A. Background Information

USDA Regulatory Enforcement and Animal Care (REAC) standards and information presented by the Public Health Service (PHS/NIH) have emphasized a need for proper documentation of animal care. More specifically, the emphasis has been on the record keeping practices for animals under treatment/observation when a variation from normal health and/or behavior exists.

The USDA regulations involving animal care requires 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.

The PHS has informally recommended that institutions assure internal controls are in place for adequate animal care records. If any responsibility for treatment or observations are delegated to the investigator, there should be a mechanism in place to ensure adequate care is provided that conforms to standard veterinary practice. In addition, records of care and treatment (i.e., medical records) should be readily accessible to the attending veterinarian and animal care staff.

USDA veterinary inspectors and Association for the Assessment and Accreditation of Animal Care (AAALAC) site visit teams routinely review research and teaching animal records when on the WSU campus.

Detailed records of experimental procedures performed, drugs administered (including dose & route of administration), collection of blood and other biologic samples, observation for possible sequel to procedures, appropriate veterinary medical diagnostics and treatments and method of euthanasia or final disposition of the animal are expected.

B. The documentation required for all animals includes:

1. A daily record/entry 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).

2. For normal animals, documentation is routinely accomplished by providing verification that someone (e.g., animal care staff, research staff or individuals) able to recognize signs of
abnormality have 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 "checkoff" list.

When providing daily care to or observation of any abnormal research or teaching animal, or administering directed care, documentation should include items in section C (below).

C. Documentation required for abnormal animals (those showing signs of illness, injury or other departure from normal health and well-being) includes:

1. Pertinent history
2. Examination findings
3. Tentative / provisional diagnosis
4. Corrective measures (diagnostic and treatment plan) being taken as the result of this variation from normal health or behavior.
5. Daily assessment of the animal's condition and/or progress over the duration of the treatment/observation period.
6. 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 administered.
7. Records of diagnostic laboratory services that are performed in order to facilitate veterinary medical care and can include gross and microscopic pathology, clinical pathology, hematology, clinical chemistry, microbiology, serology and parasitology.
8. Resolution of the problem (e.g., diagnosis, treatment, return to a normal state, euthanasia).
9. Identification of the author of all written entries made on the record and documentation that veterinary oversight and authority is in place regarding veterinary care.

D. For animals maintained in a vivarium (either small animals or farm animals), 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 important for post-operative animals or animals displaying any abnormality. Having the record in such a location:

1. Explains the condition of the animals to animal care staff (for example, a sedated animal may otherwise be thought to be ill)
2. Assures animal care staff, OCV and inspectors that the animal care/treatment is being provided
3. Informs animal care staff how recently the investigator or veterinarian has seen the animal,

Although individual records are desirable, a composite post-operative record may be used for a group of animals. Such a record might have a list of the animal numbers and entries made that would include a notation that the animal had been checked, any abnormal observations and a list of any therapeutics given including drugs, doses, and routes of administration.
E. For animals maintained in a farm environment, treatment records must be readily accessible from the facility manager, PI, or the veterinary medicine teaching hospital files.

F. Additional Information

This policy does not require or recommend a standard form for animal care and medical records. Whatever the form, 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.

Information and examples from a number of sources on this topic are available from the Office of the Campus Veterinarian (335-6246).

G. Resources

- To review the USDA Animal Welfare Act Policy Statement (#3) on veterinary care and health records, go to this web site: http://www.aphis.usda.gov/animal_welfare/policy.php?policy=3
- To review the policy statement by the American College of Laboratory Animal Medicine regarding adequate veterinary care, go to this web site: http://www.aclam.org/Content/files/files/Public/Active/position_medrecords.pdf

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