

The completeness and legibility of gynaecology ward-round documentation in a large UK centre: a clinical audit cycle and staff survey

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Background

- Complete and legible documentation of gynaecology ward-rounds is central to patient safety
- Several factors can negatively impact on the quality of such record-keeping, including busy wards, short staffing and high turnover of junior doctors
- In order to limit the negative impact these fixed factors have on the documentation during the ward round, we theorised it may be beneficial to standardise aspects of record keeping

Aim

To standardise the documentation of daily gynaecology ward rounds by improving completeness, efficiency, legibility - and ultimately optimise patient safety.

Objectives

- Carry out retrospective case note audit (Cycle I)
- Develop standardised ward round documentation
- Pilot change and re-audit (Cycle II)

Methods

- Ward round documentation was reviewed retrospectively for 50 consecutive inpatients on a gynaecology ward in a large UK centre in November 2021 (cycle I)
- Data was collected from each ward round entry – including documented reference to 24 pre-defined categories deemed important for gynaecology patient assessment on a ward round, e.g. pain, bleeding, fluid status.
- Legibility of each ward round entry was scored on a scale of 1-5
- Junior doctors working in the department were also asked to complete a questionnaire, seeking personal experience of rounds and suggestions for improvement

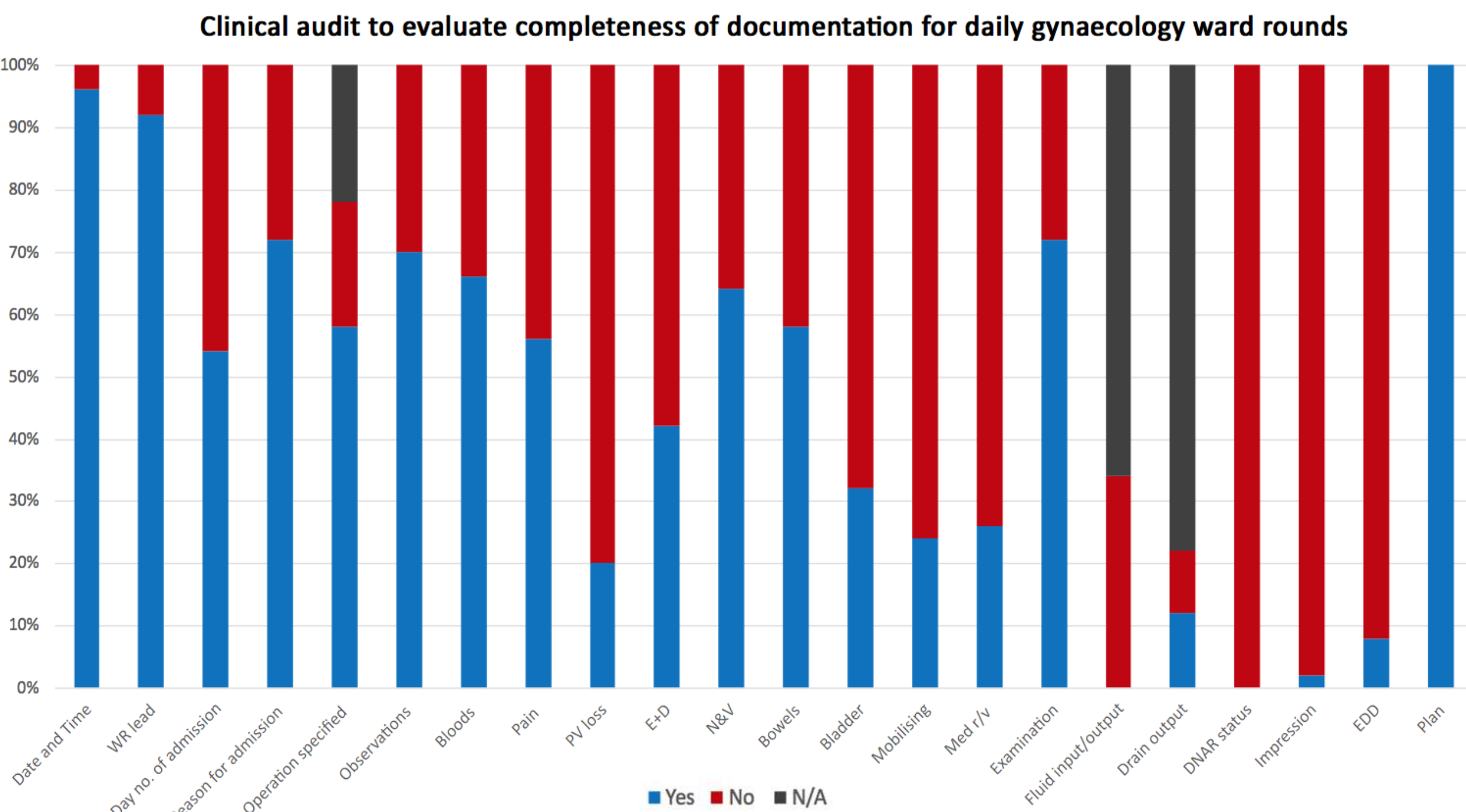


Figure 1: A bar graph representation of whether or not the patient assessment category was documented in the ward round entry, quantified by percentage of the 50 ward round entries analysed.

- Based on these findings, standardised ward-round proformas were developed - and subsequently piloted for 2 months
- A re-audit was undertaken, closing the loop and evaluating this change in practice (cycle II)

Figure 2a (above): The gynaecology ward round proforma created, used to document each ward-round.

Figure 2b (left): The patient investigations proforma created, with investigation results to be documented and reviewed each day

Results

Cycle I: n=50. x3 categories of patient assessment were documented in >90% of ward rounds – the date and time, the ward round lead and the plan; x9 categories were documented in > 50%; x6 categories were documented in < 50%; x4 categories were documented in <10%. Legibility was scored as ‘1-*perfect*’ in 45% and ‘5-*below average*’ in 8%.

Cycle II: n=35. x4 categories of patient assessment were documented in >90% of ward rounds – ward round lead, eating and drinking, observations and plan. x13 in >50%; x3 in < 50%; and x2 in <10%. For legibility, 72% scored ‘1-*perfect*’ and none as ‘5-*below average*’.

Categories	Cycle I	Cycle II	Comparison	Categories	Cycle I	Cycle II	Comparison
Date and time	96%	80%	16% decrease (time not documented)	Bowels	58%	86%	28% increase
WR lead	92%	100%	8% increase	Bladder	32%	80%	48% increase
Day n° of admission	54%	74%	20% increase	Mobilising	24%	89%	65% increase
Reason for admission	72%	80%	8% increase	Current meds	26%	89%	63% increase
Operation specified	58%	63%	5% increase	Examination findings	72%	80%	8% increase\
Observations	70%	100%	30% increase	Drain IP/OP	12%	9%	3% increase
Ix proforma filled/Bloods	66%	89%	23% increase	Fluid balance	0%	0%	No change
Pain	56%	89%	33% increase	DNAR status	0%	71%	71% increase
PV loss	20%	46%	26% increase	Impression	2%	31%	29% increase
E+D	42%	94%	52% increase	EDD	8%	43%	35% increase
N+V	64%	89%	25% increase	Plan	100%	100%	No change

Figure 3: Comparison of the percentage of assessment categories that were documented between cycle I and cycle II.

Conclusion

Global improvement was demonstrated on re-audit for documentation across 18/24 categories of patient assessment and legibility. To conclude, the utilisation of a standardised gynaecology ward round proforma appears to improve the completeness, efficiency, and legibility of documentation – generating a robust record and optimising patient safety.