



SURGERY

USER MANUAL

Version 3.0

July 1993

(Revised August 2004)

Revision History

Each time this manual is updated, the Title Page lists the new revised date and this page describes the changes. Either update the existing manual with the Change Pages document, or replace it with the updated manual.

Note: The Change Pages document may include unedited pages needed for two-sided copying. Only edited pages display the patch number and revision date in the page footer.

Date	Revised Pages	Patch Number	Description
08/04	vi, 437, 439, 441-452, 454-455, 457, 459, 461, 463-464, 464a-b, 465-466, 466a-b, 467, 469-470, 470a-b, 471-475, 475a-b, 476-482, 482a-b, 527-530	SR*3*125	Updated the Table of Contents and Index. Clarified the location of the national centers for NSQIP and CICSP. Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software and new options have been added. For an overview of the data entry changes, see the <i>Surgery NSQIP/CICSP Enhancements 2004 Release Notes</i> . Added the <i>Laboratory Test Result (Enter/Edit)</i> option and the <i>Outcome Information (Enter/Edit)</i> option to the <i>Cardiac Risk Assessment Information (Enter/Edit)</i> menu section. Changed the name of the <i>Cardiac Procedures Requiring CPB (Enter/Edit)</i> option to <i>Cardiac Procedures Operative Data (Enter/Edit)</i> option. Removed the <i>Update Operations as Unrelated/Related to Death</i> option from the <i>Surgery Risk Assessment Menu</i> .
08/04	6-10, 14, 103, 105-107, 109-112, 114-120, 122-124, 141-152, 218-219, 284-287, 324, 370-377	SR*3*129	Updated examples to include the new levels for the Attending Code (or Resident Supervision). Also updated examples to include the new fields for ensuring Correct Surgery. For specific options affected by each of these updates, please see the <i>Resident Supervision/Ensuring Correct Surgery Phase II Release Notes</i> .
04/04	All	SR*3*100	All pages were updated to reflect the most recent Clinical Ancillary Local Documentation Standards and the changes resulting from the Surgery Electronic Signature for Operative Reports project, SR*3*100. For more information about the specific changes, see the patch description or the <i>Surgery Electronic Signature for Operative Reports Release Notes</i> .

(This page included for two-sided copying.)

Comments Option.....	205
CPT/ICD9 Coding Menu.....	207
CPT/ICD9 Update/Verify Menu.....	208
Update/Verify Procedure/Diagnosis Codes	209
Operation/Procedure Report	213
Nurse Intraoperative Report	217
Cumulative Report of CPT Codes	220
Report of CPT Coding Accuracy.....	224
List Completed Cases Missing CPT Codes	230
List of Operations	232
List of Operations (by Surgical Specialty)	234
Report of Daily Operating Room Activity	236
PCE Filing Status Report.....	238
Report of Non-O.R. Procedures.....	243
Chapter Three: Generating Surgical Reports.....	249
Introduction	249
Exiting an Option or the System.....	249
Option Overview	249
Surgery Reports.....	251
Management Reports	252
List of Operations (by Surgical Priority)	267
Surgery Staffing Reports	283
Anesthesia Reports	296
CPT Code Reports	305
Laboratory Interim Report.....	319
Chapter Four: Chief of Surgery Reports.....	321
Introduction	321
Exiting an Option or the System.....	321
Option Overview	321
Chief of Surgery Menu.....	323
View Patient Perioperative Occurrences	324
Management Reports	325
Unlock a Case for Editing.....	394
Update Status of Returns Within 30 Days	395
Update Cancelled Cases	396
Update Operations as Unrelated/Related to Death	397
Update/Verify Procedure/Diagnosis Codes	398
Chapter Five: Managing the Software Package	403
Introduction	403
Exiting an Option or the System.....	403
Option Overview	403
Surgery Package Management Menu	405
Surgery Site Parameters (Enter/Edit).....	406
Operating Room Information (Enter/Edit)	409
Surgery Utilization Menu	410
Person Field Restrictions Menu.....	421

Update O.R. Schedule Devices.....	425
Update Staff Surgeon Information.....	426
Flag Drugs for Use as Anesthesia Agents	427
Update Site Configurable Files.....	428
Surgery Interface Management Menu	430
Make Reports Viewable in CPRS.....	436
Chapter Six: Assessing Surgical Risk	437
Introduction	437
Exiting an Option or the System.....	437
Surgery Risk Assessment Menu.....	439
Non-Cardiac Risk Assessment Information (Enter/Edit)	441
Creating a New Risk Assessment	441
Editing an Incomplete Risk Assessment.....	443
Preoperative Information (Enter/Edit)	444
Laboratory Test Results (Enter/Edit).....	447
Operation Information (Enter/Edit)	451
Patient Demographics (Enter/Edit).....	453
Intraoperative Occurrences (Enter/Edit).....	455
Postoperative Occurrences (Enter/Edit).....	457
Update Status of Returns Within 30 Days	459
Update Assessment Status to ‘Complete’	460
Cardiac Risk Assessment Information (Enter/Edit)	461
Creating a New Risk Assessment	461
Clinical Information (Enter/Edit)	463
Laboratory Test Results (Enter/Edit).....	464a
Enter Cardiac Catheterization & Angiographic Data	465
Operative Risk Summary Data (Enter/Edit)	467
Cardiac Procedures Operative Data (Enter/Edit).....	469
Outcome Information (Enter/Edit)	470b
Intraoperative Occurrences (Enter/Edit).....	471
Postoperative Occurrences (Enter/Edit).....	473
Resource Data (Enter/Edit).....	475
Update Assessment Status to ‘COMPLETE’	476
Print a Surgery Risk Assessment.....	477
Update Assessment Completed/Transmitted in Error	483
List of Surgery Risk Assessments	485
Print 30 Day Follow-up Letters.....	499
Exclusion Criteria (Enter/Edit).....	503
Monthly Surgical Case Workload Report	505
M&M Verification Report.....	509
Update 1-Liner Case.....	515
Queue Assessment Transmissions.....	517

Chapter Six: Assessing Surgical Risk

Introduction

Unadjusted surgical mortality and morbidity rates can vary dramatically from hospital to hospital in the VA hospital system, as well as in the private sector. This can be the result of differences in patient mix, as well as differences in quality of care. Studies are being conducted to develop surgical risk assessment models for many of the major surgical procedures done in the VA system. It is hoped that these models will correct differences in patient mix between the hospitals so that remaining differences in adjusted mortality and morbidity might be an indicator of differences in quality of care. The objective of this module is to facilitate data entry and transmission to the national centers in Denver, Colorado, where the data is analyzed. The National Surgical Quality Improvement Program (NSQIP) Executive Committee oversees the overall direction of the Surgery Risk Assessment program.

This Risk Assessment part of the Surgery software provides medical centers a mechanism to track information related to surgical risk and operative mortality. It gives surgeons an on-line method of evaluating and tracking patient probability of operative mortality. For example, a patient with a history of chronic illness may be more “at risk” than a patient with no prior illness.

Exiting an Option or the System

To get out of an option, the user should enter an up-arrow (^). The up-arrow can be entered at almost any prompt to terminate the line of questioning and return to the previous level in the routine. To completely exit the system, the user continues entering up-arrows.

(This page included for two-sided copying.)

Surgery Risk Assessment Menu

[SROA RISK ASSESSMENT]

The *Surgery Risk Assessment Menu* option provides the designated Surgical Clinical Nurse Reviewer with on-line access to medical information. The menu options provide the opportunity to edit, list, print, and update an existing assessment for a patient or to enter information concerning a new risk assessment.



This option is locked with the SR RISK ASSESSMENT key.

This chapter follows the main menu of the Risk Assessment module and contains descriptions of the options and sub-options needed to maintain a Risk Assessment, transmit data, and create reports. The options are organized to follow a logical workflow sequence. Each option description is divided into two main parts: an overview and a detailed example.

The top-level options included in this menu are listed in the following table. To the left is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
N	<i>Non-Cardiac Assessment Information (Enter/Edit) ...</i>
C	<i>Cardiac Risk Assessment Information (Enter/Edit) ...</i>
P	<i>Print a Surgery Risk Assessment</i>
U	<i>Update Assessment Completed/Transmitted in Error</i>
L	<i>List of Surgery Risk Assessments</i>
F	<i>Print 30 Day Follow-up Letters</i>
R	<i>Exclusion Criteria (Enter/Edit)</i>
M	<i>Monthly Surgical Case Workload Report</i>
V	<i>M&M Verification Report</i>
O	<i>Update 1-Liner Case</i>
T	<i>Queue Assessment Transmissions</i>

(This page included for two-sided copying.)

Non-Cardiac Risk Assessment Information (Enter/Edit)

[SROA ENTER/EDIT]

The nurse reviewer uses the *Non-Cardiac Risk Assessment Information (Enter/Edit)* option to enter a new risk assessment for a non-cardiac patient. This option is also used to make changes to an assessment that has already been entered. Cardiac cases are evaluated differently from non-cardiac cases and are entered into the software from different options. See the section, "Cardiac Risk Assessment Information (Enter/Edit)" for more information about risk assessments for cardiac cases.

The following options are available from this option, and let the user add in-depth data for a case. To the left is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
PRE	<i>Preoperative Information (Enter/Edit)</i>
LAB	<i>Laboratory Test Results (Enter/Edit)</i>
O	<i>Operation Information (Enter/Edit)</i>
D	<i>Patient Demographics (Enter/Edit)</i>
IO	<i>Intraoperative Occurrences (Enter/Edit)</i>
PO	<i>Postoperative Occurrences (Enter/Edit)</i>
RET	<i>Update Status of Returns Within 30 Days</i>
U	<i>Update Assessment Status to 'COMPLETE'</i>

The following example demonstrates how to create a new risk assessment for non-cardiac patients and how to get to the sub-option menu below.

Creating a New Risk Assessment

1. The user is prompted to select either a patient name or a case. Selecting by case lets the user enter a specific surgery case number. Selecting by patient will display any previously entered assessments for a patient. An asterisk (*) indicates cardiac cases. The user can then choose to create a new assessment or edit one of the previously entered assessments.
2. After choosing an operation on which to report, the user should respond **YES** to the prompt, "Are you sure that you want to create a Risk Assessment for this surgical case ? " The user must answer **YES** (or press the <Enter> key to accept the **YES** default) to get to any of the sub-options. If the answer is **NO**, the case created in step 1 will not be considered an assessment, although it can appear on some lists, and the software will return the user to the "Select Patient: " prompt.
3. Preoperative, operative, postoperative, and lab information is entered and edited using the sub-option(s).

If assistance is needed while interacting with the software, the user should enter one or two question marks (??) to access the on-line help.

Example: Creating a New Risk Assessment (Non-Cardiac)

```
Select Surgery Risk Assessment Menu Option: N Non-Cardiac Assessment Information (Enter/Edit)
```

```
Select Patient: ?
```

```
To lookup by patient, enter patient name or patient ID. To lookup by
surgical case/assessment number, enter the number preceded by "#",
e.g., for case 12345 enter "#12345" (no spaces).
```

```
Select Patient: MONTANA,JOHNNY 01-01-45 123456789 NSC VETERAN
```

```
MONTANA,JOHNNY 123-45-6789
```

1. 02-01-95 INTRAOCULAR LENS (INCOMPLETE)
2. 02-01-95 HIP REPLACEMENT (INCOMPLETE)
3. 09-18-91 FEMORAL POPLITEAL BYPASS GRAFT (INCOMPLETE)
4. ---- CREATE NEW ASSESSMENT

```
Select Surgical Case: 4
```

```
MONTANA,JOHNNY 123-45-6789
```

1. 10-03-91 ABDOMINAL AORTIC ANEURYSM RESECTION (NOT COMPLETE)

```
Select Operation: 1
```

```
Are you sure that you want to create a Risk Assessment for this surgical
case ? YES// <Enter>
```

To enter information for the risk assessment, use the sub-options from this menu option. These options are described in the following sections. For example, to enter operation information, select the *Operation Information Enter/Edit* option.

Editing an Incomplete Risk Assessment

To edit an incomplete risk assessment, the user can either select the assessment by patient or by surgery case number.

