188 Quality of Documentation of Patient Notes in the Surgical Department

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Aim: Quality of documentation of patient notes
Data of 100 patients over 2 weeks. Assessed:

- Patient details
- Date + time
- Examiner + grade of the doctor
- Blood results
- Author of note + contact details
- GMC
- Legibility
- Chronological order

Results: Availability of notes:
15/100 notes were not available on the wards at the time of data collection

- Patient details: 38/85 did not have patient details on the notes sheet
- Date and time: 2/85 notes weren’t dated. 9/85 did not have a time
- Examiner and grade of the doctor: 4/85 patients’ notes did not identify the doctor who saw the patient
- Blood results: 78/85 notes did not display patients’ more recent blood results
- Author of note and contact details: 41/85 did not provide the name of the doctor who scribed
- GMC number: 9/85 notes included a valid GMC number
- Legibility + Chronological order: 12/85 notes were illegible. 42/85 notes were not filed in chronological order

Conclusions: Based on above results the significances of:

- Patient details: Identify the correct patient + legal document.
- Date and time: Timeline of events
- Examiner and grade of doctor: Seniority of clinical decision, responsibility, and medical negligence
- Blood

Results: Unable to provide proof of treatment if any abnormalities were found and medical negligence

- Author of note and contact details: Difficult to contact responsible clinician in case of emergency/referral
- GMC number: Responsibility
- Legibility + Chronological order: Waste of time during emergencies or referrals + confusion for nurses and doctors