



# **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	iv-vi, 187-189, 195, 195a-195b, 196, 207-208, 219a-b, 527-528	SR*3*132	Updated the Table of Contents and Index to reflect added options. Added the new <i>Non-OR Procedure Information</i> option and the <i>Tissue Examination Report</i> option (unrelated to this patch) to the Non-OR Procedures section.
08/04	31, 43, 46, 66, 71-72, 75-76, 311	SR*3*127	Updated screen captures to display new text for ICD-9 and CPT codes.
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, 515, 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> .

Date	Revised Pages	Patch Number	Description
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> .

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# Introduction

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This section provides an overview of the Surgery package, and also provides documentation conventions used in this *Surgery V. 3.0 User Manual*. This section also discusses the use of the Screen Server in the Surgery package.

## Overview

The Surgery package is designed to be used by Surgeons, Surgical Residents, Anesthetists, Operating Room Nurses and other surgical staff. The Surgery package is part of the patient information system that stores data on the Department of Veterans Affairs (VA) patients who have, or are about to undergo, surgical procedures. This package integrates booking, clinical, and patient data to provide a variety of administrative and clinical reports.

The *Surgery V. 3.0 User Manual* is designed to acquaint the user with the various Surgery options and to offer specific guidance on the use of the Surgery package. Documentation concerning the Surgery package, including any subsequent change pages affecting this documentation, can be found at the Veterans Health Information Systems and Technology Architecture (VISTA) Documentation Library (VDL) on the Internet at <http://www.va.gov/vdl/>.

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# Documentation Conventions

This *Surgery V. 3.0 User Manual* 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: <b>25G</b>
Text centered between bent parentheses 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 <b>Y</b> for Yes or <b>N</b> 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.
 Indicates that options are locked with a particular security key. The user must hold the particular security key to be able to perform the menu option.	 Without the SROAMIS key the <i>Anesthesia AMIS</i> option cannot be accessed.

## 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 current option.

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# Using Screen Server

This section provides information about using the Screen Server utility with the Surgery software.

## Introduction

Screen Server is a screen-based data entry utility. It allows the user to display and select data elements for entering, editing, and deleting information. The format is designed to display a number of data fields at one time on a menu. With Screen Server, a number of data elements are displayed at one time on a menu and the user is able to choose on which element to work.

This section contains a description of the Screen Server format and gives examples of how to respond to the unique Screen Server prompts. The screen facsimiles used in the examples are taken from the Surgery software; however, these screens may not display on the terminal monitor exactly as they display in this manual, because the Surgery package is subject to enhancements and local modifications. In this document, the different ways to respond to the Screen Server prompt, to perform a task, and to utilize shortcuts are explained. The shortcuts are listed below:

- Enter data
- Edit data
- Move between pages
- Enter/edit a range of data elements
- Multiples
- Multiple screen shortcuts
- Word processing

The user should be familiar with **VISTA** conventions. In the examples, the user's response is presented in bold face text.

## Navigating

The user can press the Return key to move through a prompt and go to the next page or item. To return directly to the *Surgery Menu* options, the user can enter an up-arrow (^), unless he or she is in a multiple field. To exit a multiple field, enter two up-arrows (^ ^).

## Basics of Screen Server

Each Screen Server arrangement consists of three basic parts: a header, data elements, and an action prompt. These items are defined in the following table.

Term	Definition
Header	The screen heading contains information specific to the record with which you are working. This can include the patient name or case number. The information in the heading is programmed and cannot be easily changed.
Data Elements	Each Screen Server display contains from 1 to 15 data elements (or fields). If information has been entered for any of the data elements defined, it will display to the right of the element. Some data elements are multiple fields, meaning they can contain more than one piece of information. These multiple fields are distinguished by the word "Multiple" next to the data element. If the multiple field contains information, the word "Data" will be next to the data element.
Prompt	The action prompt is at the bottom of each screen. From the prompt "Enter Screen Server Functions:" you can enter, edit, or delete information from the data elements. The possible responses to this prompt are explained in more detail on the following pages. Enter a question mark (?), for help text with possible prompt responses.

The following is an example of a Screen Server display with help text.

### Example: Screen Server with On-line Help Text

The diagram shows a screen server display with four callout boxes pointing to specific parts of the text:

- Header:** Points to the top line: `** SHORT SCREEN ** CASE #16 OHIO,RAYMOND PAGE 1 OF 3`
- Data Elements:** Points to the list of data elements from line 1 to 15, such as `1 DATE OF OPERATION: AUG 01, 2001` and `4 PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE`.
- Prompt:** Points to the line `Enter Screen Server Function: ?`
- On-line Help:** Points to the help text starting with `If there is more than one page to this screen...`

```

** SHORT SCREEN ** CASE #16 OHIO,RAYMOND PAGE 1 OF 3
1 DATE OF OPERATION: AUG 01, 2001
2 IN/OUT-PATIENT STATUS: OUTPATIENT
3 SURGEON: TULSA,LARRY
4 PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5 PRIN DIAGNOSIS CODE:
6 OTHER PREOP DIAGNOSIS: (MULTIPLE)
7 PRINCIPAL PROCEDURE:: REMOVE FACIAL LESIONS
8 PRINCIPAL PROCEDURE CODE:
9 OTHER PROCEDURES: (MULTIPLE)
10 TIME PAT IN OR:
11 MARKED SITE CONFIRMED:
12 PREOPERATIVE IMAGING CONFIRMED:
13 TIME OUT VERIFIED:
14 MARKED SITE COMMENTS: (WORD PROCESSING)
15 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)

Enter Screen Server Function: ?
To change entries, enter your choices (numbers) separated by a ';', or
use a ':' for ranges. i.e. 2;3 or 1:3. Enter 'A' to enter/edit all.

If there is more than one page to this screen, entering a '+' or '-'
followed by the number of pages or entering 'P' followed by the page
number will take you to the desired page.

Enter '^' to quit, or '^ ^' to return to the menu option.
  
```

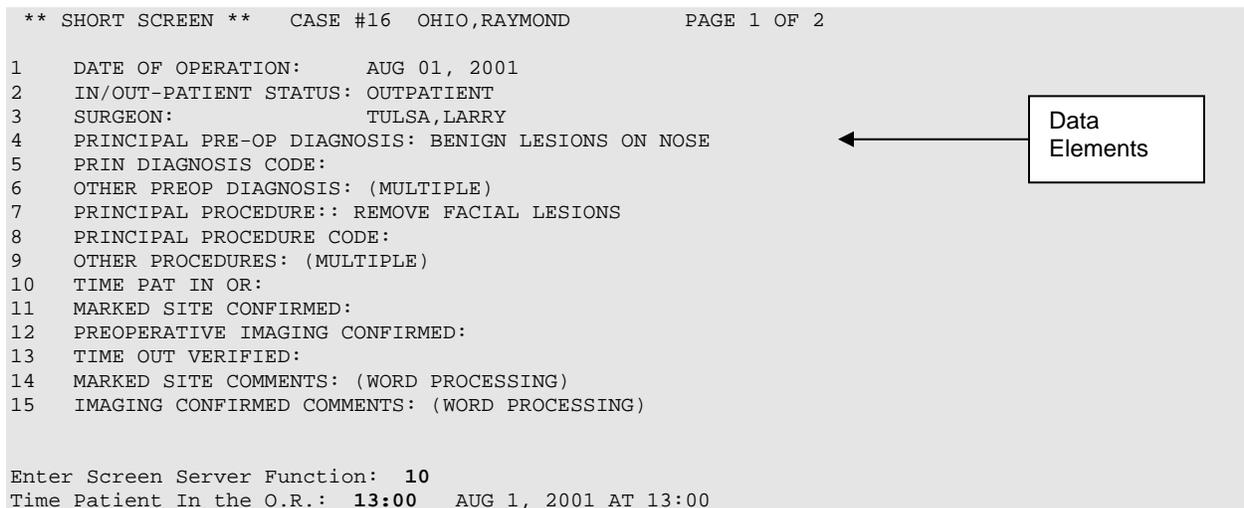
## Entering Data

To enter or edit data, the user can type the item number corresponding with the data element for which he/she is entering information and press the Return key. In the following example, we typed the number 10 at the prompt and pressed the Enter key. A new prompt appeared allowing us to enter the data. The software immediately processed this information and produced an updated menu screen and another action prompt.

```
** SHORT SCREEN **      CASE #16  OHIO,RAYMOND      PAGE 1 OF 2

1  DATE OF OPERATION:      AUG 01, 2001
2  IN/OUT-PATIENT STATUS:  OUTPATIENT
3  SURGEON:                 TULSA,LARRY
4  PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5  PRIN DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS:  (MULTIPLE)
7  PRINCIPAL PROCEDURE::  REMOVE FACIAL LESIONS
8  PRINCIPAL PROCEDURE CODE:
9  OTHER PROCEDURES:      (MULTIPLE)
10 TIME PAT IN OR:
11 MARKED SITE CONFIRMED:
12 PREOPERATIVE IMAGING CONFIRMED:
13 TIME OUT VERIFIED:
14 MARKED SITE COMMENTS:  (WORD PROCESSING)
15 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  10
Time Patient In the O.R.:  13:00  AUG 1, 2001 AT 13:00
```

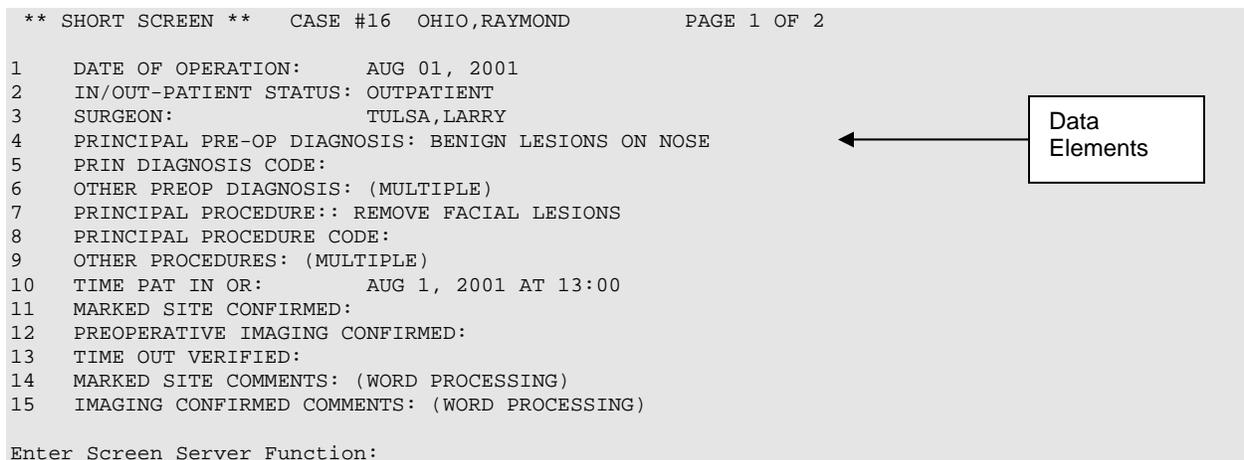


The software processes the information and produces an update.

```
** SHORT SCREEN **      CASE #16  OHIO,RAYMOND      PAGE 1 OF 2

1  DATE OF OPERATION:      AUG 01, 2001
2  IN/OUT-PATIENT STATUS:  OUTPATIENT
3  SURGEON:                 TULSA,LARRY
4  PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5  PRIN DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS:  (MULTIPLE)
7  PRINCIPAL PROCEDURE::  REMOVE FACIAL LESIONS
8  PRINCIPAL PROCEDURE CODE:
9  OTHER PROCEDURES:      (MULTIPLE)
10 TIME PAT IN OR:          AUG 1, 2001 AT 13:00
11 MARKED SITE CONFIRMED:
12 PREOPERATIVE IMAGING CONFIRMED:
13 TIME OUT VERIFIED:
14 MARKED SITE COMMENTS:  (WORD PROCESSING)
15 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:
```



## Editing Data

Changing an existing entry is similar to entering. Once again, the user can type in the number for the data element he/she wants to change and press Enter. In the following example, the number 3 was entered to change the surgeon name. A new prompt appeared containing the existing value for the data element in a default format. We entered the new value, "HELENA,LAURIE." The software immediately processed this information and produced an updated screen.

```
** SHORT SCREEN **      CASE #16  OHIO,RAYMOND      PAGE 1 OF 2

1  DATE OF OPERATION:      AUG 01, 2001
2  IN/OUT-PATIENT STATUS:  OUTPATIENT
3  SURGEON:                TULSA,LARRY
4  PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5  PRIN DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  PRINCIPAL PROCEDURE::  REMOVE FACIAL LESIONS
8  PRINCIPAL PROCEDURE CODE:
9  OTHER PROCEDURES: (MULTIPLE)
10 TIME PAT IN OR:        AUG 1, 2001 AT 13:00
11 MARKED SITE CONFIRMED:
12 PREOPERATIVE IMAGING CONFIRMED:
13 TIME OUT VERIFIED:
14 MARKED SITE COMMENTS: (WORD PROCESSING)
15 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  3
SURGEON:  TULSA,LARRY. //  HELENA,LAURIE
```



The software processes the information and produces an update.

```
** SHORT SCREEN **      CASE #16  OHIO,RAYMOND      PAGE 1 OF 2

1  DATE OF OPERATION:      AUG 01, 2001
2  IN/OUT-PATIENT STATUS:  OUTPATIENT
3  SURGEON:                HELENA,LAURIE
4  PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5  PRIN DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  PRINCIPAL PROCEDURE::  REMOVE FACIAL LESIONS
8  PRINCIPAL PROCEDURE CODE:
9  OTHER PROCEDURES: (MULTIPLE)
10 TIME PAT IN OR:        AUG 1, 2001 AT 13:00
11 MARKED SITE CONFIRMED:
12 PREOPERATIVE IMAGING CONFIRMED:
13 TIME OUT VERIFIED:
14 MARKED SITE COMMENTS: (WORD PROCESSING)
15 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:
```



## Turning Pages

No more than 15 data elements will fit on a single Screen Server formatted page, but there can be as many pages as needed. Because many screens contain more than one page of data elements, the screen server provides the ability to move between the pages. Pages are numbered in the heading. To go back one page, enter minus one (-1) at the action prompt. To go forward, enter plus one (+1). The user can move more than one page by combining the minus or plus sign with the number of pages needed to go backward or forward.

## Entering or Editing a Range of Data Elements

Colons and semicolons are used as delineators for ranges of item numbers. This allows the user to respond to two or more data elements on the same page of a screen at one time. Typing a colon and/or semicolon between the item numbers at the prompt tells the software what elements to display for editing.

Colons are used when the user wants to respond to all numbers within a sequence (for example, 2:5 means items 2, 3, 4, and 5). Semicolons are used to separate the item numbers for non-sequential items (e.g., 2;5;9;11 means items 2, 5, 9 and 11). To respond to all the data elements on the page, enter "A" for all.

### Example 1: Colon

```
** STARTUP **      CASE #24  MARYLAND,MARK      PAGE 2 OF 3

1  MARKED SITE CONFIRMED: YES
2  PREOPERATIVE IMAGING CONFIRMED: IMAGING NOT REQUIRED FOR THIS PROCEDURE
3  TIME OUT VERIFIED: YES
4  MARKED SITE COMMENTS: (WORD PROCESSING)
5  IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
6  TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
7  ASA CLASS:
8  PREOP MOOD:
9  PREOP CONSCIOUS:
10 PREOP SKIN INTEG:
11 TRANS TO OR BY:
12 PREOP SHAVE BY:
13 SKIN PREPPED BY (1):
14 SKIN PREPPED BY (2):
15 SKIN PREP AGENTS:

Enter Screen Server Function: 7:12
ASA Class: 2      2-MILD DISTURB.
Preoperative Mood: RELAXED      R
Preoperative Consciousness: ALERT-ORIENTED      AO
Preoperative Skin Integrity: INTACT      I
Transported to O.R. By: STRETCHER
Preoperative Shave By: TAMPA,ANNETTE      AT
```

### Example 2: Semicolon

```
** STARTUP **      CASE #24  MARYLAND,MARK      PAGE 1 OF 3

1  DATE OF OPERATION: APR 19, 2001 AT 800
2  PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE
3  OTHER PREOP DIAGNOSIS: (MULTIPLE)
4  OPERATING ROOM: OR4
5  SURGERY SPECIALTY: ORTHOPEDICS
6  MAJOR/MINOR:
7  REQ POSTOP CARE: WARD
8  CASE SCHEDULE TYPE: ELECTIVE
9  REQ ANESTHESIA TECHNIQUE: GENERAL
10 PATIENT EDUCATION/ASSESSMENT: YES
11 CANCEL DATE:
12 CANCEL REASON:
13 CANCELLATION AVOIDABLE:
14 DELAY CAUSE: (MULTIPLE)
15 VALID ID/CONSENT CONFIRMED BY:

Enter Screen Server Function: 4;6;
Operating Room: OR4// OR2
Major or Minor: MAJOR
```

## Working with Multiples

The notation MULTIPLE indicates a data element that can have more than one answer. Some multiple fields have several layers of screens from which to respond. Navigating through the layers may seem tedious at first, but the user will soon develop speed. Remember, the user can press the Enter key at the prompt to go back to the main menu screen, or enter an up-arrow (^) to go back to the previous screen.

In the following examples, there are other screens after the initial (also called top-level) screen. With the multiple screens, a new menu list is built with each entry.

### Example: Multiples

```
** OPERATION **      CASE #14  MONTANA,JOHNNY          PAGE 1 OF 3
1  TIME PAT IN HOLD AREA: AUG 15, 2001 AT 740
2  TIME PAT IN OR:      AUG 15, 2001 AT 800
3  MARKED SITE CONFIRMED: YES
4  PREOPERATIVE IMAGING CONFIRMED: IMAGING NOT REQUIRED FOR THIS PROCEDURE
5  TIME OUT VERIFIED:   YES
6  MARKED SITE COMMENTS: (WORD PROCESSING)
7  IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
8  TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
9  ANES CARE START TIME: AUG 15, 2001 AT 800
10 TIME OPERATION BEGAN: AUG 15, 2001 AT 900

Enter Screen Server Function:  <Enter>
```

```
** OPERATION **      CASE #14  MONTANA,JOHNNY          PAGE 2 OF 3
1  SPECIMENS:          (WORD PROCESSING)
2  CULTURES:           (WORD PROCESSING)
3  THERMAL UNIT:       (MULTIPLE)
4  ELECTROCAUTERY UNIT:
5  ESU COAG RANGE:
6  ESU CUTTING RANGE:
7  TIME TOURNIQUET APPLIED: (MULTIPLE)
8  PROSTHESIS INSTALLED: (MULTIPLE)
9  REPLACEMENT FLUID TYPE: (MULTIPLE)
10 IRRIGATION:         (MULTIPLE)
11 MEDICATIONS:        (MULTIPLE)(DATA)
12 SPONGE COUNT CORRECT (Y/N): YES
13 SHARPS COUNT CORRECT (Y/N): YES
14 INSTRUMENT COUNT CORRECT (Y/N): YES
15 SPONGE, SHARPS, & INST COUNTER:

Enter Screen Server Function:  8
```

```

** OPERATION **      CASE #14  MONTANA,JOHNNY      PAGE 1
    PROSTHESIS INSTALLED

1      NEW ENTRY

Enter Screen Server Function:  1
Select PROSTHESIS INSTALLED PROSTHESIS ITEM:  GLENOID COMPONENT
    PROSTHESIS INSTALLED ITEM: GLENOID COMPONENT//  <Enter>

```

Notice the three user responses entered above. The first response, 1, told the software that we want to enter data in the PROSTHESIS INSTALLED field. Then, at the next screen, we entered "1" because we wanted to make a new prosthesis entry for this case. The third response, GLENOID, told the software what kind of prosthesis is being installed. The software echoed back the full prosthesis name "GLENOID COMPONENT" and we accepted it by pressing the Return key. Because the PROSTHESIS INSTALLED field can contain multiple answers, a new screen immediately appeared as follows:

```

** OPERATION **      CASE #14  MONTANA,JOHNNY      PAGE 1
    PROSTHESIS INSTALLED (GLENOID COMPONENT)

1      ITEM:                GLENOID COMPONENT
2      VENDOR:
3      MODEL:
4      LOT/SERIAL NO:
5      STERILE CODE:
6      STERILE NUMBER:
7      STERILE RESP:
8      SIZE:

Enter Screen Server Function:  2:8
VENDOR: AMERICAN MEDICAL
MODEL:  NEER II
LOT/SERIAL NO: #F23101
STERILE CODE:  AA1
STERILE NUMBER: N2034
STERILE RESP: M MANUFACTURER
SIZE: 1081

```

The first response, 2:8, corresponds to data elements 2 through 8. We entered data for these elements one-by-one and the software processed the information and produced this update:

```

** OPERATION **      CASE #14  MONTANA,JOHNNY      PAGE 1 OF 1
    PROSTHESIS INSTALLED (GLENOID COMPONENT)

1      ITEM:                GLENOID COMPONENT
2      VENDOR:              AMERICAN MEDICAL
3      MODEL:               NEER II
4      LOT/SERIAL NO:       #F23101
5      STERILE CODE:        AA1
6      STERILE NUMBER:      N2034
7      STERILE RESP:        MANUFACTURER
8      SIZE:                1081

Enter Screen Server Function:  <Enter>

```

Pressing the Enter key will now bring back the top-level screen and allow us to make another entry. As many as 15 prostheses can be added to this list. If we were to add more prostheses, the N and R shortcuts discussed on the next two pages would come in handy, but it is a good idea to practice the steps just covered before attempting the shortcuts.

