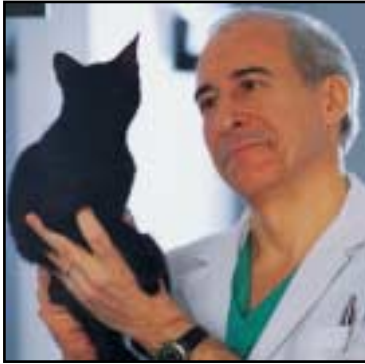


How Can I Deal With a Doctor Who Keeps Sloppy Medical Records?

By Wendy S. Myers



Q. One of our doctors has illegible handwriting and sometimes forgets to write his exam findings and recommendations in the medical record. I'm worried about patient care and legal risks. How can I approach this veterinarian about his sloppy medical records?

A. Failure to properly document medical records can lead to internal control problems, liability risks, embarrassment of the practice or client, and a loss of revenue. "These trends reduce the continuity of care, value of the medical records, and liquidity of the practice," says Dr. Thomas E. Catanzaro, Dipl. ACHE, of Veterinary Practice Consultants/Catanzaro & Associates in Golden, Colorado.

Maintaining complete, accurate, and legible medical records is everyone's responsibility—not just the doctor's. To avoid economic, legal, and patient-care risks, follow this advice from colleagues:

1. Talk to the doctor privately. Rather than complain to the practice owner or manager, discuss the concern with the veterinarian. If you feel uncomfortable bringing up the subject, a supervisor or manager can coach you on how to approach the doctor. "In our hospital, the vision statement says we strive to provide perfect care for every pet," says Carol Schubert, RVT, CVPM, MBA, co-owner of Old River Veterinary Hospital in Tracy, California, and a partner of VetTeam, an online education resource. "Focus on the vision statement as the reason you need to talk with the doctor. Explain what might go wrong with an illegible record. Missing refills, rechecks, and reminders can affect the care of the pet. Your conversation should be about the pet, not personal."

2. Establish standards of care. At Grand River Veterinary Hospital and Fisherville Animal Clinic in Ontario, Canada, team members created a standard of care for medical records. Veterinarians and staff pooled resources from AAHA, books, and consultants to develop a system that works well for its small and large animal practices. "You don't have to reinvent the wheel," advises Joan Robinson, CVPM, hospital administrator. "Look for resources and talk to other colleagues."

Consider these resources available from AAHA at (800) 252-2242 or www.aahanet.org:

- *Standard Abbreviations for Veterinary Medical Records* by Drs. Gordon W. Robinson, Jason Berg, and Mark Skeels (AAHA Press, 2000)
- *Controlled Substance Log*, 2nd edition (AAHA Press, 1999)

- *Legal Consent Forms for Veterinary Practices*, 2nd edition, by Dr. James F. Wilson, JD (AAHA Press, 1996)
- Stickers for physical exams, surgery/anesthesia summary, euthanasia, ophthalmology, canine and feline dental, and dermatology
- Forms for patient data, progress notes, radiology log, surgery/anesthesia log, and patient/client information

3. Emphasize that medical records are everyone's responsibility. Medical records contain information about exams, prescription refills, hospitalized patients, and boarding or grooming, so everyone is accountable for complete, accurate records. "The secret to improving medical records isn't just the veterinarian," says Dr. David Tollon of Oakhurst Veterinary Hospital in Seminole, Florida, and a VetTeam partner. "It needs to be a team effort. Technicians and veterinary assistants can help the doctor keep all the t's crossed and the i's dotted."

At the end of the day, receptionists can pull records for the next day's appointments and check for current vaccines, prescription refills, follow-up lab tests, and opportunities for senior profiles. During the visit, technicians and assistants record vital signs and history. Veterinarians note their diagnosis and recommendations and use a full signature for medication. Technicians and assistants circle charges on the travel sheet and double-check the record before the exam ends. When the client checks out, receptionists confirm recalls, rechecks, or reminders.

At Old River Veterinary Hospital, nurses are responsible for medical records of hospitalized pets. Nurses create cage cards, write information on the treatment board, and record procedures and lab results in medical records. "The medical record is the nurse's responsibility the entire time," Schubert says. "A receptionist sends it back if the case wasn't written up properly. Our rule is 'If you did it, write it down.'"

4. Write as you go. Don't wait until the conclusion of the exam, your next break, or the end of the day to write up medical records. Details of conversations, consent, and recommendations can get lost in minutes or hours.

"Have an assistant help you write up records as you go," Dr. Tollon advises. "As a veterinarian, it's your duty and responsibility to utilize your support staff. The more we incorporate the team into the delivery of healthcare, the better our patients will be."

5. Focus on continuity of care. Problem-oriented medical records let anyone follow a case. "With eight doctors, we don't always have the same doctors seeing the same patient," Robinson says. "One doctor can put the whole practice in jeopardy by not properly documenting what's been done. Anybody on the team needs to be able to find anything in the medical record."

Stickers, stamps, and forms can save time and ensure each patient gets the same level of care. Forms should be tailored to your practice and the philosophy of veterinarians. Dr. Catanzaro recommends scoring patients for body weight and condition, dental, anesthetic risk levels, pain, nutrition, and hospitalization levels by treatment intensity. For sample scoring sheets, visit www.v-p-c.com/catanzaro/mgtinfo/scoring.htm.

Complete medical records are critical to dispense medication. Many clients wait until they run out of a prescription and request a refill the same day. “If a client with a diabetic cat needs insulin immediately, will you know how much and what to give the client?” Schubert asks. “If an animal gets sick or has ongoing problems, the next doctor cannot carry on unless he or she understands the treatment plan.”

6. Create a peer-review system. Discuss record-keeping methods during doctor and staff meetings. This system improves medical records and provides professional development. Dr. Catanzaro suggests this approach:

- Ask a receptionist to randomly select two inpatient and two outpatient records per doctor, per month and provide copies to doctors.
- Review the records during a doctors’ meeting.
- Every doctor and paraprofessional should be able to answer “Can I follow this case without embarrassing the practice?” “Can I follow this case without embarrassing myself, the other doctor, or the client?” and “Am I willing to stand up in a group of peers and state the animal got the best care possible based on what was written?”

7. Understand legal liabilities. Witness a state board hearing and you’ll quickly learn the importance of accurate, complete medical records, Schubert says. As more clients consider pets as family members rather than property, more legal challenges will arise. Legal flags might include a tumor surgery with a missing consent form, a prescription without a reason, or ambiguous statements such as “shots current” without a date. Consent forms, signed waivers, written estimates, and detailed medical records can help keep you out of court.

Don’t forget the economic consequences, either. Incomplete records lead to missed charges and future visits. “You have more opportunity for client follow up if the medical record is well documented,” Robinson says.

As patient advocates, team members need to understand their roles in maintaining medical records. One mistake can seriously harm the practice—or worse—the patient. “Occasionally records fall through the cracks—even in the best practices,” Schubert says. “Maintaining medical records is a joint effort of everyone.”

About the Author

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