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AN AUDIT ON OPERATIVE NOTES WRITING

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Introduction

Record keeping with regard to surgery is an important but usually neglected part in the overall management of patients.

Method

The study was conducted at the Medical Records Department of the National Hospital of Sri Lanka. A sample of 100 Bead Head Tickets (BHTs) was selected randomly from the BHTs received by the department for the period of 1 week from 01-20-2008, excluding minor surgeries The Royal College of Surgeons of England guidelines for Clinicians on Medical Records and Notes were used as the standard.

Results

The procedure performed and the name of the surgeon operated were present in all operative notes. However the name of the consultant responsible was found in only 47(47%) notes when he is not operating.

An adequate description of intra-operative findings was present in 57(57%). But in 30(30%) the description was incomplete. The findings were not mentioned 13(13%).

Details of the tissue removed, altered and added were adequately mentioned in 55(55%), but was incomplete in 42(42%).

Necessary details of sutures used were mentioned adequately only in 22(22%)with. A sizable number of BHTs had the phrase "routine closure done" with regard to suturing.

Immediate post operative instructions were mentioned in all the BHTs. None of the BHTs contained the signature of the surgeon.

Conclusions

A considerable number of BHTs were lacking adequate descriptions of components such as intra operative findings, altered/added or removed tissue. Details of sutures used was absent in a majority and in a significant proportion of operative notes, non professional words such as "routine closure done" was present. Signing by the surgeon was poorly practiced with regard to operative notes writing.