Obstetric ANAESTHESIA
Princess Royal Maternity

Audit of anaesthetic chart documentation in obstetrics

E Bhatti, E Bailey, MA Broom
Princess Royal Maternity, Glasgow Royal Infirmary, Glasgow

Introduction

The anaesthetic chart is an important clinical and legal document. Poor documentation can adversely affect both patient and anaesthetist.[1] We audited pre-operative documentation on our maternity anaesthetic charts.

Results

100 consecutive cases were identified; 13 notes were unavailable, 87 were analysed. Cases were: 37/29 elective/emergency caesarean sections (CS), five tear repairs, one manual removal placenta and one with no procedure recorded. There were 31 epidurals (including 14 CS top-ups and three for tear repairs). The table shows data completion on charts. Regarding consent, specific procedure and name of consenting anaesthetist were clearly recorded next to the consent in 30% and 34% of cases respectively. Nerve damage and headache (100%) were most consistently recorded risks. Worst recorded were 'paralysis' (69%), and 'rescue analgesia' (56%). Two GA CS had appropriately documented consent.

Data point on anaesthetic chart	Number (%) documented
Patient details	87 (100%)
Free text history	87 (100%)
Allergy	86 (99%)
Operative procedure name	86 (99%)
Blood results	83 (95%)
Anaesthetist name / grade	82 (94%)
Parity	82 (94%)
Airway assessment Full/partial	81 (86%)/ 6 (7%)
Medication	80 (92%)
Date	79 (91%)
Gestation	78 (90%)
Weight	76 (87%)
Supervision	74 (85%)
Category of CS	55 (63%)
Surgeon name	43 (59%)
ASA	41 (47%)

Key Messages

Anaesthetic charts are…

- ➡ Important for communication between anaesthetists
- ➡ Important for safe continuity of patient care
- ➡ Important legal documents requiring full completion

Methods

Ethical approval was not required. Each section of the chart was recorded as completed or not. Airway assessment was: full (≥ 2 features recorded), partial (1 feature) or none. Each tick-box consent point for regional anaesthesia was recorded individually (not all are applicable to epidurals and spinals). Target completion for each element was 100%.

Discussion

In obstetric anaesthesia, patient care frequently transitions across staff shift changes. Communication and accurate recording of information are of paramount importance. Although most elements (16/23, 70%) had > 85% completion, many (ie anaesthetist name, procedure, allergy, medication, date and airway assessment), should reasonably be expected to reach 100%. Recording of which specific procedure has been consented, and by whom, was relatively inconsistent. Patients may commonly undergo more than one procedure during labour and delivery. Recording of CS category is medicolegally prudent. Poor recording of surgeon's name (59%) may display a lack of familiarity within surgical teams. Results have been shared and incorporated into trainee induction. We will re-audit in 3-months time.

References: Yentis, S.M., Hartle, A.J., Barker, I.R., et al. (2017), AAGBI: Consent for anaesthesia 2017. Anaesthesia, 72: 93-105.