MedStar Georgetown University Hospital

Department of Anesthesia	
Title:	**Policy Number:**
Post-Anesthesia Follow-up Visit	9118
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June 2, 2015	Anesthesia Follow Up Note

Purpose:

It is the policy of our anesthesia department to document a post-anesthesia follow-up visit within 48 hours for surgical inpatients (Policy # 9051). Reasons for the visit include identification of anesthesia complications, resident/SRNA education and compliance with third party payer rules and other external rules. This policy and procedure will establish a process which will facilitate both increased compliance and measurement of compliance rates. The process is also designed to optimize collection of QA/QI data.

About the Instrument:

The instrument is a two-page carbonless duplicate form referred to hereinafter as the Follow-Up Note (or Note). (See attachment.) The first sheet (white copy) is designed to record the post-anesthesia follow-up note. The second sheet (yellow copy) duplicates the follow-up note on its top half and has a QA/QI/Risk Management note on its bottom half. On the reverse side of the second sheet is a list of abbreviations for encoding and recording QA indicators.

Procedure for Perioperative Clerical Staff:

The patient label will be placed on the follow up note when the initial anesthesia record is stamped. This will apply to all anesthetics including Main & Same Day OR, GI and satellite. It will apply to inpatients as well as outpatients. The Note will be placed on the chart or sent loose to the anesthesia care team. In areas such as satellite, where the unit secretary does not routinely provide the blank anesthesia records, the anesthesia team will be responsible for obtaining a blank Follow-Up Note and labeling it.

Procedure for the Anesthesia Care Team:

The anesthesiologist will assign responsibility for the Follow-Up Note to a member of the team. If the blank form is on the chart, it will be removed at the beginning of the anesthetic. In most cases the blank Note will be given to the trainee (resident or SRNA) on the team. The team will ensure that the Note is properly labeled with the patient's name, record number and date of birth. At the time of the anesthetic, all names of the anesthesia care team will be written in the designated field of the Note. At the end of the anesthetic the responsible member of the team will keep the Note.

A post-op visit will occur the next day and be recorded on the Follow-Up Note. (This step is optional for outpatients provided that there is no complication.) The white and yellow sheets will then be separated and the white copy placed on the chart. The yellow copy (bottom half) will be used to record any critical incident.

The earliest time for writing a note to comply with this policy is *after* the patient meets criteria for discharge from Phase I PACU (or 12 hours after surgery in the case of a critically ill ICU patient who fails to meet discharge criteria).

All yellow copies will be returned to the anesthesia office. This will apply equally to inpatients and outpatients and, it will apply equally to cases that did or did not involve a critical incident. The yellow copy can be returned to anesthesia office directly or it can be placed in the return box on the door of the OR satellite pharmacy or the return box by the Pyxis in Same Day Surgery. Universal return of the yellow copies will facilitate collection of QA/QI data. In cases of uncomplicated outpatient surgery (or other procedures) the white copy may be discarded at the conclusion of the anesthetic. Do not discard the yellow copy.

If the case is on a Friday and any member of the anesthesia care team is on call Friday, Saturday or Sunday, that person should write the Follow-Up Note on Saturday or Sunday.

If no member of the anesthesia team is expected to be in the hospital the day following the anesthetic, the blank Follow-up Note should be placed in the designated collection box (in the anesthesia office) for the call team (or floating CRNA) to complete the next day.

If a surgical inpatient is discharged from the hospital prior to the post-anesthetic visit, the follow-up will include a review of the inpatient chart with an appropriate note left behind (e.g. "POD#1 after lap. chole. Patient was discharged to home this morning. Review of the chart does not suggest any complications of general anesthesia").

All OB anesthesia follow-ups will be done by the OB anesthesia team. The OB anesthesia attending will be responsible for delegating this duty.

For a Follow-Up Note which is completed in the absence of the patient's chart (e.g. based on a telephone converation with an outpatient). The note will be returned to the Anesthesia office. The white copy will be separated and forwarded to the Medical Records Department by the office staff.

Procedure for the Call Team:

After cases are done in the OR, the call team (trainees) will collect incomplete Follow-Up Notes from the collection box in the anesthesia office. They will make rounds on all the patients named on those Notes. Again, the white copy of the Note will go on the chart and the yellow copy will go to the anesthesia office (with QA/QI notes if applicable). *If an anesthetic complication is detected at the follow-up visit, the trainee should inform the attending anesthesiologist for that case on the next working day.*

The call team should complete all their follow-ups.

Procedure for the Anesthesia Office Staff:

Yellow sheets will be collected and separated into positives (with QA notes) and negatives (without QA notes). Indicators will be recorded in a computer database. Positives will be given to the QA/QI committee for review. Following review, all yellow sheets will be placed in a secure file.

Completed white sheets collected in the office will be forwarded to Medical Records.

In the Event of a Major Incident:

In any event with risk management issues, the attending anesthesiologist should inform the chairman and the Risk Management staff. If the event involves a *serious injury* (resulting from or possibly resulting from patient care activity or failure to provide care) notification should occur immediately. This includes all sentinel events (defined below). If the event occurs outside of regular working hours, notification of the chairman can occur on the next working day. If the chairman is unavailable, the anesthesia department's QA/QI Coordinator should be notified of the incident.

Cases with major complications will be referred for M&M Conference.

Hospital Policy #352 defines sentinel event as an unexpected occurrence involving unanticipated death or major permanent loss of function not related to the natural course of illness or underlying conditions.

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