STATEMENT ON DOCUMENTATION OF ANESTHESIA CARE

Committee of Origin: Quality Management and Departmental Administration

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Documentation is a factor in the provision of quality care and is the responsibility of an anesthesiologist. While anesthesia care is a continuum, it is usually viewed as consisting of preanesthesia, intraoperative/procedural anesthesia and postanesthesia components. Anesthesia care should be documented to reflect these components and to facilitate review.

The record should include documentation of:

I. Preanesthesia Evaluation*

A. Patient interview to assess:
   1. Patient and procedure identification.
   2. Verification of admission status (inpatient, outpatient, "short stay", etc.)
   3. Medical history
   4. Anesthetic history
   5. Medication/Allergy history
   6. NPO status

B. Appropriate physical examination, including vital signs and documentation of airway assessment.

C. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray) and medical records.

D. Medical consultations when applicable.

E. Assignment of ASA physical status, including emergent status when applicable.

F. Formulation of the anesthetic plan and discussion of the risks and benefits of the plan (including discharge issues when indicated) with the patient or the patient's legal representative and/or escort.

G. Documentation of appropriate informed consent(s).

H. Appropriate premedication and prophylactic antibiotic administrations (if indicated).

II. Intraoperative/procedural anesthesia (time-based record of events)

A. Immediate review prior to initiation of anesthetic procedures:
   1. Patient re-evaluation (re-verification of NPO status)
   2. Check of equipment, drugs and gas supply

B. Monitoring of the patient** (e.g., recording of vital signs and use of any non-routine monitors).

C. Doses of drugs and agents used, times and routes of administration and any adverse reactions.

D. The type and amounts of intravenous fluids used, including blood and blood products, and times of administration.

E. The technique(s) used and patient position(s).

* See Basic Standards for Preanesthesia Care

** See Standards for Basic Anesthetic Monitoring

F. Intravenous/intravascular lines and airway devices that are inserted including technique for insertion, and location.

G. Unusual events during the administration of anesthesia.

H. The status of the patient at the conclusion of anesthesia.

III. Postanesthesia

A. Patient evaluation on admission and discharge from the postanesthesia care unit.

B. A time-based record of vital signs and level of consciousness.

C. A time-based record of drugs administered, their dosage and route of administration.

D. Type and amounts of intravenous fluids administered, including blood and blood products.

E. Any unusual events including postanesthesia or postprocedural complications.

F. Postanesthesia visits.