Introduction
Globally, the use of information technology (IT) in medical settings is increasing as it has been proven that IT can improve the quality of health care effectively. Perioperative IT has the potential for reducing costs, increasing management efficiency, and allowing affordable access to health care (Sweeney 2010). Tseung Kwan O Hospital (TKOH) is a pioneer in the perioperative electronic nursing record development in Hong Kong. They developed the Perioperative Nursing Information System (PNIS) in the first operating theatre which is the first of its kind. With the standardization of peri-operative nursing data set, completed intra-operative nursing record and surgical counting record can be uploaded to CMS and incorporated to the electronic patient record (ePR). All these made retrieval of the patient’s perioperative nursing record possible from any HA hospital, regardless of time and place. Prevention of retained surgical item (RSI) is one of the priority areas in surgical safety. Accurate surgical counts help avoid RSI (Rowlands 2012). Retained surgical items can lead to detrimental consequences. After migrating to the electronic record system, intra-operative documentation was made easy. Theatre nurses can now better use their time on direct patient care. In addition, the service quality and efficiency were improved and the accuracy in documentation was ensured.

Objectives
Objectives 1. To enhance the efficacy of intraoperative documentation and counting through information technology. 2. To align with the trend of using information technology in perioperative setting and improve the quality of care through PNIS. 3. To enhance staff acceptance and satisfaction on using information technology in nursing documentation. 4. To reduce the likelihood of incidents related to retained surgical items (RSI).
Methodology
A comprehensive programme of electronic count sheet (eCS) and intra-op documentation was designed and launched in TKOH from September 2014. A task group was formed to develop the hardware and software with extensive consultation with all levels of nursing staff within the department and experts in the field. Intensive training on both content writing and the use of electronic devices were provided through tutorials and individual coaching. A systematic action plan was designed and rolled out. Critical analysis of documents at the pilot phase was performed for fine tuning. To enhance staff compliance, designated subject officers provided ample support at the clinical area. Staff acceptance was evaluated. A descriptive survey was conducted by questionnaire with Likert scale.

Result
Result 1. Staff Acceptance and Satisfaction Ensured Pre-test and post-test questionnaires were collected with return rate 100%. After the implementation of eCS, majority of the nursing staff welcome the change of using electronic counting sheet, and over 97% of the nursing staff were positive towards the use of the electronic counting system. They found it easy to operate, reliable, secure and efficient.

2. Documentation Accuracy Ensured Around 96% of the records were accurately completed during the initial eCS trial period. Result was assured by post implementation audit, with a total of 100 records reviewed retrospectively. Record completeness was checked and 100% compliance after completion of system training and software enhancement.

3. No RSI Assured. There was no RSI incident during the trial run and live run of eCS.

Conclusion The project has proved to be a success. Since the launching, staff show great enthusiasm in adopting the documentation system. With their cohered effort, the electronic count sheet and intra-op documentation are successfully integrated into our Anaesthesia Clinical Information System (ACIS) in TKOH. All these made nursing documentation visible and accessible by the healthcare staff concerned. Continuity of patient care is facilitated which after all would benefit our patients for surgery.