AB185. 145. An audit of post-operative documentation in Wexford General Hospital

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Background: Operative notes are an essential tool to ensure progress of management and continuity in patient care in the post-operative period. Non-standardized operative notes can be of poor quality and lack in sufficient detail. This may lead to deficits in patient care especially in an emergency situation.

Methods: Retrospective data was collected from 100 consecutive patients treated surgically during October 2018. The operative notes were analyzed against the Royal College of Surgeons (RCS) quality standards outlined in "Good Surgical Practice". The intervention following the initial audit was an education session that introduced the previously published POST-OP educational tool. POST-OP—physiotherapy/mobilization, operative diagnosis, sepsis, thromboprophylaxis, oral intake/fluid balance and pain. A second audit is underway to assess adherence to the guideline following the educational session.

Results: Operative notes are both written and dictated in Wexford General Hospital. The most common procedure was hernia repair (32%) followed by laparoscopic cholecystectomy (23%) and appendectomy (15%). We identified some deficits in the quality of post-operative surgical documentation. Particularly documentation of date (75%) and time (0%), anesthetist (51%), whether the procedure was emergency *vs.* elective (0%), any antibiotic use (13%), thromboprophylaxis (5%), risk of blood loss (0%) and post op care instructions (91%).

Conclusions: There were deficits identified in operative documentation in Wexford General Hospital (WGH) when compared to the RCS England Guideline. Following the education session improvement is being observed. Using these data we plan to introduce a more detailed operative proforma that can be dictated using the TPRO app on the surgeon's phone.

Keywords: Post-operative documentation; audit; continuity of care; operative notes

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