

# Documentation of surgical ward rounds



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# Pennine Acute Trust



- Pennine Acute Hospitals, North East Manchester, UK;
- Serve population of 820,000
- Four hospital sites with 400,000 admissions per year
- Surgical services at all sites

- There are three general surgical wards at Oldham
  - T4 acute admissions
  - T5 for post-op care and longer duration of stay
  - T6 mainly day case surgeries and overflow from T5 on rare occasions
- Each ward staffed with three foundation year 1 trainees, with more senior doctors working within a team.

# Reasons for audit

- Surgical ward rounds are fast paced
- Documentation is routinely done by the ward based F1 doctors
- Omissions in documentation can lead to a detrimental impact on patient care

# Aims

- To quantify the amount of information documented following surgical ward rounds - on wards T4, T5, T6.
- Set documentation standards and improve quality of documentation

## Standards collated from:

- GMC good practice guidelines
- Trust Guidelines
- MDT questionnaire circulated

# Documentation standard

## Important information

Following a focus group with members of the MDT , the following were considered to be important aspects of patient care which would aid in patient care on the wards.

### Medico-legal

- Date & time
- Patient identifier
- Signed + GMC number
- Overall Legible
- Explaining care to patient

### Patient condition

- Current issues
- Plan
- Working diagnosis
- Medication review
- Diet
- Estimated discharge
- Follow up instructions

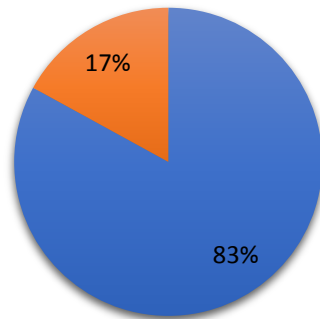
# Method

- Retrospective audit of 3 general surgical wards
- Last ward round entry analysed

