VSBSA Record Keeping Guidelines

Preamble

Professional standards must be adhered to in the delivery of all veterinary services and the responsibility for setting those standards rests with the Veterinary Surgeons Board of South Australia (the Board).

The SA Code of Professional Conduct for Veterinary Surgeons sets out:

> *Veterinary surgeons must maintain adequate records of treatment carried out. As soon as practicable after treating an animal or consulting with a client, a veterinary surgeon should ensure that a detailed record of the treatment or consultation is made. This record should include:*
>
> - *description of the problem,*
> - *differential diagnoses,*
> - *treatment carried out,*
> - *any x-ray film, radiograph or ultrasound image relating to the treatment of an animal.*
>
> *The veterinary surgeon should ensure that the record is kept in safe custody for at least 2 years after the relevant treatment or consultation.*[1]
>
> *Records of any case should be of such detail that any veterinary surgeon could take over management of the case at any time. Records should be sufficient to stand alone to justify treatment and procedure.*

Application

These Guidelines apply from and including 24 April 2024.

These Guidelines may be superseded by subsequent versions. To ascertain whether this version has been superseded, view the current version on the Board's website here.

It is the responsibility of veterinary surgeons to be conversant with the current version of these Guidelines.

Guidelines

Veterinary clinical records are an essential tool in the practice of veterinary medicine and surgery. Complete, well documented records provide evidence of practice protocols and treatments and should be able to stand alone in the event of an inquiry and be sufficient to justify the treatment and management of the case.

All veterinary surgeons are professionally obligated to ensure they maintain appropriate clinical records. This obligation is not restricted to those instances in which scheduled drugs are prescribed or dispensed but applies to all professional services provided by veterinary surgeons to their clients.

Clear and succinct record keeping is essential to provide evidence of continuity of treatment between veterinary surgeons in situations where more than one veterinary surgeon attends to a case. The records should contain the justification for patient care, including a medical history, differential diagnoses and serve as a means of

[1] The Australian Small Animal Veterinary group (ASAV) Manual of Hospital Standards and Accreditation 2019 states that medical records must be kept long enough to comply with state and federal regulations and recommends 7 years.

communication between members of staff, and with others who may be consulted or to whom a case may be referred.

For both clinical and legal purposes, they provide documentary evidence of the patient's ownership status, health status, care and treatment and serve as a basis of review, study and evaluation of veterinary care rendered to the patient by the practice.

When investigating a complaint, the Board will request veterinary surgeons involved to provide the clinical records of the case. These records should contain the premises name and contact details on top of the document.

The Board believes that the keeping of adequate clinical records is an essential component of professional conduct in contemporary veterinary practice. Consequently, the failure to keep adequate and appropriate clinical records may result in the Board instituting disciplinary action against veterinary surgeons who have failed to maintain appropriate clinical records. In addition, your records may be subpoenaed by the courts, so it is important to ensure that they are accurate and objective. Poor or non-existent clinical records may also leave a veterinary surgeon legally vulnerable.

Clinical records

A veterinary surgeon must ensure that an appropriate and relevant, clear, succinct, accurate and complete record of any veterinary service, which includes consultations, provision of advice, examinations, surgical procedures, and diagnostic examinations etc., is made as soon as is practicable.

The records need to include sufficient detail to demonstrate the veterinary surgeon’s assessment of, and treatment of a patient and to enable a continuity of clinical assessment and treatment of a patient by another veterinary practitioner in the practice or if the animal is referred. They must also comply with other relevant legislation, including the requirements for recording the supply of the drugs in the practice.

Other points regarding clinical records include:

- annotations or amendments to clinical records:
    - for handwritten records, any subsequent annotations, or entries, must include the date and the time of the annotation and be initialled by the veterinary surgeon.
    - for computer-based records, subsequent annotations must be made as a separate record rather than amending the original clinical record.
- when a patient transfers to another veterinary surgeon, the primary veterinary surgeon should, when asked by a client, make available either a copy of the entire original medical record or a summary sufficient in detail to enable appropriate ongoing care of the case. This should, where appropriate, include other resources such as laboratory results and images.
- clinical records provided to the Board should be provided in their entirety; and
- computer based records - it is essential that adequate backups of the data are kept.

