Service Priorities and Programmes

Electronic Presentations

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Electronic PACU record for post-operative patient attendance and discharge system

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Introduction

In current practice, Post Anesthetic Care Unit (PACU) nurses use manual record book for documenting postoperative patient admission. Consequently, the implication of manual record has led to the following issues:

1. time consuming on manual documentation including sticking patient's label and writing patient's operation details (Admit date and time of PACU, Operation, Surgeon, Anaesthesia Type, Anaesthesiologist, Ward, Inform Time, Staff Arrival Time, PACU Nurse and Remarks) in PACU Record Book during admission to PACU;
2. potential inaccurate documentation of the patient data by handwriting, for example, there may be incomplete or unclear entry;
3. difficult on patient data tracking and tracing;
4. insufficient space for the storage of the numerous record books; and
5. increase the cost spending on printing the record book ($4740 per year).

Objectives

Streamline the workflow of the postoperative patient documentation in the PACU by merging it to the electronic Anesthesia Clinical Information System (ACIS).

Methodology

Use Plan-Do-Check-Act (PDCA) Cycle for continuous improvement:

Plan

1. Review the essential items of the current record book and avoid double entry of data while merging to the electronic ACIS

Do

1. Discuss with ACIS administrator to design a user friendly system with concise and precise record of patient data
2. Provide training sessions for all nursing staff, to respond to their concerns as well as conduct on-site support and monitoring
3. Promulgate the change explicitly to other key stakeholders such as surgeons and anesthesiologists
4. Conduct one-month trial to enhance the system

Check

1. Make consensus with stakeholders and perform evaluation of the outcome
Act
1. Since colleagues involved in the one-month trial reflected positive opinion and satisfied with it, the process will continue

Result

From 22 August to 22 September 2016, 780 number of records utilized the new system for documentation and record. At the same time, 1 formal and 5 informal interviews were conducted. As a result, there are four salient points to reveal the outcomes as:

1. Focus on direct patient care by nurses and avoid the tedious manual documentation. There were 160 hours saved per year, leading to 320 more patient per year can be handled
2. Integrate post-operative patient attendance and discharge record in a single page. There were 12 record books saved per year.
3. Trace patient data for statistics effectively and efficiently; and
4. Save storage space and money. It saved around 0.5 m^3 and $4,740 per year.