

AB128. Orthopaedic fracture clinic documentation in need of fixation?

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Background: The orthopaedic outpatient is a high throughput environment dealing with large numbers of patients presenting with a multitude of pathologies. Continuity of care in such an environment can prove tasking and in many cases a patient is reviewed and assessed by a different member of the orthopaedic team on each attendance. Thus it is pivotal that the documentation of each attendance is complete but succinct, legible and conducted in accordance with best practice guidelines

Methods: In this study we set about to produce a metric for assessing the quality and adequacy of documentation, while complying with local hospital and best practice guidelines.

Then using said metric we subsequently audited compliance with the guidelines. We assessed 100 outpatient fracture clinic notes from Sligo University Hospital Orthopaedic Department, randomly selected from all clinics and encompassing all qualification grades over a 1-week period in September 2019.

Results: Our results demonstrated that in many aspects we are >90% compliant with the guidelines which is promising, however in some others, many of which could potentially have significant ramifications in the event of an adverse patient outcome we were significantly lacking.

Conclusions: Documentation in the outpatient clinic is extremely variable and highly doctor dependent. Clear, concise and succinct documentation is hugely advantageous to the next medical practitioner tasked with reading said note and thus the expeditions running of the clinic. Our investigation highlights the areas in which we as a unit can improve.

Keywords: Orthopaedic; outpatient; audit; documentation

doi: 10.21037/map.2020.AB128

Cite this abstract as: McCabe P, Fitzgerald E, Tahir B, Kelly J, O'Neill B. Orthopaedic fracture clinic documentation in need of fixation? *Mesentery Peritoneum* 2020;4:AB128.