WE3.5 Audit of Operative Note Standard: A Retrospective Case Series Over Two Cycles

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Aims: Clear, legible, and comprehensive operative notes allow for safe transfer of patient information and form important documentation in medical-legal cases. Compliance with criteria identified by the RCSG for the appropriate documentation of operative notes is variable and often poor. We aimed to audit the operative notes within the breast surgical department in a Dublin hospital.

Methods: A retrospective review of randomly selected operative notes, between December 2020 and September 2021, was conducted. Compliance with RCSG criteria was recorded. A poster and an educational program were delivered to surgical registrars.

Results: A total of 49 op notes were analyzed, majority of which were of elective procedures. There was at least 90% compliance in 10/20 of the RCSG criteria. Presence of signature, name of assistant, name of anesthetist, and operative diagnosis were assessed as 82%, 80%, 71% and 61% compliant, respectively. 88% of Op notes contained the start time only, whereas 51% contained both start and finishing times. Among the criteria with poorest compliance were presence of problems/
complications (4%), any extra procedures performed (4%), details of any prosthesis used (2%), elective or emergency procedure (0%) and anticipated blood loss (0%). Additional criteria were assessed including legibility (88% compliance) and use of a diagram (65% compliance).

**Conclusion:** Our results are consistent with previous similar published work, highlighting the potential for variability in appropriate documentation of surgical procedures. Impact of an educational intervention as well as inclusion of more emergency procedures will be further explored in second cycle of this audit.