

# Clinical Audit on the Practice of Documentation During Preanesthetic Evaluation

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## Abstract

Pre-anesthesia checkups play a crucial role in ensuring patient safety and positive outcomes during surgical procedures. These assessments are typically conducted before surgery to evaluate the patient's overall health, identify potential risks, and tailor anesthetic plans accordingly. The efficacy of pre-anesthesia checkups can be assessed based on several factors:

**Risk Identification:** Pre-anesthesia evaluations help identify pre-existing medical conditions, allergies, or other factors that could pose a risk during surgery.

Recognizing and addressing potential complications beforehand can contribute to better preparation and management during the perioperative period.

**Optimization of Patient Conditions:** Through pre-anesthesia assessments, healthcare providers can work to optimize a patient's medical condition before surgery, such as controlling blood pressure, managing diabetes, or addressing respiratory issues.

This optimization can contribute to a smoother anesthesia experience and faster recovery post-surgery.

**Tailored Anesthetic Plans:** Based on the information gathered during the pre-anesthesia checkup, anesthesiologists can develop individualized anesthetic plans that consider the patient's medical history, current health status, and the nature of the surgical procedure.

Tailoring the anesthesia approach helps in minimizing complications and adverse reactions.

**Informed Decision-Making:** The pre-anesthesia evaluation allows for informed decision-making by both the patient and the medical team.

Patients can be educated about the potential risks and benefits of anesthesia, and their concerns can be addressed before the procedure.

**Reduced Complication Rates:** By addressing potential issues proactively, pre-anesthesia checkups contribute to reducing the occurrence of complications during and after surgery.

This, in turn, can lead to improved patient outcomes and a lower likelihood of adverse events.

**Postoperative Recovery:** Adequate pre-anesthetic evaluation and optimization can positively impact the patient's recovery after surgery.

Patients who undergo thorough pre-anesthetic assessments are more likely to have a smoother recovery process with fewer complications.

**Efficient Resource Utilization:** Pre-anesthesia checkups help identify patients who may require additional monitoring, specialized equipment, or specific interventions during surgery.

This allows for efficient allocation of resources and personnel to address individual patient needs.

In conclusion, the efficacy of pre-anesthesia checkups on patient outcomes is well-established. These assessments contribute to safer surgical experiences, reduced complications, and improved overall outcomes by allowing for tailored, informed, and proactive care.

**Aim:** The primary aim of the audit was to check the efficacy of the pre anesthesia checkup whether it benefitted patient outcome.

**Materials and Methods:** This clinical audit was conducted in the Peerless Hospital and BK Roy research centre. Predefined 17 practice quality indicators were prepared according to modified global quality index.

**Statistical Analysis:** Descriptive statistics was performed using SPSS version 20.

## Introduction

Preanesthetic evaluation is a clinical base and framework for perioperative patient management. It potentially minimizes perioperative morbidity and mortality. The main goals of preanesthetic evaluation are to obtain vital information about the current and past medical history (PMH), settle assessments, stratify risks, essential clinical optimization, and prepare a plan of management before anesthesia and surgery. Documentation is an important part of medical practice. Good documentation may improve patient outcome and easy the transfer of information from one care provider to another. Documentation of preanesthetic evaluation and informed consent should present in the patient's chart. It is very important for both quality assurance and medico-legal purposes. Inadequate documentation and poor record-keeping are challenges for quality care and better patient outcome. The American Society of Anesthesiologists (ASA) ethical guidelines for the practice of anesthesiology stated that “anesthesiologists have ethical responsibilities to their patients and should provide a preoperative evaluation.” It also should include keeping readily accessible medical record. Completed and a well-written document is very important during perioperative management and safeguards in medico-legal courts. Inappropriate documentation has potential risk for medical malpractice liability. Real-time documentation at the end of service is recommended. However, this may not always be possible due to workload. Other factors that can affect documentation practice are a use of tools, practitioner interest, and availability of information.

## Materials and Methods

The audit is being performed to determine the quality of documentation in preanesthetic evaluation. It is being done in Peerless Hospital and B. k. Roy Research Centre, Kolkata, India. All in total there are one ophthalmology, three surgery, one cardiothoracic, one neurosurgery, one gynecology and two orthopedic theatres. All the cases posted are admitted either in the general wards or in the intensive care units. The Corresponding preanesthetic evaluations are done by 3 postgraduate trainees under the supervision of nine consultants. Approval was taken from the departmental head and the identity of all personnel are kept hidden.