## Multiple Screen Shortcuts

The help text for a multiple field mentions the N and R functions. The user can enter a question mark (?) to view the help text at the prompt, as displayed in the following example.

```
** OPERATION **      CASE #14 MONTANA,JOHNNY          PAGE 1 OF 1
    PROSTHESIS INSTALLED

1      NEW ENTRY

Enter Screen Server Function:  ?
Enter 1N to enter only the top level of this multiple, or the number
of your choice followed by an 'R' to make a duplicate entry.

Press <RET> to continue
```

## N Function

The N function allows the user to enter **new** entries without going beyond the top level screen, whereas the R function allows the user to **repeat** a previous top level response. In the following example we will build entries by entering the data element number and the letter N:

```
** OPERATION **      CASE #14 MONTANA,JOHNNY          PAGE 1 OF 1
    PROSTHESIS INSTALLED

1      NEW ENTRY

Enter Screen Server Function:  1N
Select PROSTHESIS INSTALLED PROSTHESIS ITEM:  GLENOID COMPONENT
    PROSTHESIS INSTALLED ITEM:  GLENOID COMPONENT// <Enter>
Select PROSTHESIS INSTALLED PROSTHESIS ITEM:  HUMERAL COMPONENT
    PROSTHESIS INSTALLED ITEM:  HUMERAL COMPONENT// <Enter>
Select PROSTHESIS INSTALLED PROSTHESIS ITEM:  INTRAMEDULLARY PLUG
    PROSTHESIS INSTALLED ITEM:  INTRAMEDULLARY PLUG// <Enter>
Select PROSTHESIS INSTALLED PROSTHESIS ITEM:  <Enter>
```

The software processes the information and produces an update.

```
** OPERATION **      CASE #14 MONTANA,JOHNNY          PAGE 1 OF 1
    PROSTHESIS INSTALLED

1      ITEM:                GLENOID COMPONENT
2      ITEM:                HUMERAL COMPONENT
3      ITEM:                INTRAMEDULLARY PLUG
4      NEW ENTRY

Enter Screen Server Function:  <Enter>
```

## R Function

The R function saves the user from typing in the top-level information again. In this example, we have the same anesthesia technique but different anesthesia agents. By entering the element number we want to repeat, and the letter R, we avoid having to enter the top-level data again. This feature can also be useful in cases where the same medication is repeated at different times. After the user enters the item and the letter R, the software responds with a default prompt. The user can press the Enter key to accept the default.

```
** SHORT SCREEN **      CASE #10  KENTUCKY,KENNETH  PAGE 1 OF 1
      ANESTHESIA TECHNIQUE

1  ANESTHESIA TECHNIQUE:  GENERAL
2  ANESTHESIA TECHNIQUE:  LOCAL
3  NEW ENTRY
Enter Screen Server Function:  1R
      ANESTHESIA TECHNIQUE:  GENERAL// <Enter>
```

The software processes the information and produces an update.

```
** SHORT SCREEN **      CASE #10  KENTUCKY,KENNETH  PAGE 1 OF 1
      ANESTHESIA TECHNIQUE  (0)

1  ANESTHESIA TECHNIQUE:  GENERAL
2  PRINCIPAL TECH:
3  ANESTHESIA AGENTS:      (MULTIPLE)

Enter Screen Server Function:  3
```

```
** SHORT SCREEN **      CASE #10  KENTUCKY,KENNETH  PAGE 1 OF 1
      ANESTHESIA TECHNIQUE  (0)
      ANESTHESIA AGENTS

1  NEW ENTRY

Enter Screen Server Function:  1
Select ANESTHESIA AGENTS:  PROCAINE HYDROCHLORIDE
      ANESTHESIA AGENTS:  PROCAINE HYDROCHLORIDE // <Enter>
```

```
** SHORT SCREEN **      CASE #10  KENTUCKY,KENNETH  PAGE 1 OF 1
      ANESTHESIA TECHNIQUE  (0)
      ANESTHESIA AGENTS

1  ANESTHESIA AGENTS:      PROCAINE HYDROCHLORIDE
2  NEW ENTRY

Enter Screen Server Function:  <Enter>
```

The software processes the information and produces an update.

```
** SHORT SCREEN **      CASE #10  KENTUCKY,KENNETH  PAGE 1 OF 1
      ANESTHESIA TECHNIQUE  (0)

1  ANESTHESIA TECHNIQUE:  GENERAL
2  PRINCIPAL TECH:
3  ANESTHESIA AGENTS:      (MULTIPLE)(DATA)

Enter Screen Server Function:  <Enter>
```

The updating continues through to the top layer.

```
** SHORT SCREEN **      CASE #10  KENTUCKY,KENNETH  PAGE 1 OF 1
      ANESTHESIA TECHNIQUE

1  ANESTHESIA TECHNIQUE:  INTRAVENOUS
2  ANESTHESIA TECHNIQUE:  LOCAL
3  ANESTHESIA TECHNIQUE:  INTRAVENOUS
4  NEW ENTRY

Enter Screen Server Function:
```

## Word Processing

The phrase "Word Processing" in the menu means that the user can enter as much data as needed to complete the entry.

Following is an example of how we entered text on a Screen Server word processing field. Notice that we pressed the Enter key after each line of text as there is no automatic word-wrap:

```
** SHORT SCREEN **      CASE #25  KENTUCKY,KENNETH      PAGE 3 OF 3

1  WOUND CLASSIFICATION:
2  ATTEND SURG:
3  ATTENDING CODE:      LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE
4  SPECIMENS:           (WORD PROCESSING)
5  CULTURES:           (WORD PROCESSING)
6  NURSING CARE COMMENTS: (WORD PROCESSING)
7  ASA CLASS:
8  PRINC ANESTHETIST:
9  ANESTHESIA TECHNIQUE: (MULTIPLE)
10 ANES CARE START TIME:
11 ANES CARE END TIME:
12 DELAY CAUSE:        (MULTIPLE)
13 CANCEL DATE:
14 CANCEL REASON:

Enter Screen Server Function:  6
NURSING CARE COMMENTS:
  1>Patient arrived ambulatory from Ambulatory Surgery Unit.  <Enter>
  2>Discharged via wheelchair. Lidocaine applied topically.  <Enter>
  3> <Enter>
EDIT Option: <Enter>
```

The software processes the information and produces an update.

```
** SHORT SCREEN **      CASE #25  KENTUCKY,KENNETH      PAGE 3 OF 3

1  WOUND CLASSIFICATION:
2  ATTEND SURG:
3  ATTENDING CODE:      LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE
4  SPECIMENS:           (WORD PROCESSING)
5  CULTURES:           (WORD PROCESSING)
6  NURSING CARE COMMENTS: (WORD PROCESSING) (DATA)
7  ASA CLASS:
8  PRINC ANESTHETIST:
9  ANESTHESIA TECHNIQUE: (MULTIPLE)
10 ANES CARE START TIME:
11 ANES CARE END TIME:
12 DELAY CAUSE:        (MULTIPLE)
13 CANCEL DATE:
14 CANCEL REASON:

Enter Screen Server Function:
```

# Chapter One: Booking Operations

---

## Introduction

The options described in this chapter facilitate the scheduling of surgical procedures. Automated scheduling provides better operating room use and greater ease in distributing the operating room schedule. These options help accomplish the following tasks.

- Track patients on a waiting list
- Track operation requests
- Chart operating room availability
- Designate operating rooms for a surgical service
- Schedule operations by assigning operating rooms and time slots
- Generate operating room schedules on any designated printer in the medical center
- Reschedule or cancel any operative procedures

Whether or not the user is booking a case from the Waiting List, *Request Operations* menu, or *Schedule Operations* menu, he/she will be asked to provide preoperative information about the case. Some of the preoperative information is mandatory and must be entered immediately to proceed with the option, while other information can be entered later. It is advisable to enter as much information as possible and update or correct it later. If a prompt cannot be answered, the user can press the <Enter> key to move to the next item.

## Key Vocabulary

The following terms are used in this chapter.

Term	Definition
Concurrent Case	The patient undergoes two operations, by two different specialties, at the same time in the same operating room.
Cutoff Time	An institution might have a daily cutoff time for entering requests. After the cutoff time, the user is prohibited from booking a request for an operation to take place through midnight of the following day. The user may still book requests two or more days in advance.
Outstanding Requests	Requests that have been entered but not scheduled. When the patient name is entered, the software will list the outstanding requests for this patient.
Screen Server	After the data concerning the operation has been entered, the terminal display device will clear and then present a two-page Screen Server summary. The Screen Server summary organizes the information entered and gives the user another opportunity to enter or edit data.

## Exiting an Option or the System

The user can type the up-arrow (^) at any prompt to stop the line of questioning and return to the previous level in the routine. To completely exit from the system, the user should continue entering up-arrows.

## Option Overview

The main options included in this menu are listed below. Each of these options, except the *List Operation Requests* option and *List Scheduled Operations* option, contain submenus. To the left of the option name is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
W	<i>Maintain Surgery Waiting List</i>
R	<i>Request Operations</i>
LR	<i>List Operation Requests</i>
S	<i>Schedule Operations</i>
LS	<i>List Scheduled Operations</i>

# Maintain Surgery Waiting List

## [SROWAIT]

The options within the *Maintain Surgery Waiting List* menu allow surgeons to develop waiting lists for selected surgery specialties. The patient can remain on the Waiting List until sufficient information is available to book the operation for a specific date (see *Make a Request from the Waiting List* option).



This option is locked with the SROWAIT key.

The *Maintain Surgery Waiting List* menu contains the following options. To the left is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
W	<i>Print Surgery Waiting List</i>
E	<i>Enter a Patient on the Waiting List</i>
U	<i>Edit a Patient on the Waiting List</i>
D	<i>Delete a Patient from the Waiting List</i>

## Print Surgery Waiting List [SRSWL2]

Resident surgeons use the *Print Surgery Waiting List* option to print the waiting list for one or more surgical specialties. The Waiting List includes the names of patients waiting to have an operation and the type of operation. Cases entered on the Waiting List are not assigned an operating room or a date of operation.

The report can be sorted in several different ways. First, the user can sort the report by one or more surgical specialties. Then, the user can choose to sort the report either alphabetically by patient name, by the tentative date of the operation, or by the date the case was entered on the waiting list. A brief form can be requested, as in Example 1, or a long form report, as in Example 2. The long form report includes the procedure name, comments, referring physician, tentative admission date, patient address, and phone numbers.

This report has an 80-column format and can be viewed on a software terminal or copied to a printer. When the screen is full the user will be prompted to press the Return key to continue viewing the list.

### Example 1: Print the Surgery Waiting List, Brief Form, Sort By T

```
Select Maintain Surgery Waiting List Option: W Print Surgery Waiting List

                Surgery Waiting List Reports

Print Report By:

    A   Alphabetical Order by Patient
    T   Tentative Date of Operation
    D   Date Entered on the Waiting List

Enter Selection (A,T, or D): T

Do you want to print the waiting list for all specialties ? YES// N

Select Surgical Specialty: 50          GENERAL(OR WHEN NOT DEFINED BELOW)  GENER
AL(OR WHEN NOT DEFINED BELOW)      50

Do you want to print the brief form ? YES// <Enter>

Print the Waiting List on which Device: [Select Print Device]
```

-----printout follows-----

```
Surgery Waiting List for GENERAL (OR WHEN NOT DEFINED BELOW)
Printed JUN 28, 2001 at 14:10
```

Date Entered	Patient	Operative Procedure
JAN 19, 2001	ALASKA, FRED	Bunionectomy
Tentative Admission: JAN 23, 2001		
Tentative Date of Operation: JAN 23, 2001		
JAN 21, 2001	MISSOURI, ROY	REPAIR INGUINAL HERNIA
Tentative Admission: JAN 28, 2001		
Tentative Date of Operation: JAN 29, 2001		
NOV 29, 1999	OREGON, ROBERT	ARTHROSCOPY, RIGHT SHOULDER
Tentative Admission: DEC 29, 1999		
Tentative Date of Operation: None Specified		

## Example 2: Print the long form, Sort by D

Select Maintain Surgery Waiting List Option: **W** Print Surgery Waiting List

Surgery Waiting List Reports

Print Report By:

A Alphabetical Order by Patient  
T Tentative Date of Operation  
D Date Entered on the Waiting List

Enter Selection (A,T, or D): **D**

Do you want to print the waiting list for all specialties ? YES// **N**

Select Surgical Specialty: **50** GENERAL(OR WHEN NOT DEFINED BELOW) GENER  
AL(OR WHEN NOT DEFINED BELOW) 50

Do you want to print the brief form ? YES// **N**

Print the Waiting List on which Device: [**Select Print Device**]

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

Surgery Waiting List for GENERAL (OR WHEN NOT DEFINED BELOW)  
Printed JAN 20, 2001 at 14:11

-----  
Patient: OREGON,ROBERT (123-45-6789)  
Date Entered: DEC 28, 2001 09:08  
Procedure: ARTHROSCOPY, RIGHT SHOULDER

Tentative Admission Date: JAN 29, 2001

Home Phone: (555)555-5555 Work Phone: NOT ENTERED  
Address:

Referring Physician/Institution:  
DR. DALLAS Phone: 555-555-5555  
122 1ST AVE.  
B'HAM, ALABAMA 35205

-----  
Patient: ALASKA, FRED (123-45-6789)  
Date Entered: JAN 19, 2001 15:17  
Procedure: Bunionectomy

Tentative Admission Date: JAN 23, 2001  
Tentative Date of Operation: JAN 23, 2001

Home Phone: NOT ENTERED Work Phone: NOT ENTERED  
Address:

Referring Physician/Institution:  
Steve Miami Phone:  
Sylacauga OPC

-----  
Patient: MISSOURI, ROY (123-45-6789)  
Date Entered: JAN 21, 2001 13:48  
Procedure: REPAIR INGUINAL HERNIA

Tentative Admission Date: JAN 28, 2001  
Tentative Date of Operation: JAN 29, 2001

Comments:  
Bland Diet

Home Phone: 3225678 Work Phone: NOT ENTERED  
Address: 117TH SO 40TH ST  
BIRMINGHAM, ALABAMA 35217

Referring Physician/Institution:  
JACKSON Phone: 234-567-8900  
Jefferson OPC

## Enter a Patient on the Waiting List [SROW-ENTER]

Resident surgeons use the *Enter a Patient on the Waiting List* option to enter a patient on the waiting list for a selected surgical specialty.

First, identify the surgical specialty to which the patient will be assigned. To add a new case to the waiting list, the user must enter the patient name and the procedure name. Comments, referring physician name and address, tentative admission date, and tentative operation date can also be added. This information will appear on the *Waiting List Report*. Patient names stay on the Waiting List until the data is used to make a request or until it is deleted.

### Example: Enter a Patient on the Waiting List

```
Select Maintain Surgery Waiting List Option: E Enter a Patient on the Waiting List
```

```
Select Surgical Specialty: 62 PERIPHERAL VASCULAR PERIPHERAL VASCULAR 62
...OK? YES// <Enter> (YES)
PERIPHERAL VASCULAR
```

```
Select Patient: NEVADA,NORMAN 06-04-35 123456789
```

```
Select Operative Procedure: HAVEST SAPHENOUS VEIN
```

```
General Comments/Special Instructions:
1>Patient is an insulin dependent diabetic.
2><Enter>
```

```
EDIT Option: <Enter>
```

```
Tentative Admission Date: T+14 (AUG 25, 2001)
Tentative Date of Operation: T+15 (AUG 26, 2001)
```

```
Select REFERRING PHYSICIAN: DR. ROBERT JACKSON
Street Address: VAMC HOUSTON
City: HOUSTON
State: TEXAS
Zip Code: 77005
Telephone Number: 555 555-5555
```

```
NEVADA,NORMAN has been entered on the waiting list for PERIPHERAL VASCULAR
```

```
Press RETURN to continue
```

## Edit a Patient on the Waiting List [SROW-EDIT]

The *Edit a Patient on the Waiting List* option is used to edit information collected for a patient who is already on the waiting list. The user enters the patient's name first. The user should be certain that the correct patient has been entered and that the right case (there can be more than one) has been selected. Information can then be updated by simply typing in the new data at each prompt. If there is no change for a response, press the <Enter> key and the cursor will go to the next prompt.

This option allows changes to the procedure name, the referring physician information, comments, tentative admission date, and/or the tentative operation date. A patient's name cannot be edited. A patient's name will stay on the Waiting List until the data is used to make a request or until it is deleted.

### Example: Edit Waiting List

```
Select Maintain Surgery Waiting List Option: U Edit a Patient on the Waiting List

Edit which Patient ? NEVADA,NORMAN          06-04-35          123456789

Procedures entered on the Waiting List for NEVADA,NORMAN

1. PERIPHERAL VASCULAR                      Date Entered on List:   AUG 11,2001
   HAVEST SAPHENOUS VEIN                    Tentative Operation Date: AUG 26,2001

Principal Operative Procedure: HAVEST SAPHENOUS VEIN
      Replace HA <Enter> With HAR <Enter> Replace <Enter>
      HARVEST SAPHENOUS VEIN
General Comments/Special Instructions:
  1>Patient is an insulin dependent diabetic.
EDIT Option: <Enter>
Tentative Admission Date: AUG 25,2001// 8/26 (AUG 26, 2001)
Tentative Date of Operation: AUG 26,2001// 8/27 (AUG 27, 2001)

Select REFERRING PHYSICIAN: DR. ROBERT JACKSON// <Enter>
Referring Physician/Medical Center: DR. ROBERT JACKSON
      Replace <Enter>
Street Address: VAMC HOUSON//<Enter>
City: HOUSTON// <Enter>
State: TEXAS// <Enter>
Zip Code: 77005// <Enter>
Telephone Number: 555 555-5555//<Enter>

Press RETURN to continue
```

## Delete a Patient from the Waiting List [SROW-DELETE]

The *Delete a Patient from the Waiting List* option is used to delete a patient's procedure from the Surgery Waiting List. Enter the patient's name and select the procedure from the list of procedures and his or her entry will be deleted. The software will provide a message that the procedure has been deleted.

### Example: Delete Patient From Waiting List

```
Select Maintain Surgery Waiting List Option: D Delete a Patient from the Waiting List
```

```
Delete which Patient ? NEVADA,NORMAN      06-04-35      123456789
```

```
Procedures entered on the Waiting List for NEVADA,NORMAN
```

```
1. PERIPHERAL VASCULAR          Date Entered on List:      AUG 11,2001  
   HARVEST SAPHENOUS VEIN      Tentative Operation Date: AUG 26,2001
```

```
Are you sure that you want to delete this entry ? YES// <Enter>
```

```
NEVADA,NORMAN has been removed from the Waiting List.
```

```
Press RETURN to continue
```

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

# Request Operations Menu

## [SROREQ]

The *Request Operations* menu contains several functions that the surgeons and resident surgeons use to book an operation. Options within the *Request Operations* menu are used to book an operation for a certain day. The surgeon can request, via the software, the operation(s) for a patient on a specific day and then enter additional information concerning the upcoming operation.



This option is locked with the SROREQ key.

To request an operation, the user must have a patient name, an operative procedure to perform, and a date to book it. Also required are the Surgeon, Surgical Specialty, and the Indications for Operations. If the user does not know the anticipated date of surgery, the user can enter the patient on the Waiting List. If there is enough information to book the operation for a specific time and operating room, the user can use the *Schedule Unrequested Operations* option on the *Schedule Operation* menu to schedule the operation.

The information gathered is collated by the software and used to produce reports. The person in charge of scheduling (scheduling manager) arranges the operation requests according to the hospital's Surgical Service protocols and schedules the operation by assigning the case an operating room and a time slot.

The options included in the *Request Operations* menu option are listed below. To the left of the option name is the shortcut character(s) the user can enter to select the option.

Shortcut	Option Name
A	<i>Display Availability</i>
R	<i>Make Operation Requests</i>
D	<i>Delete or Update Operation Requests</i>
W	<i>Make a Request from the Waiting List</i>
CC	<i>Make a Request for Concurrent Cases</i>
V	<i>Review Request Information</i>
OR	<i>Operation Requests for a Day</i>
WR	<i>Requests by Ward</i>

## Display Availability [SRODISP]

The *Display Availability* option is used to check on the availability of an operating room before booking an operation. This option allows the user to view the availability of operating rooms on a blockout graph. This screen is “read-only” with no editing capabilities.

Scheduled operations display on the graph as an equal sign (=) followed by the letter X. The equal sign before the X indicates the beginning of a scheduled operation. Surgical specialty blockouts are indicated by an abbreviation for the service (for more information on service blockouts, a function of the Scheduling menu, see the *Create Service Blockouts* option).

After entering this option, the user has a choice of viewing the room availability on the blockout graph in two ways. The user can either view all rooms for a particular date (as in Example 1) or view a particular operating room for a range of dates (Example 2). Notice, in the first example, that the user can also list requests, if any have been made.

### Condensed Characters

If the display terminal can print condensed characters, a 24-hour graph will display on the screen. If not, the user will be prompted to select one of three graphs representing different chunks of that day.

#### **Example 1: All O.R.S For One Day**

```
Select Request Operations Option:  A Display Availability
```

```
Do you want to view all Operating Rooms on one day ?  YES //  <Enter>
```

```
Do you want to list requests also ?  NO//  <Enter>
```

```
Display Operating Room Availability for which Date ?  T  (DEC 10, 2003)
```

```
Display of Available Operating Room Time
```

1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availability (12:00 PM - 12:00 AM)
4. Do Not Display Availability

```
Select Number: 2//  <Enter>
```

ROOM	6AM	7	8	9	10	11	12	13	14	15	16	17	18	19	20
OR1	=XXX	XXXX	XXXX	gen.	gen.	gen.									
OR2															
OR3															
OR4															
OR5															
OR6															

```
Press RETURN to continue
```

## Example 2: One O.R. for a Date Range

Select Request Operations Option: **A** Display Availability

Do you want to view all Operating Rooms on one day ? YES // **N**

Begin Display on which Date ? **T** (APR 14, 2003)

Select OPERATING ROOM NAME: **OR1**

Display of Available Operating Room Time

1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availability (12:00 PM - 12:00 AM)

Select Number: 2// **<Enter>**

Operating Room: OR1 (6:00 AM - 8:00 PM)

DATE	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
04-14-03							eye.	eye.							
04-15-03		eye.	eye.	eye.	eye.	eye.									
04-16-03		gen.	gen.	gen.	gen.	gen.									
04-17-03															
04-18-03															
04-19-03							eye.	eye.	eye.	eye.					
04-20-03															
04-21-03							eye.	eye.							
04-22-03		eye.	eye.	eye.	eye.	eye.									
04-23-03	=XXX	XXXX	XXXX	gen.	gen.	gen.									
04-24-03															
04-25-03															
04-26-03							eye.	eye.	eye.	eye.					
04-27-03															
04-28-03							eye.	eye.							

