New Zealand
SOCIETY OF
Anaesthetists

14 June 2019

Dr Rodney Mitchell
ANZCA
ANZCA House
630 St Kilda Road
Melbourne VIC 3004
AUSTRALIA
Email: profdocs@anzca.edu.au

Dear Dr Mitchell

Re: PS06 Guidelines on the Anaesthesia Record

The New Zealand Society of Anaesthetists (NZSA) welcomes the opportunity to provide feedback on the above revised position statement and background paper.

Overview
The NZSA has circulated the position statement to the NZSA Executive Committee, as well as other NZSA members to seek feedback. Overall, we are supportive of ANZCA's Revised PS06 Guidelines on the Anaesthesia Record. It is a tidy document, which provides recommendations for ideal anaesthetic note keeping. However, we have some proposed amendments, including additions, which we outline in our submission. Additionally, we have tracked some suggested changes in the PS06 draft position statement.

Proposed changes/additions

- Section 5.2 Pre anaesthesia documentation. Most of the information is available elsewhere in the clinical record and we believe there needs to be a balance between re-creating the notes and recording important information. As with all these documents, if the bar is set too high many will fail to achieve it.

- Section 5.2.2 Premedication is not included by all hospitals on the anaesthesia record and may be documented on the drug chart and nursing pathway. An addition could be included to state: "unless charted elsewhere."

- Section 5.4 appears to seek more explicit documentation than we typically do at present. Most of this is implicit in the record (such as neurological and haemodynamic status prior to moving to PACU) or on the drug chart (analgesia and IV fluid plans). Is this something that is expected to be explicitly documented separately or "unless documented elsewhere"?

- 5.4.5 Similarly with the post-operative visit, it is good to do but not always achieved especially in public practice. If the space is not filled in it may imply a low standard of practice.

- Regarding a handwritten record, information needs to be added to the effect of "this should be written as closely as practical to the time that the events/drug administrations were made."

- There should be a comment that in an emergency, where an electronic record keeping system is not being used, it is reasonable to make retrospective recalled observations. However, the anaesthetist should clearly document that the observations/events have been recorded retrospectively due to an urgent scenario, e.g. urgent transfer of a patient from theatre to another hospital's ICU.

- Given the common use of electronic record keeping systems, there should be a mention about the use of "pre-recorded templates." The use of anaesthetic templates as part of an electronic record keeping system (e.g. SAFER SLEEP) is a safe, effective and time saving tool. However, by signing an electronic anaesthetic record the anaesthetist is implying that they have checked the included templates and found them to be appropriate and correct. If the anaesthetist is using templates, it is their responsibility to modify each template according to the individual situation, e.g. remove COX 2 inhibitor from a generic discharge analgesia script in someone with severe ischaemic heart disease.

It is also reasonable to use pre-written drug and event templates, where an electronic anaesthetic record keeping system is not available. However, it is the responsibility of anaesthetists to ensure that these templates are correct and appropriate for the *individual* patient. If the circumstances on the day change, e.g. surgery is stopped due to anaphylaxis, the anaesthetist can modify the original template plan. However, any modification should be signed and dated and timed for critical events. Also, if there is a major deviation from the standard template then the original template should be clearly deleted and accompanied by an appropriate explanation for the change in events. This explanation can be written in retrospect during an emergency.

As per the current PS06 draft, all drug doses should be timed and dated. All major events or procedures should be timed and dated. Any complications should be timed and dated and a description, along with a management plan, should be documented.

We recommend that ANZCA consider the above points and incorporate them into the final document.

Closing comments
Thank you again for the opportunity to comment. If you have any questions regarding our submission, please contact me at president@anaesthesia.nz

New Zealand
SOCIETY OF
Anaesthetists

Yours sincerely

Kathryn Hagen
President

Level 1, Central House, 26 Brandon Street, Wellington 6011 | P O Box 10691, The Terrace, Wellington 6143
T: (04) 494 0124 | F: (04) 494 0125 | E: nzsa@anaesthesia.nz | **www.anaesthesia.nz**