Audit on appropriate documentation in consent form and time-out procedure in diagnostic cerebral angiogram.

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Introduction
Cerebral angiography is a valuable procedure yet can potentially lead to serious complications. We retrospectively reviewed the documentation in the “consent form” and “interventional radiology (IR) procedures safety checklist” in diagnostic cerebral angiogram (DCA) to ensure we abide by the “ACR-SIR practice parameter on informed consent for image-guided procedures” and “audit template” in Royal College of Radiologists.

Objectives
Evaluate the appropriate documentation in “consent form” and “IR procedures safety checklist” in diagnostic cerebral angiograms.

Methodology
Medical records of sample patients were retrieved from the medical record office with their “IR safety checklist”and “consent form”for DCA retrospectively reviewed. Completeness of the checklist was assessed with attention to legibility, “last menstrual period”(LMP) and adherence to the 10-day rule. Documentation of “patient’s diagnosis/ indications”, “name/nature of procedure”,“intended benefits”,“serious or frequently occurring risks”, signatures of doctors & patients, and dates in consent forms were reviewed.

Result
69 patients undertook DCA within Jan 2014-December 2014. 11 patients were excluded as 8 had “two MO consent” and 3 medical records were unavailable at the time of audit. In the consent forms of the included 58 patients, 57/58(98.3%) had “diagnosis/indications”documented. 28/58(48.3%)included abbreviations(e.g.AVM, ICA). “Name of procedure” was documented in all, including 31/58(53.4%)with
abbreviations (e.g., DSA). The "diagnostic" nature was documented in 49/58 (84.5%). For risks, documentation of "permanent neurological deficit" was 49/58 (84.5%), "puncture site complication" was 53/58 (91.4%), "allergy to contrast" was 49/58 (84.5%), and "contrast nephropathy" was 41/58 (70.7%). 6/58 (10.3%) had documented risk of "death"; however with numerical risk omitted. The numerical risk of stroke was stated in 8/58 (13.8%). All consents were obtained by residents, associate-consultants or consultants within 2 days of the procedure. "IR safety checklist" was completed and legible in all except one patient's INR was documented as "N/A" when in fact it was normal. All INR and platelet were taken within two weeks prior to procedure. “LMP” was clearly documented with pregnancy test taken when deemed appropriate (8/58, 13.8%). Results showed that we have achieved high standards in completing "IR safety checklist". With reference to the "audit template" in RCR, we can improve on documentation of risk in consent forms for DCA, especially "death" and its numerical value. Thus we recommend colleagues to include a comprehensive list of risks when obtaining informed consent for DCA, particularly on risk of "death" and its numerical data. These are prospects for further studies and a second phase audit is in planning.