



SURGERY ELECTRONIC SIGNATURE FOR OPERATIVE REPORTS

RELEASE NOTES

SR*3*100

Version 3.0
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Introduction

The Surgery Electronic Signature for Operative Reports project supports the development of a system-wide electronic medical record. The project enhancements 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 Report (Non-O.R.), and Anesthesia Report. This project introduces the ability to electronically sign the reports and store them within Text Integration Utilities (TIU), and ultimately view them in CPRS. TIU stores the electronically signed reports and manages the documents. CPRS allows the electronic surgery reports to be viewed via a new Surgery tab.

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Operation Report

The Operation Report can be electronically signed and the original text of the signed summary cannot be altered after signature. Addenda can be made to the summary, but the body of the summary always reflects the original electronically signed copy.

- The Operation Report is electronically signed using CPRS actions. When the transcription department has uploaded the summary, the surgeon (author) receives an alert that the summary is ready for signature. The Surgeon can also enter the Operation Report directly using the Edit Report features on the Surgery tab.
- After the Operation Report has been electronically signed, it is viewable to users on the Surgery tab in CPRS.
- If changes are required to the Operation Report after it is electronically signed, an addendum must be made. The electronically signed addenda are associated with the Operation Report and are always displayed with it.
- The Operation Reports for surgery cases created prior to installation of this enhancement can be made accessible in CPRS. The information displayed will consist of the unsigned dictated Operation Report stored in the Surgery database. For these historical cases, a disclaimer is provided prior to the dictated Operation Report, alerting the reader that this is not an electronically signed report.
- Operation Reports created with the class III Boston prototype software will be converted during installation of this enhancement and will be viewable with other Surgery reports on the new Surgery tab in CPRS.

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Nurse Intraoperative Report

The *Nurse Intraoperative Report* option has been revised to provide the capability to view and print the report, edit information contained in the report, and electronically sign the report.

- When selecting the *Nurse Intraoperative Report* option, the report will begin to display on the screen. At the bottom of each page, the user will be able to access the *Nurse Intraoperative Report* functions to print, edit, or sign the report.
- The new “Edit report information” feature provides a single point for editing all information contained on the Nurse Intraoperative Report.
- The report has been rearranged to list key fields at the top of the report. The date/time fields will be displayed first, followed by the major operations performed, the wound classification, and then the operation disposition.
- A field that has no data will display “* NOT ENTERED *” next to that field.
- All fields required for electronic signature will be displayed on the Nurse Intraoperative Report.
- When the TIME PATIENT OUT OR field is entered, the circulating nurse receives an alert that the report is ready for signature.
- Checks for data in key fields will be performed at the time of electronic signature. The nurse cannot sign the report if any key field is missing. Key fields are listed below.
 - TIME PATIENT IN OR
 - TIME PATIENT OUT OR
 - TIME OUT VERIFIED
 - MARKED ON SITE
 - PREOPERATIVE IMAGING CONFIRMED
- If the COUNT VERIFIER field has been entered, the following fields are also required.
 - SPONGE COUNT CORRECT (Y/N)
 - SHARPS COUNT CORRECT (Y/N)
 - INSTRUMENT COUNT CORRECT (Y/N)
 - SPONGE, SHARPS, & INST COUNTER
- After it has been electronically signed, the Nurse Intraoperative Report is viewable on the Surgery tab in CPRS. Once signed, all edits to fields on the report using the nationally released Surgery data entry options will require electronically signed addendum.

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Anesthesia Report

The current *Anesthesia Report* option contained in the Surgery package has been revised to provide the capability to view and print the report, edit information contained in the report, and electronically sign the report.

- The new “Edit report information” feature provides a single point for editing all information contained on the Anesthesia Report.
- When selecting the *Anesthesia Report* option, the report will begin to display on the screen. The *Anesthesia Report* functions to print, edit, or electronically sign can be accessed at the bottom of each page.
- The report will be rearranged to list key fields at the top of the report. The anesthesia staff fields will be displayed first, followed by the date/time fields, ASA CLASS field, OP DISPOSITION field, and then the ANESTHESIA TECHNIQUE field.
- When the ANES CARE END field is entered, the Principal Anesthetist receives an alert that the report is ready for signature.
- Checks for data in key fields will be performed at the time of electronic signature. The anesthetist will not be able to sign the report if any key field is missing. The required fields are listed below.
 - ANES CARE START TIME
 - ANES CARE END TIME
 - ANESTHESIA TECHNIQUE
 - PRINC ANESTHETIST
 - OP DISPOSITION
 - ASA CLASS
- The POSTOP ANES NOTE field has been changed from a date/time field to a word-processing field, so that the anesthetist/anesthesiologist can enter a note and electronically sign it as part of the rest of the report.
- Once electronically signed, the Anesthesia Report will be viewable on the Surgery tab in CPRS.
- Once signed, all edits to fields on the reports, using the nationally released Surgery data entry options, will require an electronically signed addendum.
- The Anesthesia Interface module provides the ability to receive Health Level 7 (HL7) based transmissions into *VISTA* Surgery files from a commercial Anesthesia Information System. If data received from incoming messages is already included on electronically signed reports, the automatic upload of data already included on electronically signed reports will be blocked. The incoming message information will be stored in an electronic alert and will be sent to the Principal Anesthetist and Anesthesiology Supervisor assigned to the case. This alert will inform them that the data needs to be manually entered and that an addendum will be made to the electronically signed report.

