

Validation of Surgical Admissions Proforma and Checklist for Improved Patient Care in a Large University Teaching Hospital

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Background

In 1990 The Royal College of Surgeons produced guidelines on medical records¹. These state that for every surgical patient admitted to hospital there should be a clinical record containing:

- an initial history,
- details of medications,
- results of a physical examination,
- a working diagnosis, and
- a medical care plan.

Objectives:

1. To investigate the standard of medical records completed for acutely unwell patients admitted under general surgery at a large university teaching hospital.
2. To investigate the impact of an emergency surgical admissions proforma on this standard and subsequent patient care.

Methods

Setting and sample

This was a prospective study of all patients admitted acutely to the general surgical wards from 21st February-26th February 2010.

The re-audit was conducted from 21st March-26th March 2010 after implementation of the surgical admissions proforma.

Procedure

A surgical checklist was created based on the mandatory features of a surgical clerking¹ and after discussion with Consultant General Surgeons in the hospital.

The checklist included documentation of:

- complete history,
- full systems examination,
- full set of observations,
- initial blood test results,
- venous thromboembolism (VTE) risk assessment,
- drug chart complete with patient's regular medications, and
- VTE prophylaxis prescription.

Medical notes were scrutinised after patient admission to the ward, but prior to the post-take ward round and without the knowledge of the admitting doctor.

The completion rate for each of the audit criteria was calculated and then compared before and after the introduction of the proforma.

Surgical admissions proforma

This was introduced prior to the re-audit. It contained:

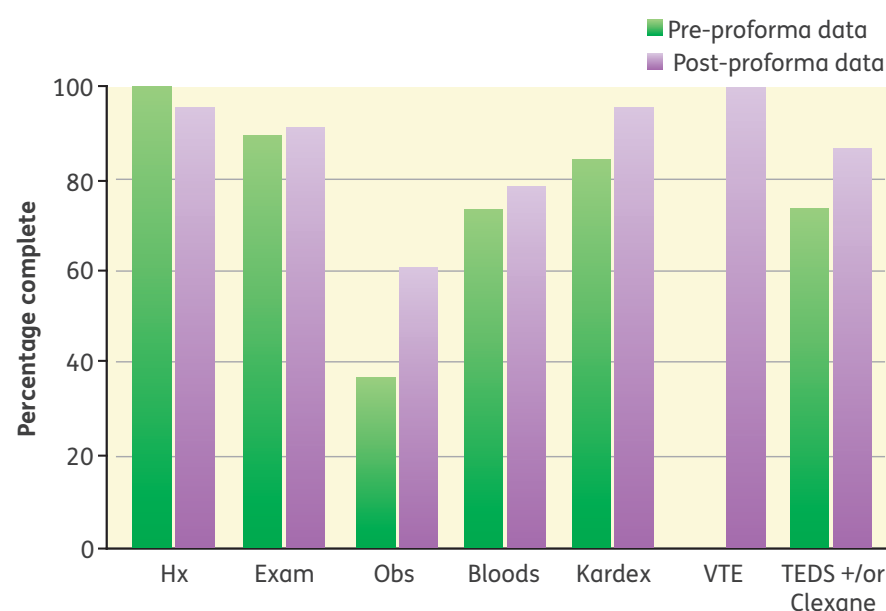
- Clearly designated areas to document the aforementioned audit criteria.
- A summarising checklist reminding clinicians to complete the VTE assessment form and prescribe appropriate prophylaxis.
- Space to document a working diagnosis, medical care plan and senior input.

Results

	Audit	Re-audit
Subjects	19	24
Mean Age (range)	54.9 (16-90)	53 (23-92)
M : F	10 : 9	8 : 15

The impact of the proforma on compliance with each feature of the surgical checklist can be seen in the bar chart (Figure 1).

Figure 1.
The differences in emergency surgical admission documentation before and after the proforma was introduced



The greatest difference was seen in compliance with the use of the VTE risk assessment tool and subsequent appropriate prophylaxis prescription.

Conclusion

- The acute surgical admissions proforma improves compliance with the mandatory aspects of a surgical clerking.
- It improves the quality of medical records, patient care and patient safety.

Recommendations

- The proforma should be introduced on a permanent basis to standardise and improve the quality of acute surgical clerkings.
- Once firmly established a further re-audit should be performed in 6-12 months to reassess compliance.

References

1. The Royal College of Surgeons of England. Guidelines for clinicians on medical records and notes. London, RCSE, 1990.