HIGH DESERT HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

SUBJECT: VI-124 PERIOPERATIVE ANESTHESIA CARE RECORD DOCUMENTATION REQUIREMENTS	**POLICY #**: 1159
	VERSION: 1
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DATE APPROVED: 06/18/2015	

PURPOSE: To state expected standards of documentation and maintenance of records of anesthesia care.

POLICY: Anesthesia care should be documented to reflect the care provided and to facilitate review and will follow the ASA position on Documentation of Anesthesia Care (attachment). Anesthesia records shall be completed and maintained, using the following rules.

PROCEDURE:

General Rules and Expectations:

1. Anesthesia records shall accurately reflect events of the peri operative period.
2. Writing should be legible.
3. All notes on the patient's chart must be timed and dated.
4. Records must be kept in a timely manner, not after the fact.
5. In case of an emergency, if information cannot be documented in a timely manner, it should be entered when possible and documented as a "late entry."
6. In difficult clinical situations, the vital signs record during anesthesia or in recovery room can be printed from the monitor and attached to the record.
7. All information about the course of the patient's anesthesia and postanesthesia will be recorded on the Anesthesia and Postanesthesia records.
8. An anesthesiologist's signature must appear on the preanesthesia and anesthesia records, to record evidence of supervision of CRNAs.
9. Data from serious events such as cardiac arrest will be collected by the responsible anesthesiologist until the case can be analyzed. If necessary, the originals can be put on the patient's chart immediately, after copies are made for departmental review.

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10. Anesthesia records (including Preoperative Evaluation, Anesthesia Record and Post Anesthesia Record) will be logged, filed by date and retained at the Ambulatory Surgical Center for a minimum of one (1) year.

Preansethesia Evaluation:

1. Patient interview to assess:
    a. Patient and procedure identification.
    b. Medical history
    c. Anesthetic history
    d. Medication/allergy history
    e. NPO status
2. Appropriate physical examination, including vital signs and documentation of airway assessment.
3. Review of objective diagnostic data and medical records.
4. Medical consultations when applicable.
5. Assignment of ASA physical status
6. Formulation of anesthesia plan and discussion of the risks and benefits of the plan and documentation of appropriate informed consent.
7. Orders for appropriate premedication and prophylactic antibiotic, if indicated.

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

1. Immediate review prior to initiation of anesthetic procedures:
    a. Patient re-evaluation
    b. Check of equipment, drugs and gas supply.
2. Preoperative vital signs should be obtained and recorded on the Anesthesia Record before medication is administered.
3. A record of immediate preoperative electrocardiogram trace is required. Strip should be timed and dated.

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4. Monitoring of the patient (per Basic Anesthesia Care Policy #VI-123), e.g., recording of vital signs and use of any non-routine monitors.

5. Doses of drugs and agents used, times, routes (if other than intravenous or inhalation) and any adverse reactions.

6. The type and amounts of fluids used, estimated blood loss and urine output (if available) shall be recorded in appropriate locations on the anesthesia record.

7. The technique(s) used and the patient position(s)

8. Intravenous lines and airway devices that are inserted including technique for insertion.

9. Unusual events during the administration of anesthesia.

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

11. If an arrhythmia occurs intraoperatively, a record shall be made as soon as possible, for accurate diagnosis. Time should be noted on the strip.

Postanesthesia

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

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

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

4. Type and amounts of IV fluid administered.

5. Any unusual events including postanesthesia or postprocedural complications.

ATTACHMENT:

Statement on Documentation of Anesthesia Care, Approved by the ASA House of Delegates on October 15, 2003, and amended on October 12, 2008.

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