

Anaesthetic charts- does one size fit all?

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Introduction

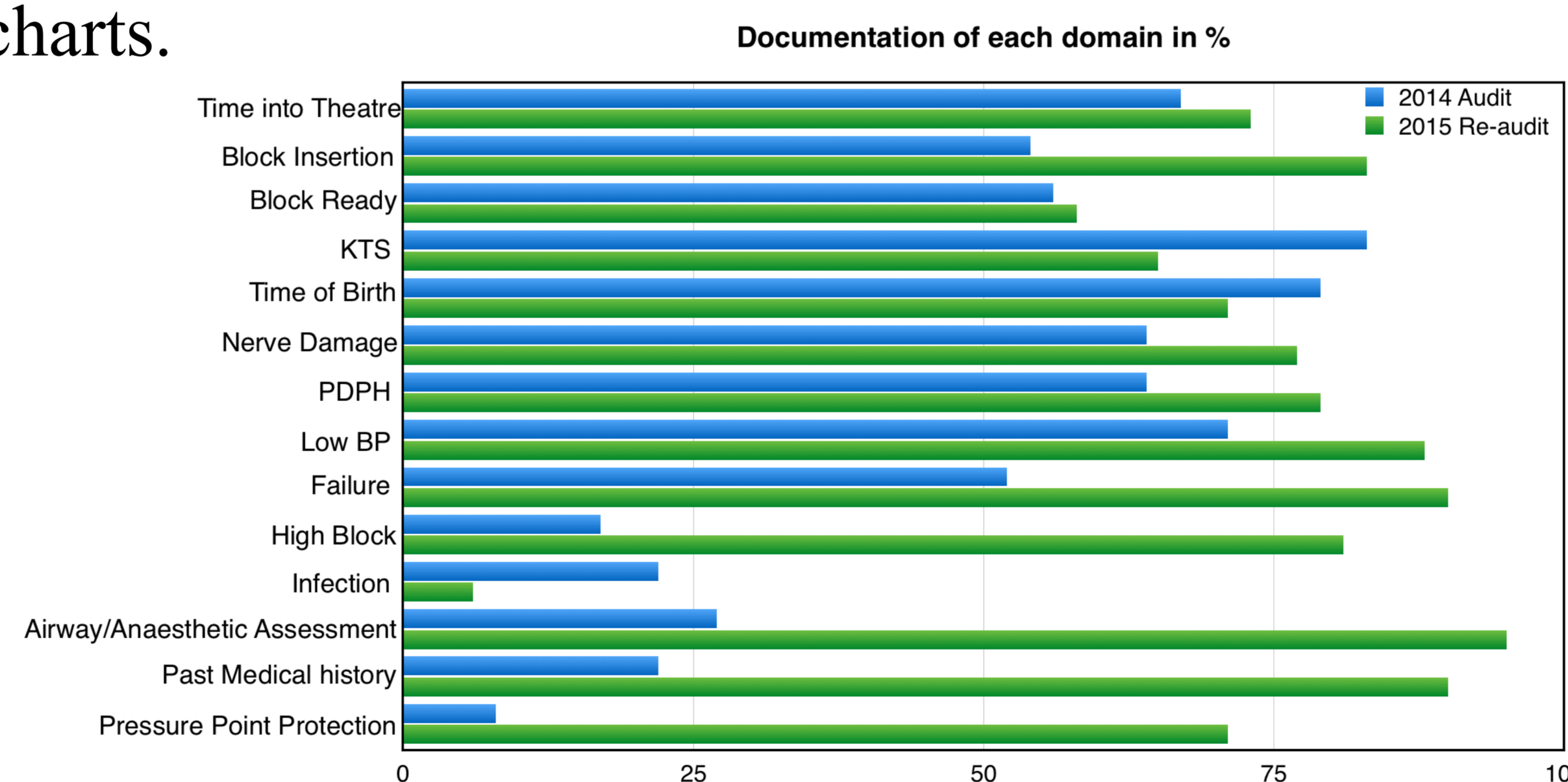
Adequate documentation is essential during every stage of obstetric anaesthesia including pre-operative assessment, consent for anaesthesia, recording of peri-delivery timelines, handover and post-operative care plans.¹ There is currently no standard obstetric anaesthetic record in the UK. The Royal College of Anaesthetists (RCoA), Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Obstetric Anaesthetists' Association (OAA) have provided guidance on minimum data sets² which the GMC uses for assessment purposes. Bespoke anaesthetic charts may improve compliance with national recommendations on documentation by providing obstetric specific prompts.

