MANUAL OF HOSPITAL STANDARDS AND ACCREDITATION 2016

The ASAVA acknowledges that much of the material in this manual is based on the publications of the American Animal Hospital Association, “2001 Hospital Standards and Accreditation Manual” and the publication of the ASAVA Handbook of Hospital Standards, 1998.

Thanks go to the Executive of the ASAVA and the former ASAVA Executive Officer, Ms Jenny Wade for their support and guidance.

Please direct any comments, criticisms or queries in relation to this manual to c/o The Executive Officer, ASAVA, Unit 40/6 Herbert Street, St. Leonards, NSW 2065.
Standards of Excellence

The standards of the **ASAVA-Accredited Hospitals Committee (ASAVA-AHC) Manual of Hospital Standards and Accreditation** are the cornerstone of the ASAVA. These standards represent the ASAVA’s commitment to achieving its mission, namely: to enhance the abilities of veterinarians to provide quality medical care to companion animals; to enable veterinarians to successfully conduct their practices and maintain their facilities with high standards of excellence; and to meet the public’s needs as they relate to the delivery of companion animal veterinary medicine.

A committee of ASAVA Executive members and other interested parties contributed to the development of the original manual, with it being further updated in 1998, 2003, 2011 and 2016.

The ASAVA-AHC Manual of Hospital Standards and Accreditation is periodically reviewed and updated to reflect advances in companion animal health care and medicine and to try to balance the requirements of high quality veterinary care with the practicality and efficiency of a busy hospital.

The format and content of the manual are jointly reviewed and approved by the ASAVA Executive and Accredited Hospitals Committee (AHC).

The current manual has been changed in its presentation in order to try to make the evaluation process easier and to provide greater assistance to the hospital director and staff.

The standards in this manual reflect today’s requirements for an Accredited ASAVA - AHC Hospital. These standards currently represent the highest veterinary hospital standards in Australia. The standards cover BOTH the physical structure of the facility housing the practice as well as the quality of veterinary health care within the practice.
The Role of Hospital Staff in the Accreditation Process

A major benefit of the ASAVA-AHC evaluation program is the involvement of hospital staff in the evaluation process. Staff members should be involved in the thoughtful completion of the accreditation manual, the preparation of the medical records and radiographs for outside evaluation, as well as the preparation of the hospital premises for the on-site inspection.

The ASAVA suggests that as many staff members as possible are involved in the accreditation process. Many hospital directors assign sections of the accreditation manual to key staff members and then compare staff answers to their own. Hospital directors and staff then can plan the necessary steps to achieve compliance.

It is important to complete the preparation check list on page 15 in order to allow adequate time to review hospital operations and make any improvements required to achieve the desired accreditation level.

Key staff members also benefit greatly from participating in the evaluation of their areas of responsibility. This allows them the opportunity to ask questions, exchange ideas, and be recognised for their important role in the veterinary health-care delivery team.

We strongly recommend that the hospital director be actively involved throughout the entire evaluation. However, if a last-minute problem arises for the director, another senior member of the staff must be appointed to respond officially for the practice.

We encourage all newly accrediting hospitals who have any questions about the accreditation process to contact the ASAVA office at asava@ava.com.au to register their interest in becoming accredited, and also to contact the office if there are any ongoing questions specifically related to the manual. The ASAVA office can put applicants in touch with an already accredited hospital who can serve as a reference and also discuss the benefits of accreditation from their perspective. This hospital may be able to provide some additional support throughout your accreditation process. These additional reference sources volunteer to help new applicants and aim to help via email and telephone communication. Whilst such assistance can be provided as outlined above, a successful accreditation is wholly the responsibility of the applicant hospital and its directors, and they must ensure that their hospital procedures, equipment and staffing are at the level as described in this manual. A period of 6–12 months is recommended for all correspondence in preparation for submission of the application by the 31st October deadline of each year.
Completing the Manual

An official version of the ASAVA- AHC Manual of Hospital Standards and Accreditation, which includes the self assessment questionnaire, must be completed by the hospital and submitted to the ASAVA along with the required medical records and radiographs for outside evaluation by October 31st for hospitals to be inspected in the following year.

How Long Will the Evaluation Take?

The on-site evaluation will usually take three to four hours to complete. The emphasis of the inspection and time may vary depending on the inspector’s needs and the preparedness of the hospital director.

While all sections of the standards are covered during the visit, the inspector can pay attention to specific areas of interest. The director should communicate the staff’s expectations of the on-site visit and need for specific feedback to the inspector, either prior to or at the beginning of the visit.

Disclaimer

While the ASAVA-AHC Standards require members to be in compliance with relevant laws and regulations established by various federal, state and territory governments and agencies, the on-site evaluation of your practice by Inspectors of the scheme is not intended to be a comprehensive review of all such applicable requirements. While we may or may not point out areas of concern or non-compliance with regard to requirements of OHS, DEA, EPA, workers’ compensation, or similar agencies, you should not rely on our evaluation as being official with regard to those agencies’ requirements. Each member should consult with the appropriate agencies, or with qualified advisors, relative to specific requirements to ensure practice compliance.

Exemptions

The Hospital Accreditation scheme was set up to accredit hospitals that offer services to all small animal species; there are certain situations which allow for an exemption to certain sections of the manual and its requirements due to the nature of the practice encompassing a narrower spectrum of services than seen in general practice. Such facilities applying for accreditation may apply for exemptions to those parts of the manual which are not applicable to their area of practice. This should be communicated with ASAVA office prior to the submission of the relevant records for assessment. Once this has been clarified, and such exemption(s), granted, these finalised details are to be again submitted in due course with the completed manual (having already been accepted by the ASAVA).
# Table of Contents

How To Use This Manual 6

**Part A - Regulations and Application Form** 7

Regulations for Hospital Accreditation 7

Procedure for Submission of Applications and Inspection 10

For Submission to the Medical Records Inspectors 12

For Submission to the Radiology Records Inspectors 13

Application for Hospital Accreditation 14

Preparation Checklist for Accreditation 15

Hospital Details 17

*Primary Facility (Clinic/Hospital) Information*
*Additional Facility (Clinic/Hospital) Information*

Personnel Information 18

*Hospital Director*
*Hospital Associate*
*Management Associate*

**Part B - Hospital Accreditation Evaluation Questionnaire** 24

Medical Records 24

Examination Facilities 29

Dispensary 31

Laboratory/Pathology 35

Diagnostic Imaging 37

Anaesthesiology 42

Surgery 46

Dentistry 50

Nursing Care And Wards 52

*Intensive Care Ward*
*Isolation Ward*

Housekeeping And Maintenance 58

Library and Continuing Education 61

Emergency Services 63

Chemotherapeutics and Cytotoxics 65

Addendum 1: Records 67

Addendum 2: Medical Record Guidelines 70

Addendum 3: How to Write a Radiology Report + Example Submissions 72
How to Use This Manual

The ASAVA–AHC Manual of Hospital Standards and Accreditation has been developed to provide guidance to practitioners and support staff to operate high-quality, full-service veterinary hospitals. The ASAVA hopes this manual will encourage study of the standards by both hospital directors and their staff. This manual is to assist you in preparing for your hospital evaluation. The ASAVA - AHC Manual of Hospital Standards and Accreditation addresses requirements in the following areas:

Medical Records  Nursing Care
Surgery        Laboratory Facilities
Dentistry      Emergency Services
Diagnostic Imaging Housekeeping and Maintenance
Anaesthesiology Record Keeping
Dispensary     Continuing Education
Chemotherapeutics

Recommendations

In this manual, the items listed under "Recommendations" may become standards at some point in the future. It is desirable but not mandatory to comply with "Recommendations."

Each section of the manual is divided into:

Objective (where applicable)

Rationale (where applicable)

Standards in subsections of:
A. Personnel and Procedures
Training required or other characteristics of who performs a function
How things are to be done

B. Equipment
Lists or characteristics of required equipment

C. Structure
Physical structure
Required sections or topics in medical records

D. Required Submissions (Diagnostic Imaging and Medical Records only)
Each requirement or standard is listed with two columns of self-assessment boxes on the right side of each page. Review each standard carefully, and then indicate the compliance status of your hospital by checking the appropriate YES/NO box.

For example:

1. A legible, individual record must be maintained for every patient.

   Compliance
   Yes  No

It is strongly advised that newly accrediting hospitals communicate with an existing accredited hospital who will aid them in the accreditation process. A minimum time frame of 6 months is recommended for such correspondence to take place. Please contact the ASAVA via email on asava@ava.com.au so this can be organised via the AHC convenor.
PART A - REGULATIONS AND APPLICATION FORM

REGULATIONS FOR HOSPITAL ACCREDITATION

The purpose of the ASAVA–Accredited Hospitals Committee is to enhance the abilities of veterinarians to provide quality medical care to companion animals, to successfully help practices maintain their facilities with high standards of excellence, and to meet the public’s needs as they relate to companion animals. As such, there are certain requirements that must be met BEFORE being eligible for hospital Accreditation. Please read these regulations carefully and mark compliance or non-compliance where indicated.

1. The hospital and its staff meet and adhere to the Code of Professional Conduct and the Constitution of the Australian Veterinary Association (AVA).

2. All matters pertaining to the maintenance of ASAVA-AHC standards and all aspects of medical care for patients of the facility are under the control of a veterinarian, duly registered by the state or territory in which the practice is located.

3. The ASAVA-AHC standards were written with the primary goal of providing high-quality veterinary care to companion animals. Accordingly, all decisions which affect the ability of the practice to operate in compliance with the ASAVA-AHC standards are also made only by registered veterinarians. Complete authority and control for all matters relating to the ASAVA-AHC standards and veterinary care are vested solely in the hospital director, who must be a registered veterinarian and a member of the AVA and ASAVA.

4. In cases of practices owned individually or collectively by registered veterinarians (51% ownership or greater), the owner(s) may designate the hospital director(s). Since ownership in these cases is in the control of registered veterinarians, complete veterinary control over all matters pertaining to the hospital standards and medical care is presumed.

5. In those cases in which 51% or greater of the practice is not owned by veterinarians, the owner(s) must submit a certified statement agreeing to vest control over the hospital standards and veterinary care to the hospital director. In the event that control is no longer vested in the hospital director, the hospital director agrees to notify ASAVA-AHC, in writing. Samples of these certified statements appear as Statement A and Statement B. Copies of these statements must be submitted at the time of application for accreditation and at each subsequent evaluation of the facility.

6. While the hospital director may delegate duties and authority to appropriately trained members of the staff, ultimate responsibility for staff actions relative to medical care and the ASAVA-AHC standards remains with the hospital director.

7. Referral of a patient to a specialist, to another veterinarian, or to another facility is often made in the best interest of the patient and the client. Since the decision to refer is a veterinary decision, the decision when to refer and where to refer should be under the direct control of a registered veterinarian.

8. If the directorship of any ASAVA-AHC hospital member changes for any reason, the original and new owners must so notify ASAVA-AHC immediately. In cases of practices owned by non-veterinarian(s), new certified statements (Statements A and B) must be submitted.
9. If the controlling ownership of a hospital member changes for any reason, ASAVA-AHC will be notified immediately. In the case of ownership changing from one non-veterinary owner to another, a new statement agreeing to control by the hospital director must be submitted by the new owner(s) (Statement A). In the event of ownership changing from a veterinary owner to a non-veterinary owner, both the owner’s statement (Statement A) and the hospital director’s statement (Statement B) must be submitted.

10. Availability, operation, and maintenance authority for all equipment and supplies to support these ASAVA - AHC standards must be under the control of the hospital director. In no event may the owner of an accredited hospital fail to provide or maintain the equipment required, as determined by the hospital director, for compliance with the ASAVA - AHC standards.

11. If the hospital is applying for initial accreditation and in the opinion of any one of the three inspectors, the hospital facility, medical records or radiography are deemed to be unsatisfactory, the directors will be notified together with the reasons for such action.

12. If, after the on-site inspection, minor changes are found to be necessary, the hospital is placed on provisional accreditation subject to the changes being completed by a specified date. Failure to complete the changes to the satisfaction of the inspector or within the specified time frame will cause the provisional accreditation to lapse. The ASAVA - AHC must be notified in writing on the completion of the changes.

13. Before accreditation is completed, the completed changes will be inspected by an inspector or an appointed ASAVA - AHC local director, representing the inspector.

14. If after further inspection of the hospital as outlined in point 13 above, deficiencies are still present and deemed to be significant, accreditation will be revoked.

15. The accreditation is for a period of four (4) years only. Application for re-accreditation is necessary after this period.

16. If the hospital is applying for re-accreditation, and in the opinion of any two of the inspectors—(hospital, medical records or radiography) the application as submitted is unsatisfactory, the directors will be notified in writing, together with the reasons for such action. In such a case, re-accreditation may be provisional for a specified time, or cancelled.

17. If the hospital is applying for re-accreditation and either the medical records submission or the radiography submission are judged to be of an unsatisfactory standard, but the rest of the on-site hospital inspection is passed, then the hospital may be granted a 12 months provisional re-accreditation. The exact time for provisional accreditation is at the discretion of the Accreditation scheme convener, or in consultation with the AHC. The failed part of the submission must be re-presented for inspection within this time, and if the resubmission is judged to be of a satisfactory standard then the hospital may be re-inspected by an inspector, or an ASAVA-AHC local director, representing the inspector, to ensure that the resubmission is a true reflection of the hospital's current medical records or radiographs. If this is confirmed then full re-accreditation will be granted. If the resubmission is again judged to be of an unsatisfactory standard, and if the provisional re-accreditation lapses, the hospital may cease to be accredited.
18. The Executive Committee of the ASAVA reserves the right to alter the standards and regulations for accreditation at any time, on the recommendation of the ASAVA-AHC. If the standards and regulations are altered, no major structural changes will be required to be made by accredited hospitals to achieve re-accreditation, unless failure to carry out such structural changes can be shown to seriously compromise patient care. It must be understood that standards of care and statutory regulatory requirements change with time and that accreditation standards will change to reflect those changes.

19. The hospital must maintain at least the standards necessary for initial accreditation throughout the entire period of accreditation.

20. All hospital directors involved with the small animal component of accredited hospitals must remain members of the AVA and ASAVA for the duration of accreditation.

21. All presentation plaques remain the property of the ASAVA and are to be returned at the request of the Executive Committee of the ASAVA on the recommendation of the ASAVA-AHC.

22. Any hospital that is refused accreditation or which chooses to withdraw from the accreditation scheme must immediately cease to use the ASAVA–AHC logo in any of its publications and literature and must not falsely claim to be an accredited ASAVA–AHC hospital.

23. Failure to comply with these regulations will lead to loss of accreditation.

24. An appeal against any decision may be made in writing, within 2 months, to the ASAVA-AHC. The appeal will be considered by a committee comprising 2 inspectors and 1 hospital director, appointed by the ASAVA-AHC. Their decision will be ratified by the ASAVA-AHC.

25. A further appeal against any decision made as a consequence of an appeal to the ASAVA-AHC may be made in writing, within 2 months, to the Executive Committee of the ASAVA. This appeal will be considered by the Executive Committee and their decision is final.

26. Hospital directors who refuse an evaluation and fail to provide the ASAVA-AHC committee with a written explanation, or who do not pay the assessed fee will be referred to the Executive Committee of the ASAVA with a recommendation for termination of accreditation.
PROCEDURE FOR SUBMISSION OF APPLICATIONS & INSPECTION

1. Please complete ALL details in the application form and evaluation questionnaire and submit the completed manual together with a cheque or EFT for the prescribed amount to:
   The Administration Officer
   ASAVA
   Unit 40, 6 Herbert St
   St. Leonards NSW 2065

2. The following must also be submitted:
   **For submission to hospital inspector/s**
   - A floor plan of the hospital, including outlines of all major fixtures and fittings (not necessary for reaccreditation, unless structural changes have occurred since initial accreditation)
   - Colour photographs of the exterior and of all major interior rooms.
   - A copy of the hospital’s housekeeping and maintenance manual.
   - Hospital to have a suitable supply of drugs to meet their needs.
   - A copy of the hospital’s protocol for cardio-pulmonary resuscitation.
   - A list of all major items of medical and surgical equipment including contents of standard surgical kits and number of such kits.”
   - A copy of the hospital’s Isolation Ward protocol. A copy of the organisational plan (job manual) for the nursing service.