The Board would consider an appropriate and relevant record of any consultation, procedure or treatment should provide the following history data at a minimum:

- Date and time of consultation (date of record if different to date of consultation)
- Identification of all veterinarian surgeons and/or staff involved
- Name of veterinarian or person entering record
- Client identification
- Animal patient or herd identification – Breed/Species
- Presenting problem
- Medical history
- DOB/Age
- Weight

- Colour
- Microchip
- Insurance information
- Physical examination details the date of consultation - a comprehensive physical examination is expected to be recorded by body system to the extent relevant to the veterinary management of the patient
- Basic objective parameters from a physical examination should be recorded – these should include, where relevant, body condition score and/or weight, heart rate, respiratory rate, temperature, mucous membrane colour and capillary refill time
- Clinical reasoning must be evident in-patient records including:
    - differential diagnoses/diagnosis
    - case management plan – approach to further investigation and treatment updated as required to reflect developments in case management over time.
- Evidence of client communication and informed consent. Communication with the client while under veterinary management must be regular and documented.
- Full description of any procedure including but not limited to surgeries, treatments, and anaesthetic records if applicable
- Medications administered including dose and route.
- Any limitations of the physical examination should be recorded
- Provisional and final diagnosis
- Vaccination record
- Copy of any certificates issued.

Additionally, where relevant a clinical record should also include:

- Prognosis
- Consultation progress notes
- Discharge instructions- the use of written discharge instructions is recommended. The instructions should be fully explained to the client
- Radiography and ultrasonography records
- Anaesthetic records
- Eye, dental and skin charts
- Laboratory reports
- Hospitalisation treatment record
- Advanced imaging reports, e.g. CT, MRI, Scintigraphy
- Specialist reports
- Surgical mortality record
- Necropsy reports

In addition to the full patient record details expected above, a clinical record also includes where applicable:

- admission/consent forms
- cage cards, hospital charts and any other hand-written records
- referral reports
- billing records
- any other physical or electronic record relating to patient care.

Do not include any gratuitous comments or information that could cause offence to any party in patient records, and always show respect for your colleagues.

Provision of records

The SA Code of Professional Conduct for Veterinary Surgeons (clause 5), sets out:

g. A veterinary surgeon who has previously treated an animal must, when asked by another veterinary surgeon who has taken over treatment of the animal, provide all relevant details of clinical history directly to the other veterinary surgeon.
h. A veterinary surgeon to whom another veterinary surgeon has referred an animal for treatment, or a second opinion should return all documents and other articles provided by the other veterinary surgeon when the animal is finally discharged or is referred to the other veterinary surgeon.

Consent should be obtained from the client before releasing records relating to that client. The Board also recommends that permission is sought from the individual veterinarian or owner of the veterinary practice depending on circumstances prior to releasing animal health records.

When a specialist or other veterinarian has visited the practice to treat an animal it is likely, based on the above, that the practice would be the owner of the records however it would be prudent and ethically appropriate to discuss this matter with the specialist or other veterinarian prior to any release.

Where the veterinary practitioner holds the records of another practitioner that have been provided pursuant to the Code, the agreement of that practitioner should be sought prior to releasing the records.

When releasing records, veterinary surgeons must also be mindful of the privacy interests of third parties whose personal information may be included in clinical records. In addition to specialists and other veterinarians as above, another example is where the records for an animal include information obtained when the animal was owned or cared for by a different client. Whilst records may be held in one file for an individual animal with multiple clients over time, each client must provide consent for release of information pertaining to when that client was responsible for the care of the animal.

Before releasing records please also consider what other personal information these records hold. A person leaving or who has left a relationship may not wish their contact details to be inadvertently provided to the former partner.

