Improving the Quality of Information Recorded on Operation Notes in the Department of Head & Neck Oncology

Dr Charlotte Goss, Dr Férenc Los and Mr Sinclair Gore

Blenheim Head and Neck Oncology Unit, Churchill Hospital, Oxford

Royal College of Surgeons — ADVANCING SURGICAL CARE

NHS Oxford University Hospitals NHS Foundation Trust

INTRODUCTION

Operation notes form a vital part of the clinical notes for any patient undergoing a surgical procedure. Not only should they provide a record of what happened in theatre, but they should also contain detailed information on post-operative management of the patient. The Royal College of Surgeons state in their publication 'Good Surgical Practice' that surgeons must ensure that there are clear operation notes for every procedure which should contain sufficient detail to enable continuity of care by another doctor.[1] In practice, the level of detail recorded on operation notes is highly variable and, at times, illegible. Poor or illegible documentation can compromise detailed medical record keeping, the quality of patient care and patient safety. Well designed proformas for procedures have shown to standardise and improve the quality of information recorded, compliance with gold standards and improve post-operative care.[2,3]

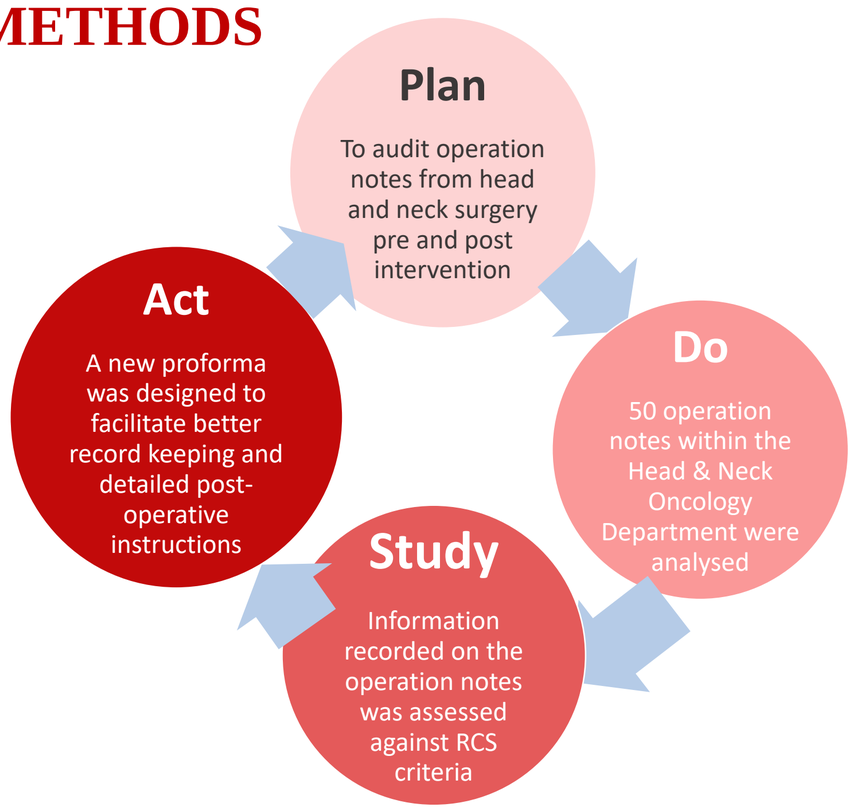
THE PROBLEM

The current operation note template used in OUH contains lots of space for free script without direction of what to record or reference to any of the RCS Gold Standard criteria. This means details are often omitted from the operation note which can subsequently affect patient care. For example, operation notes often do not indicate in appropriate detail whether or not post-operative antibiotics are required or when surgical drains should be removed. This can delay treatment and decision making which ultimately affects the quality of patient care. Furthermore, the post-operative care of surgical patients is often delivered by junior doctors. Lack of instruction on operation notes can delay decision-making as juniors have to spend time seeking senior input before actions can be taken.

