

UC Davis Office of the Attending Veterinarian Standard of Care

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Title: Animal Care Program Medical and Health Records

I. Purpose:

The purpose of this policy is to establish standards for medical record keeping for animals used in biomedical and agricultural research and teaching. This policy is based on requirements from the Animal Welfare Act, the Public Health Service Policy, the ILAR ***Guide for the Care and Use of Laboratory Animals***, and the ***Guide for the Care and Use of Agricultural Animals in Agricultural Research and Teaching***, and best practices for veterinary medical records.

II. Policy:

Medical records are required for all UC Davis owned animals. Rodents and other colonies or flocks of animals may have a group health record. Animals that are required to have a unique USDA number must have individual medical records when they are used for biomedical research and teaching. Agricultural animals used for agricultural purposes may have herd health records and must follow the ***Guide for the Care and Use of Agricultural Animals in Agricultural Research and Teaching***. These records may be kept in hard copy form or in an electronic system.

Medical records MUST ALWAYS be accessible to the Attending Veterinarian (AV) and designee(s) and to the APHIS/USDA inspection team for USDA regulated species. Paper medical records must be kept in the vicinity of the animal housing area for easy access. Electronic medical records must be accessible from a computer terminal or other appropriate device available in the vicinity of the animal housing area.

Regardless of format, records must be retained in accordance with applicable policy, specifically:

A. Medical records:

1. NIH funded research: At least three years after completion of the activity.
2. USDA covered species: Throughout an animals' life At least one year after the animals' death.

B. Surgery logs and anesthesia records:

1. USDA covered species: Three years after an animals' death.
2. Non-USDA covered species: Must be maintained for one year after animals' death.
NOTE: This may be longer depending on the requirement of the funding agency.

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Anesthetic and post-operative/post-procedure records must be kept by the provider of the anesthesia and/or post-operative/post-procedure care. Research related records for non-clinical procedures must be kept by the Principal Investigator (P.I.).

Note: Campus Veterinary Services or other core or surgical services can provide research support (for example post-operative monitoring and analgesic administration) and maintain the records as requested by the PI, but these services do not assume responsibility for provision of care and record keeping. The PI remains ultimately responsible for staffing and/or requisitioning services to ensure the procedures in this policy and in the approved Animal Care and Use Protocol are carried out. See procedure below for specific requirements and definitions.

Definitions:

Anesthesia: The administering of pharmaceuticals to obtain a surgical plane of unconsciousness and unresponsiveness.

Post-Operative: The time period after cessation of a surgical procedure, when anesthesia is no longer being administered or maintained, through healing of an incision and removal of external closure material (generally 7-14 days later).

Post-Procedural: The period after a procedure that may or may not have required anesthesia but does require follow-up monitoring per the IACUC protocol.

III. Procedure:

Veterinary Medical Records must include:

- a. Species and, if known, the strain or breed
- b. Date of birth/age, if known
- c. Date of receipt or weaning, if known
- d. Weight if required for the species and protocol (rodents, for example, would not typically have a weight since they are not routinely weighed and do not have individual records, while cats or dogs must have a current weight in their individual records)
- e. Medical history
- f. Identification number or medical record number (for species requiring a unique ID, e.g., USDA ID or other)
- g. Major procedures, physical examinations, clinical notes, mortality for colony animals, and other medically relevant information

It is highly recommended that investigators communicate major survival surgical procedures to their veterinarian for USDA regulated species to ensure that these procedures are included in the veterinary medical record to assist in compliance related activities and to ensure that the best medical care possible for the animal is provided.

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Shorter-term chemical restraint/sedation (ex. for physical exams where a surgical plane of anesthesia is not required, blood collection and other non-invasive procedures <30 minutes in duration), shorter-term exposure to gas anesthesia (ex. “boxing down” animals for ease of handling), or shorter-term sedation with local anesthetic (e.g. minor surgery such as digit or tail amputation) does not require a written anesthetic record but regular monitoring of the sedated animal.

An anesthetic record must contain the following:

- a. Individual animal ID (if animal has one) or identifying information to distinguish the animal from others in the colony
- b. IACUC protocol number under which the procedure is performed
- c. Date and type of procedure
- d. Start and stop time of drug administration (induction and maintenance)
- e. Start and stop time of procedure
- f. Recovery time and description
 - i. For example: sternal at 5:15 pm, returned to regular housing 5:20 pm
 - ii. If the animal is terminal or euthanized or does not recover this must also be indicated in lieu of a recovery time
- g. Name of person(s) monitoring anesthesia
- h. Name of person(s) performing procedure (if different)
- i. Names of drug(s) used for induction, maintenance, analgesia, and antibiotics if given and any supportive care (e.g., fluids)
- j. For inhaled anesthetics the percent administered and flow rate
 - i. For example: 3% Isoflurane at a flow rate of 2 Liters/Minute of Oxygen
- k. For all others the time administered, dose, concentration, dosage/amount administered and route
 - i. For example: 5 mg/kg of carprofen, 50 mg/mL concentration, gave 10 mg, 0.2 mL subcutaneously (SC)
- l. If needed a current weight (inhaled anesthetics do not require a weight to calculate, all others would require a weight to calculate the dosage to administer)
- m. The person who performs the care and records the entries must initial the records. The initials must be legible.

