



SURGERY ELECTRONIC SIGNATURE FOR OPERATIVE REPORTS

INSTALLATION GUIDE

SR*3*100

Version 3.0
April 2004

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Documentation Conventions

This *Surgery V. 3.0 Installation Guide* includes documentation conventions, also known as notations, which are used consistently throughout this manual. Each convention is outlined below.

Convention	Example
Menu option text is italicized.	The <i>Print Surgery Waiting List</i> option generates the long form surgery waiting list for the surgical service(s) selected.
Screen prompts are denoted with quotation marks around them.	The "Puncture Site:" prompt will display next.
Responses in bold face indicate user input.	Needle Size: 25G
Text centered between arrows represents a keyboard key that needs to be pressed for the system to capture a user response or move the cursor to another field. <Enter> indicates that the Enter key (or Return key on some keyboards) must be pressed. <Tab> indicates that the Tab key must be pressed.	Type Y for Yes or N for No and press <Enter>. Press <Tab> to move the cursor to the next field.
 Indicates especially important or helpful information.	 If the user attempts to reschedule a case after the schedule close time for the date of operation, only the time, and not the date, can be changed.

Getting Help and Exiting

?, ??, ??? One, two or three question marks can be entered at any of the prompts for online help. One question mark elicits a brief statement of what information is appropriate for the prompt. Two question marks provide more help, plus the hidden actions, and three question marks will provide more detailed help, including a list of possible answers, if appropriate.

Typing an up arrow ^ (caret or a circumflex) and pressing <Enter> can be used to exit the present option.

(This page included for two-sided copying.)

Purpose

The purpose of this document is to provide instructions for the installation of the Surgery Electronic Signature for Operative Reports patch, SR*3*100. The intended audience for this document is the medical center staff responsible for installation of the patches and setup of the Surgery site parameters as described in the section “Understanding the Installation Process.”

Scope

The enhancements provided by the Surgery Electronic Signature for Operative Reports patch allow signed operative reports to be viewed electronically through the Computerized Patient Record System (CPRS). The Surgery package produces the Operation Report, Nurse Intraoperative Report, Procedure (Non-O.R.) Report, and Anesthesia Report. This project introduces the ability to electronically sign these reports, store them within Text Integration Utilities (TIU), and ultimately view them in CPRS. Tools provided by the TIU software are used to sign and manage the electronic documents. The signed documents are then accessible through a newly created Surgery tab in CPRS.

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Pre-Installation

This section provides information that helps the user determine patch and system requirements before installing the Surgery Electronic Signature for Operative Reports patch.



DO NOT continue with the installation of this patch until the Pre-Installation Worksheet, which provides the dates and the list of reports to move, has been completed. Information from this worksheet will be required to complete the installation. The Pre-Installation Worksheet is located at the end of this *Surgery V. 3.0 Installation Guide*.

Patch Requirements

Prior to installation of the Surgery Electronic Signature for Operative Reports patch SR*3*100, the following patches must be installed. The majority of facilities will find that these patches have already been installed.

- SR*3*96
- SR*3*99
- SR*3*105
- SR*3*107
- SR*3*112
- SR*3*115
- SR*3*126
- TIU*1*112



The order of the patches listed above does not relate to the installation sequence.

System Requirements

This Surgery Electronic Signature for Operative Reports patch requires that Surgery V. 3.0 be fully patched and also requires the following Department of Veterans Affairs (VA) software.

Package	Minimum version needed
Kernel	8.0
VA FileMan	22.0
MailMan	7.1
PIMS	5.3
Laboratory	5.2
Inpatient Medications	5.0
Pharmacy Data Management	1.0
Patient Care Encounter	1.0
Health Level Seven	1.6
Order Entry/Results Reporting	3.0
TIU (requires Authorization/Subscription V. 1.0)	1.0

Data Dictionary Updates

The Surgery Electronic Signature for Operative Reports patch contains updates to the data dictionary (DD), including input templates.

SURGERY File (#130)

These existing fields in the SURGERY file (#130) are updated as indicated in the following table:

Field Number and Name	Update Made
.09 DATE OF OPERATION	AES1 index added
.111 OR CIRC SUPPORT	Field is now a multiple
.01 OR CIRC SUPPORT	AES7 index added
.14 SURGEON	AES1 index added
.164 ATTEND SURG	AES3 index added
.21 ANES CARE START TIME	AF cross reference description updated
.23 TIME OPERATION ENDS	ADIC cross reference removed
.23 TIME PAT OUT OR	AES index added, AUD1 cross reference removed
.24 ANES CARE END TIME	AESA index added
.31 PRINC ANESTHETIST	AES5 index added
.34 ANESTHESIOLOGIST SUPVR	AES6 index added
.48 TIME TOURNIQUET APPLIED	Field is now a multiple
1 SITE APPLIED	Set of codes updated
1.19 POSTOP ANES NOTE DATE	Name of field changed from POSTOP ANES NOTE
15 DATE/TIME OF DICTATION	AUD cross reference removed
122 TIME PROCEDURE ENDED	AESP index added
123 PROVIDER	AES2 index added
124 ATTEND PROVIDER	AES4 index added