3. Medical and Radiograph submissions (see below for details)

4. If the medical records and radiology submission are passed and if the application is found to be suitable, the hospital inspector will contact the hospital director to make an appointment for the physical inspection.

5. The inspection is usually done during a normal working day of the hospital and may take from three hours to one day, during which time a director, or their representative, must be free to discuss any details with the inspector. The director does not need to physically accompany the inspector at all times, but should be available to answer any questions.

6. The inspector collates all external examiners reports and makes up the inspection report with recommendations for consideration by the ASAVA-AHC. The Hospital Accreditation Committee considers all reports and either accepts or rejects the inspector’s recommendations. Their decision is ratified by the Executive Committee of the ASAVA.

7. A copy of the final report and the decision is then sent to the hospital directors.
   a) In the case of Committee acceptance, the hospital is notified of accreditation and is notified of any changes and conditions with which it must comply and the date of compliance fulfilment.
   b) In the case of Committee rejection, the hospital is notified and given the reasons for non-compliance and rejection and the opportunity to agree to comply within a future application. If this is a re-inspection, the hospital will be given a time frame in which to agree to rectify the reason for non-compliance, after which any claim to being an accredited hospital should cease forthwith.

8. The accreditation plaque is presented to the successful applicant at the Annual Conference of the ASAVA during the annual dinner and presentation of awards.

9. Newly accredited hospitals are featured in the association’s Companion Magazine. All accredited hospitals should receive correspondence throughout the year from either the AHC Convener, or ASAVA office. If directors wish to be part of the AHC, then they should contact the ASAVA office or AHC convener. AHC generally meets twice per year, at both the AVA and ASAVA conference, with email correspondence as required throughout the year. The ASAVA Accreditation Scheme is continually evolving, primarily through discussion via the AHC Committee.
10. The closing date for applications is the 31st October for hospitals to be inspected in the following year. This is to allow sufficient time for evaluation of the submissions, inspection, and preparation of the plaque for presentation at the Annual Meeting.
1. Five (5) sets of original medical records (not re-written records), including at least one of each of the following types of history:
   a) A detailed medical case (e.g. Diabetes, IMHA, Hyperadrenocorticism, trauma with extended hospital etc.)
   b) A detailed surgical case
   c) A dental case

2. Medical records must include estimate/consent/admission forms, in-hospital progress notes including cage side charts and fluid balance charts if these are maintained separately from the medical records.

3. Copies of the relevant entry in the anaesthetic log (if kept) or a copy of the anaesthetic charts must be included if these are maintained separately from the medical record.

4. Pathology records should be included if these are maintained separately from the medical record.

5. The medical records assessor has also requested that full details of the patient be included.

The records will be assessed on the quality of the record keeping with the basic criteria being that another veterinarian should be able to take over the case and understand the rationale for any treatment and diagnostic plan and that the records would be adequately defensible in court. A problem oriented approach is preferred by the records inspectors but is not mandatory. The approaches include HEAP (History Examination Assessment Plan) or SOAP (Subjective Objective Assessment Plan) formats.

Record submissions must be submitted as a single paper document or single file clearly marked. (disc or word/pdf file).

Please see Addendum 2 for further guidelines for medical record keeping and submissions.
FOR SUBMISSION TO THE RADIOLOGY RECORDS INSPECTORS

1. Three (3) sets of radiographic studies. The sets must be:
   a) Thoracic (of any sized dog or cat)
   b) Abdominal (of any sized dog or cat)
   c) Skeletal

   Radiographic studies can be of any sized dog or cat, but should be representative of the caseload of the practice e.g. large and small dog, cat.

2. For each of the three radiographic cases submitted, the following are required:
   a) Radiographic studies must be selected from clinical cases that were imaged at the facility within the previous 12 months.
   b) Animal clinical details and signalment.
   c) Computer printout or photocopy of relevant medical history pertaining to the radiograph, (not full computer records for life)
   d) The radiographs and history can be submitted, fully labelled on CD, DVD, SD Card or Thumb Drive
   e) Details of radiographic techniques used.
      - Film/Screen combination for conventional analogue systems
      - Exposure factors.
      - Automatic processing maximum requirement.
      - Radiographic studies must have facility and patient identification, date and laterality information that is permanent and consistent.
      - Radiographic studies must show proper positioning consistent with the area being radiographed.
      - Digital radiographic studies should be submitted in a DICOM format.

3. X-ray report. A computer printout or photocopy of the radiographic assessment made by you should be included. This should include:
   a) Comments on quality
   b) For each view the radiological findings should be described, both normal and abnormal
   c) For each case there should be a differential diagnosis with a preferred diagnosis, if appropriate.
   d) If further studies are indicated, they should be identified.

4. All films reviewed must show evidence of collimation by having at least two adjoining sides showing unexposed film. It is recommended that all four sides of the films demonstrate evidence of collimation.

5. No parts of the human body should appear on the films as this is an indication of poor radiographic technique and poor occupational health and safety practices.

Record submissions must be submitted as a single paper document or single file clearly marked. (disc or word/pdf file). Please see Addendum 3 for further guidelines for radiographic record submissions.
APPLICATION FOR HOSPITAL ACCREDITATION

I/We (insert full names of all directors):

____________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Wish to apply for accreditation / re-accreditation of (insert hospital name):

____________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Address:

____________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Telephone: Fax:

____________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Email:

____________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

In making this application, I/we agree to abide by the following conditions of the ASAVA Hospital Accreditation Scheme:

1. All directors of accredited hospitals must remain financial members of the AVA and ASAVA for the duration of accreditation.
2. Accreditation is for a period of four (4) years only. Application for re-accreditation is necessary after this period.
3. Any conditions for accreditation or re-accreditation are to be implemented within the specified time.
4. All findings of the inspectors are subject to written appeal as specified in the regulations above.
5. The Executive Committee of the ASAVA reserves the right to alter the standards and regulations for accreditation at any time.
6. All presentation plaques remain the property of the ASAVA and are to be returned at the request of the Executive Committee of the ASAVA.
7. The hospital must -maintain at least the standards necessary for initial accreditation or last re-accreditation throughout the entire period of accreditation.

I/We agree that failure to comply with any of these conditions will lead to loss of accreditation

____________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Signed (Directors):
PREPARATION CHECKLIST FOR ACCREDITATION

It is suggested that this checklist be removed from the manual and displayed so that all staff involved can monitor the progress of the preparation for evaluation

This manual is to assist you in preparing for your hospital evaluation.

Date/time of scheduled evaluation:

Name of Inspector:

Person assigned to fill out details and assist on the day of inspection:

Date assigned/completed:

Preparation timetable

1. Hospital director has read the Manual of Hospital Standards and Accreditation

2. Director and assigned staff have completed a photocopied first draft of Manual of Hospital Standards and Accreditation.

Section-by-section review:
- Section 1: Medical Records
- Section 2: Examination Facilities
- Section 3: Dispensary
- Section 4: Laboratory/Pathology
- Section 5: Diagnostic Imaging
- Section 6: Anaesthesiology
- Section 7: Surgery
- Section 8: Dentistry
- Section 9: Nursing Care and Wards
- Section 10: Housekeeping and Maintenance
- Section 11: Library and Continuing Education
- Section 12: Emergency Services
- Section 13: Chemotherapeutics and Cytotoxics
3. Final draft of the Manual of Hospital Standards and Accreditation has been completed. 
   YES/NO box in column to right of every standard has been checked.

4. Radiographic studies must be submitted for review. 
   All submitted radiographs will be returned.
   a) Set of three radiographs selected for submission
   b) A photocopy/copy of the radiographic interpretation(s) from the appropriate medical record(s) must accompany the envelope containing the radiographs.
   c) All submitted radiographs must be permanently identified (ref. Diagnostic Imaging Section).

5. Medical records selected for submission (including copies of all cage side paper work, anaesthesia and surgery reports, consent forms, discharge forms etc).

6. Director’s (or director’s representative) work session with the inspector has been scheduled (typically 3 to 4 hours).

7. Review of on-site hospital evaluation report and question-answer conference has been scheduled (brief staff meeting is optional).

FULL COMPLETION OF THE ASAVA-AHC HOSPITAL STANDARDS AND ACCREDITATION MANUAL INCLUDING PRIMARY FACILITY INFORMATION WITH THE HOSPITAL DIRECTOR’S SIGNATURE AND ADDITIONAL FACILITY INFORMATION IS REQUIRED FOR ACCREDITATION.
## Primary Facility (Clinic/Hospital) Information

### Additional Facility (Clinic/Hospital) Information

Please print or attach a facility business card below

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Please check category: Full Facility [ ] Satellite [ ]

A satellite clinic is a facility that is attendant, subordinate, and dependent upon and proximate to an ASAVA Accredited Hospital and that has common management and/or ownership with an ASAVA Accredited Hospital.
Each director of an Accredited Hospital shall be an ASAVA/AVA Member. A director of an animal hospital is a veterinarian who has a principal medical and administrative responsibility for that facility.

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**Hospital Associate**

A hospital associate is all other employed veterinarians associated with a hospital. They shall be appropriately licensed and registered. Associates do not have to be members of the ASAVA.

All Hospital Associate Members must be registered to practice veterinary medicine

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**Management Associate**

In recognition of the role that hospital administrators play in small animal practice, management associates are non veterinarians or non practicing veterinarians who practice this role.

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Statement A
(COMPLETE ONLY WHEN THERE IS NON-VETERINARIAN OWNERSHIP)

Certified Statement of Owner(s)

I/We

(name(s) of owner(s))

of

(practice name),

(address)

has applied for accreditation /wishes to apply for re-accreditation as a hospital member in the ASAVA – Accredited Hospitals Scheme.

Majority ownership of this practice is held by

The owner(s) of the above named facility designate/s Dr

a veterinarian duly registered in the state/territory of

as the Hospital Veterinary Director. Further, the owner(s) agree that all decisions relating to;

1) The ASAVA–AHC Hospital Standards and Accreditation Manual,

2) The medical and surgical care of all patients, and

3) The medical and surgical supplies and equipment employed in care of all patients will be under the complete authority and control of the Hospital Veterinary Director, Dr

In addition, the owner(s) acknowledge that failure to allow the hospital veterinary director control over these matters shall constitute immediate grounds for denial or termination of accreditation in the scheme.

By executing this document, the undersigned represents and warrants that he/she has the complete and full authority to execute this certificate on behalf of the hospital and its owners.

I have read and reviewed the foregoing certified statement and am knowledgeable as to the contents and statements, and that all matters and things set forth are true and accurate. I understand that if the hospital, its owners, or the undersigned have misrepresented or omitted any material facts concerning this certified statement that the hospital, its owners, and the undersigned will be responsible for any consequences, including loss of membership, which result.

Owner(s)

Signature

Address

Affidavit

The above and foregoing certificate was subscribed and sworn to before me this Day of __________, in the year

by

(Witness) Justice of the Peace
Statement B
(COMPLETE ONLY WHEN THERE IS NON-VETERINARIAN OWNERSHIP)

Certified Statement of Hospital Veterinary Director’s Authority

I, Dr

,duly registered to practice veterinary medicine in the State/Territory of

,have been designated Hospital Veterinary Director of

(practice name)

(address)

a prospective Accredited hospital of the ASAVA.

I agree that I have and will exercise complete authority and control over all matters relating to the ASAVA - AHC Manual of Hospital Standards, the medical and surgical care of all patients, and the medical and surgical supplies and equipment employed in all patient care. I further agree that if, at any time while this facility remains a hospital member, control over these matters is no longer vested in me, and I will immediately notify the ASAVA of that fact.

I understand that ASAVA-AHC retains the right to immediately revoke the hospital accreditation of any facility which does not have a registered veterinarian responsible for the matters set forth above.

I have read the foregoing certified statement and I am knowledgeable as to the contents and statements, and that all matters and things set forth are true and correct. I understand that if the hospital or I have misrepresented or omitted any material fact concerning this certified statement that the hospital and I will be responsible for any consequences, including loss of membership (of ASAVA) which result.

Signature

Address

Affidavit

The above and foregoing certificate was subscribed and sworn to before me this

Day of , in the year

by

(Witness) Justice of the Peace.
PART B - HOSPITAL ACCREDITATION EVALUATION QUESTIONNAIRE

MEDICAL RECORDS

Objective: A detailed, legible, individual record must be maintained for every patient. This includes all strays and wildlife admitted and treated.

Rationale: Medical records serve as a basis for planning patient care and promote communication among members of the hospital staff. The records furnish documentary evidence of the patient's illness, hospital care, and treatment and serve as a basis for review, study, and evaluation of medical care rendered by the hospital.

Random examples of medical records will be viewed during the inspection.

A. Personnel and Procedures

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1. There must be an established system of medical record keeping within the practice. |     |    |
2. Each animal must have a separate medical record. However, the medical record for a litter may be recorded either on the dam's record or on a litter record until the individual animals are permanently placed or reach the age of three months. |     |    |
3. Medical records must be legible if hand-written records are maintained. |     |    |
4. The patient identification used must follow through all departments on other records (such as radiographs, laboratory reports, and necropsy records). |     |    |
5. Medical records must be kept long enough to comply with state and federal regulations (7 years). |     |    |
6. The medical staff must record sufficient information in the history and examination portions of the record to justify the tentative diagnosis and to warrant the treatment. A Problem Oriented Approach is preferred. |     |    |
7. No prescribed coding is required, but the hospital director should require meticulous recording of information. Where abbreviations are used, standard use of abbreviations is encouraged. |     |    |
8. The author of all medical record entries must be identified, i.e. name, code number, employee number, or initials. |     |    |
9. Each hospital must maintain records in such a fashion that any veterinarian coming into the hospital may, by reading the medical record of a particular patient, be able to proceed with the continuity of care and treatment of this animal. |     |    |
10. Admission forms must be used when animals are presented to the hospital for inpatient procedures. A minimum amount of information should include client and patient details, procedures to be performed, and an estimate of costs. Consideration may be given to individual details of consent. |     |    |
11. Admission forms must be considered part of the medical record and maintained with records or be cross referenced if stored elsewhere. |     |    |
B. Equipment

1. No particular filing equipment or system is required, but the hospital director must review the medical record filing system for ease of retrieval and cross-referenced information.  

2. The filing system must be adequate for the case load and for staff use.

3. It is a mandatory requirement for all records to be stored on computer. Sufficient numbers of computer terminals must be available. These must be conveniently situated throughout the hospital to facilitate the efficient running of the practice. It is recommended that a multi-user or network facility should be provided with computer terminals situated at reception, in, or accessible from, each consulting room, in the treatment area and in the business office.

Type of computer and software used:

______________________________

Number of terminals:

______________________________

Date of last program upgrade:

______________________________

C. Structure

The structure of the medical record may be either problem oriented or source oriented. The problem-oriented medical record (POMR) format is strongly recommended.


Minimum requirements:

1. Medical Record

   The medical record must clearly reflect the date, initial problem, pertinent history, examination findings, and plan for treatment and care.

2. Client Information

   Each client must be identified properly. The owner’s name, address, home, and alternate telephone numbers must be recorded accurately within each patient’s medical record. Other useful data may include the name of the person who referred the client or other reason for selecting the facility.

3. Patient Information

   Each patient must be properly identified. The following identification must be recorded accurately on each patient’s medical record:
   - patient’s name (ID number if applicable)
   - species
   - breed
   - date of birth
   - sex
   - colour and/or markings
4. **Chief Complaint**
   a) The complaint is a very important part of the medical history and must be included. Observations made by the client about signs exhibited by the patient, that may be important clues to the identification of the illness and its underlying causes, should compose the balance of the history.
   b) A problem must not be entered on the record in more specific terms than can be defined by objective data. In other words, problems should be stated at the level of understanding at the time they are identified, for example “dog seen straining” – rather than “constipated” until the cause of the straining has been defined. As problems are more accurately defined, this statement can be updated.

