

ASSESSMENT OF THE ADEQUACY OF DOCUMENTATION AT THE OBSTETRICS AND GYNAECOLOGY ADMISSION ROOM

INTRODUCTION

A thorough history forms the basis of a gynaecological and obstetric consultation in an emergency setting. It is also the basis to form a differential diagnosis, serves as mode of communication with colleagues within the department and of other specialities. Not the mention litigation issues.

METHODOLOGY

Retrospective data collection from O&G admission room record sheet – patient demographics and salient points in the history / examination / investigations
March – April 2022

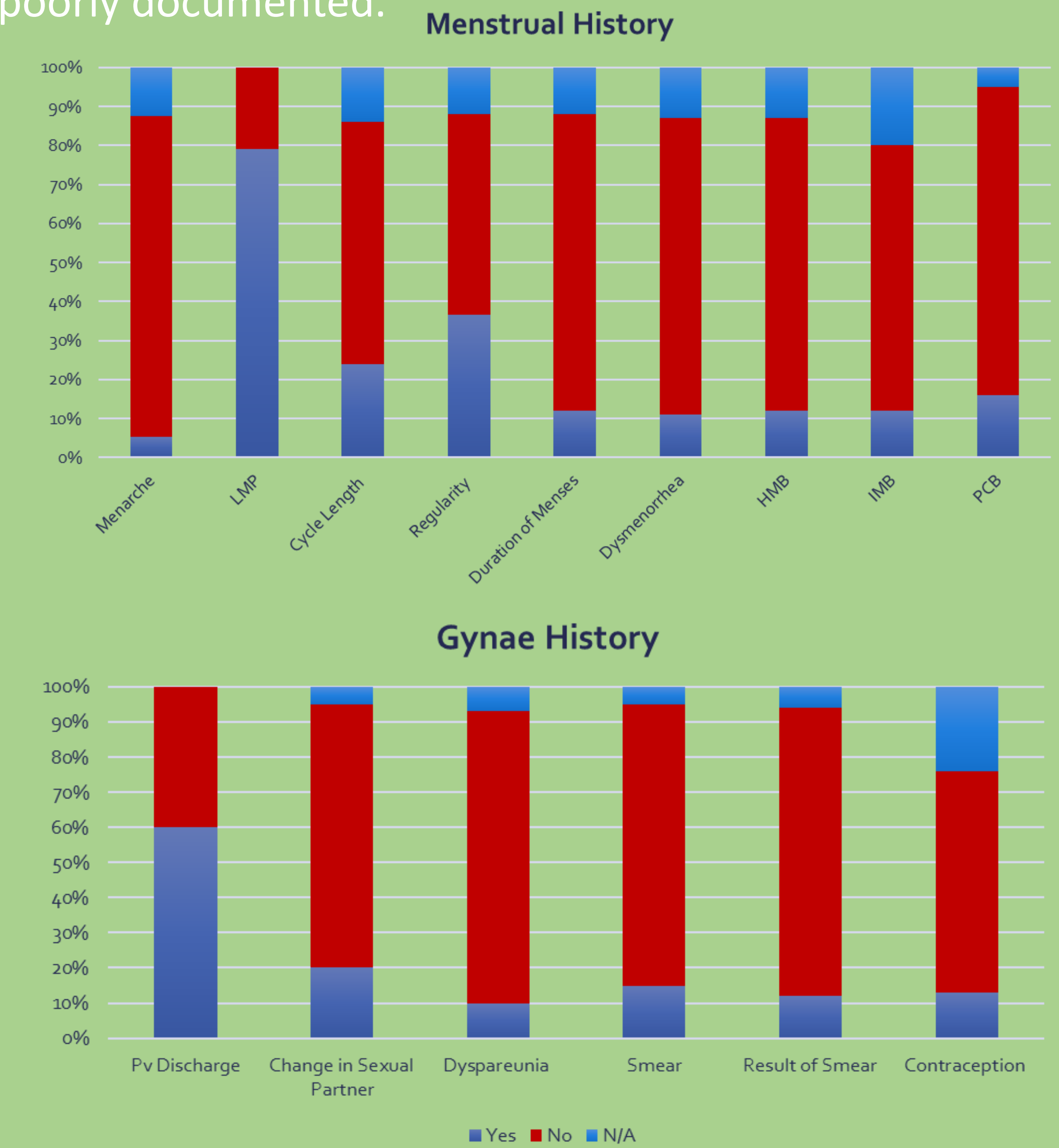
RESULTS

Name, ID and Age were mostly adequately documented, however >30% of sheets had no contact number.

60% of the consultations did not have the time and the doctor’s name documented. 95% of patients had good documentation of Date, Admitting Consultant, Doctor’s Signature including medical registration no.

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Menstrual history included documentation of the LMP in many cases but other parts of the gynae History were poorly documented.



Parity was documented in 86% of patients & gravidity recorded in 30%. Mode and date of delivery noted in 32% and 34% of cases. Hx of miscarriages/TOP was documented in 71% while the date/mode of Mx of miscarriage was reported in 7% .

The PMH, PSH and DH/Allergies were documented in around 80% of consultations. There was poor documentation of the Family Hx and Social Hx with 4% and 14% respectively. The HIT test and urinalysis results were documented in 63% and 61% respectively.

DISCUSSION & CONCLUSION

A thorough history forms the basis of patient assessment, especially those presenting acutely. Gynecological history taking involves a series of methodical questions with the aim of developing a differential diagnosis to plan further management.

The old sheet which was used in admission room was not exhaustive. As seen in this audit, there were several important history points which were not documented. The updated template, seen below, is a means of improving documentation during consultations.

OBSTETRICS & GYNAECOLOGY EMERGENCY NOTE	
Name & Surname:	Date & Time:
ID number:	Admitting Consultant:
Age:	Caring Doctor:
	Contact number:
Presenting Complaint:	
Gynaecological Hx:	
LMP:	Menarche:
Cycle Length:	Duration of menses:
Regular/Irregular:	IMB/PCB:
HMB:	Dysmenorrhoea:
PV discharge:	Deep Dyspareunia:
Change in sexual partner last 6m:	Contraception:
Last smear & result:	
Obstetric Hx:	
Gravidity + Parity:	
Last delivery - Date and Mode:	
Miscarriages - Date and Mode of management:	
PMH:	PSH:
LUTS:	Pregnancy test:
Bowels:	Urinalysis:
Allergies:	Parameters:
DH:	
Family Hx:	Ultrasound:
Social Hx:	
Examination:	
Management:	