

STATEMENT ON DOCUMENTATION OF ANESTHESIA CARE

**Committee of Origin: Quality Management and Departmental Administration
(Approved by the ASA House of Delegates on October 15, 2003, and amended on
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Documentation is a factor in the provision of quality care and is the responsibility of an anesthesiologist. While anesthesia care is a continuum, it is usually viewed as consisting of preanesthesia, intraoperative/procedural anesthesia and postanesthesia components. Anesthesia care should be documented to reflect these components and to facilitate review.

The record should include documentation of:

I. Preanesthesia Evaluation*

- A. Patient interview to assess:
 - 1. Patient and procedure identification.
 - 2. Verification of admission status (inpatient, outpatient, "short stay", etc.)
 - 3. Medical history
 - 4. Anesthetic history
 - 5. Medication/Allergy history
 - 6. NPO status
- B. Appropriate physical examination, including vital signs and documentation of airway assessment.
- C. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray) and medical records.
- D. Medical consultations when applicable.
- E. Assignment of ASA physical status, including emergent status when applicable.
- F. Formulation of the anesthetic plan and discussion of the risks and benefits of the plan (including discharge issues when indicated) with the patient or the patient's legal representative and/or escort.
- G. Documentation of appropriate informed consent(s).
- H. Appropriate premedication and prophylactic antibiotic administrations (if indicated).

II. Intraoperative/procedural anesthesia (time-based record of events)

- A. Immediate review prior to initiation of anesthetic procedures:
 - 1. Patient re-evaluation (re-verification of NPO status)
 - 2. Check of equipment, drugs and gas supply
- B. Monitoring of the patient** (e.g., recording of vital signs and use of any non-routine monitors).
- C. Doses of drugs and agents used, times and routes of administration and any adverse reactions.
- D. The type and amounts of intravenous fluids used, including blood and blood products, and times of administration.
- E. The technique(s) used and patient position(s).

* See Basic Standards for Preanesthesia Care

** See Standards for Basic Anesthetic Monitoring

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- F. Intravenous/intravascular lines and airway devices that are inserted including technique for insertion, and location.
- G. Unusual events during the administration of anesthesia.
- H. The status of the patient at the conclusion of anesthesia.

III. Postanesthesia

- A. Patient evaluation on admission and discharge from the postanesthesia care unit.
- B. A time-based record of vital signs and level of consciousness.
- C. A time-based record of drugs administered, their dosage and route of administration.
- D. Type and amounts of intravenous fluids administered, including blood and blood products.
- E. Any unusual events including postanesthesia or postprocedural complications.
- F. Postanesthesia visits.