The Code also provides that veterinary practitioners must always act with a primary concern for the welfare of animals. Even where there is no obligation to provide a copy of the clinical records to a third party, it may be appropriate for the veterinary practitioner to disclose, with consent from the client, information from the records that is necessary to facilitate the treatment and care of the animal.

Client confidentiality

A veterinary surgeon should ensure that they treat as confidential, and refrain from divulging, any information relating to clients, or their patients, acquired during their employment.

Ownership of patient records

Medical records and diagnostic images remain the property of the veterinarian or practice, not the client, and the veterinarian is legally obliged to retain all records and images as part of their original medical records and to produce them in the event of a subpoena or other call for production of the records.

The client pays a fee for the generation of medical records and diagnostic images and is therefore entitled to be informed of the results and interpretations and shown the report/image if they desire.

If a copy of the report or image is requested, it should be provided but can be done at a charge to the client. If a copy is requested by someone other than the client, such as another veterinarian, the client’s written authority to provide such a copy to that third person should be obtained.

A decision by a veterinarian to refuse to provide an animal’s patient record to a client on request by the client – is not sufficient to justify a complaint to the Veterinary Surgeons Board.

Providing patient records to another veterinarian

Case records and diagnostic images can be released upon formal request to another veterinarian only with the authorisation of the client.

If formally requested by a client, veterinarians should provide a copy of the patient record to another veterinarian if the client is seeking a second opinion or if the client wishes to nominate another veterinarian to take over the ongoing care of their animal. The receiving veterinarian should obtain consent from the original veterinarian before providing them to a client.

If a veterinarian refuses to provide patient records to another veterinarian and this results in an adverse outcome or the patient undergoes a repeat invasive procedure, the veterinarian who did not provide the patient records may be found guilty of professional misconduct.

Patient records and premises closures

In the event of a veterinary premises closure, records should be:

- retained by the veterinarian and made accessible if requested by clients for the statutory period of 3 years; or
- provided to another veterinary practice and notify clients of their location so they can organise continuity of care for their animals; or
- provided directly to clients.

The Australian Small Animal Veterinary group (ASAV) Manual of Hospital Standards and Accreditation 2019 states that medical records must be kept long enough to comply with state and federal regulations and recommends 7 years.

Board Records for Notifications/Complaints

Should a notification/complaint, be received by the Board, a request will be made to the veterinarian surgeon for the clinical records of the patient. The Board on reviewing the Notification will be looking for the following information in the records:

Medical Management

1. Physical assessment and clinical reasoning

· Comprehensive physical assessment

· Relevant and accurate detail to support clinical assessment

· Differential diagnoses/diagnosis, work-up logic, and treatment options

2. Case Management

· Case management plan – approach to further investigation and treatment

· Updated as required to reflect developments in case management over time

3. Continuity of Care

· Advice for home care

· After hours availability for the practice, along with instructions for contacting the practice

· Aware of arrangements for care of hospitalised patients during after hours

· Referral to another practice, and contact details and offering to provide medical records and cases summary information if appropriate

· Arranging referral, if required or requested by the client

· In multi-vet practices comprehensive ‘hand-over’ protocols in place and followed

4. Postoperative care and discharge process

· Clients aware of arrangements for observation and veterinary care of hospitalised patients during after hours

· Detailed discharge advice for home care

· Referral details provided where required

Clinical Records

· Diagnostic procedures, images (radiographs/ultrasound/other), clinical pathology results, findings, and interpretation

· Full description of any procedure including but not limited to surgeries, treatments, and anaesthetic records if applicable

· Medications administered including dose and route

· Certification complete, accurate and based on personal knowledge

Communication

1. Options offered

· Discussion on assessment and possible diagnosis or treatment approach

· Outlined quality of life impacts and ongoing care (where required)

· Options discussed (referral, euthanasia)

· Anticipated costs

· Level of experience and skills they have for the proposed veterinary management

2. Informed consent verbal/written

· Discussion evident in records and requisite forms signed by person with authority to consent to a procedure or treatment

· Discussion where appropriate the use of off label drugs

Animal Welfare/Additional information

1. Animal welfare prioritised

· Issues under Animal Welfare Act considered

If the information is not contained in the records, then the Board can only assume that it was not done. Your records are your 'first line' of evidence and so it is in your interest that your records are complete.

