Introduction: This study documents the incidence of breaks in continuity of transfer of information which occurs as a result of omission in required documentation as the patient moves through the six phases of the perioperative process. A transfer of information failure is defined as a failure of information to transfer from one phase of the perioperative process to the next.

Identification of the problem: The research question is “What is the frequency of failure in the transference of information in the perioperative documentation process?”

Purpose of the Study: Patients who require surgery move through various departments in order to receive the specialized care required to prepare, care for, and recover from the surgical intervention. Documentation regarding the patient’s cardiac history, general history and physical, allergy, antibiotic status, and venous thrombo-embolism risk and prophylaxis is queried, documented, and passed on to the personnel through designated documentation systems in the next perioperative phase. The significance of this study will be the analysis of the volume of these proposed near misses and the potential safety risk value of these events.

Methodology: 300 charts were reviewed for five variables across the six perioperative phases. Using a data dictionary, three raters noted the presence or absence of each variable at each documentation phase.

Results: 300 charts were reviewed with 5586 possible documentation entries. Of the 5586 possible entries, we found 572 or 10% of all of the pre-identified documentation entries were either dropped or modified somewhere along the perioperative continuum. Allergy was the most frequent datapoint either not documented or conveyed or having changed by allergies being added or omitted completely at 46.3% of the dropped documentation.

Discussion: A patient will travel through six phases of care in the perioperative process. No two phases mirror the prior phase. Of the six departments that use electronic systems, there are multiple “other” electronic systems programs used, few of which “communicate” to each other. As a result, many of the processes either need to be duplicated from paper to electronic, electronic to electronic system, or from electronic to paper system. In addition to information lost, this is a highly inefficient process and a staff dissatisfier.

Conclusion: This study confirms that information was simply disappearing at points of patient transfer across several phases of the perioperative spectrum/services. Are current IT systems an impediment to patient care if they are not comprehensive enough and integrated with other facility systems, to follow the patient through the health care spectrum?

Lastly, the big question is “how do we fix this”? Without the resources to implement a comprehensive and integrated IT system and the ability to hire the additional staff members it
would take to perform very thorough chart audits, what can we put into place that would ensure
certainty in our processes? Additional investigations are necessary to answer this question.

Implications: It is important to have a consistent documentation system that facilitates charting
from the beginning to the end of a surgical patient’s visit. That means all perioperative
documentation applications should integrate preoperative assessment, anesthesia assessment,
intraoperative charting to include anesthesia, and PACU flow sheet, as well as supporting the
surgery is a complicated event where just-in-time access to vital information is instrumental for
optimal team functioning.