Painless CE

Anesthesia Documentation Audit Form Template

Section 1: Pre-Operative Documentation

1. Patient Identification

- ☐ Patient's full name, date of birth, and medical record number are accurately documented.
- ☐ Patient identification was verified and documented.

2. Pre-Anesthesia Assessment

- ☐ Complete medical history documented, including allergies, current medications, and previous anesthesia experiences.
- ☐ Comprehensive airway assessment documented (Mallampati score, thyromental distance, neck mobility, dentition status).
- ☐ ASA Physical Status Classification documented.

3. Informed Consent

- ☐ Informed consent obtained, documented, and signed by the patient.
- ☐ Discussion of risks, benefits, and alternatives documented.

4. Pre-Operative Instructions

- ☐ NPO status and compliance documented.
- ☐ Instructions regarding pre-op medication management documented.

Section 2: Intraoperative Documentation

1. Anesthesia Start and End Times

- ☐ Anesthesia start and end times are accurately documented.

2. Monitoring and Vital Signs

- ☐ Continuous monitoring of vital signs (BP, HR, SpO_2, $EtCO_2$) documented at regular intervals.
- ☐ Any significant deviations from baseline vital signs documented with corresponding interventions.

3. Medication Administration

- ☐ All anesthetic agents, muscle relaxants, sedatives, and other medications documented with dosage, route, and time of administration.
- ☐ Documentation of any medication allergies and confirmation that no contraindicated drugs were administered.

4. Airway Management

- ☐ Method of airway management (e.g., endotracheal intubation, LMA) documented.
- ☐ Number of intubation attempts, the view obtained, and any difficulties encountered documented.
- ☐ Confirmation of tube placement documented (e.g., capnography, auscultation).

5. Intraoperative Events and Interventions

- ☐ Documentation of any significant intraoperative events (e.g., hypotension, arrhythmias) and the interventions performed.
- ☐ Any deviations from the planned anesthesia technique documented, including the rationale.

Section 3: Post-Operative Documentation

1. Transfer of Care to PACU

- ☐ Condition of the patient upon arrival in PACU documented.
- ☐ Summary of intraoperative events and any immediate post-op concerns communicated during handoff documented.

2. PACU Monitoring

- ☐ Continuous monitoring of vital signs in PACU documented, with attention to any deviations and interventions.
- ☐ Documentation of post-op pain assessments, including pain levels and responses to pain management interventions.

3. Airway and Respiratory Status

- ☐ Documentation of airway status post-extubation, noting any signs of airway obstruction or respiratory distress.
- ☐ Any required respiratory interventions (e.g., supplemental oxygen, airway support) documented.

4. Discharge from PACU

- ☐ Criteria for discharge from PACU documented (e.g., stable vital signs, pain control).
- ☐ Discharge time and receiving unit or home documented.
- ☐ Post-op instructions and any necessary follow-up care documented.

Section 4: Compliance and Quality Indicators

1. Regulatory Compliance

- ☐ Documentation meets Joint Commission standards and CMS requirements.
- ☐ Patient privacy and confidentiality maintained throughout the documentation process.

2. Documentation Completeness

- ☐ All required fields in the anesthesia record are completed, including patient identifiers, signed consent forms, and anesthesia start and end times.
- ☐ Documentation is legible, accurate, and free of unapproved abbreviations or symbols.
- ☐ Presence of all necessary signatures, including those of the anesthesia provider and supervising physicians.

3. Quality Improvement

- ☐ Any recurring documentation errors or patterns identified.
- ☐ Recommendations for process improvements or additional training documented based on audit findings.
- ☐ Follow-up actions planned to address critical gaps or errors identified during the audit.

Section 5: Auditor's Notes

1. Summary of Findings

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- ☐ Overall assessment of the quality of the anesthesia documentation.
- ☐ Specific examples of well-documented cases and those requiring attention.

2. Recommendations

- ☐ Suggestions for improving documentation practices.
- ☐ Immediate actions required to address critical gaps or errors.

3. Follow-Up

- ☐ Plan for re-auditing specific areas or cases to ensure that improvements are implemented and sustained.
- ☐ Schedule for the next audit cycle.