ANAESTHETIC NURSING RECORD STANDARD OPERATING PROCEDURE	
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1.0 Introduction

The quality of records maintained by nurses reflects the quality of nursing care provided to patients. Nurses are professionally and legally accountable for the standard of practice which they deliver and to which they contribute. Good practice in record management is an integral part of quality nursing practice (NMBI 2015). The Anaesthetic Nursing Form (ANR) was designed and introduced into perioperative practice in 2008.

2.0 Definition of Standard Operating Procedure

The term **'Standard Operating Procedure'** is a way of carrying out a particular course of action and includes operations, investigations, pharmaceutical treatment, examinations and any other treatment carried out.

The purpose of this SOP is:

- Provides a means to guide the anaesthetic nursing staff on the use of the Anaesthetic Nursing Record (ANR) form
- Ensure that ANR is used in a uniform and effective manner

3.0 Applicable to

To all nursing staff working in the perioperative setting.

4.0 Objectives of Standard Operating Procedure

This document is to facilitate the recording of nursing care during anaesthetic part of the perioperative journey.

5.0 Definitions / Terms

Anaesthetic Nursing Record (ANR)

6.0 Procedures

Principals in Documenting Perioperative Patient Care

- Record serves as a **means of communication** among providers for continuity of care. The broad assumption is that if 'if something is not documented it was not done'
- Documented on the appropriate form
- **Written legibly** in ink without erasers
- Documentation of objective data and services rendered should be very specific
- Document when care has been given.
- Stated in **understandable terminology**. Abbreviations is permissible depending on the list of acceptable medical abbreviations for charting purposes. OLCHC (2007)
- **Dated** (month, day, year) including time (AM/PM/ 24 hour clock) the note is written, and the time when action was performed, as appropriate for significant events and changes in the patient's condition
- **Signed** with the full legal signature, title, and registration number of the practicing nurse
- A signature bank is kept and maintained in the theatre department (OLCHC 2018)
- **Correct if an error is made**: The date, time and initials of the person making a correction should be noted next to the correction. A single line should be drawn through incorrect information without obliterating it and the correct information should then be entered
- The patient's name and record number should appear on every page of the record
- Regular **audit** is an integral of maintain quality records

Overview of Anaesthetic Nursing Record form

- Two-page document printed in A4 paper

- Page 1 provides for identification of patient, date, time arriving into anesthetic room, preparation of anaesthetic room, communication, patient monitoring, airway type and size, throat pack, eye care, intravascular cannulation, intravenous infusions in progress, pain management, patient positioning, skin integrity, temperature control, drains and patient transfer.

- Completing of this form involves use of tick boxes and manual writing data. Spaces for comment on relevant sections are provided. Space is provided for additional nursing information along with space for signatures and gradesa of anaesthetic nurse and if applicable circulating nurse.

- Page 2 provides additional space for nursing information and adequate space for affixing traceability labels of instruments used by named patient.

Please see appendix 1.

7.0 Implementation Plan

The effective use of this form is governed and dependent on the individual Theatre Nursing staff's awareness and compliance to regulations, policies and procedures enacted for this purpose as listed but not limited to.

The ANR form will be introduced to all staff on their orientation and will use this form as they care for patients.

8.0 Evaluation and Audit

Monitoring of compliance is an important aspect of procedural documents. Documentation audits are performed on a monthly basis in Theatre by the CNF Anaesthetic & Recovery.

9.0 References

Nursing and Midwifery Board Ireland (2015) *Recording Clinical Practice Professional Guidance* Nursing and Midwifery Board Ireland

Our Lady's Children's Hospital Crumlin (2007) *Guidelines on the use of abbreviations in hospital Documentation* Our Lady's Children's Hospital Crumlin, Dublin

Our Lady's Children's Hospital Crumlin Operating Theatre (2018) *Staff Signature Bank Booklet* Our Lady's Children's Hospital Crumlin, Dublin

Our Lady's Children's Hospital Crumlin Operating Theatre (2018) *Guidelines for Handover from Theatre Staff to Recovery Staff Post Elective/Emergency Surgery* Our Lady's Children's Hospital Crumlin, Dublin

Woodhead K. & Wicker P. (2005) A Textbook of Perioperative care Elsevier. Philadelphia.

Appendices