HSC Business Services Organisation

Directorate of Legal Services

Practitioners in Law to the Health & Social Care Sector

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Your Ref:	Our Ref:	Date:
AD-0196-10	NSC B04/1	24 February 2011

Ms Anne Dillon
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to your letter dated 6th December 2010. (AD-0196-10).

I can advise that Dr Gibson is unwell and medically retired from the Trust and is considered unfit to be approached for her assistance. Consultant Paediatric Anaesthetists who were working in RBHSC in 1995 are not aware of any document entitled "Protocols for monitoring, anaesthetic set-up and drug administration" and believe Dr. Gibson will have been referring to her perception of clinical practise in RBHSC and not to any written document.

A copy of the "Anaesthetic Record Set – Suggestion as to a reasonable content" is enclosed as requested.

Yours faithfully

pp Nicola Doeher

Wendy Beggs
Assistant Chief Legal Adviser

Direct Line: [redacted]
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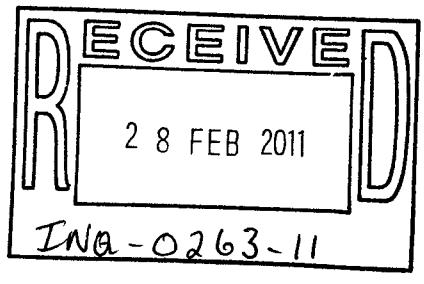

Anaesthetic Record Set

Suggestions as to a reasonable content

PRE-OPERATIVE INFORMATION

PATIENT IDENTITY
- Name / ID No. / gender
- Date of birth

ASSESSMENT & RISK FACTORS
- Date of assessment
- Assessor, where assessed
- Weight (kg), [height (m) optional]
- Basic vital signs (BP, HR)
- Medication, incl. contraceptive drugs
- Allergies
- Addiction (alcohol, tobacco, drugs)
- Previous GAs, family history
- Potential airway problems
- Prostheses, teeth, crowns
- Investigations
- Cardiorespiratory fitness
- Other problems
- ASA ± comment

URGENCY
- Scheduled - listed on a routine list
- Urgent - resuscitated, not on a routine list
- Emergency - not fully resuscitated

PEROPERATIVE INFORMATION

CHECKS
- Nil by mouth
- Consent
- Premedication, type and effect

PLACE & TIME
- Place
- Date, start and end times

PERSONNEL
- All anaesthetists named
- Operating surgeon
- Qualified assistant present
- Duty consultant informed

OPERATION PLANNED/ PERFORMED

APPARATUS
- Check performed, anaesthetic room, theatre

VITAL SIGNS RECORDING/CHARTING
- Monitors used and vital signs (specify)

DRUGS & FLUIDS
- Dose, concentration, volume
- Cannulation
- Injection site(s), time & route
- Warmer used
- Blood loss, urine output

AIRWAY & BREATHING SYSTEM
- Route, system used
- Ventilation: type and mode
- Airway type, size, cuff, shape
- Special procedures, humidifier, filter
- Throat pack
- Difficulty

REGIONAL ANAESTHESIA
- Consent
- Block performed
- Entry site
- Needle used, aid to location
- Catheter: y/n

PATIENT POSITION & ATTACHMENTS
- Thrombosis prophylaxis
- Temperature control
- Limb positions

POSTOPERATIVE INSTRUCTIONS

- Drugs, fluids and doses
- Analgesic techniques
- Special airway instructions, incl oxygen
- Monitoring

UNTOWARD EVENTS
- Abnormalities
- Critical incidents
  - Pre-op, per-op, postoperative
  - Context, cause, effect

HAZARD FLAGS
- Warnings for future care.

Commentary

BACKGROUND

This document is produced jointly by the Royal College of Anaesthetists, The Association of Anaesthetists of Great Britain & Ireland and the Society for Computing & Technology in Anaesthesia. Work has been going on for some years to standardise the data kept about anaesthetic episodes. This is worth striving for several reasons: not only would there be a welcome agreement about what requires to be written down, but terms such as 'Start time' would be defined, and therefore reports derived from the data would be comparable.

