

Improving the documentation of pleural procedures: the impact of a new standardised pleural procedure pro forma

Authors: Neda Hasan and Simon Barnes

Aims

To design, implement and evaluate the impact of a new pleural procedure pro forma, in order to standardise documentation, improve communication and enable accurate reimbursement.

Methods

We conducted a retrospective review of clinical notes of patients undergoing pleural procedures under the respiratory team between November 2014 and March 2015. Procedures included thoracic ultrasound, pleural aspiration, chest drain, talc pleurodesis, and indwelling pleural catheter.

Clinical entries were audited against a checklist of parameters adapted from the 2010 British Thoracic Society guidelines on pleural procedures. The checklist included six general parameters: consent, operator details, indication, type of procedure, complications, and a risk assessment (INR and platelets). The checklist also included six pleural-specific parameters: site of abnormality, ultrasound findings, medications administered, aspirate amount and character, tests requested, and post-procedure management.

A pro forma that directly complimented the checklist was designed and introduced in April 2015. These were completed by the attending physician and filed into the patient's notes. Pro forma completion was reviewed on a monthly cycle between April and July 2015, with 12 randomly selected, completed pro formas, audited against the checklist. Electronic discharge letters (EDLs) were also reviewed to assess whether procedural details were added due to the introduction of the new pro forma. Throughout this process, the pro forma was peer evaluated and reviewed at our clinical governance meetings.

Results

During each cycle we completed an average of 30 procedures. There was significant variability in documentation between individual physicians. However, in no cases were all 12 parameters recorded. Following the introduction of the pro forma, 66% of forms achieved full completion of all 12 parameters, which was maintained on subsequent cycles ($p = 0.002$). This improvement in documentation was also

reflected in accurate completion of EDLs, rising from one to seven out of 12 EDLs following introduction of the pro forma. Parameters that were least frequently recorded were complications, consent and post-procedure management.

Conclusions

The introduction of a new pro forma significantly improved clinical documentation and communication of pleural procedures between physicians and primary care. Additionally there has been positive feedback from the clinical coding department, as the new form has aided accurate clinical coding and therefore financial reimbursement. However, there are some parameters that we still fail to record, including post-procedural management.

In our experience, a procedural pro forma has improved the clarity and consistency of our documentation, leading to optimised communication and patient care. ■

Authors: Royal Berkshire NHS Foundation Trust, Reading, UK