# Results n= 47

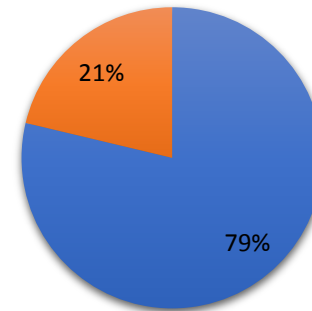
## Date and Time

■ Y ■ N



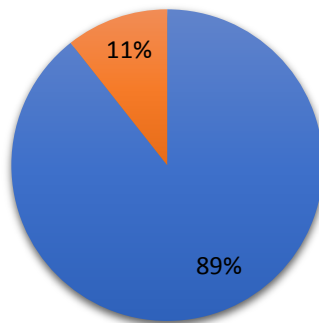
## Patient identifier

■ Y ■ N



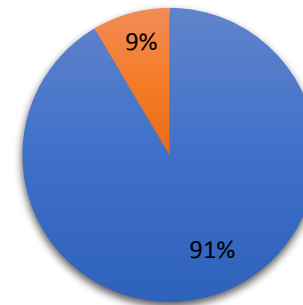
## Signed + GMC

■ Y ■ N



## Overall legible

■ Y ■ N

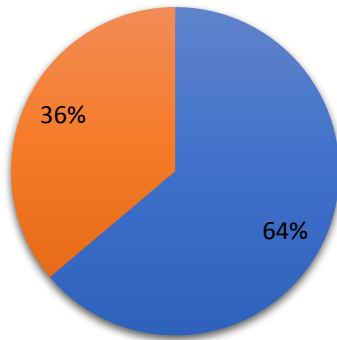




# Results n=47

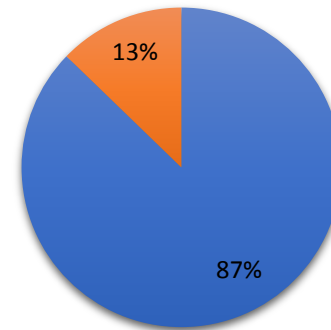
## Current issues

■ Y ■ N



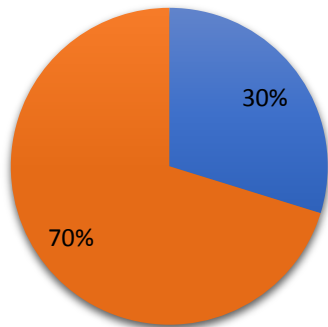
## Plan

■ Y ■ N



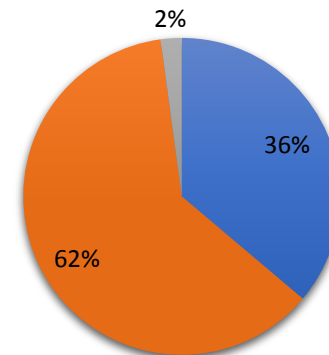
## Diagnosis

■ Y ■ N



## Medication R/v

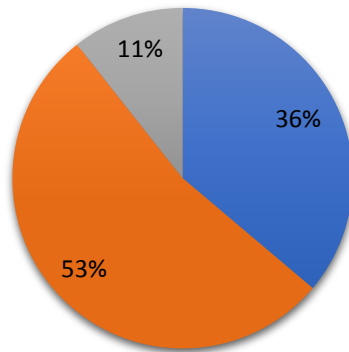
■ Y ■ N ■ N/a



# Results n=47

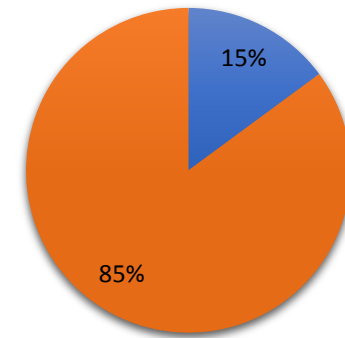
## Diet post-op

■ Y ■ N ■ N/a



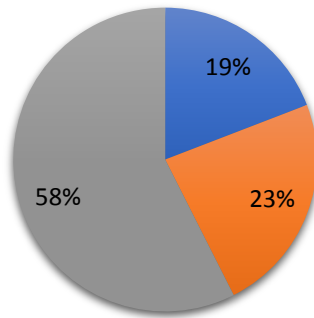
## Estimated Discharge Date

■ Y ■ N



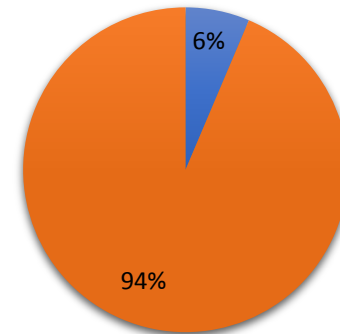
## Follow up instructions

■ Y ■ N ■ N/a



## Explained to patient

■ Y ■ N




# Summary of Results

## Areas requiring improvement

- Working diagnosis
- Explanation given to patient
- Medication review
- Diet
- Estimated discharge date

# Action Plan

- Implement new pro-forma to improve documentation

WARD ROUND SUMMARY		Date	Time:
<i>(attach patient label or complete fully)</i> Patients full name		Consultant / Registrar/SHO(circle)	
Current issues 		Plan-	
Diagnosis		Discharge: Yes / No	
Explained to patient    Y        N		Follow up instructions: GP care OP clinic:.....wks Other (specify)	
Diet NBM /30ml/hr /CF /FF / Full (circle)		Signed	

# Implementation of pro-forma

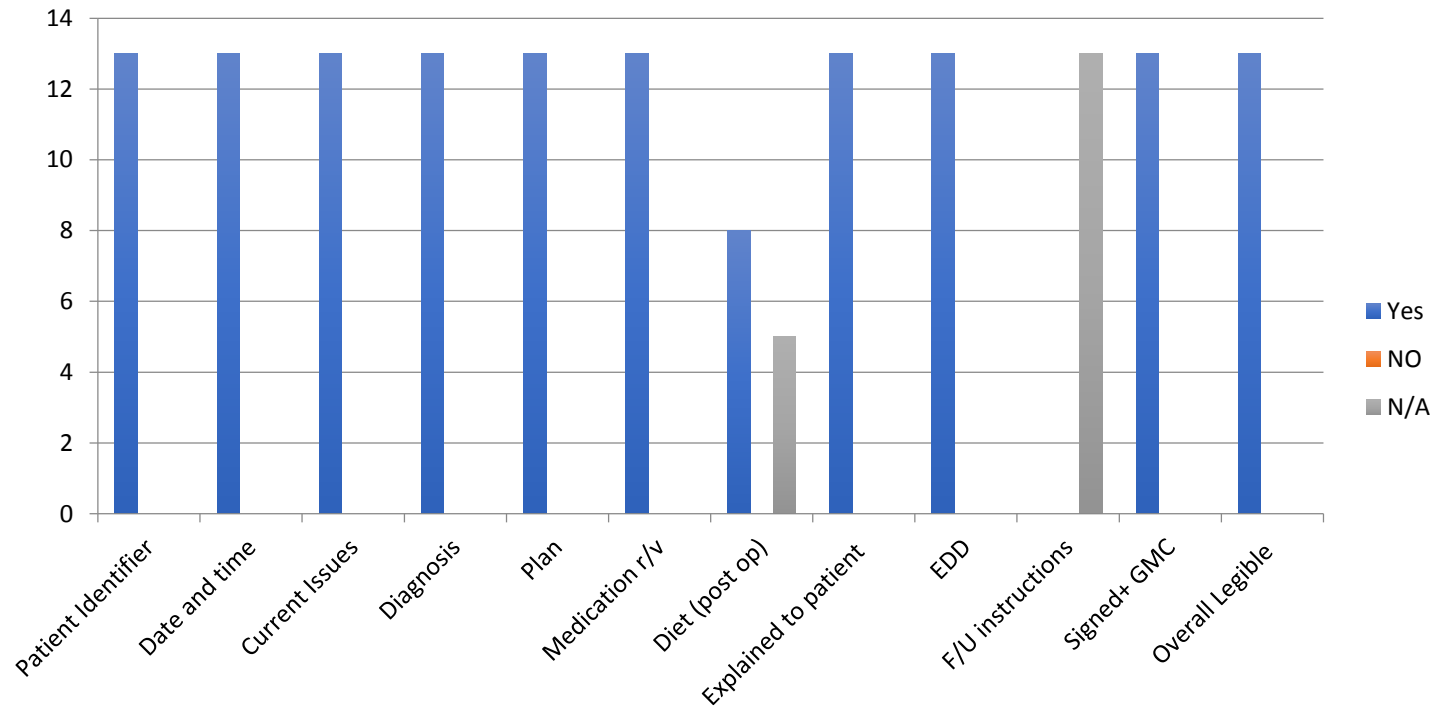
- Initial feedback for the pro-forma
  - More detailed information
  - Reduced delays on ward round
  - All boxes were filled by both juniors and seniors
  - Positive MDT response
  - Patient aware of current plan and further investigations
  - Teaching opportunity for senior to juniors to explain decision making process

