AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ABN 82 055 042 852

THE ANAESTHESIA RECORD

RECOMMENDATIONS ON THE RECORDING OF AN EPISODE OF ANAESTHESIA CARE

INTRODUCTION

The anaesthesia record is an essential part of the patient's medical record. The record should allow the anaesthetist to document all aspects of the anaesthesia management, including the pre and post-operative management, that are of relevance to the anaesthesia.

The anaesthesia record provides information that may assist other staff involved in the care of the patient and to any subsequent anaesthetists. It may also be of medico-legal importance and can be used for quality assurance and research purposes. The record must be signed by the anaesthetist/s.

The information may be on a single record or may be covered by separate records for the pre-anaesthesia, anaesthesia and post-anaesthesia phases of the patient's care. All components of the anaesthesia record must be readily available throughout a patient's hospital stay, and for all subsequent attendances.

The Anaesthesia Record should include:

1. Basic Information

1.1 The name of the patient and the hospital, the hospital record number, the age, gender and weight of the patient.

1.2 The dates of the pre-anaesthesia consultation and of the anaesthesia.

1.3 The name(s) of the anaesthetist(s).

1.4 The name of the surgeon or other proceduralist.

1.5 A brief description of the procedure actually performed.

2. Pre-anaesthesia Consultation Information

2.1 Documentation of the pre-anaesthesia assessment of the patient. This will normally include:

2.1.1 A summary of general medical status by relevant systems and diseases.

2.1.2 Concurrent therapy and any known drug or other sensitivities.

2.1.3 The history of previous anaesthesia and relevant surgery.

2.1.4 An assessment of the airway, dental condition and risk of gastric reflux, where appropriate.

2.1.5 Results of relevant laboratory data and other investigations.

2.2 Any pre-medicant drugs, time given, route of administration and description of any unusual response (if not recorded elsewhere).

2.3 An outline of the anaesthesia plan, if appropriate.

2.4 Documentation of discussion with the patient or guardian on the anaesthesia plan, possible therapies and possible outcomes and risks (if not recorded elsewhere). See College Professional Document PS26 *Guidelines on Consent for Anaesthesia or Sedation*.

3. Anaesthesia Information

3.1 **Technique:** The full details of the anaesthetic technique used, whether general, regional or sedation with monitored anaesthesia care.

3.2 **Medication:** The details of administration of all drugs including any used by the surgeon, and a description of any unusual response.

3.3 **Airway:** The size and type of any artificial airway used, a description of any airway problems encountered and the method of their solution.

3.4 **Anaesthesia Breathing System:** Details of the anaesthesia circuit, gas flows, and controlled ventilation techniques.

3.5 **Monitoring:** The monitoring methods used and regular documentation of relevant information obtained. Information provided as a monitor print-out must have correct patient identification. See College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*.

3.6 **Fluid Therapy and Vascular Access:**

3.6.1 Intravenous infusion: Details of intravenous solutions including the site, size of cannula and the nature and volume of fluids infused.

3.6.2 Details of central venous and arterial access.

3.7 **Blood loss:** An estimate of blood and fluid loss where appropriate.

3.8 **Position:** The position of the patient during the procedure and, where appropriate, any protective measures employed .

3.9 **Time:** The time of significant anaesthesia and operative events, observations and interventions including administration of drugs.

3.10 **Complications or problems:** A detailed description of any complications or problems encountered.

3.11 Other information that the anaesthetist considers is particularly relevant to a particular case should also be recorded.

4. Post-Anaesthesia Information (if not recorded elsewhere)

4.1 Respiratory, cardio-vascular and neurological status and any other relevant information.

4.2 Incidents arising during this period and their management. Refer College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room*.

4.3 Plan for pain management, fluid therapy and oxygen therapy for first 24 hours if appropriate, but certainly for guidance of Recovery Room Staff.

4.4 Time and discharge destination on transfer from operating theatre or recovery room.

4.5 Space for documentation of the post-anaesthesia visit.

4.6 Space for documentation of outcome data, including Clinical Indicators, audit and quality assurance information as decided by the anaesthesia department/anaesthetists.

RELATED ANZCA DOCUMENTS

PS7 *Recommendations on the Pre-Anaesthesia Consultation*

PS26 *Guidelines on Consent for Anaesthesia or Sedation*

PS18 *Recommendations on Monitoring During Anaesthesia*.

PS4 *Recommendations for the Post-Anaesthesia Recovery Room*.

COLLEGE PROFESSIONAL DOCUMENTS

College Professional Documents are progressively being coded as follows:

TE *Training and Educational*

EX *Examinations*

PS *Professional Standards*

T *Technical*

***POLICY** – defined as 'a course of action adopted and pursued by the College'. These are matters coming within the authority and control of the College.*

***RECOMMENDATIONS** – defined as 'advisable courses of action'.*

***GUIDELINES** – defined as 'a document offering advice'. These may be clinical (in which case they will eventually be evidence-based), or non-clinical.*

***STATEMENTS** – defined as 'a communication setting out information'.*

This document is intented to apply wherever anaesthesia is administered.

This document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of this document in each case.

Professional documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Professional documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

Promulgated: *1990*
Reviewed: *1996, 2001*
Date of current document: *Oct 2006*

College Website: http://www.anzca.edu.au/