Australian and New Zealand College of Anaesthetists (ANZCA)

Guidelines on the Anaesthesia Record

1. PURPOSE

The aims of the guidelines 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

These guidelines are 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 guidelines are 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 anaesthesia provider is used.

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 care and their journey through the perioperative period. It 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 should comply with relevant standards see in NZ HQSC Standards for Charting on the NMC

Its secondary functions include:

- Management of future care.
- Education.
- Research.
- Medico-legal.[4]
- Departmental administration.
- Quality assurance.[5]
- It may be used for billing purposes

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 increases and vigilance can be optimised, and errors minimised.[6] To that end the information that should be recorded should be considered either as mandatory, highly desirable or optional. [Comment: Within this document there is no guidance on what is mandatory, highly desirable or optional. Is this to be left to the individual institution or anaesthetist?}

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. Any electronic record should be integrated with other electronic patient data and in an ideal situation be accessible within institutions and should provide feed to such data-bases as the NHI in NZ. The data must be tamper proof and only accessible to the provider of the service or to the named persons with access with institutions. Once the record is obtained and the anaesthetic complete no changes should be allowed for medicolegal reasons. Privacy is important and safe storage and access is vital.

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 a 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. This should only be done taking into account privacy issues and by designated persons who have access to such for medicolegal reasons.

It is mandatory that handwritten records ~~should~~ be legible and able to be understood by subsequent health care professionals. Only standard abbreviations should be used and in order to comply with the Standards for Charting of the NMC full generic drug names and units need to be written.

6. RECOMMENDATIONS

The anaesthesia record should include the following:

5.1 Basic Information

5.1.1 Identity:

5.1.1.1 Patient information including name, date of birth, gender, weight, height, and hospital record number.
5.1.1.2Surgeon(s)/Proceduralist(s).
5.1.1.3 Anaesthetist(s).
5.1.1.4 Hospital.

5.1.2 Procedure:
Description of the procedure(s) performed.

Date of the procedure

5.2 Pre-anaesthesia Consultation Information

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

5.2.1.1 A summary of general medical status by relevant systems and diseases including co-morbidities and ASA risk classification.
5.2.1.2 Concurrent therapy and any known drug or other sensitivities.
5.2.1.3 History of previous anaesthesia and relevant surgery.
5.2.1.4 Assessment of the airway and dental condition.
5.2.1.5 Results of relevant laboratory data and other investigations.

5.2.2 Any pre-medicant drugs prescribed, time given, route of administration and description of any side effects or reactions. I disagree. Any premedicant should be prescribed on the NMC or Hospital Medicine chart so that medicine reconciliation and risk of doubling up on doses or inadequate timing between doses be reduced. Multiple sites of prescribing of medicines increase risks

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

Commented [C1]: This information is sometimes put in the consent form or in the notes rather than the anaesthesia form

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

5.2.5 Documentation of consent should include, where relevant, anaesthesia, financial, staffing, including presence of students etc. and/or intimate examination by others, and photography. It needs to be remembered that consent for photography does not give consent to subsequent use of photos for example in a journal article. This requires further consent within NZ

5.2.6. Within NZ anaesthetists are responsible for obtaining consent for the use of blood products as we are the ones that will be administering them in the theatre environment.

5.3 Anaesthesia Information

5.3.1 **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*).

5.3.2 **Medication:** The details of dosage, timing and route of administration of all drugs including any used by the surgeon, and a description of any side effects or reactions. Full drug names, units and timing are required within NZ to comply with standards and should be mandatory.

5.3.3 **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.

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

5.3.5 **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*).

5.3.6 **Fluid Therapy and Vascular Access**:

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

5.3.6.2 Details of central venous and arterial access.

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

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

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

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

5.3.11 Other information that is considered particularly relevant should also be recorded.

5.4 Post-Anaesthesia Information

5.4.1 Respiratory, cardio-vascular and neurological status, prior to transfer from theatre to the post anaesthesia care unit (PACU) should be noted as well as any other relevant information. Comment: This is not generally part of the anaesthetic record as anaesthetists are usually more involved with extubation, airway management and safe transfer of the patient. This data is usually collected and annotated on arrival in recovery

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

5.4.3 Plan for pain management, fluid therapy and oxygen therapy as required, for guidance of PACU staff. Charting of such.

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

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

5.4.6 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 Guidelines.

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 Guidelines on Consent for Anaesthesia or Sedation.

REFERENCES

1. Dickinson P, Berrington J. l. Anaesthetic records. Anaesthesia and Intensive Care Medicine. 2014 Feb;15(2):56-8

2. Anderson BJ, Merry AF. Merry, Paperless anesthesia: uses and abuses of these data. Pediatr Anesth.2015;25:1184-92
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;15:13.
8. Webster CS, Merry AF. Forcing functions and their consequences. (Correspondence) Anaesthesia. 2017;72:266
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.

FURTHER READING

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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