5. **Medical History**
   A thorough medical history must be documented. There may be several problems present, though the owner may have noticed only that one for which the animal was presented to the veterinarian. It is very important to both problem definition and treatment to acquire and record as complete a medical history as possible, including all previous illnesses, injuries, surgeries, radiographs, vaccinations, laboratory tests, anthelmintics administered, and current medical regimens.

6. **Physical Examination**
   a) A report of physical examinations must be made. All patients must be given an appropriate physical examination prior to all medical or surgical procedures. A systematic procedure of examination should be followed. An appropriate examination is recommended prior to the development of any treatment plan or administration of any procedure.
   b) The medical record must clearly reflect provisional diagnoses and rule-outs.
   c) Current weight must be recorded in the medical record at all visits.
   d) The record must accurately reflect the findings (both normal and abnormal) for each system examined.

7. **Problem List or Index**
   a) A problem is anything that interferes with the patient’s well-being and requires management or further evaluation. This may be a clinical sign, physiological abnormality, physical finding, abnormal laboratory test result, or a diagnosis.
   b) A separate listing of the patient’s problems must be maintained and can serve as the index or table of contents for the entire record.
   c) Each problem or diagnosis must be listed chronologically and represent the current health status of the animal. In the traditional, source-oriented medical record, this list is called the diagnostic summary index; in the problem-oriented medical record, it is called the problem list.

8. **Diagnostic Reports**
   a) The patient’s permanent record must contain a report of all laboratory tests conducted, significant abnormal conditions detected, and results of all biopsy specimen evaluations. These should be linked to the laboratory report using the code used by the relevant laboratory.
   b) A summary of diagnostic reports, including histopathological, cytological, and ECG evaluations, must be written on the patient’s record, even if they are recorded elsewhere on a separate form.
c) If laboratory reports are recorded on a separate record, they must be dated and linked to the summary on the patient record.

d) A summary of diagnostic imaging evaluations must be noted in the medical record even if they are recorded on a separate form. The summary should include details of the part imaged, special techniques, and a diagnostic record of findings. The record should contain a cross-reference so that the patient's imaging files may be easily located. The practice of filing radiographic films separate from the patient's medical record should be encouraged.

e) It is recommended but not mandatory, that a separate laboratory log be maintained. Such a log should record details of all laboratory tests as they are conducted and/or requested. Details of findings in this log should be linked to a summary in the medical record.

9. Vaccination Record

The vaccination history must be part of the medical record and be easily retrievable. Clients should be given a certificate of vaccination to verify which vaccines have been administered to their pets and the dates of administration. A schedule for the remainder of the vaccination program also should be provided.

10. Specialist Consultation

Specialist consultation reports must be summarised in the patient's medical record. The report can also be written on a separate form linked to the patient's record. Relevant details of telephone or on-site consultations with other professionals also must be recorded, showing the consultant, date, and recommendations from the consultation.

11. Progress Notes

a) Records of treatment, both medical and surgical, must minimally reflect all procedures performed in chronological order and in the context of the medical or surgical problem to which they pertain.

b) The record of medical treatment must include identification of each medication given in the hospital, together with the date, dosage, route of administration (when more than one route is acceptable), frequency, and duration of treatment.

c) All medications dispensed or prescribed must be recorded on the medical record, including directions for use and quantity. Any changes in medications or doses, including changes made by telephone, also must be recorded on the patient's chart or record.

d) Client waivers or deferrals of recommended care must be noted on the progress notes.

e) Client communication, including recall or recheck recommendations made to the client must be noted on the progress notes.

12. Necropsy Reports

If a necropsy is performed, the findings as required by the pathology section of these standards must be placed in the patient’s record.

13. Anaesthesia and Surgical Record

a) An accurate summary of all surgical procedures including identity of the surgeon must be kept in the patient’s medical record.

b) Anaesthesia and surgery logs are strongly recommended but not mandatory. These may be combined. An accurate summary of the analgesic and anaesthetic agents used and any adverse reactions should be recorded on the patient’s medical record.
14. Dental Records
   a) A record of all dental procedures must be kept on the patient’s medical record or on a separate form attached to the patient’s record. The specific tooth (by name, picture, or number) must be listed when corrective measures are taken.

15. Prognosis
   In complex or serious cases, following a thorough examination and tentative or definitive diagnosis, the prognosis should be recorded. This is usually recorded as “Good”, “Fair”, “Guarded”, “Grave” or “Hopeless”.
EXAMINATION FACILITIES

Objective: The veterinary hospital shall provide examination facilities in which space, light and dark, diagnostic equipment, means of restraint and trained professional and paraprofessional personnel are adequate to ensure the proper examination of patients.

Consulting rooms are provided for the complete physical examination of patients. They are the rooms in which history taking, physical examination, vaccination and other prophylactic procedures, minor therapy, client education, etc., take place. Admission to the hospital and discharge from the hospital are also functions of the consulting rooms.

A. Personnel and Procedures

The hospital director is responsible for seeing that proper procedures are performed at all times. It is the duty of the hospital director to see that the techniques and methods used by the professional and paraprofessional staff are continually assessed and, where necessary, updated.

A client has the right, ethically and by law, to have animals cared for by a trained and qualified veterinary surgeon. Care of the animals must be the responsibility of a registered veterinarian.

B. Equipment

1. Diagnostic equipment and adequate lighting must be available for proper examination of patients.

2. Minimum equipment in each examination room or convenient to each examination room must include:
   - Reflex hammer
   - Examination table with a readily sanitised, fluid-impervious surface
   - Sterile materials for vaccination and parenteral administration of medications
   - Stethoscope
   - Scales capable of accurately weighing all patients treated
   - Restraint equipment
   - Thermometer
   - Otoscope
   - Ophthalmoscope
   - Clippers

   Readily available equipment should include:
   - Schirmer tear tests
   - Ultraviolet light source
   - Fluorescein dye
   - Magnifying binocular loupe or Voroscope™

3. Each examination room must be supplied with cleaning materials, disinfectant, disposable towels, and a waste receptacle.

4. To facilitate hand washing between each patient, a sink must be located in or convenient to each examination room.

5. A radiographic viewer must be located in or convenient to each examination room.
6. A rubbish bin with plastic liner must be available for waste disposal. "Sharps" containers should also be available in or adjacent to each consulting room.

C. Structure

1. Examination facilities must be provided.

2. Examination room(s) must be of adequate size to allow for patient examinations.
   It is suggested that not less than 8 square metres be allotted for each examination room. There must be sufficient space for doctor, patient, client and assistant.

3. The room(s) must be clean and professional and should be attractive in appearance.

4. The rooms should be convenient to the laboratory and dispensary as well as to the reception area and business office.

5. The consulting rooms require lighting which is adequate for most examinations. Additional more intense lighting must be available for intermittent use where necessary. The consulting rooms should be able to be adequately darkened for certain examinations.

6. Some type of rapid exhaust facility is required to remove any intermittent odours.

7. Soundproofing, to maintain privacy of consultations, is recommended.

8. Consideration should be given for additional room for a desk, chair/stool and a computer terminal.
DISPENSARY

Objective: Facilities must be provided for storage, safekeeping and use of drugs in accordance with federal and state or territory regulations.

Pharmaceutical services exist to meet the medication needs of patients. The scope of these services shall be consistent with the patients' needs and should include a programme for control and accountability of drugs, chemicals, biologics and related equipment throughout the hospital.

The dispensary is the location in which drugs are stored, kept safe and prepared for use or dispensing. It is the physical centre for the provision of the hospital's pharmaceutical service.

A. Personnel and Procedures

Since a registered pharmacist is not employed in most veterinary hospitals, the responsibility for maintaining the pharmaceutical service rests primarily with the director of the hospital or a veterinary surgeon designated by the director to see that adequate supplies are available at all times. The person designated to control the pharmaceutical service should see that outdated (expired) drugs are disposed of properly.

Veterinary nurses can be trained to assist in some of the procedures for maintenance of the dispensary.

Personnel authorised to work in the dispensary must adhere to the following policies which are essential for the safe administration and dispensing of drugs:

a) Drugs must only be administered by, or on the advice of, a registered veterinary surgeon.

b) Drugs must only be dispensed by a registered veterinary surgeon.

Paraprofessional personnel may select the medication from the shelves and after checking by the veterinary surgeon, apply the label prepared by the veterinary surgeon or administer the medication, under the supervision of the veterinary surgeon. They may also, under supervision, take drugs from a larger container and place them into containers in dispensable quantities.

c) The veterinary surgeon is responsible for giving any cautionary advice necessary for the medication. The client should be made aware of possible significant adverse drug reactions and the procedure to follow if problems occur.

Responsibility for the pharmaceutical services includes the following:

1. Establishing specifications for the procurement and disposal of all drugs, chemicals, biologics and related equipment.

2. Dispensing drugs, chemicals and biologics

This should be standardised for all areas of the hospital. Great care must be exercised in dispensing drugs for client administration at home. As a minimum each drug should be dispensed in a container which in no way alters the drug being dispensed and which is moisture resistant.

Labelling must be in accordance with federal and state or territory laws. Each label should be typed or computer printed to ensure legibility and the label should be permanently affixed to the container. The label should contain, at least the following information:

- "Keep Out Of Reach of Children".
- "For Animal Treatment Only" or similar wording as approved.
- Details of the practice - Name, address and telephone number. The directors' names are also recommended.
- Species and the owner’s name. The animal's name is also required.
- The name, strength (if required) of the drug and directions for use.
- The date.
- It is recommended that the prescribing veterinary surgeon be identified.

Storage and stability of drugs, chemicals and biologics:
1. Written S8 or Dangerous Drugs logs must not be stored in the locked cabinet used to store those drugs to which they apply.
2. Each hospital director must ensure that all records comply with federal, state, or territorial regulations. This includes but is not limited to the following:
   - Initial inventory.
   - Biennial (every two years) inventory.
   - Balance on hand.
3. Adequate quantities of drugs and supplies must be available at all times.
4. The hospital director must ensure that all outdated drugs are returned or disposed of in accordance with federal, state, provincial and local regulations.
5. When dispensing medication, each label must:
   - Be typed or printed (clear tape may be placed over the label to preserve it).
   - Be permanently affixed to the container.
   - Include expiration, if appropriate.
   - Include warning labels, if appropriate.
6. Where the use of child-resistant containers is declined by the client, it must be noted on the patient's medical record.
7. Drugs used for euthanasia procedures must be stored in a locked cabinet.
8. Telephone calls changing medications or dosages must be recorded on the patient's chart or record.
9. If clients bring previously dispensed medication to the hospital, these drugs must not be administered unless they can be identified. Orders to administer these medications must be given by the veterinarian in charge of the animal. Any drugs which are not to be used should be stored and returned to the client upon the discharge of the animal from the hospital.
10. Hazardous medications (e.g. cytotoxic chemotherapeutic medications) must be handled in accordance with federal, state or territory regulations.

B. Equipment

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1. The dispensary should contain adequate shelving for the storage of drugs, chemicals, biologics and related equipment (needles, syringes, vials etc.), shelves for reference books, clean work surfaces for the preparation of drugs, an approved safe for the storage of Schedule 8 drugs and a refrigerator for those drugs and biologics which require refrigeration.
2. Proper storage of drugs must not allow for any cross-contamination, but it should permit all preparations to be found readily and easily. One of several storage systems may be used: alphabetical, by usage, or by type.
3. All dispensed or repackaged medications must be in approved containers and where applicable, child-resistant containers.
4. The container must in no way alter the drugs being dispensed and must be moisture resistant.

5. Drug kits which are easily portable should be available and maintained for anaesthetic and emergency usage. They should be conveniently located in the hospital but should be stored appropriately (e.g. under lock and key) when a veterinary surgeon is not on the premises.

6. Current editions of appropriate pharmaceutical and drug text and reference books should be available.

7. Current antidote information must be readily available for emergency reference in addition to the telephone number of the nearest poison control centre.

8. A computer printer must be provided to complete drug labels. Hand written drug labels are not acceptable.

9. Appropriate safety equipment (e.g. gloves, masks, gowns) must be available for handling noxious or hazardous substances.

C. Structure

The hospital may have a single dispensary, a central dispensary, or multiple dispensary areas located throughout the hospital which are convenient to work areas and inaccessible to clients. The dispensary areas should be well organised and adequate in size for their use.

1. Facilities must be provided for storage, safekeeping, and use of drugs in accordance with federal and state or territory regulations. All dispensaries are to be lockable regardless of their federal, state or territory regulations.

2. Controlled drugs must be stored in a securely locked, substantially constructed cabinet or safe as required by federal and state or territory regulations.
**Approve Locked Storage at all Times**
(M = Mandatory)

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**Locked Storage if Vet Not on Premises**
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**Not on Public Display to Promote Sale**
(M = Mandatory)

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**Storage Area Inaccessible to Public**
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* Please note: Whilst these schedules were correct at the time of publication it is ultimately the responsibility of the veterinarian to ensure they keep abreast of any updates or changes to storage regulations.
LABORATORY/PATHOLOGY

**Objective:** Objective: Routine clinical pathology services must be provided in the hospital laboratory or through outside sources.

**Rationale:** Pathology services are necessary for the proper diagnosis and treatment of many cases. Whether the procedures are performed within or outside the hospital will be determined by the availability of alternative services. Factors such as economics, proximity of the hospital to outside laboratories, and qualifications of such laboratories to handle animal samples have to be considered. In any case, results of life-dependent procedures must be available within 12 hours following sample collection. Results for periodic health monitoring, geriatric examinations, histopathology, and other tests of this nature should be timely. The choice of procedures used with any particular patient is a professional decision.

A. Personnel and Procedures

1. Pathology services available must include the following:
   - Haematology and serology.
   - Blood chemistry analysis.
   - Urinalysis, including urine sediment examination and urolith analysis.
   - Microbiology, culturing, and antibiotic sensitivity.
   - Parasitological examinations (faecal, blood, and skin).
   - Exfoliative cytology.
   - Histology or histopathology.
   - Toxicology.

2. The hospital director is responsible for evaluating the accuracy of tests performed both in and outside the hospital. The director or a practice associate must be fully aware of all techniques used within the hospital in order to train personnel, monitor the performances of non-veterinary personnel, and perform basic tests in emergency situations. If in-house pathology machines are used, they must be subjected to regular control procedures as recommended by the manufacturer to ensure accuracy of the results. A record of control procedures must be kept.

3. Specimen Data
   Each specimen must be identified with the identification of the patient.

4. Necropsy Data
   a) Each necropsy procedure and record thereof must be thorough and detailed.
   b) Tentative diagnosis, where appropriate, must be recorded promptly in the patient’s medical record. The final report must be made a part of this record.

B. Equipment

1. Instrumentation for tests performed on the premises must be adequate. Minimum equipment must include:
   - Microhaematocrit.
   - Binocular Microscope
   - Clinical centrifuge.
   - Urine refractometer.
   - Refrigerator.
   - Glucometer.
• Dipsticks for urine assessment.
• Suitable cytology and microbiology stains.
• Freezer for storage of bodies and autopsy wastes.
• A full range of appropriate specimen tubes and jars for the transport of samples to the laboratory.
• Activated Clotting Time (ACT) tubes.

2. If the services of an outside laboratory are not used, the following equipment and necessary supplies must be available in-house:
   • Haemocytometer or electronic cell counter.
   • Incubator, 37°C.
   • Blood chemistry analyser.
   • In-house serology kit(s).

3. Adequate space must be provided for performance of services and proper storage of reagents. Counters should permit efficient handling of specimens while providing permanent space for standard equipment.

4. The countertop must be impervious and stain resistant.

5. A stainless steel sink with garbage disposal and fume hood over the sink is preferred, but not mandatory.

6. There should be adequate lighting in all work areas and extra power outlets on the counter.
   A separate circuit or special voltage regulator, such as an uninterruptible power supply, is recommended to minimise electrical supply fluctuations for in-house laboratory equipment.