The following new fields are added to SURGERY file (#130):

Field Number and Name
1.2 POSTOP ANES NOTE
129 LASER UNIT
.01 LASER UNIT/ID
1 LASER DURATION
2 WATTAGE
3 LASER OPERATOR
4 PLUME EVACUATOR
5 LASER COMMENTS
130 CELL SAVER (multiple)
.01 CELL SAVER
1 CELL SAVER OPERATOR
2 AMT SALVAGED (ML)
3 AMT REINFUSED (ML)

Field Number and Name	
4	DISPOSABLES USED (multiple)
.01	DISPOSABLES NAME
1	LOT NUMBER
2	QUANTITY
5	CELL SAVER COMMENTS
131	DEVICE(S)
1000	TIU OPERATIVE SUMMARY
1001	TIU NURSE INTRAOP REPORT
1002	TIU PROCEDURE REPORT (NON-OR)
1003	TIU ANESTHESIA REPORT
1004	DICTATED SUMMARY EXPECTED

The following existing input templates are updated:

SRNON-OR
SROMEN-OPER

The following new input templates are added:

SROARPT
SRONRPT

SURGERY SITE PARAMETERS File (#133)

The following existing field is updated as indicated:

Field Number and Name	Update Made
6 CANCEL IVS	Field description updated

The following new fields are added to SURGERY SITE PARAMETERS file (#133):

Field Number and Name	
40	ANESTHESIA REPORT IN USE
42	DEFAULT CLINIC FOR DOCUMENTS

The following existing input template is updated:

SRPARAM

Environment Check Routine

The environment-check routine SR100ENV does not perform any actual environment check activities. This routine contains code that is executed during the installation question process. (The environment-check routine is the only routine in the build that will be loaded on the installing facility's system at the time the installation questions are asked.)

Pre-Installation Routine

The pre-installation process calls PRE^SR100UTL to delete the "ADIC," "AUD," and "AUD1" cross references and the associated cross reference nodes in global ^SRF.

Post-Installation Routine

The post-installation process calls POST^SR100UTL to perform the following tasks:

- Deletes the SURGERY TRANSCRIPTION FILE (#136).
- Sets default values for new site parameters.
- Activates the Surgery tab system wide.
- Converts cases with documents in TIU filed by the Boston Prototype (Class III) software.
- Creates stub entries in TIU for reports for cases completed on or after the date selected as the starting date for reports to be signed electronically.
- Moves reports for historical cases into TIU, if selected.
- Sends mail message notification when post-installation process is completed.

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Understanding the Installation Process

During installation, three installation steps must be completed.

1. Setting Site Parameters
2. Identifying Existing Cases To Be Signed With The New Electronic Signature Features
3. Making Reports For Pre-Existing Surgery Cases Viewable Through CPRS

These three steps are explained in detail in the following sections.

1. Setting Site Parameters

Two new site parameters related to the new features for electronically signing the Operation Report, Nurse Intraoperative Report, and Anesthesia Report have been added to the Surgery package. One new parameter, ANESTHESIA IN USE, will be distributed with pre-defined settings. This setting can be changed using the *Surgery Site Parameters (Enter/Edit)* option contained within the *Surgery Package Management Menu* option.

The other new site parameter, DEFAULT CLINIC FOR DOCUMENTS, may be entered immediately following patch installation. For more information, see the section “Default Clinic For Documents.”

This section defines each parameter, identifies the default settings, and provides an example of the option that may be used to update the information.



The LOCK AFTER HOW MANY DAYS parameter should be reviewed to consider the number of days that is set for cases to be locked after completion. If the “lock” number is set for fewer days than what is specified to “go back” in this option, then the cases may need to be “unlocked” before they can be edited or signed. To avoid having to unlock cases, check the site parameter LOCK AFTER HOW MANY DAYS to determine the number of days set for locking a case. Then, compare this number to the total of days that will pass after specifying the starting date.

Use Anesthesia Report

Many Veterans Affairs Medical Centers (VAMCs) do not use the Anesthesia Report provided with the Surgery package. A new parameter, ANESTHESIA REPORT IN USE, has been created so that the automatic creation of stub Anesthesia Reports in the TIU files can be eliminated when an operation is completed. If a facility does not use the report, there is no need to create the stub for eventual signature.



The new ANESTHESIA REPORT IN USE parameter defaults to **NO** when the Surgery patch, SR*3*100, is installed. This parameter can be changed to **YES** during installation or at any time afterward using the *Surgery Site Parameters (Enter/Edit)* option contained within the *Surgery Package Management Menu* option.

Example of Site Parameter Question Asked During Installation

(The answer to the question below will vary based on the facility's responses to the Pre-Installation Worksheet.)

```
>>> New Site Parameter <<<
Answer the following question to define the default site parameter
related to the use of the Anesthesia Report at your facility. This
response will be stored for each division defined in the SURGERY SITE
PARAMETERS file (#133) and may be updated after this patch is
installed.
```

```
Does this facility use the Anesthesia Report? NO// NO
```

The previous example shows one facility's selections; the options selected will vary by facility. This facility does not use the Anesthesia Report, so the selection is set to NO.

