



Statement on Documentation of Anesthesia Care

Committee of Origin: Committee on Quality Management and Departmental Administration (QMDA)

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Accurate and thorough documentation is an essential element of high quality and safe medical care, and accordingly a basic responsibility of physician anesthesiologists. Anesthesia care is a continuum including three general phases of care: preanesthesia, intraoperative/intraoperative anesthesia and postanesthesia care. To contribute to accuracy in medical records and to facilitate any future necessary chart review, anesthesiologists should ensure that accurate and thorough documentation is accomplished in all three phases of anesthesia related care. Information that is relevant to the perioperative care of a patient that exists elsewhere in the medical record need not be duplicated in the preanesthesia evaluation, the anesthesia record or postanesthesia evaluation. Departments and practices should develop local policies that address how information may be provided when documenting patient evaluations. These policies may include how information should be referenced and incorporated in an evaluation without requiring duplication of information from elsewhere in the medical record.

Depending upon several local factors, documentation may be provided on a paper record or within an electronic record. Anesthesiologists may delegate to appropriately trained and credentialed anesthesia care team members any portion of the periprocedural record keeping, but they should play an active role to ensure that accurate and thorough medical record keeping is accomplished. Documentation should meet all applicable regulatory, legal and billing compliance requirements

In specific circumstances (e.g. emergencies, rapidly developing critical events, time sensitive sequential clinical care activities) an anesthesiologist or anesthesia care team member may be in conflict between a primary obligation to ensure patient safety and best clinical care, and contemporaneous medical record documentation. In these circumstances, attention to clinical care requirements remains the primary obligation. Medical record documentation should be provided as soon as appropriate in view of competing, primary clinical care requirements. The record should include documentation of:

I. Preanesthesia Evaluation*

A. Patient interview to assess:

1. Patient and procedure identification
2. Anticipated disposition
3. Medical history – includes patient's ability to give informed consent
4. Surgical History (PSHx)
5. Anesthetic history
6. Current Medication List (preadmission and postadmission)



7. Allergies/Adverse Drug Reaction (including reaction type)
8. NPO status
9. Documenting the presence of and the perioperative plan for existing advance directives.

B. Appropriate physical examination, including vital signs, height and weight and documentation of airway assessment and cardiopulmonary exam.

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. The anesthetic plan – including plans for post-anesthesia care and pain management.

G. Documentation of informed consent (to include risks, benefits and alternatives) of the anesthetic plan and postoperative pain management plan.

H. Appropriate premedication and prophylactic antibiotic administrations (if indicated).

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

A. Immediately prior to the start of anesthesia care and anesthesia procedures:

1. Patient re-evaluation
2. Confirmation of availability of and appropriate function of all necessary equipment, medications and staff.

B. Physiologic monitoring data** (e.g., recording of results from routine and nonroutine monitoring devices).

C. Medications administered: dose, time, route, response (where appropriate).

D. Intravenous fluids: type, volume and time.

E. Technique(s) used.

F. Patient positioning and actions to reduce the chance of adverse patient effects/complications related to positioning.

G. Additional Procedures performed: vessel location, catheter type/size, specific insertion technique (e.g., sterile technique, use of ultrasound), actions to reduce the chance of related complications (ex., catheter based infection prevention measures), stabilization technique and dressing.



H. Unusual or noteworthy events during surgery and anesthesia care.

I. Patient status at transfer of care to staff in a Postanesthesia Care Unit (PACU) or an area which provides equivalent postanesthesia care (e.g., ICU, SDS or floor nurse).

III. Postanesthesia

A. A time-based record of events that reflects the patient status on admission and discharge from the Postanesthesia Care Unit (PACU), as determined by a qualified anesthesia provider or by local departmental preset discharge protocols (i.e. postanesthesia note to be completed only when a patient is sufficiently recovered from acute administration of anesthesia and can participate in the evaluation) or admission to the intensive care unit.

B. If the PACU is bypassed, criteria demonstrating that patient status at transfer of care are appropriate.

C. It is not the responsibility of the anesthesiologist to document the patient's condition throughout the PACU stay or when leaving the PACU.

D. Significant or unexpected post-procedural events/complications.

E. Postanesthesia evaluation documenting physiologic condition and presence/absence of anesthesia related complications or complaints.

* See Basic Standards for Preanesthesia Care

** See Standards for Basic Anesthetic Monitoring