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Anaesthetic record quality in fractured neck of femur surgery at Midlands Regional Hospital Tullamore

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Background: Clinical record keeping is a core element of good professional practice, delivery of quality patient care and is a central interdisciplinary communication tool. Good standards in anaesthetic records allow efficient communication between anaesthetist and their immediate team as well as the extended clinical staff. Furthermore, it enhances communication with patients and ensures continuity of care. This continuity is important as more than one anaesthetist may be involved in a patient's care and accurate and up to date records aid potential future decisions. Primarily a medical record, the anaesthetic record has many roles; as a patient-safety tool, a medico-legal document and a quality assurance aid.

Methods: We reviewed the anaesthetic records for all fractured neck of femur (NOF) surgeries carried out between January 1st and March 31st 2019. In total, 38 anaesthetic record forms (ARFs) were included. This record consists of a handwritten two-sided A4 page which encompasses the pre-operative assessment, intra-operative management (drugs, vitals and techniques) and post-operative plan. The quality of the record technique was assessed by determining how much of the form was completed and to what degree of detail.

Results: ASA grade was present of 90% of ARFs. Eighty-two percent of ARFs included a list of patient medications. Seventy-six percent included if the patient had a previous anaesthetic or not. Seventy-six percent documented smoking status. All ARFs documented the type of anaesthesia used. Forty-five percent had a record of recent

U&Es, 79% documented recent Hb. Thirty-two percent of spinal anaesthesia records did not comment on the number of attempts for spinal anaesthesia. Re spinal anaesthesia; 50% recorded no issues, 11% commented on issues.

Conclusions: This review highlights that despite a standardised ARF, these forms can vary considerably from case to case with regard to what information is documented on them. Overall, the majority of fields were completed on all forms. Nonetheless, there is clear evidence of omission of information. In an era where there is increasing emphasis on documentation of information, compliance with the anaesthetic record form will benefit both professional communication and patient safety standards.

Keywords: Anaesthetic record keeping; documentation; safety; communication

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Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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