Default Clinic for Documents

One of the new site parameters included with this patch is the DEFAULT CLINIC FOR DOCUMENTS parameter. This non-count clinic will be the location passed to TIU, and is used to establish an encounter when Surgery documents are created if no other location can be identified. The user can enter this parameter immediately following patch installation using the *Surgery Site Parameters (Enter/Edit)* option. Before entering this parameter, it may be necessary to create an active, non-count clinic in the HOSPITAL LOCATION file (#44), if a suitable one does not already exist.

The default clinic will ensure that each surgery document will be linked to a clinic in the same division where the surgery occurred. It is recommended that multidivisional facilities define a clinic for each Surgery Site defined in the SURGERY SITE PARAMETERS file (#133) to ensure document linkage to the proper division.

Example of a non-count clinic in the Hospital Location file:

```
NAME: SURGERY OP REPORT NON-COUNT      ABBREVIATION: SNC
TYPE: CLINIC                           INSTITUTION: ALBANY
STOP CODE NUMBER: NON-COUNT            SERVICE: SURGERY
DIVISION: ALBANY                       NON-COUNT CLINIC? (Y OR N): YES
TREATING SPECIALTY: GENERAL SURGERY    TYPE EXTENSION: CLINIC
ASK FOR CHECK IN/OUT TIME: NO          WORKLOAD VALIDATION AT CHK OUT: NO
REQUIRE ACTION PROFILES?: NO          ALLOWABLE CONSECUTIVE NO-SHOWS: 0
MAX # DAYS FOR FUTURE BOOKING: 11      PROHIBIT ACCESS TO CLINIC?: YES
LENGTH OF APP'T: 15                    OVERBOOKS/DAY MAXIMUM: 1
```

2. Identifying Existing Cases To Be Signed With The New Electronic Signature Features

Recent surgery cases may not already have a signed Operation Report on file. This part of the installation process allows you to identify those Surgery cases whose reports will be electronically signed using the new electronic signature features. A stub entry will be created in TIU for the Nurse Intraoperative Report, Operation Report, and Anesthesia Report for each of these cases. When installation is complete, alerts are then sent to the authors when each report is ready for signature.

The software prompts for a starting date. All Surgery cases with a date of operation on or after that date will require an electronic signature for these reports even if the surgeon's dictation has already been uploaded to the SURGEON'S DICTATION field. This will include documents that may have already been signed on paper. The software will create a stub entry in TIU and require the documents to be electronically signed for EVERY case on or after the date you enter.

If a facility uploads dictation for a case performed before the designated start date and the case was completed before the patch was installed, the case will have no stub to upload to. The TIME PAT OUT OR will need to be deleted and re-entered to create a stub.

If the case was not completed before the patch was installed, when the TIME PAT OUT OR is entered, a stub for the Operation Report will be created and will be ready to accept the upload.

If the surgeon's dictation on cases performed on or after the selected start date is already uploaded, the uploaded dictation will NOT automatically be moved into the stub document created for the Operation Report. Those Operation Reports will have to be uploaded again into the stub document.



BEFORE SETTING THE STARTING DATE: Consider the number of days that is set for cases to be locked after completion. If the "lock" number is set for fewer days than what is specified to "go back" in this option, then the cases may need to be "unlocked" before they can be edited. To avoid having to unlock cases, check the site parameter LOCK AFTER HOW MANY DAYS to determine the number of days set for locking a case. Then, compare this number to the total of days that will pass after specifying the starting date.

Example: Creating Operation Report Stub for Recent Surgical Cases

```
>>> Starting Date for Reports to be Signed Electronically <<<
During the post-installation process, all reports for completed cases
with an operation date on or after the date selected will be identified
to be signed electronically and stub entries will be created in TIU.

Enter starting date for reports to be signed electronically: TODAY// 1/1/03 (JA
N 01, 2003)
```

3. Making Reports for Pre-Existing Surgery Cases Viewable through CPRS

The Surgery Electronic Signature for Operative Reports patch provides the ability to merge Operation Reports, Nurse Intraoperative Reports, Anesthesia Reports, and Procedure Reports (Non-O.R.) for pre-existing surgical cases into the TIU files and make them viewable through the CPRS software. During the installation process, the installer is asked to identify which reports should be merged and how far back to gather this data. These reports are displayed along with a disclaimer that states, *“This information is provided from historical files and it cannot be verified that the author has authenticated/approved this information. The authenticated source document in the patient's medical record should be reviewed to ensure that all information concerning this event has been reviewed or noted.”*

The *Make Reports Viewable in CPRS* option contained on the *Surgery Package Management Menu* option has also been provided so that, after installation, additional reports can be moved into the new structure.

The Pre-Installation Worksheet at the end of this guide contains a section for listing which reports should be merged for specific date ranges. During installation, only one starting date may be selected for the cases to be considered. Then, one or more reports can be selected to be included. If different date ranges are needed for each report, the stand-alone *Make Reports Viewable in CPRS* option contained on the *Surgery Package Management Menu* option can be used after installation to make additional reports viewable in CPRS.

