Standardized Handoff Report using Electronic Medical Record

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Background: Our Orthopedic Medical and Surgical Unit approached our Practice Council hoping to adapt a report tool that was successfully used when transferring patients from the ED to the inpatient unit. The handoff smart text note was entered in the Electronic Medical record using key items from the RN's charting.

Objectives:

- Create a standardized report through our Electronic Medical Record to eliminate variations in nurse to nurse report out when transferring from PACU to inpatient unit.
- Improve communication that could inadvertently be omitted during a verbal handoff.

Implementation:

- Representatives from our Practice Council met with the Med/Surg Nurse Manager and Clinical Analyst to modify the current note template created by the ER.
- Informatic specialists created a draft of initial template.
- While trialing template PACU nurses gave suggestions for drop down menu items that would not autofill from our charting.
- Final team meeting focused on efficiency of note and eliminating unnecessary key strokes.
- Tip sheets were distributed to the staff for self-guided training.
- Initial implementation, PACU staff both entered the smart text note, but also gave verbal report over the phone.

Successful: With the Med/Surg Nurse reviewing key components of our patient's history through the smart text note prior to our phone call we decrease time away from the bedside to give report over the phone. Nurses were giving a more consistent report as it is all prompted in the smart text note created. While our previous report given over the phone was not recorded, our new report is saved as a nurse's note in the chart for future shifts to reference.

Implications: When using a smart text note within the Electronic Medical Record Nurses give a complete handoff that prompts them to address key components for their patient's care.