A meeting was set up by the Society for Computing and Technology in Anaesthesia (SCATA) at the Association of Anaesthetists of Great Britain & Ireland in 1990, attended by representatives from the Royal College of Anaesthetists, and some terms used in the dataset were defined. [1] The next move was to define the content of the anaesthetic record. All concerned recognised that there is no ideal content - that what is appropriate for cardiac anaesthesia or a manipulation of a wrist are totally different, and the appropriate content must increase with the complexity of the anaesthetic. We therefore agreed to list the fields that could be included, and will later deal with the issues of what should be added. It was also fully recognised that datasets and content are continually changing; we expect that as thinking and requirements change, we will need to reissue this guidance at reasonable intervals. We also recognise that several of these definitions are contentious, and fully anticipate further serious discussion.

We have *not* attempted to design a form, but rather to show what information might be presented.

COMMENTS ON PARTICULAR FIELDS

Many items will be present 'by association' - in other words, already present in the patient's notes, and making it pointless to rewrite them. This does not diminish the need for key items of anaesthetic relevance to be copied on occasion - to emphasise that the anaesthetist was aware of them, but defining precisely which these are is not sensible.

URGENCY

This is a long debated issue, probably the most contentious in the whole set. The problem is that CEPOD uses a four division classification, *Elective*, *Scheduled*, *Urgent* and *Emergency*, and the difference between Elective and Scheduled is a purely surgical one not discernible by the anaesthetist. The CEPOD definitions were used in the dataset published in 1994.

Elective - Operation at time to suit both patient and surgeon.

Scheduled - An early operation but not immediately life-saving. Operation usually within 1-3 weeks.

Urgent - Delayed operation as soon as possible after resuscitation. Operation usually within 24 hours.

Emergency - Immediate operation, resuscitation simultaneous with surgical treatment. Operation usually within one hour.

Because of the difficulties with this classification, the 'Classes' of listed and unlisted were introduced.

Listed - An operation published on a scheduled list

Unlisted - Not published on a scheduled list

We are now recommending that these two classifications are amalgamated to make a more anaesthetically realistic classification that reflects daily life.

Scheduled - listed on a routine list
Urgent - not on a routine list, but fully resuscitated
Emergency - not fully resuscitated

PATIENT POSITION & ATTACHMENTS

The way in which a patient was lying during anaesthesia should be recorded, including the position of the limbs and any special precautions taken against injury.

UNTOWARD EVENTS

There is a whole series of terms developing in this field - critical incidents, complications, abnormalities, negative outcomes, recovery room impact events, and more. Thinking in this field is changing sufficiently rapidly so being dogmatic about which terms to use is not sensible.

In general terms, the need is to record events so that anaesthesia may be safer in the future; to record, therefore, not only things that went wrong (complications), but also that nearly went wrong (critical incidents). We should also record 'abnormalities' such as a difficult intubation, which are not preventable, both for the patient's future safety, and for educational reasons. The severity of the incident should also be recorded.

HAZARD FLAGS

Any important abnormalities (drug sensitivities, errors of metabolism etc.) affecting the patient clearly should be flagged both on the record and in the notes.

Reference

1. Lack, J.A., Stuart-Taylor, M.E., and Tecklenburg, A. An anaesthetic minimum dataset and report format. The Society for Computing and Technology in Anaesthesia (SCATA), The European Society for Computing and Technology in Anaesthesia (ESCTAIC). *British Journal of Anaesthesia* 1994; **73**(2): 256-260.