For multi-divisional facilities, if different parameter settings should be applied for each division, the installer should answer **NO** to the question: “Do you want to move reports during the patch installation?” After patch installation, the new *Make Reports Viewable in CPRS* option may be used to move reports by division.



As part of the Surgery Electronic Signature for Operative Reports patch, Operation Reports created using the class III Boston Prototype software will be transparently converted into the new system. The conversion is done automatically during the post-installation process.

Example of Questions Asked Regarding Making Reports Viewable through CPRS During Installation
(The answers to the questions below will vary based on the facility's responses to the Pre-Installation Worksheet.)

```
>>> Making Reports for Historical Cases Viewable through CPRS <<<
This patch includes a post-installation process that will move designated
reports for historical Surgery cases into TIU. By doing so, these
reports, while unsigned electronically, will be viewable within the CPRS
Surgery tab. These "electronically unsigned" reports will contain a
disclaimer stating; "This information is provided from Historical files
and can not be verified that the author has authenticated/approved this
information. The authenticated source document in the patient's medical
record should be reviewed to ensure that all information concerning this
event has been reviewed or noted."

NOTE: The site parameters entered above will be applied in this process.
For multi-divisional facilities, if different parameter settings should
be applied for each division, or if for any reason the process to make
reports for historical surgery cases viewable in CPRS should not be run
during this patch installation, answer NO to this question. A new option
is provided to run this process later.

Do you want to move reports during the patch installation? NO// YES

Enter the starting date for reports to be moved: JAN 1,2003// 1/1/01 (JAN 01, 2
001)

Do you want to move the Operation Reports? NO// YES

Do you want to move the Nurse Intraoperative Reports? NO// YES
Do you want to move the Anesthesia Reports? NO// NO
Do you want to move the Procedure Reports (Non-O.R.)? NO// YES

During the post-installation process, the following reports will be moved
beginning JAN 1,2001 to the present:
  Operation Report
  Nurse Intraoperative Report
  Anesthesia Report
  Procedure Report (Non-O.R.)

Is this correct? NO// YES

If you need to move additional reports for a different date range, the
Make Reports Viewable in CPRS option contained on the Surgery Package
Management Menu can be used after this patch is installed.

The post-installation process will be tasked to run immediately at the end
of patch installation. The following actions will occur in the following
order:
(1) Conversion of cases with documents in TIU filed by the Boston
    Prototype (Class III) software
(2) Creation of stub entries in TIU for reports for cases completed on or
    after the date selected above as the starting date for reports to be
    signed electronically
(3) Movement of reports for historical cases into TIU
```

Installation of Patch

DO NOT continue with the installation of this patch until the Pre-Installation Worksheet, which provides the dates and the list of reports to be moved, has been completed. The Pre-Installation Worksheet is located at the end of this *Installation Guide*.



Before installing this patch, use the TaskMan *List Tasks* option to list currently running tasks. This patch should be installed during a period of low system activity with Surgery users off the system. Installation times may vary depending on the number of cases converted during the post installation process. At test sites, the conversion process took several hours. The test sites used a date range of 2-3 years.

To install SR*3*100:

1. The global ^SRT is deleted during installation. Global protection on ^SRT should be set to allow purging prior to installation.
2. Using the *EP Edit Parameters* action within the *Scheduling Parameters* option, remove the mail group contained at the “Late Activity Mail Group:” prompt. Removing the mail group temporarily suppresses generation of the late activity messages during conversion. This mail group must be reestablished after completion of the post installation process. (You may need to make a note of the mail group for step 14.)
3. Download the KIDS file, SR_3_P100.KID, from one of the OI Field Office anonymous directories.
4. Review your mapped set. If any of the routines in this patch are mapped, they should be removed from the mapped set before continuing.
5. From the *Kernel Installation & Distribution System* menu, select the *Installation* menu.
6. Use the *Load a Distribution* option to load the distribution from the distribution file downloaded in step 1.

7. From the *Installation* menu, you may select to use the following options (when prompted for "INSTALL NAME", enter SR*3.0*100):
 - a. *Backup a Transport Global* option - This option creates a backup message of any routines exported with the patch. It will **NOT** backup any other changes, such as Data Dictionaries (DDs) or templates.
 - b. *Compare Transport Global to Current System* option - This option allows you to view all changes that will be made when the patch is installed. It compares all components of the patch (for example, routines, DDs, templates, and more).
 - c. *Verify Checksums in Transport Global* option - This option ensures the integrity of the routines that are in the transport global.
 - d. *Print Transport Global* option - This option allows you to view the components of the KIDS build.
8. Use the *Install Package(s)* option and select the package SR*3.0*100.
9. When prompted "Want KIDS to Rebuild Menu Trees Upon Completion of Install? YES//", respond **YES**.
10. Answer the install questions with the predetermined responses indicated on the completed Pre-Installation Worksheet.
11. When prompted "Want KIDS to INHIBIT LOGONs during the install? YES//", respond **NO**.
12. When prompted "Want to DISABLE Scheduled Options, Menu Options, and Protocols? YES//" respond **NO**.
13. If any routines were unmapped as part of step 3, they should be returned to the mapped set once the installation has run to completion.