Press RETURN to continue

## Make Operation Requests [SROOPREQ]

The *Make Operation Requests* option allows the resident surgeon or scheduling manager to request an operation for a patient on a specific day. To request an operation the user must know the patient name, the operative procedure to be performed, and the date on which to book the procedure.

This option also asks for detailed information concerning the upcoming operation. First, the user will be prompted to enter required information, including the Date of Operation, Surgeon, Surgical Specialty, Principal Procedure, and indications for the operation. Facilities can set up additional required fields using the *Surgery Site Parameters (Enter/Edit)* option within the *Surgery Package Management* menu. Then, the user will be prompted to enter procedure information, such as the estimated case length, blood product information, and other information about the operation.

The user should enter as much information as possible when making the request. Later, more information can be added or corrections can be made by using the *Delete or Update Operation Requests* option.

### About Outstanding Requests

When the patient name is entered, the software will list any requests that have been made but not scheduled. These requests are called outstanding requests. If the user discovers that the request being entered has already been made, he or she should respond **YES** to the prompt "Do you want to update the outstanding request ? ". Answering **YES** allows the user to view the information and make changes (see the following example).

If the user is entering a new, separate request for the same patient, he or she should respond **NO** to this prompt.

### Example: Making an Operation Request

```
Select Request Operations Option:  R  Make Operation Requests
Select Patient:      HAWAII, LOU      12-09-51      123456789      NSC VETERAN

The following requests are outstanding for HAWAII, LOU:

1.  09-15-99
    Release of Hammer Toes
2.  11-20-99
    CHOLECYSTECTOMY

Do you want to update the outstanding request ?  YES// <Enter>

Select Operation Request:  1
```

Prompts that require a response before the user can continue with the option include the following.

"Make a Request for which Date ?"

"Surgeon:"

"Surgical Specialty:"

"Principal Operative Procedure:"

"Indications for Operations:"

## Entering Preoperative Information

At this prompt:	The user should do this:
Indications for Operations	<p>Type in the reason this procedure is being performed. The user must enter information into this field prompt before the option can be completed. (In the Line Editor, the notation 1&gt; indicates this is row 1 of an open-text word-processing field. As many lines (rows) as needed can be added.)</p> <p>To exit the Line Editor, press <b>Ctrl+E</b>. The user will be prompted to save changes.</p>
Principal Procedure Code (CPT)	Type in the Current Procedural Terminology (CPT) identifying code for each procedure. If the code number is not known, the user can enter the type of operation (i.e., appendectomy) or a body organ and select from a list of codes.
Estimated Case Length (HOURS:MINUTES)	Either accept the default answer by pressing the <Enter> key, or enter a number for the length of time needed for this procedure. If a CPT Code is entered, the software will display the average length of time for the procedure based on the Surgical Specialty and CPT Code.
BRIEF CLINical History	This information will display on the Tissue Examination Report. It should contain any information relevant to the specimens being sent to the laboratory. This is also an open-text word-processing field.

-----*chart continues*-----

At this prompt:	The user should do this:
Select REQ BLOOD KIND	<p>Enter the type of blood product that will be needed for the operation.</p> <p>The package coordinator can select a default response to this prompt when installing the package. If the default product is not what is wanted for a case, it can be deleted by entering the at-sign (@) at this prompt. The user can then select the preferred blood product (enter two question marks for a list of blood products).</p> <p>If no blood products are needed, do not enter <b>NO</b> or <b>NONE</b>. Instead, press the <b>&lt;Enter&gt;</b> key to bypass this prompt.</p> <p>To order more than one product for the same case, use the screen server summary that concludes the option and select item 9, REQ BLOOD KIND. This is a multiple field; as many blood products as needed may be entered.</p>
Requested Preoperative X-Rays	<p>Enter the types of preoperative x-ray films and reports required for delivery to the operating room before the operation. This field may be left blank if the user does not intend to order any x-ray products.</p>
Request Clean or Contaminated	<p>Enter the letter code <b>C</b> for clean or <b>D</b> for contaminated, or type in the first few letters of either word. This information allows the scheduling manager to determine how much time is needed between operations for sanitizing a room.</p>

### Example: Make Operation Requests

```
Select Request Operations Option: R Make Operation Requests

Select Patient: CALIFORNIA,JAMES          03-27-40      123456789

The following request is outstanding for CALIFORNIA,JAMES:

1.      03-09-2002
        CARPAL TUNNEL RELEASE

Do you want to update the outstanding request ? YES// N

Do you want to make a new request for CALIFORNIA,JAMES ? NO// Y

Make a Request for which Date ? 12/1 (DEC 01, 2001)
```

```
OPERATION REQUEST: REQUIRED INFORMATION

CALIFORNIA,JAMES (123-45-6789)                                DEC 1, 2001
=====

Surgeon: TOPEKA,MARK
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BE LOW)      50
Principal Operative Procedure: CHOLECYSTECTOMY
Indications for Operations:
  1>ACUTE OBSTRUCTIVE GALLBLADDER DISEASE.
  2><Enter>
EDIT Option: <Enter>
```

```
OPERATION REQUEST: PROCEDURE INFORMATION

CALIFORNIA,JAMES (123-45-6789)                                DEC 1, 2001
=====
Principal Procedure:      CHOLECYSTECTOMY
Principal Procedure Code (CPT): 47480      INCISION OF GALLBLADDER
  CHOLECYSTOTOMY OR CHOLECYSTOSTOMY WITH EXPLORATION, DRAINAGE, OR REMOVAL
  OF CALCULUS (SEPARATE PROCEDURE)      ACTIVE
Modifier: 66      SURGICAL TEAM
  Modifier: <Enter>
Select OTHER PROCEDURE: <Enter>
Estimated Case Length (HOURS:MINUTES): 2:45
Brief Clinical History:
  1>SUBSCAPULAR PAIN FOR 3 DAYS. NAUSEA AND VOMITING. ACHOLIC
  2>STOOLS. CHOLANGIOGRAM SHOWS COMMON DUCT OBSTRUCTION.
  3><Enter>
EDIT Option: <Enter>
```

Enter a '^' at this prompt to bypass entering additional information related to this request.

```

OPERATION REQUEST: BLOOD INFORMATION

CALIFORNIA,JAMES (123-45-6789)                                DEC 1, 2001
=====

Request Blood Availability ? YES// <Enter>
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH//<Enter> TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// @
  SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y (YES)
Select REQ BLOOD KIND: FAL FRESH FROZEN PLASMA, CPDA-1      18201
Units Required: 2

```

```

OPERATION REQUEST: OTHER INFORMATION

CALIFORNIA,JAMES (123-45-6789)                                DEC 1, 2001
=====

Principal Preoperative Diagnosis: CHOLELITHIASIS
Principal Diagnosis Code (ICD9): 574.01 574.01          'C'          CHOLELITH/AC GB INF-OBST
COMPLICATION/COMORBIDITY
  ...OK? YES// <Enter> (YES)
Hospital Admission Status: I// <Enter> INPATIENT
Case Schedule Type: U URGENT
First Assistant: TULSA,LARRY
Second Assistant: <Enter>
Attending Surgeon: TOPEKA,MARK
Requested Postoperative Care: WARD          W
Case Schedule Order: 1
Select SURGERY POSITION: SUPINE// <Enter>
  Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: GENERAL <Enter> GENERAL
Request Frozen Section Tests (Y/N): N NO
Requested Preoperative X-Rays: ABDOMIN
Intraoperative X-Rays (Y/N): N
Request Medical Media (Y/N): N
Request Clean or Contaminated: CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
  No existing text
  Edit? NO//<Enter>
SPD Comments: <Enter>
  No existing text
  Edit? NO//<Enter>

```

After entering the request information, the Screen Server redisplay all fields, providing an opportunity to the user to update the information.

```

** REQUESTS **      CASE #227 CALIFORNIA,JAMES                PAGE 1 OF 3

1  PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2  PRINCIPAL PROCEDURE CODE: 47480-66
3  OTHER PROCEDURES: (MULTIPLE)
4  PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
5  PRIN DIAGNOSIS CODE: 574.01
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  IN/OUT-PATIENT STATUS: INPATIENT
8  PRE-ADMISSION TESTING:
9  CASE SCHEDULE TYPE: URGENT
10 SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)
11 SURGEON:          TOPEKA,MARK
12 FIRST ASST:      TULSA,LARRY
13 SECOND ASST:
14 ATTEND SURG:     TOPEKA,MARK
15 REQ POSTOP CARE: WARD

Enter Screen Server Function: <Enter>

```

\*\* REQUESTS \*\* CASE #227 CALIFORNIA,JAMES PAGE 2 OF 3

1 CASE SCHEDULE ORDER: 1  
2 SURGERY POSITION: (MULTIPLE)(DATA)  
3 REQ ANESTHESIA TECHNIQUE: GENERAL  
4 REQ FROZ SECT: NO  
5 REQ PREOP X-RAY: ABDOMIN  
6 INTRAOPERATIVE X-RAYS: NO  
7 REQUEST BLOOD AVAILABILITY: YES  
8 CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH  
9 REQ BLOOD KIND: (MULTIPLE)(DATA)  
10 REQ PHOTO: NO  
11 REQ CLEAN OR CONTAMINATED: CLEAN  
12 REFERRING PHYSICIAN: (MULTIPLE)  
13 GENERAL COMMENTS: (WORD PROCESSING)  
14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)  
15 BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function: <Enter>

\*\* REQUESTS \*\* CASE #227 CALIFORNIA,JAMES PAGE 3 OF 3

1 SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function: <Enter>

A request has been made for CALIFORNIA,JAMES on 12-01-01.

Press RETURN to continue

## **Service Classifications**

The Surgery software allows the user to associate a patient's Service Classification status when entering or editing a surgical case or Non-OR procedure. Service Classifications can be designated for a surgical case *only* if the veteran is first registered with these designations. The Service Classification questions only display if the Surgery Site parameter "Ask Classification Questions" is set to YES.

The Service Classifications that the user selects for the case also apply to the principal diagnosis.



These classifications default to each Other Postop Diagnosis as they are added to the case.

---

## **Updating an Operation Request with Service Classification Information**

After the user selects the patient and enters the required data, a screen displays with questions about the Service Classifications.



If the patient is not enrolled, or his/her status is not populated in enrollment, the software displays the text "*SC/NSC status not found, N will be defaulted into all SC/EI categories.*" The software defaults **N** into all Service Connected/Environmental Indicator fields related to the case.

---

If the user changes the SC/EI classifications at the case level, the software prompts the user with the message "*Update all 'OTHER POSTOP DIAGNOSIS' Eligibility and Service Connected Conditions with these values?*"

The following example depicts Service Classification status change when the user updates a case.

The user can also edit diagnosis classification status individually using the *Surgeon's Verification of Diagnosis & Procedures* option or the *Update/Verify Procedure/Diagnosis Codes* option.

**Example: Make an Operation Request with Service Classification Information**

```
TENNESSEE,JOHN (123-45-6789)          ALLIED VETERAN

* * * Eligibility Information and Service Connected Conditions * * *

Primary Eligibility: SERVICE CONNECTED 50% to 100%
A/O Exp.: NO          ION Rad.: YES          Env Contam: YES

SC Percent: 100%
Rated Disabilities: NONE STATED
-----

Please supply the following required information about this operation:

Treatment related to Service Connected condition (Y/N): N NO
Treatment related to Ionizing Radiation Exposure (Y/N): N NO
Treatment related to Environmental Contaminant Exposure (Y/N): N NO
Treatment related to Military Sexual Trauma (Y/N): N NO
Treatment related to Head & Neck Cancer (Y/N): <Enter>

Update all 'OTHER POSTOP DIAGNOSIS' Eligibility and
Service Connected Conditions with these values? Enter YES or NO. <NO> Y

Press RETURN to continue
```

## Delete or Update Operation Requests [SRSUPRQ]

The *Delete or Update Operation Requests* option is used to delete a request, to update information, or to change the date of a requested operation. When a user enters this option and selects a patient's name and case, he or she can choose one of the three functions. The three functions are explained below and the next few pages contain examples of how to use them.

The prompts differ for concurrent cases (operations performed by two different specialties at the same time on the same patient), as illustrated in Examples 4, 5, and 6. Whenever a user makes a change or updates information for one of the concurrent cases, the software wants to know if the other case is affected.

The three functions available in this option are also available in the *Request Operations* option when the user selects an outstanding request.

<b>With this function:</b>	<b>The user can:</b>
Delete	Permanently remove an operation request from the software files (Examples 1 and 4). Example 4 shows the deletion of one operation in a set of concurrent cases.
Update Request Information	Change the length of the operation and edit other data fields that were entered earlier (Example 2). The software can automatically update each case in a set of two concurrent cases (Example 5).
Change the Request Date	Alter the operation date of the request (Examples 3 and 6). For a set of concurrent cases to remain concurrent, the user must change the request date for both operations (Example 6).

### Example 1: Delete a Request

```
Select Request Operations Option: D Delete or Update Operation Requests
Select Patient: HAWAII, LOU 12-09-51 123456789 NSC VETERAN
```

The following cases are requested for HAWAII, LOU:

1. 08-15-99 CHOLECYSTECTOMY
2. 09-15-99 Release of Hammer Toes

Select Operation Request: **2**

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: **1**

Are you sure that you want to delete this request ? YES// **<Enter>**

Deleting Operation ...

Press RETURN to continue

### Example 2: Update Request Information

```
Select Request Operations Option: D Delete or Update Operation Requests
Select Patient: CALIFORNIA, JAMES 03-27-40 123456789
```

The following case is requested for CALIFORNIA, JAMES:

1. 12-01-99 CHOLECYSTECTOMY

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: **2**

How long is this procedure ? (HOURS:MINUTES) 2:45 // **2:30**

```
** UPDATE REQUEST ** CASE #227 CALIFORNIA, JAMES PAGE 1 OF 3
1 PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2 OTHER PROCEDURES: (MULTIPLE)
3 PRINCIPAL PROCEDURE CODE: 47480-66
4 PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
5 PRIN DIAGNOSIS CODE: 574.01
6 OTHER PREOP DIAGNOSIS: (MULTIPLE)
7 IN/OUT-PATIENT STATUS: INPATIENT
8 PRE-ADMISSION TESTING:
9 CASE SCHEDULE TYPE: URGENT
10 SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)
11 SURGEON: TOPEKA, MARK
12 FIRST ASST: TULSA, LARRY
13 SECOND ASST:
14 ATTEND SURG: TOPEKA, MARK
15 REQ POSTOP CARE: WARD

Enter Screen Server Function: 13
Second Assistant: NASHVILLE, NANCY
```

```

** UPDATE REQUEST **   CASE #227   CALIFORNIA,JAMES   PAGE 1 OF 3

1  PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2  PRINCIPAL PROCEDURE CODE: 47480-66
3  OTHER PROCEDURES: (MULTIPLE)
4  PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
5  PRIN DIAGNOSIS CODE: 574.01
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  IN/OUT-PATIENT STATUS: INPATIENT
8  PRE-ADMISSION TESTING:
9  CASE SCHEDULE TYPE: URGENT
10 SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)
11 SURGEON: TOPEKA,MARK
12 FIRST ASST: TULSA,LARRY
13 SECOND ASST: NASHVILLE,NANCY
14 ATTEND SURG: TOPEKA,MARK
15 REQ POSTOP CARE: WARD

Enter Screen Server Function: <Enter>

```

```

** UPDATE REQUEST **   CASE #227   CALIFORNIA,JAMES   PAGE 2 OF 3

1  CASE SCHEDULE ORDER: 1
2  SURGERY POSITION: (MULTIPLE)(DATA)
3  REQ ANESTHESIA TECHNIQUE: GENERAL
4  REQ FROZ SECT: NO
5  REQ PREOP X-RAY: ABDOMIN
6  INTRAOPERATIVE X-RAYS: NO
7  REQUEST BLOOD AVAILABILITY: YES
8  CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
9  REQ BLOOD KIND: (MULTIPLE)(DATA)
10 REQ PHOTO: NO
11 REQ CLEAN OR CONTAMINATED: CLEAN
12 REFERRING PHYSICIAN: (MULTIPLE)
13 GENERAL COMMENTS: (WORD PROCESSING)
14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15 BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function: <Enter>

```

```

** UPDATE REQUEST **   CASE #227   CALIFORNIA,JAMES   PAGE 3 OF 3

1  SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function: <Enter>

```

**Example 3: Change the Request Date**

```

Select Request Operations Option: D Delete or Update Operation Requests
Select Patient: CALIFORNIA,JAMES 03-27-40 123456789

```

```

The following case is requested for CALIFORNIA,JAMES:

1. 12-01-99 CHOLECYSTECTOMY

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: 3

Change to which Date ? 11/30 (NOV 30, 1999)

The request for CALIFORNIA,JAMES has been changed to NOV 30, 1999.

Press RETURN to continue

```

## Deleting or Updating Requests for Concurrent Cases

Any changes made to one concurrent case can affect the other case. When one of the concurrent cases is deleted, a prompt will ask if the user wishes to delete the other case also. If the user responds with **NO**, the remaining operation will stay in the records as a single case. When the user changes the date of one operation of a concurrent case, the user must simultaneously change the date for the other operation, otherwise the operations will no longer be considered concurrent.

When updating a response to a prompt or group of related prompts, the software will ask if the user wants to store (meaning duplicate) the information in the other case. This saves time by storing the information into the other case so that it does not have to be entered again. If the user does not want the prompt response duplicated for the other case, enter **N** or **NO**.

### Example 4: Delete a Request for Concurrent Cases

```
Select Request Operations Option: D Delete or Update Operation Requests
Select Patient: KENTUCKY,KENNETH 01-16-35 123456789 NSC VETERAN

The following cases are requested for KENTUCKY,KENNETH:

1. 03-15-99 APPENDECTOMY
2. 08-15-99 CAROTID ARTERY ENDARTERECTOMY
3. 08-15-99 AORTO CORONARY BYPASS

Select Operation Request: 2

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: 1

Are you sure that you want to delete this request ? YES// <Enter>

A concurrent case has been requested for this operation. Do you want to
delete the request for it also ? YES//<Enter>

Deleting Operation ...
Deleting Concurrent Operation ...

Press <Enter> to continue <Enter>
```

Responding **YES** here will delete both operation requests. **NO** leaves the single remaining case, no longer concurrent.

### Example 5: Update Request Information for a Concurrent Case

```
Select Request Operations Option: Delete or Update Operation Requests
Select Patient: IDAHO,PETER 02-12-28 123456789

The following cases are requested for IDAHO,PETER:

1. 03-16-99 CAROTID ARTERY ENDARTERECTOMY
2. 03-16-99 AORTO CORONARY BYPASS GRAFT

Select Operation Request: 1

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: 2

How long is this procedure ? (HOURS:MINUTES) 1:30 // <Enter>
```

```

** UPDATE REQUEST **   CASE #178   IDAHO,PETER   PAGE 1 OF 3

1  PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2  OTHER PROCEDURES:   (MULTIPLE)
3  PRINCIPAL PROCEDURE CODE: 35301-59
4  PRINCIPAL PRE-OP DIAGNOSIS:
5  PRIN DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  IN/OUT-PATIENT STATUS:
8  PRE-ADMISSION TESTING:
9  CASE SCHEDULE TYPE:  STANDBY
10 SURGERY SPECIALTY:   PERIPHERAL VASCULAR
11 SURGEON:             TOPEKA,MARK
12 FIRST ASST:
13 SECOND ASST:
14 ATTEND SURG:
15 REQ POSTOP CARE:     SICU

Enter Screen Server Function:  4;5;8;14
Principal Preoperative Diagnosis:  CAROTID ARTERY STENOSIS
Principal Diagnosis Code (ICD9):  433.1      'C'      CAROTID ARTERY OCCLUSION
      COMPLICATION/COMORBIDITY
      ...OK? YES//  <Enter> (YES)

Pre-admission Testing Complete (Y/N):  YES      YES
Do you want to store this information in the concurrent case ?  YES//  N

Attending Surgeon:  TOPEKA,MARK

```

```

** UPDATE REQUEST **   CASE #178   IDAHO,PETER   PAGE 1 OF 3

1  PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2  OTHER PROCEDURES:   (MULTIPLE)
3  PRINCIPAL PROCEDURE CODE: 35301-59
4  PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5  PRIN DIAGNOSIS CODE: 433.10
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  IN/OUT-PATIENT STATUS: INPATIENT
8  PRE-ADMISSION TESTING: YES
9  CASE SCHEDULE TYPE:  STANDBY
10 SURGERY SPECIALTY:   PERIPHERAL VASCULAR
11 SURGEON:             TOPEKA,MARK
12 FIRST ASST:
13 SECOND ASST:
14 ATTEND SURG:         TOPEKA,MARK
15 REQ POSTOP CARE:     SICU

Enter Screen Server Function:  <Enter>

```

```

** UPDATE REQUEST **   CASE #178   IDAHO,PETER   PAGE 2 OF 3

1  CASE SCHEDULE ORDER: 1
2  SURGERY POSITION:     (MULTIPLE)
3  REQ ANESTHESIA TECHNIQUE: GENERAL
4  REQ FROZ SECT:      NO
5  REQ PREOP X-RAY:    DOPPLER STUDIES
6  INTRAOPERATIVE X-RAYS: NO
7  REQUEST BLOOD AVAILABILITY:
8  CROSSMATCH, SCREEN, AUTOLOGOUS:
9  REQ BLOOD KIND:     (MULTIPLE)
10 REQ PHOTO:
11 REQ CLEAN OR CONTAMINATED: CLEAN
12 REFERRING PHYSICIAN: (MULTIPLE)
13 GENERAL COMMENTS:   (WORD PROCESSING)
14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15 BRIEF CLIN HISTORY: (WORD PROCESSING)

** UPDATE REQUEST **   CASE #229   IDAHO,PETER   PAGE 3 OF 3

1  SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:

```

### Example 6: Change the Request Date of Concurrent Cases

Select Request Operations Option: **D** Delete or Update Operation Requests  
Select Patient: **KENTUCKY, KENNETH** 01-16-35 123456789 NSC VETERAN

The following cases are requested for KENTUCKY, KENNETH:

1. 04-04-99 ARTHROSCOPY, RIGHT KNEE
2. 04-04-99 REMOVE MOLE
3. 06-01-99 CAROTID ARTERY ENDARTERECTOMY
4. 06-01-99 AORTO CORONARY BYPASS GRAFT

Select Operation Request: **3**

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: **3**

Change to which Date ? **6/2** (JUN 02, 1999)

There is a concurrent case associated with this operation. Do you want to change the date of it also ? YES// ?