Example: Using the Select by Case Number Function to Edit an Incomplete Assessment

```
Select Surgery Risk Assessment Menu Option: N Non-Cardiac Assessment Information (Enter/Edit)
```

```
Select Patient: #210
```

```
FLORIDA,FRANK 123-45-6789
```

```
03-22-02      HIP REPLACEMENT (INCOMPLETE)
```

1. Enter Risk Assessment Information
2. Delete Risk Assessment Entry
3. Update Assessment Status to 'COMPLETE'

```
Select Number: 1// <Enter>
```

```
Division: ALBANY (500)
```

```
FLORIDA,FRANK 123-45-6789 Case #210 - MAR 22,2002
```

- PRE Preoperative Information (Enter/Edit)
- LAB Laboratory Test Results (Enter/Edit)
- O Operation Information (Enter/Edit)
- D Patient Demographics (Enter/Edit)
- IO Intraoperative Occurrences (Enter/Edit)
- PO Postoperative Occurrences (Enter/Edit)
- RET Update Status of Returns Within 30 Days
- U Update Assessment Status to 'COMPLETE'

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option:
```

These options are described in the following sections.

Preoperative Information (Enter/Edit) [SROA PREOP DATA]

The *Preoperative Information (Enter/Edit)* option is used to enter or edit preoperative assessment information. The software will present two pages. At the bottom of each page is a prompt to select one or more preoperative items to edit. If the user does not want to edit any items on the page, pressing the <Enter> key will advance to the next page or, if the user is already on page two, will exit the option.

About the “Select Preoperative Information to Edit:” Prompt

At this prompt the user enters the item number he or she wishes to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (☺ can be entered to respond to a range of items. Number-letter combinations can also be used, such as **2C**, to update a field within a group, such as CURRENT PNEUMONIA.

Each prompt at the category level allows for an entry of **YES** or **NO**. If **NO** is entered, each item under that category will automatically be answered **NO**. On the other hand, responding **YES** at the category level allows the user to respond individually to each item under the main category.

For instance, if number **2** is chosen, and the “PULMONARY:” prompt is answered **YES**, the user will be asked if the patient is ventilator dependent, has a history of COPD, and has pneumonia. If the “PULMONARY:” prompt is answered **NO**, the software will place a **NO** response in all the fields of the Pulmonary group. The majority of the prompts in this option are designed to accept the letters **Y**, **N**, or **NS** for **YES**, **NO**, and **NO STUDY**.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

This functionality allows the nurse reviewer to duplicate preoperative information from an earlier operation within 60 days of the date of operation on the same patient.

Example 1: Enter/Edit Preoperative Information

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: PRE Preoperative Information  
(Enter/Edit)
```

```
This patient had a previous non-cardiac operation on APR 28,1998@09:00
```

```
Case #63592 CHOLEDOCHOTOMY
```

```
Do you want to duplicate the preoperative information from the earlier assessment in this  
assessment? YES// NO
```

INDIANA,SUSAN (123-45-6789) Case #63592 PAGE: 1 OF 2
JUN 23,1998 CHOLEDOCHOTOMY (47420-58,62,22,78)

1. GENERAL: 3. HEPATOBILIARY:
A. Height: A. Ascites:
B. Weight:
C. Diabetes Mellitus:
D. Current Smoker W/I 1 Year:
E. Pack/Years:
F. ETOH > 2 Drinks/Day:
G. Dyspnea:
H. DNR Status:
I. Pre-illness Funct Status:
J. Preop Funct Status:
2. PULMONARY:
A. Ventilator Dependent:
B. History of Severe COPD:
C. Current Pneumonia:
4. GASTROINTESTINAL:
A. Esophageal Varices:
5. CARDIAC:
A. CHF Within 1 Month:
B. MI Within 6 Months:
C. Previous PTCA:
D. Previous Cardiac Surgery:
E. Angina Within 1 Month:
F. Hypertension Requiring Meds:
6. VASCULAR:
A. Revascularization/Amputation:
B. Rest Pain/Gangrene:

Select Preoperative Information to Edit: **1:3**

INDIANA,SUSAN (123-45-6789) Case #63592
JUN 23,1998 CHOLEDOCHOTOMY (47420-58,62,22,78)

GENERAL: YES

Patient's Height: **62**
Patient's Weight: **175**
Diabetes Mellitus Requiring Therapy With Oral Agents or Insulin: **I** INSULIN
Current Smoker: **Y** YES
Pack/Year Cigarette History: **??**
NSQIP Definition (2004):
If the patient has ever been a smoker, enter the total number of pack-years of smoking for this patient. Pack-years are defined as the number of packs of cigarettes smoked per day times the number of years the patient has smoked. If the patient has never been a smoker, enter "0". If pack-years are >200, just enter 200. If smoking history cannot be determined, enter "NS". The possible range for number of pack-years is 0 to 200. If the chart documents differing values for pack year cigarette history, or ranges for either packs/day or number of years patient has smoked, select the highest value documented, unless you are confident in a particular documenter's assessment (e.g., preoperative anesthesia evaluation often includes a more accurate assessment of this value because of the impact it may have on the patient's response to anesthesia).
Pack/Year Cigarette History: **25**
ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: **N** NO
Dyspnea: **N**
1 NO
2 NO STUDY
Choose 1-2: **1** NO
DNR Status (Y/N): **N** NO
Functional Health Status at Evaluation for Surgery: **1** INDEPENDENT
Functional Health Status Prior to Current Illness: **1** INDEPENDENT
PULMONARY: **NO**
HEPATOBILIARY: **NO**

-
- | | | | |
|-------------------------------|-------------|------------------------------|----|
| 1. GENERAL: | YES | 3. HEPATOBILIARY: | NO |
| A. Height: | 62 INCHES | A. Ascites: | NO |
| B. Weight: | 175 LBS. | | |
| C. Diabetes Mellitus: | INSULIN | 4. GASTROINTESTINAL: | |
| D. Current Smoker W/I 1 Year: | YES | A. Esophageal Varices: | |
| E. Pack/Years: | 25 | | |
| F. ETOH > 2 Drinks/Day: | NO | 5. CARDIAC: | |
| G. Dyspnea: | NO | A. CHF Within 1 Month: | |
| H. DNR Status: | NO | B. MI Within 6 Months: | |
| I. Preop Funct Status: | INDEPENDENT | C. Previous PTCA: | |
| J. Pre-illness Funct Status: | INDEPENDENT | D. Previous Cardiac Surgery: | |
2. PULMONARY:
- | | | | |
|----------------------------|----|---------------------------------|--|
| A. Ventilator Dependent: | NO | E. Angina Within 1 Month: | |
| B. History of Severe COPD: | NO | F. Hypertension Requiring Meds: | |
| C. Current Pneumonia: | NO | | |
6. VASCULAR:
- | | |
|----------------------------------|--|
| A. Revascularization/Amputation: | |
| B. Rest Pain/Gangrene: | |
-

Select Preoperative Information to Edit: <Enter>

-
- | | | | |
|---------------------------|--|------------------------------|--|
| 1. RENAL: | | 3. NUTRITIONAL/IMMUNE/OTHER: | |
| A. Acute Renal Failure: | | A. Disseminated Cancer: | |
| B. Currently on Dialysis: | | B. Open Wound: | |
2. CENTRAL NERVOUS SYSTEM:
- | | | | |
|----------------------------------|--|-----------------------------------|--|
| A. Impaired Sensorium: | | C. Steroid Use for Chronic Cond.: | |
| B. Coma: | | D. Weight Loss > 10%: | |
| C. Hemiplegia: | | E. Bleeding Disorders: | |
| D. History of TIAs: | | F. Transfusion > 4 RBC Units: | |
| E. CVA/Stroke w. Neuro Deficit: | | G. Chemotherapy W/I 30 Days: | |
| F. CVA/Stroke w/o Neuro Deficit: | | H. Radiotherapy W/I 90 Days: | |
| G. Tumor Involving CNS: | | I. Preoperative Sepsis: | |
| H. Paraplegia: | | | |
| I. Quadriplegia: | | | |
-

Select Preoperative Information to Edit: **3E**

History of Bleeding Disorders (Y/N): **Y** YES

-
- | | | | |
|---------------------------|--|------------------------------|--|
| 1. RENAL: | | 3. NUTRITIONAL/IMMUNE/OTHER: | |
| A. Acute Renal Failure: | | A. Disseminated Cancer: | |
| B. Currently on Dialysis: | | B. Open Wound: | |
2. CENTRAL NERVOUS SYSTEM:
- | | | | |
|----------------------------------|--|-----------------------------------|-----|
| A. Impaired Sensorium: | | C. Steroid Use for Chronic Cond.: | |
| B. Coma: | | D. Weight Loss > 10%: | |
| C. Hemiplegia: | | E. Bleeding Disorders: | YES |
| D. History of TIAs: | | F. Transfusion > 4 RBC Units: | |
| E. CVA/Stroke w. Neuro Deficit: | | G. Chemotherapy W/I 30 Days: | |
| F. CVA/Stroke w/o Neuro Deficit: | | H. Radiotherapy W/I 90 Days: | |
| G. Tumor Involving CNS: | | I. Preoperative Sepsis: | |
| H. Paraplegia: | | | |
| I. Quadriplegia: | | | |
-

Select Preoperative Information to Edit:

Laboratory Test Results (Enter/Edit) [SROA LAB]

Use the *Laboratory Test Results (Enter/Edit)* option to enter or edit preoperative and postoperative lab information for an individual risk assessment. The option is divided into the three features listed below. The first two features allow the user to merge (also called “capture” or “load”) lab information into the risk assessment from the **VISTA** software. The third feature provides a two-page summary of the lab profile and allows direct editing of the information.

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results

To “capture” preoperative lab data, the user must provide both the date and time the operation began. Likewise, to capture postoperative lab data, the user must provide both the date and time the operation was completed. If this information has already been entered, the system will not prompt for it again.

If assistance is needed while interacting with the software, entering one or two question marks (??) will access the on-line help.

Example 1: Capture Preoperative Laboratory Information

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: LAB Laboratory Test Results  
(Enter/Edit)
```

```
MAINE,JOE (123-45-6789) Case #68112  
SEP 19, 2003 CHOLEDOCHOTOMY (47425)
```

```
-----  
Enter/Edit Laboratory Test Results
```

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results

```
Select Number: 1
```

```
This selection loads the most recent lab data for tests performed within 90 days before the  
operation.
```

```
Do you want to automatically load preoperative lab data ? YES// <Enter>
```

```
The 'Time Operation Began' must be entered before continuing.
```

```
Do you want to enter 'Time Operation Began' at this time ? YES// <Enter>
```

```
Time the Operation Began: 8:00 (SEP 15, 2003@08:00)
```

```
..Searching lab record for latest preoperative test data...
```

```
..Moving preoperative lab test data to Surgery Risk Assessment file...
```

```
Press <RET> to continue
```

Example 2: Capture Postoperative Laboratory Information

Select Non-Cardiac Assessment Information (Enter/Edit) Option: **LAB** Laboratory Test Results (Enter/Edit)

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results

Select Number: **2**

This selection loads highest or lowest lab data for tests performed within 30 days after the operation.

Do you want to automatically load postoperative lab data ? YES// **<Enter>**

'Time the Operation Ends' must be entered before continuing.

Do you want to enter the time that the operation was completed at this time ? YES// **<Enter>**

Time the Operation Ends: 12:00 (SEP 25, 2003@12:00)

..Searching lab record for postoperative lab test data...

..Moving postoperative lab data to Surgery Risk Assessment file...

Press <RET> to continue

Example 3: Enter, Edit, or Review Laboratory Test Results

Select Non-Cardiac Assessment Information (Enter/Edit) Option: **LAB** Laboratory Test Results (Enter/Edit)

Enter/Edit Laboratory Test Results

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results

Select Number: **3**

MAINE,JOE (123-45-6789) Case #68112 PAGE: 1 OF 2
LATEST PREOP LAB RESULTS IN 90 DAYS PRIOR TO SURGERY
SEP 19,1998 CHOLEDOCHOTOMY (47425)

1. Serum Sodium: 139 (SEP 18,2003)
2. BUN: 13 (SEP 18,2003)
3. Serum Creatinine: 1 (SEP 18,2003)
4. Serum Albumin: 4 (SEP 18,2003)
5. Total Bilirubin: .8 (SEP 18,2003)
6. SGOT: 29 (SEP 18,2003)
7. Alkaline Phosphatase: 120 (SEP 18,2003)
8. WBC: 12.8 (SEP 18,2003)
9. Hematocrit: 45.7 (SEP 18,2003)
10. Platelet Count: NS
11. PTT: NS
12. PT: NS
13. INR: NS

Select Preoperative Laboratory Information to Edit: **10:12**

MAINE,JOE (123-45-6789) Case #68112
SEP 19,2003 CHOLEDOCHOTOMY (47425)

Preoperative Platelet Count (X 1000/mm3): **289**
Date Preoperative Platelet Count was Performed: **9/18/03** (SEP 18, 2003)
Preoperative PTT (seconds): **33.7**
Date Preoperative PTT was Performed: **9/18/03** (SEP 18, 2003)
Preoperative PT (seconds): **11.8**
Date Preoperative PT was Performed: **9/18/03** (SEP 18, 2003)

MAINE,JOE (123-45-6789) Case #68112 PAGE: 1 OF 2
LATEST PREOP LAB RESULTS IN 90 DAYS PRIOR TO SURGERY
SEP 19,2003 CHOLEDOCHOTOMY (47425)

1. Serum Sodium: 139 (SEP 18,2003)
2. BUN: 13 (SEP 18,2003)
3. Serum Creatinine: 1 (SEP 18,2003)
4. Serum Albumin: 4 (SEP 18,2003)
5. Total Bilirubin: .8 (SEP 18,2003)
6. SGOT: 29 (SEP 18,2003)
7. Alkaline Phosphatase: 120 (SEP 18,2003)
8. WBC: 12.8 (SEP 18,2003)
9. Hematocrit: 45.7 (SEP 18,2003)
10. Platelet Count: 289 (SEP 18,2003)
11. PTT: 33.7 (SEP 18,2003)
12. PT: 11.8 (SEP 18,2003)
13. INR: NS

Select Preoperative Laboratory Information to Edit: **<Enter>**

MAINE,JOE (123-45-6789) Case #68112 PAGE: 2 OF 2
POSTOP LAB RESULTS WITHIN 30 DAYS AFTER SURGERY
SEP 19,2003 CHOLEDOCHOTOMY (47425)

1. Highest Serum Sodium: 139 (SEP 20,2003)
2. Lowest Serum Sodium: 135 (SEP 20,2003)
3. Highest Potassium: 4.4 (SEP 20,2003)
4. Lowest Potassium: 3.4 (SEP 20,2003)
5. Highest Serum Creatinine: 1.2 (SEP 20,2003)
6. Highest CPK: NS
7. Highest CPK-MB Band: NS
8. Highest Total Bilirubin: NS
9. Highest WBC: 11.8 (SEP 20,2003)
10. Lowest Hematocrit: 40.3 (SEP 20,2003)
11. Highest Troponin I: 10.18 (SEP 24,2003)
12. Highest Troponin T: 12.13 (SEP 24,2003)

Select Postoperative Laboratory Information to Edit: **1**

MAINE,JOE (123-45-6789) Case #68112
SEP 19,1998 CHOLEDOCHOTOMY (47425)

Highest Postoperative Serum Sodium: 139// **144**
Date Highest Serum Sodium was Recorded: **9/21/03** (SEP 21, 2003)

MAINE,JOE (123-45-6789) Case #68112 PAGE: 2 OF 2
POSTOP LAB RESULTS WITHIN 30 DAYS AFTER SURGERY
SEP 19,2003 CHOLEDOCHOTOMY (47425)

1. Highest Serum Sodium:	144	(SEP 21,2003)
2. Lowest Serum Sodium:	135	(SEP 20,2003)
3. Highest Potassium:	4.4	(SEP 20,2003)
4. Lowest Potassium:	3.4	(SEP 20,2003)
5. Highest Serum Creatinine:	1.2	(SEP 20,2003)
6. Highest CPK:	NS	
7. Highest CPK-MB Band:	NS	
8. Highest Total Bilirubin:	NS	
9. Highest WBC:	11.8	(SEP 20,2003)
10. Lowest Hematocrit:	40.3	(SEP 20,2003)
11. Highest Troponin I:	10.18	(SEP 24,2003)
12. Highest Troponin T:	12.13	(SEP 24,2003)

Select Postoperative Laboratory Information to Edit:

Operation Information (Enter/Edit) [SROA OPERATION DATA]

The *Operation Information (Enter/Edit)* option is used to enter or edit information related to the operation. At the bottom of each page is a prompt to select one or more operative items to edit. If the user does not want to edit any items on the page, pressing the <Enter> key will exit the option. If they are not already there, it is important that the operation's beginning and ending times be entered so that the user can later enter postoperative information.

About the "Select Operative Information to Edit:" Prompt

The user should first enter the item number to edit at the "Select Operative Information to Edit:" prompt. To respond to every item on the page, the user should enter **A** for **ALL** or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information has been entered or edited, the display will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data. If information has been entered for the **OTHER PROCEDURES** field or the **CONCURRENT PROCEDURES** field, the summary will say *****INFORMATION ENTERED***** to the right of the items.

If assistance is needed while interacting with the software, the user should enter one or two question marks (??) to receive on-line help.

Example: Enter/Edit Operation Information

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option:  Operation  
Information (Enter/Edit)
```

```
MISSISSIPPI,RANDALL (123-45-6789)          Case #61851          PAGE: 1 OF 2  
Surgeon: TOPEKA,MARK  
JUN 17,1998  PULMONARY LOBECTOMY (32485)
```

```
-----  
1. Surgical Specialty:          THORACIC SURGERY (INC. CARDIAC SURG.)  
2. Principal Operation:        PULMONARY LOBECTOMY  
3. Principal CPT Code:         32485  
4. Other Procedures:           ***INFORMATION ENTERED***  
5. Concurrent Procedure:       ***INFORMATION ENTERED***  
6. PGY of Primary Surgeon:     2  
7. Surgical Priority:          ELECTIVE  
8. Wound Classification:  
9. ASA Classification:  
10. Principal Anesthesia Technique: GENERAL  
11. RBC Units Transfused:      99  
12. Postop Diagnosis Code (ICD9): 115.01  HISTOPLASM CAPSUL MENING  
13. Major or Minor:           MAJOR  
-----
```

```
Select Operative Information to Edit: 8:9
```