7. It is recommended but not mandatory that a log or logs be maintained for all laboratory work.
   Where an external laboratory log is kept, it must reflect:
   • Data from specimen
   • Date of sample collection.
   • Identity of outside laboratory.
   • Tests required.
   • Date results received.
   • Date summary of results entered in patient record.

9. In House Quality Control Program.
   a) All in-house laboratory services performed must be carried out by competent personnel using approved standard laboratory procedures. The quality control system within the pathology laboratory must be designed to ensure medical reliability of laboratory data.
   b) For in-hospital laboratory procedures, equipment must be operated and evaluated according to the manufacturer’s recommendations and have a written protocol of operation.
   c) Reagents required for the operation of serology and biochemistry units must be stored as required by the manufacturer.
   d) A record of the quality control tests and maintenance procedures performed on all laboratory equipment must be maintained. This will be examined at inspection.
   e) Reports of all pathology services and examinations must be made part of the patient’s medical record in accordance with Medical Record Standards.
DIAGNOSTIC IMAGING

**Objective:** The hospital must have the capacity to generate quality radiographic images on the premises.

**Rationale:** Diagnostic imaging exists to aid in the accurate diagnosis and evaluation of medical and surgical problems and to assist in determining an appropriate course of management. The hospital must provide diagnostic radiology services at all times whilst meeting all obligations under the Code of Practice and Safety Guide for Radiation in Veterinary Medicine Radiation Protection Series Publication No. 17 (2009). This is available online and will be further referred to as RPS 17.

The radiology department must have equipment capable of producing radiographs of diagnostic quality. The department must also have safety equipment and must be free from known hazards to patients and personnel. Equipment to permanently identify radiographs and to properly view and store radiographs is required.

A hospital seeking accreditation that routinely performs procedures such as contrast studies or myelography, should submit examples for review by the inspector.

### A. Personnel and Procedures

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**Operation of Equipment**

All radiographic and radiation therapy equipment must be operated only by appropriately licensed personnel or under the direct supervision of such personnel, where appropriate. It is the hospital director’s responsibility to ensure that all personnel are aware of all hazards, actual and potential, and must eliminate or reduce these to the minimum acceptable level for themselves, assisting personnel, other nearby individuals and the patient.

**Radiation Safety**

1. The minimum number of people essential for the procedure should be in the room during exposure and other methods of restraint should be used where possible (refer to RPS 17).

2. All people present during exposure are required to wear protective clothing or be protected by a lead shield. Gloves or equivalent must be used if the hands are within one metre of the primary beam. Hands and arms, even when protected by gloves, must never be in the primary beam (refer to RPS 17).

3. Owners are not to be used to hold their pets or to be in the room during exposure. Pregnant women and anyone under 18 years of age are not allowed in the room during exposure, under any circumstances.

**Personal Radiation Monitoring of Exposure**

1. Dosimeter monitoring of exposure levels must be provided for all personnel working with or near an X-ray generator.

2. The individual badge must be worn near the collar on the outside of the leaded apron or under the leaded apron dependent on the type of monitor used.

3. Records of the results must be maintained indefinitely and be readily available.

4. All staff members shall be made aware of their dose meter reports and are made to sign off on each quarterly report.
**Inspections**

1. Machines must be licensed / inspected in accordance with federal, state or territory regulations.
2. Licenses / results of inspections must be posted in a visible place in the radiology area.

**Processing**

1. Processing of radiographs must be by automatic processor unless digital radiography is being utilised.
   - Automatic processors must be maintained according to accepted standards.
2. Cleaning of rollers and maintenance cleaning of the tanks must be scheduled according to the manufacturers’ advice.
3. Maintenance schedule must be clearly displayed and signed off.

**Digital Radiography**

Digital radiography (DR) or Computerised Radiography (CR) is recommended. Storage of images should be in DICOM format and abide by accepted standards of labelling and identification. Archival storage of images shall be on remote hard drive or alternative mass storage devices.

**Records**

The results of all radiographic evaluations must be noted in the patient’s medical record, including the part radiographed, any special techniques, and a summary of the radiological findings. Radiographs should be filed, appropriately cross-referenced, separate from the patient’s medical record.

**Radiograph Identification**

Permanent identification of each radiograph is required. Minimal radiograph identification must include hospital, owner and patient identification and the date. Positional markers should also be used.

**Radiograph Storage and Filing**

Radiographs of patients are considered to be the property of the veterinary hospital as part of the medical records. A copy of the radiographs must be made available, at the owner’s expense, if requested. Retention and proper storage of all radiographs is advisable for legal reasons and for comparative purposes. They must be properly and permanently identified and filed manually or electronically for easy retrieval.

1. Hospital personnel should be made aware of the medical and legal importance of proper identification and storage of radiographs.
2. A file containing radiographs of special conditions or good examples of normal structures is of particular value. These radiographs can then be easily retrieved for comparative and demonstration purposes. There are also numerous text books available that can be utilised for this purpose.

**Radiography Log**

The log facilitates appropriate follow-up radiographs of a particular animal. For legal purposes the log documents particular animal exposures and provides proof of the number of radiographs taken in a year.
An imaging log must be maintained and must include:
- Date.
- Owner and patient identification.
- Area imaged.
- View.
- Species or breed.
- Date of birth or age.
- Time.
- kVp.
- mA.

B. Equipment

**Equipment for non-digital radiography**
1. Loaded cassettes must be stored in a manner to protect them from unintended exposure.

2. Two or more of each size of cassette used should be available. A balanced combination of film and imaging screens must be used. A rare-earth high-speed system is recommended to reduce radiation exposure.

3. If the machine is not already programmed for areas of the body exposure, a reliable exposure chart (technique chart) must be available near the X-ray controls and should be used by all personnel.

4. Proper safelight(s) with lamps of correct wattage must be mounted at the recommended distance from work areas. The colour of safelight filters depends upon the type of films being used.

**Equipment for all types of radiology**
1. Radio-opaque characters must be used to identify right (R) and left (L) sides of the patient.

2. Permanent identification of each image is required and must occur prior to processing. Minimal image identification must include date, patient identification, hospital identification, owner name and patient date of birth or age.

3. If the machine is not already programmed for areas of the body, measuring calipers to determine accurately the thickness of the part being radiographed must be used to reduce non-diagnostic exposures and a reliable exposure chart (technique chart) must be available near the X-ray controls and should be used by all personnel (a technique chart may not be necessary where the generator has anatomical preprogramming).

4. Lead aprons and gloves must be used during exposure. They must be in safe condition and properly cared for to ensure a reasonable life.

5. A warning light at the entrance to the radiographic suite should show when the machine is in use and an audible sound emitted when a radiograph is about to be taken.

6. No hands should be seen on the radiographs. Two aprons and two pairs of gloves are recommended. Leaded thyroid collars (shields) and lead glasses are recommended. All protective apparel must meet federal, state or territory regulations.
X-ray Machine

1. The hospital must have the capacity to generate consistently diagnostic quality radiographic images of all patients routinely treated on the premises.

2. All regulatory agencies require a minimum of 2 mm of aluminium filtration in the X-ray beam. It must be within, above, or part of the collimator.

3. The X-ray table must be large enough to accommodate the largest patient seen by the practice positioned for a ventrodorsal view of the pelvis and femurs. Adequate working space around three sides of the table must be provided.

4. The radiographic machine must have an adjustable collimator to restrict the size and shape of the primary X-ray beam to the size of the cassette being used.

5. Positioning devices and tie-downs must be provided and should be used when radiographing anesthetised patients so that personnel are not needlessly exposed.

Radiation Therapy, Computed Tomography and Magnetic Resonance Imaging

If any of these services are provided in-house rather than referred, it (they) must be performed in a competent and safe manner. The procedures, facility, and radiation safety aspects of the operation must be in compliance with federal, state and territory regulations.

Diagnostic Ultrasonography

If ultrasonography services are provided, equipment for this alternative imaging modality must be a type that is appropriate for patients imaged. For example, the transducers used are relatively specific for anatomical areas and types of study. It is recommended that the machine used be equipped to record the study as it is being performed.

C. Structure

If digital radiography is not utilised then the darkroom must be light tight and sufficient in size. The light-tight darkroom should be painted a light colour to enhance safelight effectiveness. The darkroom must be adequately ventilated in compliance with federal, state, and territory regulations.

It is highly desirable to have a separate room devoted to radiography; however, it could serve other purposes provided it is not the major surgery room. It is recommended that the X-ray controls, at least the exposure control device, be located outside the radiographic room proper. The protective barrier effect of the walls and doors should be such that adjacent occupied areas would not receive radiation above recommended levels. Room structure, shielded control booth, or other restrictive barriers must comply with federal, state and territory radiation safety regulations.

D. Required Submissions

1. For submission to the radiology records inspectors:
   Three (3) sets of radiographic studies. The sets must be:
   a) Thoracic (of any sized dog or cat)
   b) Abdominal (of any sized dog or cat)
   c) Skeletal
Radiographic studies can be of any sized dog or cat, but should be representative of the caseload of the practice e.g. large and small dog, cat.

2. For each of the three radiographic cases submitted, the following are required:
   a) Radiographic studies must be selected from clinical cases that were imaged at the facility within the previous 12 months.
   b) Animal clinical details and signalment.
   c) Computer printout or photocopy of relevant medical history pertaining to the radiograph (not full computer records for life).
   d) The radiographs and history can be submitted, fully labelled on CD, DVD, SD Card or Thumb Drive.
   e) Details of radiographic techniques used.
      • Film/Screen combination for conventional analogue systems
      • Exposure factors.
      • Automatic processing maximum requirement.
      • Radiographic studies must have facility and patient identification, date and laterality information that is permanent and consistent.
      • Radiographic studies must show proper positioning consistent with the area being radiographed.
      • Digital radiographic studies should be submitted in a DICOM format.

3. X-ray report. A computer printout or photocopy of the radiographic assessment made by you should be included. This should include:
   a) Comments on quality
   b) For each view the radiological findings should be described, both normal and abnormal
   c) For each case there should be a differential diagnosis with a preferred diagnosis, if appropriate.
   d) If further studies are indicated, they should be identified.

4. All films reviewed must show evidence of collimation by having at least two adjoining sides showing unexposed film. It is recommended that all four sides of the films demonstrate evidence of collimation.

5. No parts of the human body should appear on the films as this is an indication of poor radiographic technique and poor occupational health and safety practices.

Record submissions must be submitted as a single paper document or single file clearly marked (disc or word/pdf file).
ANAESTHESIOLOGY

Rationale:
Anaesthesia services must include performance of routine pre-anaesthetic physical examinations and exercise of proper safeguards in selection and use of anaesthetics.
Although the type of anaesthesia used for each procedure is left to the discretion of the attending veterinarian, the continued study, evaluation, and use of newer and safer anaesthetic agents and equipment is recommended.

A. Personnel and Procedures

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<td>1.</td>
<td>Anaesthesia services must be provided.</td>
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<td>Anaesthesia services must include performance of routine pre-anaesthetic examinations (including laboratory testing where indicated) and exercise of proper safeguards in selection and use of anaesthetics.</td>
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<td>Anaesthetic agents must be administered by a veterinarian or by persons trained in their administration and then only under supervision of a veterinarian who must be on the premises.</td>
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<td>It is the direct responsibility of the hospital director to provide support staff anaesthetic safety and training programs and ensure supervision of the programs.</td>
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<td>Cardiac, respiratory, arterial blood pressure or other electronic monitors should be used. Some method of respiratory monitoring must be used, such as observing chest movements, watching the rebreathing bag and use of a respiratory monitor.</td>
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<td>Body temperature maintenance and monitoring is essential during anaesthesia and the recovery phase.</td>
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<td>If endotracheal tubes are used, they must remain in place during recovery from anaesthesia until appropriate protective reflexes have returned.</td>
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<td>On what percentage of general anaesthetics are endotracheal tubes used?</td>
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<td>9.</td>
<td>In the event of cardiac arrest, standard procedures for cardiac resuscitation should be followed using drugs and equipment to be found in an emergency cabinet, on a crash cart, or on an emergency tray. Doses and dosages should be printed on all emergency drugs and be readily available in chart form.</td>
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<td>10.</td>
<td>Anaesthesia charts must be maintained for all general anaesthesia procedures. Generic versions of these charts are readily available. They should record all parameters measured throughout the anaesthesia and be maintained until the patient is extubated and sufficiently regained consciousness. (see addendums)</td>
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<td>Charts should be maintained with the patient’s hospital record or cross referenced if stored separately.</td>
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*Attach copy of anaesthesia chart used routinely.*
Minimum recorded monitoring parameters are:

- Percentage vapouriser setting.
- Oxygen flow rate.
- Type of circuit used (rebreathing circuit, T-piece, Bain etc).
- Heart rate +/- peripheral pulse
- Respiratory rate and depth.
- Mucus membrane colour and capillary refill time.
- Globe position.
- Oxygen saturation.
- Core body temperature. Ideally include:
  - ECG
  - Capnography

12. Every animal needs an individual anaesthesia chart recorded for the entire duration of the anaesthetic.

   The anaesthesia chart must contain:
   - Date.
   - Patient identification.
   - Pre-anaesthetic agent/s used and doses used.
   - Anaesthetic agent; volume drawn and used.
   - Inhalation agent used
   - Procedure performed.
   - Duration of the anaesthetic and duration of the procedure.
   - Nature of induction / recovery and any complications.
   - Patient pulse and respiration rate recorded every 5 minutes for the duration of the anaesthetic.

13. An admission form for anaesthesia and/or surgery must be available and used in all cases where a general anaesthetic is required.

   Attach copy of admission form.

B. Equipment

1. All equipment needed for the administration of local and general anaesthesia must be readily available and in good repair. Equipment must be available for inspection when the hospital is inspected.

2. The anaesthetic area must have adequate fixed and portable emergency lighting available.

3. At times of anaesthesia the anaesthetic area must contain the following:
   - Pre-anaesthetic agents.

   Please detail the pre-anaesthetic agents used:

   - Induction anaesthetic agents for intravenous administration.

   Please detail the induction agents used:
• Anaesthetic and pre-anaesthetic antagonists, as appropriate.
• Appropriately-sized endotracheal tubes and tube adapters.
• Antiseptic agent for preparation of the venipuncture site.
• Sterilised needles and syringes.
• A stethoscope (oesophageal stethoscope optional).
• A device to retain an animal’s body heat.
• A machine for the administration of gaseous anaesthesia that includes a canister containing a fresh agent to absorb carbon dioxide. Anaesthetic machines should be capable of achieving satisfactory induction and maintenance of anaesthesia in companion animals of all sizes. The anaesthetic machine must be suitable to allow intermittent positive pressure ventilation if required.

Number of anaesthetic machines used:

The minimum requirements are:

a) An out of circuit, calibrated vaporiser (fully temperature and pressure and flow regulated) - with a circle absorber for larger patients or alternatively a Komarsaroff type in-circuit (non temperature and pressure regulated vaporiser) can be used. For those facilities using an out-of-circuit vaporiser, a T-piece, Bain circuit or equivalent can be used for smaller patients. The equipment must be serviced on a regular basis.

b) Gaseous agent (Isoflurane is minimum requirement, Halothane, Ether and Chloroform should not be used) for the induction and maintenance of general anaesthesia. Please detail the inhalational agent(s) used:

c) Medical grade oxygen should be piped through a fixed manifold within the operating room to the anaesthetic machine. The source of anaesthetic gases needs to be in a well ventilated area distant to the operating room, preferably in a non-public area. A minimum of two cylinders with an appropriate switching device for when one cylinder becomes empty and a warning device should the supply of oxygen become low. If an oxygen generator is used then an emergency supply of oxygen from a cylinder is essential in case of power failure. Nitrous oxide appears to have limited to no benefit for animal patients and the risks to patients and staff outweigh its benefits. If a practice wishes to utilise this gas, it will need to submit a protocol emphasising the reduction in risk to patients and staff.

