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 their own medical record 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 3 years after completion of the activity.
2. USDA covered species: Throughout an animals’ life and 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.

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

Note: CVS 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 cannot 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.

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 (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 the best medical care possible for the animal is provided.

Anesthetic records are required for all anesthetic procedures both surgical and non-
surgical. **Short-term chemical restraint or “boxing down” animals for ease of handling does not require an anesthetic record.**

An anesthetic record must contain the following:

a. Animal ID (for animals with a unique ID this must be included) versus for colony or group species an identifier is required that correlates with each specific animal  
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  
g. For example: sternal at 5:15 pm, returned to regular housing 5:20 pm  
h. If the animal is terminal or euthanized or does not recover this must also be indicated in lieu of a recovery time  
i. Name of person(s) monitoring anesthesia  
j. Name of person(s) performing procedure (if different)  
k. Names of drug(s) used for induction, maintenance, analgesia, and antibiotics if given and any supportive care (e.g., fluids)  
l. For inhaled anesthetics the percent administered and flow rate  
m. For example: 3% Isoflurane at a flow rate of 2 Liters/Minute of Oxygen  
n. For all others the dose, concentration, dosage/amount administered and route  
o. For example: 5 mg/kg of carprofen, 50 mg/mL concentration, gave 10 mg, 0.2 mL subcutaneously (SC)  
p. 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)

**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 same area 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 is **seven days** for research-related procedures or as directed by the clinical veterinarian or clinical veterinary standard operating procedure (SOP) for clinical procedures.

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

For procedures that do not require an incision but still include analgesics and/or cause an injury or defect, monitoring is required for the duration of the healing period or if ambulation or physiological function is impaired. The time frame may be set by the AV or written into the IACUC protocol. Procedures that may be painful after the procedure require monitoring at the discretion of the AV or designee with regards to frequency and duration, or may be included in the IACUC protocol.

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
b. Description of procedure
c. Date and time of recovery
d. Treatments and assessment - including analgesia, antibiotics, and any supportive care.

   i. For example, an incision on the neck, spay incision, post lung lavage monitoring for respiratory difficulty or discharge.

   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 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. Pain/analgesic assessment  
c. Assessment of activity and the ability to reach food and water  
d. Assessment of food intake (for rodents or other animals in small cages or group housing situations or on ad libitum chow this may not be feasible to assess)  
e. Urine and fecal output if feasible to assess (for rodents this may be difficult to assess due to their standard housing conditions)  
f. Administration and documenting analgesics and/or antibiotics and/or supportive care given  
g. For example: carprofen, enrofloxacin, or lactated ringers, supplementing chow  
h. Documentation of drugs must include drug name, dose, concentration, dosage and amount administered, frequency, and route  
i. Documenting the healing of the incision, wound, or site  
j. Removal and documentation that external closures are removed (some rodents or other animals may self-remove) or dissolved if absorbable. This is annotated as it happens but is checked daily.  
k. Documentation of any abnormalities  
  i. For example: dehiscence or discharge  
l. 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  
m. Adverse effects must also be addressed with the IACUC

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 for 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 clinical veterinarian.