MISSISSIPPI,RANDALL (123-45-6789) Case #61851
Surgeon: TOPEKA,MARK
JUN 17,1998 PULMONARY LOBECTOMY (32485)

Wound Classification: C CLEAN
ASA Class: 3 3-SEVERE DISTURB.

MISSISSIPPI,RANDALL (123-45-6789) Case #61851 PAGE: 1 OF 2
Surgeon: TOPEKA,MARK
JUN 17,1998 PULMONARY LOBECTOMY (32485)

1. Surgical Specialty: THORACIC SURGERY (INC. CARDIAC SURG.)
2. Principal Operation: PULMONARY LOBECTOMY
3. Principal CPT Code: 32485
4. Other Procedures: ***INFORMATION ENTERED***
5. Concurrent Procedure: ***INFORMATION ENTERED***
6. PGY of Primary Surgeon: 2
7. Surgical Priority: ELECTIVE
8. Wound Classification: CLEAN
9. ASA Classification: 3-SEVERE DISTURB.
10. Principal Anesthesia Technique: GENERAL
11. RBC Units Transfused: 99
12. Postop Diagnosis Code (ICD9): 115.01 HISTOPLASM CAPSUL MENING
13. Major or Minor: MAJOR

Select Operative Information to Edit: <Enter>

MISSISSIPPI,RANDALL (123-45-6789) Case #61851 PAGE: 2 OF 2
Surgeon: TOPEKA,MARK
JUN 17,1998 PULMONARY LOBECTOMY (32485)

1. Patient in Room (PIR): JUN 17, 1998 05:00
2. Procedure/Surgery Start Time (PST): JUN 17, 1998 05:05
3. Procedure/Surgery Finish (PF): JUN 17, 1998 11:10
4. Patient Out of Room (POR): JUN 17, 1998 11:20
5. Anesthesia Start (AS): JUN 17, 1998 05:01
6. Anesthesia Finish (AF): JUN 17, 1998 11:25
7. Discharge from PACU (DPACU): JUN 17, 1998 13:15

Select Operative Information to Edit:

Patient Demographics (Enter/Edit) [SROA DEMOGRAPHICS]

The surgical clinical nurse reviewer uses the *Patient Demographics (Enter/Edit)* option to capture patient demographic information from the Patient Information Management System (PIMS) record. The nurse reviewer can also enter, edit, and review this information. The demographic fields captured from PIMS are Race, Ethnicity, Hospital Admission Date, Hospital Discharge Date, Admission/Transfer Date, Discharge/Transfer Date, Observation Admission Date, Observation Discharge Date, and Observation Treating Specialty. With this option, the nurse reviewer can also edit the length of postoperative hospital stay, in/out-patient status, and transfer status.



The Race and Ethnicity information is displayed, but cannot be updated within this or any other Surgery package option.

Example: Entering Patient Demographics

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: D Patient Demogr  
aphics (Enter/Edit)
```

```
MISSISSIPPI,RANDALL (123-45-6789)          Case #61851  
June 17, 1998  PULMONARY LOBECTOMY (32480-59,66)
```

```
-----  
Enter/Edit Patient Demographic Information
```

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information

```
Select Number: (1-2): 1
```

```
Are you sure you want to retrieve information from PIMS records ? YES// <Enter>
```

```
...EXCUSE ME, JUST A MOMENT PLEASE...
```

```
MISSISSIPPI,RANDALL (123-45-6789)          Case #61851  
June 17, 1998  PULMONARY LOBECTOMY (32480-59,66)
```

```
-----  
Enter/Edit Patient Demographic Information
```

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information

```
Select Number: (1-2): 2
```

MISSISSIPPI,RANDALL (123-45-6789) Case #61851
June 17, 1998 PULMONARY LOBECTOMY (32480-59,66)

1. Transfer Status: NOT TRANSFERRED
2. Observation Admission Date/Time: NA
3. Observation Discharge Date/Time: NA
4. Observation Treating Specialty: NA
5. Hospital Admission Date/Time: JUN 15, 1998@10:15
6. Hospital Discharge Date/Time: JUN 25, 1998@15:10
7. Admit/Transfer to Surgical Svc.: JUN 16, 1998@14:20
8. Discharge/Transfer to Chronic Care: JUN 19, 1998@08:00
9. Length of Postop Hospital Stay: 1 Day
10. In/Out-Patient Status: INPATIENT
11. Patient's Ethnicity: NOT HISPANIC
12. Patient's Race: WHITE,ASIAN

Select number of item to edit:

Intraoperative Occurrences (Enter/Edit) [SRO INTRAOP COMP]

The nurse reviewer uses the *Intraoperative Occurrences (Enter/Edit)* option to enter or change information related to intraoperative occurrences (called complications in earlier versions). Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, enter a question mark (?) at the "Enter a New Intraoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter an Intraoperative Occurrence

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: IO Intraoperative Occurrences  
(Enter/Edit)
```

```
MAINE,JOE (123-45-6789) Case #58112  
SEP 19,1997 CHOLEDOCHOTOMY (47425)
```

There are no Intraoperative Occurrences entered for this case.

Enter a New Intraoperative Occurrence: **CARDIAC ARREST REQUIRING CPR**
NSQIP Definition (April, 2004):
The absence of cardiac rhythm or presence of chaotic cardiac rhythm
that results in loss of consciousness requiring the initiation of any
component of basic and/or advanced cardiac life support.

Press RETURN to continue: <Enter>

```
MAINE,JOE (123-45-6789) Case #58112  
SEP 19,1997 CHOLEDOCHOTOMY (47425)
```

1. Occurrence: CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Occurrence Comments:

Select Occurrence Information: **4:5**

```
MAINE,JOE (123-45-6789) Case #58112  
SEP 19,1997 CHOLEDOCHOTOMY (47425)
```

Type of Treatment Instituted: **CPR**
Outcome to Date: **I IMPROVED**

MAINE,JOE (123-45-6789) Case #58112
SEP 19,1997 CHOLEDOCHOTOMY (47425)

1. Occurrence: CARDIAC ARREST REQUIRING CPR
 2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
 3. ICD Diagnosis Code:
 4. Treatment Instituted: CPR
 5. Outcome to Date: IMPROVED
 6. Occurrence Comments:
-

Select Occurrence Information: <Enter>

MAINE,JOE (123-45-6789) Case #58112
SEP 19,1997 CHOLEDOCHOTOMY (47425)

Enter/Edit Intraoperative Occurrences

1. CARDIAC ARREST REQUIRING CPR
Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:

Postoperative Occurrences (Enter/Edit) [SRO POSTOP COMP]

The nurse reviewer uses the *Postoperative Occurrences (Enter/Edit)* option to enter or change information related to postoperative occurrences (called complications in earlier versions). Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user should enter a question mark (?) at the "Enter a New Postoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter a Postoperative Occurrence

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: PO Postoperative Occurrences  
(Enter/Edit)
```

```
MAINE,JOE (123-45-6789) Case #58112  
SEP 19,1997 CHOLEDOCHOTOMY (47425)
```

```
-----  
There are no Postoperative Occurrences entered for this case.
```

```
Enter a New Postoperative Occurrence: WOUND DISRUPTION  
NSQIP Definition (April, 2004):  
Separation of the layers of a surgical wound, which may be partial or  
complete, with disruption of the fascia.
```

```
MAINE,JOE (123-45-6789) Case #58112  
SEP 19,1997 CHOLEDOCHOTOMY (47425)
```

```
-----  
1. Occurrence: WOUND DISRUPTION  
2. Occurrence Category: WOUND DISRUPTION  
3. ICD Diagnosis Code:  
4. Treatment Instituted:  
5. Outcome to Date:  
6. Date Noted: SEP 21,1997  
7. Occurrence Comments:  
-----
```

```
Select Occurrence Information: 4
```

MAINE,JOE (123-45-6789) Case #58112
SEP 19,1997 CHOLEDOCHOTOMY (47425)

Treatment Instituted: **SUTURE**

MAINE,JOE (123-45-6789) Case #58112
SEP 19,1997 CHOLEDOCHOTOMY (47425)

1. Occurrence: WOUND DISRUPTION
 2. Occurrence Category: WOUND DISRUPTION
 3. ICD Diagnosis Code:
 4. Treatment Instituted: SUTURE
 5. Outcome to Date:
 6. Date Noted: SEP 21,1997
 7. Occurrence Comments:
-

Select Occurrence Information: **<Enter>**

MAINE,JOE (123-45-6789) Case #58112
SEP 19,1997 CHOLEDOCHOTOMY (47425)

Enter/Edit Postoperative Occurrences

1. WOUND DISRUPTION
Category: WOUND DISRUPTION

Select a number (1), or type 'NEW' to enter another occurrence:

Update Status of Returns Within 30 Days [SRO UPDATE RETURNS]

The *Update Status of Returns Within 30 Days* option is used to update the status of Returns to Surgery within 30 days of a surgical case.

Example: Update Status of Returns

Select Non-Cardiac Assessment Information (Enter/Edit) Option: **RET** Update Status of Returns Within 30 Days

INDIANA,SUSAN 123-45-6789

1. 07-06-98 REPAIR INGUINAL HERNIA (COMPLETED)
2. 06-25-98 CHOLECYSTECTOMY, APPENDECTOMY (COMPLETED)
3. 06-23-98 CHOLEDOCHOTOMY (COMPLETED)
4. 04-10-97 CRANIOTOMY (COMPLETED)

Select Operation: **3**

INDIANA,SUSAN (123-45-6789) Case #62192 RETURNS TO SURGERY
JUN 23,1998 CHOLEDOCHOTOMY (47420-58,62,22,78)

1. 07/06/98 REPAIR INGUINAL HERNIA (49521-59) - UNRELATED
2. 06/25/98 CHOLECYSTECTOMY (47610-59,20,66,78) - UNRELATED

Select Number: **2**

INDIANA,SUSAN (123-45-6789) Case #62192 RETURNS TO SURGERY
JUN 23,1998 CHOLEDOCHOTOMY (47420-58,62,22,78)

2. 06/25/98 CHOLECYSTECTOMY (47610-59,20,66,78) - UNRELATED

This return to surgery is currently defined as UNRELATED to the case selected.
Do you want to change this status ? NO// **Y**

INDIANA,SUSAN (123-45-6789) Case #62192 RETURNS TO SURGERY
JUN 23,1998 CHOLEDOCHOTOMY (47420-58,62,22,78)

1. 07/06/98 REPAIR INGUINAL HERNIA (49521-59) - UNRELATED
2. 06/25/98 CHOLECYSTECTOMY (47610-59,20,66,78) - RELATED

Select Number:

Update Assessment Status to 'Complete' [SROA COMPLETE ASSESSMENT]

Use the *Update Assessment Status to 'Complete'* option to upgrade the status of an assessment to Complete. A complete assessment has enough information for it to be transmitted to the centers where data are analyzed. Only complete assessments are transmitted. After updating the status, the patient's entire Surgery Risk Assessment Report can be printed. This report can be copied to a screen or to a printer.

Example : Update Assessment Status to COMPLETE

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: U Update Assessm  
ent Status to 'COMPLETE'
```

```
This assessment is missing the following items:
```

