Clinical Audit on the Accuracy of Perioperative Record Keeping in a Teaching Hospital

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Introduction:
Accurate record keeping is a mandatory part of the perioperative care of the patient. Significant medico-legal and patient safety implications are associated with documentation failures.

Objectives:
- To evaluate preoperative documentation practice among anaesthetic staff in Beaumont Hospital
- To highlight areas for improvement

Method:
A standardised proforma was created to record the presence or absence of responses to sections of the anaesthetic preoperative assessment chart.
Patients were selected in the theatre recovery room, with the proforma completed following chart review.
150 charts were reviewed from 8th February to 10th March 2020.
SPSS version 27 was used for analysis.

Results:
136/150 patients underwent elective operations. No significant difference was found between documentation for elective and emergency operations.

Section of Preoperative Assessment Chart	Percentage Documented
Patient Addressogram	95.3%
Date	98.0%
Proposed Operation	97.3%
Anaesthetic History	91.3%
Postoperative Nausea/Vomiting	34.7%
Medical History	100.0%
Medications	92.7%
Allergies	98.7%
Systemic Review	44.0%
Investigations	69.3%
ASA Grade	91.3%
Dentition	68.7%
Mallampati Score	67.3%
Fasting Status	63.3%
Smoker	66.0%
Weight	67.3%
BMI	17.3%
Plan of Anaesthesia	88.0%
Admission Route	62.7%
Postoperative Plan	77.3%
Risks and Alternatives Discussed	27.3%
Name and Signature of Anaesthetist	94.0%
IMC Number	91.3%

Table 1: The percentage of responses to sections of the Anaesthetic Preoperative Assessment Chart

Evaluation:
No preoperative assessment chart was found fully completed.
There is a severe lack of documentation surrounding discussion of risks and alternatives.
Sections with poorly completed documentation correlate to factors that can have significant impact on perioperative medical care.

Discussion:
Failure to identify factors impacting upon patient outcomes (e.g. PONV, BMI) can increase the risk of adverse events in the perioperative period.
There is a need to emphasise the importance of preoperative assessment and the documentation of same among anaesthetic staff.
Paper based records have limitations which can encourage poor documentation. Implementation of electronic-based records has the potential to improve record keeping.

References:
1. American Society of Anesthesiologists (2018) Statement on Documentation of Anesthesia Care
2. Woldegerima, Y. Semira, K. (2019) 'Clinical audit on the practice of documentation at preanesthetic evaluation in a specialized university hospital', International Journal of Surgery Open, 16(1), pp. 1-5.