NB: Trolley mounted or mobile cylinders are not permitted within the operating room. Trolley mounted or mobile cylinders may be utilised in other areas of the hospital (* this stipulation is applicable to newly constructed or newly renovated hospitals only. Existing hospitals may continue to utilise trolley mounted or mobile oxygen and nitrous oxide cylinders within the operating room provided such cylinders are clean and appropriately covered. In certain cases, the inspector may indicate that piped oxygen / nitrous oxide to the operating area should be a condition of re-accreditation).

d) All anaesthetic machines must be fitted with an effective scavenging system to prevent waste gases from entering the room air.

Type of scavenging system used?

e) A rebreathing bag.

f) An electronic respiratory monitor
g) Pulse oximetry
h) Oesophageal stethoscope

Routine use of the above plus ECG and End Tidal (ET) CO2 (capnograph) is mandated for procedures over 10 minutes.

4. Support equipment
   a) Emergency medications and equipment required in the event of a cardiac arrest (may be located in the operating room) must be available.

   List resuscitative equipment available:

   b) Intravenous catheters, administration sets, intravenous fluids and/or other cardiovascular support medications (plasma expanders, whole blood) must be readily available. Intravenous catheters are recommended for every procedure requiring a general anaesthetic. It is also recommended that intravenous fluids be given to all patients who undergo procedures requiring a general anaesthetic of duration greater than 10 minutes. Such fluids should be given for a suitable period of time prior to induction for such procedures.

   List items readily available:

   c) Some means of assisting ventilation must be readily available during general anaesthesia, either manual or mechanical.

d) A method for the indirect monitoring of arterial blood pressure should be available.

C. Structure

1. The facility must contain an area for the administration of general anaesthesia.

2. A recovery area outside the operating room or a recovery room where the patient can be observed closely until appropriate protective reflexes have returned must be available. Observations should occur at frequent intervals until the patient is in sternal recumbency.
SURGERY

Objective: A separate room for the performance of aseptic surgical procedures only must be provided (i.e. the operating room).

Surgery - The act of incising living tissue; an operative procedure; and/or a room or facility where an operative procedure is done (i.e. the operating room).

Aseptic Surgery - Surgery performed in ways or by means sufficiently free from micro-organisms so that significant infection or suppuration does not occur.

Minor Surgery - Any surgical intervention that neither penetrates and exposes a body cavity nor produces permanent impairment of physical or physiologic function. Examples are superficial wound suturing and cutaneous biopsy.

Major Surgery - Any surgical intervention that penetrates and exposes the body cavity; any procedure that has the potential for producing permanent physical or physiological impairment; and/or any procedure associated with extensive transection or dissection of tissue.

A. Records

All surgical procedures and any untoward sequelae related to the surgery must be recorded on the patient's medical record.

A surgical log (which may be combined with the anaesthetic log) is recommended. This log should contain such information as:

- Date
- Client's name
- Animal identification - name, species, breed, age, sex
- Weight
- Pre-anaesthetic agents, dose and route of administration
- Anaesthetic agents, dose and route of administration
- Induction time and duration of anaesthesia
- Procedure
- Time of commencement and duration of procedure
- Fluid therapy
- Record of any adverse reactions

Consent forms for performing surgery may be attached to the patient's medical record or filed, appropriately cross-referenced and dated, separate from the patient's medical record.

B. Sterilisation

Autoclaving

1. The hospital must have an efficient steam autoclave. This should be used to sterilise articles such as surgical instrument packs, drapes, gowns and ‘disposables’.

2. The temperature and pressure generated by this equipment must be sufficient to kill all types of micro-organism, including bacterial spores. Since pressure and temperature gauges may be inaccurate, the efficiency of autoclave equipment must be routinely monitored by the use of standard sterilisation indicators. Such monitors must be placed in the centre of every surgical pack.
3. Autoclaves represent a considerable safety hazard and all personnel should be trained in the correct usage of such equipment. Where required by state or territory legislation, such equipment should be licensed and maintained.

Maintenance log available?

Dry Heat Sterilisation is used?
Dry heat may be used for certain items of equipment. The process is slow and very high temperatures must be used.

The hospital must have an acceptable means of monitoring the efficiency of dry heat sterilisation if it is used.

Ethylene Oxide Gas Sterilisation is used?
Ethylene oxide gas may be used to sterilise delicate equipment that may be damaged by either heat or steam.

The hospital must have an acceptable means of monitoring the effectiveness of ethylene oxide sterilisation if it is used.

Ethylene oxide is flammable, tissue toxic and possibly mutagenic and carcinogenic. Suitable safety precautions, including effective scavenging, to avoid any health hazards to either patients or hospital personnel must be observed if it is used.

Chemical Sterilisation is used?
Glutaraldehyde is an effective chemical disinfectant that is permitted for special instruments such as endoscopes, which cannot be sterilised with heat or steam.

Use of glutaraldehyde for general sterilisation of instruments is discouraged.

C. Personnel and Procedures

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

1. Preparation of Patient
A standard, accepted procedure must be used to prepare the patient for surgery.
All personnel assisting in the pre-surgical preparation of the patient must be aware of the danger and sources of bacterial contamination. They must be adequately trained and under the direct supervision of a registered veterinarian.

2. Surgical Attire
Surgical assistants and the surgeon must be properly attired with cap, mask, sterile gown and sterile gloves when major surgery is performed.

Surgeons, surgical assistants, and operating room attendants must wear a surgical cap and mask at all times while in the surgical suite and when a sterile field exists therein. All scalp and facial hair must be completely covered by the cap and mask.

Operating room attendants must remain outside of the sterile field. The sterile field is the area above the sterile drapes on the operating table and adjacent instrument trays. The sterile field extends from the edges of these drapes in a vertical plane to the ceiling.
3. **Sterility**

Surgical procedures require the use of sterilised instruments, gowns, towels, drapes and gloves as well as clean caps and masks.

Brushes used for scrubbing surgeon's hands must be thoroughly washed and sterilised. Reusable caps and masks should be laundered after each day’s use. Disposable caps, masks and scrub brushes may be used if desired.

4. Surgical instrumentation must be properly cleaned, in good repair, and sufficient in number and variety to match the requirements of the surgical case load.

5. Every patient presented for surgery must have a documented pre-surgical physical examination immediately prior to the procedure. There must be a notation of the findings (both normal and abnormal) for each system examined.

The following factors must be addressed and documented:
- Positive patient identification
- Positive identification of the procedure /s to be performed
- Client consent to the procedure / s to be performed

**D. Structure**

**Compliance**

<table>
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<tr>
<th>Yes</th>
<th>No</th>
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</table>

1. **Surgical Preparation Room**

Preoperative preparation must be performed outside the operating room. The preparation room should be a separate room convenient to the operating room and well lit. Floors, walls, and counter tops should be of smooth, impervious material which is easily cleaned. This room might double as a laboratory, scrub room, treatment room, or extra examination room.

All equipment for proper preparation techniques must be readily available in the preparation room, including the following:
- Oxygen
- Anaesthetic machine
- Gas scavenger system
- Emergency drugs
- Endotracheal tubes
- Instruments used for intubation
- Clippers with a surgical blade or other accepted means of hair removal
- A vacuum device to remove loose hair clipped from the patient.

2. **Operating Room**

   a) The operating room must be a separate, closed, single-purpose room for the performance of aseptic surgical procedures with only one entrance/exit.

   b) An aseptic surgical suite can be located anywhere in the hospital, provided it is convenient to the recovery rooms and the prep room. It must be out of traffic areas.

   c) The operating room must be so constructed and equipped that cleanliness can be easily maintained.

   d) Flooring must be of an impervious material.

   e) Walls must be of a washable, impervious material.

   f) Doors must be well fitted and should be wide enough to permit passage of patients.
g) Doors must be kept closed and traffic into the surgical suite kept to a minimum.

h) A viewing window is recommended to reduce the need for support personnel to open the door to see into the room.

i) Windows must have the glass flush mounted to eliminate dust accumulation on window sills.

j) Any built-in cupboards must be flush-mounted with the walls to limit dust accumulation. Any other furniture must be mobile.

k) Sinks are not permitted in the operating room as they create aerosol contamination and can collect dust.

l) There must be a cleaning protocol sufficiently detailed to ensure that all surfaces within the operating room are free from dust / dirt and contamination. Horizontal surfaces can collect dust, which is not acceptable, so specific attention needs to be paid to these during the cleaning process.

Equipment that must be present in the operating room:

- Surgical light of adequate candle power to illuminate the surgical field, preferably the type of lamp which is completely enclosed to avoid dust accumulation.
- Instrument table(s) constructed of impervious material.
- Surgical table(s) constructed of impervious material.
- Intravenous fluid hanger(s) / stands.
- An anaesthetic machine capable of being able to provide respiratory assistance with a vapouriser(s) compatible with the gaseous anaesthetic agent(s) used.
- A bucket / receptacle of impervious material (kick bucket), preferably mobile.
- A supply of reticulated / piped oxygen (cylinders are not permitted in theatre suite)*
- Oxygen cylinders supplying reticulated oxygen need to be located away from publicly accessible space, are duplicated with an audible low pressure warning. If there is an oxygen generator used to provide the reticulated oxygen then a spare cylinder should be available in the case of a power failure.
- Fixed and portable emergency lighting.
- Adequate drugs for emergency use readily available in an accessible emergency box or designated place (may be located in the anaesthetic induction area).
- Thick pads on the surgery table(s) for comfort and alleviation of possible injury to patients may be used. A thermostatically controlled warming method should be considered.
- Radiographic viewer or computer monitor limited to surgical use. The unit should be mounted flush with the wall where possible, to prevent dust accumulation. If the device is not flush-mounted, it should be mounted in such a way as to be readily cleaned.
- A wall clock.
- Suture Materials. An appropriate range of sterile suture materials shall be stored where they are readily accessible to the operating room. Cassette type suture materials are not to be used.
- Surgical Suction. A unit for delivering sterile surgical suction should be available. This unit should be either electrically or gas driven. If gas driven, the gas should be piped to the suction unit from an external supply. No gas cylinders are permitted within the operating room.* Water driven sink suction units are not permitted in the operating room.
- The operating room should have positive pressure air flow to avoid contamination as much as possible.
DENTISTRY

The veterinary hospital shall provide a dental service that includes prophylaxis and extractions where necessary. Restorative, endodontic and orthodontic procedures need not necessarily be performed in the hospital but appropriate referrals should be offered.

Dental prophylaxis can only be performed properly under general anaesthesia. After scaling and subgingival therapy, teeth should be polished.

A. Personnel and Procedures

1. A routine examination of any animal must include examination of the teeth, gums, oral cavity, and any other structures and tissues associated with the teeth.  

2. Prophylactic dental services (scaling and polishing) must be provided.

3. Only properly trained personnel may perform dental procedures. Such performance must be in compliance with state or territory registration bodies.
   a) Dentistry should be performed according to the AVDS guidelines and relevant State or Territory laws.
   b) Paraprofessional personnel may only clean teeth supragingivally with hand scalers. If an ultrasonic scaler is used, then only under the direct supervision of a veterinarian.

4. Personnel operating dental equipment must wear masks, eye protection and gloves, or other protective equipment to prevent nosocomial infection.

5. The decision to extract teeth must be made by the veterinarian and performed by the veterinarian.

6. Dental prophylaxis must not be done in the operating room. Only in the case of oral surgery may the operating room be used for dental work.

7. After scaling, teeth should be polished using an electric or air-driven, low-speed hand piece. It is recommended that this hand piece operate at 2,000-10,000 RPM.

Records

1. A record of all dental procedures shall be kept on the patient’s medical record. The specific tooth by name, picture or number should be listed when pathology exists or when corrective measures are taken.

2. Dental prophylaxis includes the pre- and post-treatment charting of the dentition. The dental chart should include a record of missing teeth, extracted teeth and pre- and post-treatment pathology. An assessment of the occlusion should also be noted.

B. Equipment

The following are the mandatory minimum requirements:

The proper instrumentation for dental work performed within the hospital must be available.

The minimum set of instruments for dental prophylaxis shall include:
   • Periodontal probe.
• Selection of scalers for supragingival scaling.
• Selection of curettes for subgingival scaling.
• Dental mirror.

The minimum set of instruments for dental extraction shall include:
• Bone rongeurs.
• Periosteal elevator.
• Dental elevators (at least 2 sizes).
• Apical elevator.
• Extraction forceps.
• An ultrasonic scaler.
• Dental work station with a high-speed handpiece, low-speed handpiece and triplex syringe

Other, please state:

An adequate supply of dental burs and prophy cups.

Intraoral radiography
Periodontal and extraction equipment are autoclaved between patients.
NURSING CARE AND WARDS

Nursing care covers a broad spectrum of skills from medical and surgical nursing, through infection control and cleanliness to record-keeping and communication. At all times the welfare of the patient must be the prime concern of all personnel providing nursing care. The training and supervision of the paraprofessional and lay personnel are continuing duties of the hospital director or another person assigned this responsibility. A staff room, lounge or designated gathering place for all personnel should be provided. This will enable better communications through staff discussions of cases, practice policies and courses attended, thus resulting in better patient care.

A. Personnel and Procedures

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1. Nursing care must be provided.</td>
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<tr>
<td>Nursing care is confined to reception hours?</td>
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<td>If so give details of out of hours care provided:</td>
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2. Nursing care includes the provision of diagnostic, pre-surgical, surgical, and recovery procedures as well as custodial care. | | |

3. All patient care provided by the nursing staff must be under the supervision of a veterinarian. | | |

4. All patients must be positively and properly identified (sufficient to differentiate between two like animals) during their hospital stay. | | |

5. Each medication must be entered on the patient’s medical record showing date, name of drug, type, dose, route of administration (when more than one route is acceptable), and frequency of administration. | | |

6. The practice staff must demonstrate humane care of animals. The facility must provide for the care and prevention of animal abuse or neglect of patients. | | |

7. Nursing personnel must ensure that all animals are individually and securely housed. NB: Sometimes owners request that housemates are housed together. This should be allowed. | | |

8. Nursing personnel must be trained to know the proper maintenance of optimum body temperature of all patients and to ensure patients’ comfort and cleanliness. | | |

9. A patient’s urination and defecation should be monitored and recorded when appropriate. | | |

10. Nursing personnel must ensure that water and food is withheld or provided when required. Feeding requirements should be recorded on the patient’s medical record, along with details of the consumption of the food and amount of food consumed by the patient. | | |

11. Nursing personnel must be trained in the proper restraint and handling of patients. | | |
12. Nursing personnel must be trained in the principles of contagious nursing care. Proper hand washing between patients is considered to be the most effective way to prevent cross-contamination, however suitable protective clothing must be provided and changed when appropriate.

13. All nursing personnel must be trained and routinely monitored to ensure that medications are administered in accordance with the directions of the veterinarian.

14. Assignments must be made so that one person is responsible for the proper observation of each surgical patient.

15. The nursing staff must be familiar with the proper handling and disposal of all waste materials and the cleaning and disinfection of compartments, exercise areas, and runs.

16. If the exterior exercise area cannot be easily cleaned, all faecal waste must be removed promptly.

17. Nursing personnel must be trained in the proper use of oxygen and anaesthetic agents, placement of endotracheal tubes, and correct use of anaesthetic monitoring and resuscitative equipment.

18. Nursing personnel must be capable of setting up and performing an ECG for purposes of patient monitoring or diagnostic testing.

19. Nursing personnel must be trained to assist in the resuscitation of patients and the proper method of handling animals found in a state of shock or respiratory or cardiac collapse.

20. Proper attire must be used for handling animals with contagious diseases. Proper attire includes disposable or easily disinfected gowns, disposable foot coverings or a means of disinfecting footwear, and disposable gloves.

21. All contaminated materials must be double-bagged or decontaminated before removal from the area where a patient with infectious disease is housed or examined.

