College of Veterinarians of British Columbia

CASE SUMMARY

A small breed, older dog was taken to a clinic for vomiting, lethargy, and a reduced appetite.

There were no significant findings on examination. Bloodwork revealed an elevated WBC count, consisting of neutrophilia, monocytosis and eosinophilia. A mild anemia and elevated globulin levels were also noted.

The dog was admitted for treatment of suspected infection and started on IV fluids and intravenous antibiotics and anti-nauseant medication

During a two-day stay at the hospital, the dog was given acepromazine but the reason was not documented. Repeat bloodwork showed a mild improvement in the WBC counts (except for the eosinophil count), but there was a worsening of the dog's anemia. A radiograph was taken to look for pulmonary edema, however, there were no notes in the medical record documenting why pleural effusion was suspected nor an interpretation of the radiograph. There was also no record of client communication in the medical record regarding the reason for and assessment of the radiograph. Records noted further administration of acepromazine caused significant sedation. A heart murmur grade IV/VI was noted in the record, yet there was no record of a physical exam having been performed on the patient over the two day hospitalization period.

The clients decided to take the dog home. Continued hospitalization was advised, and it was noted the dog remained in critical condition. The next day the client indicated the dog had passed away, and no post-mortem was offered to the client.

The College received a complaint from the client regarding the care and treatment the dog received from the veterinary team at the practice facility.

CASE CONSIDERATIONS

A review of medical records and written submissions from the client and the registrant.

Medical Management

- It's important to review a patient's medical history prior to initiating treatment so the patient's medical status and any comorbidities are understood. This informs decision-making when arriving at differential diagnoses and proposed treatment. In this case, there was no indication this was done.
- A daily physical examination of a hospitalized patient assists assessment of differential diagnoses and determines the need for diagnostic testing.
- Timely communication with clients about the seriousness of a patient's condition is also important.
- It is also an important consideration any time an animal dies during or after veterinary care has been provided, that a post-mortem is offered to the client. A definitive cause of death is always beneficial for the veterinarian and the client.

Medical Records

Comprehensive medical records are a professional responsibility and one of the most common issues identified by the Investigation Committee as well as the Practice Facility Accreditation Committee. In this case, the records lacked a detailed history, daily examination findings, clinical rationale and client consent for tests performed, and an updated list of differential diagnoses as the dog's condition changed.

The Professional Practice Standard: Companion Animal Medical Records indicates complete medical records include appropriate details about

every veterinary intervention. Proper record keeping is an integral component of veterinary practice and continuity of care.

Keeping complete medical records facilitates good patient care, allows a subsequent practitioner to understand the patient's condition and the basis for the current treatment, provides a method of communication with fellow veterinarians and satisfies ethical and regulatory obligations for maintaining appropriate records.