Introduction & Aims

Good anaesthetic records are essential for many reasons; to maintain excellent clinical care, enable inter-speciality communication, allow patient identification without error and allow staff to assume care of a patient at any time.

In medico-legal cases the outcome is often dependent on the anaesthetic record, and an untidy, illegible or scantily completed chart may be taken as evidence of shoddy or inattentive care. 1 Accurate records also facilitate the collection of data for research, audit and teaching purposes. Standards of record keeping have been highlighted as a cause for concern nationally and have been criticised over the years. 2

We wanted to look specifically at documentation of patient and anaesthetist identifiers and since there are few specific Royal College of Anaesthetists or AAGBI standards for this kind of generic record keeping, we compared our performance to those set by the Academy of Medical Royal Colleges (AoMRC) in 2008. 3

The relevant Generic Standards as set by the AoMRC

1. Every page in the medical notes should contain the patients name, identification number and location.
2. Every entry in the medical record should be dated, timed (24hr clock), legible and signed by the person who made the entry. The name and designation of the person making the entry should be legibly printed against their signature. 4
3. Entries to the medical record should be made as soon as possible after the event.
4. Every entry in the notes should identify the most senior healthcare professional present/responsible.

Methods

Data from 80 completed anaesthetic records was collected in the recovery room over two days, covering approximately 30 theatre lists, using a standard spreadsheet. Cardiac, AMH and RACH theatres were excluded.

We counted the number of correctly documented pieces of information as follows:

- Patient Name
- CHI and/or Unit Number
- Ward
- Pre-assessment date & time
- Anaesthetising anaesthetist name and designation (a legible signature or printed name was accepted).
- Duty Consultant (data collected from non-consultant led lists only).
- The percentage of correctly documented data was calculated.

Results

The percentages of correctly documented data are shown in their respective positions on the standard NHS Grampian Anaesthetic Record.

Discussion

Compliance with recording patient name and ID numbers was generally excellent as we had expected, however one chart contained no patient name.

Notably, in the absence of a patient label, nobody recorded their patient’s sex even though there is a field for this on our chart. Most charts contained a sticky label with patient details on it which includes sex.

Recording of pre-op assessor and time of pre-op assessment was poor with only 56% of charts containing a legible name, 14% a grade and only 78% recording the date of pre-op assessment. A record of who performed pre-assessment is as important as who performs anaesthesia and needs documented.

Only 23% of records showed on which ward the patient was located. On the reverse of the chart, records of time of operation were satisfactory at 100% but only 81% recorded the date of the operation. It is important to remember that dates of pre-assessment and operation can be the same or different and no assumptions can be made.

Finally, records of name and designation of anaesthetising doctor were poor with 12% of signatures/printed names illegible and only 33% of grades recorded. It is for this reason that the Royal College of Anaesthetists recommends we should print our GMC number beside our name, to make identification for medico-legal purposes easier. This may initially seem like an unreasonable request but we found that 12% of anaesthetists cannot be identified on their own records by printed name or signature.

Summary

We are all responsible for good medical record keeping by law and by duty and this audit has highlighted a few simple areas where we can all improve, notably by clearly identifying ourselves on our own anaesthetic charts.

References

2. Medical Record Keeping (NHS Grampian). Dr. Abdullah Al Shukry, Dr Thirumalesha Desavenkatarayana and Clinical Effectiveness Team (Acute Sector), NHS Grampian. Aberdeen 2010