IMPROVING ANAESTHETIC DOCUMENTATION OF NON-THEATRE CASES

CREATION OF A PAEDIATRIC EMERGENCY DEPARTMENT ANAESTHETIC CHART

01. BACKGROUND/CONTEXT

Introduction of a paediatric emergency department (PED) anaesthetic chart for use when a patient requires invasive anaesthetic management in the Paediatric Emergency Department in Royal Manchester Children's Hospital (RMCH).

02. THE PROBLEM

A retrospective notes review was performed to assess the adequacy of documentation following anaesthetic intervention in the paediatric emergency department. 18 patients' notes were reviewed with an average age of 5 years old. Following this there was a clear need to improve the documentation of PED anaesthetic interventions and a method of finding this information quickly within case notes.

- ✗ NO DOCUMENTATION OF ASSESSMENT
- ✗ LACK OF AIRWAY DETAIL
- ✗ TIMELINE DIFFICULT TO TRACE
- ✗ HARD TO FIND RETROSPECTIVELY
- ✗ LARGE VARIATION
- ✗ UNDOCUMENTED HANDOVER

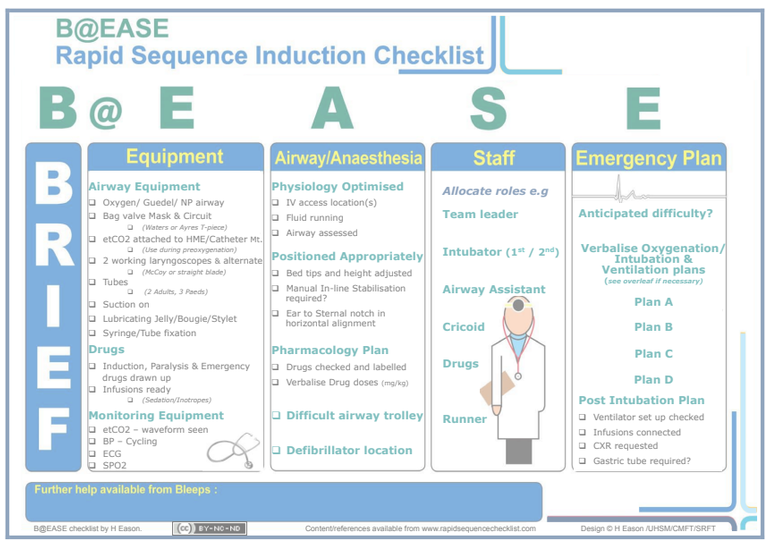
03. STRATEGY FOR CHANGE

To address this problem the RMCH anaesthetic chart was modified. It was decided to do this as RMCH anaesthetists are familiar with the chart and additional data such as patient observations pre, during and post induction can be recorded. It has also been demonstrated that to improve documentation of non-theatre intubations a specially designed form such as altered anaesthetic chart for pre-operative use is required [1] [2]. Another advantage of using a modified anaesthetic chart is to improve its detectability within notes. The original RMCH anaesthetic chart has a thick red line along the vertical edge, this was altered to interrupted red stripes to make it different from a normal anaesthetic chart but still easily identifiable within notes.

The PED anaesthetic chart is a two-sided document (see images below). The first page includes past medical and anaesthetic history, airway assessment, intubation details, airway complications and their management and the following information relevant to emergency cases;

- Times of patient arrival, anaesthetic team informed and being present
- Indication for intubation
- C-spine immobilisation
- B@EASE checklist
- Anaesthetic staff present including their role
- Monitoring used
- Line insertion

The second page documents drugs including infusions with corresponding observations, complications, key points for handover and if a post intubation chest X-ray has been performed.



Royal Manchester Children's Hospital
Emergency Intubation Anaesthetic Record

FIRST NAME	**DOB/AGE**
SURNAME	**WEIGHT (Estimate)**
HOSPITAL NUMBER	**WEIGHT (Actual)**

LOCATION	**DATE**	**TIME** Pt Arrival **TIME** Anaes Attended

Anaesthetic Assessment: **TIME Assessed**:

HR BP RR SpO_2 Temp Hb Pupils	Last Ate BM PMSH Previous GA?	Significant drug therapy **Allergies**

Airway Assessment

C-spine immobilised? Y/N

Indication for Intubation

Responsible Anaesthetic Consultant: ..... Informed? ☐

Anaesthetic Management and Events: **TIME Anaesthestised**:

Anaesthetic Staff Present: ..... Role: .....
..... Role: .....
..... Role: .....

B@EASE Checklist Used ☐

Airway
Operator..... Grade.....
Easy BMV Y/N Guedel Y/N
Intubation Attempts .....
Cricoid pressures Y/N
Laryngoscopy grade.....
Laryngoscope blade.....
Video Laryngoscopy Y / N
ETT Type.....Size.....
Oral/Nasal.....cm@lips/nare
Cuffed ☐ Uncuffed ☐
Cuff P check ☐ Equal AE ☐
Ventilator.....
Vent settings.....

Line Insertion: US guided ☐ Aseptic Technique ☐

Monitoring: ECG ☐ NIBP ☐ Sats/O2 ☐ ETCO2 ☐ Temp ☐ Art Line ☐ CVP ☐ Other .....

Name	DOB	Hospital number

Time

200
150
100
50
0

SpO_2
CO_2
FIO_2
Peak P / PEEP
Temperature

Fluid Balance
In

Out Urine
Blood
NG

Events Under Anaesthesia/ Complications

Key Points for Handover

Post Intubation CXR ☐

Signed..... GMC No..... Bleep.....
Print..... Time documented.....

04. LESSONS LEARNT

The PED anaesthetic chart is included in trauma packs placed in every resus bay in PED for ease of use. Previous documentation of emergency paediatric department anaesthetic intubations has been varied with information either not recorded or misplaced within case notes. This prompted the creation of the PED anaesthetic chart to improve documentation and standardisation of anaesthetic management of emergency department cases. Our message for others would be to consider modification of local trust's anaesthetic charts for non-theatre emergency cases to improve clinical documentation while under clinical and time pressures.

05. AUTHORS

- Dr Hilary Eason (Consultant Paediatric Anaesthetist)
- Dr Emilie Nicholls (ST7 Anaesthetist)
- Dr Marni Lechler (Clinical Fellow)

Royal Manchester Children's Hospital

REFERENCES

[1] Winton J, Celenza A, Jackson T. Improving documentation of endotracheal intubation in an adult emergency department. Emergency Medicine Australasia. 2008 Dec;20(6):488-93.
[2] Simmonds M, Petterson J. Anaesthetists' records of pre-operative assessment. British Journal of Clinical Governance. 2000 Mar 1.