Audit of Anaesthetic Record Keeping for Caesarean Sections at Heart of England NHS Trust

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Not only is an accurate, complete record useful for continuing care, but also medico-legal enquiry following obstetric anaesthesia is more common than for other anaesthetics.

This audit focussed on documentation of:

Explanation of anaesthetic risks, implying informed consent.
Regional block testing,
Recovery period.

Standards – based on OAA/AAGBI guidelines, 2005, and RCA Audit Recipe book, 2005.

100% should have:

- main complications explained
- complete Recovery record for at least 30 minutes.

100% Regional techniques should have documented:

- touch sensation testing
- block height of T5 or above
- patient's comfort

Methods:

Relevant data were collected from the Anaesthetic/Recovery records of 88 women over a 2-month period.

Main Results:

Documentation of explanations:

- Post-dural puncture headache and neurological damage 88%
- Conversion to general anaesthesia 60%
- Nausea and vomiting* 69%
- Pain* 27%
- No record of any complications being explained* 9%

(*Regional & General anaesthesia)

Regional block recording:

- 12% had no block height recorded or block below T5
- 81% had no touch testing documented
- 63% had no documentation of their comfort or discomfort.

Recovery: 23% had recordings for less than 30 minutes.

Main Conclusions:

- Documentation of explanation of anaesthetic complications was inadequate.
- Documentation of block testing and patient comfort was unsatisfactory.

Action Plan:

- Training emphasis on informed consent and testing regional blocks.
- Introduction of pre-printed stickers of complications to discuss and attach to charts.
- Information leaflets to be given at ante-natal appointments.