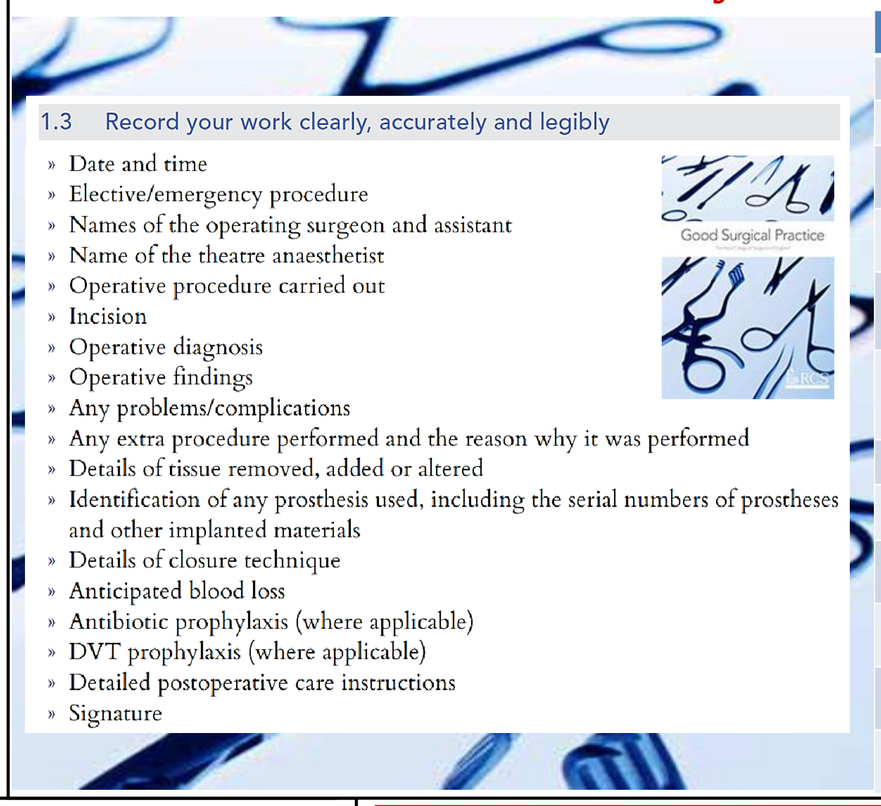
AIM

To standardise and improve the quality of information recorded in operation notes from major Head and Neck Oncology surgery

METHODS



The Gold Standard vs Reality: Post-Op Instructions Insufficient



RCS Criteria	Recorded	Not Recorded / Insufficient
Operative Diagnosis	68%	32%
Operative Findings	88%	12%
Complications	12%	88% unclear if none or not recorded
Extra Procedures	12%	88% unclear if none or not recorded
Details of tissues added / removed / altered	100%	0%
Identification of Prostheses / Implanted Materials	8%	92%
Closure Technique	72%	28%
Anticipated Blood Loss	0%	100%
Antibiotic Prophylaxis (recorded in detail)	24%	**76%**
DVT Prophylaxis (recorded in detail)	18%	**82%**
Detailed Post-Operative Instructions	38%	**62%**
Signature Present	94%	**6%** None or illegible

FOCUS OF NEW DESIGN

- **Specifically target areas of insufficiency and ambiguity**
- **Facilitate information recording without adding to the surgeons' workload**
- **Pre-printed sections that can be circled to reduce the time spent hand writing instructions**
- **RCS Gold Standard aides-mémoire in free script sections to reduce omissions**

NEW OPERATION NOTE DESIGN

Side 1

OUH BLENHEIM UNIT
OPERATION NOTE

Patient sticker
MRN
First Name
Surname

OPERATION TITLE:

DATE ..... TIME ..... ANAESTHETIST(S) .... GA / LA / SED^N

SURGEONS ....

DIAGNOSIS: .....

PROCEDURE: INCISION, FINDINGS, RESECTION, RECONSTRUCTION, ADDITIONAL STEPS, CLOSURE

Further notes / mandatory RCSE data / post-op instructions / prosthesis stickers / signatures overleaf

Side 2

OPERATIVE NOTE CONTINUED

POST OPERATIVE INSTRUCTIONS

Airway; Breathing; Circulation; Specific medication; Mobility; Wounds, flaps, drains, sutures & dressings; Diet; Discharge, Follow up

RSCEng MANDATORY INFORMATION www.rcseng.ac.uk/library-and-publications/college-publications/docs/good-surgical-practice/