# Re-audit

- Ward round proforma initially implemented on T4 and T5
- T5 had stopped using pro-forma ~2 months into implementation
- A comparison between T4- with pro-forma and T5- without pro-forma
- As T6 mainly elective surgical cases. The pro-forma had limited benefits on this ward so data was not included in the re-audit

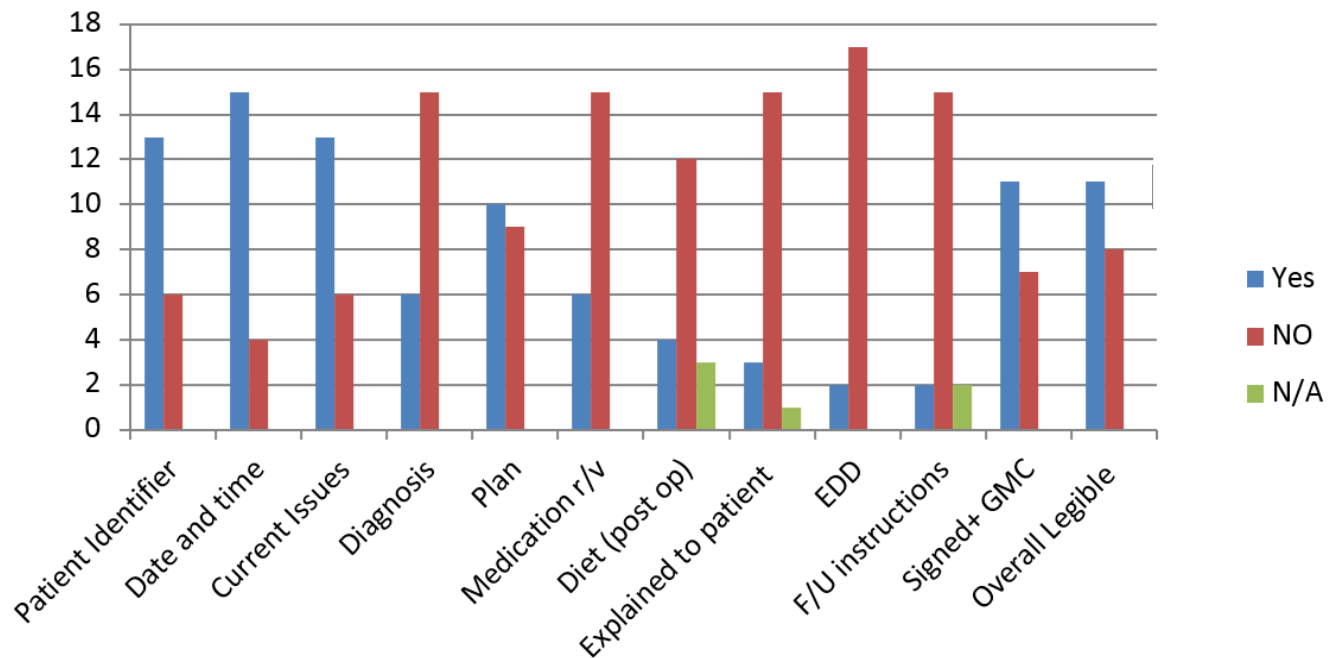
# T4 Result- Pro-forma Used

N=13



# T5- Pro-forma not in use

N=19





# Summary of results

- T4 all documentation was up-to-date with an appropriate amount of information in each patients notes
- T5 limited detail in most notes re-audited
- On T5 4 patients did not have any documentation in their notes for the days ward round.

# Re-audit Discussion

- Pro-forma improved documentation when used.
- T5 doctors felt that cutting and sticking completed pro-forma into notes was not effective use of their time
- Factors that may have influenced results:
  - Staffing levels
  - Workload
  - Individual doctors and their standards
  - Patient complexity

# Plan for the future

- Proforma rolled out site wide within surgical wards
- Regular re-audits
- Proforma to be printed as stickers
- Teaching sessions on good documentation

Questions please?