RECORD KEEPING

Key point

In 49% of cases no contemporaneous monitoring record was available in the notes.

Table 25. Monitoring chart for the procedure in the patient's notes

Monitoring chart	Total	*(%)*
Yes	807	*(51)*
No	761	*(49)*
Sub-total	**1,568**	
Not answered	250	*(14)*
Total	**1,818**	

A monitoring chart was not present in the patient's notes in 49% of cases (Table 25). This was not acceptable particularly considering the age and physical status of this sample. For 14% of cases the question was not answered, but surely, if a chart is used it should be filed in the casenotes. Respondents were asked to forward the monitoring chart for the procedure to NCEPOD. However, it was submitted for only 62% (501/807) of cases where one was used. Of the monitoring charts that were submitted, many were deficient. Some contained a record of oxygen saturation, heart rate and blood pressure before and after the procedure, but few contained contemporaneous recordings during the procedure. The UK Academy of Medical Royal Colleges[1] recommends making a written record, but there are no published recommendations on the frequency of recording vital signs during sedation. For many therapeutic procedures, particularly if the procedure is long and/or complicated and some of the procedures reported in this study took several hours, or the patient is sick, a contemporaneous record of vital signs on a suitable monitoring chart should be kept. The question of frequency should be addressed.