1. Major or Minor
2. Case Schedule Type
3. ASA Class

```
Do you want to enter the missing items at this time? NO// YES
```

```
MAJOR/MINOR: MA MAJOR
```

```
CASE SCHEDULE TYPE: EL ELECTIVE
```

```
ASA CLASS: 2 2-MILD DISTURB.
```

```
Are you sure you want to complete this assessment ? NO// YES
```

```
Updating the current status to 'COMPLETE'...
```

```
Do you want to print the completed assessment ? YES// NO
```

Cardiac Risk Assessment Information (Enter/Edit)

[SROA CARDIAC ENTER/EDIT]

The Surgical Clinical Nurse Reviewer uses the options within the *Cardiac Risk Assessment Information (Enter/Edit)* menu to create a new risk assessment for a cardiac patient. Cardiac cases are evaluated differently from non-cardiac cases and the prompts are different. This option is also used to make changes to an assessment that has already been entered.

The example below demonstrates how to create a new risk assessment for cardiac patients and get to the sub-option menu as follows.

Shortcut	Option Name
CLIN	<i>Clinical Information (Enter/Edit)</i>
LAB	<i>Laboratory Test Results (Enter/Edit)</i>
CATH	<i>Enter Cardiac Catheterization & Angiographic Data</i>
OP	<i>Operative Risk Summary Data (Enter/Edit)</i>
CARD	<i>Cardiac Procedures Operative Data (Enter/Edit)</i>
IO	<i>Intraoperative Occurrences (Enter/Edit)</i>
PO	<i>Postoperative Occurrences (Enter/Edit)</i>
OUT	<i>Outcome Information (Enter/Edit)</i>
R	<i>Resource Data</i>
U	<i>Update Assessment Status to 'COMPLETE'</i>

These 10 sub-options are used for entering more in-depth data for a case, and are covered in depth in this chapter.

Creating a New Risk Assessment

1. Enter either the patient's name/patient ID (for example, Delaware, David) or the surgical case assessment number preceded by # (for example, #47063). If the patient has any previous assessments, they will be displayed. An asterisk (*) indicates a cardiac case. The user can now choose to create a new assessment or edit one of the previously entered assessments.
2. After choosing an operation on which to report, the user should respond **YES** to the prompt "Are you sure that you want to create a Risk Assessment for this surgical case ?" The user must answer **YES** (or press the <Enter> key to accept the **YES** default) to get to any of the sub-options. If the answer given is **NO**, the case created in step 1 will not be considered an assessment, although it can appear on some lists, and the software will return the user to the "Select Patient:" prompt.
3. The screen will clear and present the sub-options menu. The user can select a sub-option now to enter more in-depth information for the case, or press the <Enter> key to return to the main menu.

Example: Creating A New Risk Assessment (Cardiac)

Select Surgery Risk Assessment Menu Option: **C** Cardiac Risk Assessment Information (Enter/Edit)

Select Patient: MAINE,JAMES 03-03-45 333221212 NSC VETERAN

MAINE,JAMES 123-45-6789

1. ---- CREATE NEW ASSESSMENT

Select Surgical Case: **1**

MAINE,JAMES 123-45-6789

1. 01-18-95 CORONARY ARTERY BYPASS (COMPLETED)

2. 06-18-93 INGUINAL HERNIA (COMPLETED)

Select Operation: **1**

Are you sure that you want to create a Risk Assessment for this surgical case ? YES// **<Enter>**

Clinical Information (Enter/Edit) [SROA CLINICAL INFORMATION]

The *Clinical Information (Enter/Edit)* option is used to enter the clinical information required for a cardiac risk assessment. The software will present one page; at the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the <Enter> key will advance the user to another option.

About the "Select Clinical Information to Edit:" Prompt

At the "Select Clinical Information to Edit:" prompt, the user should enter the item number to edit. The user can then enter an **A** for **ALL** to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data. If assistance is needed while interacting with the software, the user can enter one or two question marks (??) to receive on-line help.

Example: Enter Clinical Information

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CLIN Clinical  
Information (Enter/Edit)
```

```
DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1  
JUN 18,1997 CORONARY ARTERY BYPASS (33510)
```

```
-----  
1. Height: 13. Prior MI:  
2. Weight: 14. Number prior heart surgeries:  
3. Diabetes: 15. Prior heart surgeries:  
4. COPD: 16. Peripheral Vascular Disease:  
5. FEV1: 17. Cerebral Vascular Disease:  
6. Cardiomegaly (X-ray): 18. Angina (use CCS Class):  
7. Pulmonary Rales: 19. CHF (use NYHA Class):  
8. Current Smoker: 20. Current Diuretic Use:  
9. Active Endocarditis: 21. Current Digoxin Use:  
10. Resting ST Depression: 22. IV NTG within 48 Hours:  
11. Functional Status: 23. Preop circulatory Device:  
12. PCI: 24. Hypertension (Y/N):  
-----
```

```
Select Clinical Information to Edit: A
```

DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

Patient's Height: **76**
Patient's Weight: **210**
Diabetes: **0** ORAL
History of Severe COPD (Y/N): **Y** YES
FEV1 : **NS**
Cardiomegaly on Chest X-Ray (Y/N): **Y** YES
Pulmonary Rales (Y/N): **Y** YES
Current Smoker: **2** WITHIN 2 WEEKS OF SURGERY
Active Endocarditis (Y/N): **N** NO
Resting ST Depression (Y/N): **N** NO
Functional Health Status at Evaluation for Surgery: **I** INDEPENDENT
PCI: **0** NONE
Prior Myocardial Infarction: **1** LESS THAN OR EQUAL TO 7 DAYS PRIOR TO SURGERY
Number of Prior Heart Surgeries: **1** 1

DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

Prior heart surgeries:

0. None
1. CABG-only
2. Valve-only
3. CABG/Valve
4. Other
5. CABG/Other

Enter your choice(s) separated by commas (0-5): // **2**
2 - Valve-only

Peripheral Vascular Disease (Y/N): **Y** YES
Cerebral Vascular Disease (Y/N): **N** NO
Angina (use CCS Functional Class): **IV** CLASS IV
Congestive Heart Failure (use NYHA Functional Class): **II** SLIGHT LIMITATION
Current Diuretic Use (Y/N): **Y** YES
Current Digoxin Use (Y/N): **N** NO
IV NTG within 48 Hours Preceding Surgery (Y/N): **Y** YES
Preop use of circulatory Device: **N** NONE
History of Hypertension (Y/N): **Y** YES

DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

1. Height: 76 in 13. Prior MI: < OR = 7 DAYS
2. Weight: 210 lb 14. Number prior heart surgeries: 1
3. Diabetes: ORAL 15. Prior heart surgeries: VALVE-ONLY
4. COPD: YES 16. Peripheral Vascular Disease: YES
5. FEV1: NS 17. Cerebral Vascular Disease: NO
6. Cardiomegaly (X-ray): YES 18. Angina (use CCS Class): IV
7. Pulmonary Rales: YES 19. CHF (use NYHA Class): II
8. Current Smoker: WITHIN 2 WEEKS OF S 20. Current Diuretic Use: YES
9. Active Endocarditis: NO 21. Current Digoxin Use: NO
10. Resting ST Depression: NO 22. IV NTG within 48 Hours: YES
11. Functional Status: INDEPENDENT 23. Preop circulatory Device: NONE
12. PCI: NONE 24. Hypertension (Y/N): YES

Select Clinical Information to Edit: <Enter>

Laboratory Test Results (Enter/Edit) [SROA LAB-CARDIAC]

The *Laboratory Test Results (Edit/Edit)* option is used to enter or edit preoperative laboratory test results for an individual cardiac risk assessment. The option is divided into the two features listed below. The first feature allows the user to merge (also called “capture” or “load”) lab information into the risk assessment from the *VISTA* software. The second feature provides a two-page summary of the lab profile and allows direct editing of the information.

1. Capture Laboratory Information
2. Enter, Edit, or Review Laboratory Test Results

To “capture” preoperative lab data, the user must provide both the date and time the operation began. If this information has already been entered, the system will not prompt for it again.

If assistance is needed while interacting with the software, entering one or two question marks (??) allows the user to access the on-line help.

About the "Select Laboratory Information to Edit:" Prompt

At this prompt the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter Laboratory Test Results

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: LAB Laboratory  
Test Results (Enter/Edit)
```

```
DELAWARE, DAVID (123-45-6789)          Case #60183          PAGE: 1  
JUN 18,1997  CORONARY ARTERY BYPASS (33510)
```

```
-----  
Enter/Edit Laboratory Test Results
```

- ```
1. Capture Laboratory Information
2. Enter, Edit, or Review Laboratory Test Results
```

```
Select Number: 1
```

```
This selection loads the most recent cardiac lab data for tests performed
preoperatively.
```

```
Do you want to automatically load cardiac lab data ? YES// <Enter>
```

```
..Searching lab record for latest test data...
```

```
Press <RET> to continue
```

DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1  
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

---

Enter/Edit Laboratory Test Results

1. Capture Laboratory Information
2. Enter, Edit, or Review Laboratory Test Results

Select Number: 2

DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1  
PREOPERATIVE LABORATORY RESULTS  
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

---

- |                        |     |            |
|------------------------|-----|------------|
| 1. HDL:                | NS  |            |
| 2. LDL:                | 168 | (JAN 2004) |
| 3. Total Cholesterol:  | 321 | (JAN 2004) |
| 4. Serum Triglyceride: | >70 | (JAN 2004) |
| 5. Serum Potassium:    | NS  |            |
| 6. Serum Bilirubin:    | NS  |            |
| 7. Serum Creatinine:   | NS  |            |
| 8. Serum Albumin:      | NS  |            |
| 9. Hemoglobin:         | NS  |            |
- 

Select Laboratory Information to Edit: 1

DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1  
PREOPERATIVE LABORATORY RESULTS  
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

---

HDL (mg/dl): NS// 177  
HDL, Date: **JAN, 2004** (JAN 2004)

DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1  
PREOPERATIVE LABORATORY RESULTS  
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

---

- |                        |     |            |
|------------------------|-----|------------|
| 1. HDL:                | 177 | (JAN 2004) |
| 2. LDL:                | 168 | (JAN 2004) |
| 3. Total Cholesterol:  | 321 | (JAN 2004) |
| 4. Serum Triglyceride: | >70 | (JAN 2004) |
| 5. Serum Potassium:    | NS  |            |
| 6. Serum Bilirubin:    | NS  |            |
| 7. Serum Creatinine:   | NS  |            |
| 8. Serum Albumin:      | NS  |            |
| 9. Hemoglobin:         | NS  |            |
- 

Select Laboratory Information to Edit:

## Enter Cardiac Catheterization & Angiographic Data [SROA CATHETERIZATION]

The *Enter Cardiac Catheterization & Angiographic Data* option is used to enter or edit cardiac catheterization and angiographic information for a cardiac risk assessment. The software will present one page. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the <Enter> key will advance the user to another option.

### **About the "Select Cardiac Catheterization and Angiographic Information to Edit:" Prompt**

At this prompt the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items.

