

Standardising day 1 post Caesarean section documentation and improving communication with primary care

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Introduction

Legible and accurate documentation in patient’s medical record is essential for patient safety and future reference. When assessing patients 1 day post Caesarean section (CS) the team should include:

- Indication for CS and antenatal issues
- Intraoperative complications / blood loss
- Observations
- Recent bloods
- Contraception advice

According to NICE(1) communication when transferring post-natal women from secondary to primary care should include:

- issues during pregnancy, complications during birth and postnatal period
- plan for long-term conditions
- mental health concerns
- safeguarding concerns
- concerns about the baby’s health

At 6-8 weeks after birth GP should carry out the necessary assessments and investigations for women with gestational diabetes, gestational hypertension, pre-eclampsia and hypothyroidism.

Aims

1. Review and aim to standardise Day 1 post Caesarean section documentation
 - a. Reason for CS
 - b. Antenatal issues and intraoperative complications
 - c. Blood loss, blood results
 - d. Mother’s concerns
 - e. Contraception
 - f. Follow up plan
2. Review letters to GP at discharge for patients post CS - ensure
 - a. Antenatal issues and complications during birth
 - b. Follow up plan

Methodology

- Retrospective study
- Elective and emergency Caesarean section patients at Milton Keynes University hospital
- Cycle 1 identified 35 patients during a 2 week period in October 2021
- Cycle 2 identified 58 patients during a 3 week period in March 2022
- Data collection
 - e-Care used to look into the documentation notes and discharge letters
 - Data recorded on Excel spreadsheet

Implementing change

- Standard Day 1 post CS review implemented by introducing a /MATDAY1CS autotext for all to use
- Knowledge disseminated to doctors and midwives via email and daily ward rounds
- Follow up plan section in the Day 1 review autotext can be used in the GP discharge letter

Results

1. Day 1 CS documentation - Improvement in all variables

D1 CS variable	Cycle 1 % documented	Cycle 2 % documented
Auto text used	N/A	88%
Indication	63%	98%
Intraoperative complications recorded	20%	88%
Blood loss	86%	98%
Blood products given	60%	64%
Antenatal issues recorded*	34%	66%
Hb before/ Hb after/ platelets	66% / 80% / 20%	84%
Mother’s concerns	11%	43%
Contraception	20%	57%
Follow up plan	26%	53%

Results

2. Discharge letters – minimal information

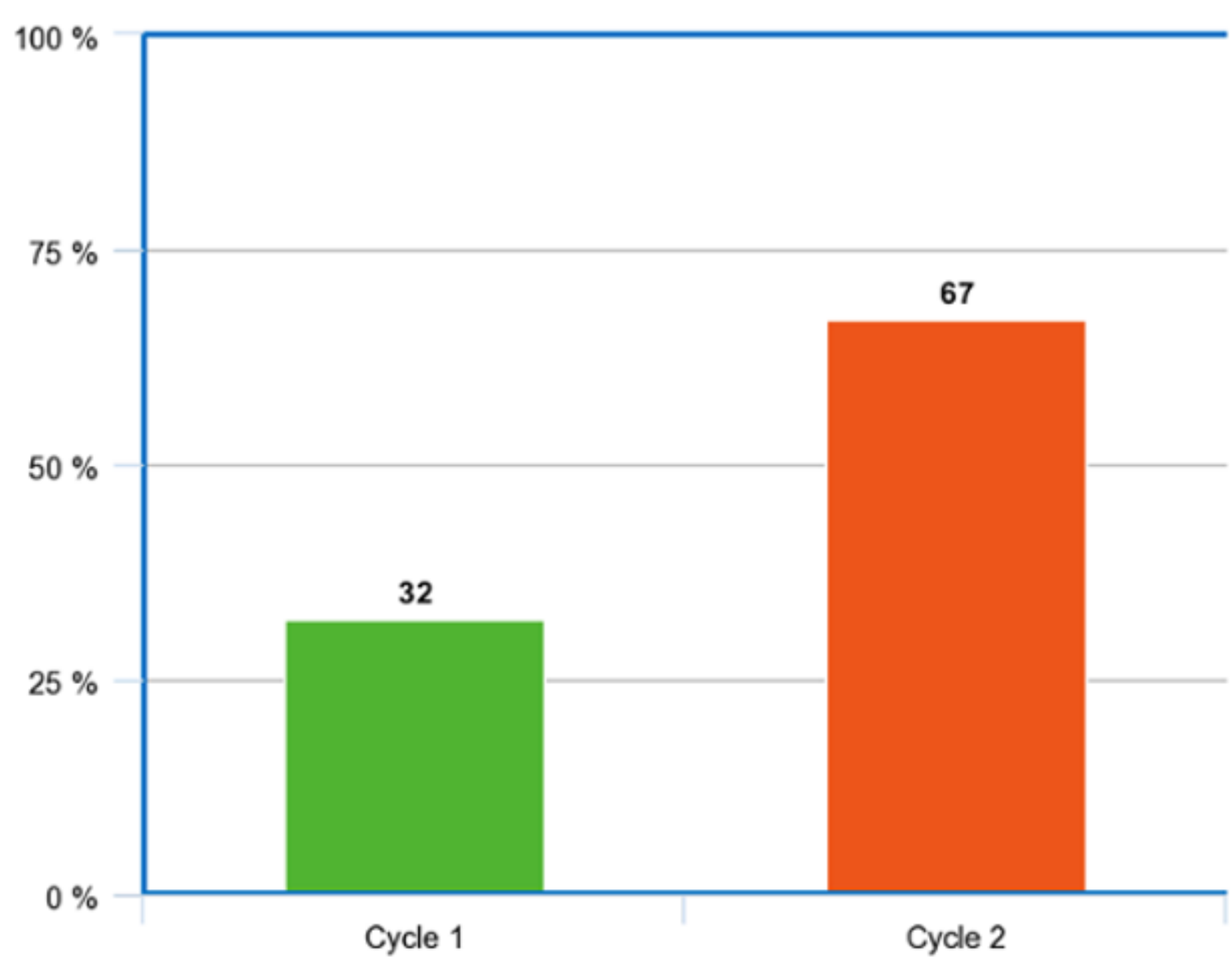
Cycle 1

- ONLY 8 out of 25 (32%) patients had complications recorded in their discharge letters.
- NONE of the patients (0%) had the follow up plan in the discharge letter to the GP.