Be certain that the installer has received the post installation MailMan message before completing step 14.

14. After the post installation has been completed, use the *EP Edit Parameters* action of the *Scheduling Parameters* option to reestablish the mail group at the "Late Activity Mail Group:" prompt.
15. Use the *Surgery Site Parameters (Enter/Edit)* option to enter an active, non-count clinic in the DEFAULT CLINIC FOR DOCUMENTS field for each Surgery Site defined in the SURGERY SITE PARAMETERS file (#133).

Installation Example

```
Select Installation Option: Load a Distribution
Enter a Host File: SR_3_P100.KID

KIDS Distribution saved on Feb 06, 2003@09:55:51
Comment: Surgery Patch SR*3*100

This Distribution contains Transport Globals for the following Package(s):
  SR*3.0*100
Distribution OK!

Want to Continue with Load? YES// <Enter>
Loading Distribution...

Build SR*3.0*100 has an Environmental Check Routine
Want to RUN the Environment Check Routine? YES// <Enter>
  SR*3.0*100
Will first run the Environment Check Routine, SR100ENV

Use INSTALL NAME: SR*3.0*100 to install this Distribution.

1      Load a Distribution
2      Verify Checksums in Transport Global
3      Print Transport Global
4      Compare Transport Global to Current System
5      Backup a Transport Global
6      Install Package(s)
       Restart Install of Package(s)
       Unload a Distribution

Select Installation Option: Install Package(s)
Select INSTALL NAME: SR*3.0*100      Loaded from Distribution 2/6/03@11:34:05
=> Surgery patch SR*3*100 ;Created on Feb 06, 2003@09:55:51

This Distribution was loaded on Feb 06, 2003@11:34:05 with header of
  Surgery patch SR*3*100 ;Created on Feb 06, 2003@09:55:51
It consisted of the following Install(s):
  SR*3.0*100
Checking Install for Package SR*3.0*100
Will first run the Environment Check Routine, SR100ENV

Install Questions for SR*3.0*100

Incoming Files:

130      SURGERY (Partial Definition)
Note: You already have the 'SURGERY' File.

133      SURGERY SITE PARAMETERS (Partial Definition)
Note: You already have the 'SURGERY SITE PARAMETERS' File.

Want KIDS to Rebuild Menu Trees Upon Completion of Install? YES// YES

Do you have the completed pre-installation worksheet? NO// YES

>>> New Site Parameter <<<
Answer the following question to define the default site parameter
related to the use of the Anesthesia Report at your facility. This
response will be stored for each division defined in the SURGERY SITE
PARAMETERS file (#133) and may be updated after this patch is
installed.
```

Does this facility use the Anesthesia Report? NO// **YES**

>>> Starting Date for Reports to be Signed Electronically <<<
During the post-installation process, all reports for completed cases with an operation date on or after the date selected will be identified to be signed electronically and stub entries will be created in TIU.

Enter starting date for reports to be signed electronically: TODAY// **1/1/03** (JAN 01, 2003)

>>> Making Reports for Historical Cases Viewable through CPRS <<<
This patch includes a post-installation process that will move designated reports for historical Surgery cases into TIU. By doing so, these reports, while unsigned electronically, will be viewable within the CPRS Surgery tab. These "electronically unsigned" reports will contain a disclaimer stating; "This information is provided from Historical files and can not be verified that the author has authenticated/approved this information. The authenticated source document in the patient's medical record should be reviewed to ensure that all information concerning this event has been reviewed or noted."

NOTE: The site parameters entered above will be applied in this process. For multi-divisional facilities, if different parameter settings should be applied for each division, or if for any reason the process to make reports for historical surgery cases viewable in CPRS should not be run during this patch installation, answer NO to this question. A new option is provided to run this process later.

Do you want to move reports during the patch installation? NO// **YES**

Enter the starting date for reports to be moved: JAN 1,2001// **1/1/01** (JAN 01, 2001)

Do you want to move the Operation Reports? NO// **YES**

Do you want to move the Nurse Intraoperative Reports? NO// **YES**

Do you want to move the Anesthesia Reports? NO// **YES**

Do you want to move the Procedure Reports (Non-O.R.)? NO// **YES**

During the post-installation process, the following reports will be moved beginning JAN 1,2001 to the present:

- Operation Report
- Nurse Intraoperative Report
- Anesthesia Report
- Procedure Report (Non-O.R.)

Is this correct? NO// **YES**

If you need to move additional reports for a different date range, the Make Reports Viewable in CPRS option contained on the Surgery Package Management Menu can be used after this patch is installed.

The post-installation process will be tasked to run immediately at the end of patch installation. The following actions will occur in the following order:

- (1) Conversion of cases with documents in TIU filed by the Boston Prototype (Class III) software
- (2) Creation of stub entries in TIU for reports for cases completed on or after the date selected above as the starting date for reports to be signed electronically
- (3) Movement of reports for historical cases into TIU

Press ENTER to continue <Enter>

Want KIDS to INHIBIT LOGONs during the install? YES// **NO**

Want to DISABLE Scheduled Options, Menu Options, and Protocols? YES// **NO**

Enter the Device you want to print the Install messages.

