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Completeness in clerking: The surgical admissions proforma

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HIGHLIGHTS

- A study comparing the implementation of a surgical clerking proforma vs. freehand clerking.
- The coherency of patient notes before and after proforma implementation was assessed.
- 5 of the 17 criteria showed significant improvement post proforma implementation.
- Fewer healthcare staff were required to revisit patient notes following proforma implementation.
- The study illustrates that the implementation of a surgical admissions proforma improves patient documentation.

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ABSTRACT

Background: The accessibility of surgical patient data is a key safety concern, and relies on efficient clerking and handovers. This project assessed whether the introduction of a surgical clerking proforma improved the recording of patient information in the surgical admissions unit (SAU) at Northwick Park Hospital.

Materials and methods: Existing patient notes were assessed on content and ease of access, using two independent surveys conducted over a 5-day period. The first survey audited patient notes before ($n = 28$) and after ($n = 23$) the introduction of the proforma. It assessed whether key patient details were documented, in line with the 17 criteria set out in the Guidelines for Clinicians on Medical Records and Notes by The Royal College of Surgeons in England. The second survey questioned healthcare professionals before ($n = 25$) and after ($n = 17$) proforma implementation on the accessibility of patient data and coherency of patient notes.

Results: 5 of the 17 criteria showed significant differences post proforma implementation. Of these differences, the recording of height and occupation was most notable ($p < 0.01$). Medication history, weight and investigations also showed significant increases in documentation ($p < 0.05$). In all 3 questions asked to healthcare professionals, fewer healthcare professionals were required to revisit archived notes following proforma implementation ($p < 0.05$).

Conclusion: Our study illustrates that a comprehensive surgical clerking proforma improves patient data documentation and saves healthcare professionals' time compared to the freehand clerking method. The implications of such work are far reaching, and if well implemented could allow a new reliable platform for further clinical audits.

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1. Background

Good quality patient care relies on the completeness of information, to which accurate documentation is essential [1]. Failure to produce accessible notes can lead to delayed patient treatment. For effective communication to take place between healthcare professionals, patient information must be recorded as accurately as possible. However, notes are notoriously inaccessible and poorly maintained [2].

The Royal College of Surgeons of England (RCSE) have produced Guidelines for Clinicians on Medical Records and Notes [3]. This sets out 17 criteria that should be included in all surgical patient documentation. This includes the patient's name, address, date of birth, unique identification number, occupation, patient history,

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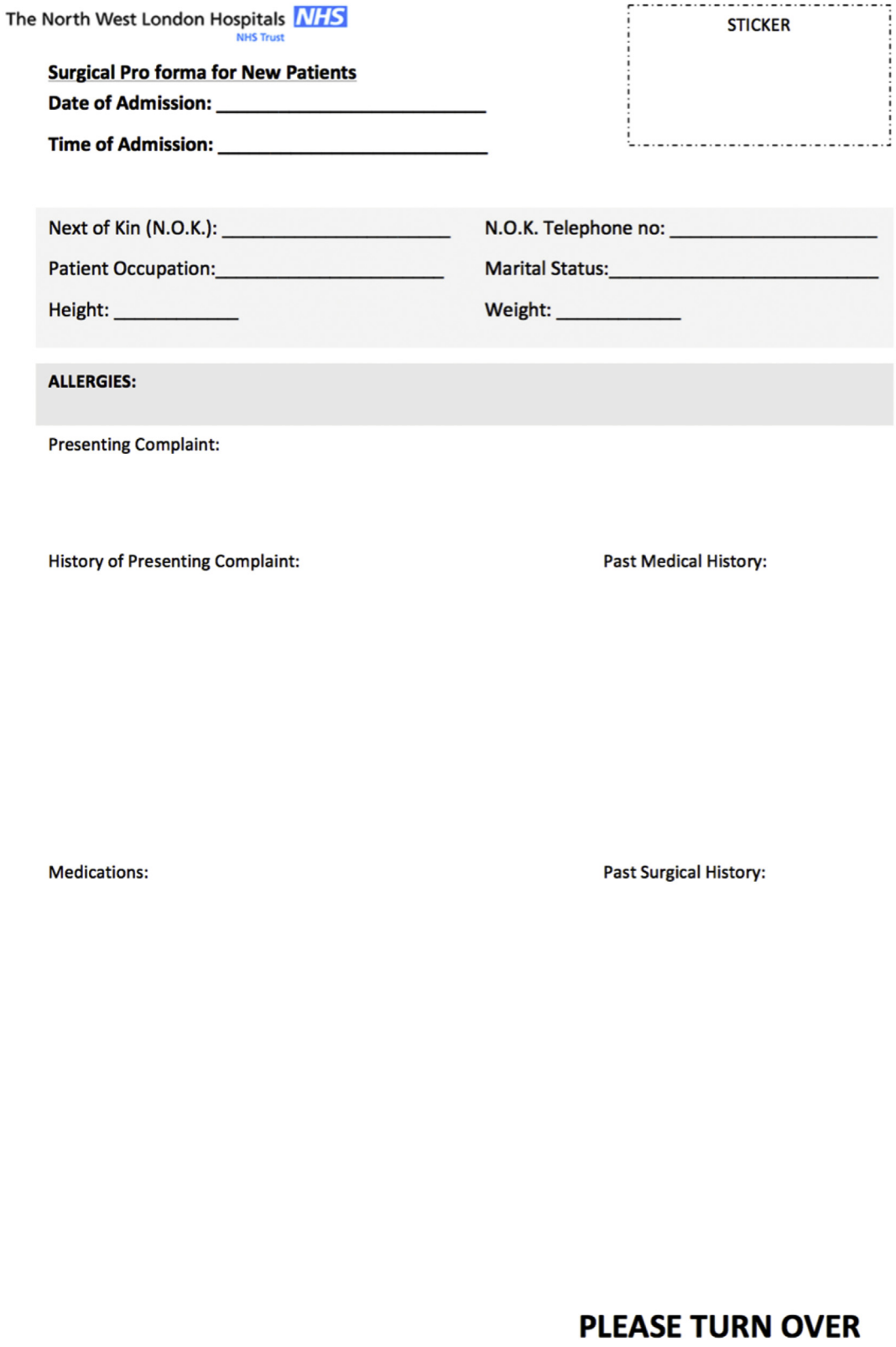

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STICKER

Surgical Pro forma for New Patients

Date of Admission: _____

Time of Admission: _____

Next of Kin (N.O.K.): _____ N.O.K. Telephone no: _____

Patient Occupation:_____ Marital Status:_____

Height: _____ Weight: _____

ALLERGIES:

Presenting Complaint:

History of Presenting Complaint:

Past Medical History:

Medications:

Past Surgical History:

PLEASE TURN OVER

Sticker: This is where a pre-printed patient sticker is stuck which already contains the patient's address and postcode and NHS number (if available)

Fig. 1. The Surgical Clerking Proforma. A double sided A4 document where patient details can be documented.

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