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**Development of a Shared Multidisciplinary Electronic Preanesthetic Record**

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**Background:** A shared multidisciplinary electronic preanesthetic record allows for patient history and physical examination data to be entered by preoperative nurses, perioperative internal medicine hospitalists, same-day surgery nurses, and/or anesthesiologists and be continually carried forward, verified, corrected, and updated throughout the perioperative period.

**Purpose:** To create a multidisciplinary tool that accomplishes necessary documentation for nursing, perioperative hospitalists, anesthesiologists, and surgeons sharing patient care by charting important patient data that remains in a centralized location accessible throughout a patient's hospitalization. A shared process allows for the most correct and thorough patient health information to be included in the preoperative H&P and postoperative admitting note for the surgical or hospitalist team assisting with postoperative care.

**Description:** Advantages of electronic medical records include legibility and central data storage to provide access from multiple locations by multiple providers simultaneously. The anesthesiology and information technology departments at Northwestern Memorial Hospital worked in conjunction in 2007–2008 to develop the original electronic version of the preanesthetic record that generated an anesthesia preoperative H&P note in the hospital inpatient Cerner Power-chart system. In 2008 this was expanded to include a Pre-op Assessment Signout “tear-off sheet” report that extracted patient information from the anesthesia H&P (systems assessment, physical exam, anesthetic plan) and central areas (allergies, medication list, problem list, etc.) and created this tool that looks more like a traditional paper anesthesia preop record, allowing for quick access to key patient data in the operating room. In 2009, variations of the note were created to serve the needs of preoperative medical risk evaluations done by the perioperative medicine hospitalist physicians in clinic and the preoperative nurses completing patient phone screens and same-day surgery nurses doing patient intake.

**Results:** A shared multidisciplinary electronic preanesthetic record allowed any provider to copy a record forward, regardless of its original author, and update its information to reflect their individual documentation needs and exam findings without losing any of the information already documented by another provider. It seems logical that this throughput of information can reduce transcription errors and build a stronger database of patient information, particularly regarding medications and past medical history.

**Conclusions:** It is possible to create a shared multidisciplinary electronic preanesthetic record that satisfies the documentation needs of perioperative physicians and nursing staff.