



## Purpose

Utilize clinical summary pages within the electronic health record (EHR) to facilitate interprofessional communication during hand-off of the post-operative patient in order to save time and improve patient safety.

## Relevance & Significance

- The EHR stores millions of pieces of data. Finding the exact information can prove daunting.
- Anesthesia documentation moved from a paper trifold to an electronic format
- Electronic version 3-15 pages
- Developing strategies to produce meaningful real-time viewable information assists in:
  - Strengthening Communication
  - Enhancing Quality Care
  - Improving Patient Safety
  - Strengthening Interprofessional Communication

## Methodology

- Collaboration with Anesthesia, Nursing, IT resources
- Define key data elements
- Map data to summary page
- Enhance summary page appearance & customizability

### Team Members:

- End Users
- Informatics
- Data Base Administrators
- Clinical Champions

## Summary Page

## Analysis

- Decreased length of time to locate information
- Most important anesthesia data identified as:
  - IV Site Insertion
  - Time of Antibiotic Administration
  - Location of Blocks Used

## Implications for Practice

- Improved interprofessional communication across care settings
- Enhances patient care delivery
- Heightens safety
- Improved clinician satisfaction

## Future Considerations

- Additional projects underway including a nurse chart review summary page
- Replicate use of summary page for other clinical areas

## References & Acknowledgements

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