# Guideline on the anaesthesia record

## 1. Purpose

The aims of the guideline are to:

1.1 Encourage best practice in the management and care of patients and define the standards.

1.2 Guide the development and review of anaesthesia records to ensure they capture critical and relevant information.

1.3 Provide guidance to all practitioners administering general anaesthesia, sedation, or regional blocks, in documenting and recording the episode.

1.4 Provide guidance in relation to the storage, availability, and security of records.

## 2. Scope

This guideline is intended to apply to all instances:

2.1 Where general anaesthesia, sedation, and/or regional blocks are administered for therapeutic or diagnostic procedures.

2.2 Of monitored care as defined in *PS19 Recommendations on Monitored Care by an Anaesthetist*.

The guideline is not intended to apply to procedures where small doses of local anaesthesia are the sole medications administered to perform the procedure.

## 3. Definitions

Anaesthesia includes general anaesthesia, sedation, regional analgesia/anaesthesia.

Anaesthetist refers to practitioners who are registered as specialists in anaesthesia with either the Medical Board of Australia or the Medical Council of New Zealand, trainees of ANZCA, and specialist international medical graduates. For all other practitioners administering sedation the term sedation provider should be substituted.

Regional block refers to administration of local anaesthesia to block sensations in a select region of the body.

Digital record refers to any record stored in computers or other digital storage devices irrespective of whether it was generated manually, electronically, or by imaging.

## 4. Background

The anaesthesia record documents a patient's journey through the perioperative period and their care and is an essential part of the patient's medical record.[1] It needs to contribute to the patient's

clinical management[2] as well as to their future care with regard to future anaesthesia but also to assist multi-disciplinary teams during the postoperative phase and beyond.[3]

Primarily, the anaesthesia record serves the purpose of documenting the clinical management of any patient's care as well as guiding management. It is also a record of drug administration and as such must comply with the relevant Australian and New Zealand jurisdictional requirements (see further reading below).

Its secondary functions include:

- Management of future care
- Education
- Research
- Medico-legal[4]
- Departmental administration
- Coding
- Quality assurance[5]

With the advent of computerised and digital records it is important to seek opportunities to enhance the quality of patient records as well as the means by which information is captured such that clinical efficiency is increased, vigilance is optimised, and errors are minimised.[6] Consequently, information should be considered either as mandatory, highly desirable, or optional when designing digital systems and deciding on data to be captured and features to be included. Input from credentialled anaesthetists is essential when distinguishing between mandatory, highly desirable, or optional.

## 5. General principles

The functionality of an electronic anaesthesia record should synchronise with the complexities of anaesthesia work-flow,[7,8] ideally providing enhanced patient safety, and physician decision support. Data collected should be accessible to allow analytical interrogation in order to enhance patient outcomes.9 Ideally such a system should also be able to reliably collect data for coding.

The development of electronic anaesthesia records should aim to facilitate the primary role of guiding clinical management. Enhancements such as Clinical Decision Support[10,11,12] should be considered for inclusion. The desirable features of any anaesthesia information management system are included in the Appendix attached to this guideline.

The record must be signed by the anaesthetist/s responsible for that patient's care. Digital signatures are an acceptable form of signature.

All components of the anaesthesia record must be readily available throughout any patient's hospital stay, and for all subsequent attendances. Records must also be able to be provided to patients and other health care facilities as required in a clear and easily understood format. Access to records must be in accordance with privacy laws.

Handwritten records should be legible and able to be understood by subsequent health care professionals. Where there are regulatory requirements, as per the Standards for Charting of the NMC in New Zealand, these must be observed.

## 6. Recommendations

The anaesthesia record should include the following:

### 6.1 Basic Information

6.1.1. Identity:

6.1.1.1. Patient details including name, date of birth, gender, weight, height, and hospital record number.

6.1.1.2. Pre-anaesthesia baseline observations

6.1.1.3. Surgeon(s)/Proceduralist(s).

6.1.1.4. Anaesthetist(s).

6.1.1.5. Hospital.

6.1.2. Procedure:

Description of the procedure(s) performed.

6.2. Pre-anaesthesia Consultation Information

6.2.1. Documentation of the pre-anaesthesia assessment of the patient. (See PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation.) This will normally include:

6.2.1.1. A summary of general medical status by relevant systems and diseases including co-morbidities and ASA risk classification.

6.2.1.2. Concurrent therapy and any known drug or other sensitivities.

6.2.1.3. History of previous anaesthesia and relevant surgery.

6.2.1.4. Physical examination of the patient including assessment of the airway and dental condition.

6.2.1.5. Results of relevant laboratory data and other investigations.

6.2.1.6. Fasting status of the patient

6.2.2. Any pre-medicant drugs prescribed, time given, route of administration and description of any side effects or reactions. Prescriptions must comply with any applicable regulatory requirements.

6.2.3. An outline of the anaesthesia plan including documentation of discussion with the patient or guardian.

6.2.4. Documentation of discussion of risks and consent, if not recorded elsewhere. (See *PS26 Guidelines on Consent for Anaesthesia or Sedation*).

6.2.5. Documentation of consent should include, where relevant, anaesthesia, blood or blood products, financial, staffing, including presence of students etc. and/or intimate examination by others, and photography.

6.3. Anaesthesia Information

6.3.1. Technique: The full details of the anaesthesia technique used, whether general, regional, sedation, or monitored care (see *PS19 Recommendations on Monitored Care by an Anaesthetist*).