22. The biomedical waste must be disposed of in accordance with federal, state and territory regulations.

23. Waste Disposal
   a) Rubbish disposal done by:
      • Local government service
      • Private service
      • Other, please state:

24. b) Bodies, discarded tissues and other infectious wastes disposed by:
      • Local government service
      • Private service
      • Other, please state:
c) Sharps are handled by:
- Local government service
- Private service
- Other, please state:

---

d) Whilst awaiting collection sharps are stored in:
- Approved Sharps containers
- Other, please state:

---

24 Nursing personnel must be trained in the proper establishment, monitoring, and administration of fluid therapy. This includes operation, priming and maintenance of intravenous fluid pumps.

25. When and if animals with contagious diseases are hospitalised, they must be housed in a separate, single-purpose isolation room. Following the use of a room for the isolation of animals with contagious diseases, all surfaces and cages must be thoroughly disinfected and all contaminated materials must be disposed of in accordance with federal, state and territory regulations for waste disposal.

26. In a single-purpose isolation room, only the equipment and material for the care and treatment of the current patient(s) within the isolation room may be kept therein.

27. Traffic in the isolation room must be restricted to the care of contagious patients.

28. When this room is not housing contagious patients, it may be used for other purposes if the room is sanitised in accordance with recognised procedures.

B. Equipment

1. A means by which an oxygen-enriched environment can be created must be in evidence within the facility.

2. The hospital must provide all equipment deemed necessary for improving safety, comfort, and quality of life for patients. Cage racks or other suitable means for preventing decubital ulcers must be available.

3. A controlled means of maintaining body temperature is required

4. A means of accurately delivering intravenous fluid requirements, such as paediatric burettes and fluid infusion pumps must be available.

5. ECG (preferably with printout capabilities) and respiratory monitors must be available on premises for monitoring critical patients.
C. Structure

### Number of wards:

- **General**
- **Dog**
- **Cat**
- **Isolation**
- **Surgical**
- **ICU**
- **Recovery**
- **Other?**

### Total number of animal compartments:

- **Cat**
- **Dog (M)**
- **Dog (L)**
- **Walk-ins/Runs**
- **Boarding Cat**
- **Boarding Dog**

1. Lighting, which is adequate to allow patient observation, must be provided.  
2. There are no specific ward requirements; however, all animal holding areas must be secure, escape-proof, and easily cleaned.  
3. Runs and/or exercise areas must be available, maintainable, secure, escape-proof, and adequate in relation to the normal case load.  
4. The facility must provide cages and/or runs that are large enough to permit the largest patient admitted to the facility to turn about freely and to easily stand, sit, and lie in a comfortable, normal position.  
5. All runs should be sloped and individually drained to prevent cross-contamination. If drained by a common trough, the trough must be covered and easy to keep clean and fresh.  
6. Concrete floors and runs must be well-sealed, clean, and in good repair.  
7. Cage doors and run gates must be clean and in good repair. All cages and runs must be constructed in such a way that contamination and contact from one animal to the next is controlled at all times.  
8. The partitions between the runs must be of solid construction and impervious material to a minimum height of 48 inches above the finished floor. Nose-to-
nose contact above the partitions can be prevented by not housing large-breed dogs in adjacent runs.

**Highly Recommended (not mandatory)**

1. A job description should delineate functions, responsibilities, and desired qualifications for each position of nursing service.

**Intensive Care Ward**

**Structure**

1. An intensive care facility must be provided to enable the extra observation and care necessary for these cases. The intensive care facility may be a separate ward or area, or combined with an anaesthetic recovery area.

2. The intensive care facility must be situated in the hospital such that direct visualisation or audio-visual monitoring of the patients from the main working areas is possible.

3. Strict attention must be given to temperature control in this area.

4. Soundproofing, ventilation, lighting and drainage requirements are as in the general ward.

5. As in the general ward a separate compartment must be available for each animal.

**Equipment**

1. Such equipment and supplies as are necessary to properly observe and care for these cases must be available in, or readily accessible from, the intensive care facility. List equipment used to monitor critical patients.

**Isolation Ward**

**Structure**

1. Provision of a separate isolation ward to house contagious cases is mandatory. When not housing specific contagious cases, it may be used for other purposes provided proper disinfection procedures are adhered to.

2. The isolation ward must be situated in the hospital removed from the main flow of traffic.

3. Soundproofing and lighting requirements are as in the general ward.

4. Ventilation requirements are as in the general ward with the added requirement that the exhaust facility be such that recirculation of air, from the isolation ward to other parts of the hospital, does not occur.

5. When and if animals with contagious diseases are hospitalised, the isolation room must have a negative air flow system in place. All air should be exhausted to the outside of the facility (no return air is permitted). 15-20 room air changes per hour are suggested.
6. Strict attention must be given to temperature control in this area.

7. Compartments, walls, floors and ceiling must be made of impervious material, capable of being disinfected.

8. Drainage and refuse removal from the Isolation ward must be such that there can be no contamination of other parts of the hospital or any public areas.

9. There must be a specific written protocol regarding the handling of animals with contagious disease with particular respect to disinfection of hands, clothing and footwear, disposal of contaminated materials and general disinfection of the patient and the ward.

Please provide a copy of protocol with submission

Equipment
1. Isolation ward must contain facilities for the washing of hands and be supplied with suitable hand disinfectant and disposable towels.

2. Bedding, food and water receptacles must be disposable or capable of being sterilised.

3. A separate set of cleaning equipment must be maintained for the isolation ward.

Fire Prevention and Safety
1. Written instructions for staff, clients and patient evacuation are posted

2. Patient evacuation must never compromise human safety

3. Evacuation plans must denote an assembly area or areas for staff.

4. Employee training must include fire safety and fire prevention procedures.

5. Emergency services phone numbers are displayed

6. Fire extinguishers and equipment are provided, please supply details:

7. Fire extinguishers are checked by the appropriate authority
HOUSEKEEPING AND MAINTENANCE

Rationale: The housekeeping goal is to maintain an environment that is safe for the patients, clients and employees. There must be a written housekeeping and maintenance programme (check lists at a minimum). This program must provide maximum disease control throughout the hospital.

A. Personnel and Procedures

<table>
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<tr>
<th>Compliance</th>
<th>Yes</th>
<th>No</th>
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Housekeeping Place

1. A written housekeeping and maintenance manual must be available. This manual should be kept up to date. It should describe the objectives of the housekeeping and maintenance programme, the responsibilities of personnel and the details of daily, weekly and monthly housekeeping and maintenance tasks. The manual should explain every task in detail and sequence.

The staff must be aware of the written housekeeping program and practice standards.

Please include a copy of the hospital’s housekeeping and maintenance manual.

The housekeeping manual or check list must include the following details:

- Mechanical equipment maintenance and cleaning, such as vents, air conditioning and fans.
- Window washing, ceiling cleaning.
- Wall cleaning care and carpet cleaning.
- Furniture dusting, washing and/or polishing.
- Plumbing maintenance.
- Upholstery and drapery cleaning.
- Garbage removal from animal and employee areas.
- Light fixture cleaning and electrical maintenance.
- Disinfection and sanitation.
- Replacement of worn or unsafe equipment, furniture and floor covering.
- Description of the cleaning job.
- Detailed procedures for daily, weekly and monthly housekeeping tasks.
- Personnel responsible for the fulfilment of these responsibilities.

2. Personnel responsible for the supervision of housekeeping must have a basic knowledge of health care and sanitation, including the principles of bacteriology, chemistry, and related sciences as they apply to disease control and prevention.

3. The facility and staff must present a professional appearance. The following must be in clean and good repair:

- Walls
- Ceilings
- Windows
- Floors and carpets
- Furniture and draperies
- Fixtures, including light and plumbing fixtures
- Equipment and appliances
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
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<tbody>
<tr>
<td>1</td>
<td>When was the hospital last painted?</td>
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<tr>
<td>2</td>
<td>Interior?</td>
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<tr>
<td>3</td>
<td>Exterior?</td>
</tr>
<tr>
<td>4</td>
<td>How often is the hospital painted?</td>
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<tr>
<td>5</td>
<td>The entire hospital must be free of persistent offensive odours.</td>
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<tr>
<td>6</td>
<td>Reception area displays (e.g. brochures, retail items, pictures) must be neat and orderly.</td>
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<tr>
<td>7</td>
<td>All cleaning supplies must be used in accordance with manufacturers’ instructions and in compliance with federal, state and territory regulations.</td>
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<tr>
<td>8</td>
<td>Safety data sheets on chemicals used should be included in staff manual or housekeeping manual.</td>
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<tr>
<td>9</td>
<td>Furnishings must be properly maintained and conveniently arranged in order to be pleasing to the client and conducive to the patient’s comfort.</td>
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<tr>
<td>10</td>
<td>All fixtures, furnishings and equipment must be maintained free from excessive wear and in good repair.</td>
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<tr>
<td>11</td>
<td>Linens must be stored in such a way as to minimise contamination from surface contact or airborne sources.</td>
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<tr>
<td>12</td>
<td>All contaminated linens, supplies and materials must be disposed of or decontaminated before leaving the area where a contagious patient is housed or examined. Containers with materials from contagious patients must be identified as potentially infectious.</td>
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<tr>
<td>13</td>
<td>Soiled or contaminated linens must be handled in such a way as to prevent cross-contamination of other areas of the hospital.</td>
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<tr>
<td>14</td>
<td>Cleaning equipment must be thoroughly cleaned and properly stored when not in use.</td>
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<tr>
<td>15</td>
<td>Equipment and supplies must be stored off the floor to promote a sanitary environment.</td>
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<tr>
<td>16</td>
<td>Storage areas, basements and attics must be clean, well-organised and adequate in size.</td>
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<td>17</td>
<td>Taps and drains must be inspected regularly and maintained in proper working order.</td>
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<td>18</td>
<td>Tanks containing compressed gases must be securely fastened to prevent falling or tipping.</td>
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<tr>
<td>19</td>
<td>Compressed gas tank valves, regulators, lines and washers must be checked periodically for leakage.</td>
</tr>
<tr>
<td>20</td>
<td>Mechanical systems throughout the hospital must be maintained in accordance with written preventative maintenance programs.</td>
</tr>
<tr>
<td>21</td>
<td>All hospitals must provide adequate emergency lighting. The hospital’s battery-operated lights or alternate power source must be maintained on a regular basis.</td>
</tr>
</tbody>
</table>
21. An adequate number of smoke or heat detectors must be in place, operable and maintained. The number and location must be in accordance with manufacturers’ recommendations.

22. Intrusion alarms and temperature alarms (where warranted) are recommended.

23. Ventilation and heating systems and air conditioning and heating equipment must be installed in accordance with applicable codes and appropriate standards.

24. The ventilation system must ensure that a controlled and regularly filtered air supply is provided in critical areas, such as the surgical suite, preparation areas, special care units and ward areas.

25. Water must be safe for use by employees, patients and clients. When water is obtained from a source other than a public water supply, it must be tested periodically and treated as necessary in accordance with federal, state, territory and local regulations.

Building Exterior

1. Grounds surrounding an animal hospital must be neat, attractive and in safe condition at all times.

2. Lawns, flowers, and plantings must be regularly cut, watered and trimmed.

3. Rubbish, papers and faecal material from animals must be picked up from lawns, sidewalks and parking areas on a daily schedule.

4. Parking must be area appropriate in size, sealed and in good repair, properly marked and kerbed and illuminated for safety.

5. Signage must be of a professional appearance and in good repair.

6. Exterior lighting must be in good taste and useful in identifying the facility.
LIBRARY & CONTINUING EDUCATION

Objective: The library must contain current textbooks, journals, conference proceedings and other printed materials appropriate to the needs of the staff. Audio visual and computer-based reference material may also be available.

The most recent journals and the latest references on subjects relative to the activities of the hospital must be available in an organised manner.

All reference material within the hospital library should be updated continually.

Best practice veterinary medicine and surgery requires that all staff are kept up to date with current best practice information. Hospitals should be able to demonstrate ongoing strategic learning strategies for every staff member. All new staff should have an induction program that helps them to assimilate in their new work place similar to the ‘new graduate friendly’ practice scheme. All staff should have an annual performance review which includes goal setting and identification of training required, with this information to be documented.

A. Personnel and Procedures

1. The professional and paraprofessional personnel should follow an organised plan of educational self-improvement and information dissemination. Continuing education requirements must be met for applicable state or territory regulations.

B. Equipment

1. The professional library must include current books, periodicals and other multimedia materials appropriate to the needs of the staff.

2. Adequate shelves for the orderly storage of books and periodicals must be provided.

3. It is recommended that the library be conveniently located so that hospital staff can enter, quickly refer to relevant literature, and return to their work. The library should offer seating and writing surfaces for more leisurely research.

All continuing education must be documented.

List all journals subscribed to by your hospital:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
List audio or visual resources acquired or studied in the last three years:


List other books in the library deemed to be important:


EMERGENCY SERVICES

Objective: Emergency services (professional diagnosis and emergency treatment) must be provided and must be readily available at all times.

While a veterinary hospital need not be open to the public at all times, professional personnel must always be available to ensure assessment and treatment of emergency cases within a reasonable length of time. Professional or paraprofessional personnel must also be available to ensure adequate monitoring and treatment of any hospital patients.

The hospital must have a protocol that ensures that sick or injured animals can be assessed, monitored and treated on a 24-hourly basis. The protocol should ensure assessment of the animal within 30 minutes of the client initiating contact if this is necessary for the welfare of the animal.

The out of hours emergency service may be organised in various ways such as: the assignment of hospital staff, co-operative arrangements with other hospitals/clinics or by referral to an emergency centre. Similar arrangements for the monitoring and treatment of hospital patients are also satisfactory.

A. Personnel and Procedures

1. Every accredited ASAVA hospital must have a procedure by which a sick or injured animal may be assessed and either treated or referred to an appropriate facility.

2. Emergency services or referral to an appropriate facility must be available 24 hours a day.

3. Emergency services must be adequate to ensure the treatment of the patient within 30 minutes.

4. A medical record shall be kept for every animal, including strays and wildlife, received by the emergency service, both in hours and out of hours.

5. When a patient is transferred for emergency services, a copy or summary of the medical record must either accompany the patient or be transmitted by telephone, facsimile or e-mail ahead of the patient’s arrival at the referral veterinarian. A record of this transmission of medical records should be made in the patient record.

B. Equipment

1. The hospital must be equipped appropriately to deal with all reasonably expected emergencies.

2. There must be basic equipment and supplies available for assessment, treatment and monitoring of emergency cases.

   All resuscitative equipment and supplies must be available, including:
   • Those used for endotracheal intubation and tracheotomy tube placement for animals of various sizes
   • A source of oxygen adaptable to continuous oxygen delivery
   • Air viva or AMBU bag
   • All equipment necessary for parenteral fluid administration including fluid infusion pumps
• Adequate disposables such as chest drains, 3 way taps, catheters, etc.
• Suction
• Warming pads
• Equipment for gastric lavage and enemas
• Standard drugs
• Parenteral fluids, plasma substitutes and surgical supplies must be on hand for immediate use in case of life-threatening problems
CHEMOTHERAPEUTICS AND CYTOTOXICS

Objective: If chemotherapeutic and cytotoxic drugs are routinely utilised or prescribed, the hospital must ensure it complies with the occupational health and safety requirements of relevant federal, state and territory legislation.

Suitable facilities must be provided for safe storage and use of cytotoxic drugs in accordance with federal and state or territory regulations.

The hospital must have a protocol for control and accountability of chemotherapeutics and cytotoxics and disposal of unused drugs, chemicals, biologics and contaminated equipment.

A copy of the relevant federal, state or territory regulations or act must be maintained and be available for inspection at all times.

A. Personnel and Procedures

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

1. The responsibility for safety, management and prescribing of all chemotherapeutics and cytotoxic drugs rests primarily with the director of the hospital or a veterinary surgeon designated by the director.

2. Veterinary nurses can be trained to assist in some of the procedures for administration and prescribed use of these medications.

3. Drugs must only be dispensed by a registered veterinary surgeon.

4. Drugs must be administered in accordance with best occupational health and safety policies.

5. Medical records must include a copy of the treatment protocol being followed; including timings of doses administered, doses administered, rationale for use of drug/protocol, patients’ weights and any possible or actual adverse reactions.

