
PACUC Policy

Documentation of Animal Care and Medical Records for Research and Teaching Animals

Background:

Regulations and standards for animal care require that daily observations be made of all animals to assess their health and well-being. This observation may be accomplished by someone other than a veterinarian provided that a mechanism is in place to communicate problems of animal health and well-being to the veterinarian on a timely basis.

If you have questions regarding the PACUC Policy on Documentation of Animal Care & Veterinary Medical Records, please contact the Laboratory Animal Program office .

Policy:

The documentation required to conform to the PACUC policy for Documentation of Animal Care & Medical Records for Research and Teaching Animals includes:

- A daily record of animal well-being or evidence of such daily observation. This is needed for both normal and "abnormal" (e.g., post-surgical or ill animal) animal(s).

For normal animals, documentation is routinely accomplished by providing verification that someone (e.g., animal care staff, research staff or individual able to recognize signs of abnormality) has observed the animal(s) and that no evidence of illness, injury, or abnormal behavior was noted. This documentation is most often provided in the form of a room "checkoff" list.

When providing daily care to or observation of an abnormal research or teaching animal, or administering directed care, documentation should meet certain additional standards as outlined below. The intent is a need to document that the circle of veterinary care is complete.

The documentation required for an abnormal animal (one showing signs of illness, injury or other departure from normal health and well-being) includes:

- Animal identification.
- Pertinent history / description of abnormality.
- Examination findings.
- Tentative / provisional diagnosis.
- Corrective measures (diagnostic and treatment plan) being taken as the result of this variation from normal health or behavior.
- Assessment of the animal's condition and progress seen over the duration of the treatment/observation period.
- The author of all entries made on the record must be identified. If daily assessment is being performed by a lay person (animal care staff, research staff member, etc.) under the direction of a veterinarian, the record must reflect the guidance provided by the

veterinarian or direct involvement of the veterinarian providing primary care concerning diagnosis, treatments or planning. It is necessary to document that veterinary oversight and authority is in place regarding the veterinary care of animals.

- Record of veterinary care given or directed to include daily treatment provided as well as dosages, routes and frequency of administration of any drugs/medications.
- Records of diagnostic laboratory services that are performed in order to facilitate veterinary medical care that can include gross and microscopic pathology, clinical pathology, hematology, clinical chemistry, microbiology, serology and parasitology.
- Resolution of the problem (e.g., diagnosis, treatment, return to a normal state, euthanasia).

For an abnormal animal, it is critical that documentation of the animal(s) condition be available for review.

For small animals or farm animals maintained in a vivarium, treatment record(s) must be maintained in a manner that allows for immediate access (e.g., in or adjacent to the room where the animals are housed). This is especially critical for animals in the post-operative period or those displaying any abnormality. Having the record in such a location accomplishes several functions.

- It explains the condition of the animals to animal care staff (a sedated animal may otherwise be thought to be ill)
- It assures animal care staff, the Purdue Attending Veterinarian and visiting USDA veterinary officer that the animal care / treatment is being provided
- It informs animal care staff how recently the investigator or a veterinarian has seen the animal. This knowledge helps them decide whether or not there is a need to contact the investigator or the Purdue Attending Veterinarian to inform him or her of the present condition of the animal.

For large animal or farm species maintained in a farm environment, the records must also be readily accessible from the facility manager or the veterinary medicine teaching hospital files.

Although individual records are desirable, a composite record may be used, for example, in the case of a group of rodents or for preventive medical procedures (e.g., vaccinations). A composite record should have a list of the animal numbers and entries made that would include a notation that the animals had been checked, any abnormal observations and a list of any therapeutics given including drugs, doses, and routes of administration as well as date of suture /wound clip removal.

Once the animal(s) returns to a normal state and this is documented on the record, the medical record requires no further entries but should continue to be kept in the area where housed.

When the study is completed or the animal(s) euthanized, the record must still be kept for at least three years. If an animal is transferred to another location or project, the appropriate records should accompany the animal(s).

There is no one format that would suit all situations and as such, this policy does not require nor recommend a standard form to be used in each instance. Suffice it to say, the record(s) should be readily available and should contain all clinical information pertaining to the animal with sufficient information being provided to justify the tentative diagnosis and warrant the actions taken and/or treatment provided. Sparse, incomplete or sloppy records make it difficult to ascertain what happened and why.

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