Post-operative records are kept to monitor for signs of pain, incision healing, and external closures. Post-operative and post-procedure monitoring records are required.

These records are kept in the area where the animal is housed and must be readily accessible by anyone monitoring the animal, such as husbandry or veterinary staff performing daily health checks. The minimum time required for incision monitoring post-operatively is 7 days for research-related procedures or as directed by the clinical veterinarian or clinical veterinary standard operating procedure (SOP) for clinical procedures.

For Post-operative records: Day 0 is the day the incision is made, and day 1 is the following day. External sutures, staples, clips, or any other material used to close an incision requires monitoring daily until such material is removed or in the case of absorbable materials, completely absorbed and no longer present. The incision is monitored until healed. This typically

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takes 7-10 days but could take up to 14 days. Intervals longer than 14 days should be discussed with the veterinary service. For buried or subcuticular closures and/or those using wound adhesive the 7-day minimum still applies. Animals, such as NHPs, may have shorter monitoring periods as returning animals to their social groups is integral to their animal welfare. In these cases, absorbable suture is used to eliminate the need for suture removal.

For Post-Procedural Records: For procedures that do not require an incision but still may cause pain or physical impairment, monitoring is required for the duration of the healing period. The IACUC protocol will stipulate when post procedural monitoring is required. The Clinical Veterinary Staff may also institute monitoring for clinical cases or for research related activities.

The post-operative or post-procedural monitoring record must contain at a minimum the following identifying information:

- a. Species
- b. Approximate age or date of birth (if known)
- c. Weight (if needed for dosage calculations)
- d. Protocol number
- e. Animal ID or other identifier that correlates directly to the animal (for animals with an individual ID such as a USDA ID number this must be included) for others a designation must be included to identify the animal being monitored

The following procedural Information is also required:

- a. Date of Procedure or surgery
- b. Description of procedure or surgery
- c. Date and time of recovery (If applicable)
- d. Treatments and assessment - including analgesia, antibiotics, and any supportive care.
 - i. Examples of assessments: healing of an incision after surgery, or respiratory difficulty/ discharge after lung lavage etc.
 - ii. Duration of monitoring may change based on clinical signs. Any treatments that are scheduled including analgesia, antibiotics, and/or supportive care must be recorded and performed as directed by a clinician or as a part of an approved IACUC protocol.
- iii. The release from these observations and monitoring must also be included, for example: incision healed, incision healed, and sutures removed, animal euthanized, released by clinician, monitoring complete.

Monitoring post-operatively or post-procedurally shall consist of a written record containing the following information that is recorded daily for the monitoring period:

- a. An incision, wound, or site check
- b. Documenting the healing of the incision, wound, or site
- c. Pain/analgesic assessment
- d. Assessment of activity and the ability to reach food and water
- e. Assessment of food intake (for rodents or other animals in group housing or on ad libitum chow this may not be feasible to assess)
- f. Urine and fecal output if feasible to assess (for rodents this may be difficult to assess due to their standard housing conditions)
- g. Administration and documenting analgesics and/or antibiotics and/or supportive care
 - i. For example: carprofen, enrofloxacin, lactated ringers solution, or diet supplementation
- h. Documentation of drugs must include drug name, dose, concentration, dosage and amount administered, frequency, and route
- i. Removal and documentation that external closures are removed (some rodents or other animals may remove their own) or dissolved if absorbable. This is annotated when it happens but is checked daily.
- j. Documentation of any abnormalities
 - i. For example: dehiscence or discharge
- k. Documentation of follow-up care with the veterinary service regarding any abnormalities and/or treatments prescribed for clinical symptoms or outcomes not addressed in the approved IACUC protocol
- l. Adverse effects not already stated in the approved IACUC protocol must also be addressed with the IACUC or Campus Veterinary Services

Records are kept individually for animals that are required to have an individual ID (e.g., a USDA ID number).

Groups of rodents or others that do not have an individual ID requirement can be monitored on a group sheet as long as all of the parameters are the same and each animal has its own line or column for daily post-operative/post-procedural checks.

For group monitoring records, each cage must be clearly identifiable on the list and on the cage. **The use of post-operative/post-procedural monitoring cards is highly encouraged and may be required by the facility manager/technician in charge or by the clinical veterinarian.**