**Good Documentation Practices (GDP) -   
Anesthesia Record (OR)**

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1. Anesthesia Times: (based on OR clock)

* Date (MM/DD/YY)
* Anesthesia Start:
  + *Time at which you give a pre-medication and/or start to accompany the patient to the OR)*
* Anesthesia Finish:
  + *Time at which you finish the OR-PACU Transfer-Of-Care Checklist)*
* Surgery Start:
  + *Time at which a skin incision is made, insertion of an invasive instrument is carried out, or the beginning of a non-invasive imaging sequence (e.g. ~~CT, MRI~~) or procedure (e.g. shockwave lithotripsy)*
* Surgery Finish:
  + *Time at which a skin incision is closed, removal of an invasive instrument is carried out, or the completion of a non-invasive imaging sequence (e.g. ~~CT, MRI~~) or procedure (e.g. shockwave lithotripsy)*

2. Pre-Op Medications:

* IV antibiotic prophylaxis (route, type, dose) (e.g. *cefazolin*)
* Ongoing IV antibiotics
* PO analgesics (route, type, dose) (e.g. *acetaminophen, celecoxib*)
* Pre-anesthetic medications (route, type, dose) (e.g. *fentanyl, midazolam*)

3. Diagnosis: (*Include both Pre AND Post diagnoses*)

* Pre-Procedure Diagnosis: (*Surgical Consent form* [see OR workflow])
* Post-Procedure Diagnosis: (*Post-Procedure Time-Out*)

4. Operation:

* Proposed Operation: (*Pre-Procedure Time-Out*)
* Final Operation: (*Post-Procedure Time-Out*)

5. Pre-Op Data:

* Recommended data: Hct, PLT, Weight, Airway issues, ASA—3 related medical diagnoses)
  + *“See Preop here”*
* Airway (e.g. *Mallampati classification*)
* ASA classification (*I – V; Emergency [E] for cases scheduled after 1700 or on the weekend, primary or “crash” C-sections*)
* Checkboxes:
  + Patient and planned procedure identified
  + Consent identified
  + Re-evaluation prior to induction
  + Anesthesia machine & equipment checked

6. Names:

* Anesthesiologist 🡪 *Last name of Anesthetist / Anesthesiologist*
* Surgeon 🡪 *Last name of Surgeon / Proceduralist*

7. Ventilator (*record the following every fifteen (15) minutes*)

* Mode of ventilation (e.g. *spontaneous [SV], volume control [VC], pressure control [PC], pressure support [PS]*)
* Ventilation parameters (e.g. Tidal Volume [Vt], respiratory rate [RR], peak inspiratory airway pressure (PIAP)

8. Fluids:

* Type:
  + IV Fluids (e.g. *LR, NS, D5 ½ NS*)
    - *Draw a line across the chart timetable to demonstrate continuous infusion*
  + Others (i.e. *albumin*)
  + Blood Products (e.g. *packed red blood cells [pRBCs], fresh frozen plasma [FFP], platelets [PLT], cryoprecipitate [CRYO*])
  + Urine Output
* Case Totals:
  + Total Fluids infused (*sum of LR + NS; report sum of other infusions* *separately (e.g. D5 1/2NS)*
  + Others Totals (e.g. albumin)
  + Total Blood Infused
  + Estimated Blood Loss (*Post-Procedure Time Out*)
  + Total Urine Output

9. For Epidural / Spinal patients ONLY:

* Fentanyl/Duramorph (i.e. *preservative-free morphine)*
* Local Anesthetic (Agent):
  + Volume (ml)
  + Concentration (%)
  + + / - epinephrine (mcg or ratio)
* Needle Size:
  + Space
* Level of Anesthesia (Sensory block)

10. Monitors:

* O2 Analyzer
* Pulse oximetry (Spo2)
* Capnometer (ETCO2)
* ECG (3-lead)
* NIBP cuff (L vs. R, UE vs LE)
* Temperature (*write “available” if not used, or write in additional method*)
  + Skin
  + Esophageal
* ART /CVP /PAC
* EEG
* Others
* Heating Device (e.g. *Forced Warm-Air Heating Machine, Fluid Warmer, blankets from the OR Blanket Warmer*)

11. Airway Type:

* O2 mask vs. NC (*for MAC / sedation cases*)
* Airway (*OA vs NP Airway, regardless of case type*)
* LMA (*size, type*)
* ETT:
  + Oral vs. Nasal
  + Cuffed vs uncuffed
* Bil Bis – *leave blank*

12. Position (i.e. *supine [SUP], lateral decubitus [LLD or RLD], prone [PRO], sitting [SIT])*

* Report changes during case on Chart
* Specify additional positions (Trendelenburg [TBURG], Reverse Trendelenburg (R/TBURG)