Further copies may be obtained from
Professional Standards Directorate
Royal College of Anaesthetists
Tel: 0171-813 1900

APRIL 1996

AS - INQ

305-013-601

A revised anaesthetic record set

Professor A P Adams, Chairman, Record Working Party

In 1990 following a meeting organised by the Society for Computing and Technology in Anaesthesia (SCATA) attended by a representative of the College and the Association, a set of terms of use for anaesthetic records was defined[1]. Further meetings held with representatives from the college, AAGBI and SCATA defined the content for an anaesthetic record. Whilst no record is ideal - what is needed for cardiac surgery may well differ greatly from that needed for a simple manipulation under anaesthesia - there is a need for a starting set. The list is a start. The Working Party recognises that changes will be needed with time and intends to reissue the guide at reasonable intervals. It did not attempt to design a form but aimed to show what information might be presented. The set has been discussed and approved by the Council of the College.

Some of the items in the lists will already be present in the patient's notes and it may appear pointless to rewrite them. But several items of key information should appear on the anaesthetic chart. Four points are worthy of special note:

Urgency

There is a problem in that CEPOD uses a four-division classification - Elective, Scheduled, Urgent and Emergency. The distinction between the first two classes is purely surgical. A second classification uses: Listed and Unlisted. The Working Party proposes a more anaesthetically related classification:

- *Scheduled* - a patient listed on routine list.
- *Urgent* - a patient not on a routine list but fully resuscitated.
- *Emergency* - a patient not fully resuscitated.

Patient position and attachments

The record should note the position of the patient and the limbs together with any special precautions taken against injury.

Untoward events

There are many terms such as critical incidents, complications and negative outcomes which describe events during the perioperative period. Thinking in this field is still developing. The aim should be to make anaesthesia safer in the future by recording events where things went wrong (complications) and where they nearly did (critical incidents). Abnormalities such as difficult intubations need to be recorded.

Hazard flags

Any important abnormality such as a drug sensitivity or an error of metabolism which affects the patient should be flagged both on the anaesthetic record and in the notes.

Reference

1 Lack JA, Stuart-Taylor M, Tecklenburg A. SCATA and ESCTAIC. An anaesthetic minimum data set and report format. British Journal of Anaesthesia 1994;73:256–260.

Suggestions as to a reasonable content

The record set can be divided into groups:

PRE-OPERATIVE INFORMATION

Patient Identity

Name/Identity Number/Gender

Assessment and Risk Factors

Date of Assessment
Assessor and where assessed
Weight (kg), [height (m) optional]
Basic vital signs (BP and Heart Rate)
Medication including contraceptive drugs
Allergies
Addiction (tobacco, alcohol, drugs)
Previous general anaesthetics
Family history
Potential airway problems
Prostheses, teeth, crowns
Investigations
Cardiorespiratory fitness
Other problems
ASA status ± comment

Urgency

Scheduled – listed on a routine list
Urgent – resuscitated, not on routine list
Emergency – not fully resuscitated

PER-OPERATIVE INFORMATION

Checks

Nil by mouth
Consent to operation
Premedication, type and effect

Place and Time

Place
Date of operation
Time started and finished

Personnel

All anaesthetists named
Qualified assistant present
Operating surgeon
Duty consultant informed

Operation planned/performed

Apparatus

Checks performed, anaesthetic room and theatre

Vital Signs Recording/Charting

Monitoring used and vital signs (specify)

Drugs and Fluids

Doses, concentrations and volume
Cannulation
Injection site(s), time and route
Warmer used
Blood loss, urine output

Airway and Breathing System

Route, system used
Ventilation: type and mode
Airway type, size, cuff and shape
Special procedures, humidifier, filter
Throat pack
Difficulty

Regional anaesthesia

Consent
Block performed
Entry site
Needle used, aid to location
Catheter: yes/no

Patient Position and Attachments

Thrombosis prophylaxis
Temperature control
Limb positions

POSTOPERATIVE INSTRUCTIONS

Drugs, fluids and doses
Analgesic techniques
Special airway instructions
Oxygen therapy
Monitoring

UNTOWARD EVENTS

Abnormalities
Critical Incidents
Pre-, per- or post-operative
Context, cause and effect

HAZARD FLAGS

Warnings for future care