Aim: Auditing the adherence of Trauma and Orthopaedics Operative notes to the RCS Good Surgical Practice Guidelines.
Method: Clinical audit conducted on 150 operative notes over a period of 2 months April- May, including emergency and elective surgeries performed in Ashford and St. Peter's Hospital. The RCS Good Practice Surgical Guidelines for an ideal operative note was used to compare.
Results: Date of the procedure and signature of the surgeon were mentioned in all the notes by default in the electronic template being used. Title of the operation performed and whether elective or emergency were mentioned by 92% and 45% respectively. Name of theatre anaesthetist and operating surgeons were mentioned by 73% and 93% respectively. Time of surgery mentioned by 26%. Operative findings and operative diagnosis mentioned by 83% and 53% respectively. Incision and complications of surgery mentioned in 80% and 53% respectively. Details of tissue added/ altered/ removed mentioned by 46%. Information on prosthesis or implant used is mentioned by 54%. Details of closure and anticipated blood loss mentioned in 91% and 45% respectively. Antibiotic prophylaxis and VTE prophylaxis mentioned in 63% and 84% respectively but most of the notes lack the type of prophylaxis and duration.
Conclusion: There is more for improvement in the operative notes for better continuity of care. Recommended to follow a standardized guidelines by all the surgeons to prevent any room for confusion and proper documentation according to the guidelines. It will be very useful if similar audits are performed across all the trusts nationwide and a standard template to be followed by all.