College of Veterinary Medicine Policies and Procedures

Subject: ***Medical Records: Maintenance***

Section: Animal Health Center *Administration*
Number: CVM *6.1.01*
Pages: *3*
Date: *2012*
Replaces Policy Dated: 2004; 2007; 2010
To Be Reviewed Yearly by: *Medical Records Supervisor and AHC Director*
Source:
Cross Reference:

MEDICAL RECORDS- MAINTENANCE

Purpose
Accurate, complete, legible, and accessible medical records are essential to quality medical care. Ethics and legal responsibilities require that medical information be kept confidential.

Personnel
Medical records may be handled and reviewed by the clinicians, interns, residents, veterinary technicians, veterinary students, veterinary technology students, medical record staff, and business office staff.

Upon the approval of a clinician, individual medical records may be viewed by general staff members.

Facility maintenance staff, and other staff not engaged in medical care are not authorized to view or make medical record entries.

Location
Because medical information may be needed at any moment, all active original medical records must be kept on the Animal Health Center premises.

Medical records that are not in active use must be stored in an orderly and readily retrievable form in the medical records department, in the storage area in the basement, or in an offsite storage area.

Medical records may not be taken to any area of the Animal Health Center where they may be damaged or degraded by water, animals, or environmental effect. Hospitalized patient records that are not in active use should be kept in clipboards at the nurses' station.

Records may be checked out of the medical records department by personnel authorized to view them. The file folder will be placed in the student bookcase with the correct check out sheet listing the date, the correct person checking out the record, and reason it is being checked out (admission, incomplete, or personal).

Entries
Clinicians, students, veterinary technology students and veterinary technicians/technologists may make entries in any portion of the medical record. The accuracy and completion of patient information is ultimately the responsibility of the primary clinician.

Medical Record staff may make entries only in those portions of the medical record that contain client communications or that are directly associated with the medical record functions.

Patient care team members may make records of patient observations and other entries if specifically approved by a clinician.

The person making the entry must sign all entries. Entries made in the electronic medical records by a person logged in with their username and unique assigned password are captured by the computer program and notes the ID number and name of person making the entry which is considered an electronic signature.

Confidentiality
No staff member may communicate to any person other than the owner of the patient any information regarding the presence or condition of any patient in the clinic. Clinicians and students may discuss any patient's case in the context of veterinary medical education. Clinicians and students should be mindful that ethics and legal responsibilities require medical information be kept confidential.

Record maintenance
Hybrid medical records will consist of the referring veterinary discharge instructions (case summary), any information from a referring veterinarian if applicable, send out lab results (in chronological order), ECG's, anesthesia reports, sedation record, ICU sheets (in chronological order) followed by the signed treatment authorization and finally any applicable pharmacy sheets.

Scanned medical records are kept in a separate database and are backed up in the computer services server room daily. Medical records may be maintained in the form of microfilm, paper records, paper records scanned into a database, or electronic medical records as required by state statue.

Supervision
The medical records supervisor will oversee the physical assembly and maintenance of records by medical records staff. The hospital board (Animal Health Center Director, PPM Department Head and DCS Department Head) will oversee proper entry and compliance with applicable accreditation standards, state statutes and other standards.

Training
All new hired staff and clinicians receive Electronic Medical Records (EMR) training at the scheduled time during their orientation process.

All second year students receive EMR training when they begin their second year and the EMR is used in their sophomore surgery lab.

All third year students entering the clinics receive a refresher training during orientation into the clinics.

Electronic Medical Records
Every individual with privileges to document in the electronic medical record or review information in the electronic medical record is given a username and password. This username and password is used to log into the EMR database and access the electronic medical record. Each username and password should remain confidential and ONY be used to access the EMR by the assigned individual.

The medical record - episode of care is located in the medical record case summary in the EMR. Each individual is to be logged into the EMR with their own personal username and password prior to entering any information into the EMR with the exception of approving prescriptions. For prescription approval clinicians may enter their username and password on the screen where the student or other clinician has entered the prescription to approve it. The database is backed up daily on-site as well as at an offsite location.

In the event of a power failure or computer hardware/software issues, patient information will be entered and maintained on paper until such time as the power has returned or the computer issue resolved. The information will then be entered into the database by the appropriate individuals.

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