You can queue the install by enter a 'Q' at the device prompt.
Enter a '^' to abort the install.

DEVICE: HOME// ;P-DEC TELNET

Install Started for SR*3.0*100 :
Feb 06, 2003@11:37

Build Distribution Date: Feb 06, 2003

Installing Routines:.....
Feb 06, 2003@11:37:01

Installing Data Dictionaries:
Feb 06, 2003@11:37:03

Installing PACKAGE COMPONENTS:

Installing INPUT TEMPLATE.....

Installing OPTION.....
Feb 06, 2003@11:37:05

Running Post-Install Routine: POST^SR100UTL.
SR*3*100 post-install process queued...

Updating Routine file.....

Updating KIDS files.....

SR*3.0*100 Installed.
Feb 06, 2003@11:37:06

Install Message sent #693

Call MENU rebuild

Starting Menu Rebuild: Feb 06, 2003@11:37:07

Collecting primary menus in the New Person file...

.
. .
.

Install Completed

(This page included for two-sided copying.)

Post-Installation

MailMan Message

When the post-installation process is finished, a MailMan message is sent to the installer. Following is an example of the MailMan message the installer should expect to receive.

Example: Post-Installation Message

```
Subj: SR*3*100 Post-Install Is Completed [#696] 06 Feb 03 12:35 1 line
From: POSTMASTER In 'IN' basket. Page 1 *New*
```

```
-----
The post-install process for patch SR*3*100 is completed.
```

Activating the Surgery Tab

The Surgery tab will be activated at the System Level when SR*3*100 is installed. The *General Parameter Tools* option can be used to control the display of the Surgery tab following installation.

Example: Utilizing the General Parameter Tools option

```
Select OPTION NAME: XPAR MENU TOOLS          General Parameter Tools      menu

LV      List Values for a Selected Parameter
LE      List Values for a Selected Entity
LP      List Values for a Selected Package
LT      List Values for a Selected Template
EP      Edit Parameter Values
ET      Edit Parameter Values with Template

Select General Parameter Tools Option: EP  Edit Parameter Values
--- Edit Parameter Values ---

Select PARAMETER DEFINITION NAME: ORWOR SHOW SURGERY TAB      Show Surgery Tab in
GUI

ORWOR SHOW SURGERY TAB may be set for the following:

1  User          USR      [choose from NEW PERSON]
2  Service       SRV      [choose from SERVICE/SECTION]
3  Division      DIV      [REGION 5]
5  System        SYS      [ROX-REV.ISC-SLC.VA.GOV]
7  Package       PKG      [ORDER ENTRY/RESULTS REPORTING]

Enter selection: 5  System      ROX-REV.ISC-SLC.VA.GOV

----- Setting ORWOR SHOW SURGERY TAB for System: ROX-REV.ISC-SLC.VA.GOV -----
SHOW SURGERY TAB: YES

ORWOR SHOW SURGERY TAB may be set for the following:

1  User          USR      [choose from NEW PERSON]
2  Service       SRV      [choose from SERVICE/SECTION]
3  Division      DIV      [REGION 5]
5  System        SYS      [ROX-REV.ISC-SLC.VA.GOV]
7  Package       PKG      [ORDER ENTRY/RESULTS REPORTING]

Enter selection:
```

Configuring Business Rules

No Authorization/Subscription Utility (ASU) Business Rules are exported for the titles in this patch. The titles exported with this patch will inherit from Clinical Documents the rules that the facility has already established.

The Business Rules recommended below are a guideline. Each facility should review the rules to see if they meet the requirements of local business practices.

