Painless CE

Anesthesia Documentation Checklist

1. Pre-Operative Documentation

- **Patient Information:**
  - ☐ Patient's full name and identification number.
  - ☐ Date of birth and contact information.
  - ☐ Confirm patient's informed consent for the anesthesia procedure.
- **Medical History:**
  - ☐ Complete patient medical history, including previous surgeries and anesthesia experiences.
  - ☐ Documentation of all known allergies, including specific reactions and severity.
  - ☐ Current medications, including dosages and last dose taken.
  - ☐ ASA (American Society of Anesthesiologists) classification and any identified risks.
- **Physical Examination:**
  - ☐ Airway assessment (Mallampati score, neck mobility, dentition).
  - ☐ Cardiovascular and respiratory evaluation.
  - ☐ Baseline vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation).
- **Pre-Operative Instructions:**
  - ☐ NPO (nil per os) status and time of last oral intake.
  - ☐ Pre-operative medications administered, including dosage and timing.
  - ☐ Patient's understanding of the anesthesia plan and procedure.

2. Intraoperative Documentation

- **Anesthesia Plan:**
  - ☐ Type of anesthesia planned (general, regional, local, MAC).
  - ☐ Medications planned for induction, maintenance, and emergence.
  - ☐ Patient positioning and any special considerations (e.g., prone, lateral).
- **Induction of Anesthesia:**
  - ☐ Time of induction and agents used (including doses).
  - ☐ Airway management (method used, intubation details, confirmation of tube placement).
  - ☐ Initial vital signs following induction.
- **Intraoperative Monitoring:**
  - ☐ Continuous recording of vital signs (BP, HR, SpO_2, $EtCO_2$).
  - ☐ Anesthesia depth monitoring (e.g., BIS, MAC value).
  - ☐ Fluid management (IV fluids, blood products, urine output).

- ☐ Documentation of all administered medications (dosages, timing, and patient response).
- ☐ Record of any deviations from the anesthesia plan and rationale for changes.

- **Surgical Events:**
  - ☐ Time of incision and closure.
  - ☐ Documentation of significant surgical events or complications.
  - ☐ Blood loss estimation and replacement therapy.
- **Emergence from Anesthesia:**
  - ☐ Time of cessation of anesthetic agents.
  - ☐ Reversal agents administered (if applicable) and patient's response.
  - ☐ Extubation details (time, patient condition).
  - ☐ Final intraoperative vital signs.

3. Post-Operative Documentation

- **PACU Admission:**
  - ☐ Time of admission to PACU.
  - ☐ Initial vital signs upon arrival (BP, HR, SpO2, RR).
  - ☐ Pain assessment and management plan.
  - ☐ Nausea/vomiting management (medications given and response).
- **Recovery Status:**
  - ☐ Level of consciousness (e.g., Alert, Drowsy, Unresponsive).
  - ☐ Patient's ability to maintain airway and breathe independently.
  - ☐ Ability to tolerate oral fluids and food.
  - ☐ Mobility status (e.g., able to sit up, stand, or walk).
- **Complications:**
  - ☐ Any post-operative complications (e.g., pain, nausea, hypotension) and interventions provided.
  - ☐ Documentation of any additional medications administered in PACU.
- **Discharge from PACU:**
  - ☐ Time of discharge from PACU and transfer to ward or discharge home.
  - ☐ Final vital signs and assessment.
  - ☐ Discharge criteria met (e.g., Aldrete score).
  - ☐ Documentation of follow-up care instructions provided to the patient or caregiver.

4. Special Considerations

- **Patient Communication:**
  - ☐ Documentation of patient questions and concerns during pre-operative and post-operative periods.

- ☐ Summary of patient education regarding anesthesia, potential risks, and post-operative care.

- **Team Communication:**
  - ☐ Record of any intraoperative consultations with other healthcare providers (e.g., surgeons, nurses).
  - ☐ Handoff communication between anesthesia provider and PACU team, including key intraoperative events and recovery plan.
- **Legal and Regulatory Compliance:**
  - ☐ Verification that all documentation meets institutional, state, and federal guidelines.
  - ☐ Confirmation that patient consent forms are completed and signed.

5. Review and Finalization

- **Documentation Review:**
  - ☐ Review all entries for accuracy, completeness, and legibility.
  - ☐ Ensure all time-stamps are accurate and in chronological order.
  - ☐ Correct any errors or discrepancies in the documentation.
- **Final Sign-Off:**
  - ☐ Anesthesia provider's signature and date on the completed chart.
  - ☐ Confirmation that the chart has been reviewed by a peer or supervisor if required.