Improving the Quality of the Documentation of Anaesthesia Consent – Is Cerner the answer?

Dr J Khera, Dr I Barker
Charing Cross Hospital, Imperial College Healthcare NHS Trust

Introduction

- The 2017 AAGBI Consent for Anaesthesia Guidance states that "Anaesthetists should record details of the elements of a discussion in the patient record, noting the risks, benefits and alternatives (including no treatment) that were explained." The importance of this stems from changes in ethical and legal frameworks with new case law and an increased emphasis on patient-centered care.[1,2]
- Our audit in January 2018 found poor documentation of consent for anaesthesia with only 35% of charts having a documented plan.

Objectives

- To improve the quality of anaesthetic consent documentation with an electronic anaesthetic record.

Methods

- Retrospective audit of patients who underwent surgery between 15th-19th July 2019.
- Analysis of the Cerner electronic records.

Results

- 76 patient records assessed. 15 patients excluded due to no electronic Cerner record (n = 61).
- Anaesthetic plan documented in 100% of Cerner records, compared to 35% pre-Cerner.
- Comparing documentation on post-Cerner records to pre: alternative plan 33% vs 8%, common General Anaesthetic (GA) side effects 80% records vs 32%, serious risks or opportunity to discuss with patient 33% vs 14%, risks of invasive monitoring 80% vs 50%, risks of Regional Anaesthesia (RA) 70% vs 33% and risks of combined GA + RA 67% vs 17%. (Figure 1)
- However, specific risks for RA were better documented using Cerner such as failure (60% vs 0%); post dural puncture headache (50% vs 0%) and backache (60% vs 0%).(Figure 2)

Conclusion

- The introduction of the electronic Cerner record has improved the documentation of anaesthetic consent particularly in: documentation of anaesthetic plans; alternatives; serious risks and opportunities of them being discussed; as well as risks associated specifically with invasive monitoring, RA and combined GA + RA.
- However, further work is needed to improve documentation of anaesthetic consent – this may be implemented with pre-formed checklists on the electronic record.

References

1. Yentis S, Hartle A. AAGBI: Consent for Anaesthesia 2017. Association of Anaesthetists of Great Britain and Ireland. Anaesthesia, 2017, 72, 93–105.
2. General Medical Council. Consent: patients and doctors making decisions together. London: GMC, 2008. http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_contents.asp (accessed 2/08/2019).

