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Research Article

LSCS notes audit in a tertiary referral centre of Uttar Pradesh, India

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ABSTRACT

Background: Obstetrics is a very litigious branch as the nature of job is highly pressured and it deals with two lives a mother and baby/babies. There are situations where there are no mistakes but there is no 'documentation' of due to high turnover of labouring women which leads to difficulty in dealing with medico legal cases. It is due to this reasons we decided to do an audit of our Caesarean section operative notes.
Methods: We planned to audit the quality of caesarean section documentation in a University teaching hospital of North India at Banaras Hindu University. The study involved 57 case notes from the first January 2015 to 24 February 2015. The proforma was filled by residents within 72 hours of the operative procedure.
Results: Date of Lower Segment Caesarean Section (LSCS) was from 01.01.2015 to 24.02.2015 and total of 57 case notes were included in this study. Hospital number, date of LSCS and time of LSCS was written in the operative notes of all patients. Written consent was also taken from patient party in all cases of LSCS. There were 6 cases of General anaesthesia (GA) in which two GA were preceded by spinal which had failed. Hand writing was legible in all records and was written by second year residents and signed.
Conclusions: The above audit done at University teaching hospital of North India at Banaras Hindu University which included 57 notes shows a very high quality of record maintenance. This audit was conducted while the Obstetric team was aware that audit of record keeping is taking place. It is difficult to ascertain whether such a high level of record maintenance is a true reflection or a Hawthorne effect.

Keywords: Lower segment Caesarean section, Complications, Suturing technique, Legibility

INTRODUCTION

Obstetrics is a very litigious branch as the nature of job is highly pressured and it deals with two lives a mother and baby/babies. Labour room is also a place where there is high throughput of patients.

Due to the very nature of job, mistakes are made in spite of all efforts to prevent it.[1] There are situations where there are no mistakes but there is no 'documentation 'of due to high turnover of labouring women.

If a medico legal case happens in this situation then we don't stand a chance as it said 'what you have not written, you have not done'. This is what our judiciary system assumes as well. It is due to above reasons we decided to do an audit of our Caesarean section operative notes.[2]

METHODS

We planned to audit the quality of caesarean section documentation in a University teaching hospital of North India at Banaras Hindu University.

The study involved 57 case notes from the first January 2015 to 24 February 2015. The proforma was filled by residents within 72 hours of the operative procedure.

RESULTS

Statistical calculation was done using Microsoft Excel and SPSS software.

Date of Lower Segment Caesarean Section (LSCS) was from 01.01.2015 to 24.02.2015 and total of 57 case notes were included in this study.

Table 1 shows the indications of LSCS at our hospital, in majority they were emergency LSCS. Table 2 represents per operative finding in those procedures. Those procedures which became a necessity during LSCS are shown in table 3.

Table 1: Indication of LSCS.

Indication of LSCS	Frequency	Percentage
Eclampsia	4	7
Elective	21	36.8
Foetal Distress	16	28.1
FPOL	10	17.5
Malpresentation	6	10.5
Total	57	100

Table 2: Per operative findings.

Per_op_findings	Frequency	Percent
Abruption	1	1.8
Cord abnormalities	2	3.5
Fibroid	3	5.3
Malpresentation	13	22.8
Meconium	15	26.3
Placental abnormalities	8	14
Polyhydroamnios	3	5.3
Uneventful	11	19.3
Uterine anomaly	1	1.8
Total	57	100

Table 3: Operative steps.

Operative steps	Frequency	Percent
Adhesiolysis	4	7
B Lynch Suture application	1	1.8
Breech extraction	1	1.8
J shaped incision	2	3.5
Routine steps	49	86
Total	57	100

Hospital number, date of LSCS and time of LSCS was written in the operative notes of all patients. Written consent was also taken from patient party in all cases of LSCS. Name of the surgeons, assistant and scrub sister was written in all the operative notes. Anaesthetist's name was mentioned in all cases. There were 6 cases of General anaesthesia (GA) in which two GA were preceded by spinal which had failed (Table 6).

