Quantity of drugs prescribed to be dispensed at a pharmacy or feed mill			
3. (d) Dose of drugs prescribed to be dispensed at a pharmacy or feed mill			
3. (e) Directions for use of drugs prescribed to be dispensed at a pharmacy or feed mill			
4. (a) Withholding time is documented			
4. (b) Indication client was advised of withholding time			
Total			

Section 8: Surgical Treatment and Anesthetic Notes/Protocols			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Surgical treatment details are recorded (in progress notes or a protocol) and include the approach used, findings and type of repair.			
2. The anesthetic details are recorded. (includes name, strength, dose and route of anesthetic drugs used)			
Total			

Section 9: Annual Risk Issue - Informed Client Consent			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Documentation of consent (written or verbal)			
2. Refusal of treatment documented			
3. Indication that client was advised of costs of recommended services (on consent form, in progress notes, or itemized estimate).			
Total			

Section 10: Advice and Communication			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Description of the advice given			
2. To whom the advice was provided (e.g. client, other)			
3. Mode of communication (e.g. in-person, phone, email, voicemail)			
Total			

Section 11: Reports, Invoices			
RECORD CONTENT	**Yes**	**No**	**N/A**
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.			
Total			

Section 12: Radiographic Logs[1]			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. The date each radiograph is taken			
2. The identification of the animal and of the client			
3. MAS and KV, if varies from the technique chart			
4. The area of the body exposed to the radiograph			
5. The number of radiographs taken of each animal on a particular visit			
6. No discrepancies are noted between the information in the log and the patient record when cross-referenced			
Total			

Section 13: Controlled Drug Logs			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. The date the controlled substance is dispensed or administered			
2. The name and address of the client; or, alternatively, a unique client ID			
3. The identification of the animal			
3. The name, strength and quantity of the controlled substance dispensed or administered			
4. (a) The name of the controlled substance dispensed or administered			
4. (b) The strength of the controlled substance dispensed or administered			
4. (c) The quantity of the controlled substance dispensed or administered			
5. The quantity of the controlled substance remaining in the member's inventory after the controlled substance is dispensed or administered			
6. Signature or initials of the staff member who removed or added to the inventory			
7. No discrepancies are noted between the information in the log and the patient record when cross-referenced			
8. The calculation for drug remaining in the inventory after it was dispensed or administered to this patient is correct.			
Total			

[1] Not applicable to poultry

Section 14: Anesthetic and Surgical Logs[2]			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. The date of induction/procedure			
2. The name of the client			
3. The breed, age, sex, estimated weight and identity of the anesthetized animal/animals 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			
11. No discrepancies are noted between the information in the log and the patient record when cross-referenced			
Total			

Section 15: General Requirements			
RECORD CONTENT	**Yes**	**No**	**N/A**
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.			
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).			
Total			

[2] Not applicable to poultry

Section 16: Written Prescriptions			
RECORD CONTENT	**Yes**	**No**	**N/A**
1. Veterinarian's name and address			
2. Date the prescription is issued (includes day/month/year)			
3. Client's name and address			
4. Identity of the animal or group of animals for which the drug is prescribed			
5. Approximate number of animals in the case of groups			
6. Weight of the animal if dispensing veterinarian is different than prescribing veterinarian			
7. Name, strength and quantity of drug			
8. Prescribed directions for use (dose, route of administration, frequency, duration)			
9, Withholding times			
10. Number of refills permitted if any, or expiry date, or total amount of drug prescribed			
11. Veterinarian's license number and signature			
Additional requirements for medicated feed prescriptions:			
12. Animal production type			
13. Weight or age			
14. Type of feed			
15. Total amount of feed or feeding period			
16. Amount of drug used per tonne			
17. Manufacturing instructions			
18. Cautions			
19. CgFARAD number (if applicable)			

How to Calculate an Overall Score

1. Put the total number of "Yes" and "No" marked in each section in the chart below. (Note that Section 16 is not included in the overall score.)
2. In the last column, add the numbers in the "Yes" and "No" columns to calculate the total number of times there was an opportunity for a requirement to be met in that section.
3. At the bottom, tally the grand total numbers in each column.
4. Divide the grand total in the "Yes" column by the grand total in the last column.
5. This provides you with a percentage that is the Overall Score. To be successful in meeting the requirements, the goal is to achieve a score > 83%.

SECTIONS	Yes	No	Total of Yes + No
Section 1			
Section 2			
Section 3			
Section 4			
Section 5			
Section 6			
Section 7a			
Section 7b			
Section 8			
Section 9			
Section 10			
Section 11			
Section 12			
Section 13			
Section 14			
Section 15			
Grand Total			

Overall Score = (Grand Total "Yes"/ Grand Total of Last Column) x 100		
Grand Total "Yes"	**Grand Total of Yes + No**	**Overall Score**