

[The policies must ensure that the following are provided for each patient:]

§482.52(b)(2) - An intraoperative anesthesia record.

Interpretive Guidelines §482.52(b)(2)

There must be an intraoperative anesthesia record or report for each patient who receives general, regional or monitored anesthesia. While current practice dictates that the patient receiving moderate sedation be monitored and evaluated before, during, and after the procedure by trained practitioners, an intraoperative anesthesia report is not required because, as explained above, moderate sedation is not “anesthesia”. Current standard of care stipulates that an intraoperative anesthesia record, at a minimum, includes:

- Name and hospital identification number of the patient;
- Name(s) of practitioner(s) who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner;
- Name, dosage, route and time of administration of drugs and anesthesia agents;
- Techniques(s) used and patient position(s), including the insertion/use of any intravascular or airway devices;
- Name and amounts of IV fluids, including blood or blood products if applicable;
- Timed-based documentation of vital signs as well as oxygenation and ventilation parameters; and

- Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

Survey Procedures §482.52(b)(2)

Review records to determine that each patient has an intraoperative anesthesia record that includes the elements described above.