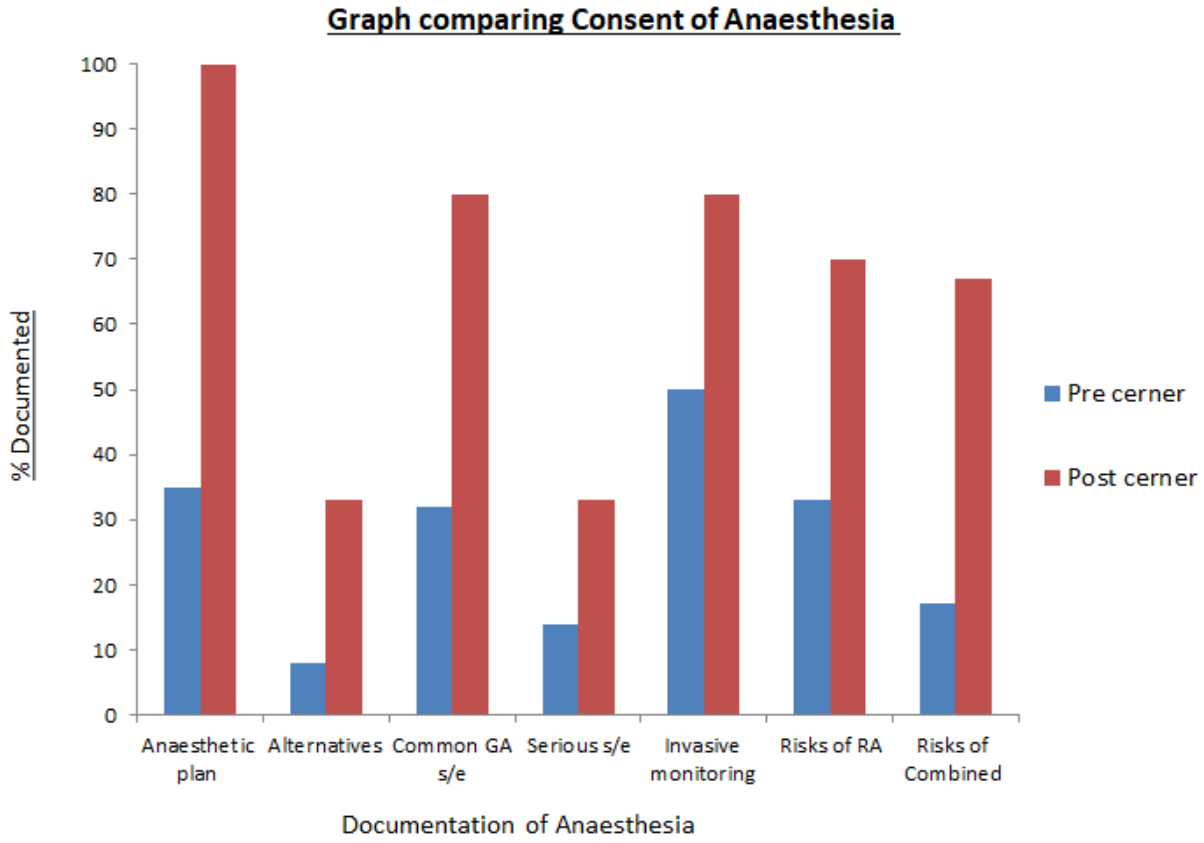


Figure 1: The documentation of consent of Anaesthesia. Comparing the pre-electronic record (pre-Cerner) to the electronic (post-Cerner) records. RA = Regional anaesthesia s/e= side effects

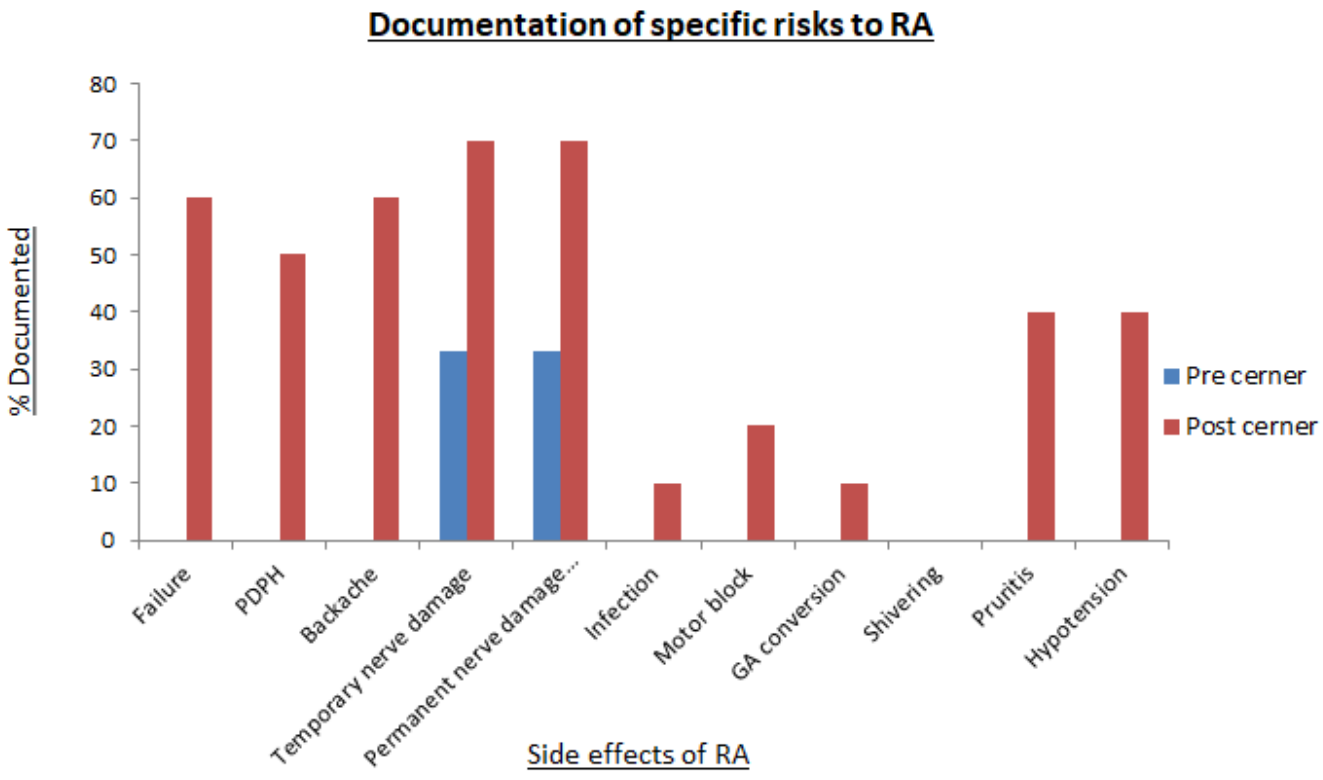


Figure 2 Documentation of specific Regional Anaesthesia (RA) risks comparing pre-electronic records (pre-Cerner) to electronic (post-Cerner) records.