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Original article

The use of an aide-memoire to improve the quality of operation notes in an orthopaedic unit

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Each year the medical defence societies report cases where surgeons have lost medicolegal cases because of poor recording of operation details in operation notes.[1] This has cost the NHS a huge amount of unnecessary expense and undoubtedly damaged the reputation of many surgeons.[1] Poor operation notes make it difficult for medical and nursing staff to understand what type of procedure has been performed on the patient, what the postoperative requirements are and this affects postoperative care. Medical abbreviations are a common problem in understanding operating notes, and are now widely discouraged by medical journals due to possible ambiguity in their use.[2,3] In response to complaints about operation notes in our unit, we established an audit to assess the quality of operation notes.

Have you included the following in your operation note?

			Please tick
1.	The patient's details, date, ward and department	Yes	❑
2.	The name of the surgeon	Yes	❑
3.	The tourniquet time and pressure if applicable	Yes	❑
4.	The operative steps	Yes	❑
5.	Postoperative instructions	Yes	❑
6.	Only acceptable abbreviations	Yes	❑

Please be legible

Note acceptable abbreviations: MUA, EUA, POP, ORIF, K wire, #.

Figure 1: Aide-memoire attached to the operation sheet.

Methods

An audit for a period of one calendar month, June 1999, of all operations performed by the department of orthopaedics was carried out. The operation sheets were reviewed by a single observer with regard to the inclusion and legibility of: (i) accuracy of patient's details; (ii) date of the procedure; (iii) ward and department; (iv) name of surgeon; (v) tourniquet time and pressure where applicable; (vi) surgical approach; (vii) postoperative instructions; and (viii) the use of abbreviations.

The results of the June 1999 audit were presented at the departmental audit meeting, indicating the overall quality of operation notes produced by the department of orthopaedics was poor with a large number of illegible operating sheets and a large number of abbreviations being used. It was recommended that in the future only specifically agreed upon abbreviations would be allowed and that the use of an aide-memoire may help to improve operating note quality. It was decided to close the audit loop using the above

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recommendations. An identical audit was repeated for one calendar month in November 1999 with the addition of a small aide-memoire and a list of acceptable abbreviations attached to the front of each operating sheet (Fig. 1).

Results

In the June audit there were 70 patients (41 elective and 29 emergency cases) and in the November audit there were 82 patients (49 elective and 33 emergency cases). The results are shown in Table 1 and graphically in Figure 2.

In the June audit, 90% of patient details were correct with 7 patients having incomplete details. In the November audit, 97.1% of patients details were correct. In June the date was incorrect in two and missing in six operation sheets. In November the date was correct in all. Details with regard to ward and department were absent in 40% of June operation sheets and was 100% correct in the November audit.

The name of the operating surgeon could not be identified due to it being illegible in 4.3% operation sheets in June and 2.4% in the November audit. The tourniquet time and pressure was absent in 45.7% of operation sheets in the June audit and only 3.6% of applicable cases in the November audit.

Operative steps used were present in 70% of operation sheets in the June audit and a 100% of applicable cases in the November audit. Postoperative instructions were present in 97.6% of operation sheets in November, but only in 88.6% in the June audit. Unacceptable abbreviations were present in 38.6% of operation sheets in the June audit and only 3.6% in the November audit. The use of the aide-memoire also seemed to improve the overall legibility of operation sheets. An operation sheet was defined as legible if all words contained within it could be read by the observer. In the June audit operation note legibility was 90% which improved to 97.6% in the November audit.

Discussion

Meticulous medial record keeping is essential in our present climate of increasing number of medical negligence claims. Poor medical records may prejudice medical negligence cases.[4] Surgical operation notes are often used as evidence in medicolegal cases, those which are illegible and incomplete often result in the medical profession's downfall.[1] The use of confusing medical abbreviations has resulted in a number of errors in clinical practice,[2,3] there are a number of papers in the literature that actively discourage the use of medial abbreviations if at all possible.[2,3] Therefore, any mechanism or system that discourages the use of abbreviations, incomplete record keeping or prevents illegible record production will go a long way in avoiding the above problems. The use of an aide-memoire attached to the front of an operation sheet can dramatically improve the quality of operation notes as shown in the above audit.

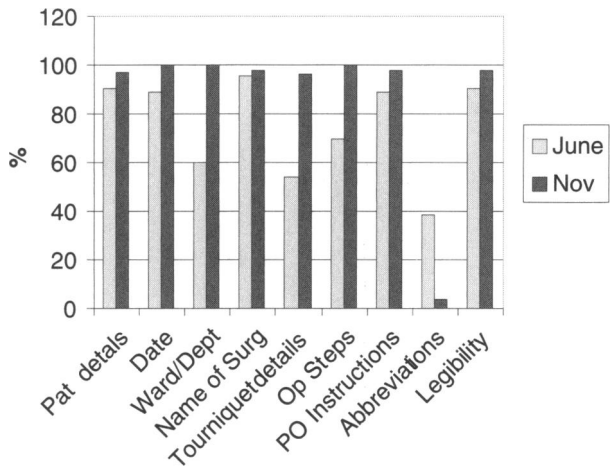

Figure 2 Graphical results of the June and November audit.

Table 1 Results of the June and November audits

	June %	November %
Patient details correct	90.0	97.1
Date correct	88.6	100
Ward and department correct	60	100
Name of surgeon legible	95.7	97.6
Tourniquet time and pressure recorded	54.3	96.3
Operative steps recorded	70	100
Postoperative instructions recorded	88.6	97.6
Unacceptable abbreviations	38.6	3.6
Legibility of operation note	90	97.6

Conclusions

We strongly recommend the use of an aide-memoire to other orthopaedic units as a means of improving surgical record keeping.

References

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