Table 4: Uterine Closure.

Uterine Closure	Frequency	Percent
Double	52	91.2
Single	5	8.8
Total	57	100

Table 5: Closure of rectus sheath.

Closure of Rectus sheath	Frequency	Percent
PDS	44	77.2
Vicryl	13	22.8
Total	57	100

Table 6: Anaesthesia type.

Anaesthesia Type	Frequency	Percent
General	4	7
Failed Spinal f/b General	2	3.5
Spinal	51	89.5
Total	57	100

Table 7: Post-operative order.

Post_op_order	Frequency	Percent
Blood transfusion	1	1.8
Magnesium sulphate	2	3.5
Normal post op	51	89.5
Platelet transfusion	3	5.3
Total	57	100

Type of skin incision was low transverse in all cases except two in which it was midline vertical. Uterine incisions were lower segment caesarean section except two cases in which a J-shaped incision was made due to difficult delivery of baby and in the other one incision was made a little higher as it was the case of LSCS in a parturient that was fully dilated. Per operatively there were 2 cases of atonic PPH which were managed by medicines and in one B Lynch suturing with B/L internal iliac ligation was done. Uterine closure was single layer in 5 cases. Uterus was closed by Vicryl, rectus sheath by PDS and skin by Monosyn or Vicryl rapide (table 4 and 5). Swab and mop counts were correct and written in all cases.

Two cases had persistent hypertension as they were cases of Eclampsia and managed accordingly. Two patients were transfused postoperatively platelets, FFP and was given Kenadion (they were cases of Hepatitis). One patient had platelet as she had ITP.

Two patients had Mag Sulph for Eclampsia). One patient needed blood transfusion in whom atonic PPH had occurred and we did B Lynch with B/L internal iliac ligation (Table 7).

Table 8&9 describes relation between complications and duration of surgery. Hand writing was legible in all records and was written by second year residents and signed.

Table 8: Association between per operative finding and complication.

	Complications			
Per Op Findings	**Hypertension Number (%)**	**PPH Number (%)**	**None Number (%)**	**Total Number (%)**
Uneventful	1 (9.09)	0 (0)	10 (90.91)	11 (100)
Abruption	0 (0)	0 (0)	1 (100)	01 (100)
Cord Abnormalities	0 (0)	0 (0)	2 (100)	02 (100)
Fibroid	0 (0)	0 (0)	3 (100)	03 (100)
Malpresentation	0 (0)	0 (0)	13 (100)	13 (100)
Meconium	1 (6.67)	2 (13.33)	12 (80)	15 (100)
Placental Abnormalities	0 (0)	3 (37.5)	5 (62.5)	08 (100)
Polyhydroamnios	0 (0)	1 (33.33)	2 (66.67)	03 (100)
Uterine Anomaly	0 (0)	0 (0)	1 (100)	01 (100)
Total	2 (3.51)	6 (10.53)	49 (85.96)	57 (100)

Table 9: Association between duration of surgery and complications.

	Duration of Surgery (in minutes)						P value using t test
		Number	Mean	S.D.	Min	Max	
Complication	Hypertension / PPH	8	78.75	38.06	45	150	t=1.25 p=0.254
	None	49	61.63	22.85	35	150	
	Total		64.04	25.78	35	150	

DISCUSSION

The above audit done at University teaching hospital of North India at Banaras Hindu University which included 57 notes shows a very high quality of record maintenance. This audit was conducted while the Obstetric team was aware that audit of record keeping is taking place. It is difficult to ascertain whether such a high level of record maintenance is a true reflection or a Hawthorne effect.[3]

We plan to do the next audit in the near future while the Obstetric team is not aware. We also want to include in our proforma presenting part of baby during Caesarean, explanation of baby delivery, uterine cavity check, presence of a paediatrician, adnexal check and complete sutures used. We will also audit the justification for LSCS.[4]

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