A SINGLE-SHEET COMBINED ANAESTHETIC RECORD AND CONSENT FORM

BY

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HISTORY

In 1932 Tovell and Dunn described the use of anaesthetic records at the Mayo Clinic. The method employed was based on the Hollerith punch-card for use with a sorting and tabulating machine. This punch-card system gained wide popularity in the United States and was adopted by the American Society of Anesthetists in 1937 (Saklad, 1940). In the same year Nosworthy complained that the practice of keeping routine anaesthetic records had received little attention in this country (Nosworthy, 1937). He listed the following advantages of keeping anaesthetic records:

1. Statistical.
2. Any significant pre-operative findings can be seen at a glance before induction, together with records of any previous anaesthetics.
3. The periodic recording of pulse rate, blood pressure and other parameters encourages closer observation of the patient during the operation.
4. A chart of parameters aids quicker appreciation of the patient's condition and earlier opportunity to correct an undesirable state.
5. It allows a quicker assessment of the patient's state and behaviour if a more experienced anaesthetist is called, or the anaesthetists change during an operation.
6. The record can be used as a teaching aid.
7. The surgeon may realize the effects of his techniques or the posture of the patient and the knowledge may lead to modifications which improve postoperative results.
8. Information on the anaesthetic record supplied to the recovery ward allows greater continuity of treatment in the immediate postoperative period.
9. The record is readily available should it be needed for medico-legal purposes.

Punch-card systems involve the use of a codebook and sorting machine. Completion of the form is a lengthy and complicated procedure. To overcome these disadvantages Nosworthy introduced his card system in 1943 (Nosworthy, 1943). Cards are clipped by hand and can be sorted with a knitting-needle.

Another method is the Cardiff anaesthetic record system (Mushin et al., 1954). This is a four-page, self-coding record from which data are transferred to a Hollerith punch-card by hand. Mechanical sorting and tabulation are carried out yearly.

The use of any record system for statistical purposes thus entails the completion of a complex form and the involvement of statistical and clerical staff. The advantages to be gained from such a system fully justify its use whenever possible, but in the day-to-day work of many anaesthetic departments information retrieval and statistical analysis are not important objectives. In such cases a simple, quickly completed form is to be preferred, provided it retains the other advantages listed by Nosworthy.

A record of this type has been used at the Royal Marsden Hospital for the past year.

DESCRIPTION

The record is a single sheet of paper of the same size as the case notes and salmon-pink in colour for easy identification. A consent form is printed on the back.

The front is divided into boxes. At the top is a blank space for an Elliot Automation Addressall slip containing the patient's full name, age, date of birth and hospital number. Beneath this are recorded the date, a brief description of the operation, the names of the anaesthetist and surgeon, and details of the patient's pre-operative condition and premedication. “Relevant disease or abnormality” includes other diseases (e.g. hypertension, diabetes), relevant anatomical abnormalities, biochemical disturbances, e.g. changes, abnormal reactions to previous anaesthetics and possibly an
The Royal Marsden Hospital

Anaesthetic Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Operation</th>
<th>Began</th>
<th>Ended</th>
<th>Patient's Weight</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Anaesthetist</th>
<th>Surgeon</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Drugs:</th>
<th>Premedication</th>
<th>Relevant Disease or Abnormality</th>
<th>Haemoglobin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Given:</td>
<td>Route:</td>
<td>Effect:</td>
<td>Blood Pressure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relevant Drug Therapy</th>
<th>Drug Sensitivity</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Intravenous Fluids</th>
<th>Condition on Leaving Theatre</th>
<th>Post-op. Instructions to Ward</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Anaesthetic Technique</th>
<th>Operating Conditions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>24-Hour Post-Operative Nursing Report</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Uneventful Recovery</th>
<th>Pallor</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restless Recovery</td>
<td>Nausea</td>
<td></td>
</tr>
<tr>
<td>Tremor</td>
<td>Vomiting</td>
<td></td>
</tr>
<tr>
<td>Cyanosis</td>
<td>Hypotension</td>
<td></td>
</tr>
<tr>
<td>Respiratory Obstruction</td>
<td>Patient's Complaints</td>
<td></td>
</tr>
</tbody>
</table>

Fig. 1
Anaesthetic record: front.
THE ROYAL MARSDEN HOSPITAL
Consent to operation - Hospital and Amenity Bad patients
To: The Board of Governors and Medical Staff of the Royal Marsden Hospital.

