Evaluation of the quality of operative notes in a Trauma and Orthopaedics centre. Are the guidelines being followed?

Sir

Operative notes form an integral part of patient documentation and are also considered as important medico-legal documents. In 1994, the Royal College of Surgeons of England (RCSE) published guidelines for Clinicians on Medical Records and Notes\(^1\). They recommend that an operative record should be complete, legible and accurate, thus allowing good continuity of care by another doctor\(^2\).

A 6-month retrospective study was carried out in the Trauma and Orthopaedics department at Our Lady of Lourdes Hospital, Drogheda (2012 – 2013). One hundred operative records were chosen at random and evaluated against the RCSE guidelines. Doctors with > 4yrs experience (consultants and registrars) in Trauma and Orthopaedics surgery were considered senior doctors and those with < 4yrs experience (senior house officers), considered as junior doctors.

All 100 operative records were handwritten by the orthopaedics consultant (16%), registrars (62%) and senior house officer (22%). Twenty-three percent were written by the operating surgeon and only 26% identified the responsible consultant. Senior doctors had clear mention of: time of surgery, operative diagnosis, operative findings and post-operative instructions in more than 75% of records evaluated. Nevertheless, they showed discrepancy while recording important data in 4.6 – 53.6% of cases. The latter include; Elective/emergency surgery (44.6%), consultant names (42.8%), assistant name (53.6%), complications (1.8%), details of tissues altered (7.14%), closure techniques (30.4%), incision type (18.2%), complications (18.2%), extra procedures (4.6%) and prosthesis details (26.8%).

Legibility was good/fair in 97.7% of operative notes written by junior doctors compared to only 32.1% for those written by senior doctors. Additionally, 93.2% of the operative notes written by junior doctors were considered complete, compared to 58.9% for those recorded by senior doctors. Only 3% of the operative notes analysed had a diagram to further elaborate on the procedure undertaken.

Operative notes form an essential part of surgical practice and it is the responsibility of the operating surgeon to make sure that they are written in a legible, structured and accurate manner. Our study shows that approximately 20 years after the initial publication of a set of guidelines by the RCSE, we are still struggling to meet the minimum standards.

In order to avoid incomplete operative notes, surgeons need to familiarise themselves with the RCSE
guidelines and begin to use standardised pro-formas. The latter, when used in different institutions, have resulted in more accurate and complete operative records\(^3\).

On the other hand, illegibility of operative notes is best dealt with by the introduction of an electronic input system. Many authors agree that the optimum way for recording operative notes is via an electronic template based system\(^4\).

We therefore strongly recommend the implementation of electronic recording via standardised pro-formas. This should ideally be applied to all surgical sub-specialities to maintain a good continuity and standard of care. Any new system should then be evaluated through re-auditing to ensure that improvements have been made.

Shakeel Mohammud Inder, Amir Siddique

**Conflict of Interest:**

The authors confirm no conflict of interest regarding this article

**Correspondence:**

Shakeel M Inder

Department of Trauma and Orthopaedics Surgery, Our Lady of Lourdes Hospital, Drogheda

mohammudsinder@rcsi.ie

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