13. Type of Anesthesia

* General Anesthesia (GA)
  + Mask (Circuit)
  + ETT
  + LMA
* Spinal
* Epidural
* Monitored Anesthesia Care (MAC)
  + With local
  + Without local
* Block
  + *Must complete anecdote in written section*

14. Airway Note

* Blade (Type/Size) - *for direct or video laryngoscopy for ETT placement*
* Difficult (Yes/No) – *report any difficulty with ventilation, intubation and/or LMA placement*
* Tube Size (*ETT or LMA*)

15. Remarks section - *Written anecdote section*

* Pre-operative discussion
  + Discussion of risks and benefits with patient/parent/guardian/DPOA
  + All questions answered
  + Chart reviewed (with specific abnormalities acknowledged)
    - Labs
    - Vitals signs / Physical Exam
    - Medications
    - Allergies
  + Consent signed
  + Surgeon proceeding with case against anesthesia advice and/or proper clearances (will need justification in Remark section)
  + Transport to OR
* Induction/Airway note
  + Inhalation / Intravenous / Intramuscular
  + # of airway attempts (ETT or LMA)
  + Airway adjunctive maneuvers (e.g. cricoid pressure, stylet use
  + Grade view (I, IIa IIb, III, IV)
  + ETT placement depth of securement (\_\_\_cm at teeth/lips)
  + ETT/LMA cuff insufflation volume
  + +/- complications
* Intraoperative notes (with event marker and time)
  + A close up of text on a white background

    Description automatically generatedCardiopulmonary issues (hemodynamic aberrations, desaturations)
  + Surgical issues
  + Case justification
  + Delays
  + Intraoperative lab values
  + Blood product unit numbers
* Emergence note
  + Smooth versus difficult emergence
  + Removal of lines and tubes (ETT/LMA, OG tube, extra IVs, etc.)
  + Suctioned (yes/no, oropharynx vs ETT, # of times)
  + Responsiveness head lift, hand grasp, cough/swallow, follows commands, adequate respirations)
  + Need for oral/nasal airway
  + Supplemental O2 (yes/no, # L/min)
  + Transport to PACU
* Block Notes (report local anesthetic type and dose on Chart)
  + Type of block
  + Laterality
  + For billing: “Surgeon (Dr. \_\_\_) requests block for post-operative analgesia. Ultrasound (U/S) guidance used with image retained)
  + Monitors (if different from above)
  + Block Time-Out Completed (Y/N)
  + Type of needle used (i.e. 20g 4in, 22g 2 in.)
* Epidural and Spinal Notes
  + See Good Documentation Practices (GDP) – Labor & Delivery
  + Patient position, sterile prep, monitors, +/- supplemental O2
  + Local anesthetic for superficial skin infiltration + needle gauge, Tuohy (+gauge)
  + \_, depth loss of resistance (LOR) (cm), catheter threaded to \_\_ cm at skin
  + +/- heme
  + +/- CSF
  + +/- test dose
  + +/- pain on injection
  + Provide sensory level in blank \_ above.

16. Complications

17. Vital signs (V/S) upon discharge from PACU

18. Signature

19. Chart:

1. Tabular Data

* Timekeeping row:
  + Pre-Induction Assessment Time = In Room Time
  + Write out military times in thirty (30)-minute intervals across the chart. Add a tick (i.e. “x,” “.”) staggered by fifteen minutes from each written time, also in thirty (30)-minute intervals across the chart
* Gases:
  + O2 (L/min) – record flow and drag line until next flowmeter change
  + N2O (L/min) - record flow and drag line until next flowmeter change
  + VA (Sevo/Iso/Des) (%) – *record flow (L/m) and drag line until next flowmeter change*
* IV Medications (use generic names, write units next to each one)
  + Individual Medications
    - Midazolam
    - Propofol (*or other hypnotic*)
    - Fentanyl
    - Muscle relaxant (*Atracurium*, *Vecuronium, Rocuronium, etc*)
    - Succinylcholine
    - Other medications to include:
      * Anti-emetics: *Dexamethasone, Ondansetron*
      * Non-opioid analgesics: *Acetaminophen (PO, PR, IV), Ketorolac*
      * Long-acting opioid analgesic: *Hydromorphone, Morphine*
      * Reversal agents: *Neostigmine, Glycopyrrolate*
  + Medication Totals
    - In the very last column, add and circle the sum of each opioid medication. Press hard when writing to make sure the ink goes through all four (4) copies of the record.

1. Graphical Data

* Every fifteen (15) minutes
  + ECG
  + O2 Sat
  + EtCO2
  + Temp
* Every five (5) minutes
  + NIBP or ABP *(^, v)*
  + HR *(.)*
* Incidental Events
  + Note the time interval and associated event marker (20). Mark with an asterix *(\*)*
  + Record event, along with timestamp and event marker, in the Remarks section

20. Patient sticker

- Make sure to label all four (4) sheets associated with the Anesthesia Record

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19A

19B

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