Introduction

The Veterinary Practitioners Code of Professional Conduct (Code (cl 15(1))) requires that a veterinarian must ensure that a detailed record of any consultation, procedure or treatment is made as soon as practicable. The record (cl 15(2)):

(a) must be legible and in sufficient detail to enable another veterinary practitioner to continue the treatment of the animal, and

(b) must include the results of any diagnostic tests, analysis and treatments.

The Code (cl 15(3) also requires that if the record is altered, the alteration must be clearly identified in the record as such and under (cl 15(4)), all records of any consultation, procedure or treatment must be retained for at least 3 years after they are made.

The Code (cl 10) requires a veterinarian who has previously treated an animal, when requested to do so and with the consent of the person responsible for the care of the animal (client), provide copies or originals of all relevant case history records directly to another veterinarian who has taken over the treatment of the animal.

Finally, the Code (cl 11) requires the veterinarian to whom another veterinarian has referred an animal for treatment or a second opinion to return records provided by the referring veterinarian as soon as practicable.

Purpose

The purpose of this guideline is to assist veterinarians to comply with record keeping requirements and in doing so enable optimum management of cases both within an individual veterinary practice over time and for the continuation of care by other veterinarians if required.

Policy

1. A veterinarian must ensure that records contain sufficient information to clearly identify the animal relevant to the circumstances. For an individual animal or group of animals this includes the name of the client (or owner), their address and contact details, and a description of the animal sufficient to identify the individual or group of animals. For wildlife, the details of the animal and the contact details of the person presenting the animal together with the location found should be recorded.
2. The record must also include the name of the veterinarian (may also include the veterinarian's registration number) and the date of entry of the record.

Application of the Code

1. The record must ensure a detailed record of any consultation, procedure or treatment is made as soon as practicable:
    a. The record should be created at the time veterinary services are delivered or as soon as practicable.

2. The record must be legible and in sufficient detail to enable another veterinarian to continue the treatment of the animal and must include the results of any diagnostic tests, analysis and treatments.
    The following are recommended:
    a. The reason for the visit or presentation
    b. History of clinical signs including what abnormalities have been noticed, onset, duration, and any changes (static, improving, deteriorating); other pertinent history depending on presentation such as housing, supervision, access to poisons or other material (scavenging), diet, vaccination and parasiticide administration, known sensitivities, and current medication; other pertinent previous history.
    c. Physical examination findings including weight for small animals; body temperature if indicated by history and clinical signs; what was examined and findings both normal and abnormal; if a particular examination has not been performed (e.g., mouth) it should be recorded as not examined; other clinical observations made during the examination such as behaviour or abnormal movements.
    d. An assessment identifying problems determined from the history and physical examination and a provisional diagnosis, differential diagnoses, or final diagnosis; the most likely disease processes causing the problems (likely extent of the veterinary services) should also be discussed and noted in the record. Prognosis or prognoses (likely outcome of veterinary services) associated with possible diseases discussed should also be discussed and noted in the record if relevant to the condition.
    e. A plan should include what if any diagnostic testing is recommended to further investigate the possible causes identified; possible treatment recommendations; possible alternative approaches to management discussed with the client including advantages, limitations, risks, likely costs; discussions

on a plan for reassessment or further treatment if required, and availability for emergency treatment and referral if appropriate.

f. Medications administered and/or supplied including name, formulation, dose, duration of treatment, instructions for use and possible side effects or precautions as indicated; withholding periods for food producing species.
g. For hospitalised patients the record for each day should also include: findings of diagnostic tests; clinical assessment and interpretation of diagnostic tests; updated care plan; update in communications with the client; update on likely extent and outcome and costs of treatment; discharge instructions including possible signs that would necessitate further assessment or emergency treatment.
h. For patients where any procedure or general anaesthetic is performed, a record of the medications administered, including doses, and a description of the procedure performed.
i. Other reports should be maintained in the record including: images and imaging interpretation; laboratory results and interpretation; necropsy reports and interpretation; referral reports; signed consent forms; surgical records; anaesthetic records; hospital observation charts and treatment records; dental records; and a copy of any certificate issued or received.
j. Where templates are used for records these should be checked for accuracy.
k. All communications with the client by any staff member should be recorded in the record if possible.

3. If the record is altered, the alteration must be clearly identified in the record as such:
    a. For computer records, a note should be made against each alteration and the audit facility must be employed.

4. All records of any consultation, procedure or treatment must be retained for at least 3 years after they are made:
    a. Veterinarians should ensure a back-up of electronic records is regularly created and accessible in the event of loss of primary records.

