AB023. SOH23ABS_066. Standardised surgical admission proformas: a quality improvement project

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Background: "Documentation burden" in a busy healthcare setting is a commonly cited cause for suboptimal documentation and its associated adverse implications. While electronic patient records have been heralded as a solution, costs associated with necessary infrastructure may be prohibitive. We designed and implemented a standardised surgical admission proforma and evaluated its impact on improving compliance with standards for documentation.

Methods: Freehand admission notes for consecutive surgical admissions over a 4-week period were audited against guidelines produced by the Royal College of Surgeons (England). A standardised and structured admission proforma was introduced over a 2-week period to replace freehand documentation, its efficacy subsequently reaudited over a 4-week period.

Results: A total of 67 freehand admission notes were evaluated. Key components such as vital signs, medications and allergies were documented in less than 46%, 43% and 72% respectively. Additionally, smoking and alcohol consumption were documented in less than 40% of admission notes. Fifty-one admission proformas, with a 100% uptake, were evaluated post-intervention. The mean improvement in documentation of vital signs was 60.0% (SD =0.11). Documentation of existing medications, alcohol consumption, smoking status and laboratory investigations results improved significantly by 46.9%, 43.1%, 40.6% and 17.5% respectively. Additionally, 96.1% of admission notes had identifiable medical council registration numbers. Improvements in legibility and efficiency of documentation were also noted.

Conclusions: Introduction of a standardised admission proforma resulted in significant improvements in quality and completeness of admission documentation. Concise, legible, and accurate documentation is fundamental in maintaining effective clinical governance, allowing for the provision of safe and efficient patient care.

Keywords: Admission proforma; clinical governance; general surgery; patient safety; quality improvement

Acknowledgments

Funding: None.

Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

doi: 10.21037/map-23-ab023

Cite this abstract as: Chan KY, Gaffney M, Raftery N, Abdelhafiz T, Rayis A, Johnston S. AB023. SOH23ABS_066. Standardised surgical admission proformas: a quality improvement project. Mesentery Peritoneum 2023;7:AB023.