It is recommended that the following Business Rules be followed for the Surgery titles exported with this patch.

```
1 A COMPLETED (CLASS) SURGICAL REPORT may BE VIEWED by a USER
2 An UNSIGNED (CLASS) SURGICAL REPORT may BE EDITED by an AUTHOR/DICTATOR
3 An UNSIGNED (CLASS) SURGICAL REPORT may BE DELETED by an AUTHOR/DICTATOR
4 An UNSIGNED (CLASS) SURGICAL REPORT may BE VIEWED by an AUTHOR/DICTATOR
5 An UNCOSIGNED (CLASS) SURGICAL REPORT may BE VIEWED by an AUTHOR/DICTATOR
6 An UNCOSIGNED (CLASS) SURGICAL REPORT may BE VIEWED by an EXPECTED OSIGNER
7 An UNSIGNED (CLASS) SURGICAL REPORT may BE PRINTED by an AUTHOR/DICTATOR
8 An UNCOSIGNED (CLASS) SURGICAL REPORT may BE PRINTED by an AUTHOR/DICTATOR
9 An UNCOSIGNED (CLASS) SURGICAL REPORT may BE PRINTED by an EXPECTED COSIGNER
10 An UNSIGNED (CLASS) SURGICAL REPORT may BE SIGNED by an AUTHOR/DICTATOR
11 An UNCOSIGNED (CLASS) SURGICAL REPORT may BE COSIGNED by an EXPECTED COSIGNER
12 An UNSIGNED (CLASS) SURGICAL REPORT may BE VIEWED by a CHIEF, MIS
13 An UNSIGNED (CLASS) SURGICAL REPORT may BE DELETED by a CHIEF, MIS
14 An UNCOSIGNED (CLASS) SURGICAL REPORT may BE VIEWED by a CHIEF, MIS
15 An UNCOSIGNED (CLASS) SURGICAL REPORT may BE DELETED by a CHIEF, MIS
16 An UNSIGNED (CLASS) SURGICAL REPORT may BE EDITED by an EXPECTED COSIGNER
17 An UNSIGNED (CLASS) SURGICAL REPORT may BE VIEWED by an EXPECTED COSIGNER
18 An UNSIGNED (CLASS) SURGICAL REPORT may BE EDITED by a CLINICAL SERVICE CHIEF
19 An UNSIGNED (CLASS) SURGICAL REPORT may BE VIEWED by a CLINICAL SERVICE CHIEF
20 An UNSIGNED (CLASS) SURGICAL REPORT may BE SIGNED by a CLINICAL SERVICE CHIEF
21 An UNSIGNED (CLASS) SURGICAL REPORT may BE SIGNED by an EXPECTED COSIGNER
22 An UNCOSIGNED (CLASS) SURGICAL REPORT may BE VIEWED by a USER
23 An UNCOSIGNED (CLASS) SURGICAL REPORT may BE COSIGNED by an ATTENDING PHYSICIAN
24 A COMPLETED (CLASS) SURGICAL REPORT may BE DELETED by a CHIEF, MIS
25 An UNTRANSCRIBED (CLASS) SURGICAL REPORT may BE VIEWED by an AUTHOR/DICTATOR
```

While each facility is responsible for determining which business rules to include, some facilities may want to allow clinicians to directly enter reports. The following business rules allow clinicians to do direct entry of the reports.



```
An UNDICTATED (CLASS) SURGICAL REPORT may BE EDITED by a CHIEF, MIS
An UNDICTATED (CLASS) SURGICAL REPORT may BE EDITED by an AUTHOR/DICTATOR
An UNDICTATED (CLASS) SURGICAL REPORT may BE EDITED by an ATTENDING
PHYSICIAN OR an EXPECTED COSIGNER
```

Reviewing Document Definitions

TIU stores the electronically signed reports and manages the documents. CPRS allows the electronic surgery reports to be viewed via the Reports tab, a new Surgery tab, and/or Progress Note tab, depending on site-specific setup of document title(s) in the TIU hierarchy.

A standard Surgery document hierarchy in TIU is available with this project release, and is also documented in the *Surgery Electronic Signature for Operative Reports Implementation Guide*.

Clinical Documents

Surgical Reports	Class
Operation Report	Document Class
Operation Report	Title
Nurse Intraoperative Report	Document Class
Nurse Intraoperative Report	Title
Anesthesia Report	Document Class
Anesthesia Report	Title
Procedure Report (NON-O.R.)	Document Class
Procedure Report	Title

(This page included for two-sided copying.)

Appendix A: Surgery Electronic Signature for Operative Reports— Pre-Installation Worksheet

This worksheet contains three sections, “Setting Site Parameters,” “Identifying Existing Reports To Be Signed with the New Electronic Signature Features” and “Making Reports for Pre-Existing Cases Viewable through CPRS.”

The following worksheets should be completed in their entirety before installing the Surgery patch SR*3*100.

I. Setting Site Parameters

A new site parameter related to the new features for electronically signing the Operation Report, Nurse Intraoperative Report, and Anesthesia Report has been added to the Surgery package. This site parameter is set during installation and can be changed after installation using the *Surgery Site Parameters (Enter/Edit)* option contained within the *Surgery Package Management Menu* option. The *Surgery Technical Manual/Security Guide*, found at the VISTA Documentation Library (VDL) at <http://www.va.gov/vdl>, defines the parameter, identifies the default setting, and provides an example of the option used to update the information.

**This worksheet should be completed in its entirety
before installing the Surgery patch SR*3*100**

Use Anesthesia Report? (Default = No)

NO: This facility does not use the Anesthesia Report.

YES: This facility does use the Anesthesia Report.

Enter the setting you want to use for this parameter: _____

II. Identifying Existing Cases To Be Signed With The New Electronic Signature Features

After reading this section carefully, enter the start date for cases to be signed using the new electronic signature feature.

Recent surgery cases may not yet have a signed Operation Report on file. This part of the installation process allows you to identify Surgery cases whose reports will be electronically signed using the new electronic signature features. A stub entry is then created in TIU for the Nurse Intraoperative Report, Operation Report, Procedure Report (Non-O.R.), and the Anesthesia Report for each of these cases. Upon completion of installation, alerts are sent to authors when each report is ready for signature.

The software prompts for a starting date. All Surgery cases with a date of operation on or after that date will require an electronic signature for these reports even if the surgeon's dictation has already been uploaded to the SURGEON'S DICTATION field. This will include documents that may have already been signed on paper. The software will create a stub entry in TIU and require the documents to be electronically signed for EVERY case on or after the date you enter.