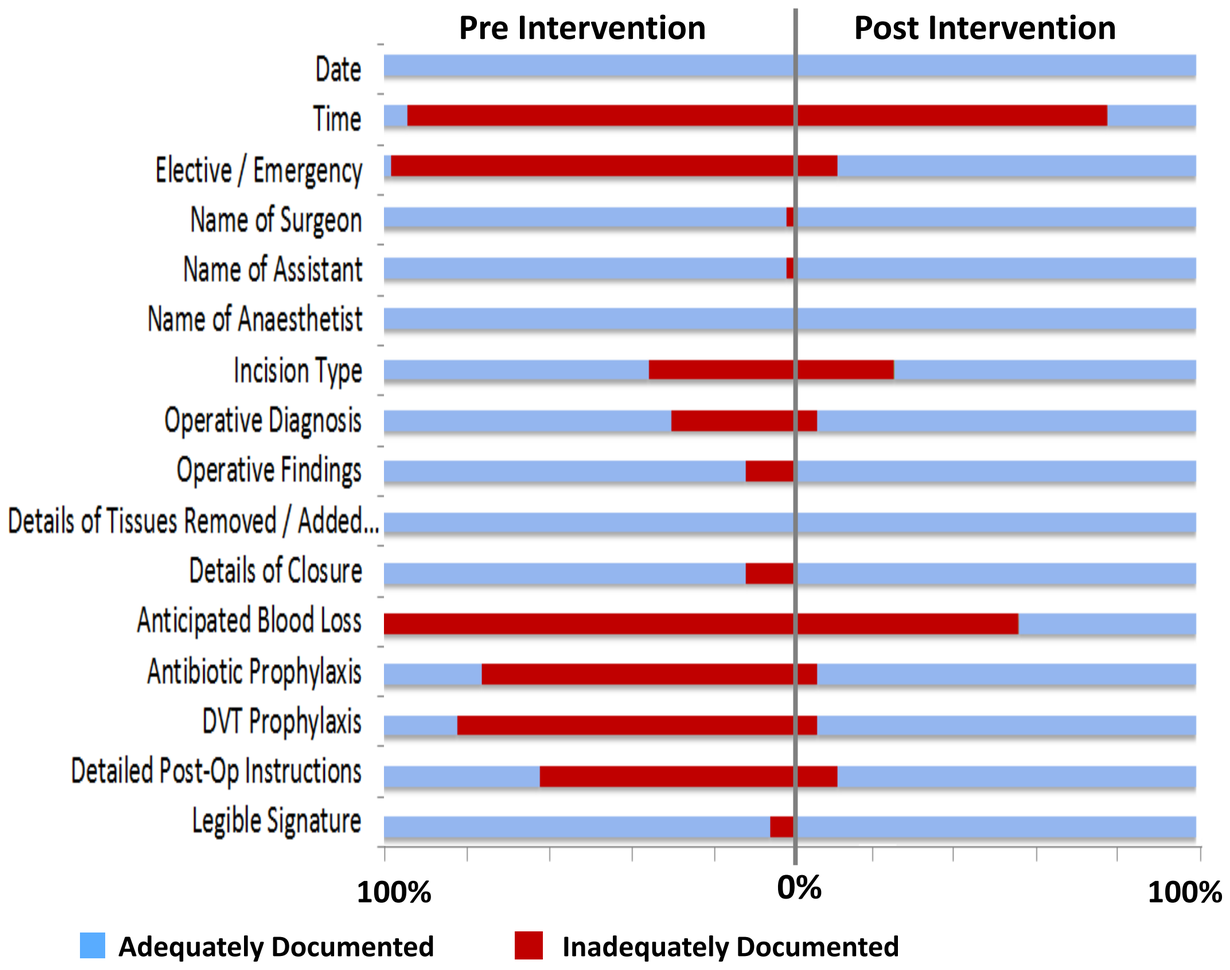
ANTIBIOTIC PROPHYLAXIS PRE-OP GIVEN YES / NO
ANTICIP. BLOOD LOSS cc
TIMING EMERGENCY / ELECTIVE
NO. OF PATHOLOGY SPECIMENS .....
PROSTHESES USED (stickers please) .....

POST-OP ANTIBIOTIC: ..... PO / IV
DOSE .....FREQ ..... DUR^N .....
VTE START DATE & TIME .....
DALTEPARIN TEDS FLOWTRON/IPC
FEEDING TO START ..... NG / PEG / ORAL

SURGEON(S) NAME(S) .....

SURGEON(S) SIGNATURE(S) .....

RESULTS



CONCLUSION

- **New operation note improved quality of documentation in all areas** that previously had not meet the RCS gold standard
- **Greatest improvement seen in the post-operative care instructions** particularly antibiotic prescription, VTE prophlyaxis and feeding regimes
- **Provides a template for design of future electronic operation notes**

References

1. Good Surgical Practice (2014) RCSENG - Professional Standards and Regulation
2. Chow J, Yvon C, Stranger T. (2014). How complete are our clerkings? A project aimed at improving the quality of medical records by using a standardised proforma. BMJ Qual Improv Rep. 25;2(2)
3. Abbas SH, Singh S, Sundran R, Akbari K, Gilmour J, Puttick M (2016) A thorough note: Does a procedure-specific operation note proforma for laparoscopic appendicectomy improve compliance with the Royal College of Surgeons of England Guidelines? *Int J of Surg Op* 2:1-5