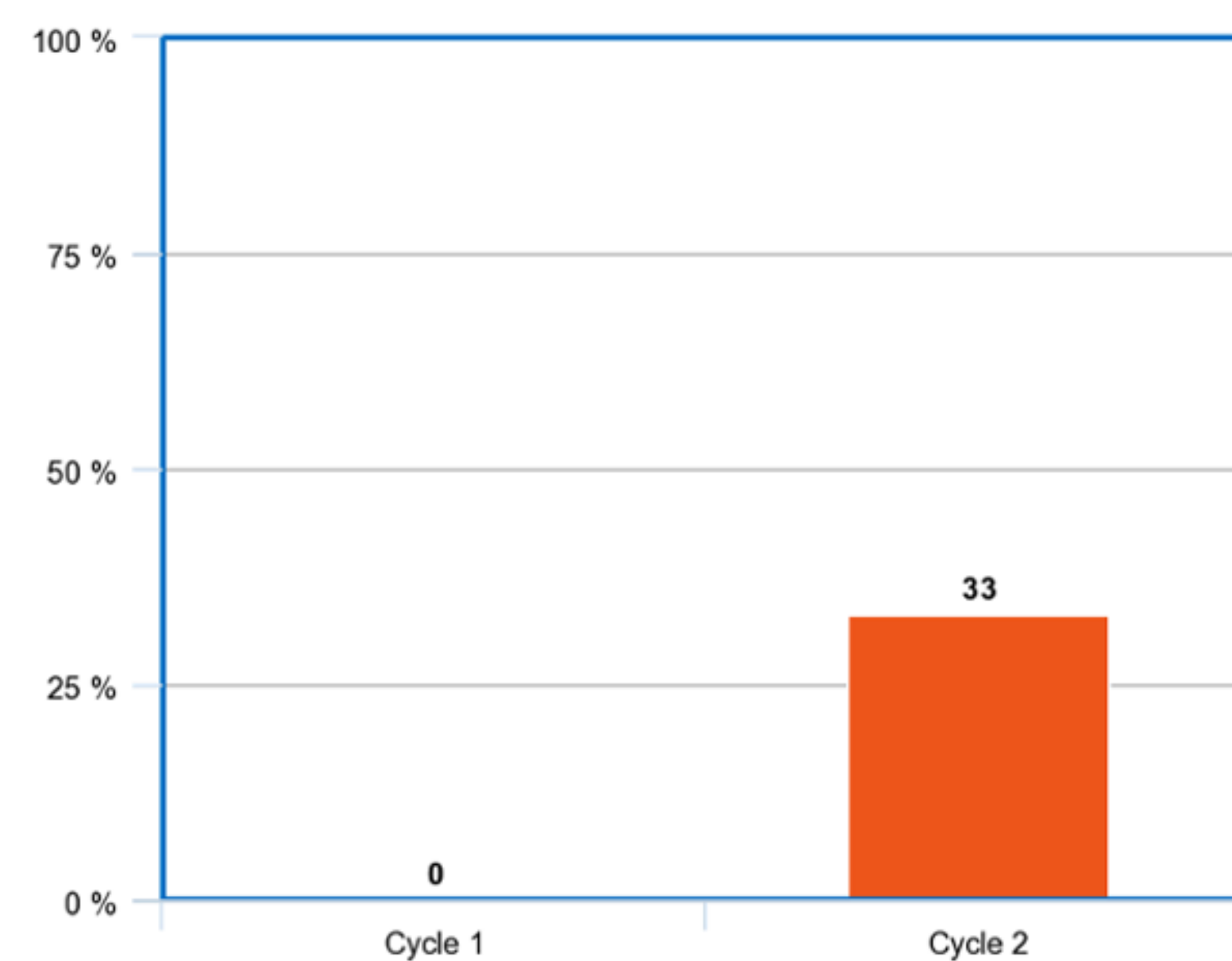
Cycle 2

- 10 out of 15 (67%) patients had complications recorded in their discharge letters.
- 5 out of 15 (33%) had the follow up plan in the discharge letter to the GP.

Comparison of documentation of antenatal issues in discharge letters



Comparison of documentation of follow up plan in discharge letters



Conclusion

- There has been a great use of the /MATDAY1CS autotext (88%)
- This improved documentation of **all the variables** in Day 1 CS review
 - We need to ensure that contraception (57%), mother’s concerns (43%) and follow up (53%) are included in the review
- Follow up information in the discharge letters has improved (33% compared to 0%)
- MKUH hospital now ensures that awareness of the autotext is raised to all junior doctors on their induction days in order to continue improving accurate documentation.

Limitations

- Small group of participants
- Only a two/three week period was chosen
- We did not look at whether these participants were followed up appropriately at the GP
- GPs already receive letters for patients with Gestational Diabetes
- Did not review follow up for vaginal birth



References

NICE 2006. *Postnatal care up to 8 weeks after birth*. Available from: www.nice.org.uk/CG37.