5. A veterinarian who has previously treated an animal must, when requested to do so, and with the consent of the person responsible for the care of the animal, provide copies or originals of all relevant case history records directly to another veterinarian who has taken over the treatment of the animal:
    a. Consent from the client (person responsible for the care of the animal) at the time the record was created can be obtained verbally and noted in the record.
    b. If another person takes over responsibility for the care or ownership of the patient, that person is not able to provide consent to release prior records.

6. A veterinarian to whom another veterinarian has referred an animal for treatment or a second opinion must return records provided by the referring veterinarian as soon as practicable:
    a. This is not required for a copy of records or electronic records where the primary record is kept by the first veterinarian.
    b. The records provided remain the property of the first veterinarian or veterinary practice and consent from the first veterinarian or practice, and client, is required before providing these records to a third party.

Monitoring

1. The Board may request (Act (s 41)) or summons(Act (s 44)) a copy of all patient records to monitor compliance with the Code when investigating a complaint.
2. The Hospital Inspector may view or seize records (Act (s 91)) when conducting inspections of premises to monitor compliance with the Code or to assist with the investigation of a complaint.
3. The Board will consult with the profession, veterinary, and other regulatory bodies as required regarding this guideline.

Conflict of Interest

Members of the Board must comply with the Code of Conduct for Board members in relation to decisions regarding this guideline.

Review

This guideline shall be reviewed annually or as required to ensure that it remains in line with current standards of practice, appropriate to the operations of the Board and compliant with the relevant legislation.

Example: Dog presenting with vomiting

Client details	Iva Cane 247 Coward St Mascot NSW 2020 04XX XXX XXX
Veterinarian	Emma Record (NSW VXXXX)
Date	27 November 2023
Patient details	George Canine Labrador Yellow Male neutered 7.1 Years 37.0 kg
Reason for visit	Vomiting
History	Recent RHL lameness assessed yesterday and meloxicam supplied Quiet and appears uncomfortable this morning Single vomit this morning, no diarrhoea, no cough Appetite normal Single dose oral meloxicam administered at home Prior medical problems: Multiple surgeries for gastrointestinal foreign bodies LHL TPLO June 2023 Suburban home Toxin exposure – rat bait locked in box on property, seen to eat dirt in area of box Diet: dry kibble Parasiticides: monthly Nexgard Spectra UTD
Physical examination	Mentation BAR Body condition 7/9 Temperature 38.5 ^{0}C Mouth: grade 1/4 periodontal disease, no pain on opening mouth, mucous membranes pink and moist CRT 1.5 s Cardiovascular: auscultation no murmur, good pulse, HR=PR=100, no arrhythmia Abdominal palpation: soft and comfortable, no masses or organomegaly detected, GIT sounds present and normal Respiratory: lung sounds normal, panting with normal effort, no upper respiratory tract noise Musculoskeletal: ambulatory, lame RHL, bilateral stifle thickening, crepitus on palpation of right stifle, no neck or spinal pain on manipulation Neurological: normal mentation, normal gait Ears: no abnormalities Eyes: no abnormalities Lymph nodes: peripheral lymph nodes normal size, shape, consistency Urogenital: bladder soft and comfortable Integument: good hair coat, normal skin turgor

Assessment	1. RHL lameness Recent RHL lameness with discomfort and crepitus on palpation of stifle. Possible cruciate ligament disease, septic/immune-mediated arthritis less likely. Commenced meloxicam yesterday. Appointment for assessment, possible surgery, made for next week. 2. Unsettled Unsettled and seemed unable to get comfortable today. May be associated with orthopaedic discomfort, abdominal discomfort and nausea. Comfortable on abdominal palpation today. 3. Vomiting Single vomit this morning. May be associated with primary gastrointestinal or extra gastrointestinal disease. History or multiple intestinal foreign bodies concerning for possible obstruction, no significant distension or foreign body on abdominal palpation. Vomiting may also be secondary to recent NSAIDs or vaccination/worming. 4. Pica Eats dirt in area close to locked box containing rat bait. At risk of possible rat bait exposure or infectious diseases associated with rats (leptospirosis).
Plan	Findings and possible causes discussed with client. Elected - Monitor at home - Recheck if ongoing vomiting or inappetence for body function profile and/or abdominal ultrasound - Discontinue meloxicam - Start paracetamol for pain relief 500 mg (13.5 mg/kg) every 12 hours PO for maximum 5 days until surgical assessment - Bland diet - Surgery assessment next week if doing well - Consider coagulation testing prior to surgery or if signs consistent with rodenticide intoxication