To conduct this audit a total of 100 subjects were taken who came for both elective and emergency procedures. A checklist was developed by the investigators based on the indicators in the modified GQI. Twenty-two quality practice indicators were selected from the GQI and labeled as “Yes” for complete documentation or checked negative, “Illegible” for partial documentation and “No” if left blank. For each item, completeness was predefined by components of the item. PAETs used by the anesthetists at the university hospital were reviewed after corresponding anesthetists completed each preoperative assessment. Expected completion rate was 100% for all indicators. Indicators with >90% completion rate were marked as acceptable. Completion rate of <50% was considered as areas of critically need improvement.

**Table 1.**

name	
age	
sex	
Name of consultant	
Type of surgery	
Date of surgery	
History of past medical conditions	
Past surgical history	
medications	
allergies	
Asa status	
Plan of anesthesia	
Vital signs	
Airway and spine examination	
General examination	
consent	
Pre medication	

**Results**

A total of 100 patients were selected for the clinical audit. Among all these cases 74 were elective cases and 26 emergency cases. Of all these patients 61 patients were male and the remaining 39 were female patients posted for their corresponding operations. Below is the results based on the above indicators.

indicators	yes	no	Yes (elective)	No (elective)	Yes (emergency)	No (emergency)
Age	86	14	68	6	18	8
Sex	100	0	74	0	26	0
Name	98	2	73	1	25	1
Type of surgery	56	44	38	36	18	8
Per oral status	48	52	26	48	22	4
Allergy history	84	16	70	4	14	12
Past medication history	77	23	72	2	5	21
Past history of anesthesia	54	46	34	40	20	6
Name of anesthetist	13	87	8	66	5	21

After proper examination. Interpretation was that only 48 percent of the patients who were posted for any operation only knew about the nil per mouth status. 87 percent of the patients didn't even know the name of the consultant anesthetist who is going to give the anesthesia. Although 77 percent people knew about the past surgical history, only 54 percent of the people knew about the past history of what kind of anesthesia was given to them.

Proper documentation was done in all the cases and the concerned anesthetist was notified about the anticipated difficult airway, venous access and hemodynamics before any procedure. It was remarkably seen that in 92 percent of the cases no other management was required for the patient but among the remaining 8 cases, 3 patients had difficult unanticipated airway, 2 cases had difficult venous access and 3 patients had uncontrolled hemodynamics before any operation.

### Conclusion

In conclusion, comprehensive documentation of pre-anesthesia checkups is an integral component of perioperative care that significantly contributes to patient safety, effective communication among healthcare providers, and legal compliance. A well-documented pre-anesthesia assessment encompasses various aspects of the patient's medical history, physical condition, and proposed anesthesia plan, providing a detailed foundation for the entire surgical process. The key elements of documentation include patient demographics, thorough physical examination findings, airway and cardiovascular assessments, results of laboratory tests and diagnostic studies, medication review, allergy information, informed consent, anesthesia plan details, preoperative instructions, communication with the surgical team, emergency plans, and the signature and date of the responsible healthcare provider.

This documentation serves several critical purposes:

**Patient Safety:** It aids in identifying potential risks and optimizing the patient's health before surgery, contributing to safer anesthesia administration and overall positive outcomes.

**Communication:** Clear documentation fosters effective communication among members of the healthcare team, ensuring that everyone involved in the patient's care has access to crucial information.

**Continuity of Care:** Documented pre-anesthesia assessments provide a baseline for ongoing patient care, facilitating seamless transitions between preoperative, intraoperative, and postoperative phases.

**Legal Compliance:** Proper documentation meets legal and regulatory standards, serving as a legal record of the informed consent process, the anesthesia plan, and any specific instructions provided to the patient.

**Resource Allocation:** It helps in efficient resource allocation by providing insights into the patient's unique needs, enabling the allocation of appropriate personnel and equipment for the procedure.

In summary, the efficacy of pre-anesthesia checkup documentation lies in its role as a comprehensive record that guides and informs the anesthesia team throughout the surgical journey. By capturing relevant information and decisions, it supports safe and tailored anesthesia care, promoting positive patient outcomes and mitigating potential risks associated with the perioperative period.

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