



Guidelines on Minimum Requirements for an Anaesthetic Record

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1. INTRODUCTION

- 1.1 Anaesthetic record is an essential and important part of a patient's record.
- 1.2 Anaesthetic care is documented in simple and logical manner, either electronically or in legible hand-written format, and provided in electronic print-out or paper record according to departmental and local unit policies. Details of all the phases of anaesthetic management including pre-anaesthetic assessment, anaesthetic care and the post-anaesthetic recovery are recorded.
- 1.3 Pre-anaesthetic consultation may be done prior to, and in addition to, pre-procedural assessment, to optimize patients' health status, prepare for procedures, discuss anaesthetic plans and risks with patients and/or guardians, and obtain written informed consents. Notes for these consultations, if done, should be easily available.
- 1.4 Additional documents in perioperative care, including screening questionnaires, nursing assessments, educational pamphlets, written consents, care pathway protocols, safety checklists etc. if done, are attached to supplement the record.
- 1.5 The anaesthetic record permits tabulation of data, graphs, charts, and spaces for comments and remarks.
- 1.6 All records are medico-legal document, which are also used for patient management, future anaesthetic care, quality assurance and research purposes.
- 1.7 Records must be signed by anaesthesiologists.
- 1.8 Records must be readily available throughout a patient's hospital stay, and for all subsequent attendances.
- 1.9 Documentation is normally done contemporaneously, except in emergencies and crisis situations when attention to patient clinical care remains the primary obligation of an anaesthesiologist. Medical record documentation of the events is done as soon as clinical condition allows.

2. INFORMATION RECORDED IN ANAESTHETIC RECORD

2.1 Basic Information pertinent to all records should include

- 2.1.1 Patient's name, identity number of corresponding episode of hospital



admission, sex, age and weight.

2.1.2 Name(s) of anaesthesiologist(s) involved

2.1.3 Name(s) of the surgeon(s) or other proceduralist(s).

2.1.4 Diagnosis and related medical condition(s).

2.1.5 Proposed operation or procedure, including side of operation.

2.1.6 Date of proposed operation or procedure.

2.2 Pre-anaesthetic evaluation should include

2.2.1 Date and time of consultation or assessment.

2.2.2 General medical history and cardiorespiratory fitness.

2.2.3 Recent and current medications and their perioperative arrangements, prescription of premedications.

2.2.4 Salient points of previous anaesthesia and any untoward reactions.

2.2.5 Known sensitivity reactions to drugs, materials or foodstuffs.

2.2.6 Physical examination findings of relevance, as a minimum, respiratory, cardiovascular and airway examinations as well as vital signs.

2.2.7 An assessment of the airway, dental condition, fasting status and risk of aspiration.

2.2.8 Relevant laboratory, radiological and other investigation results.

2.2.9 Assessment of American Society of Anesthesiologists (ASA) physical status, including emergency status when applicable.

2.2.10 An outline of the anaesthesia plan, such as mode(s) of anaesthesia, postoperative pain management, postoperative level of care, if appropriate.

2.2.11 Fasting instructions

2.2.12 Perinatal history and developmental history for paediatric patients.

2.2.13 Documentation of discussion with the patient or guardian on the anaesthesia plan, possible options of therapies and possible outcomes and risks (if not recorded elsewhere).



2.2.14 Consultations to other specialties.

2.2.15 Other instructions where appropriate.

2.3 Anaesthetic information should include

2.3.1 Review of patient's conditions and documents prior to initiation of anaesthetic procedures, especially when there are major anaesthetic and surgical concerns. These include patients with significant co-morbidities, where major operation is planned, and when there are changes in patient's conditions from previous evaluation such as fasting status and vital signs.

2.3.2 Documentation of completion of checking the anaesthetic machine.

2.3.3 Details of administration of all medications, for example, the dosage, timing, route and description of any untoward reactions.

2.3.4 Details of anaesthetic technique(s) used and any relevant problem(s) encountered.

2.3.5 Details of airway management, associated difficulty encountered and solutions used to overcome the difficulty.

2.3.6 Details of anaesthetic circuit and ventilation technique.

2.3.7 Details of intravenous and arterial (if any) cannulation including site(s), size(s) and type(s) of cannulae used.

2.3.8 Details of fluid therapy such as nature, volume, rate and time of administration.

2.3.9 Estimation of blood and other fluid losses.

2.3.10 Operative positioning and corresponding protective measures, if appropriate.

2.3.11 Details of monitors used and relevant information obtained. Documents provided as a monitor print-out must have correct patient identification. Minimum monitoring data (heart rate, blood pressure, peripheral oxygen saturation, end-tidal carbon dioxide and anaesthetic vapour concentration, if general anaesthesia is provided) must be recorded at least every five minutes, and more frequently if the patient is clinically unstable.



2.3.12 Details of significant anaesthetic or operative events, timings, observations and interventions.

2.3.13 Details of any complications or problems encountered.

2.3.14 If regional anaesthesia had been performed, additional information such as technique, infection control measures, drug regimes, assessment of blockade, monitoring, management of adverse effects, removal of catheters and treatment of complication (if any).

2.3.15 The status of the patient at the conclusion of anaesthesia, especially in high risk patients where the chance of change in patient condition on the way to post-anaesthetic care unit (PACU) is high.

2.3.16 Signature of the anaesthesiologist.

2.3.17 Other information in which attending anaesthesiologist considered appropriate.

2.4 Post-anaesthesia information should include

2.4.1 Conditions of the patient which include cardiovascular and respiratory status, level of consciousness and neurological status, muscle power, body temperature, pain control and adequacy of pain relief.

2.4.2 Written instructions for the PACU staff, such as prescription of analgesia or other medication, intravenous therapy, oxygen supplementation, monitoring and other management plans as appropriate.

2.4.3 Recovery details upon arrival, during PACU stay, and upon PACU discharge.

2.4.4 Time of arrival and discharge from PACU

2.4.5 Incident(s) arising during this period and the corresponding management.

2.4.6 Discharge destination and instructions for the ward nursing staff.



3. REFERENCES

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