After the information has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

### **Example: Enter Cardiac Catheterization & Angiographic Data**

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CATH Enter Cardiac
Catheterization & Angiographic Data
```

```
DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1 OF 2
JUN 18,1997 CORONARY ARTERY BYPASS (33510)
```

- ```
-----  
1. Procedure:  
2. LVEDP:  
3. Aortic Systolic Pressure:  
  
For patients having right heart cath  
4. PA Systolic Pressure:  
5. PAW Mean Pressure:  
  
6. LV Contraction Grade (from contrast  
   or radionuclide angiogram or 2D echo):  
  
7. Mitral Regurgitation:  
8. Aortic Stenosis:  
  
-----
```

```
Select Cardiac Catheterization and Angiographic Information to Edit: A
```

DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

Procedure Type: C CATH
Left Ventricular End-Diastolic Pressure: 56
Aortic Systolic Pressure: 120
PA Systolic Pressure: 30
PAW Mean Pressure: 15
LV Contraction Grade: ?

Enter the grade that best describes left ventricular function.

Screen prevents selection of code III.

Choose from:

I > EQUAL 0.55 NORMAL
II 0.45-0.54 MILD DYSFUNC.
IIIa 0.40-0.44 MOD. DYSFUNC. A
IIIb 0.35-0.39 MOD. DYSFUNC. B
IV 0.25-0.34 SEVERE DYSFUNC.
V <0.25 VERY SEVERE DYSFUNC.
NS NO STUDY

LV Contraction Grade: IIIa 0.40-0.44 MOD. DYSFUNC. A

Mitral Regurgitation: ?

Enter the code describing presence/severity of mitral regurgitation.

Choose from:

0 NONE
1 MILD
2 MODERATE
3 SEVERE
NS NO STUDY

Mitral Regurgitation: 2 MODERATE

Aortic Stenosis: 1 MILD

DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1 of 2
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

1. Procedure: Cath
2. LVEDP: 56 mm Hg
3. Aortic Systolic Pressure: 120 mm Hg

For patients having right heart cath

4. PA Systolic Pressure: 30 mm Hg
5. PAW Mean Pressure: 15 mm Hg
6. LV Contraction Grade (from contrast
or radionuclide angiogram or 2D echo): IIIa 0.40-0.44 MODERATE DYSFUNCTION A

7. Mitral Regurgitation: MODERATE
8. Aortic Stenosis: MILD

Select Cardiac Catheterization and Angiographic Information to Edit: <Enter>

DELAWARE, DAVID (123-45-6789)
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

Case #60183

PAGE: 2 of 2

----- Native Coronaries -----

1. Left main stenosis:
2. LAD Stenosis:
3. Right coronary stenosis:
4. Circumflex Stenosis:

If a Re-do, indicate stenosis in graft to:

5. LAD:
6. Right coronary:
7. Circumflex:

Select Cardiac Catheterization and Angiographic Information to Edit: 3

Right Coronary Artery Stenosis: NS// ?
Enter the percent (0-100) stenosis.
Right Coronary Artery Stenosis: NS// 30

DELAWARE, DAVID (123-45-6789)
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

Case #60183

PAGE: 2 of 2

----- Native Coronaries -----

1. Left main stenosis: NS
2. LAD Stenosis: NS
3. Right coronary stenosis: 30
4. Circumflex Stenosis: NS

If a Re-do, indicate stenosis in graft to:

5. LAD: NS
6. Right coronary: NS
7. Circumflex: NS

Select Cardiac Catheterization and Angiographic Information to Edit:

(This page included for two-sided copying.)

Operative Risk Summary Data (Enter/Edit) [SROA CARDIAC OPERATIVE RISK]

The *Operative Risk Summary Data (Enter/Edit)* option is used to enter or edit operative risk summary data for a cardiac risk assessment. This option records the physician's subjective estimate of operative mortality. To avoid bias, this should be completed preoperatively. The software will present one page. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any of the items, the <Enter>key can be pressed to proceed to another option.

About the "Select Operative Risk Summary Information to Edit:" prompt

At this prompt the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items.

Example: Operative Risk Summary Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: OP Operative Risk Summary Data (Enter/Edit)
```

```
DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1  
JUN 18,1997 CORONARY ARTERY BYPASS (33510)
```

```
-----  
1. Physician's Preoperative Estimate of Operative Mortality:  
2. ASA Classification:  
3. Surgical Priority:  
4. Date/Time Operation Began: JUN 18,1997 08:45  
5. Date/Time Operation Ended: JUN 18,1997 14:25  
6. Principle CPT Code: 33510  
7. Other Procedures CPT Code: ***INFORMATION ENTERED***  
8. Preoperative Risk Factors: [This field is used to further explain any preoperative risk factors that cannot be answered above. The maximum length of this field is 130 characters.]  
-----
```

```
Select Operative Risk Summary Information to Edit: 1:3
```

```
DELAWARE, DAVID (123-45-6789) Case #60183  
JUN 18,1997 CORONARY ARTERY BYPASS (33510)
```

```
-----  
Physician's Preoperative Estimate of Operative Mortality: 32  
Date/Time of Estimate of Operative Mortality: JUN 17,1997@18:15  
// <Enter>  
ASA Class: 3 3-SEVERE DISTURB.  
Cardiac Surgical Priority: ?  
Enter the surgical priority that most accurately reflects the acuity of patient's cardiovascular condition at the time of transport to the operating room.  
CHOOSE FROM:  
1 ELECTIVE  
2 URGENT  
3 EMERGENT (ONGOING ISCHEMIA)  
4 EMERGENT (HEMODYNAMIC COMPROMISE)  
5 EMERGENT (ARREST WITH CPR)  
Cardiac Surgical Priority: 3 EMERGENT (ONGOING ISCHEMIA)  
Date/Time of Cardiac Surgical Priority: JUN 17,1997@13:29  
// <Enter>
```

DELAWARE, DAVID (123-45-6789)
JUN 18,1997

Case #60183
CORONARY ARTERY BYPASS (33510)

PAGE: 1

-
1. Physician's Preoperative Estimate of Operative Mortality: 32%
 - A. Date/Time Collected: JUN 17,1997 18:15
 2. ASA Classification: 3-SEVERE DISTURB.
 3. Surgical Priority: EMERGENT (ONGOING ISCHEMIA)
 - A. Date/Time Collected: JUN 17,1997 09:46
 4. Date/Time Operation Began: JUN 18,1997 08:45
 5. Date/Time Operation Ended: JUN 18,1997 14:25
 6. Principle CPT Code: 33510
 7. Other Procedures CPT Code: ***INFORMATION ENTERED***
 8. Preoperative Risk Factors:
-

Select Operative Risk Summary Information to Edit:

Cardiac Procedures Operative Data (Enter/Edit) [SROA CARDIAC PROCEDURES]

The *Cardiac Procedures Operative Data (Enter/Edit)* option is used to enter or edit information related to cardiac procedures requiring cardiopulmonary bypass (CPB). The software will present two pages. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the <Enter> key will advance the user to another option.

About the "Select Operative Information to Edit:" prompt

At this prompt, the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items. You can also use number-letter combinations, such as **11B**, to update a field within a group, such as VSD Repair.

Each prompt at the category level allows for an entry of **YES** or **NO**. If **NO** is entered, each item under that category will automatically be answered **NO**. On the other hand, responding **YES** at the category level allows the user to respond individually to each item under the main category.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter Cardiac Procedures Operative Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CARD Cardiac Pr  
ocedures Operative Data (Enter/Edit)
```

```
DELAWARE, DAVID (123-45-6789) Case #60183 PAGE: 1 OF 2  
JUN 18,1997 CORONARY ARTERY BYPASS (33510)
```

```
-----  
Cardiac surgical procedures with or without cardiopulmonary bypass  
CABG distal anastomoses:
```

```
1. Number with vein:
2. Number with IMA:
3. Number with Radial Artery:
4. Number with Other Artery:
5. Number with Other Conduit:
6. Aortic Valve Replacement:
7. Mitral Valve Replacement:
8. Tricuspid Valve Replacement:
9. Valve Repair:
10. LV Aneurysmectomy: NO
11. Bridge to transplant/Device:
12. TMR:
13. Maze procedure:
14. ASD repair:
15. VSD repair:
16. Myectomy for IHSS:
17. Myxoma resection:
18. Other tumor resection:
19. Cardiac transplant:
20. Other CT procedures: *
```

```
* Other CT Procedure, specify: OTHER CT PROCEDURE #1, OTHER CT  
PROCEDURE #2, OTHER CT PROC
```

```
-----  
Select Operative Information to Edit: A
```

DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

CABG Distal Anastomoses with Vein: **1**
CABG Distal Anastomoses with IMA: **1**
Number with Radial Artery: **0**
Number with Other Artery: **1**
CABG Distal Anastomoses with Other Conduit: **1**
Aortic Valve Replacement (Y/N): **Y** YES
Mitral Valve Replacement (Y/N): **N** NO
Tricuspid Valve Replacement (Y/N): **N** NO
Valve Repair: **??**

CICSP Definition (2004):

Indicate if the patient has had any reparative procedure to a native valve, either with or without placing the patient on cardiopulmonary bypass. Valve repair is defined as a procedure performed on the native valve to relieve stenosis and/or correct regurgitation (annuloplasty, commissurotomy, etc.); the native valve remains in place. Indicate the one appropriate response.

Choose from:

- 1 AORTIC
- 2 MITRAL
- 3 TRICUSPID
- 4 OTHER/COMBINATION
- 5 NONE

Valve Repair: **1** AORTIC

LV Aneurysmectomy (Y/N): **N** NO

Device for bridge to cardiac transplant / Destination therapy: **??**

CICSP Definition (2004):

Indicate if patient received a mechanical support device (excluding IABP) as a bridge to cardiac transplant either during the same admission as the transplant procedure or during a prior admission; or patient received the device as destination therapy (does not intend to have a cardiac transplant), either with or without placing the patient on cardiopulmonary bypass.

Choose from:

- Y YES
- N NO

Device for bridge to cardiac transplant / Destination therapy: **N** NO

Transmyocardial Laser Revascularization: **N** NO

Maze Procedure: **N** NO

ASD Repair (Y/N): **N** NO

VSD Repair (Y/N): **N** NO

Myectomy for IHSS (Y/N): **N** NO

Myxoma Resection (Y/N): **N** NO

Other Tumor Resection (Y/N): **N** NO

Cardiac Transplant (Y/N): **N** NO

Other CT Procedure: **NS**

Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:

1. Number with vein:	1	11. Bridge to transplant/Device:	NO
2. Number with IMA:	1	12. TMR:	NO
3. Number with Radial Artery:	0	13. Maze procedure:	NO
4. Number with Other Artery:	1	14. ASD repair:	NO
5. Number with Other Conduit:	1	15. VSD repair:	NO
6. Aortic Valve Replacement:	YES	16. Myectomy for IHSS:	NO
7. Mitral Valve Replacement:	NO	17. Myxoma resection:	NO
8. Tricuspid Valve Replacement:	NO	18. Other tumor resection:	NO
9. Valve Repair:	AORTIC	19. Cardiac transplant:	NO
10. LV Aneurysmectomy:	NO	20. Other CT procedures:	NS

Select Operative Information to Edit: <Enter>

Indicate other cardiac procedures only if done with cardiopulmonary bypass

1. Great Vessel Repair:
2. Foreign Body Removal:
3. Pericardiectomy:
4. Other Non-CT Procedures:
Other Operative Data details:

5. Total CPB Time:
6. Total Ischemic Time:
7. Incision Type:
8. Convert Off Pump to CPB: N/A (began on-pump/ stayed on-pump)

Select Operative Information to Edit:

Outcome Information (Enter/Edit) [SROA CARDIAC-OUTCOMES]

This option is used to enter or edit outcome information for cardiac procedures.

Example: Enter Outcome Information

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: OUT Outcome Inf  
ormation (Enter/Edit)
```

```
CALIFORNIA,JAMES (123-45-6789) Case #238 PAGE: 1  
OUTCOMES INFORMATION  
FEB 10,2004 CABG (33517)
```

```
-----  
1. Perioperative MI: NO 8. Repeat cardiac surg procedure: NO  
2. Endocarditis: NO 9. Tracheostomy: YES  
3. Renal failure require dialys: NO 10. Repeat ventilator w/in 30 days: YES  
4. Mediastinitis: YES 11. Stroke: NO  
5. Cardiac arrest requiring CPR: YES 12. Coma >= 24 hr: NO  
6. Reoperation for bleeding: NO 13. New Mech Circ Support: YES  
7. On ventilator >= 48 hr: NO  
-----
```

```
Select Outcomes Information to Edit: 8  
Repeat Cardiac Surgical Procedure (Y/N): NO// Y YES  
Cardiopulmonary Bypass Status: ?
```

Enter the CPB status for the repeat cardiac surgical procedure.

Choose from:

```
0 None  
1 On-bypass  
2 Off-bypass
```

```
Cardiopulmonary Bypass Status: 1 On-bypass
```

```
CALIFORNIA,JAMES (123-45-6789) Case #238 PAGE: 1  
OUTCOMES INFORMATION  
FEB 10,2004 CABG (33517)
```

```
-----  
1. Perioperative MI: NO 8. Repeat cardiac surg procedure: YES  
2. Endocarditis: NO 9. Tracheostomy: YES  
3. Renal failure require dialys: NO 10. Repeat ventilator w/in 30 days: YES  
4. Mediastinitis: YES 11. Stroke: NO  
5. Cardiac arrest requiring CPR: YES 12. Coma >= 24 hr: NO  
6. Reoperation for bleeding: NO 13. New Mech Circ Support: YES  
7. On ventilator >= 48 hr: NO  
-----
```

```
Select Outcomes Information to Edit:
```

Intraoperative Occurrences (Enter/Edit) [SRO INTRAOP COMP]

The nurse reviewer uses the *Intraoperative Occurrences (Enter/Edit)* option to enter or change information related to intraoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user can enter a question mark (?) at the "Enter a New Intraoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another opportunity to enter or edit data.