Method

After local audit committee approval, a retrospective snap shot audit of generic anaesthetic charts was carried out over a 2 week period in 2014. Records were examined for risks informed during consent, airway assessment, past medical and anaesthetic history, significant illness and documentation of time line in theatre. Following introduction of a bespoke anaesthetic chart in our Maternity unit in 2015, the new anaesthetic chart was reaudited against the same criteria over a further 2 week period and the results were compared.

Results

The 2014 audit examined 48 charts and the 2015 study assessed 52 charts. Data capture was approximately 60% for the relevant details in the initial audit and 75% with the new charts. There were several improvements in documentation of the 'times of interest' from the 2014 audit: time of entering theatre 67% to 73%, time of block insertion 54% to 83%. Improvements in consent for risks of regional anaesthesia were most improved. These included risk of failure 52% to 90%, high block 17% to 81%. The amount of charts documenting 'no explained risks' decreased from 27% to 0% when the new charts were implemented. Airway assessment and past anaesthetic history documentation was missing in 73% of the old style charts and in only 5% of the new maternity charts.



Conclusion

An anaesthetic chart is an important indicator of quality of care and an essential tool for risk management.³ It is a GMC Good Medical Practice requirement to enter all relevant details clearly and accurately. Recording every activity and intervention that a patient receives enhances peri-operative care⁴ and accurate record keeping is essential for resolution of any medico-legal allegations. Results of the initial audit indicated a need for a bespoke chart for obstetric anaesthesia practice to reflect the style of information required to enhance care. The redesign has provided an invaluable tool to enhance care and the reaudit has proved that the levels of documentation have improved considerably.

Extracts from the new bespoke Anaesthetic that have helped levels of documentation

Informed Consent for Planned Anaesthetic Technique		Consent for General Anaesthesia	
Spinal	Epidural de novo	Spinal	Epidural
<input type="checkbox"/> Sensation (tugging, touching, pulling and pressure)		<input type="checkbox"/> Sore throat 1:5	
<input type="checkbox"/> Failure 1:20		<input type="checkbox"/> PONV 1:5	
<input type="checkbox"/> Headache 1:500	1:200	<input type="checkbox"/> Hypoxia/Aspiration 1:100	
<input type="checkbox"/> Low blood pressure 1:5	1:50	<input type="checkbox"/> Wake up prior to surgery if difficult airway	
<input type="checkbox"/> Nausea/vomiting		<input type="checkbox"/> Damage to teeth 1:4,500	
<input type="checkbox"/> Itching		<input type="checkbox"/> Awareness 1:250-1000	
<input type="checkbox"/> Shivering		<input type="checkbox"/> Anaphylaxis 1:10,000-20,000	
<input type="checkbox"/> Motor block		<input type="checkbox"/> Death less than 1:100,000	
<input type="checkbox"/> High block/ total spinal		<input type="checkbox"/> Succinylcholine Pains	
<input type="checkbox"/> Nerve damage		<input type="checkbox"/> Post operative pain	
<input type="checkbox"/> Transient 1:1,000		<input type="checkbox"/> Compartment leaves	
<input type="checkbox"/> Permanent 1:13,000			
<input type="checkbox"/> Severe / Permanent harm 1:70,000	1:70,000	<input type="checkbox"/> Consent for blood transfusion	
<input type="checkbox"/> Urinary catheter		<input type="checkbox"/> Senior informed Y / N	
<input type="checkbox"/> Conversion to GA		Sign	
Other			

Timings	Fetal Heart Rate
Decision made
Time informed
Time in Theatre
Anaesthesia start
Ready for KTS
KTS
Uterine incision
Time of birth
Time of operation finish
Time out of Theatre

References:

- 1.NHS 1998-2005. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007832 (accessed 28/10/2008)
- 2.<http://www.rcoa.ac.uk/system/files/CSQ-GoodPractice2006.pdf>
- 3.Clayton Petty. Risk Management and Quality Assurance in Anaesthesia; Anaesthesiology; 1986; 88-94