6. The veterinarian responsible for the cytotoxic chemotherapy service should be trained in the following aspects:

   a) Establishing specifications for the procurement and disposal of all chemotherapeutic and cytotoxic drugs, chemicals, biologics and related equipment.

   b) Dispensing drugs, chemicals and biologics. This should be standardised for all areas of the hospital. Great care must be exercised in dispensing drugs for client administration at home. As a minimum each drug should be dispensed in a container which in no way alters the drug being dispensed and which is moisture resistant.

   Labelling must be in accordance with Commonwealth and/or State or Territory laws (see Dispensary Section).

   c) Advising about actions, adverse reactions and contraindications for the use of all drugs, chemicals and biologics used in or dispensed by the hospital.

Storage and stability of chemotherapeutic and cytotoxic drugs

1. Storage and handling of these drugs must be in accordance with the manufacturers’ recommendations and relevant federal, state and territory regulations.
2. It is strongly recommended that injectable chemotherapeutic agents be ordered by individualised doses or aliquots from pharmacy companies that provide this service in the correct dose aliquots required for each treatment to avoid unnecessary handling of these chemicals.

B. Equipment

1. The dispensary should maintain separate storage area for these drugs, chemicals, biologics and related equipment (needles, syringes, vials etc.).

2. A refrigerator for those drugs which require refrigeration is required. Storage of refrigerated cytotoxic drugs should be separate from non-cytotoxic drugs and food.

3. All dispensed or repackaged medications must be in approved containers and where applicable, child-resistant containers.

4. The container must in no way alter the drugs being dispensed and must be moisture resistant.

5. Drugs kits which are easily portable should be available and maintained for chemotherapeutic and cytotoxic drug usage.

6. A typewriter or computer printer must be provided to complete drug labels. Hand written drug labels are not acceptable.

7. Appropriate safety items must be available for handling these hazardous substances.
   These should include:
   • Approved spill kits
   • Appropriate gloves
   • Impervious gowns
   • Splash glasses/goggles
   • Approved masks or respirators
   • Adequate ventilation

C. Structure

(See Dispensary Section)

1. Facilities must be provided for storage, safekeeping, and use of chemotherapeutics and cytotoxic drugs in accordance with federal, state and territory regulations.

2. Controlled drugs must be stored in a securely locked, substantially constructed room, cabinet or safe as required by federal, state and territory regulations.

3. Administration of these compounds should be in a designated area separate to working areas of the hospital, away from public access and with adequate ventilation.

4. If decanting of injectable medications occurs then this must be performed in accordance with federal, state and territory regulations.
ADDENDUM 1: Records

With computer programs being utilised by most clinics it is suggested that a standard consultation set-up is used that lists systems and prompts the recording of information in a standardised format. A comment is made against each prompt if relevant. With the majority of current veterinary programs it is very easy to set up a template for such standard consultations or even procedures that can be applied to each consultation. Some programs however, are limited to the number of lines it will allow (e.g. Dos VetAid, limits you to 10 lines) however, this can form the basis for a good start to each consultation record.

Other programs e.g. RxWorks allow the use of pre-formatted templates. An example of such a SOAP set-up is below. One can have a number of pre-set versions of the below example to satisfy more routine consultations i.e. New Puppy Vaccination Consult, Annual Vaccination Consult, Post–op Consultation, etc.

Example 1: SOAP Consult template

| Chief complaint / Reason:          |
| Subjective / History:             |
| Last well                         |
| Last ate                          |
| Med Hx:                           |
| Diet:                             |
| Vacc/ Worming:                    |
| Companions:                       |
| Environment:                      |
| **Objective:** Tmm CRT HR FP AmtP RR |
| Systems:                          |
| CV:                               |
| Resp/Chest:                       |
| U/G:                              |
| GIT:                              |
| Neuro:                            |
| M/S:                              |
| Integ:                            |
| Ophth:                            |
| Otic:                             |
| Other findings:                   |

Assessment / Problems identified:
Plan: Plan of treatment / diagnosis for each identified problem

Treatment: Treatment given

Progress notes:
*These should be added with the time and initials of the person performing the treatment. They can be a shortened form of the problem oriented approach.*
**Chief complaint/ Reason:** Collapse

**History:**
- Last well
- Last ate: Breakfast this am. Dry food.
- Med Hx: None.
- Diet: Commercial dog foods- euk, Good-Os.
- Vacc/Worming: +ve
- Companions: None, kids
- Environment: Confined to yard, no access to toxins.

Dog was mucking around in garden with kids and family, Gardening etc. Noticed that Gypsy retched a few times and then appeared to be staggery and fell over. Thought had had heart attack. Now can’t walk at all. 20 minutes ago only.

**Subjective:** Carried in by owners. Weak, subdued.

**Objective:**
- T 37.8 MM ppink/mauve  CRT1-2s  HR160 = FP AmtP +ve, weak
- CV: tachy
- Resp/Chest: harsh resps all fields.  RR 28
- U/G: NAD
- GIT:
- Neuro: Depressed, owners say much improved in past 20 minutes.
- M/S: Placed on floor and can stand. Appears now relatively BAR. Walking around and sniffing.
- Integ: ? mb small amt swelling on lip appearing. No stingers found.
- Ophth: NAD
- Otic: NAD

**Assessment/Problems identified:**
- Acute collapse, emesis/retching
- Spontaneous/rapid recovery
- suspect insect bite/ Bee sting reaction
- DDx Snake bite. Other HS reaction.

**Plan:** Discussed with owner- owner thinks may have been playing with something in grass and certain not a snake. Observe in waiting room for 20 minutes or so, Home, Watch closely for next few hours. Owners advised that may develop facial swelling etc. Any concerns return.

**Treatment:** Inj Chlorpheniramine 1 mg SQ

Or Snakes seen in area recently. Advise admission for few hours obs. If any signs, ACT, (+/- SVDK etc etc)

Some computer programs allow the full consultations like this example above to be saved as a “procedure”. This “procedure” can then be applied to a similar consultation and the details changed to suit the individual case. In the space of a few seconds a complete new and suitably detailed record can be generated for a new case. Many such “procedures” can be saved and used in many “routine” or “formulaic” consultations e.g. FLUTDS cases, vaccination, dog spey, GDV cases, etc.
Chief complaint/ Reason: collapse

History: Last well: Two days ago.
Last ate: Breakfast 2 days ago
Med Hx: None.
Vacc/ Worming: Not recent
Companions: younger puppy, kids
Environment: confined to yard, no access to toxins, compost bin.

Started vomiting occasionally Friday night. Initially just ? last meal. V sev times over Sunday, watery/froth. Every time tried to drink. Not interested in food Saturday or Sunday. Little loose motion passed Saturday pm. Nothing since. Very depressed, lethargic.
Overnight vomited several times, small amt blood present, seems very depressed and uncomfortable. Yelped when lifted in car.
Urinating??

Subjective: Ambulatory, weak, subdued.
Objective: T 39.8 MM pink/red CRT 1s HR 160 = FP AmtP +ve, weak
CV: tachy
Resp/Chest: NAD. RR 28
U/G: 
Neuro: Depressed,
M/S: NAD
Integ: skin tenting- marginal.(3+%) 
Ophth: NAD
Otic: NAD

Assessment/Problems identified:
Vomition 2 days
Pyrexia
Dehydration.
Abdominal pain
Overweight female
??urine
ddx FB, pancreatitis, renal disease, peritonitis, hepatitis, etc

Plan: Admit for blood tests, Ivfs, Rx, pending lab results, for suspect pancreatitis

Treatment: 20# catheter, start LRS @ 20 ml/kg for 6 hrs, then 10 ml/kg for 12 hours
(see treatment sheets for details)
Collect EDTA/Lith.hep/smears – lab.
In-house: PCV/TP/BG/Azo – 49% / TP 86g/L/ 3.3mmol/L/
>12mmol/L Collect Urine sample: SG, Dipstik, etc etc
---------------------------------------------------------------
Blood results:(CVDL) Ref number 12345
Suggests Acute pancreatitis. Add summary of abnormal results and pertinent info. Etc etc

Plan: Client communication: Spoke to owners, advised that suspect acute pancreatitis, discussed pancreatitis and possible outcomes and problems, discussed ex.lap and J tube etc etc. Owner keen to avoid surgery and high costs if possible. Try conservative care ats.

Treatment:
Rx Buprenorphine q 8 hrs.
Rx Cef xx mg q 8 hrs
Radiograph Abd +/- U/S
NPO, Check urine production
Etc etc (see treatment sheets for details)
ADDENDUM 2: Medical Record Guidelines

The computerised medical records need to be accurate and reflect any treatment the patient is receiving and all pertinent medical notes about the case are reflected in the medical record. Where cageside side notes are used, they may be very detailed (nursing notes about feeding / types of food offered, amount of time spent, technique used to encourage eating, TLC provided, description of any physio performed, etc, etc) giving information which is useful and very important on the day, but are often not important for the ongoing management of the case.

The computer records need to contain all the necessary information so that a colleague can look at the medical records (either the next day or in 2 months time) and tell what is/was happening with the case without having to go back and look at the paper cage side cards.

Some options and suggestions for medical records are outlined below, acknowledging that there is no ‘one size fits all’ approach for every hospital. What works great for one hospital may be impractical for another:

1. **Computerised SOAP formats with transcribed nursing notes chronologically written to files.**
   Some Veterinary management programs automatically record a time whenever an entry is made, which makes ongoing chronological addition of observations/treatments easy. Where this is not the case, it may be easier to have a separate ‘nursing’ section at the bottom of the daily computer record, separate from the ‘Veterinarian SOAP records. Not every piece of nursing information needs to be transcribed – useful information includes what meds are given, dose and time, when they are due, catheters placed, removed, intravenous fluids commenced, stopped, total volumes infused, admission and discharge times. Ins and outs might be included if they are of particular importance. Care needs to be given such that entries do not contain extraneous, unwanted information – i.e. keeping things simple. All entries are initialled since many people may be involved in managing a particular medical case - each entry takes very little time to add, questions and queries can be clearly directed to the appropriate person, and at the end of a given ‘day/night/24 hour period’, a complete record is present without the need for someone to sift through the cageside charts and transcribe the relevant information - this is of particular importance when transferring cases to other hospitals, such as Emergency facilities, for ongoing care.

2. **Computerised SOAP formats with cageside records scanned and attached to daily treatment consult records.**
   At the end of each treatment period, the cageside treatment charts are scanned and attached to the patient file. This would be suitable if it were easy to access both daily computer records and the scanned cageside records to get the full picture.

3. **Computer records with no cageside paper records.**
   Everything is recorded similar to 1 above. This works particularly well where the Practice Management System (PMS) records a time automatically whenever the consult is altered. Disadvantages include possibility of inclusion of extraneous unwanted information making records overly long and complicated. Other disadvantages may be present where cases are particularly complicated involving multiple intravenous therapies – CRIs and different fluid types given concurrently.

4. **A quick daily summary at the top of each record/consult/24hour period.**
   Concise summary of when the current disease started, current problem list, what drugs are being used, when patient admitted, when they expect to be discharged. By stating this, any clinician taking on the case can quickly see and know what's going on with having to troll through cageside charts and reading through all the patient history. This may be particularly helpful where the SOAP/HEAP format is substituted/modified for ongoing hospitalised medical cases being treated continuously over a number of days.
5. **Cageside treatment charts, when used, need to have all relevant including, but not is exhaustive of:**

- TPR assessments and times performed.

- Medications given, dosage and time, with indications of when the next dose is due. Ideally, the Generic name of the drug is used as this is universally known by Veterinary/Medical practitioners. Short hand is fine *e.g.* 7am Metronidazole 200mg PO, next due 3pm [staff initials].

- All ‘ins and outs’ – i.e. urine, defaecation, waking - time performed and by whom. What is fed and when and by whom. Other relevant information/Special instructions regarding food and water. *Eg 12am U+, F- BAR [staff initials].*

- Catheter sizes, where placed, what time and by whom *e.g.* 7pm 22G ivc placed LF cephalic and LRS commenced @ 200ml/hr (AC/LS) [ *e.g.* of staff initials].

- Fluid rates, types of fluids given, and total volumes infused over a given time, upon removal of catheter, or discharge with giving set wrapped in place etc. *e.g.* 8pm Ivfs disconnected, TVI 920ml, extension set wrapped in place, discharged [staff initials].

- Admission and discharge times, by whom and what instructions were given.

- Premedications given, what time and what doses. It is recommended that individual premedication doses are tailored for each patient *e.g.* 0.3ml ACP 2mg/ml, 0.6ml Methadone 10mg/ml s/c @ 9am [staff initials].

6. **Advantages of transcribing pertinent cageside information immediately to computerised records:**

- When done immediately, this takes little time to do, and if all staff responsible for patient care perform this task, then, by the end of the day, a ‘complete’ medical record is present, rather than a hurried transcription by one person which invariably leads to omissions and inaccuracies.

- By initialling these entries, any queries of what was done and when can be addressed with the staff member concerned, and with absolute clarity.

- By adding entries as they are done, a chronological medical record is performed with ease. This is especially important when referring onto overnight emergency centres for ongoing care, who might otherwise need to read both computerised and cageside records in order to get the ‘complete picture’ - best to have one set of records detailing everything.

- A veterinarian taking on a case the following day will have a simpler task reading one complete file compared to having to go through both records, neither of which are complete on their own.

- A clinician can check a patient’s ongoing status (whether it be checking that medications have actually been given by a particular time, or a particular test has been performed) via any computer terminal throughout the hospital during their shift rather than having to physically go to the cage, get the cageside records and read them.

The above are only suggestions, and have been included in the manual as an aid for hospitals going through the accreditation process, and as a response to enquiries for such guidelines to be given.
ADDENDUM 3: How to Write a Radiology Report

Cathy Beck FANZCVSc (Radiology)

The Radiology Report forms part of your medicolegal record. The report should be a clear statement of the projections evaluated, their quality, with a concise description of the radiographic findings. The findings are then summarised in the radiographic interpretation or conclusion. This is followed by a rank order list of the possible differential diagnoses and recommendations of further tests or treatments. Thus the report should be presented in a number of sections:

**Projections and Quality**

The radiology report within your medical records should list the projections provided, including any techniques used, for example contrast studies. A comment should then be made on radiographic technique and quality – including a comment on: positioning, exposure and collimation and state if any artefacts are present. A method for remembering these aspects is the PLACE system:

- **P**ositioning
- **L**abelling (i.e. is the film correctly labelled with patient details and left and right labels, prior to processing)
- **A**rtefacts - are any present, if so list
- **C**ollimation
- **E**xposure

**Radiographic Description**

In this section you describe your radiographic findings. Radiologic findings include consideration of the Roentgen signs such as size, shape, opacity, number and position of organs. Avoid using the term “there appears to be” if something actually is. The radiographic signs must be described leaving the interpretation of the signs to the next section of the report. For a lesion in a distal radius of a large dog for example describe lysis, the pattern of periosteal new bone production and so on.

**Radiographic Interpretation or Conclusion:**

This is where you state the interpretation of your findings e.g. “aggressive bone lesion within the distal radius”. This is not the place to introduce new information; it is a summary of your findings. You must provide an interpretation of each abnormality you described in your description.

**Differential diagnoses:**

List the differential diagnoses for each abnormality in a rank order of most to least likely, for example with the aggressive bone lesion in the distal radius: primary bone neoplasia is most likely such as osteosarcoma, chondrosarcoma; fibrosarcoma; haemangiosarcoma, less likely osteomyelitis.