Enter <Enter> if these cases will remain concurrent, or 'NO' if they will no longer be associated together.

There is a concurrent case associated with this operation. Do you want to change the date of it also ? YES// **<Enter>**

The request for KENTUCKY, KENNETH has been changed to JUN 2, 1999.

Press RETURN to continue

## Make a Request from the Waiting List [SRSWREQ]

The *Make a Request from the Waiting List* option uses data from the Waiting List to make an operation request. It can save time by moving data from the Waiting List to the request (simultaneously removing it from the waiting list). As with any request, a date for the surgery is required.

After the user enters the patient name, the software will list any operations on the Waiting List for that patient. The user then selects the operative procedure wanted. The software will advise if the patient selected has any outstanding requests.

Each institution might have a daily cutoff time for entering requests. After the cutoff time for a particular day, the users are prohibited from booking a request for an operation to take place through midnight of that day.

When a request is made, the user is asked to provide preoperative information about the case. It is best to enter as much information as available.

### Example: Making A Request From the Waiting List

```
Select Request Operations Option: W Make a Request from the Waiting List
Make a request from the waiting list for which patient ? KANSAS,THOMAS
08-16-51      123456789
Procedures Entered on the Waiting List for KANSAS,THOMAS:
1. GENERAL(OR WHEN NOT DEFINED BELOW)   Date Entered on List: NOV 17, 2001
   REPAIR DIAPHRAGMATIC HERNIA
Is this the correct procedure ? YES// <Enter>
The following requests are outstanding for KANSAS,THOMAS:
1.   09-16-2001
     CHOLECYSTECTOMY
Do you want to update the outstanding request ? YES// N
Do you want to make a new request for KANSAS,THOMAS ? NO// Y
Make a request for which Date ? 12/1 (DEC 01, 2001)

OPERATION REQUEST: REQUIRED INFORMATION
KANSAS,THOMAS (123-45-6789)                                DEC 1, 2001
=====
Surgeon: TULSA,LARRY
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)
Principal Operative Procedure: REPAIR DIAPHRAGMATIC HERNIA
Indications for Operations:
  1>REFLEX ESOPHAGITIS.
  2><Enter>
EDIT Option: <Enter>
```

## OPERATION REQUEST: PROCEDURE INFORMATION

KANSAS, THOMAS (123-45-6789)

DEC 1, 2001

```

=====
Principal Procedure:      REPAIR DIAPHRAGMATIC HERNIA
Principal Procedure Code (CPT): 39540 REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN
NEONATAL), TRAUMATIC; ACUTE ACTIVE
Modifier: <Enter>
Select OTHER PROCEDURE: <Enter>
Estimated Case Length (HOURS:MINUTES): 2:00
BRIEF CLIN HISTORY:
  1>Patient was reporting indigestion and a burning
  2>sensation in esophagus. Upper GI indicated hernia.
  3><Enter>
EDIT Option: <Enter>

```

## OPERATION REQUEST: BLOOD INFORMATION

KANSAS, THOMAS (123-45-6789)

DEC 1, 2001

```

=====
Request Blood Availability ? YES// <Enter>
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH// <Enter> TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// <Enter>
  Required Blood Product: CPDA-1 WHOLE BLOOD// <Enter>
  Units Required: 2

```

## OPERATION REQUEST: OTHER INFORMATION

KANSAS, THOMAS (123-45-6789)

DEC 1, 2001

```

=====
Principal Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA
Principal Diagnosis Code (ICD9): 551.3 551.3 'C' DIAPHRAGM HERNIA W
GANGR COMPLICATION/COMORBIDITY
  ...OK? YES// <Enter> (YES)
Hospital Admission Status: I// <Enter> INPATIENT
Case Schedule Type: S STANDBY
First Assistant: TOPEKA, MARK
Second Assistant: <Enter>
Attending Surgeon: TULSA, LARRY
Requested Postoperative Care: WARD
Case Schedule Order: 2
Select SURGERY POSITION: SUPINE// <Enter>
  Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: GENERAL
Request Frozen Section Tests (Y/N): N NO
Requested Preoperative X-Rays: ABDOMEN
Intraoperative X-Rays (Y/N): N NO
Request Medical Media (Y/N): N NO
Request Clean or Contaminated: C CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
  No existing text
  Edit? NO//<Enter>
SPD Comments: <Enter>
  No existing text
  Edit? NO//<Enter>

```

\*\* SCHEDULING \*\* CASE #229 KANSAS,THOMAS PAGE 1 OF 3

1 PRINCIPAL PROCEDURE: REPAIR DIAPHRAGMATIC HERNIA  
2 PRINCIPAL PROCEDURE CODE: 39540  
3 OTHER PROCEDURES: (MULTIPLE)  
4 PRINCIPAL PRE-OP DIAGNOSIS: ACUTE DIAPHRAGMATIC HERNIA  
5 PRIN DIAGNOSIS CODE: 551.3  
6 OTHER PREOP DIAGNOSIS: (MULTIPLE)  
7 IN/OUT-PATIENT STATUS: INPATIENT  
8 PRE-ADMISSION TESTING:  
9 CASE SCHEDULE TYPE: STANDBY  
10 SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)  
11 SURGEON: TULSA,LARRY  
12 FIRST ASST: TOPEKA,MARK  
13 SECOND ASST:  
14 ATTEND SURG: TULSA,LARRY  
15 REQ POSTOP CARE: WARD

Enter Screen Server Function: <Enter>

\*\* SCHEDULING \*\* CASE #229 KANSAS,THOMAS PAGE 2 OF 3

1 CASE SCHEDULE ORDER: 2  
2 SURGERY POSITION: (MULTIPLE)(DATA)  
3 REQ ANESTHESIA TECHNIQUE: GENERAL  
4 REQ FROZ SECT: NO  
5 REQ PREOP X-RAY: ABDOMEN  
6 INTRAOPERATIVE X-RAYS: NO  
7 REQUEST BLOOD AVAILABILITY: YES  
8 CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH  
9 REQ BLOOD KIND: (MULTIPLE)(DATA)  
10 REQ PHOTO: NO  
11 REQ CLEAN OR CONTAMINATED: CLEAN  
12 REFERRING PHYSICIAN: (MULTIPLE)  
13 GENERAL COMMENTS: (WORD PROCESSING)  
14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)  
15 BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)

Enter Screen Server Function: <Enter>

\*\* SCHEDULING \*\* CASE #229 KANSAS,THOMAS PAGE 3 OF 3

1 SPD COMMENTS: (WORD PROCESSING)

A request has been made for KANSAS,THOMAS on 12/01/2001.

Press RETURN to continue.

## **Make a Request for Concurrent Cases [SRSREQCC]**

The *Make a Request for Concurrent Cases* option is used to book concurrent operations. Concurrent cases are two operations performed on the same patient by different surgical specialties simultaneously, or back-to-back in the same room. A request may be made for each case at one time with this option. As usual, whenever a request is entered, the user is asked to provide preoperative information about the case. It is best to enter as much information as possible and update it later if necessary.

### **Mandatory Prompts**

After the patient name has been entered, the user will be prompted to enter some required information about the first case (the mandatory prompts include the date of operation, procedure, surgeon, indications for operation, and time needed). If a mandatory prompt is not answered, the software will not book the operation and will return the user to the *Request Operations* menu. After answering the prompts for the first case, the user is prompted to answer the same questions about the second case. Then, the software will provide a message that the two requests have been entered and simultaneously prompt the user to select one of the cases for entering detailed information. If the user does not want to enter detailed preoperative information at this time, pressing the <Enter> key will send the user to the *Request Operations* menu. In Example 1, detailed information is entered for the first case only.

### **Storing the Request Information**

After most prompts, the software will ask if the user wants to store (meaning duplicate) this information in the concurrent, or other, case. This saves time by storing the information into the other case so that information does not have to be entered again. If the user does not want the prompt response duplicated for the other case, he or she should enter **N** or **NO**.

Finally, the software will display the Screen Server summary and store any duplicated information into the other case. At this point, the software will provide another message that the two requests have been entered and again prompt the user to select either case for entering detailed information. This whole process may be repeated with the other case by selecting the number for it, or pressing the <Enter> key to get back to the *Request Operations* option.

### **Updating the Preoperative Information Later**

Use the *Delete or Update Operation Requests* option to change or update any of the information entered for the either or both concurrent cases (Example 2).

### Example 1: Make a Request for Concurrent Cases

Select Request Operations Option: **CC** Make a Request for Concurrent Cases

Request Concurrent Cases for which Patient ? **IDAHO,PETER** 02-12-28 123456789

Make a Request for Concurrent Cases on which Date ? **12/1** (DEC 01, 1999)

FIRST CONCURRENT CASE  
OPERATION REQUEST: REQUIRED INFORMATION

IDAHO,PETER (123-45-6789) DEC 1, 1999  
=====

Surgeon: **TOPEKA,MARK**  
Surgical Specialty: **62** PERIPHERAL VASCULAR PERIPHERAL VASCULAR  
62  
Principal Operative Procedure: **CAROTID ARTERY ENDARTERECTOMY**  
Principal Procedure Code (CPT): **35301** RECHANNELING OF ARTERY  
THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;  
CAROTID, VERTEBRAL, SUBCLAVIAN, BY NECK INCISION

Indications for Operations:  
1>**Unstable angina and impending stroke.**  
2><Enter>  
EDIT Option: <Enter>

SECOND CONCURRENT CASE  
OPERATION REQUEST: REQUIRED INFORMATION

IDAHO,PETER (123-45-6789) DEC 1, 1999  
=====

Surgeon: **TULSA,LARRY**  
Surgical Specialty: **58** THORACIC SURGERY (INC. CARDIAC SURG.) THORACIC  
SURGERY (INC. CARDIAC SURG.) 58  
Principal Operative Procedure: **AORTO CORONARY BYPASS GRAFT**

Indications for Operations:  
1>**UNSTABLE ANGINA.**  
2><Enter>  
EDIT Option: <Enter>

The following requests have been entered.

1. Case # 230 DEC 1, 1999  
Surgeon: TOPEKA,MARK PERIPHERAL VASCULAR  
Procedure: CAROTID ARTERY ENDARTERECTOMY
2. Case # 231 DEC 1, 1999  
Surgeon: TULSA,LARRY THORACIC SURGERY (INC. CARDIAC SURG.)  
Procedure: AORTO CORONARY BYPASS GRAFT

1. Enter Request Information for Case #230
2. Enter Request Information for Case #231

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

```

                SECOND CONCURRENT CASE
                OPERATION REQUEST: PROCEDURE INFORMATION

IDAHO,PETER (123-45-6789)                                DEC 1, 1999
=====
Principal Procedure:      AORTO CORONARY BYPASS GRAFT
Principal CPT Code: 35526 ARTERY BYPASS GRAFT
Modifiers: -66 SURGICAL TEAM
Principal Procedure Code (CPT): 35526 BYPASS GRAFT, WITH VEIN; AORTOSUBCLAVIAN
OR CAROTID
// <Enter>
Select OTHER PROCEDURE: <Enter>
Estimated Case Length (HOURS:MINUTES): 3:30
BRIEF CLIN HISTORY:
  1>CARDIAC CATH SHOWS 80% OCCLUSION OF THE LAD, 75% OCCLUSION OF
  2>RIGHT CORONARY. ALSO, ANTERIOR INFERIOR HYPOKINESIS WITH
  3>POOR LEFT VENTRICULAR FUNCTION, 27%.
  4><Enter>
EDIT Option: <Enter>

```

```

                SECOND CONCURRENT CASE
                OPERATION REQUEST: BLOOD INFORMATION

IDAHO,PETER (123-45-6789)                                DEC 1, 1999
=====

Request Blood Availability ? N// YES
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH// <Enter> TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// @
  SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y (YES)
Select REQ BLOOD KIND: 04061 CPDA-1 RED BLOOD CELLS, DIVIDED UNIT      04061
Units Required: 4

```

```

                SECOND CONCURRENT CASE
                OPERATION REQUEST: OTHER INFORMATION

IDAHO,PETER (123-45-6789)                                DEC 1, 1999
=====

Principal Preoperative Diagnosis: CORONARY ARTERY DISEASE
Principal Diagnosis Code (ICD9): 996.03 996.03 'C' MALFUNC CORON BYPASS GRF
COMPLICATION/COMORBIDITY
  ...OK? YES// <Enter> (YES)
Hospital Admission Status: I// <Enter> INPATIENT

Do you want to store this information in the concurrent case ? YES// <Enter>

Case Schedule Type: S STANDBY

Do you want to store this information in the concurrent case ? YES// <Enter>

First Assistant: BOISE,WILLIAM.
Second Assistant: <Enter>
Attending Surgeon: TULSA,LARRY
Requested Postoperative Care: SICU

Do you want to store this information in the concurrent case ? YES// <Enter>

Case Schedule Order: 2

Do you want to store this information in the concurrent case ? YES// N

Select SURGERY POSITION: SUPINE// <Enter>
Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: GENERAL

```

Do you want to store this information in the concurrent case ? YES// <Enter>

Request Frozen Section Tests (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES//<Enter>

Requested Preoperative X-Rays: **DOPPLER STUDIES**

Do you want to store this information in the concurrent case ? YES// N

Intraoperative X-Rays (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES// <Enter>

Request Medical Media (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES// <Enter>

Request Clean or Contaminated: **C** CLEAN

Do you want to store this information in the concurrent case ? YES// <Enter>

Select REFERRING PHYSICIAN:<Enter>

General Comments: <Enter>

No existing text

Edit? NO//<Enter>

SPD Comments: <Enter>

No existing text

Edit? NO//<Enter>

The information to be duplicated in the concurrent case will now be entered....

```

** REQUESTS **      CASE #231  IDAHO,PETER                PAGE 1 OF 3

1  PRINCIPAL PROCEDURE: AORTO CORONARY BYPASS GRAFT
2  PRINCIPAL PROCEDURE CODE: 35526-66
3  OTHER PROCEDURES:      (MULTIPLE)
4  PRINCIPAL PRE-OP DIAGNOSIS: CORONARY ARTERY DISEASE
5  PRIN DIAGNOSIS CODE: 996.03
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  IN/OUT-PATIENT STATUS: INPATIENT
8  PRE-ADMISSION TESTING:
9  CASE SCHEDULE TYPE:  STANDBY
10 SURGERY SPECIALTY:   THORACIC SURGERY (INC. CARDIAC SURG.)
11 SURGEON:             TULSA,LARRY
12 FIRST ASST:          BOISE, WILLIAM.
13 SECOND ASST:
14 ATTEND SURG:         TULSA,LARRY
15 REQ POSTOP CARE:     SICU

Enter Screen Server Function:  <Enter>

```

```

** REQUESTS **      CASE #231  IDAHO,PETER                PAGE 2 OF 3

1  CASE SCHEDULE ORDER:  2
2  SURGERY POSITION:      (MULTIPLE)(DATA)
3  REQ ANESTHESIA TECHNIQUE: GENERAL
4  REQ FROZ SECT:       NO
5  REQ PREOP X-RAY:     DOPPLER STUDIES
6  INTRAOPERATIVE X-RAYS: NO
7  REQUEST BLOOD AVAILABILITY: YES
8  CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
9  REQ BLOOD KIND:      (MULTIPLE)(DATA)
10 REQ PHOTO:           NO
11 REQ CLEAN OR CONTAMINATED: CLEAN
12 REFERRING PHYSICIAN: (MULTIPLE)
13 GENERAL COMMENTS:   (WORD PROCESSING)
14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15 BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)

Enter Screen Server Function:  <Enter>

```



## Example 2: Update Request Information for a Concurrent Case

```
Select Request Operations Option: D Delete or Update Operation Requests
Select Patient: IDAHO,PETER 02-12-28 123456789
```

The following cases are requested for IDAHO,PETER:

1. 03-09-99 REMOVE FACIAL LESIONS
2. 12-01-99 CAROTID ARTERY ENDARTERECTOMY
3. 12-01-99 AORTO CORONARY BYPASS GRAFT

Select Operation Request: **2**

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: **2**

How long is this procedure ? (HOURS:MINUTES) // **1:30**

```
** UPDATE REQUEST ** CASE #230 IDAHO,PETER PAGE 1 OF 2

1 PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2 PRINCIPAL PROCEDURE CODE: 35301-59
3 OTHER PROCEDURES: (MULTIPLE)
4 PRINCIPAL PRE-OP DIAGNOSIS:
5 PRIN DIAGNOSIS CODE:
6 OTHER PREOP DIAGNOSIS: (MULTIPLE)
7 IN/OUT-PATIENT STATUS: INPATIENT
8 PRE-ADMISSION TESTING:
9 CASE SCHEDULE TYPE: STANDBY
10 SURGERY SPECIALTY: PERIPHERAL VASCULAR
11 SURGEON: TOPEKA,MARK
12 FIRST ASST:
13 SECOND ASST:
14 ATTEND SURG:
15 REQ POSTOP CARE: SICU

Enter Screen Server Function: 4;5;14
Principal Preoperative Diagnosis: CAROTID ARTERY STENOSIS
Principal Diagnosis Code (ICD9): 433.1 433.1 'C' CAROTID ARTERY OCCLUSION
COMPLICATION/COMORBIDITY
...OK? YES// <Enter> (YES)
Attending Surgeon: BISMARK,ANDREW
```

```
** UPDATE REQUEST ** CASE #230 IDAHO,PETER PAGE 1 OF 2

1 PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2 PRINCIPAL PROCEDURE CODE: 35301-59
3 OTHER PROCEDURES: (MULTIPLE)
4 PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5 PRIN DIAGNOSIS CODE: 433.10
6 OTHER PREOP DIAGNOSIS: (MULTIPLE)
7 IN/OUT-PATIENT STATUS: INPATIENT
8 PRE-ADMISSION TESTING:
9 CASE SCHEDULE TYPE: STANDBY
10 SURGERY SPECIALTY: PERIPHERAL VASCULAR
11 SURGEON: TOPEKA,MARK
12 FIRST ASST:
13 SECOND ASST:
14 ATTEND SURG: BISMARK,ANDREW
15 REQ POSTOP CARE: SICU

Enter Screen Server Function: <Enter>
```

1    CASE SCHEDULE ORDER:  
2    SURGERY POSITION:    (MULTIPLE)  
3    REQ ANESTHESIA TECHNIQUE: GENERAL  
4    REQ FROZ SECT:        NO  
5    REQ PREOP X-RAY:  
6    INTRAOPERATIVE X-RAYS: NO  
7    REQUEST BLOOD AVAILABILITY:  
8    CROSSMATCH, SCREEN, AUTOLOGOUS:  
9    REQ BLOOD KIND:        (MULTIPLE)  
10   REQ PHOTO:            NO  
11   REQ CLEAN OR CONTAMINATED: CLEAN  
12   REFERRING PHYSICIAN: (MULTIPLE)  
13   GENERAL COMMENTS:    (WORD PROCESSING)  
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)  
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function:

## Review Request Information [SROREQV]

Surgeons and nurses use the *Review Request Information* option to edit or review the preoperative information that was entered when the case was requested. This option can be accessed after the case has been scheduled.

### Example: Review Request Information

```
Select Request Operations Option: V Review Request Information
Select Patient: OHIO, RAYMOND 02-23-53 123456789
```

```
OHIO, RAYMOND
```

```
1. 03-09-99 REVISE MEDIAN NERVE (REQUESTED)
```

```
Select Operation: 1
```

```
** REVIEW REQUEST ** CASE #35 OHIO, RAYMOND PAGE 1 OF 2
```

```
1 PRINCIPAL PROCEDURE: REVISE MEDIAN NERVE
2 PRINCIPAL PROCEDURE CODE: 64721
3 OTHER PROCEDURES: (MULTIPLE)
4 PRINCIPAL PRE-OP DIAGNOSIS: CARPAL TUNNEL SYNDROME
5 PRIN DIAGNOSIS CODE: 354.0
6 OTHER PREOP DIAGNOSIS: (MULTIPLE)
7 IN/OUT-PATIENT STATUS: INPATIENT
8 CASE SCHEDULE TYPE: ELECTIVE
9 SURGERY SPECIALTY: ORTHOPEDICS
10 SURGEON: TOPEKA, MARK
11 FIRST ASST: SPRINGFIELD, JACK
12 SECOND ASST: AUGUSTA, DON
13 ATTEND SURG: TOPEKA, MARK
14 REQ POSTOP CARE: WARD
15 CASE SCHEDULE ORDER: 2ND
```

```
Enter Screen Server Function: <Enter>
```

```
** REVIEW REQUEST ** CASE #35 OHIO, RAYMOND PAGE 2 OF 2
```

```
1 SURGERY POSITION: (MULTIPLE)(DATA)
2 REQ ANESTHESIA TECHNIQUE: GENERAL
3 REQ FROZ SECT:
4 REQ PREOP X-RAY: CARPAL TUNNEL, R WRIST
5 INTRAOPERATIVE X-RAYS:
6 REQUEST BLOOD AVAILABILITY: NO
7 CROSSMATCH, SCREEN, AUTOLOGOUS:
8 REQ BLOOD KIND: (MULTIPLE)
9 REQ PHOTO:
10 REQ CLEAN OR CONTAMINATED: CLEAN
11 REFERRING PHYSICIAN: (MULTIPLE)
12 GENERAL COMMENTS: (WORD PROCESSING)
13 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
14 BRIEF CLIN HISTORY: (WORD PROCESSING)
```

```
Enter Screen Server Function:
```



## Example 2: Long Form

Select Request Operations Option: OR Operation Requests for a Day

Print Requests for which date ? 3/15 (MAR 15, 1999)

Would you like the long or short form ? SHORT// L

Do you want the requests for all surgical specialties ? YES// N

Print Requests for which Surgical Specialty ? GENERAL  
(OR WHEN NOT DEFINED BELOW) GENERAL(OOR WHEN NOT DEFINED BELOW) 50

Print the Requests on which Device: HOME// [Select Print Device]

-----printout follows-----

=====

OPERATION REQUESTS FOR GENERAL(OOR WHEN NOT DEFINED BELOW)  
ON MAR 15, 1999

-----

Patient: CALIFORNIA,JAMES ID #: 123-45-6789  
Age: 51 Ward: NOT ENTERED

Surgeon: TOPEKA,MARK Attending: TOPEKA,MARK  
Preoperative Diagnosis: CHOLELITHIASIS

Principal Procedure: CHOLECYSTECTOMY  
Other Procedures: INTRAOPERATIVE CHOLANGIOGRAM  
Estimated Case Length: 2:30

Req. Anesthesia Technique: GENERAL  
Blood Requested: CPDA-1 WHOLE BLOOD UNITS  
FRESH FROZEN PLASMA, CPDA-1 2 UNITS  
Restraints: SAFETY STRAP  
Requested by: TAMPA,JAN on JAN 7, 1999 13:45

Press <Enter> to continue, or '^' to quit: <Enter>

=====

OPERATION REQUESTS FOR GENERAL(OOR WHEN NOT DEFINED BELOW)  
ON MAR 15, 1999

-----

Patient: KANSAS,THOMAS ID #: 123-45-6789  
Age: 40 Ward: 1 SOUTH

Surgeon: TULSA,LARRY Attending: TULSA,LARRY  
Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA

Principal Procedure: REPAIR DIAPHRAGMATIC HERNIA  
Estimated Case Length: 2:00

Req. Anesthesia Technique: GENERAL  
Blood Requested: CPDA-1 WHOLE BLOOD 2 UNITS  
Restraints: SAFETY STRAP  
Requested by: TAMPA,JAN on JAN 13, 1999 14:39

Press RETURN to continue <Enter>

## Requests by Ward [SROWRQ]

Users can utilize the *Requests by Ward* option to print request information for patients in all wards or a specific ward. The first prompt asks if the user wants to print the requests for all wards. If not, accept the **NO** default and the next prompt will ask "Print schedule for which ward?". If the user enters a question mark (?), the help screen will list the ward names from which to choose. Patients not assigned to a ward are listed under the category "Outpatient."

