Audit on Documentation in Obstetric Emergencies

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Abstract

Background: Accurate documentation in obstetric emergencies is essential for effective communication, continuity of care, quality assessment, and legal protection. This audit evaluates compliance with documentation standards in an obstetric department, focusing on **pre-procedure notes, post-procedure notes, duty of candour, follow-up plans, and incident reporting.**

Methods: A retrospective observational study was conducted in 2017-18, analysing **selected obstetric emergencies** from patient medical records. Key documentation aspects included **pre-procedure and post-procedure notes for LSCS (category 1/2), assisted vaginal deliveries (AVD), and obstetric anal sphincter injuries (OASIS). Additionally, complications, duty of candour adherence, follow-up plans, and incident reporting (Datix) were reviewed.**

Results:

- Initial audit revealed **gaps in pre-procedure documentation,** especially in LSCS, AVD, and OASIS cases.
- **Post-procedure documentation showed improvement,** but some cases remained incomplete.
- **Duty of candour** was performed inconsistently, particularly in major obstetric haemorrhage (MOH), OASIS, and shoulder dystocia cases.
- **Follow-up plans** were underutilized, especially in MOH and OASIS patients.
- **Critical incident reporting (Datix) was largely neglected,** raising concerns regarding safety culture.

Following an intervention, a **re-audit demonstrated significant improvements,** including enhanced documentation compliance, better follow-up planning, and increased duty of candour adherence.

Conclusion: While documentation in obstetric emergencies improved significantly post-intervention, **areas for further enhancement remain.** Emphasizing documentation at handovers, department meetings, and through periodic re-audits can foster sustained improvement.

Recommendations: To ensure ongoing progress, it is recommended that **monthly departmental reminders, regular re-audits (every 6-12 months), and structured training sessions** be implemented to reinforce best practices in obstetric documentation.