

Quality of Operative notes in a District General Hospital: A Time for Change?

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Abstract

Maintaining a full and proper record of the operative notes is a Professional responsibility of a surgeon. There is a need to replace existing traditional ways of recording operative notes with the use of a Database. Such Databases can also be used at regional and national levels to assess workload and training.

INTRODUCTION

Operative notes are often used in medico legal cases and patients have a legal right to access their records subject to certain conditions. Maintaining a full and proper record of the operative notes is a professional responsibility of every surgeon. 1992/93 National confidential enquiry into perioperative deaths (NCEPOD) suggested considerable variation in the quality of operative notes (NCEPOD 95). In September 2002, The Royal College of surgeons published new guidelines for recording operative notes (Good surgical practise 2002). The aim of our study was to identify to what extent, surgeons at a District General Hospital were adhering to the guidelines set by the Royal College of Surgeons (RCS) on recording of operative notes.

METHODS

An audit of recording operative notes was carried out in a District General hospital. 52 patients who underwent surgery in the year 2001 were selected at random and the quality of their operation record in case notes were assessed. As per RCS guidelines, good operative notes should include information regarding patient identification, date and time of surgery. It should also include the type of surgery, grade of surgeon, the incision used, operative findings and the final diagnosis. Details of procedure, type of closure, postoperative instructions and signature are an essential part of an operation record. Complications or uneventful procedure must be mentioned. Case notes were evaluated against these standards. Legibility and ability to comprehend operative details was assessed at the level of a Pre-registration house officer.

Adherence to the RCS guidelines was noted for consultants (Group1) and registrars (Group2), and tabulated to be present or absent.

RESULTS

There were 41 elective and 11 emergency operations. 31 records were entered by the consultants and 21 by the registrars. The type of the operation was recorded in all the operative notes. The time of the operation was recorded in 6% of the operative notes written by the consultants and 16% of the notes recorded by the registrars (Table1). Patient's identification was not noted by 6% of consultant's and 10% of notes entered by the registrars. 19% of the consultant's notes did not mention the type of incision. Operative complications were mentioned in 16% of the consultant's notes and none in the registrar's notes. This may be related to acts of omission or the fact that the operation was uneventful. Post-operative instructions were recorded in 71% and 90% of the consultants and registrars notes respectively. 10% of the consultant's notes did not have a signature.

Figure 1

Table 1:

	Consultant %	Registrar %
Type of operation	100	100
Date	100	94
Time	06	19
Patient's ID noted	94	90
Surgeon noted	97	100
Incision	81	95
Diagnosis	90	95
Findings	97	95
Operative complication	16	0
Closure	90	95
Post-op instruction	71	90
Signature	90	100
100% Legibility	60	75

DISCUSSION

In medico legal cases, hand-written operation notes are often produced as evidence. Illegible and incomplete notes, along with the use of confusing abbreviations, are a common source of weakness for a surgeon's defence. The quality of medical record keeping is being subjected to increasingly close scrutiny. The 1992 report of the National Confidential Enquiry into Perioperative Deaths (NCEPOD) noted a considerable variation in the quality of operation notes submitted by all contributing surgical specialities.

In our study, although a good percentage of the operative notes contained satisfactory information, some of the records missed vital points such as patient's identification and post-operative instructions. This assumes importance as there are chances of operative notes getting lost /misplaced due to lack of patient identification details. With limited junior working and the onset of shift system, issuing clear postoperative instructions is essential to maintain continuity of care. Legibility did not pose considerable problem in understanding the content of the notes. To record all the vital information, a format of the operation notes should be introduced satisfying the guidelines put forward by the RCS (Good surgical practice 2002) and should be available in the theatre at all times.

Previous studies have shown that quality of the operation notes can be improved by adding simple aide-memoire attached to operation note sheets (Bateman 1999) or word processor in theatres (Baigrie1994). In a study comparing the quality of operative notes recorded on specially designed proformas and those by word processors, the computer notes (word processor) scored higher in all criteria and took the same amount of time to generate (O'Bichere 1997).

The most effective method of recording operation notes would be an operative database. The accuracy of a computerised audit system custom has been validated by comparison with operating theatre records and patients' case notes (Barlow 1994). The study revealed only 2.5 per cent missed entries.

Of the recorded entries information regarding the nature of the operation was found to be 92.5 per cent complete and 98 per cent accurate. The advantages of an excellent database include a printed legible operative record, automatic OPCS coding and automatic grading. It also allows the storage of data in a form that allows later analysis for audit and research and the production of an operating log for trainees. The potential value of using the same data for the production of discharge documentation suggests an opportunity for improving the efficiency in the production of such documentation. Such databases could also include incorporation of scores like POSSUM to predict mortality/morbidity. One of the drawbacks for this system is the cost involved in such databases on individual trusts. But considering the future potential of such system (Data-base), one should try to incorporate it in trusts all over UK. Operative logbooks for surgeons (ASIT website), data recording of colorectal cancer database, are being used through out United Kingdom. It is surprising that a common operating database is not being used nationally, despite the growing investment in Information technology at all levels. Such a database could be invaluable in importing data regarding workload, training and even planning human resources.

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