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Procedure Report (Non-O.R.)

The Procedure Report (Non-O.R.) is electronically signed and never altered after signature. Addenda can be made to the summary, but the body of the summary always reflects the original electronically signed copy.

- A new DICTATED SUMMARY EXPECTED field has been created to address whether or not a summary will be created for a specific Non-O.R. procedure. When the procedure end time is entered, the software determines whether or not a summary will be created for the case based on the value of the DICTATED SUMMARY EXPECTED field. Upon upload of the dictated summary, an alert is sent to the provider, informing the provider that the summary is ready for signature.
- If the DICTATED SUMMARY EXPECTED field is initially set to NO, but the user later decides a Procedure Report (Non-O.R.) is needed, then the following procedure should be completed. First, the user should edit the Non-O.R. procedure in the Surgery software, and set the DICTATED SUMMARY EXPECTED field to “Yes.” Then, the user should re-enter the TIME PROCEDURE ENDED field. This will create the Non-OR stub in TIU.
- The possible statements that may display after the Procedure Report (Non-O.R.) summary when printing the report are:

If the procedure summary has not been signed, the following statement displays: “A Procedure Report (Non-OR) is not available.”

If the DICTATED SUMMARY EXPECTED field is set to NO, do not include a summary, the following statement displays: “A Procedure Report (Non-OR) will not be created for this procedure.”

- The *Procedure Report (Non-O.R.)* option within the Surgery software will display the dictated summary only when dictation was done and the summary is electronically signed.
- The Surgeon can also enter the Procedure Report (Non-O.R.) directly using the Edit Report features on the Surgery tab.

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Other Enhancements

The following enhancements are also included in this release of the Surgery package.

- A new Surgery tab has been added to the CPRS display to allow easy identification and retrieval of surgery reports in the electronic record.
- The Nurse Intraoperative Report now contains two new fields, the LASER UNIT field and the CELL SAVER field.
- The *Surgery Package Management* menu contains a new *Make Reports Viewable in CPRS* option to make the Operation Reports, Nurse Intraoperative Reports, Procedure Report (Non-O.R.), and Anesthesia Reports for existing cases viewable in CPRS.
- The *Surgery Site Parameters (Enter/Edit)* options have been modified to allow changes to a new parameter. These parameters are DEFAULT CLINIC FOR DOCUMENTS and ANESTHESIA REPORT IN USE.
- The following Surgery options related to dictation have been removed.

Enter/Edit Date of Dictation option
List of Untranscribed Surgeon's Dictation option
Undictated Operations option
List of Undictated Operations option

- The following options related to transcription have been removed.

Transmit Transcribed Operation Notes option
Batch Print Transcribed Operation Notes option
List Operation Notes in the 'Print' Queue option
List of Unmerged Operation Notes option
Transcribe Surgeon's Dictation (FileMan) option
Enter/Edit Date of Dictation option

- If the Surgery Site Parameter CANCEL IVS is set to "CANCEL", upon entering the anesthesia care start time for a case, the time entered will be compared with the current time. If the difference is more than 24 hours, order cancellation will not be allowed. If the difference is more than 1 hour, but not more than 24 hours, the user will be warned that a considerable amount of time has passed since the start of the operation or procedure. Finally, if order cancellation is allowed, the user will be prompted to cancel current IV orders or not.

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Issues to be Addressed in Follow-Up Patches

At the time of release of SR*3*100 and TIU*1*112, some functional issues related to retracting and reassigning documents remained. There was also an intermittent problem with addenda not being attached to the parent operative report document. All of these issues will be addressed in follow-up patches to TIU and Surgery software. The patch numbers are TIU*1*187 and SR*3*128.

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