This report prints in an 80-column format and can be viewed on the screen.

### Example: Print Requests by Ward

```
Select Request Operations Option:  WR  Requests by Ward
```

```
Do you wish to print the requests for all wards ?  NO// Y
```

```
Print Requests on which Device:  [Select Print Device]
```

-----printout follows-----

#### Requests for Operations

Ward: 1 SOUTH

```
=====
Patient: KANSAS,THOMAS (123-45-6789)           Case Number: 180
Date of Operation:    03/15/99           Case Order:
Requested Anesthesia: GENERAL
Operation(s): REPAIR DIAPHRAGMATIC HERNIA
```

Comments:

Press RETURN to continue or '^' to quit. <Enter>

#### Requests for Operations

Ward: 2 WEST

```
=====
Patient: IDAHO,PETER (123-45-6789)           Case Number: 178
Date of Operation:    03/15/99           Case Order: 1
Requested Anesthesia: GENERAL
Operation(s): CAROTID ARTERY ENDARTERECTOMY
```

Comments:

```
Concurrent Case Number: 179
Procedure: AORTO CORONARY BYPASS GRAFT
```

Comments:

```
=====
Patient: IDAHO,PETER (123-45-6789)           Case Number: 179
Date of Operation:    03/15/99           Case Order: 1
Requested Anesthesia: GENERAL
Operation(s): AORTO CORONARY BYPASS GRAFT
```

Comments:

```
Concurrent Case Number: 178
Procedure: CAROTID ARTERY ENDARTERECTOMY
```

Comments:

Press RETURN to continue or '^' to quit. <Enter>

Requests for Operations

Ward: OUTPATIENT

Patient: NEBRASKA,NICK (123-45-6789) Case Number: 172  
Date of Operation: 03/25/99 Case Order:  
Requested Anesthesia:  
Operation(s): HEMMORHOIDECTOMY

Comments:

Patient: CALIFORNIA,JAMES (123-45-6789) Case Number: 173  
Date of Operation: 03/15/99 Case Order:  
Requested Anesthesia: GENERAL  
Operation(s): CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM

Comments:

Patient: MINNESOTA,RONALD (123-45-6789) Case Number: 175  
Date of Operation: 03/14/99 Case Order:  
Requested Anesthesia: LOCAL  
Operation(s): REMOVE BUNION

Comments:

# List Operation Requests

[SRSRBS]

Users can use the *List Operation Requests* option to produce a list of requested cases, including cases on the Waiting List. This report sorts by ward or surgical specialty.

This report prints in an 80-column format and can be viewed on the screen.

## Example 1: List Operation Requests, by Specialty

```
Select Surgery Menu Option:  LR  List Operation Requests

List requests by SPECIALTY or WARD ?  SPECIALTY// <Enter>

Do you want requests for all surgical specialties ? YES// N

List Request for which Specialty ?  GENERAL  (OR WHEN NOT DEFINED BELOW)  GENERA
L(OR WHEN NOT DEFINED BELOW)          50

Print to Device: [Select Print Device]
```

-----printout follows-----

Operative Requests for GENERAL(OR WHEN NOT DEFINED BELOW)

Date	Patient	Ward Location
Case Number	Operative Procedure	
APR 4, 1999	KENTUCKY, KENNETH	1 SOUTH
180	123-45-6789 REMOVE MOLE	
JUN 1, 1999	MICHIGAN, MATTHEW	1 SOUTH
178	123-45-6789 REPAIR DIAPHRAGMATIC HERNIA	
AUG 15, 1999	HAWAII, LOU	1 NORTH
145	123-45-6789 CHOLECYSTECTOMY	

Press RETURN to continue

## Example 2: List Operation Requests, by Ward

Select Surgery Menu Option: **LR** List Operation Requests

List requests by SPECIALTY or WARD ? SPECIALTY// **WARD**

Do you want requests for all wards ? YES// **N**

Select Requests for which Ward ? **1 SOUTH**

Print the Report on which Device: HOME// **[Select Print Device]**

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

### Operative Requests for 1 SOUTH

Date	Patient	Surgical Specialty
Case Number	Operative Procedure	
APR 4, 1999	KENTUCKY, KENNETH	ORTHOPEDICS
179	123-45-6789	
	ARTHROSCOPY, RIGHT KNEE	
APR 4, 1999	MONTANA, JOHNNY	GENERAL
180	123-45-6789	
	REMOVE MOLE	
JUN 1, 1999	MICHIGAN, MATTHEW	GENERAL
178	123-45-6789	
	REPAIR DIAPHRAGMATIC HERNIA	
JUN 1, 1999	IDAHO, PETER	PERIPHERAL VASCULAR
181	123-45-6789	
	CAROTID ARTERY ENDARTERECTOMY	
JUN 1, 1999	HAWAII, LOU	THORACIC SURGERY
182	123-45-6789	
	AORTO CORONARY BYPASS GRAFT	

Press RETURN to continue

# Schedule Operations

## [SROSCHOP]

The options contained within the *Schedule Operations* menu are designed to be used by surgeons or the Scheduling Manager to book an operation when the date, time, and operating room are determined. The scheduling manager may schedule an already requested operation using the *Schedule Requested Operation* option. On the other hand, the scheduling manager may book an operation that has not been previously requested if the date, time and operating room are known. In this case, the *Request Operations* option can be skipped and the operation can be scheduled using the *Schedule Unrequested Operations* option.



This option is locked with the SROSCH key.

Whether a user is booking a case from the Waiting List, *Request Menu*, *Scheduling Menu*, or as a new surgery, he or she will be asked to provide preoperative information about the case. It is advisable to enter as much information as possible. Later, the information can be updated.

The information gathered by the *Request Operations* options is collated by the software and used to produce reports. The person in charge of scheduling (scheduling manager) arranges the requests according to the hospital's Surgical Service protocols and schedules the operation by assigning the case an operating room and a time slot. The information gathered by the *Schedule Operations* menu is collated by the software and is used to produce reports for the scheduling manager.



---

Local restrictions can be applied to the scheduling of procedures. For example, a facility can require CPT codes be entered before a surgical case is scheduled. The *Surgery Site Parameters* (Enter/Edit) option is used to select required fields.

---

The options included in the *Schedule Operation* menu are listed below. To the left of the option name is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
A	<i>Display Availability</i>
SR	<i>Schedule Requested Operations</i>
SU	<i>Schedule Unrequested Operations</i>
CON	<i>Schedule Unrequested Concurrent Cases</i>
R	<i>Reschedule or Update Scheduled Operations</i>
C	<i>Cancel Scheduled Operation</i>
UC	<i>Update Cancellation Reason</i>
AN	<i>Schedule Anesthesia Personnel</i>
B	<i>Create Service Blockout</i>
DB	<i>Delete Service Blockout</i>
S	<i>Schedule of Operations</i>

## Display Availability [SRODISP]

A user can view the availability of operating rooms on a blackout graph before booking an operation with the *Display Availability* option. A user might also use this option to check a booking or service blackout. This feature is the same as the *Display Availability* option available on the *Request Operations* menu option.

Scheduled operations show up on the graph as an equal sign (=) followed by the letter X. The equal sign before the X indicates the beginning of a scheduled operation. Surgical specialty blockouts are indicated by an abbreviation for the service. For more information on service blockouts, a function of the scheduling menu, see the *Create Service Blockout* option.

If the facility has a display terminal that can print condensed characters, a 24-hour graph will display on the screen. If not, the user will be prompted to select one of three graphs representing different chunks of that day.

### Example: Display all O.R.s for One Day

```
Select Schedule Operations Option: A Display Availability
Do you want to view all Operating Rooms on one day ? YES // <Enter>
Do you want to list requests also ? NO// <Enter>
Display Operating Room Availability for which Date ? T (JUL 01, 1999)

Display of Available Operating Room Time
1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availability (12:00 PM - 12:00 AM)
4. Do Not Display Availability
Select Number: 2// <Enter>

ROOM  6AM  7    8    9    10   11   12   13   14   15   16   17   18   19   20
OR1   |____|uro.|uro.|uro.|uro.|uro.|uro.|uro.|uro.|uro.|____|____|____|____|____|
OR2   |____|card|card|card|card|card|card|card|card|card|card|____|____|____|____|
OR3   |____|thor|thor|thor|thor|thor|thor|thor|thor|thor|____|____|____|____|
OR4   |____|gen.|gen.|gen.|gen.|gen.|gen.|gen.|gen.|gen.|____|____|____|____|
OR5   |____|=XXX|XXXX|=XXX|XXXX|____|____|____|____|____|____|____|____|

Press RETURN to continue
```

## Schedule Requested Operation [SRSCHD1]

Users utilize the *Schedule Requested Operation* option to schedule a previously requested operation when enough information is available to assign an operating room and time slot. The user will also be prompted to provide anesthesia personnel information. The information entered here is reflected in the Schedule of Operations report. This option is designed for the scheduling manager to expeditiously schedule any or all requests on a specific date.

First, the user enters the patient to be scheduled. The software will automatically display all requests for that patient. The user then picks the request he or she wishes to schedule and assigns the operating room, beginning and end times, and anesthesia personnel for the case. The user can then choose another patient to schedule, or press the <Enter> key to leave the option.

The prompts that require a response before the user can continue with this option include the following.

"Schedule a Case for which Operating Room ?"

"Reserve from what time ? (24HR:NEAREST 15 MIN):"

"Reserve to what time ? (24HR:NEAREST 15 MIN):"

### Scheduling a Concurrent Case

A concurrent case occurs when a patient undergoes two operations by different surgical specialties simultaneously, or back-to-back in the same operating room. Example 2 demonstrates scheduling a requested concurrent case. When a user schedules a concurrent case, he or she must answer the prompt "There is a concurrent case associated with this operation. Do you want to schedule it for the same time? (Y/N) ". If the answer is **NO**, the two cases will no longer be considered concurrent. The user can enter anesthesia personnel information for each case.



The user should allow enough time for **both** surgeries when he or she answers the prompts, "Reserve from what time ? (24HR:NEAREST 15 MIN):" and "Reserve to what time ? (24HR:NEAREST 15 MIN):".

---

### Example 1: Schedule a Requested Operation

Select Schedule Operations Option: **SR** Schedule Requested Operations

Select Patient: **MISSOURI,ROY** 04-04-30 123456789

The following case is requested for MISSOURI,ROY:

1. 04-24-99 CHOLECYSTECTOMY

Case Information:

CHOLECYSTECTOMY

By TULSA,LARRY

Case # 210

On MISSOURI,ROY

For 1:00 Hours

Comments:

Is this the correct operation ? YES// **<Enter>**

Display of Available Operating Room Time

1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availability (12:00 PM - 12:00 AM)
4. Do Not Display Availability

Select Number: 2// **<Enter>**

ROOM	6AM	7	8	9	10	11	12	13	14	15	16	17	18	19	20
OR1									gen.	gen.	gen.				
OR2		card													
OR3															
OR4															
OR5															

Schedule a Case for which Operating Room ? **OR1**

Reserve from what time ? (24HR:NEAREST 15 MIN): **7:00**

Reserve to what time ? (24HR:NEAREST 15 MIN): **8:00**

Principal Anesthetist: **PHOENIX,SALLY**

Anesthesiologist Supervisor: **AUGUSTA,DON**

Select Patient:

## Example 2: Schedule Operation for a Concurrent Case

Select Schedule Operations Option: **SR** Schedule Requested Operations

Select Patient: **GEORGIA, PAUL** 09-14-54 123456789

The following cases are requested for GEORGIA, PAUL:

1. 07-06-99 CAROTID ARTERY ENDARTERECTOMY
2. 07-06-99 AORTO CORONARY BYPASS GRAFT

Select Operation Request: **1**

Case Information:

CAROTID ARTERY ENDARTERECTOMY

By TOPEKA, MARK

On GEORGIA, PAUL

Case # 262

STANDBY

\* Concurrent Case # 263 AORTO CORONARY BYPASS GRAFT

Is this the correct operation ? YES// **<Enter>**

Display of Available Operating Room Time

1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availability (12:00 PM - 12:00 AM)
4. Do Not Display Availability

Select Number: 2// **<Enter>**

ROOM	6AM	7	8	9	10	11	12	13	14	15	16	17	18	19	20
OR1															
OR2		card													
OR3		orth	orth	orth	orth	orth	orth								
OR4															
OR5															

Schedule a Case for which Operating Room ? **OR2**

Reserve from what time ? (24HR:NEAREST 15 MIN): **7:15**

Reserve to what time ? (24HR:NEAREST 15 MIN): **12:30**

Principal Anesthetist: **PHOENIX, SALLY**

Anesthesiologist Supervisor: **AUGUSTA, DON**

There is a concurrent case associated with this operation. Do you want to schedule it for the same time ? (Y/N) **Y**

Select Patient:

## Schedule Unrequested Operations [SROSRES]

Users can use the *Schedule Unrequested Operations* option to schedule an operation that has not been requested. To schedule an operation, the user must determine the date, time, and operating room. The information entered in this option is reflected in the Schedule of Operations Report.

Whenever a new case is booked, the user is asked to provide preoperative information about the case. Enter as much information as possible. Later, the information can be updated or corrected.

Prompts that require a response before the user can continue with this option are listed below.

"Schedule Procedure for which Date ?"

"Select Patient:"

"Schedule a case for which operating Room ?"

"Reserve from what time ? (24HR:NEAREST 15 MIN):"

"Reserve to what time ? (24HR:NEAREST 15 MIN):"

"Surgeon:"

"Surgical Specialty:"

"Principal Operative Procedure:"

"Indications for Operations:"

## Entering Preoperative Information

At this prompt:	The user should do this:
Principal Procedure Code (CPT)	Enter the Current Procedural Terminology (CPT) identifying code for each procedure. If the code number is not known, the user can enter the type of operation (i.e., appendectomy) or a body organ and select from a list of codes.
Indications for Operations	Enter the reason this procedure is being performed. This prompt must be answered before the user can continue with the option.
Brief Clinical History	Enter any information relevant to the specimens being sent to the laboratory. This is an open-text word-processing field. This information will display on the Tissue Examination Report.
Select REQ BLOOD KIND	<p>Enter the type of blood product needed for the operation.</p> <p>If no blood products are needed, do not enter <b>NO</b> or <b>NONE</b>; instead, press the &lt;Enter&gt; key to bypass this prompt.</p> <p>The package coordinator at each facility can select a default response to this prompt when installing the package. If the default product is not what is wanted for a case, it can be deleted by entering the at-sign (@) at this prompt. Then, the user can select the preferred blood product. (Enter two question marks for a list of blood products).</p> <p>To order more than one product for the same case, use the screen server summary that concludes the option. On page two of the summary, select item 7, REQ BLOOD KIND, to enter as many blood products as needed.</p>
Requested Preoperative X-Rays	Enter the types of preoperative x-ray films and reports required for delivery to the operating room before the operation. If the user does not intend to order any x-ray products, this field should be left blank.
Request Clean or Contaminated	Enter the letter code <b>C</b> for clean or <b>D</b> for contaminated, or type in the first few letters of either word. This information allows the scheduling manager to determine how much time is needed between operations for sanitizing a room.

**Example: Schedule an Unrequested Operation**

Select Schedule Operations Option: **SU** Schedule Unrequested Operations

Schedule a Procedure for which Date ? **T+5** (JUL 18, 1999)

Select Patient: **MONTANA,JOHNNY** 12-19-53 123456789

Display of Available Operating Room Time

- 1. Display Availability (12:00 AM - 12:00 PM)
- 2. Display Availability (06:00 AM - 08:00 PM)
- 3. Display Availability (12:00 PM - 12:00 AM)
- 4. Do Not Display Availability

Select Number: 2// **<Enter>**

ROOM	6AM	7	8	9	10	11	12	13	14	15	16	17	18	19	20
OR1															
OR2															
OR3															
OR4															
OR5															

Schedule a case for which operating Room ? **OR1**

Reserve from what time ? (24HR:NEAREST 15 MIN): **8:00**

Reserve to what time ? (24HR:NEAREST 15 MIN): **13:00**

SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

MONTANA,JOHNNY (123-45-6789) JUL 18, 1999  
 =====

Surgeon: **MINNEAPOLIS,SUSAN**  
 Surgical Specialty: **54** ORTHOPEDICS ORTHOPEDICS 54  
 Principal Operative Procedure: **SHOULDER ARTHROPLASTY-PROSTHESIS**  
 Indications for Operations:  
 1>**PROGRESSIVE PAIN AND INABILITY TO MOVE THE JOINT.**  
 2>**<Enter>**  
 EDIT Option: **<Enter>**

SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

MONTANA,JOHNNY (123-45-6789) JUL 18, 1999  
 =====

Principal Anesthetist: **PHOENIX,SALLY**  
 Anesthesiologist Supervisor: **AUGUSTA,DON**

SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION

MONTANA,JOHNNY (123-45-6789) JUL 18, 1999  
 =====

Principal Procedure: **SHOULDER ARTHROPLASTY-PROSTHESIS**  
 Principal Procedure Code (CPT): **23470** ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIART  
 Brief Clinical History:  
 1>**CHRONIC DEBILITATING PAIN. X-RAY SHOWS SEVERE**  
 2>**DEGENERATIVE OSTEOARTHRITIS.**  
 3>**<Enter>**  
 EDIT Option: **<Enter>**

SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

MONTANA,JOHNNY (123-45-6789) JUL 18, 1999

=====

Request Blood Availability (Y/N): Y//<Enter> YES

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH//<Enter> TYPE & CROSSMATCH

Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// @

SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y (YES)

Select REQ BLOOD KIND: **FA1** FRESH FROZEN PLASMA, CPDA-1 18201

Units Required: **4**

SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

MONTANA,JOHNNY (123-45-6789) JUL 18, 1999

=====

Principal Preoperative Diagnosis: **DEGENERATIVE JOINT DISEASE, L SHOULDER**

Principal Diagnosis Code (ICD9): **715.11** 715.11 LOC PRIM OSTEOART-SHLDER

...OK? YES// <Enter> (YES)

Hospital Admission Status: I// <Enter> INPATIENT

Case Schedule Type: **S** STANDBY

First Assistant: **RR** RALEIGH,RICHARD

Second Assistant: **RICHMOND**,ARTHUR

Attending Surgeon: **TULSA,LARRY**

Requested Postoperative Care: **W** WARD

Case Schedule Order: **1**

Requested Anesthesia Technique: **G** GENERAL

Request Frozen Section Tests (Y/N): **N** NO

Requested Preoperative X-Rays: **LEFT SHOULDER**

Intraoperative X-Rays (Y/N/C): **Y** YES

Request Medical Media (Y/N): **N** NO

Request Clean or Contaminated: **C** CLEAN

GENERAL COMMENTS:

1><Enter>

SPD Comments:

1><Enter>

\*\* SCHEDULING \*\* CASE #264 MONTANA,JOHNNY PAGE 1 OF 2

1 PRINCIPAL PROCEDURE: SHOULDER ARTHROPLASTY-PROSTHESIS  
 2 PRINCIPAL PROCEDURE CODE: 23470  
 3 OTHER PROCEDURES: (MULTIPLE)  
 4 PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER  
 5 PRIN DIAGNOSIS CODE: 715.11  
 6 OTHER PREOP DIAGNOSIS: (MULTIPLE)  
 7 IN/OUT-PATIENT STATUS: INPATIENT  
 8 PRE-ADMISSION TESTING:  
 9 CASE SCHEDULE TYPE: STANDBY  
 10 SURGERY SPECIALTY: ORTHOPEDICS  
 11 SURGEON: MINNEAPOLIS,SUSAN  
 12 FIRST ASST: RALEIGH,RICHARD  
 13 SECOND ASST: RICHMOND,ARTHUR  
 14 ATTEND SURG: TULSA,LARRY  
 15 REQ POSTOP CARE: WARD

Enter Screen Server Function: <Enter>

1    CASE SCHEDULE ORDER: 1  
2    REQ ANESTHESIA TECHNIQUE: GENERAL  
3    REQ FROZ SECT:            NO  
4    REQ PREOP X-RAY:        LEFT SHOULDER  
5    INTRAOPERATIVE X-RAYS: YES  
6    REQUEST BLOOD AVAILABILITY: YES  
7    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH  
8    REQ BLOOD KIND:        (MULTIPLE)(DATA)  
9    REQ PHOTO:              NO  
10    REQ CLEAN OR CONTAMINATED: CLEAN  
11    PRINC ANESTHETIST:    PHOENIX,SALLY  
12    ANESTHESIOLOGIST SUPVR: AUGUSTA,DON  
13    BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)  
14    GENERAL COMMENTS:    (WORD PROCESSING)  
15    SPD COMMENTS:        (WORD PROCESSING)

Enter Screen Server Function:

## Schedule Unrequested Concurrent Cases [SRSCHDC]

The *Schedule Unrequested Concurrent Cases* option is used to schedule concurrent cases that have not been requested. A concurrent case is when a patient undergoes two operations by different surgical specialties simultaneously, or back to back in the same room. The user can schedule both cases with this one option. As usual, whenever the user enters a request, he or she is asked to provide preoperative information about the case. It is best to enter as much information as possible and update it later if necessary.

