

Audit on Consent to Anaesthesia

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Citation

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Abstract

Objective: To ensure a uniform approach to the taking of consent in line with Trust Policy and make recommendations to improve consenting for anaesthesia. **Method:** A list of all procedures who had an anaesthetic during one month was obtained. 50 cases were randomly selected from this list. Anaesthetic charts were assessed for consenting details. **Results :** Verbal consent to anaesthesia was documented in 74%. Written consent to anaesthesia for high risk patients was documented in 100%. Details of anaesthetic consent like anaesthetic techniques and risks were documented in 26% of anaesthetic records. **Conclusion:** The audit revealed incomplete documentation of anaesthetic consent in the anaesthetic records. The reasons were discussed and recommendations were suggested to improve or modify anaesthetic records and increase education and awareness among anaesthetists regarding documentation of risks and techniques.

INTRODUCTION

Patient has a fundamental right to know what he is undergoing and it is the duty of the anaesthetist taking care of the patient to provide the necessary information and seek an informed consent.

The Association of Anaesthetists of Great Britain and Ireland's 'Information and Consent to Anaesthesia' clearly explains the legal, professional and ethical responsibilities of the anaesthetist in providing information and obtaining consent.

It is highly recommended to document the details of discussion between the patient and the anaesthetist. Documentation is an important feature of risk management in order to defend against claims of clinical negligence².

Previous audits of consent have been undertaken in other medical disciplines but these did not address anaesthetic consent in any detail. As a result, the action plan from the last audit of consent stressed the need for a separate audit of anaesthetic consent to be undertaken.

METHOD

STANDARDS

The standards selected were from the trust policy and they were:

1. 100% of patients should give either verbal or written consent to anaesthesia.

2. Written consent should be obtained in 100% of cases where anaesthesia represents a significant risk to the patient.

3. Where verbal consent is given, details of the discussion with and agreement of the patient (including details of the anaesthetic techniques, risks involved etc.) should be documented in the anaesthetic record.

A list of all procedures during one month was obtained from information services and all procedures known to be performed without anaesthetic or using only local anaesthetic were removed. A sample was obtained by randomly selecting 50 cases from the list using a random number generator. Any cases that did not meet the inclusion criteria when reviewed were replaced with another randomly selected set of case notes.

Data was collected and analysed with the assistance of the audit department.

RESULTS

Figure 1

Standard 1	Achieved
100% of patients should give either verbal or written consent to anaesthesia	74% (37/50)

A Trust 'Consent to Anaesthesia' form was found in only one case but verbal consent was documented on the anaesthetic record in a further 35 cases. In 1 case, there was documentation on the anaesthetic record, which confirmed that the patient was unable to consent. These cases all met

standard one.

In 13 cases no evidence was found to suggest that the patient had consented to anaesthesia.

Figure 2

Standard 2	Achieved
Written consent should be obtained in 100% of cases where anaesthesia represents a significant risk to the patient	100% (1/1)

A significant anaesthetic risk was identified in only one case and this patient gave written consent to anaesthesia.

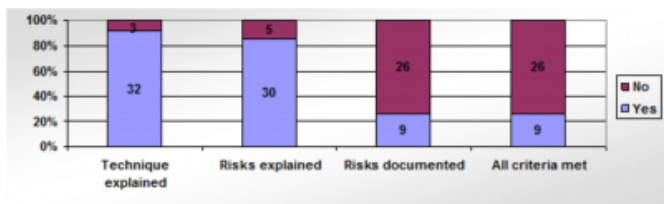
Figure 3

Standard 3	Achieved
Where verbal consent is given, details of the discussion with and agreement of the patient (including details of the anaesthetic techniques, risks involved etc.) should be documented in the anaesthetic record	26% (9/35)

The criterion regarding details of the anaesthetic technique was met if the checkbox ‘Technique explained’ on the anaesthetic record was ticked or if there were written details regarding anaesthetic technique in any notes made by the anaesthetist. Similarly for risks explained, there is a checkbox. The criterion regarding documentation of risks however, was only met if the risks of anaesthesia were listed in the anaesthetic notes/on the anaesthetic record

The chart below shows the proportion of the 35 patients who gave verbal consent, in which each criterion was met. The last column of the chart shows the percentage of cases in which all 3 criteria were met.