Example: Enter an Intraoperative Occurrence

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: IO Intraoperative Occurrences (Enter/Edit)
```

```
DELAWARE, DAVID (123-45-6789) Case #60183  
JUN 18,1997 CORONARY ARTERY BYPASS (33510)
```

```
-----  
There are no Intraoperative Occurrences entered for this case.
```

```
Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
```

```
NSQIP Definition (2004):
```

```
The absence of cardiac rhythm or presence of chaotic cardiac rhythm  
that results in loss of consciousness requiring the initiation of any  
component of basic and/or advanced cardiac life support.
```

```
CICSP Definition (2004):
```

```
Indicate if there was any cardiac arrest requiring external or open  
cardiopulmonary resuscitation (CPR) occurring in the operating room,  
ICU, ward, or out-of-hospital after the chest had been completely  
closed and within 30 days of surgery.
```

```
Press RETURN to continue: <Enter>
```

```
DELAWARE, DAVID (123-45-6789) Case #60183  
JUN 18,1997 CORONARY ARTERY BYPASS (33510)
```

```
-----  
1. Occurrence: CARDIAC ARREST REQUIRING CPR  
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR  
3. ICD Diagnosis Code:  
4. Treatment Instituted:  
5. Outcome to Date:  
6. Occurrence Comments:  
-----
```

```
Select Occurrence Information: 2:5
```

DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

Occurrence Category: CARDIAC ARREST REQUIRING CPR
// <Enter>
ICD Diagnosis Code: 102.8 102.8 LATENT YAWS
...OK? YES//<Enter> (YES)
Type of Treatment Instituted: CPR
Outcome to Date: I IMPROVED

DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

1. Occurrence: CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code: 102.8
4. Treatment Instituted: CPR
5. Outcome to Date: IMPROVED
6. Occurrence Comments:

Select Occurrence Information: <Enter>

DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

Enter/Edit Intraoperative Occurrences

1. CARDIAC ARREST REQUIRING CPR
Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:

Postoperative Occurrences (Enter/Edit) [SRO POSTOP COMP]

The nurse reviewer uses the *Postoperative Occurrences (Enter/Edit)* option to enter or change information related to postoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user can enter a question mark (?) at the "Enter a New Postoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another opportunity to enter or edit data.

Example: Enter a Postoperative Occurrence

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: PO Postoperative Occurrences
(Enter/Edit)
```

```
DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)
```

There are no Postoperative Occurrences entered for this case.

Enter a New Postoperative Occurrence: **CARDIAC ARREST REQUIRING CPR**

NSQIP Definition (2004):

The absence of cardiac rhythm or presence of chaotic cardiac rhythm that results in loss of consciousness requiring the initiation of any component of basic and/or advanced cardiac life support.

CICSP Definition (2004):

Indicate if there was any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) occurring in the operating room, ICU, ward, or out-of-hospital after the chest had been completely closed and within 30 days of surgery.

Press RETURN to continue: **<Enter>**

```
DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)
```

1. Occurrence: CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

Select Occurrence Information: **4:6**

DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

Treatment Instituted: **CPR**
Outcome to Date: **I** IMPROVED
Date/Time the Occurrence was Noted: **6/19/97** (JUN 19, 1997)

DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

1. Occurrence: CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted: CPR
5. Outcome to Date: IMPROVED
6. Date Noted: 06/19/97
7. Occurrence Comments:

Select Occurrence Information: **<Enter>**

DELAWARE, DAVID (123-45-6789) Case #60183
JUN 18,1997 CORONARY ARTERY BYPASS (33510)

Enter/Edit Intraoperative Occurrences

1. CARDIAC ARREST REQUIRING CPR
Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:

Resource Data (Enter/Edit) [SROA CARDIAC RESOURCE]

The nurse reviewer uses the *Resource Data (Enter/Edit)* option to enter, edit, or review risk assessment and cardiac patient demographic information such as hospital admission, discharge dates, and other information related to the surgical episode.

Example: Resource Data (Enter/Edit)

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: R Resource Data
```

```
IOWA, LUKE (123-45-6789) Case #49413  
JUN 18,1997 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
```

```
-----  
Enter/Edit Patient Resource Data
```

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information

```
Select Number: (1-2): 1
```

```
Are you sure you want to retrieve information from PIMS records ? YES//<Enter>
```

```
...HMMM, I'M WORKING AS FAST AS I CAN...
```

```
IOWA, LUKE (123-45-6789) Case #49413  
JUN 18,1997 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
```

```
-----  
Enter/Edit Patient Resource Data
```

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information

```
Select Number: (1-2): 2
```

```
IOWA, LUKE (123-45-6789) Case #49413  
JUN 18,1997 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
```

- ```

1. Hospital Admission Date: JUN 16, 1997@08:00
2. Hospital Discharge Date: JUN 30, 1997@08:00
3. Cardiac Catheterization Date: JUN 21, 1997
4. Time Patient In OR: JUN 18, 1997@07:30
5. Time Patient Out OR: JUN 18, 1997@14:30
6. Date/Time Patient Extubated: JUN 18, 1997@08:05
7. Date/Time Discharged from ICU:
8. Homeless: NO
9. Cardiac Surg Performed at Non-VA Facility: NO
10. Resource Data Comments:
11. Employment Status Preoperatively: SELF EMPLOYED
```

```

Select number of item to edit: 11
```

```
Employment Status Preoperatively: EMPLOYED FULL TIME// ?
Enter the patient's employment status preoperatively.
Choose from:
1 EMPLOYED FULL TIME
2 EMPLOYED PART TIME
3 NOT EMPLOYED
4 SELF EMPLOYED
5 RETIRED
6 ACTIVE MILITARY DUTY
9 UNKNOWN
Employment Status Preoperatively: 3 NOT EMPLOYED
```

```
IOWA, LUKE (123-45-6789) Case #49413
JUN 18,1997 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)

1. Hospital Admission Date: JUN 16, 1997@08:00
2. Hospital Discharge Date: JUN 30, 1997@08:00
3. Cardiac Catheterization Date: JUN 21, 1997
4. Time Patient In OR: JUN 18, 1997@07:30
5. Time Patient Out OR: JUN 18, 1997@14:30
6. Date/Time Patient Extubated: JUN 18, 1997@08:05
7. Date/Time Discharged from ICU:
8. Homeless: NO
9. Surg Performed at Non-VA Facility: NO
10. Resource Data Comments:
11. Employment Status Preoperatively: NOT EMPLOYED

Select number of item to edit:
```

*(This page included for two-sided copying.)*

## Update Assessment Status to 'COMPLETE' [SROA COMPLETE ASSESSMENT]

The *Update Assessment Status to 'COMPLETE'* option is used to upgrade the status of an assessment to "Complete." A complete assessment has enough information for it to be transmitted to the centers where data are analyzed. Only complete assessments are transmitted. After updating the status, the user can print the patient's entire Surgery Risk Assessment Report. This report can be copied to a screen or to a printer.

### Example: Update Assessment Status to COMPLETE

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: U Update Assess
ment Status to 'COMPLETE'
```

```
This assessment is missing the following items:
```

```
1. Foreign Body Removal (Y/N)
```

```
Do you want to enter the missing items at this time? NO// YES
```

```
FOREIGN BODY REMOVAL (Y/N): N NO
```

```
Are you sure you want to complete this assessment ? NO// YES
```

```
Updating the current status to 'COMPLETE'...
```

```
Do you want to print the completed assessment ? YES// NO
```

# Print a Surgery Risk Assessment

## [SROA PRINT ASSESSMENT]

The *Print a Surgery Risk Assessment* option prints an entire Surgery Risk Assessment Report for an individual patient. This report can be displayed temporarily on a screen. As the report fills the screen, the user will be prompted to press the **<Enter>** key to go to the next page. A permanent record can be made by copying the report to a printer. When using a printer, the report is formatted slightly differently from the way it displays on the terminal.

### Example 1: Print Surgery Risk Assessment for a Non-Cardiac Case

```
Select Surgery Risk Assessment Menu Option: P Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO// <Enter>

Select Patient: MAINE,JOE 05-07-23 123456789 NO NSC VET
ERAN

MAINE,JOE 123-45-6789

1. 02-10-04 * CABG (INCOMPLETE)
2. 01-09-04 APPENDECTOMY (COMPLETED)

Select Surgical Case: 2

Print the Completed Assessment on which Device: [Select Print Device]

-----printout follows-----
```

=====

Medical Center: ALBANY  
Age: 56  
Sex: MALE

Operation Date: JAN 09, 2004  
Ethnicity: NOT HISPANIC OR LATINO  
Race: AMERICAN INDIAN OR ALASKA  
NATIVE, NATIVE HAWAIIAN OR  
OTHER PACIFIC ISLANDER, WHITE

Transfer Status: NOT TRANSFERRED  
Observation Admission Date: NA  
Observation Discharge Date: NA  
Observation Treating Specialty: NA  
Hospital Admission Date: JAN 7,2004 11:15  
Hospital Discharge Date: JAN 12,2004 10:30  
Admitted/Transferred to Surgical Service: JAN 7,2004 11:15  
Discharged/Transferred to Chronic Care: JAN 12,2004 10:30  
In/Out-Patient Status: INPATIENT

-----

PREOPERATIVE INFORMATION

|                               |                 |                                |      |
|-------------------------------|-----------------|--------------------------------|------|
| GENERAL:                      | YES             | HEPATOBIILIARY:                | YES  |
| Height:                       | 176 CENTIMETERS | Ascites:                       | YES  |
| Weight:                       | 89 KILOGRAMS    |                                |      |
| Diabetes Mellitus:            | INSULIN         | GASTROINTESTINAL:              | YES  |
| Current Smoker W/I 1 Year:    | YES             | Esophageal Varices:            | YES  |
| Pack/Years:                   | 0               |                                |      |
| ETOH > 2 Drinks/Day:          | NO              | CARDIAC:                       | NO   |
| Dyspnea:                      | NO              | CHF Within 1 Month:            | NO   |
| DNR Status:                   | NO              | MI Within 6 Months:            | NO   |
| Functional Status:            | INDEPENDENT     | Previous PTCA:                 | NO   |
|                               |                 | Previous Cardiac Surgery:      | NO   |
| PULMONARY:                    | YES             | Angina Within 1 Month:         | NO   |
| Ventilator Dependent:         | NS              | Hypertension Requiring Meds:   | NO   |
| History of Severe COPD:       | NO              |                                |      |
| Current Pneumonia:            | NO              | VASCULAR:                      | YES  |
|                               |                 | Revascularization/Amputation:  | NO   |
|                               |                 | Rest Pain/Gangrene:            | YES  |
| RENAL:                        | YES             | NUTRITIONAL/IMMUNE/OTHER:      | YES  |
| Acute Renal Failure:          | NO              | Disseminated Cancer:           | NO   |
| Currently on Dialysis:        | NO              | Open Wound:                    | NO   |
|                               |                 | Steroid Use for Chronic Cond.: | NO   |
| CENTRAL NERVOUS SYSTEM:       | YES             | Weight Loss > 10%:             | NO   |
| Impaired Sensorium:           | NO              | Bleeding Disorders:            | NO   |
| Coma:                         | NO              | Transfusion > 4 RBC Units:     | NO   |
| Hemiplegia:                   | NO              | Chemotherapy W/I 30 Days:      | NO   |
| History of TIAs:              | NO              | Radiotherapy W/I 90 Days:      | NO   |
| CVA/Stroke w. Neuro Deficit:  | YES             | Preoperative Sepsis:           | NONE |
| CVA/Stroke w/o Neuro Deficit: | NO              |                                |      |
| Tumor Involving CNS:          | NO              |                                |      |
| Paraplegia:                   | NO              |                                |      |
| Quadriplegia:                 | NO              |                                |      |

OPERATION DATE/TIMES INFORMATION

Patient in Room (PIR): JAN 9,2004 07:25  
Procedure/Surgery Start Time (PST): JAN 9,2004 07:25  
Procedure/Surgery Finish (PF): JAN 9,2004 08:00  
Patient Out of Room (POR): JAN 9,2004 08:10  
Anesthesia Start (AS): JAN 9,2004 07:15  
Anesthesia Finish (AF): JAN 9,2004 08:08  
Discharge from PACU (DPACU): JAN 9,2004 09:15

=====

OPERATIVE INFORMATION

Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Principal Operation: APPENDECTOMY  
Principal CPT Code: 44950

Concurrent Procedure:  
CPT Code:

PGY of Primary Surgeon: 0  
Emergency Case (Y/N): NO  
Major or Minor: MAJOR  
Wound Classification: CONTAMINATED  
ASA Classification: 3-SEVERE DISTURB.  
Airway Trauma: NONE  
Mallampati Scale: CLASS 3  
Principal Anesthesia Technique: GENERAL  
Airway Index: NOT ENTERED  
RBC Units Transfused: 0

PREOPERATIVE LABORATORY TEST RESULTS

Serum Sodium: 144.6 (JAN 7,2004)  
Serum Creatinine: .9 (JAN 7,2004)  
BUN: 18 (JAN 7,2004)  
Serum Albumin: 3.5 (JAN 7,2004)  
Total Bilirubin: .9 (JAN 7,2004)  
SGOT: 46 (JAN 7,2004)  
Alkaline Phosphatase: 34 (JAN 7,2004)  
White Blood Count: 15.9 (JAN 7,2004)  
Hematocrit: 43.4 (JAN 7,2004)  
Platelet Count: 356 (JAN 7,2004)  
PTT: 25.9 (JAN 7,2004)  
PT: 12.1 (JAN 7,2004)  
INR: 1.54 (JAN 7,2004)

POSTOPERATIVE LABORATORY RESULTS

\* Highest Value  
\*\* Lowest Value

\* Serum Sodium: 148 (JAN 12,2004)  
\*\* Serum Sodium: 144.2 (FEB 2,2004)  
\* Potassium: 4.5 (JAN 12,2004)  
\*\* Potassium: 4.5 (JAN 12,2004)  
\* Serum Creatinine: 1.4 (FEB 2,2004)  
\* CPK: 88 (JAN 12,2004)  
\* CPK-MB Band: <1 (JAN 12,2004)  
\* Total Bilirubin: 1.3 (JAN 12,2004)  
\* White Blood Count: 12.2 (JAN 12,2004)  
\*\* Hematocrit: 42.9 (JAN 12,2004)  
\* Troponin I: 1.42 (JAN 12,2004)  
\* Troponin T: NS