### Required Prompts

After the patient name is entered, the user will be prompted to enter some required information about the first case. The mandatory prompts include the date, procedures, surgeon, indications for operation, and time needed. If a mandatory prompt is not answered, the software will not book the operation and will return the cursor to the *Schedule Operations* menu. After answering the prompts for the first case, the user will be asked to answer the same prompts for the second case. The software will then provide a message stating that the two requests have been entered. The user can then select a case for entering detailed preoperative information. If the user does not want to enter details at this time, he or she should press the <Enter> key and the cursor will return to the *Schedule Operations* menu. In the example, detailed information for the first case has been entered.

### Storing the Request Information

After every prompt or group of related prompts, the software will ask if the user wants to store (meaning duplicate) the answers in the concurrent case. This saves time by storing the information into the other case so that it does not have to be typed again. The software will then display the screen server summary and store any duplicated information into the other case. Finally, the software will inform the user that the two requests have been entered and prompt to select either case for entering detailed information. The user can select a case or press the <Enter> key to get back to the *Schedule Operations* menu.

## Updating the Preoperative Information Later

Use the *Reschedule or Update a Scheduled Operation* option to change or update any of the information entered for either of the concurrent cases.

### Example: Schedule Unrequested Concurrent Cases

```
Select Schedule Operations Option: CON Schedule Unrequested Concurrent Cases
Schedule Concurrent Cases for which Patient ? NEVADA,NORMAN 06-04-20
123456789
Schedule Concurrent Procedures for which Date ? T+12 (JUL 25, 1999)

Display of Available Operating Room Time
1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availability (12:00 PM - 12:00 AM)
4. Do Not Display Availability

Select Number: 2// 4

Schedule a case for which operating Room ? OR2

Reserve from what time ? (24HR:NEAREST 15 MIN): 11:15 (11:15)
Reserve to what time ? (24HR:NEAREST 15 MIN): 16:00 (16:00)
```

```

FIRST CONCURRENT CASE
SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

NEVADA,NORMAN (123-45-6789) JUL 25, 1999
=====
Surgeon: TOPEKA,MARK
Surgical Specialty: 62 PERIPHERAL VASCULAR PERIPHERAL VASCULAR 62

Principal Operative Procedure: CAROTID ARTERY ENDARTERECTOMY
Indications for Operations:
1>UNSTABLE ANGINA
2><Enter>
EDIT Option:<Enter>
```

```

SECOND CONCURRENT CASE
SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

NEVADA,NORMAN (123-45-6789) JUL 25, 1999
=====
Surgeon: TULSA,LARRY
Surgical Specialty: 58 THORACIC SURGERY (INC. CARDIAC SURG.) THORACIC
SURGERY (INC. CARDIAC SURG.) 58
Principal Operative Procedure: AORTO CORONARY BYPASS GRAFT
Indications for Operations:
1>UNSTABLE ANGINA.
2><Enter>
EDIT Option: <Enter>
```



FIRST CONCURRENT CASE  
SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

NEVADA,NORMAN (123-45-6789) JUL 25, 1999  
=====

Principal Preoperative Diagnosis: **CAROTID ARTERY STENOSIS**  
Principal Diagnosis Code (ICD9): **433.11** OCCL&STEN/CAR ART W/CRB INF  
COMPLICATION/COMORBIDI  
TY ACTIVE  
Hospital Admission Status: I// **<Enter>** INPATIENT

Do you want to store this information in the concurrent case ? YES// **N**

Case Schedule Type: **S** STANDBY

Do you want to store this information in the concurrent case ? YES// **<Enter>**

First Assistant: **RICHMOND,ARTHUR**  
Second Assistant: **RR RALEIGH,RICHARD**  
Attending Surgeon: **TOPEKA,MARK**  
Requested Postoperative Care: **SICU**

Do you want to store this information in the concurrent case ? YES// **N**

Case Schedule Order: **2**

Do you want to store this information in the concurrent case ? YES// **N**

Requested Anesthesia Technique: **G** GENERAL

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Request Frozen Section Tests (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Requested Preoperative X-Rays: **DOPPLER STUDIES**

Do you want to store this information in the concurrent case ? YES// **N**

Intraoperative X-Rays (Y/N/C): **N** NO

Do you want to store this information in the concurrent case ? YES// **N**

Request Medical Media (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES// **Y**

Request Clean or Contaminated: **C** CLEAN

Do you want to store this information in the concurrent case ? YES// **<Enter>**

GENERAL COMMENTS:

1>**<Enter>**

SPD Comments:

1>**<Enter>**

The information to be duplicated in the concurrent case will now be entered....

Press RETURN to continue **<Enter>**

```
** SCHEDULING **      CASE #265  NEVADA,NORMAN      PAGE 1 OF 2

1  PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2  PRINCIPAL PROCEDURE CODE: 35301
3  OTHER PROCEDURES: (MULTIPLE)
4  PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5  PRIN DIAGNOSIS CODE: 433.1
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  IN/OUT-PATIENT STATUS: INPATIENT
8  PRE-ADMISSION TESTING:
9  CASE SCHEDULE TYPE: STANDBY
10 SURGERY SPECIALTY: PERIPHERAL VASCULAR
11 SURGEON: TOPEKA,MARK
12 FIRST ASST: RICHMOND,ARTHUR
13 SECOND ASST: RALEIGH,RICHARD
14 ATTEND SURG: TOPEKA,MARK
15 REQ POSTOP CARE: SICU

Enter Screen Server Function: <Enter>
```

```
** SCHEDULING **      CASE #265  NEVADA,NORMAN      PAGE 2 OF 2

1  CASE SCHEDULE ORDER: 2
2  REQ ANESTHESIA TECHNIQUE: GENERAL
3  REQ FROZ SECT: NO
4  REQ PREOP X-RAY: DOPPLER STUDIES
5  INTRAOPERATIVE X-RAYS: NO
6  REQUEST BLOOD AVAILABILITY: YES
7  CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8  REQ BLOOD KIND: (MULTIPLE)(DATA)
9  REQ PHOTO: NO
10 REQ CLEAN OR CONTAMINATED: CLEAN
11 PRINC ANESTHETIST: PHOENIX,SALLY
12 ANESTHESIOLOGIST SUPVR: AUGUSTA,DON
13 BRIEF CLIN HISTORY: (WORD PROCESSING)
14 GENERAL COMMENTS: (WORD PROCESSING)
15 SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:
```

## Reschedule or Update a Scheduled Operation [SRSCHUP]

The *Reschedule or Update a Scheduled Operation* option has three uses: 1) to add a concurrent case, 2) to reschedule an operation for another date, time, and/or operating room, 3) to update the preoperative information that was entered earlier.

### **Adding a Concurrent Case (See Example 1)**

After the case is selected, the software will ask whether the user wishes to add a concurrent case. If the response is **YES**, the software will prompt for information on the second case. To add the case, the user must enter a principal operative procedure, a surgical specialty, and the indications for operations. The software will then inform the user that the case has been added. The user can then select another case or the same case for entering detailed preoperative information, or the user can press the **<Enter>** key to return to the *Schedule Operations* menu.

### **Changing the Date, Time, or Operating Room (See Example 2)**

If a user does not wish to add a concurrent case, the software will prompt to change the date, time or operating room. If the user enters **YES**, the software will erase the old date, time, and operating room and prompt to re-enter this information. The user will be prompted to select a new date, but if the **<Enter>** key is pressed, the software will default to the original date and allow the user to change the room and time. The software supplies a blockout graph to help with rescheduling.



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.

---

### **Updating the Preoperative Info (See Example 3)**

To update the preoperative information that was entered earlier, the user should respond **NO** to the prompt asking if the user wishes to change the date, time or operating room. The terminal display screen will clear and present a two-page Screen Server summary. Any of the data fields may be changed, as in Example 2.



Example 3 also shows the user how to order more than one blood product for a case.

---

### Example 1: How to Add a Concurrent Case to a Scheduled Operation

Select Schedule Operations Option: **R** Reschedule or Update a Scheduled Operation

Select Patient: **MISSOURI,ROY** 04-04-30 123456789  
MISSOURI,ROY (123-45-6789)

1. 09/16/98 CARPAL TUNNEL RELEASE (SCHEDULED)
2. 02/02/99 BUNIONECTOMY (SCHEDULED)

Select Number: **1**

Do you want to add a concurrent case ? NO// **Y**

SECOND CONCURRENT CASE  
SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

MISSOURI,ROY (123-45-6789) SEP 16, 1998  
=====

Surgeon: **TULSA,LARRY**  
Surgical Specialty: **54** ORTHOPEDICS ORTHOPEDICS 54  
Principal Operative Procedure: **ARTHROSCOPY, R SHOULDER**  
Indications for Operations:  
1>**PROGRESSIVE PAIN AND INABILITY TO MOVE THE JOINTS.**  
2>**X-RAYS ARE CONCLUSIVE.**  
3> **<Enter>**  
EDIT Option: **<Enter>**

SECOND CONCURRENT CASE  
SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

MISSOURI,ROY (123-45-6789) SEP 16, 1998  
=====

Principal Anesthetist: **PHOENIX,SALLY**  
Anesthesiologist Supervisor: **AUGUSTA,DON**

SECOND CONCURRENT CASE  
SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION

MISSOURI,ROY (123-45-6789) SEP 16, 1998  
=====

Principal Procedure: **ARTHROSCOPY, R SHOULDER**  
Principal Procedure Code (CPT): **23470** RECONSTRUCT SHOULDER JOINT  
**ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIARTHROPLASTY ACTIVE**  
Modifier: **<Enter>**  
Select OTHER PROCEDURE: **<Enter>**  
Brief Clinical History:  
1>**CHRONIC DEBILITATING PAIN. X-RAY SHOWS SEVERE**  
2>**DEGENERATIVE OSTEOARTHRITIS.**  
3>**<Enter>**  
EDIT Option: **<Enter>**

SECOND CONCURRENT CASE  
SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

MISSOURI,ROY (123-45-6789) SEP 16, 1998  
=====

Request Blood Availability ? YES// **<Enter>**  
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH// **<Enter>** TYPE & CROSSMATCH  
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// **FA1** FRESH FROZEN PLASMA, CPDA-1  
18201  
Units Required: **2**

SECOND CONCURRENT CASE  
SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

MISSOURI,ROY (123-45-6789)

SEP 16, 1998

Principal Preoperative Diagnosis: **DEGENERATIVE OSTEOARTHRTIS**  
Principal Diagnosis Code (ICD9): **715.90** 715.90      OSTEOARTHROS NOS-UNSPEC  
ACTIVE

...OK? Yes// **<Enter>** (Yes)  
(Hospital Admission Status: I// **<Enter>** INPATIENT

Do you want to store this information in the concurrent case ? YES// **N**

Case Schedule Type: **S** STANDBY

Do you want to store this information in the concurrent case ? YES// **N**

First Assistant: **RR** RALEIGH,RICHARDETTE  
Second Assistant: **<Enter>**  
Attending Surgeon: **TULSA,LARRY**  
Requested Postoperative Care: **WARD**

Do you want to store this information in the concurrent case ? YES// **N**

Case Schedule Order: **1**

Do you want to store this information in the concurrent case ? YES// **N**

Requested Anesthesia Technique: **GENERAL**

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Request Frozen Section Tests (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Requested Preoperative X-Rays: **<Enter>**  
Intraoperative X-Rays (Y/N): **Y** YES

Do you want to store this information in the concurrent case ? YES// **N**

Request Medical Media (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Request Clean or Contaminated: **C** CLEAN

Do you want to store this information in the concurrent case ? YES// **<Enter>**

GENERAL COMMENTS:

1> **<Enter>**  
SPD Comments:  
1>**<Enter>**

The information to be duplicated in the concurrent case will now be entered....

```
** SCHEDULING **      CASE #245  MISSOURI,ROY      PAGE 1 OF 2

1  PRINCIPAL PROCEDURE: ARTHROSCOPY, R SHOULDER
2  PRINCIPAL PROCEDURE CODE: 23470
3  OTHER PROCEDURES:      (MULTIPLE)
4  PRINCIPAL PRE-OP DIAGNOSIS: DEGERATIVE OSTEOARTHRITIS
5  PRIN DIAGNOSIS CODE: 715.90
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  IN/OUT-PATIENT STATUS: INPATIENT
8  PRE-ADMISSION TESTING:
9  CASE SCHEDULE TYPE:   STANDBY
10 SURGERY SPECIALTY:   ORTHOPEDICS
11 SURGEON:             TULSA,LARRY
12 FIRST ASST:         RALEIGH,RICHARDETTE
13 SECOND ASST:
14 ATTEND SURG:        TULSA,LARRY
15 REQ POSTOP CARE:    WARD

Enter Screen Server Function:  <Enter>
```

```
** SCHEDULING **      CASE #245  MISSOURI,ROY      PAGE 2 OF 2

1  CASE SCHEDULE ORDER: 1
2  REQ ANESTHESIA TECHNIQUE: GENERAL
3  REQ FROZ SECT:       NO
4  REQ PREOP X-RAY:
5  INTRAOPERATIVE X-RAYS: YES
6  REQUEST BLOOD AVAILABILITY: YES
7  CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8  REQ BLOOD KIND:      (MULTIPLE)(DATA)
9  REQ PHOTO:           NO
10 REQ CLEAN OR CONTAMINATED: CLEAN
11 PRINC ANESTHETIST:   PHOENIX,SALLY
12 ANESTHESIOLOGIST SUPVR: AUGUSTA,DON
13 BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)
14 GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

```
The following cases have been entered.

1. Case # 224                               SEP 16, 1998
   Surgeon: TOPEKA,MARK                     NEUROSURGERY
   Procedure:  CARPAL TUNNEL RELEASE

2. Case # 245                               SEP 16, 1998
   Surgeon: TULSA,LARRY                     ORTHOPEDICS
   Procedure:  ARTHROSCOPY, R SHOULDER

1. Enter Information for Case #224
2. Enter Information for Case #245

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

## Example 2: How to Reschedule an Operation, Change the Date, Time, or Operating Room

Select Schedule Operations Option: **R** Reschedule or Update a Scheduled Operation

Select Patient: **MONTANA,JOHNNY** 12-19-53 123456789

MONTANA,JOHNNY (123-45-6789)

1. 09/15/98 SHOULDER ARTHROPLASTY-PROTHESIS (SCHEDULED)

Select Number: **1**

Do you want to add a concurrent case ? NO// **<Enter>**

Do you want to change the date/time or operating room for which this case is scheduled ? NO// **Y**

Operating Room Reservations:

Surgeon: TOPEKA,MARK

Patient: MONTANA,JOHNNY

Procedure(s): SHOULDER ARTHROPLASTY-PROTHESIS

Operating Room: OR3

Scheduled Start: SEP 15, 1998 08:00

Scheduled End: SEP 15, 1998 13:00

Reschedule this Procedure for which Date ? **<Enter>**

Since no date has been entered, I must assume that you want to re-schedule this case for the same date. If you have made a mistake and want to leave this case scheduled for the same operating room at the same times, enter RETURN when prompted to select an operating room.

Press RETURN to continue **<Enter>**

Display of Available Operating Room Time

1. Display Availability (12:00 AM - 12:00 PM)

2. Display Availability (06:00 AM - 08:00 PM)

3. Display Availability (12:00 PM - 12:00 AM)

4. Do Not Display Availability

Select Number: 2// **4**

Schedule this case for which Operating Room: **OR3**

Reserve from what time ? (24HR:NEAREST 15 MIN): **7:30**

Reserve to what time ? (24HR:NEAREST 15 MIN): **13:00**

Principal Anesthetist: PHOENIX,SALLY//**<Enter>**

Anesthesiologist Supervisor: AUGUSTA,DON// **<Enter>**

### Example 3: How to Update a Scheduled Operation

Select Schedule Operations Option: **R** Reschedule or Update a Scheduled Operation

Select Patient: **MONTANA,JOHNNY** 12-19-53 123456789

MONTANA,JOHNNY (123-45-6789)

1. 09/15/98 SHOULDER ARTHROPLASTY-PROTHESIS (SCHEDULED)

Select Number: **1**

Do you want to add a concurrent case ? NO// **<Enter>**

Do you want to change the date/time or operating room for which this case is scheduled ? NO// **<Enter>**

\*\* SCHEDULING \*\* CASE #218 MONTANA,JOHNNY PAGE 1 OF 2

1 PRINCIPAL PROCEDURE: SHOULDER ARTHROPLASTY-PROSTHESIS  
2 PRINCIPAL PROCEDURE CODE: 23470  
3 OTHER PROCEDURES: (MULTIPLE)  
4 PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER  
5 PRIN DIAGNOSIS CODE: 715.11  
6 OTHER PREOP DIAGNOSIS: (MULTIPLE)  
7 IN/OUT-PATIENT STATUS: INPATIENT  
8 PRE-ADMISSION TESTING:  
9 CASE SCHEDULE TYPE: STANDBY  
10 SURGERY SPECIALTY: ORTHOPEDICS  
11 SURGEON: TOPEKA,MARK  
12 FIRST ASST: TULSA,LARRY  
13 SECOND ASST: RICHMOND,ARTHUR  
14 ATTEND SURG: TOPEKA,MARK  
15 REQ POSTOP CARE: WARD

Enter Screen Server Function: **<Enter>**

\*\* SCHEDULING \*\* CASE #218 MONTANA,JOHNNY PAGE 2 OF 2

1 CASE SCHEDULE ORDER: 1  
2 REQ ANESTHESIA TECHNIQUE: GENERAL  
3 REQ FROZ SECT: NO  
4 REQ PREOP X-RAY: LEFT SHOULDER  
5 INTRAOPERATIVE X-RAYS: YES  
6 REQUEST BLOOD AVAILABILITY: YES  
7 CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH  
8 REQ BLOOD KIND: (MULTIPLE)(DATA)  
9 REQ PHOTO: NO  
10 REQ CLEAN OR CONTAMINATED: CLEAN  
11 PRINC ANESTHETIST: PHOENIX,SALLY  
12 ANESTHESIOLOGIST SUPVR: AUGUSTA,DON  
13 BRIEF CLIN HISTORY: (WORD PROCESSING)  
14 GENERAL COMMENTS: (WORD PROCESSING)  
15 SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function: **8**

```
** SCHEDULING ** CASE #218 MONTANA,JOHNNY PAGE 1
    REQ BLOOD KIND

1  REQ BLOOD KIND:      FRESH FROZEN PLASMA, CPDA-1
2  NEW ENTRY

Enter Screen Server Function:  2
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD      00160
    REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// <Enter>
```

```
** SCHEDULING ** CASE #218 MONTANA,JOHNNY PAGE 1
    REQ BLOOD KIND (CPDA-1 WHOLE BLOOD)

1  REQ BLOOD KIND:      CPDA-1 WHOLE BLOOD
2  UNITS REQ:

Enter Screen Server Function:  2
Units Required:  2
```

```
** SCHEDULING ** CASE #218 MONTANA,JOHNNY PAGE 1 OF 1
    REQ BLOOD KIND (CPDA-1 WHOLE BLOOD)

1  REQ BLOOD KIND:      CPDA-1 WHOLE BLOOD
2  UNITS REQ:          2

Enter Screen Server Function:  <Enter>
```

```
** SCHEDULING ** CASE #218 MONTANA,JOHNNY PAGE 1 OF 1
    REQ BLOOD KIND

1  REQ BLOOD KIND:      FRESH FROZEN PLASMA, CPDA-1
2  REQ BLOOD KIND:      CPDA-1 WHOLE BLOOD
3  NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
** SCHEDULING ** CASE #218 MONTANA,JOHNNY PAGE 2 OF 2

1  CASE SCHEDULE ORDER: 1
2  REQ ANESTHESIA TECHNIQUE: GENERAL
3  REQ FROZ SECT:      NO
4  REQ PREOP X-RAY:    LEFT SHOULDER
5  INTRAOPERATIVE X-RAYS: YES
6  REQUEST BLOOD AVAILABILITY: YES
7  CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8  REQ BLOOD KIND:      (MULTIPLE)(DATA)
9  REQ PHOTO:          NO
10 REQ CLEAN OR CONTAMINATED: CLEAN
11 PRINC ANESTHETIST:   PHOENIX,SALLY
12 ANESTHESIOLOGIST SUPVR: AUGUSTA,DON
13 BRIEF CLIN HISTORY: (WORD PROCESSING)
14 GENERAL COMMENTS:   (WORD PROCESSING)
15 SPD COMMENTS:      (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

## Cancel Scheduled Operation [SRSCAN]

When a scheduled operation is cancelled, the *Cancel Scheduled Operation* option will remove that case from the list of scheduled operations. If cancellation occurs before the schedule close time and is not rescheduled, it will be changed to a Request and will eventually be removed from the system. If cancellation occurs after the schedule close time, the case will remain in the system as a cancelled case and will be used in computing the facility's cancellation rate.

Enter the patient name and select the operation to be deleted from the choices listed. The "Cancellation Reason:" prompt is a mandatory prompt. Enter a question mark for a list of cancellation reasons from which to select. If a mistake is made, or the user finds out later that the cancellation reason was not correct, the *Update Cancellation Reason* option allows the cancellation reason to be edited.

If there is a concurrent case associated with the operation being cancelled, the software will ask if the user wants to cancel it also.

### Example 1: Cancel a Single Scheduled Operation