A

I, ___________, hereby consent to undergo the operation of ___________, the effect and nature of which has been explained to me.

I also consent to such further or alternative operative measures as may be found necessary during the course of such operation, and to the administration of a local, general, or other anaesthetic for any of the foregoing purposes.

I understand that no assurance has been given that the operation will be performed by a particular surgeon.

Signed:
Dated:

B

(To be obtained only if specifically required by the Surgeon)

I, ___________, hereby also consent to such operation, the nature and effect of which has been explained to me.

Signed:
Dated:

C

I, ___________, hereby consent to the submission of my child to the operation of

the effect and nature of which has been explained to me.

I also consent to such further or alternative operative measures as may be found necessary during the course of such operation, and to the administration of a local, general, or other anaesthetic for any of the foregoing purposes.

I understand that no assurance has been given that the operation will be performed by a particular surgeon.

Signed:
Dated:

Section 3 and 4.

FORM No.: R.465/6.

FIG. 2
Anaesthetic record: reverse side.
indication of the patient's general condition. Under “Relevant drug therapy” are recorded details of drugs the patient is receiving and which are of importance to the anaesthetist.

Much of this section is completed by the anaesthetist pre-operatively. Details of premedication are recorded by the nursing staff and the effects recorded by the anaesthetist when the patient arrives in the anaesthetic room.

The middle section contains a chart similar to that on the Nosworthy card. Details of the anaesthetic technique and course and a brief indication of operating conditions are recorded here.

The boxes below this contain information for those involved in the immediate postoperative care of the patient—level of consciousness, blood pressure, etc., and a space for instructions to the recovery ward.

The 24-hour postoperative nursing report is based on that of Middleton (1958). The nursing staff complete this section with ticks and record the patient's complaints and other relevant information not included in the headings.

On the reverse side are alternative consent forms for the patient, relative or parent respectively.

USE OF THE FORM

Every patient attending the Royal Marsden Hospital has a combined anaesthetic record and consent form included in his case notes. Each ward has a further supply should more than one anaesthetic be needed.

The form accompanies the patient to the operating theatre clipped to the front of the notes. The anaesthetist has only to glance at the front of the notes to determine that consent to operation and anaesthesia has been given and to be reminded of the premedication given, the patient's pre-operative condition and his reaction to previous anaesthetics. This last piece of information is particularly important at the Royal Marsden Hospital because the majority of patients have malignant disease. This very often entails repeated anaesthetics for surgical and other procedures during the course of therapy.

After leaving the operating theatre the form is handed to the recovery ward nurse receiving the patient. She then knows what operation has been performed, the condition of the patient and what drugs and intravenous therapy have been given. She also knows the anaesthetist's instructions regarding postoperative medication, intravenous fluids, etc.

When the 24-hour postoperative nursing report has been completed the form is replaced in its original position in the patient's folder. It is then readily available for future reference. If required, data can be transferred to other records for statistical purposes.

Use of the form in over 2,000 anaesthetics during the past year has shown it to be satisfactory. By providing the nursing staff with relevant information when the patient reaches the recovery ward it has also ensured continuity of treatment in the immediate postoperative period.

ACKNOWLEDGEMENT

I wish to thank Dr. D. S. Robbie, Consultant Anaesthetist at the Royal Marsden Hospital, for his advice and encouragement during the preparation of this report.

REFERENCES