6.3.2. Medication: The details of dosage, timing and route of administration of all drugs and a description of any side effects or reactions. Where relevant it is advisable to record medications administered by the proceduralist.

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

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

6.3.5. Monitoring: Documentation of the physiological variables monitored and the equipment used, where relevant. Information provided as a monitor print-out must include accurate patient identification (see *PS18 Recommendations on Monitoring During Anaesthesia*).

6.3.6. Fluid Therapy and Vascular Access:

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

6.3.6.2. Details of central venous and arterial access.

6.3.7. Blood loss: An estimate of blood and fluid loss where relevant.

6.3.8. Position: The position of the patient during the procedure and any protective measures employed.

6.3.9. Time: The time of significant anaesthesia and operative events, observations and interventions, including administration of drugs, should be readily identifiable from the record.

6.3.10. Complications or problems: A detailed description of any complications or problems encountered should be included.

6.3.11. Other information that is considered particularly relevant should also be recorded such as details of interoperative investigation.

6.4. Post-Anaesthesia Information

6.4.1. Respiratory, cardio-vascular and, where applicable, neurological status, prior to transfer from theatre to the post anaesthesia care unit (PACU) should be noted.

6.4.2. Incidents arising during this period and their management should be documented (see PS04 Statement on the Post-Anaesthesia Care Unit).

6.4.3. Plan for pain management, fluid therapy and oxygen therapy as required, should be charted for guidance of PACU staff.

6.4.4. Discharge plan including destination on transfer from operating theatre or PACU.

6.4.5. Space should be available for documenting any post-anaesthesia visits.

6.4.6. Documentation of outcome data, including Clinical Indicators, audit and quality assurance information as decided by the anaesthesia department/anaesthetists or the relevant jurisdictional authorities.

**This document is accompanied by a background paper (PS06BP) which provides more detailed information regarding the rationale and interpretation of the Guideline.**

## Related ANZCA documents

PS04 Recommendations for the Post-Anaesthesia Recovery Room.

PS07 Recommendations on the Pre-Anaesthesia Consultation.

PS18 Recommendations on Monitoring During Anaesthesia.

PS19 Recommendations on Monitored Care by an Anaesthetist.

PS26 Guideline on Consent for Anaesthesia or Sedation.

## References

1. Dickinson P, Berrington J. Anaesthetic records. Anaesthesia and Intensive Care Medicine. 2014 Feb;15(2):56-8.
2. Anderson BJ, Merry AF. Paperless anesthesia: uses and abuses of these data. Paediatr Anaesth. 2015 Dec;25(12):1184-92.
3. Sessler DI, Big Data – and its contributions to peri-operative medicine. (Editorial) Anaesthesia. 2014 Feb;69(2):100-5.
4. Curtis WB, Sethi R, Visvanathan T, Sethi S. Peri-operative anaesthetic documentation: A report of three sequential audits on the quality of outcomes, with an insight into surrounding legal issues. Turk J Anaesthesiol Reanim. 2018 Sep; 46(5): 354-61.
5. Motamed C, Bourgain JL. An anaesthesia information management system as a tool for a quality assurance program: 10 years of experience; Anaesth Crit Care Pain Med 2016 Jun; 35(3): 191-5.
6. Bowdle TA, Jelacic S, Nair B, Togashi K, Caine K, Bussey L, et al. Facilitated self-reported anaesthetic medication errors before and after implementation of a safety bundle and barcode-based safety system. Br J Anaesth. 2018 Dec;121(6):1338-45.
7. Wacker J, Steurer J, Manser T, Leisinger E, Stocker R, Mols G. Perceived barriers to computerised quality documentation during anaesthesia: a survey of anaesthesia staff. BMC Anesthesiol. 2015 Jan 31;15:13.
8. Webster CS, Merry AF. Forcing functions and their consequences. Anaesthesia. 2017 Feb;72(2):266-267.
9. Gálvez JA, Rothman BS, Doyle CA, Morgan S, Simpao AF, Rehman MA.. A narrative review of meaningful use and anesthesia information management systems. Anesth Analg. 2015 Sep;121(3): 693-706.
10. Nair BG, Gabel E, Hofer I, Schwid HA, Cannesson M. Intraoperative clinical decision support for anaesthesia: A narrative review of available systems. Anaesth Analg. 2017 Feb;124(2):603-17.
11. Simpao AF, Tan JM, Lingappan AM, Galvez JA, Morgan SE, Krall MA. A systematic review of near real-time and point-of-care clinical decision support in anaesthesia information systems. J Clin Monit Comput. 2017 Oct;31(5):885-894.
12. Chau A, Ehrenfield JM. Using real time clinical decisions support to improve performance on perioperative quality and process measures. Anaesthesiol Clin. 2011 Mar;29(1):57-69.

## Further reading

Australian Commission on Safety and Quality in Health Care (the Commission). The National Safety and Quality Health Service (NSQHS) Standards. Patient safety and quality systems, Action 1.16: healthcare records. [Internet]. Sydney: the Commission. Available from: https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-116

Standards New Zealand. NZS 8153: 2002 Health records. Wellington: Standards New Zealand; 2002.

Checketts MR, Alladi R, Ferguson K, Gemmell L, Handy JM, Klein AA, et al. Recommendations for standards of monitoring during anaesthesia and recovery 2015: Association of Anaesthetists of Great Britain and Ireland. Anaesthesia. 2016 Jan;71(1): 85-93.

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