```
Select Schedule Operations Option: C Cancel Scheduled Operation
Cancel a Scheduled Procedure for which Patient: DELAWARE,DAVID      01-01-40      123456789
YES      SC VETERAN
```

```
DELAWARE,DAVID (123-45-6789)
1. 09/12/98  FRONTAL CRANIOTOMY TO RULE OUT TUMOR (SCHEDULED)
Select Number: 1
Reservation for OR3
Scheduled Start Time: 09-12-98 11:00
Scheduled End Time: 09-12-98 13:00
Patient: DELAWARE,DAVID
Physician: HELENA,LAURIE
Procedure: FRONTAL CRANIOTOMY TO RULE OUT TUMOR
Is this the correct operation ? YES// <Enter>
Case #330 has been removed from the schedule and changed to a request.
Enter RETURN to continue or '^' to exit:
```



When a case is removed from the schedule, the Surgery software automatically changes the case to a request, and uses the original operation date as the procedure date.

---

## Example 2: Cancel a Scheduled Concurrent Case

Select Schedule Operations Option: **C** Cancel Scheduled Operation

Cancel a Scheduled Procedure for which Patient: **MISSOURI,ROY** 04-04-30  
123456789

MISSOURI,ROY (123-45-6789)

1. 09/16/98 ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)
2. 09/16/98 CARPAL TUNNEL RELEASE (SCHEDULED)

Select Number: **1**

Reservation for OR2

Scheduled Start Time: 09-16-98 08:00

Scheduled End Time: 09-16-98 13:00

Patient: MISSOURI,ROY

Physician: TULSA,LARRY

Procedure: ARTHROSCOPY, RIGHT SHOULDER

Is this the correct operation ? YES// **<Enter>**

Do you want to create a new request for this cancelled case ?? YES// **N**

There is a concurrent case associated with this operation. Do you want to  
cancel it also ? YES// **N**

## Update Cancellation Reason [SRSUPC]

The *Update Cancellation Reason* option is used to update the cancellation date and reason e previously entered for a selected surgical case.

### Example: Update Cancellation Reason

```
Select Schedule Operations Option:  UC Update Cancellation Reason
Update Cancellation Information for which Patient:  DELAWARE,DAVID      01-01-40      123456789
NSC VETERAN
1. 06-01-98  FRONTAL CRANIOTOMY TO RULE OUT TUMOR (CANCELLED)

Select Operation:  1
DELAWARE,DAVID      123-45-6789      Case # 21199
06-01-98      FRONTAL CRANIOTOMY TO RULE OUT TUMOR (CANCELLED)

Cancellation Date: JUN 01,1998@10:53//  <Enter>
Cancellation Reason: LAB TEST//  EM  EMERGENCY CASE SUPERSEDES      EM
Cancellation Avoidable: NO//  <Enter>
Press RETURN to continue  <Enter>
```

## Schedule Anesthesia Personnel [SRSCHDA]

The *Schedule Anesthesia Personnel* option allows anesthesia staff to assign, or change, anesthesia personnel for surgery cases. The scheduling manager may have already assigned some personnel to a case using other menu selections. For the user's convenience, the software will default to any previously entered data.



This option is locked with the SROANES key and will not appear on the menu if the user does not have this key.

This option is used to enter the names of the principal anesthetist, the supervisor, and anesthesia techniques for cases scheduled on a specific date. The user should first enter the date, and then select an operating room. The software will display all cases scheduled in that room. After scheduling personnel for any or all cases in one operating room, the user can do the same for other operating rooms without leaving this option.



This option also appears on the *Anesthesia* menu.

### Example: Schedule Anesthesia Personnel

```
Select Schedule Operations Option: AN Schedule Anesthesia Personnel
```

```
Schedule Anesthesia Personnel for which Date ? 8/16 (AUG 16, 1999)
```

```
Schedule Anesthesia Personnel for which Operating Room ? OR2
```

```
Scheduled Operations for OR2
```

```
-----  
Case # 5 Patient: CALIFORNIA,JAMES  
From: 07:00 To: 09:00  
HARVEST SAPHENOUS VEIN
```

```
Requested Anesthesia Technique: GENERAL// <Enter>  
Principal Anesthetist: PHOENIX,SALLY CW 112G  
Anesthesiologist Supervisor: AUGUSTA,DON GAJ
```

```
Press RETURN to continue, or '^' to quit <Enter>
```

```
Scheduled Operations for OR2
```

```
-----  
Case # 14 Patient: MONTANA,JOHNNY  
From: 13:00 To: 18:00  
SHOULDER ARTHROPLASTY
```

```
Requested Anesthesia Technique: GENERAL// <Enter>  
Principal Anesthetist: PHOENIX,SALLY// <Enter> SP 112G  
Anesthesiologist Supervisor: AUGUSTA,DON DA
```

```
Press RETURN to continue, or '^' to quit <Enter>
```

```
Would you like to continue with another operating room ? YES// <Enter>
```

```
Schedule Anesthesia Personnel for which Operating Room ? OR1
```

```
There are no cases scheduled for this operating room.
```

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

```
Would you like to continue with another operating room ? YES// N
```

## Create Service Blockout [SRSBOUT]

At times, the surgical staff may need to set aside an operating room for a particular service on a recurring basis. The *Create Service Blockout* option is used by the scheduling manager to blockout the operating room(s) on a graph.

The resulting service blockout is automatically charted on a graph that can be viewed from the *Display Availability* option. This service blockout does not restrict the operating room to the service, but can assist the scheduling manager when assigning operating rooms.

The scheduling manager can create the service blockouts by following the example provided on the following page. The required data fields are listed in the following table.

<b>At this prompt:</b>	<b>The user should do this:</b>
For what service?	Enter a three or four letter abbreviation for the surgical service the room is being reserved (for example, card for cardiology, gen for general surgery).  Do not use the letter X or an equal sign (=).
Select Operating Room	Enter the operating room name or code. The operating room must already exist in the HOSPITAL LOCATION file and the OPERATING ROOM file. The user should enter a question mark to get a list of operating rooms already included in these files. The supervisor or package coordinator can add an operating room to these files.
Select Starting Date	The user should enter the date for the blockout to begin.
Reserve from what time?	Enter the times for which this room will be blocked-out for a particular service. A room may be reserved at any time during the 24-hour cycle to the nearest 15 minutes.
Reserve to what time?	Enter the end time for the service blockout.

### Example: Create a Service Blockout

```
Select Schedule Operations Option: B Create Service Blockout

For what service ? (3-4 characters, do not use 'X' or '=') CARD
Select Operating Room: OR2

Select Starting Date: T (NOV 18, 1999)

Reserve from what time ? (24HR:NEAREST 15 MIN): 7 (07:00)
Reserve to what time ? (24HR:NEAREST 15 MIN): 12 (12:00)

1. Every week, same time
2. Every other week
3. Every month, same day of week & week of month

Select Number: 1

Updating Schedules...
```

After the service blockout has been created, it will appear on the operating room availability graph display, as shown below.

ROOM	6AM	7	8	9	10	11	12	13	14	15	16	17	18	19	20
OR1	____	uro.	____	____	____	____	____								
OR2	____	card	____	____	____	____									
OR3	____	thor													
OR4	____	gen.	____	____	____	____	____								
OR5	____	=XXX	XXXX	=XXX	XXXX	____	____	____	____	____	____	____	____	____	____

## Delete Service Blockout [SRBDEL]

The following example shows how to remove a service blockout from the blockout graph. A service blockout can be deleted for just one date or for all the reserved dates.

After starting this option, if the user decides not to delete a service blockout, he or she can enter an up-arrow (^) to exit.

### Example: Delete Service Blockout

```
Select Schedule Operations Option: DB Delete Service Blockout
Select service you wish to delete. (3-4 characters) CARD

The service 'card' has the following time(s) scheduled:
  1. OR1 on Tuesday from 07.00 to 12.00

Which number would you like to delete ? 1

Delete the Blockout starting with which date ? 3/29 (MAR 29, 1999)

Do you want to delete the blockout for this service on this
date only ? NO// <Enter>

Updating Schedules...

Press RETURN to continue
```

## Schedule of Operations [SROSCH]

The *Schedule of Operations* option generates the Operating Room Schedule used by the OR nurses, surgeons, anesthesiologists and other hospital services. The report lists operations and patients scheduled for a particular date. It sorts by operating room and includes the procedure(s), blood products requested, and any preoperative x-rays requested. The schedule also provides anesthesia information and surgeon names.

This report has a 132-column format and is designed to be copied to a printer.



By setting up default printers in the SURGERY SITE PARAMETERS file, this report can be queued to print in various locations simultaneously. Please see “Chapter 5: Managing the Software Package” for more information.

---

### Example: Print Schedule of Operations

```
Select Schedule Operations Option:  S  Schedule of Operations
Print Schedule of Operations for which date ?  9/8  (SEP 08, 1999)
Do you want to print the schedule at all locations ?  NO// <Enter>
This report is designed to use a 132 column format.
DEVICE:  [Select Print Device]
```

-----printout follows-----

PRINTED: SEP 07, 1999 11:12

SIGNATURE OF CHIEF: DR. ROBERT JACKSON

PATIENT ID#	AGE	DISPOSITION START TIME	PREOPERATIVE DIAGNOSIS OPERATION(S)	REQ ANESTHESIA ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
-------------	-----	------------------------	-------------------------------------	---------------------------------------------------	---------------------------------

OPERATING ROOM: OR1

OHIO, RAYMOND 123-45-6789 TO BE ADMITTED Case # 143	46	WARD 07:30 09:30	CARPAL TUNNEL SYNDROME REVISE MEDIAN NERVE	GENERAL RICHMOND, A BISMARK, A	JACKSON, R MIAMI, S JACKSON, R
--------------------------------------------------------------	----	------------------------	-----------------------------------------------	--------------------------------------	--------------------------------------

PREOPERATIVE XRAYS: CARPAL TUNNEL, R WRIST

OPERATING ROOM: OR2

KANSAS, THOMAS 123-45-6789 HICU 212-B Case # 141	36	WARD 06:30 08:00	CHOLELITHIASIS CHOLECYSTECTOMY	GENERAL AUGUSTA, D PHOENIX, S	JACKSON, R TULSA, L JACKSON, R
IDAHO, PETER 123-45-6789 TO BE ADMITTED Case # 142	71	WARD 08:00 09:30	ACUTE DIAPHRAGMATIC HERNIA REPAIR DIAPHRAGMATIC HERNIA	GENERAL AUGUSTA, D PHOENIX, S	TULSA, L JACKSON, R TULSA, L
ALASKA, FRED 123-45-6789 TO BE ADMITTED Case # 150	48	WARD 11:15 16:00	CAROTID ARTERY STENOSIS CAROTID ARTERY ENDARTERECTOMY	GENERAL AUGUSTA, D PHOENIX, S	JACKSON, R RICHMOND, A JACKSON, R
** Concurrent Case #157			AORTO CORONARY BYPASS GRAFT		
ALASKA, FRED 123-45-6789 TO BE ADMITTED Case # 157	48	WARD 11:15 16:00	CORONARY ARTERY DISEASE AORTO CORONARY BYPASS GRAFT	GENERAL AUGUSTA, D PHOENIX, S	TULSA, L ADAMS, D TULSA, L
** Concurrent Case #150			CAROTID ARTERY ENDARTERECTOMY		

TOTAL CASES SCHEDULED: 5

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

# List Scheduled Operations

[SRSCD]

The *List Scheduled Operations* option provides a short form listing of scheduled cases for a given date. It will sort by surgical specialty, operating room, or ward location.

This report is in 80-column format and can be viewed on the screen.

## Example: List Scheduled Operations

Select Surgery Menu Option: **LS** List Scheduled Operations

List of Scheduled Operations:

List Scheduled Operations for which date ? **3/12** (MAR 12, 1999)

Do you want to sort by OPERATING ROOM, SPECIALTY or WARD LOCATION ? **SPE**

Do you want a list of scheduled operations for a specific specialty ? YES// **N**

Print to Device: **[Select Print Device]**

-----printout follows-----

\* Scheduled Operations for GENERAL \*  
MAR 12, 1999

Start Time	Patient ID #	Operating Room	Ward Location
08:00	CALIFORNIA, JAMES 123-45-6789 CHOLECYSTECTOMY	OR2	OUTPATIENT

Press RETURN to continue **<Enter>**

\* Scheduled Operations for ORTHOPEDICS \*  
MAR 12, 1999

Start Time	Patient ID #	Operating Room	Ward Location
07:15	MONTANA, JOHNNY 123-45-6789 SHOULDER ARTHROPLASTY-PROTHESIS	OR4	1 WEST

Press RETURN to continue **<Enter>**

\* Scheduled Operations for PERIPHERAL VASCULAR \*  
MAR 12, 1999

Start Time	Patient ID #	Operating Room	Ward Location
11:15	NEVADA,NORMAN 123-45-6789 CAROTID ARTERY ENDARTERECTOMY	OR2	1 NORTH

Press RETURN to continue or '^' to quit. <Enter>

\* Scheduled Operations for THORACIC SURGERY \*  
MAR 12, 1999

Start Time	Patient ID #	Operating Room	Ward Location
11:15	NEVADA,NORMAN 123-45-6789 AORTO CORONARY BYPASS GRAFT	OR2	1 NORTH

Press RETURN to continue

# Chapter Two: Tracking Clinical Procedures

---

## Introduction

The options described in this chapter provide online access to medical administration and laboratory information and provide tracking of operative procedures. They allow the following:

- Entry of information specific to an individual surgical case (for example, staff, times, diagnoses, complications, anesthesia).
- Online entry of data inside the operating room during the actual operative procedure.
- Generation of patient records and reports.

## Key Vocabulary

The following terms are used in this chapter.

Term	Definition
Concurrent Case	The patient undergoes two operations, by two different specialties, at the same time in the same operating room.
Screen Server	After the data concerning the operation has been entered, the terminal display device will clear and then present a two-page Screen Server summary. The Screen Server summary organizes the information entered and gives the user another opportunity to enter or edit data.

## Exiting an Option or the System

The user should enter an up-arrow (^) to stop what he or she is currently doing. The user can use the up-arrow at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continue entering up-arrows to completely exit the system.

## Option Overview

The main options included in this chapter are listed in the following table. The *Operation Menu* option, *Anesthesia Menu* option, and the *Non-O.R. Procedures* menu contain submenus. To the left of the option name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
O	<i>Operation Menu</i>
A	<i>Anesthesia Menu</i>
PO	<i>Perioperative Occurrences Menu</i>
NON	<i>Non-O.R. Procedures</i>
C	<i>Comments</i>

# Operation Menu

## [SROPER]

The *Operation Menu* provides operating room personnel with online access to medical administration and laboratory information and generates post-operative reports, including the Nurse Intraoperative Report and the Operation Report. The menu options provide the opportunity to delete, edit, or review a patient's operation history or to enter information concerning a new surgery. The *Operation Menu* allows the user to select an area on which to concentrate data entry or review, such as post operation or anesthesia information. It is designed for operating room nurses, surgeons, and anesthesiologists to use before, during, and after surgery. The Screen Server utility is used extensively to provide quick access to relevant information.



This option is locked with the SROPER key.

The *Operation Menu* contains the following options. To the left is the keyboard shortcut the user can enter to select the option. A restricted option, such as the *Anesthesia Menu*, will not display if the user does not have security clearance for that option.

Shortcut	Option Name
I	<i>Operation Information</i>
SS	<i>Surgical Staff</i>
OS	<i>Operation Startup</i>
O	<i>Operation</i>
PO	<i>Post Operation</i>
PAC	<i>Enter PAC(U) Information</i>
OSS	<i>Operation (Short Screen)</i>
V	<i>Surgeon's Verification of Diagnosis &amp; Procedures</i>
A	<i>Anesthesia Menu</i>
OR	<i>Operation Report</i>
AR	<i>Anesthesia Report</i>
NR	<i>Nurse Intraoperative Report</i>
TR	<i>Tissue Examination Report</i>
R	<i>Enter Referring Physician Information</i>
RP	<i>Enter Irrigations and Restraints</i>
M	<i>Medications (Enter/Edit)</i>
B	<i>Blood Product Verification</i>

## Using the Operation Menu Options

This section provides information on the following:

- accessing the *Operation Menu* option
- entering information
- reviewing information
- deleting a surgery case
- entering a new surgical case

### **Accessing the Operation Menu**

To use one of the *Operation Menu* options, the user must first identify the patient and case on which he or she is currently working. When the *Operation Menu* option is selected, the user will be prompted to enter a patient name. The software will then list all the cases on record for the patient, including scheduled or requested cases and any operations that have been started or completed. Each case will have one of the following designations.

<b>Designation</b>	<b>Definition</b>
REQUESTED	The procedure is booked for a particular day but the time of surgery and the operating room are not yet confirmed.
SCHEDULED	The procedure is booked for both an operating room and a day, and the starting time of the surgery is scheduled.
NOT COMPLETE	The start time of the operation is recorded and the patient is still in the operating room.
COMPLETE	The operation is completed and the patient has left the operating room.
ABORTED	The patient entered the operating room, but the operation had to be cancelled.

Following is an example of how the software lists existing cases on record for a patient.

```
Select Surgery Menu Option:  Operation Menu
Select Patient: MISSOURI,ROY. 04-04-30 123456789 NSC VETERAN

MISSOURI,ROY. 123-45-6789

1. 01-25-92 ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)
2. 01-05-92 CORONARY BYPASS (REQUESTED)
3. ENTER NEW SURGICAL CASE

Select Operation: <Enter>
```

The user can select from the case(s) listed or, as in an emergency situation, enter a new surgical case. When the existing case is selected, the software will ask whether the user wants to:

- 1) enter information for the case,
- 2) review the information already entered, or
- 3) delete the case.

```
MISSOURI,ROY. 123-45-6789

01-25-92 ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)

1. Enter Information
2. Review Information
3. Delete Surgery Case

Select Number: 1//
```

## Entering Information

First, the user selects the patient name. The Surgery software will then list all the cases on record for the patient, including scheduled or requested cases and any operations that have been started or completed. Then, the user selects the appropriate case.

### Example: Enter Information

```
Select Surgery Menu Option: 0 Operation Menu
Select Patient: MONTANA,JOHNNY      12-19-53      123456789
```

```
MONTANA,JOHNNY      123-45-6789

1. 03-12-92  SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)
2. 08-15-88  SHOULDER ARTHROPLASTY (NOT COMPLETE)
3. ENTER NEW SURGICAL CASE
```

```
Select Operation: 2
```

```
MONTANA,JOHNNY      123-45-6789

08-15-88      SHOULDER ARTHROPLASTY (NOT COMPLETE)
```

```
1. Enter Information
2. Review Information
3. Delete Surgery Case
```

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

After the case is displayed, the user will press the **<Enter>** key or enter the number **1** to enter information for the case.