VSBSA Vets
ABN 81 994 904 775

Phone: 08 8359 3334

Ms Rebecca Registrar
GPO Box 11020
ADELAIDE SA 5001

Ref: 11111PL

Patient History for Consults

Breed:	Species:
Age:	Colour:
Current weight:	Microchip:

15 April 2024 Ref Dr Vet Vet Age

Vital signs: Name	Value	Notes	Low

History details: Reason: Standard consult

Subjective:
Objective:
HR/PR/CV:
MM/CRT/Hydration:
RESP/RR:
Temp:
GIT/UG:
Skin/Ears:
M/S:
Eyes:
Dental:
Lymph Nodes:
BCS: /9
Assessment:
Treatment:
Plan:

INSURANCE HX
Initial assessment >
Suspected cause>
Date of first clinical signs >
Any other conditions/treatments >

SAMPLE REPEAT MEDICATION TEMPLATE

VSBSA Vets
ABN 81 994 904 775

Phone: 08 8359 3334

Ms Rebecca Registrar
GPO Box 11020
ADELAIDE SA 5001

Ref: 11111PL

Patient History for Consults

Breed:	Species:
Age:	Colour:
Current weight:	Microchip:

15 April 2024 **Ref Dr Vet Vet** **Age**

Vital signs: Name	Value	Notes	Low

History details:

Reason: Repeat Medication

Subjective:
Treatment:
Drug:
Dose:
No Supplied:
Prepared by:

VSBSA Vets **Phone: 08 8359 3334**
ABN 81 994 904 775

Ms Rebecca Registrar **Ref: 11111PL**
GPO Box 11020
ADELAIDE SA 5001

Patient History for Consults

Breed:	Species:
Age:	Colour:
Current weight:	Microchip:

15 April 2024 **Ref Dr Vet Vet** **Age**

Vital signs: Name	Value	Notes	Low

History details:

Reason: Standard Ultrasound

Treatment:
Sedation: Entered in the drug book Yes No

>Liver	>Not seen
>Gall Bladder	>Not seen
>Spleen	>Not seen
>Left Kidney	>Not seen
>Right Kidney	>Not seen
>Urinary Bladder	>Not seen
>Left Adrenal	>Not seen
>Right Adrenal	>Not seen
>Stomach	>Not seen
>Duodenum	>Not seen
>Jejunum/Ileum	>Not seen
>Colon	>Not seen
>Pancreas	>Not seen
>Peritoneum	>Not seen
>Lymph Nodes	>Not seen
>Prostrate/Uterus	>Not seen
>Testes/Ovaries	>Not seen

Assessment:

Plan:

VSBSA Vets **Phone: 08 8359 3334**

ABN 81 994 904 775

Ms Rebecca Registrar **Ref: 11111PL**
GPO Box 11020
ADELAIDE SA 5001

Patient History for Consults

Breed:	Species:
Age:	Colour:
Current weight:	Microchip:

15 April 2024 **Ref Dr Vet Vet** **Age**

Vital signs: Name	Value	Notes	Low

History details: **Reason: Standard surgery**

Objective:
HR/PR:
MM/CRT/Hydration:
RR:
Temp:
MM
CRT
Status
Laboratory:
Treatment:
Premed
Induction
Intubated with size ## cuffed ET tube and maintained iso %/oxygen L/min
IVFT started Hartmans ml/hr
Ears:
Teeth:
Nails:
Surgery started
Technique
Surgery finished
Anaesthesia finished
Recovery
Pain relief
Plan:
F/U call tomorrow
Suture removal in 10-14 days