If the surgeon's dictation on cases performed on or after the selected start date is already uploaded, the uploaded dictation will NOT automatically be moved into the stub document created for the Operation Report. Those Operation Reports will have to be uploaded again into the stub document.

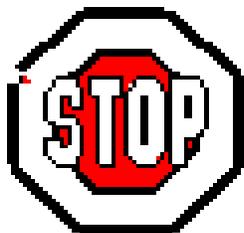
BEFORE SETTING THE STARTING DATE: Consider the number of days that is set for cases to be locked after completion. If the "lock" number is set for fewer days than what is specified to "go back" in this option, then the cases may need to be "unlocked" before they can be edited. To avoid having to unlock cases, check the site parameter LOCK AFTER HOW MANY DAYS to determine the number of days set for locking a case. Then, compare this number to the total of days that will pass after specifying the starting date.

Enter the Starting Date for Surgical cases that will have reports signed using the new electronic signature features. _____

III. Making Reports for Pre-Existing Surgery Cases Viewable through CPRS

During installation, you will be given the opportunity to move reports that have not been electronically signed into the TIU files so that they can be viewed from the Surgery tab within CPRS. These reports will be displayed along with a disclaimer that states, “*This information is provided from historical files and it cannot be verified that the author has authenticated/approved this information. The authenticated source document in the patient's medical record should be reviewed to ensure that all information concerning this event has been reviewed or noted.*”

The software will ask you to identify a starting date for moving reports and prompt you to select the reports within that range that you wish to make viewable through CPRS. All cases on or after that date will be evaluated and moved. You should only move those reports that you believe are *complete* and *accurate* within the Surgery software. For example, you would not include the Anesthesia Report and Procedure Report (Non-O.R.) if those reports were not typically used at your facility.



The software flags all reports as “viewable in CPRS but not electronically signed” using a date range. It starts with the starting date you select during installation. The end date is the date prior to the date you entered when identifying cases to be signed using the new features in section II. If no date was entered in section II, then that means that you do not want to have any existing cases signed using the new features. In this case, all cases with a date of operation on or after the start date entered will be made viewable within CPRS as historical records, not electronically signed cases.

Following installation, the *Make Reports Viewable in CPRS* option within the *Surgery Package Management Menu* option can also be used to move reports for an additional date range. For example, this option could be used if your facility is multi-divisional, and the date range for making reports viewable is different for each division. This option could also be used if the date range for each of the reports is different.



Use caution when determining the starting date. You should only go back to a starting date where you are reasonably confident the report information is accurate.

Please review the following example. Then, fill in the appropriate information in the following table. The Information Resources Management (IRM) staff will use this information when installing the software.

Example: Completing the Installation Worksheet

This is an example of how a fictitious medical center determined the reports to be made viewable. How you complete the form will depend on your facility's use of the Surgery software.

The facility that filled out the chart below has been using the Surgery software since March of 1990. They do not think the Operation Report or Nurse Intraoperative Report are accurate for all cases prior to January 1, 1986. Additionally, they do not currently use the Anesthesia Report. They did not begin using the Procedure (Non-OR) module of the Surgery package until October 1, 1993. Because the Procedure (Non-OR) Reports require a different date range than the other reports, the Procedure (Non-OR) Reports for cases after October 1, 1993 will need to be moved in a separate step following installation of the patch. The facility will install the Surgery Electronic Signature for Operative Reports patch on November 1, 2003 (today's date).

During installation of the Surgery Electronic Signature for Operative Reports patch, they will enter the date that they want to begin creating stub entries to be signed using the new electronic signature features. In this example, it is November 1, 2003.

During installation of the Surgery Electronic Signature for Operative Reports patch, they will move the Operation Reports and Nurse Intraoperative Reports for all surgical cases beginning January 1, 1986 up until they want to begin electronically signing the report. (In this case, it is November 1, 2003.) They selected January 1, 1986 because they are confident that the reports for cases starting on this date are complete and accurate.

After installation of the Surgery Electronic Signature for Operative Reports patch is complete, they will use the *Make Reports Viewable in CPRS* option in the *Surgery Package Management Menu* option to move the Procedure (Non-OR) Reports for Non-OR cases from October 1, 1993 to the present (November 1, 2003).

Example of completed form:

Report Name	Update During Installation <i>Note: All updates during installation must have the same date range</i>	Update After Installation using the <i>Make Reports Viewable in CPRS</i> option	Don't Update	Start Date
Operation Report	X			03/01/90
Nurse Intraoperative Report	X			03/01/90
Anesthesia Report			X	
Procedure (Non-O.R.) Report		X		10/01/93



After reviewing the previous examples, please fill in the following form before installing patch SR*3*100.

Report Name	Update During Installation <i>Note: All updates during installation must have the same date range</i>	Update After Installation using the <i>Make Reports Viewable in CPRS</i> option	Don't Update	Start Date
Operation Report				
Nurse Intraoperative Report				
Anesthesia Report				
Procedure (Non-O.R.) Report				

Pre-Installation Worksheet — Tasks Completed

You have completed the Pre-Installation Worksheet, and can now provide the information to the person responsible for installing the Surgery patch SR*3*100.

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