**Further recommendations**

The recommendations depend on the case being discussed; it may involve further imaging or sampling. For example for the aggressive bone lesion within the distal radius further imaging is recommended: a three view thorax to assess for the presence of pulmonary metastases, and further tests: a bone biopsy for the definitive diagnosis.
An Example Report

2 yo FS JRT “Susie”
Presented for intermittent vomiting

Projections and quality
Left laterally recumbent and ventrodorsal radiographs of the abdomen
Positioning is good, maybe stretch hind limbs further caudally, exposure good.
(patient ID has been removed for the purposes of client confidentiality for this example)

Radiographic Description
There is good intraabdominal serosal detail. The stomach contains gas and fluid but is not distended. The small intestines contain gas and fluid. There is one gas filled loop within the mid abdomen measuring 12mm in diameter on the lateral projection which is 1.4 times the height of L5 vertebral body ( >1.6 x L5 vertebral body is suggestive of mechanical obstruction). On the VD projection, there are several irregularly marginated curvilinear fragmented gas lucencies and the gas filled loop is again noted. The colon contains granular faeces. The liver, spleen left and right kidneys and urinary bladder are normal. There are eight lumbar vertebrae. There are no further osseous abnormalities. The portion of the thorax that is seen is normal.

Radiographic Interpretation
Focal small intestinal distension ddx ileus - functional or mechanical.
Eight lumbar vertebrae – anatomic variation.
An abdominal ultrasound is recommended for further evaluation to rule in/out a SI obstruction

Do not be overwhelmed by this task - just describe what you see.

Good references include
BSAVA Manual of Canine and Feline Radiography and Radiology
By McConnell F and Holloway A
BSAVA 2014
This is the updated version of the BSAVA Manual of Diagnostic Imaging

Radiography of the Dog and Cat: Guide to making and interpreting radiographs
By Muhlbauer MC and Kneller SK
Wiley Blackwell 2013
I think you will find this a useful resource. It is a well written overview of radiography and radiology with some lovely quotes

Textbook of Veterinary Diagnostic Radiology 6th ed
Thrall DE. Saunders Elsevier 20012
Always useful

www.veterinaryradiology.net
A fantastic site for the teaching and learning of veterinary diagnostic imaging.
Radiographic Submission for ASAVA Accreditation

Case #1 Skeletal

"Genevieve" 13yr 9m Female Entire Papillon

Rx works record attached detailing history, examination and radiographic findings.

Radiography information:
- Fuji Medical Xray Film 100NIF Mammography 24 x 30cm (single-emulsion film)
- Screen: Single intensifying screen within Fuji Cassette 24 x 30cm
- Exposure factors:
  - Lateral views 60 kV, 100 mA, 0.125 s
  - Ventrodorsal view 50kV, 100mA, 0.125s
- Automatically processed
- Labelling as evident on films (facility and patient identification, date and laterality information)
- Appropriate positioning for views required, and given lightly sedated nature of patient.

Xray report included in Rx works record.
# Patient History - Period 25/09/2014 to 4/10/2014

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<tr>
<th>Patient Name: Genevieve</th>
<th>Species: Dog</th>
<th>Sex: Female</th>
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<tbody>
<tr>
<td>Breed: Papillon</td>
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<td></td>
</tr>
<tr>
<td>DOB: 11/12/2000 Age: 13 yrs 10 mths</td>
<td>Current Weight: 3.10</td>
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</tbody>
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26/09/2014 Vet: Dr Nicole

Invoice Details: Dislocated hip and PTS

<table>
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<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>26/09/2014</td>
<td>Vet: Dr Nicole</td>
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<td>26/09/2014</td>
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<tr>
<td>4/10/2014</td>
<td>Weight: 3.10</td>
</tr>
</tbody>
</table>

4/10/2014 - 10:20:07AM
Patient History - Period 25/09/2014 to 4/10/2014

History Details:
Reason: WALK IN Leg Injury 8:45am
Appointment Notes: RK

History: Fell down stairs last night and has been non-weight bearing since. Slept through the night okay, not eaten this morning. Blind/deaf, spends most of time sleeping.

Examination: Bilateral marked clouding to the eyes - O' managed with pred drops (see report from MK). HR 160bpm, regular, panting, some crackles in chest but no history of coughing. No murmur. Abdo relaxed. RHL - stifie externally rotated, toes under body and unable to weight bear. RHL shorter than LHL. Able to extend hip on R side but she reacts painfully with flexion.

Assessment: Suspect hip dislocation.
9am Methadone 0.13mL SC and admit for x-rays of pelvis (avoided acp with age/possible crackles).
X-rays of hips/pelvis - both VD and lateral view. First R lateral view was overexposed and under-collimated, so the mAs was reduced and the collimation was narrowed. Good quality images thereafter.
L lateral view cranioventral hip dislocation. No evidence of fracture to femur or pelvis. VD view - cranial hip dislocation, unable to determine ventral or dorsal on this view. Again, femur and pelvis appeared normal otherwise.

Diagnosis:
Revealed cranioventral hip dislocation. Not seen this before - normally craniodorsal or caudoventral. It appears as though the femoral head has come out of the joint, rotated externally and moved cranially - because on lateral view, the femoral head is cranial and gtr troch is caudal - as though patella is pointing to the ceiling.

Treatment:
Spent 1hr 20 mins attempting closed reduction with various techniques including manipulation and stretching the muscles by gently hanging her from her foot. Felt I was able to replace the femoral head at one point - obvious clunk and hip moving better, but as soon as I release my grip, it pops back out again.

Spoke to owner and gave 3 options:
1) Recover from GA and send to specialist to attempt closed reduction
2) Excision arthroplasty here next week - advised can book with DVN for $1200 or I can do it for $500 as long as O' aware that I don't have as much experience as DVN.
3) PTS.

O' opted for euthanasia. Verbal consent from Euth and cremation, with ashes returned. O' to come in next week to pick up her collar and pay the account.

Invoiced Items:

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>No.</th>
</tr>
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<tbody>
<tr>
<td>Consultation Standard</td>
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</tr>
<tr>
<td>Radiology</td>
<td></td>
</tr>
<tr>
<td>Medication Methadone Injection</td>
<td>0.29</td>
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4/10/2014 - 10:20:07AM

ASAVA Manual of Hospital Standards and Accreditation 2016
### Patient History - Period 25/09/2014 to 4/10/2014

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Radiographic Submission for ASAVA Accreditation

Case #2 Abdominal

"Oscar" 9yrs Male Entire Retriever

Rx works record attached detailing history, examination and radiographic findings.

Radiographic information:
- Fuji Medical Xray Film 100NIF 35 x 43cm (double-emulsion film)
- Screen: Double intensifying screen within Fuji Cassette 35cm x 43cm
- Exposure factors;
  - Lateral views 66kV, 300 mA, 0.025s
  - Ventrodorsal view 83kV, 300mA, 0.025s
- Automatically processed
- Labelling as evident on films (facility and patient identification, date and laterality information)
- Appropriate positioning for views required

Xray report included in Rx works record
Patient History - Period 18/01/2014 to 20/01/2014

Patient Name: Oscar
Breed: Retriever
DOB: 1/01/2005 Age: 9 yrs 0 mths
Species: Dog Sex: Male
Colour: Gold
Current Weight: 25.00

18/01/2014  Vet: Dr David  Weight: 29.00
Invoice Details: Constipation
History Details: Constipated-
Severe constipation following cooked bone ingestion.
Admit for plain abdominal radiographs +/- enema
Plain lateral and VD abdominal radiographs show large chain of faeces containing
undigested bone, but also show a massive 10 x 20cm calcified structure in caudal
abdomen extending into pelvis. Further pelvic rads show this structure passes completely
through the pelvis ventral to the colon/rectum. It is calcified and is in region of
bladder/prostate. Likely paraprostatic cyst or similar. Rectal exam confirms this is a solid
mass compromising pelvic canal.

Some gas filled intestinal loops but remainder of abdominal contents within normal
parameters.

Discussed with owner- proceed with major enema under GA, but declines further worjup
regarding mass due to age of dog and limited ability to surgically remove such a lesion.
Owner aware will need to manage dog chronically with stool softening agents
lactulose/psyllium

Premed anarv/methadone.
GA alfaxan alone, IV top up
Cannulated R cephalic, IV plasmalyte rep.
Major warm scoop enema, flushed all bowel contents clear. Really good result, although
unable to fully palpate colon due to calcified structure.
Hospitalised overnight, ate immediately on recovery from GA, feeling much better.

This dog needs chronic stool softening with lactulose or psyllium.

Invoiced Items:

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## Patient History - Period 18/01/2014 to 20/01/2014

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<td>IV General Anaesthetic</td>
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Radiographic Submission for ASAVA Accreditation

Case #3 Thoracic

“Leo”  
11yrs 8m Male Entire Shih Tzu x Maltese

Rx works record attached detailing history, examination and radiographic findings.

Radiographic information:
- Fuji Medical Xray Film 100NIF 35 x 35cm (double-emulsion film)
- Screen: Double intensifying screen within Fuji Cassette 35.8cm x 35.8cm
- Exposure factors;
  - Lateral views 58kV, 300 mA, 0.02s
  - Ventrodorsal view 58kV, 300mA, 0.02s
- Automatically processed
- Labelling as evident on films (facility and patient identification, date and laterality information)
- Appropriate positioning for views required

Xray report included in Rx works record
## Patient History - Period 23/07/2014 to 10/08/2014

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<th>Patient Name: Leo</th>
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<tr>
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<td>DOB: 23/02/2003  Age: 11 yrs 6 mths</td>
<td>Current Weight: 10.50</td>
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23/07/2014  Vet: Dr Phil  Weight: 9.80
Invoice Details: Shaking/D* - inflammatory disease
Patient History - Period 23/07/2014 to 10/08/2014

History Details:
Reason: Diarrhoea
Appointment Notes: Special payment terms exist

Dog developed d" and shaking this morning, seems quite stirred up.

DVN recently increased the pred dose, and dog also was given something fatty last night. Likely combination effect causing pancreatitis or similar inflammatory disease?

T=40.4, relaxed cranial abdo but sensitive caudal abdo, hr rapid, gums pink, panting.

Suggested CP2 and admit for IVFT, clav and temgesic.

Monitor temp and then consider if to offer i/d later. Likely stay in over night.

Bloods collected for CP2, given clav and temgesic sc.

T 39.7 at 11am
T 39.1 at 1pm
T 38.3 at 330pm

Offered small amt i/d food and ate it down. Still panting but seems relaxed

Results: Inflammatory disease is present with a superimposed stress/steroid response. White blood cell inflammatory response. Pancreatic/hepatic enzymes okay.

O's brother called to say wonders if related to seizure episode had recently as had another of these recently again. Also had ongoing cough which is what the steroids and bisolvin are for.

STO updated.

STO - O will confirm if happy to leave in here overnight and resasess tomorrow, or is she would prefer him to be monitored at PVS-EC overnight. PVS are calling us back at 5pm with costings and if can collect him with ambulance.

545pm dog offered small amt i/d tin food. Given 0.4ml Temgesic sc.

Plan:
Dog will go to PVS-EV overnight for nursing monitoring care $170, and we can send fluid bag, another temgesic dose for 1am, and tin of i/d food. They will discuss with owner on arrival tonight to organise transfer of dog back to CAH on Thursday morning.

Discharge to owner to transfer to PVS-EC along with temgesic dose, fluids, i/d tin and notes/referall form as well as faxed directly.

O unsure if can collect from PVS-EC in morning and PVS advised they would see if they have a nurse available in the morning to transfer here, but if they dont, and client is unable to collect, one of our nurses from may have to go collect during the morning.

Plan:
Patient History - Period 23/07/2014 to 10/08/2014

For Thursday, once back at GGL please reassess temp/demeanour/abdomen and assess if needs ongoing IVFT/pain relief or other. O also asking about the steroid use and increased dose recently by DVN and whether this contributed to this episode now. Also wants to find out what the cough is, and so have mentioned imaging eg of chest, but also imaging eg scan of head to assess cause of seizure episodes (see prev hx).

O very worried, so please reassess dog first thing once back and update her and discuss plan from here.

Invoiced Items:

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<tr>
<td>CP2: Super Profile</td>
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24/07/2014 Vet: Therese
Invoice Details: PVS overnight report attached.
History Details: Overnight report from PVS attached.

24/07/2014 Vet: Dr Glenn
Invoice Details: Possible pancreatitis, Right lung disease
Patient History - Period 23/07/2014 to 10/08/2014

History Details: Reason: Back From PVS-EC

History:
See hx from yesterday and PVS-EC.

Examine:

Treatment:
Admitted for continued IV fluid therapy through the day with Plasmalyte at 2x maintenance. Monitored for pain but seemed quite comfortable with most recent tramal inj 30mg given by PVS-EC at 5am.

Sedated with methadone 0.4ml/Anamav 0.15ml SC at 2pm and chest radiographs taken. Left & right lateral and VD views taken, some rotation on VD views. Rads show consolidation of one right lung lobe, probably middle lobe especially apparent on VD. VDs esp show alveolar pattern with air bronchogram evident in one view. This is supported on left lateral with large air bronchogram appearing to overlie cranial border of heart. Same view shows opacity overlying the 3rd and 4th sternebrae, which is probably too caudal for suprasternal lymph node and is probably pleural fluid in fissure. Small amount of pleural fluid evident on one of the VD views too, but only between cranial and middle lobes right side. Left lung and other lung fields appear within normal limmits. DDx for focal alveolar consolidation of lung lobe include lobar collapse/atelectasis, local bronchopneumonia, foreign body esp bronchial foreign body, neoplasia, haemorrhage. Unlikely oedema due to location/distribution. Exact cause not evident from plain radiographic study.

Swab taken from some of the right nostril pus and send to vetpath for fungal culture.

Assessment:
Good response to treatment for acute pyrexia/abdo pain. Most likely acute abdo pain was due to flare of pancreatitis (previously diagnosed with chronic pancreatitis/pathology earlier this year and had a fatty meal prior to symptoms developing), although bloods were not supportive.
Pyrexia may be linked to Right middle lung lobe pathology and/or Right nasal discharge - eg pneumonia.

Cannot explain how the focal area of lung disease and unilateral nasal discharge are linked - possible inhaled grass seed with some foreign material in Right nasal cavity and some in Right middle lung lobe? Are these problems linked to the acute abdominal pain. Also had seizures earlier in the year. ?????
Cough is not severe at this stage and clinically seems well now with acute pyrexia controlled and eating well, so no urgency to get definitive diagnosis straight away/ O concerned though and would like to get to the bottom of it as soon as is practical.

Plan:
Discharged on meds as below:
Baytril 50mg sid for 2 weeks
Uroclav 125mg bid for 2 weeks
Continue Bisolvon 8mg bid
Continue pred 2.5mg eod (Has previous hx of relapsing severe IMHA - obviously would prefer not to have him on pred but I cant risk relapse of IMHA, even though currently not on immunosuppressive doses).
Feed i/d diet only for next week, then in future must be strict with no fatty foods.
Patient History - Period 23/07/2014 to 10/08/2014

Await nasal fungal culture results - due in 1 week and 4 weeks
Speak to DVN re rads interpretation. Likely to need head and chest CT scans but get DVN's opinion on case first. GL will call owner Wednesday with recommendations

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26/07/2014
Vet: Dr David
Invoice Details: Chest radiograph review
History Details: Reason: Chest rads- review by DVN. Definitely an area of poor lung filling caudal right lung with pleural fluid. Temperature recheck NAD- is 38.3 Recommend finish course of antibiotics, recheck then, likely repeat chest x-rays. If continuing to be febrile or still lung opacity then recommend advanced imaging.

28/07/2014
Vet: Rachelle
Invoice Details: Returned ID cans
History Details: 

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8/08/2014
Vet: Dr David
Invoice Details: Repeat chest radiographs
History Details: Reason: Recheck With DVN
Admit for repeat chest radiographs

- Tried for conscious radiographs but impossible- sedated domitor/butorphanol
- Plain lateral and VD radiographs shows complete resolution of pleural fluid and no changes to pulmonary parenchyma, lung patterns normal. Essentially complete resolution of previous condition.

I'm not certain what has happened here. I don't know if lung pathology is tied into nasal disease or not. Possibly migrating grass awn, other foreign body, however now appears resolved. Recommend return to pred and tramadol but can discontinue antibiotics.
## Patient History - Period 23/07/2014 to 10/08/2014

<table>
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