Figure 4



ADDITIONAL INFORMATION OBTAINED FROM THE AUDIT

DOCUMENTATION OF TYPE OF ANAESTHESIA

The intended type of anaesthesia was documented in 54% (27/50) of cases.

Figure 5

Type of Anaesthesia	No. of cases
General	40
Spinal	6
Regional	3
Local	1
Total	50

Of the 13 cases where there was no evidence of consent to anaesthesia, 8 were given General Anaesthesia, 3 were given Regional Anaesthesia, 1 was given Spinal Anaesthesia and 1 was given Local Anaesthesia.

GRADE OF ANAESTHETIST

Figure 6

Grade of Anaesthetist	No. of cases
Consultant	5
Middle Grade	10
Specialist Registrar	8
Trust Grade / SHO	25
Unknown	2
Total	50

Of the 13 cases where there was no evidence of consent to anaesthesia, 2 were assessed by consultants, 2 by specialist registrars and 8 by senior house officers. In one case the anaesthetist had not signed the anaesthetic record.

DOCUMENTATION OF PROCEDURE

The intended procedure was documented on the anaesthetic record in 84% (42/50) of cases.

Figure 7

Speciality	No. of cases
General Surgery	16
Orthopaedics	15
Obs & Gynae	9
ENT	7
Ophthalmology	2
Orthodontics	1
Total	50

Of the 13 cases where there was no evidence of consent to anaesthesia, 5 were Obs & Gynae procedures, 4 were General Surgery procedures and 4 were Orthopaedics procedures.

ASA GRADE

Figure 8

ASA Grade	No. of cases
1	26
2	8
3	4
1E	4
Unknown	8
Total	50

Of the 13 cases where there was no evidence of consent to anaesthesia, 7 were ASA 1, 1 was ASA 2, 1 was ASA 3, 2 were ASA 1E and there was no ASA grade in 2 cases.

DISCUSSION

Under common law, patient has the right to give or withhold consent (except in special circumstances) and failure to recognize this right amounts to negligence.

Verbal consent for anaesthesia is acceptable and a formal written consent for anaesthesia and anaesthetic related procedures is not necessary¹³.

The guidelines, produced by a working party of the Association of Anaesthetists of Great Britain and Ireland(AAGBI) has emphasized that written and patient signed consent for anaesthesia should not be a formal requirement¹.

Primary therapeutic interventional procedures may need a signed consent in accordance with local policies¹.

There is no acceptable place or time to provide information to the patients and there are no acceptable standards or guidelines regarding the amount and nature of information to be provided to the patients, however relevant and reasonable information which can help the patient to come to a decision should be given²⁴.

There is no uniform opinion regarding obtaining and documenting consent and can vary between different hospitals and between different anaesthetists in the same hospital.

Surveys have shown that to comply with the CNST requirements and ensure a uniform approach was being followed some of the departments had their own local guidelines and separate trust consent forms⁵. Studies have shown that use of formatted pre-printed standardized records improved the quality of documentation⁶⁷.

In the world of ever increasing cases of litigation it is essential to ensure that consent is recorded properly in the notes and especially for procedures which carry significant risks.

Accurate and clear documentation is not only good medical practice but would also create an impression of professional competence. Proper documentation of the conversation between the anaesthetist and the patient will help to protect the anaesthetist from later disputes, legal complications and would prove invaluable in defending claim of negligence.

CONCLUSIONS

The audit has shown incomplete documentation of anaesthetic consent.

Action plan to improve documentation of consent in anaesthetic records included:

Modifying the anaesthetic record by adding tick boxes and using ink stamps/preprinted stickers.

Increasing education and awareness among the anaesthetists.

Use of trust consent form in high risk patients and consenting patients in preassessment clinics.

RECOMMENDATIONS

Doing a re-audit to monitor continuing compliance with standards and to assess whether implementation of the action plan has improved practice.

ACKNOWLEDGEMENT

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