

**GUIDELINES FOR THE ANAESTHETIC RECORD**

**MINIMUM REQUIREMENTS FOR AN ANAESTHETIC RECORD**

**1. GENERAL COMMENTS**

- 1.1 The anaesthetic record is an essential and important part of a patient's record. It should record, in a simple and logical manner, either electronically or by hand, all aspects of anaesthetic management for the preanaesthetic assessment and care, the anaesthetic, and the postanaesthetic recovery. It should permit tabulation of data, have a chart for graphic recording and it should have space for comments.
- 1.2 The anaesthetic record is a medicolegal document, which is also of use for subsequent anaesthesia and management of the patient.

The record should include: -

**2. BASIC INFORMATION**

- 2.1 Patient's name, record number, sex, age and weight.
- 2.2 Date of anaesthesia.
- 2.3 Name of anaesthesiologist(s) involved.
- 2.4 Name of the operator.
- 2.5 Diagnosis and related medical conditions.
- 2.6 Proposed operation or procedure.

**3. PREANAESTHETIC HISTORY**

- 3.1 Relevant medical history and clinical assessment.
- 3.2 Relevant investigations.
- 3.3 Known sensitivity to drugs, materials or foodstuffs.
- 3.4 Recent and current medication taken by the patient.
- 3.5 Details of previous anaesthetics and any associated reactions.
- 3.6 Assessment of risk status.
- 3.7 Prescription of premedication and preanaesthetic therapy if not recorded on the drug chart.

**4. ANAESTHETIC RECORD**

- 4.1 Details of all medication to include dosage, route and untoward reactions
- 4.2 Details of anaesthetic technique(s) used and any relevant problems encountered.
- 4.3 Timings of significant events, observation and interventions.

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- 4.4 Details of airway maintenance and comments on any associated difficulties.
- 4.5 Details of the intravascular cannulation to include site(s) and size(s) and type(s) of cannulae used.
- 4.6 Details of any parenteral fluids administered.
- 4.7 Estimate of blood and other fluid losses.
- 4.8 Operative positioning.
- 4.9 Details of the monitors used. Print outs must be marked with the patient name, number and operation date.
- 4.10 Signature of the anaesthesiologist.

**5. POSTOPERATIVE RECOVERY**

- 5.1 Written instructions for the recovery staff, which should include the prescription for any analgesia or other medication, intravenous therapy, oxygen supplementation, and monitoring.
- 5.2 Recovery details, which should include the level of consciousness, vital signs, the adequacy of respiration and analgesia, and muscle power.
- 5.3 Time of arrival and departure from the recovery area.
- 5.4 Instructions for the ward nursing staff.