=====

OUTCOME INFORMATION

Postoperative Diagnosis Code (ICD9): 540.1 ABSCESS OF APPENDIX  
Length of Postoperative Hospital Stay: 3 DAYS  
Date of Death:  
Return to OR Within 30 Days: NO

PERIOPERATIVE OCCURRENCE INFORMATION

|                             |          |                                |          |
|-----------------------------|----------|--------------------------------|----------|
| WOUND OCCURRENCES:          | YES      | CNS OCCURRENCES:               | YES      |
| Superficial Incisional SSI: | NO       | Stroke/CVA:                    | NO       |
| Deep Incisional SSI:        | NO       | Coma > 24 Hours:               | NO       |
| Organ/Space SSI:            | 01/11/04 | Peripheral Nerve Injury:       | 01/10/04 |
| Wound Disruption:           | 01/10/04 |                                |          |
| * 427.31 ATRIAL FIBRILLATI  | 01/10/04 |                                |          |
| URINARY TRACT OCCURRENCES:  | YES      | CARDIAC OCCURRENCES:           | YES      |
| Renal Insufficiency:        | NO       | Arrest Requiring CPR:          | NO       |
| Acute Renal Failure:        | NO       | Myocardial Infarction:         | 01/09/04 |
| Urinary Tract Infection:    | 01/11/04 |                                |          |
| RESPIRATORY OCCURRENCES:    | YES      | OTHER OCCURRENCES:             | YES      |
| Pneumonia:                  | NO       | Bleeding/Transfusions:         | NO       |
| Unplanned Intubation:       | NO       | Graft/Prosthesis/Flap Failure: | NO       |
| Pulmonary Embolism:         | NO       | DVT/Thrombophlebitis:          | NO       |
| On Ventilator > 48 Hours:   | NO       | Systemic Sepsis: SEPTIC SHOCK  | 01/11/04 |
| * 477.0 RHINITIS DUE TO P   | 01/12/04 |                                |          |

\* indicates Other (ICD9)

## Example 2: Print Surgery Risk Assessment for a Cardiac Case

Select Surgery Risk Assessment Menu Option: **P** Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO// **<Enter>**

Select Patient: **R9922** GEORGIA, PAUL 03-03-34 123456789 NO SC  
VETERAN

GEORGIA, PAUL 123-45-6789

1. 08-01-97 \* CABG X3 (1A,2V), ARTERIAL GRAFTING (TRANSMITTED)
2. 03-27-97 INGUINAL HERNIA (TRANSMITTED)
3. 07-03-95 PULMONARY LOBECTOMY (TRANSMITTED)

Select Surgical Case: Select Surgical Case: **1**

Print the Completed Assessment on which Device: **[Select Print Device]**

-----*printout follows*-----

VA CONTINUOUS IMPROVEMENT IN CARDIAC SURGERY PROGRAM (CICSP/CICSP-X)

I. IDENTIFYING DATA

Patient: GEORGIA, PAUL 123-45-6789 Case #: 238 Fac./Div. #: 500  
 Surgery Date: 02/10/04 Address: 1492 Anywhere Way  
 Phone: NS/Unknown Zip Code: 33445-1234 Date of Birth: 09/17/47

II. CLINICAL DATA

|                           |                   |                                    |                  |
|---------------------------|-------------------|------------------------------------|------------------|
| Gender:                   | MALE              | PCI:                               | >72 hrs - 7 days |
| Age:                      | 56                | Prior MI:                          | > 7 DAYS OF SURG |
| Height:                   | 72 in             | # of prior heart surgeries:        | NONE             |
| Weight:                   | 120 kg            | Prior heart surgeries:             |                  |
| Diabetes:                 | DIET              | Peripheral Vascular Disease:       | NO               |
| COPD:                     | NO                | Cerebral Vascular Disease:         | NO               |
| FEV1:                     | NS                | Angina (use CCS Class):            | III              |
| Cardiomegaly (X-ray):     | YES               | CHF (use NYHA Class):              | I                |
| Pulmonary Rales:          | NO                | Current Diuretic Use:              | NO               |
| Current Smoker: >3 MONTHS | PRIOR TO SUR      | Current Digoxin Use:               | NO               |
| Active Endocarditis:      | NO                | IV NTG 48 Hours Preceding Surgery: | NO               |
| Resting ST Depression:    | YES               | Preop circulatory Device:          | VAD              |
| Functional Status:        | PARTIAL DEPENDENT | Hypertension:                      | NO               |

III. DETAILED LABORATORY INFO - PREOPERATIVE VALUES

|               |                       |                 |                      |
|---------------|-----------------------|-----------------|----------------------|
| Creatinine:   | 1.1 mg/dl (02/08/04)  | T. Bilirubin:   | .9 mg/dl (02/08/04)  |
| Hemoglobin:   | 15.6 mg/dl (02/08/04) | T. Cholesterol: | 230 mg/dl (02/08/04) |
| Albumin:      | 4.4 g/dl (02/08/04)   | HDL:            | 90 mg/dl (02/08/04)  |
| Triglyceride: | 77 mg/dl (02/08/04)   | LDL:            | 125 mg/dl (02/08/04) |
| Potassium:    | 4.6 mg/L (02/08/04)   |                 |                      |

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA

Cardiac Catheterization Date: 02/08/04

|                                       |    |                               |    |
|---------------------------------------|----|-------------------------------|----|
| Procedure:                            | NS | Native Coronaries:            |    |
| LVEDP:                                | NS | Left Main Stenosis:           | NS |
| Aortic Systolic Pressure:             | NS | LAD Stenosis:                 | NS |
|                                       |    | Right Coronary Stenosis:      | NS |
| For patients having right heart cath: |    | Circumflex Stenosis:          | NS |
| PA Systolic Pressure:                 | NS |                               |    |
| PAW Mean Pressure:                    | NS | If a Re-do, indicate stenosis |    |
|                                       |    | in graft to:                  |    |
|                                       |    | LAD:                          | NS |
|                                       |    | Right coronary (include PDA): | NS |
|                                       |    | Circumflex:                   | NS |

LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):

|             |                         |            |
|-------------|-------------------------|------------|
| Grade       | Ejection Fraction Range | Definition |
| NO LV STUDY |                         |            |

Mitral Regurgitation: NS  
 Aortic stenosis: NS

V. OPERATIVE RISK SUMMARY DATA

|                                  |                                       |
|----------------------------------|---------------------------------------|
|                                  | (Operation Began: FEB 10, 2004@10:10) |
| Physician's Preoperative         | (Operation Ended: 02/10/04 12:20)     |
| Estimate of Operative Mortality: | NS (MAR 23, 2004@15:30)               |
| ASA Classification:              | 3-SEVERE DISTURB.                     |
| Surgical Priority:               | ELECTIVE (MAR 23, 2004@15:31)         |
| Principal CPT Code:              | 33517                                 |
| Other Procedures CPT Codes:      | NONE; 33510; NONE                     |
| Preoperative Risk Factors:       |                                       |

=====

VI. OPERATIVE DATA

Cardiac surgical procedures with or without cardiopulmonary bypass  
 CABG distal anastomoses: Bridge to transplant/Device: NO  
 Number with Vein: 2 TMR: NO  
 Number with IMA: 2 Maze procedure: NO  
 Number with Radial Artery: 0 ASD repair: NO  
 Number with Other Artery: 0 VSD repair: NO  
 Number with Other Conduit: 0 Myectomy for IHSS: NO  
 Aortic Valve Replacement: NO Myxoma resection: NO  
 Mitral Valve Replacement: NO Other tumor resection: NO  
 Tricuspid Valve Replacement: NO Cardiac transplant: NO  
 Valve Repair: NONE  
 LV Aneurysmectomy: NO  
 Other CT procedures (Specify): OTHER CT PROCEDURE #1, OTHER CT PROCEDURE #2,  
 OTHER CT PROC  
 Indicate other cardiac procedures only if done with cardiopulmonary bypass  
 Great vessel repair: NO  
 Foreign body removal: YES  
 Pericardiectomy: YES  
 Other Non-CT procedures-independently requiring CPB (Specify): OTHER NON-CT  
 PROCEDURE #1, OTHER NON-CT PROCEDURE #2, OTHER NON-CT PROCEDURE #3, OTHER  
 NON-CT PROCEDURE #4, OTHER NON-CT PROCEDURE #5, OTHER NON-CT PROCEDURE #6,  
 OTHER NON-CT PROCEDURE #7, OTHER NON-CT PROCEDURE #8, OTHER NON-CT PROCEDURE #9

Other Operative Data details

Total CPB Time: 85 min Total Ischemic Time: 60 min  
 Incision Type: FULL STERNOTOMY  
 Conversion Off Pump to CPB: N/A (began on-pump/ stayed on-pump)

VII. OUTCOMES

Operative Death: NO Date of Death:  
 Perioperative (30 day) Occurrences:  
 Perioperative MI: NO Repeat cardiac Surg procedure: YES  
 Endocarditis: NO Tracheostomy: YES  
 Renal Failure Requiring Dialysis: NO Ventilator supp within 30 days: YES  
 Mediastinitis: YES Stroke/CVA: NO  
 Cardiac Arrest Requiring CPR: YES Coma > or = 24 Hours: NO  
 Reoperation for Bleeding: NO New Mech Circulatory Support: YES  
 On ventilator > or = 48 hr: NO

VIII. RESOURCE DATA

Hospital Admission Date: 02/10/04 06:05  
 Hospital Discharge Date: 02/16/04 08:50  
 Time Patient In OR: 02/10/04 10:00  
 Time Patient Out OR: 02/10/04 12:30  
 Date and Time Patient Extubated: 02/10/04 13:13  
 Date and Time Patient Discharged from ICU: 02/11/04 08:00  
 Patient is Homeless: NS  
 Cardiac Surg Performed at Non-VA Facility: UNKNOWN  
 Resource Data Comments: Indicate other cardiac procedures only if done  
 with cardiopulmonary bypass

=====

IX. SOCIOECONOMIC, ETHNICITY, AND RACE

Employment Status Preoperatively: SELF EMPLOYED  
 Ethnicity: NOT HISPANIC OR LATINO  
 Race Category(ies): AMERICAN INDIAN OR ALASKA NATIVE,  
 NATIVE HAWAIIAN OR OTHER PACIFIC  
 ISLANDER, WHITE

X. DETAILED DISCHARGE INFORMATION

Discharge ICD-9 Codes: 414.01 V70.7 433.10 285.1 412. 307.9 427.31

Type of Disposition: TRANSFER  
 Place of Disposition: HOME-BASED PRIMARY CARE (HBPC)  
 Primary care or referral VAMC identification code: 526  
 Follow-up VAMC identification code: 526

\*\*\* End of report for MADISON,JAMES 123-45-6789 assessment #238 \*\*\*

*(This page included for two-sided copying.)*

Pages 507-508 referred to options that are no longer in the package and have been removed from the manual.

Pages 507-508 referred to options that are no longer in the package and have been removed from the manual.

# Update 1-Liner Case

## [SROA ONE-LINER UPDATE]

The *Update 1-Liner* option may be used to enter missing data for the 1-liner cases (major cases marked for exclusion from assessment, minor cases and cardiac-assessed cases that transmit to the NSQIP database as a single line or two of data). Cases edited with this option will be queued for transmission to the NSQIP database at Chicago.

