Guideline on the anaesthesia record
Background Paper

1. Introduction

The anaesthesia record is designed to be a comprehensive document depicting any patient's management throughout their perioperative journey.[1] As such it is a critical document that serves numerous purposes beyond its primary purpose to record the clinical management. It is used to guide management, including future care, for education, research, medicolegal, and departmental administration.[2,3]

The accompanying guideline is intended to:

- Promote best practice by defining the standards.
- Guide the development, design, storage, and security of records.
- Guide practitioners who provide anaesthesia services in documenting and recording relevant perioperative management.

2. Background

Since PS06 was last reviewed in 2006, there have been significant developments in technology as well as regulatory and jurisdictional demands that warranted a review of the anaesthesia record.

There has been a progressive increase in the development and adoption of digital records comprising either fully automated computerised charts or hybrid digital/manual charts.[4] In either case, it must be ensured that records capture critical and relevant information and that there is consistency, irrespective of the nature of capturing data.

While there are perceived barriers to automation of the record by anaesthesia staff,[5,6] including medicolegal concerns,[7] and they are subject to abuse through misuse of data and data breaches, automated records are more accurate.[8]

3. Discussion

3.1 The title of PS06 has been changed from "Recommendations" to "Guideline" as a result of the re-classification of ANZCA professional documents in 2010. The review process has followed that designated in *A01 Policy for the development and review of professional documents*.

3.2 Since 2010, all new professional documents and all subsequently reviewed documents must be accompanied by a background paper.

3.3 It was decided that the purpose of the document should be identified and listed at the beginning. The scope has also been defined, as well as terms used within the guideline.

Anaesthesia is defined to include general anaesthesia, sedation, and regional analgesia/anaesthesia. It is recognised that sedation is provided by a range of practitioners, and that ANZCA has no mandate over practitioners from other colleges, however, the guidelines should serve as a standard for recording all forms of anaesthesia.

For reasons of clarity, the term anaesthetist has been defined so as to differentiate practitioners who provide sedation services, termed “anaesthesia providers”, from those whose scope of practice includes general and regional anaesthesia. The latter includes medical practitioners registered as specialists in anaesthesia with either the Medical Board of Australia, or the Medical Council of New Zealand, trainees of ANZCA, specialist international medical graduates, and general practitioners/rural generalists with recognised training in anaesthesia.

3.4 The diverse roles of the anaesthesia record were explored[9,10,11,12] so that the needs of the record could be identified and prioritised. In addition, the spectrum of healthcare facilities and services provided were considered in the recommendations made, on the understanding that over and above the basic essential information for all records, there will be varying needs depending on many factors - in particular the size of the unit (quaternary units to small stand-alone facilities), the caseload (complex major cases to rapid turnover minor cases) and, most importantly, patient factors (comorbidities, past anaesthesia and medical history etc).

3.5 General principles were identified including the need for efficient and purposeful data collection; ready access as and when required either internally or externally; acceptability of digital signatures; and facilitation of data coding.

The benefits of incorporating Clinical Decision Support[12,13,14] technology into electronic records includes the ability to facilitate the primary role of guiding clinical management. The importance of this function is acknowledged and recommended for consideration when developing such records.

Ideally, the design of records should be such that data is captured accurately and free of errors, and collection of information addresses the perceived barriers to computerised documentation.

3.6 Contents of the record have been listed in a manner that should facilitate design of records and data collection. With reference to digital records attention should be paid to ensure that data entry/capture is not intrusive and does not distract from patient care, particularly during induction of anaesthesia and emergence from anaesthesia.

3.6.1 The issue of including consent as part of the anaesthesia record was discussed. It was agreed that documentation of consent should be included and that *PS26 Statement on informed consent for anaesthesia or sedation* be consulted for the process of consent.

4. Summary

The guideline in the accompanying professional document has been reviewed taking into consideration the technological changes since 2006, the changing medicolegal and regulatory environment, and the need to continually improve standards of clinical practice and patient care.

5. Document development

The oversight committee for the review of PS06 was the ANZCA Safety and Quality Committee (SQC). The document development group (DDG) members were:

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Related ANZCA documents

PS04 Statement on the post-anaesthesia care unit

PS07 Guideline on pre-anaesthesia consultation and patient preparation

PS18 Guideline on monitoring during anaesthesia

PS19 Recommendations on monitored care by an anaesthetist

PS26 Statement on informed consent for anaesthesia or sedation

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Further reading

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