AB216. 75. Clinical audit: peri-operative blood loss recording

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Background: The aim was to assess the consistency of peri operative blood loss recording in the surgical anaesthetic and peri operative nursing report charts. The standard to which this audit was measured is Joint Commission International (JCI) standard ASC.7.2.

Methods: A retrospective audit of 60 surgical charts was conducted. Surgical procedures included were hysterectomy (abdominal/vaginal/laparoscopic), thyroidectomy (total/left/right), total hip replacement (left/right), anterior resection (laparoscopic), radical prostatectomy and hemi colectomy (total/lap/right). Data was collected from the patients' charts using an audit tool developed in Sphinx software.

Results: Overall, peri-operative blood loss was recorded in 37% of the audited surgical anaesthetic charts and 90% of the peri operative nursing records. Additional information regarding the blood loss e.g., exact mL loss extracted from swab use or other, was reported in 58% (35/60) of audited charts. Blood loss was not recorded in the surgical anaesthetic chart for any of the hemicolectomy (n=5) or thyroidectomy (n=13) procedures. Importantly, 10% (6/60) of patient charts did not have blood loss recorded in either the surgical anaesthetic or peri-operative nursing chart. Of those 1/6 patients had a significant reduction in haemoglobin (defined as Hb<9 g/dL) in the post-operative phase and an unexpected complication following a hemicolectomy.

Conclusions: Peri-operative blood loss is not consistently documented in the surgical anaesthetic chart (37%) but is relatively well documented in the peri operative nursing record (90%). The importance of recording peri-operative blood loss and communication between medical/surgical/nursing teams needs to be reiterated.

Keywords: Audit; blood loss

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