### Example: Update 1-Liner Case

```
Select Surgery Risk Assessment Menu Option: Update 1-Liner Case
Select Patient: IDAHO, PETER 02-12-28 123456789 YES
 SC VETERAN
```

```
IDAHO, PETER 123-45-6789
1. 08-07-04 REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)
2. 02-18-99 TRACHEOSTOMY, BRONCHOSCOPY, ESOPHAGOSCOPY (COMPLETED)
3. 09-04-97 CHOLECYSTECTOMY (COMPLETED)
Select Case: 1
```

```
IDAHO, PETER (123-45-6789) Case #142
Transmission Status: TRANSMITTED
AUG 7, 2004 REPAIR DIAPHRAGMATIC HERNIA (39540-62,66,78)

1. In/Out-Patient Status: OUTPATIENT
2. Major or Minor: MAJOR
3. Surgical Specialty: GENERAL (OR WHEN NOT DEFINED BELOW)
4. Surgical Priority: STANDBY
5. Attending Code: LEVEL A. ATTENDING DOING THE OPERATION
6. ASA Class: 2-MILD DISTURB.
7. Wound Classification:
8. Anesthesia Technique: GENERAL
9. Principal Operation (CPT): 39540-62,66,78
10. Other Procedures: ***NONE ENTERED***

Select number of item to edit: 7
Wound Classification: C CLEAN
```

```
IDAHO, PETER (123-45-6789) Case #142
Transmission Status: QUEUED TO TRANSMIT
AUG 7, 2004 REPAIR DIAPHRAGMATIC HERNIA (39540-62,66,78)

1. In/Out-Patient Status: OUTPATIENT
2. Major or Minor: MAJOR
3. Surgical Specialty: GENERAL (OR WHEN NOT DEFINED BELOW)
4. Surgical Priority: STANDBY
5. Attending Code: LEVEL A. ATTENDING DOING THE OPERATION
6. ASA Class: 2-MILD DISTURB.
7. Wound Classification: CLEAN
8. Anesthesia Technique: GENERAL
9. Principal Operation (CPT): 39540-62,66,78
10. Other Procedures: ***NONE ENTERED***

Select number of item to edit:
```

*(This page included for two-sided copying.)*

## Options

- Admissions Within 14 Days of Outpatient Surgery, 385
- Anesthesia AMIS, 171, 297
- Anesthesia Data Entry Menu, 161
- Anesthesia for an Operation Menu, 128
- Anesthesia Information (Enter/Edit), 162
- Anesthesia Menu, 160
- Anesthesia Provider Report, 303
- Anesthesia Report, 131, 170
- Anesthesia Reports, 296
- Anesthesia Technique (Enter/Edit), 165
- Annual Report of Non-O.R. Procedures, 196
- Annual Report of Surgical Procedures, 255
- Attending Surgeon Reports, 284
- Blood Product Verification, 158
- Cancel Scheduled Operation, 81
- Cardiac Procedures Operative Data (Enter/Edit), 469
- Chief of Surgery, 323
- Chief of Surgery Menu, 321
- Circulating Nurse Staffing Report, 294
- Clinical Information (Enter/Edit), 463
- Comments Option, 205
- Comparison of Preop and Postop Diagnosis, 335
- CPT Code Reports, 305
- CPT/ICD9 Coding Menu, 207
- CPT/ICD9 Update/Verify Menu, 208
- Create Service Blockout, 85
- Cumulative Report of CPT Codes, 220, 306
- Deaths Within 30 Days of Surgery, 378
- Delay and Cancellation Reports, 337
- Delete a Patient from the Waiting List, 23
- Delete or Update Operation Requests, 36
- Delete Service Blockout, 87
- Display Availability, 26, 60
- Edit a Patient on the Waiting List, 22
- Edit Non-O.R. Procedure, 189
- Ensuring Correct Surgery Compliance Report, 391
- Enter a Patient on the Waiting List, 21
- Enter Cardiac Catheterization & Angiographic Data, 465
- Enter Irrigations and Restraints, 155
- Enter PAC(U) Information, 121
- Enter Referring Physician Information, 154
- Enter Restrictions for 'Person' Fields, 422
- Exclusion Criteria (Enter/Edit), 503
- File Download, 433
- Flag Drugs for Use as Anesthesia Agents, 427
- Flag Interface Fields, 431
- Intraoperative Occurrences (Enter/Edit), 176, 455, 471
- Laboratory Interim Report, 319
- Laboratory Test Results (Enter/Edit), 447, 464a
- List Completed Cases Missing CPT Codes, 230, 316
- List of Anesthetic Procedures, 299
- List of Invasive Diagnostic Procedures, 387
- List of Operations, 232, 257
- List of Operations (by Postoperative Disposition), 259
- List of Operations (by Surgical Priority), 267
- List of Operations (by Surgical Specialty), 234, 265
- List of Operations Included on Quarterly Report, 389
- List of Surgery Risk Assessments, 485
- List of Unverified Surgery Cases, 352
- List Operation Requests, 57
- List Scheduled Operations, 91
- M&M Verification Report, 330, 509
- Maintain Surgery Waiting List menu, 17
- Make a Request for Concurrent Cases, 45
- Make a Request from the Waiting List, 42
- Make Operation Requests, 28
- Make Reports Viewable in CPRS, 436
- Management Reports, 252, 325
- Medications (Enter/Edit), 157, 169
- Monthly Surgical Case Workload Report, 505
- Morbidity & Mortality Reports, 183, 326
- Non-Cardiac Risk Assessment Information (Enter/Edit), 441
- Non-O.R. Procedures, 187
- Non-O.R. Procedures (Enter/Edit), 188
- Non-Operative Occurrence (Enter/Edit), 180
- Normal Daily Hours (Enter/Edit), 413
- Nurse Intraoperative Report, 140, 217
- Operating Room Information (Enter/Edit), 409
- Operating Room Utilization (Enter/Edit), 411
- Operating Room Utilization Report, 361, 415
- Operation, 113
- Operation (Short Screen), 122
- Operation Information, 103
- Operation Information (Enter/Edit), 451
- Operation Menu, 95
- Operation Report, 129
- Operation Requests for a Day, 53
- Operation Startup, 108
- Operation/Procedure Report, 213

Operative Risk Summary Data (Enter/Edit), 467  
 Outcome Information (Enter/Edit), 474a  
 Outpatient Encounters Not Transmitted to NPCD, 278  
 Patient Demographics (Enter/Edit), 453  
 PCE Filing Status Report, 238, 273  
 Perioperative Occurrences Menu, 175  
 Person Field Restrictions Menu, 421  
 Post Operation, 119  
 Postoperative Occurrences (Enter/Edit), 178, 457, 473  
 Print 30 Day Follow-up Letters, 499  
 Print a Surgery Risk Assessment, 477  
 Print Blood Product Verification Audit Log, 389  
 Print Surgery Waiting List, 18  
 Procedure Report (Non-O.R.), 193  
 Purge Utilization Information, 420  
 Quarterly Report Menu, 368  
 Quarterly Report--Surgical Service, 369  
 Queue Assessment Transmissions, 517  
 Remove Restrictions on 'Person' Fields, 424  
 Report of Cancellation Rates, 347  
 Report of Cancellations, 345  
 Report of Cases Without Specimens, 357  
 Report of CPT Coding Accuracy, 224, 310  
 Report of Daily Operating Room Activity, 236, 271, 355  
 Report of Delay Reasons, 340  
 Report of Delay Time, 342  
 Report of Delayed Operations, 338  
 Report of Missing Quarterly Report Data, 391  
 Report of Non-O.R. Procedures, 198, 243  
 Report of Normal Operating Room Hours, 417  
 Report of Returns to Surgery, 353  
 Report of Surgical Priorities, 269  
 Report of Unscheduled Admissions to ICU, 359  
 Request Operations menu, 25  
 Requests by Ward, 55  
 Reschedule or Update a Scheduled Operation, 74  
 Resource Data (Enter/Edit), 471  
 Review Request Information, 52  
 Risk Assessment, 461  
 Schedule Anesthesia Personnel, 84, 173  
 Schedule of Operations, 88, 253  
 Schedule Operations, 59  
 Schedule Requested Operation, 61  
 Schedule Unrequested Concurrent Cases, 69  
 Schedule Unrequested Operations, 64  
 Scrub Nurse Staffing Report, 292  
 Surgeon Staffing Report, 288  
 Surgeon's Verification of Diagnosis & Procedures, 125  
 Surgery Interface Management Menu, 430  
 Surgery Package Management Menu, 405  
 Surgery Reports, 251  
 Surgery Site Parameters (Enter/Edit), 406  
 Surgery Staffing Reports, 283  
 Surgery Utilization Menu, 410  
 Surgical Nurse Staffing Report, 290  
 Surgical Staff, 104  
 Table Download, 434  
 Tissue Examination Report, 153  
 Unlock a Case for Editing, 394  
 Update 1-Liner Case, 515  
 Update Assessment Completed/Transmitted in Error, 483  
 Update Assessment Status to 'Complete', 460  
 Update Assessment Status to 'COMPLETE', 478  
 Update Cancellation Reason, 83  
 Update Cancelled Cases, 396  
 Update Interface Parameter Field, 435  
 Update O.R. Schedule Devices, 425  
 Update Operations as Unrelated/Related to Death, 397, 507  
 Update Site Configurable Files, 428  
 Update Staff Surgeon Information, 426  
 Update Status of Returns Within 30 Days, 181, 395, 459  
 Update/Verify Procedure/Diagnosis Codes, 209, 398  
 View Patient Perioperative Occurrences, 324  
 Wound Classification Report, 363  
 outstanding requests  
     defined, 15

**P**

PACU, 121  
 PCE filing status, 238, 273  
 percent utilization, 361, 415  
 person-type field  
     assigning a key, 422  
     removing a key, 422, 424  
 Pharmacy Package Coordinator, 427  
 positioning devices, 155  
 Post Anesthesia Care Unit (PACU), 121

- postoperative occurrence, 385
  - entering, 457, 473
- preoperative assessment
  - entering information, 444
- preoperative information, 15
  - editing, 52
  - entering, 29, 65
  - reviewing, 52
  - updating, 74
- Preoperative Information (Enter/Edit), 444
- principal diagnosis, 103
- procedure
  - deleting, 23
  - dictating a summary, 189
  - editing data for non-O.R., 189
  - entering data for non-O.R., 189
  - filed as encounters, 278
  - summary for non-O.R., 193
- purging utilization information, 420

## Q

- Quarterly Report, 368
- quick reference on a case, 103

## R

- referring physician information, 154
- reporting
  - tracking cancellations, 337
  - tracking delays, 337
- reports
  - Admissions Within 14 Days of Outpatient Surgery Report, 385
  - Anesthesia AMIS Report, 171, 297
  - Anesthesia Provider Report, 303
  - Anesthesia Report, 131
  - Annual Report of Non-O.R. Procedures, 196
  - Annual Report of Surgical Procedures, 255
  - Attending Surgeon Cumulative Report, 284, 286
  - Attending Surgeon Report, 284
  - Cases Without Specimens, 357
  - Circulating Nurse Staffing Report, 294
  - Clean Wound Infection Summary, 367
  - Comparison of Preop and Postop Diagnosis, 335
  - Completed Cases Missing CPT Codes, 230, 316
  - Cumulative Report of CPT Codes, 220, 222, 306, 308

- Daily Operating Room Activity, 236, 271, 325, 355
- Deaths Within 30 Days of Surgery, 379, 381, 383
- Ensuring Correct Surgery Compliance Report, 391, 392
- Laboratory Interim Report, 319
- List of Anesthetic Procedures, 299, 301
- List of Invasive Diagnostic Procedures, 387
- List of Operations, 232, 257
- List of Operations (by Surgical Specialty), 234
- List of Operations by Postoperative Disposition, 259, 261, 263
- List of Operations by Surgical Priority, 267
- List of Operations by Surgical Specialty, 265
- List of Operations by Wound Classification, 365
- List of Operations Included on Quarterly Report, 389
- List of Unverified Cases, 352
- M&M Verification Report, 330, 333, 509, 512
- Missing Quarterly Report Data, 391
- Monthly Surgical Case Workload Report, 505
- Mortality Report, 183, 328
- Nurse Intraoperative Report, 141
- Operating Room Normal Working Hours Report, 417
- Operating Room Utilization Report, 415
- Operation Report, 130, 213
- Operation Requests, 57
- Operation Requests for a Day, 53
- Outpatient Surgery Encounters Not Transmitted to NPCD, 278, 280
- PCE Filing Status Report, 239, 241, 274, 276
- Perioperative Occurrences Report, 183, 326
- Procedure Report (Non-O.R.), 195, 216
- Procedure Report (Non-OR), 215
- Quarterly Report - Surgical Service, 374
- Quarterly Report - Surgical Specialty, 370
- Re-Filing Cases in PCE, 282
- Report of Cancellation Rates, 347, 349
- Report of Cancellations, 345
- Report of CPT Coding Accuracy, 224, 310, 312, 314
- Report of CPT Coding Accuracy for OR Surgical Procedures, 226, 228
- Report of Daily Operating Room Activity, 271
- Report of Delay Time, 342
- Report of Delayed Operations, 338

- Report of Non-O.R. Procedures, 198, 200, 202, 243, 245, 247
- Report of Returns to Surgery, 353
- Report of Surgical Priorities, 269, 270
- Requests by Ward, 55
- Schedule of Operations, 88
- Scheduled Operations, 91
- Scrub Nurse Staffing Report, 292
- Surgeon Staffing Report, 288
- Surgery Risk Assessment, 477
- Surgery Waiting List, 18
- Surgical Nurse Staffing Report, 290
- Tissue Examination Report, 153
- Unscheduled Admissions to ICU, 359
- Wound Classification Report, 363

request an operation, 25

restraint, 108, 155

risk assessment, 330, 437

- changing, 441
- creating, 441
- creating cardiac, 461
- entering non-cardiac patient, 441
- entering the clinical information for cardiac case, 463

Risk Assessment, 477, 524

Risk Assessment module, 439

route, 157, 169

## S

- schedule an unrequested operation, 64
- scheduled, 79, 84, 98, 524
- scheduling a concurrent case, 61

Screen Server, 93

- data elements, 6
- Defined, 5
- editing data, 8
- entering a range of elements, 9
- entering data, 7
- header, 6
- multiple screen shortcut, 12
- multiples, 10
- Navigation, 5
- prompt, 6
- turning pages, 8
- word processing, 14

- service blackout, 60
  - creating, 85
  - removing, 87
- short form listing of scheduled cases, 91
- site-configurable files, 428
- specimens, 153
- staff surgeon
  - designating a user as, 426
- surgeon key, 422
- Surgery
  - major,defined, 108
  - minor,defined, 108
- Surgery case
  - cancelled, 396
  - unlocking, 394
- Surgery package coordinator, 403
- Surgery Site parameters
  - entering, 406
- Surgical Service Chief, 321
- Surgical Service managers, 406
- surgical specialty, 21, 57, 74, 234
- Surgical staff, 104

## T

- time given, 157, 169
- transfusion
  - error risk management, 158

## U

- utilization information, 361, 415
  - purging, 420

## V

- VA Central Office, 255

## W

- Waiting List
  - adding a new case, 21
  - deleting a procedure, 23
  - editing a patient on the, 22
  - entering a patient, 21
  - printing, 18
- waiting lists, 17
- workload
  - report, 505
  - uncounted, 278
- wound classification, 363