Excerpt from “The Immunization Encounter: Critical Issues satellite broadcast”, originally broadcast June 27, 2002.

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Documentation and Record Keeping Segment

ATKINSON:
Documentation and record keeping is a critical post encounter activity. A medical record is the backbone of a patient care plan. Healthcare providers need access to information about a person's medical history and vaccination status before immunizations are scheduled and given. Accurate documentation allows timely immunizations and helps prevent unnecessary disease. A complete list of past immunizations also avoids the cost and inconvenience associated with over- immunization and laboratory testing. Judy, tell us more about maintaining immunization records.

SCHMIDT:
Bill, there are TWO immunization records that providers should maintain- the record in the office medical chart, and the record held by the person being vaccinated. The information that should be included on these records is similar. Let's talk first about the office immunization record.

An immunization record is considered part of the person's permanent medical record and should be maintained as part of each patient's chart. The immunization record should be located in the FRONT of the patient's chart for quick review at each visit. Providers report that by simply keeping documentation on one record placed at the front of the chart, vaccine coverage improves and missed opportunities are eliminated. Placing the immunization record at the front of the chart avoids this crucial information being out of sight and out of mind.

When a provider sees the record, it's a reminder to review it to be sure the patient is up to date. Placing the immunization record at the front of the chart applies to everyone, from children to senior adults.

Although there may be some variation from one practice to another, or one state to another, all records- print and electronic- should include the following information: the entry

begins with the type of vaccine, dose number, and dose amount. The manufacturer is noted as well as the vaccine lot number, the date the vaccine was administered, and the anatomic site and route. Finally, the name of the person giving the vaccine, the office address, and publication date of the Vaccine Information Statement should be noted. The publication date is printed on each VIS.

There is one footnote to charting vaccine lot numbers. A diluent that is licensed separately has a separate lot number that must be noted. Currently, this applies only to the combination vaccine TriHibit, because the diluent is a vaccine- DTAP, used to reconstitute Hib vaccine.

You may be wondering why the lot number of a vaccine needs to be charted at all. The answer is that if a particular lot of vaccine is ever recalled, the lot number in your chart will indicate which of your patients may need to be notified.

How long should your office retain medical and immunization records? The length of time medical records should be kept by each office or clinic varies by state. We believe immunization records should be kept indefinitely.

Donna, what about lost immunization records?

WEAVER:
Yes, we often get questions about reconstructing immunization records that are either lost or incomplete. Let's talk about incomplete immunization records first. Families change vaccine providers for a variety of reasons. This may result in one person having several medical records located in different provider offices, with each record showing an incomplete series of immunizations. When the person's medical records are located, it's perfectly acceptable to review all dated, properly documented doses and consolidate the information into a single immunization record.

It's wise for all of us to keep a personal immunization record, separate from the office medical record. Parents need to know that a personally held record for each of their children is critical in documenting vaccines required for day care or school entry. Adults need a personally held immunization record for employment or international travel.

When a record documenting one or more immunizations is lost, the history of having the vaccine is lost. The National Immunization

Program frequently receives requests for copies of personal immunization records. There is no national database of immunization records so we can't help individuals obtain their immunization histories. If the patient or parent doesn't have a personal held immunization record, you should contact other health care providers to obtain the history. Day cares or schools may also have a record of their immunizations.

If a reasonable search does not locate a record, the person should be vaccinated according to age. Administering doses that may have already been given is safe and assures protection. Serologic testing for some antigens, such as diphtheria and tetanus, can be considered. This is a good opportunity to talk about the advantages of immunization registries. Having a readily accessible, central repository of immunization records helps assure that people get the vaccines they need. Registries ultimately save time, money, and inconvenience for everyone.

We are seeing the need for registries today more than ever before. We know that nationally, 20 percent of children move by the age of two and change providers for this or other reasons. This leads to incomplete documentation in a single medical record. The childhood immunization schedule is complex. A registry can help simplify the process of deciding which vaccine is due at a visit. Parents and patients become complacent about returning for vaccination appointments when the disease rate is low. A registry can help generate reminder and recall notices for your patients who miss appointments. Finally, a registry can facilitate the exchange of vaccine information among providers and improve continuity of care.

We strongly encourage all providers to participate in a local or state immunization registry if one is available in your area. Much more information on this topic is available on our website.

Office policies that place a priority on maintaining immunization records provide benefits to the provider staff as well as the patients. For example, patients receive the benefit of timely, age- appropriate immunization each time they visit the office. The provider practice staff benefit when they are able to demonstrate a high level of vaccination coverage among their patient population, and the satisfaction of knowing their patients are protected from dangerous diseases.

To summarize immunization record keeping: remember that a single complete immunization record in the FRONT of the chart will act as a reminder to check vaccination status of your patient at

every visit, and facilitate review. All information about the vaccines administered, and the Vaccine Information Statements given to the patient should be recorded. You should retain these records indefinitely. And be sure to emphasize the need for the patient to keep and maintain their personally held immunization record.

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