```
MONTANA,JOHNNY (123-45-6789) Case #14 - MAR 12,1999

I      Operation Information
SS     Surgical Staff
OS     Operation Startup
O      Operation
PO     Post Operation
PAC    Enter PAC(U) Information
OSS    Operation (Short Screen)
V      Surgeon's Verification of Diagnosis & Procedures
A      Anesthesia for an Operation Menu ...
OR     Operation Report
AR     Anesthesia Report
NR     Nurse Intraoperative Report
TR     Tissue Examination Report
R      Enter Referring Physician Information
RP     Enter Irrigations and Restraints
M      Medications (Enter/Edit)
B      Blood Product Verification
```

```
Select Operation Menu Option:
```

Now the user can select any of the *Operation Menu* options.

## Reviewing Information

The user enters the number **2** to access this feature. This feature displays a two-page summary of the case. The user cannot edit from this feature. Press the **<Enter>** key at the "Enter Screen Server Function:" prompt to move to the next page, or enter **+1** or **-1** to move forward or backward one page.

### Example: Review Information

```
Select Surgery Menu Option: Operation Menu
Select Patient: MONTANA,JOHNNY 12-19-53 123456789
```

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

1. 08-15-99 SHOULDER ARTHROPLASTY (NOT COMPLETE)
2. 03-12-92 SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)
3. ENTER NEW SURGICAL CASE

```
Select Operation: 2
```

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

```
08-15-88 SHOULDER ARTHROPLASTY (NOT COMPLETE)
```

1. Enter Information
2. Review Information
3. Delete Surgery Case

```
Select Number: 1// 2
```

```
** REVIEW ** CASE #14 MONTANA,JOHNNY PAGE 1 OF 3
```

- 1 TIME PAT IN HOLD AREA: AUG 15, 1999 AT 07:40
- 2 TIME PAT IN OR: AUG 15, 1999 AT 08:00
- 3 ANES CARE START TIME: AUG 15, 1999 AT 08:00
- 4 TIME OPERATION BEGAN: AUG 15, 1999 AT 09:00
- 5 SPECIMENS: (WORD PROCESSING)
- 6 CULTURES: (WORD PROCESSING)
- 7 THERMAL UNIT: (MULTIPLE)
- 8 ELECTROCAUTERY UNIT: 7571
- 9 ESU COAG RANGE:
- 10 ESU CUTTING RANGE:
- 11 TIME TOURNIQUET APPLIED: (MULTIPLE)
- 12 PROSTHESIS INSTALLED: (MULTIPLE)(DATA)
- 13 REPLACEMENT FLUID TYPE: (MULTIPLE)(DATA)
- 14 IRRIGATION: (MULTIPLE)(DATA)
- 15 MEDICATIONS: (MULTIPLE)

```
Enter Screen Server Function: <Enter>
```

```

** REVIEW **      CASE #14  MONTANA,JOHNNY                PAGE 2 OF 3
1  SPONGE COUNT CORRECT (Y/N): YES
2  SHARPS COUNT CORRECT (Y/N): YES
3  INSTRUMENT COUNT CORRECT (Y/N): YES
4  SPONGE, SHARPS, & INST COUNTER:
5  COUNT VERIFIER:
6  SEQUENTIAL COMPRESSION DEVICE:
7  LASER UNIT:
8  CELL SAVER:
9  NURSING CARE COMMENTS: (WORD PROCESSING)(DATA)
10 PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE L SHOULDER
11 PRIN DIAGNOSIS CODE:
12 PRINCIPAL PROCEDURE:  SHOULDER ARTHROPLASTY
13 PRINCIPAL PROCEDURE CODE:
14 OTHER PROCEDURES:    (MULTIPLE)
15 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)

Enter Screen Server Function:  <Enter>

```

```

** REVIEW **      CASE #14  MONTANA,JOHNNY                PAGE 3 OF 3
1  BRIEF CLIN HISTORY:   (WORD PROCESSING)

Enter Screen Server Function:

```

### **Deleting a Surgery Case**

The user enters the number **3** to access this feature. The *Delete Surgery Case* feature will permanently remove all information on the operative procedure from the records.

#### **Example: How to Delete A Case**

```

Select Surgery Menu Option:  Operation Menu
Select Patient:  HAWAII,LOU      12-09-51      123456789      NSC VETERAN

```

```

HAWAII,LOU  123-45-6789
1. 04-26-92  CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)
2. 12-20-90  REMOVE FACIAL LESIONS (NOT COMPLETE)
3. ENTER NEW SURGICAL CASE

Select Operation:  2

```

```

HAWAII,LOU  123-45-6789

12-20-90    REMOVE FACIAL LESIONS (NOT COMPLETE)

1. Enter Information
2. Review Information
3. Delete Surgery Case

Select Number:  1//  3

Are you sure that you want to delete this case ?  NO//  Y

Deleting Operation...

```

## Entering a New Surgical Case

A new surgical case is a case that has not been previously requested or scheduled. This option is designed primarily for entering emergency cases. Be aware that a surgical case entered in the records without being booked through scheduling will not appear on the operating room schedule or as an operative request.

At the "Select Operation:" prompt the user enters the number corresponding to the ENTER NEW SURGICAL CASE field. He or she will then be prompted to supply preoperative information concerning the case.

After the user has entered data concerning the operation, the screen will clear and present a two-page Screen Server summary and provide another opportunity to enter or edit data.

### **Prompts that require a response include:**

"Select the Date of Operation:"

"Enter the Principal Operative Procedure:"

"Select Surgical Specialty:"

"INDICATIONS FOR OPERATIONS:"

### **Example: Entering a New Surgical Case**

```
Select Surgery Menu Option: 0 Operation Menu
Select Patient: MISSOURI,ROY          04-04-30      123456789

MISSOURI,ROY  123-45-6789

1. ENTER NEW SURGICAL CASE

Select Operation: 1

Select the Date of Operation: T (FEB 14, 1999)

Enter the Principal Operative Procedure: APPENDECTOMY

Select Surgeon: TOPEKA,MARK

Select Surgical Specialty: 50          GENERAL(OR WHEN NOT DEFINED BELOW)

INDICATIONS FOR OPERATIONS:
 1>ABDOMINAL PAIN IN RIGHT LOWER QUADRANT.
 2>ELEVATED WHITE BLOOD COUNT.
 3><Enter>
EDIT Option: <Enter>

Brief Clinical History:
 1>PATIENT WITH 5-DAY HISTORY OF INCREASING ABDOMINAL
 2>PAIN, ONSET OF FEVER IN LAST 24 HOURS. REBOUND
 3>TENDERNESS IN RIGHT LOWER QUAD. NAUSEA AND
 4>VOMITING FOR 3 DAYS.
 5><Enter>
EDIT Option: <Enter>
Request Blood Availability (Y/N): N// YES

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH// <Enter> TYPE & CROSSMATCH

Select REQ BLOOD KIND: CPDA-1 RED BLOOD CELLS// <Enter>

Required Blood Product: CPDA-1 RED BLOOD CELLS// <Enter>
Units Required: 2

Principal Preoperative Diagnosis: APPENDICITIS
```

Principal Diagnosis Code (ICD9): 540.9 540.9 ACUTE APPENDICITIS NOS COM  
 PLICATION/COMORBIDITY ACTIVE  
 .....OK? YES// <Enter> (YES)  
 Hospital Admission Status: I// <Enter> INPATIENT  
 Case Schedule Type: EM EMERGENCY  
 First Assistant: TOPEKA,MARK  
 Second Assistant: RICHMOND,ARTHUR  
 Attending Surgeon: TULSA,LARRY  
 Requested Postoperative Care: W WARD  
 Case Schedule Order: <Enter>  
 Select SURGERY POSITION: SUPINE// <Enter>  
 Surgery Position: SUPINE//<Enter>  
 Requested Anesthesia Technique: G GENERAL  
 Request Frozen Section Tests (Y/N): N NO  
 Requested Preoperative X-Rays: <Enter>  
 Intraoperative X-Rays (Y/N): N NO  
 Request Medical Media: N NO  
 Request Clean or Contaminated: C CLEAN  
 Select REFERRING PHYSICIAN: <Enter>  
 General Comments:  
 1><Enter>

\*\* NEW SURGERY \*\* CASE #185 MISSOURI,ROY PAGE 1 OF 3

1 PRINCIPAL PROCEDURE: APPENDECTOMY  
 2 PRINCIPAL PROCEDURE CODE:  
 3 OTHER PROCEDURES: (MULTIPLE)  
 4 PRINCIPAL PRE-OP DIAGNOSIS: APPENDICITIS  
 5 PRIN DIAGNOSIS CODE: 540.9  
 6 OTHER PREOP DIAGNOSIS: (MULTIPLE)  
 7 IN/OUT-PATIENT STATUS: INPATIENT  
 8 PRE-ADMISSION TESTING:  
 9 CASE SCHEDULE TYPE: EMERGENCY  
 10 SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)  
 11 SURGEON: TOPEKA,MARK  
 12 FIRST ASST: TOPEKA,MARK  
 13 SECOND ASST: RICHMOND,ARTHUR  
 14 ATTEND SURG: TULSA,LARRY  
 15 REQ POSTOP CARE: WARD

Enter Screen Server Function: <Enter>

\*\* NEW SURGERY \*\* CASE #185 MISSOURI,ROY PAGE 2 OF 3

1 CASE SCHEDULE ORDER:  
 2 SURGERY POSITION: (MULTIPLE)(DATA)  
 3 REQ ANESTHESIA TECHNIQUE: GENERAL  
 4 REQ FROZ SECT: NO  
 5 REQ PREOP X-RAY:  
 6 INTRAOPERATIVE X-RAYS: NO  
 7 REQUEST BLOOD AVAILABILITY: YES  
 8 CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH  
 9 REQ BLOOD KIND: (MULTIPLE)(DATA)  
 10 REQ PHOTO: NO  
 11 REQ CLEAN OR CONTAMINATED: CLEAN  
 12 REFERRING PHYSICIAN: (MULTIPLE)  
 13 GENERAL COMMENTS: (WORD PROCESSING)  
 14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)  
 15 BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)

Enter Screen Server Function: <Enter>

\*\* NEW SURGERY \*\* CASE #185 MISSOURI,ROY PAGE 3 OF 3

1 SPD COMMENTS

## Operation Information [SR0MEN-OPINFO]

Surgeons and other members of the surgical staff use the *Operation Information* option for a quick reference on a case. It produces a report that touches on the more important areas of interest recorded for the case. The report can be viewed on screen but cannot be edited from this option.

An asterisk indicates the principal diagnosis for the case, since some cases have more than one diagnosis. Notice that the INTRAOP OCCURRENCES field and the POSTOP OCCURRENCES field indicate if there are occurrences; however, the occurrences will not be defined, as access to this information is restricted.

### Example: Operation Information

Select Operation Menu Option: **I** Operation Information

```
-----  
Patient: MISSOURI,ROY (123-45-6789)      Operation Date: MAR  9, 1999  
Surgeon: PITTSBURGH,ANTHONY             Major/Minor:  
Attending Surgeon: RICHMOND,ARTHUR      Operation Time: 45 Minutes  
Attending Code: LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE  
-----  
Operation(s):  
APPENDECTOMY  
-----  
Postop Diagnosis:                       Intraop Occurrences: YES  
* APPENDICITIS                          Postop Occurrences:  YES  
-----  
Anesthesia Technique:                   Anesthetist: BISMARK,ANDREW  
  INHALATION  
  ENFLURANE 125ML  
-----  
Wound Classification:  
Intraoperative Blood Loss: 100 CC'S  
-----  
Press RETURN to continue
```

## Surgical Staff [SRROMEN-STAFF]

The *Surgical Staff* option allows the operating room nurse or scheduling manager to enter or edit the names of the surgical team prior to the operation. Some data fields may be automatically filled in based on previous responses. The names entered will be reflected in the Nurse Intraoperative Report and other staffing reports.

At the "Enter Screen Server Function:" prompt, the user may choose the field(s) to be edited or press the <Enter> key to continue. Some of the data fields are "multiple" and may contain more than one value. When a field labeled "multiple" is selected, a new screen is generated so that the user can enter data related to that multiple. For example, the CIRC SUPPORT, SCRUB SUPPORT, and SCRUBBED ASSISTANT fields generate new screens that allow the user to add the TIME ON, TIME OFF, REASON FOR RELIEF, and STATUS. The TIME ON and TIME OFF fields also generate additional screens so that the user may enter more than one TIME ON/OFF for the same operation as some assistants must enter and exit more than once.



If entering times on a day other than the day of surgery, enter both the date and the time. Entering only a time will default the date to the current date.

---

### Field Information

The following are fields that correspond to the Surgical Staff entries.

Field Name	Definition
ATTENDING CODE	This field corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure. Enter a question mark (?) to retrieve the list of codes.
OTHER SCRUBBED ASSISTANTS	If there are more than two assistants scrubbed for this case, they can be entered here.
OTHER PERSONS IN O.R.	This field includes any observers, such as equipment vendors, in the operating room.

## Example: Entering Surgical Staff

Select Operation Menu Option: **SS** Surgical Staff

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1 OF 1
1 SURGEON: JACKSON,R
2 PGY OF PRIMARY SURGEON:
3 FIRST ASST: HELENA,LAURIE
4 SECOND ASST: TULSA,LARRY
5 ATTEND SURG: JACKSON,R
6 ATTEND CODE:
7 PRINC ANESTHETIST: DENVER,DONNA
8 ASST ANESTHETIST:
9 ANESTHESIOLOGIST SUPVR: AUGUSTA,DON
10 PERFUSIONIST:
11 ASST PERFUSIONIST:
12 OR CIRC SUPPORT: (MULTIPLE)
13 OR SCRUB SUPPORT: (MULTIPLE)
14 OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15 OTHER PERSONS IN OR: (MULTIPLE)
```

Enter Screen Server Function: **6;13;15**

Attending Code: **C** LEVEL C: ATTENDING IN O.R., NOT SCRUBBED C

The supervising practitioner is physically present in the operative or procedural room. The supervising practitioner observes and provides direction. The resident performs the procedure.

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1
OR SCRUB SUPPORT
```

1 NEW ENTRY

Enter Screen Server Function: **1**

Select OR SCRUB SUPPORT: **MONTPELIER,MELINDA**

OR SCRUB SUPPORT: MONTPELIER,MELINDA// <Enter>

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1
OR SCRUB SUPPORT (MONTPELIER,MELINDA)
```

```
1 OR SCRUB SUPPORT: MONTPELIER,MELINDA
2 TIME ON: (MULTIPLE)
3 STATUS:
```

Enter Screen Server Function: **2:3**

Educational Status: **?**

CHOOSE FROM:

O ORIENTEE

F FULLY TRAINED

Educational Status: **F** FULLY TRAINED

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1
OR SCRUB SUPPORT (MONTPELIER,MELINDA)
TIME ON
```

1 NEW ENTRY

Enter Screen Server Function: **1**

Select TIME ON: **8:00** (JUN 06, 1999@08:00)

TIME ON: JUN 06, 1999@08:00// <Enter>

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1
OR SCRUB SUPPORT (MONTPELIER,MELINDA)
TIME ON (2920606.08)
```

```
1 TIME ON: JUN 06, 1999 AT 08:00
2 TIME OFF:
3 REASON FOR RELIEF:
```

```
Enter Screen Server Function: 2:3
Time Off: 13:00 (JUN 06, 1999@13:00)
Reason for Relief: ?
```

```
Enter the code corresponding to the reason for relief.
CHOOSE FROM:
```

```
P PERSONAL
S SHIFT CHANGE
A ADMINISTRATIVE
```

```
Reason for Relief: S SHIFT CHANGE
```

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1 OF 1
OR SCRUB SUPPORT (MONTPELIER,MELINDA)
TIME ON (2920606.08)
```

```
1 TIME ON: JUN 06, 1999 AT 08:00
2 TIME OFF: JUN 06, 1999 AT 13:00
3 REASON FOR RELIEF: SHIFT CHANGE
```

```
Enter Screen Server Function: <Enter>
```

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1 OF 1
OR SCRUB SUPPORT (MONTPELIER,MELINDA)
TIME ON
```

```
1 TIME ON: JUN 06, 1999 AT 08:00
2 NEW ENTRY
```

```
Enter Screen Server Function: <Enter>
```

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1 OF 1
OR SCRUB SUPPORT (MONTPELIER,MELINDA)
```

```
1 OR SCRUB SUPPORT: MONTPELIER,MELINDA
2 TIME ON: (MULTIPLE)(DATA)
3 STATUS: FULLY TRAINED
```

```
Enter Screen Server Function: <Enter>
```

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1 OF 1
OR SCRUB SUPPORT
```

```
1 OR SCRUB SUPPORT: MONTPELIER,MELINDA
2 NEW ENTRY
```

```
Enter Screen Server Function: <Enter>
```

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1 OF 1
OTHER PERSONS IN OR
```

```
1 NEW ENTRY
```

```
Enter Screen Server Function: 1
Select OTHER PERSONS IN OR: WILLIAM MILWAUKEE
OTHER PERSONS IN OR: WILLIAM MILWAUKEE// <Enter>
```

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1 OF 1
    OTHER PERSONS IN OR (0)

1  OTHER PERSONS IN OR: WILLIAM MILWAUKEE
2  TITLE/ORGANIZATION:

Enter Screen Server Function: 2
Title and Organization: TECHNICIAN, AMERICAN SURGICAL EQUIP
```

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1 OF 1
    OTHER PERSONS IN OR (0)

1  OTHER PERSONS IN OR: WILLIAM MILWAUKEE
2  TITLE/ORGANIZATION:  TECHNICIAN, AMERICAN SURGICAL EQUIP

Enter Screen Server Function: <Enter>
```

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1 OF 1
    OTHER PERSONS IN OR

1  OTHER PERSONS IN OR: WILLIAM MILWAUKEE
2  NEW ENTRY

Enter Screen Server Function: <Enter>
```

```
** SURGICAL STAFF ** CASE #193 MONTANA,JOHNNY PAGE 1 OF 1

1  SURGEON: JACKSON,R
2  PGY OF PRIMARY SURGEON:
3  FIRST ASST: HELENA,LAURIE
4  SECOND ASST: TULSA,LARRY
5  ATTEND SURG: JACKSON,R
6  ATTEND CODE: LEVEL C: ATTENDING IN O.R., NOT SCRUBBED
7  PRINC ANESTHETIST: DENVER,DONNA
8  ASST ANESTHETIST:
9  ANESTHESIOLOGIST SUPVR: AUGUSTA,DON
10 PERFUSIONIST:
11 ASST PERFUSIONIST:
12 OR CIRC SUPPORT: (MULTIPLE)
13 OR SCRUB SUPPORT: (MULTIPLE)(DATA)
14 OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15 OTHER PERSONS IN OR: (MULTIPLE)(DATA)

Enter Screen Server Function:
```

## Operation Startup [SROMEN-START]

The nurse or other operating room staff uses the *Operation Startup* option to enter data concerning the patient's preparation for the surgery (for example, diagnosis, delays, skin prep, and position aids). Some data fields may be automatically filled in based on previous responses.

Some of the data fields are "multiple fields" and can have more than one value. For example, a patient can have more than one diagnosis or restraint/position aid. When a multiple field is selected, a new screen is generated so that the user can enter data related to that multiple. At the "Enter Screen Server Function:" prompt, the user can choose the field(s) to be edited, or press the <Enter> key to go to the next item or page.

### Field Information

The following are fields that correspond to the Operation Startup entries.

Field Name	Definition
MAJOR/MINOR:	Major surgery is any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies, regardless of anesthesia administered. Minor surgery is any operation not designated as Major.
CANCEL REASON:	The user must respond to this prompt if he or she has information in the CANCEL DATE field. Typing in a question mark (?) at the "Cancel Reason:" prompt allows the user to select from a list of cancellation reasons. The "Cancel Reason:" prompt should only be answered if the case has been aborted. Use the <i>Cancel Scheduled Case</i> option if the patient has not yet entered the operating room.
DELAY CAUSE:	If the actual start time of the surgery is significantly delayed (15 minutes or more, depending on the institution's policy) it is necessary to select a reason at the "Delay Cause:" prompt. Type in a question mark (?) at this prompt to select from a list of delay causes.
RESTR & POSITION AIDS:	A safety strap is automatically included as a restraint.

## Example: Operation Startup

Select Operation Menu Option: **OS** Operation Startup

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 1 OF 3

1  DATE OF OPERATION:      DEC 06, 1999 AT 08:00
2  PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
3  OTHER PREOP DIAGNOSIS: (MULTIPLE)
4  OPERATING ROOM:        OR2
5  SURGERY SPECIALTY:     ORTHOPEDICS
6  MAJOR/MINOR:           MAJOR
7  REQ POSTOP CARE:       WARD
8  CASE SCHEDULE TYPE:    ELECTIVE
9  REQ ANESTHESIA TECHNIQUE: GENERAL
10 PATIENT EDUCATION/ASSESSMENT:
11 CANCEL DATE:
12 CANCEL REASON:
13 CANCELLATION AVOIDABLE:
14 DELAY CAUSE:           (MULTIPLE)
15 VALID ID/CONSENT CONFIRMED BY:

Enter Screen Server Function: 6;10
Major or Minor: J MAJOR
Preoperative Patient Education: Y YES
```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 1 OF 3

1  DATE OF OPERATION:      DEC 06, 1999 AT 08:00
2  PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
3  OTHER PREOP DIAGNOSIS: (MULTIPLE)
4  OPERATING ROOM:        OR2
5  SURGERY SPECIALTY:     ORTHOPEDICS
6  MAJOR/MINOR:           MAJOR
7  REQ POSTOP CARE:       WARD
8  CASE SCHEDULE TYPE:    ELECTIVE
9  REQ ANESTHESIA TECHNIQUE: GENERAL
10 PATIENT EDUCATION/ASSESSMENT: YES
11 CANCEL DATE:
12 CANCEL REASON:
13 CANCELLATION AVOIDABLE:
14 DELAY CAUSE:           (MULTIPLE)
15 VALID ID/CONSENT CONFIRMED BY:

Enter Screen Server Function: <Enter>
```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 2 OF 3

1  MARKED SITE CONFIRMED:
2  PREOPERATIVE IMAGING CONFIRMED:
3  TIME OUT VERIFIED:
4  MARKED SITE COMMENTS: (WORD PROCESSING)
5  IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
6  TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
7  ASA CLASS:
8  PREOP MOOD:
9  PREOP CONSCIOUS:
10 PREOP SKIN INTEG:
11 TRANS TO OR BY:
12 PREOP SHAVE BY:
13 SKIN PREPPED BY (1):
14 SKIN PREPPED BY (2):
15 SKIN PREP AGENTS:

Enter Screen Server Function: A
```

```

Mark on Surgical Site Confirmed: YES
Preoperative Imaging Confirmed: YES
Time Out Verification Completed (Y/N): YES// <Enter>
Mark on Surgical Site Comments:
  No existing text
  Edit? NO// <Enter>
Imaging Confirmed Comments:
  No existing text
  Edit? NO// <Enter>
Time Out Verification Comments:
  No existing text
  Edit? NO// <Enter>
ASA Class: 2 2-MILD DISTURB.
Preoperative Mood: ?
  Enter the code corresponding to the preoperative assessment of the
  patient's emotional status upon arrival to the operating room.
  ANSWER WITH PATIENT MOOD NAME, OR CODE
  CHOOSE FROM:
    AGITATED          AG
    ANGRY             ANG
    ANXIOUS          ANX
    APATHETIC        AP
    DEPRESSED        D
    RELAXED          R

Preoperative Mood: ANXIOUS          ANX
Preoperative Consciousness: AO ALERT-ORIENTED          AO
Preoperative Skin Integrity: INTACT          I
Transported to O.R. By: PACU BED
Preoperative Shave By: SACRAMENTO, SHARON
Skin Prepped By: <Enter>
Skin Prepped By (2): <Enter>
Skin Preparation Agent: HIBICLENS          HI

```

```

** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 2 OF 3

1  MARKED SITE CONFIRMED: YES
2  PREOPERATIVE IMAGING CONFIRMED: YES
3  TIME OUT VERIFIED:      YES
4  MARKED SITE COMMENTS: (WORD PROCESSING)
5  IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
6  TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
7  ASA CLASS:              2-MILD DISTURB.
8  PREOP MOOD:             ANXIOUS
9  PREOP CONSCIOUS:        ALERT-ORIENTED
10 PREOP SKIN INTEG:        INTACT
11 TRANS TO OR BY:         PACU BED
12 PREOP SHAVE BY:         DENVER, DONNA
13 SKIN PREPPED BY (1):
14 SKIN PREPPED BY (2):
15 SKIN PREP AGENTS:       HIBICLENS

Enter Screen Server Function: <Enter>

```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 3 OF 3

1  SECOND SKIN PREP AGENT:
2  SURGERY POSITION:      (MULTIPLE)(DATA)
3  RESTR & POSITION AIDS: (MULTIPLE)(DATA)
4  ELECTROGROUND POSITION:
5  ELECTROGROUND POSITION (2):

Enter Screen Server Function:  A
```

```
Second Skin Preparation Agent: <Enter>
Electroground Placement:  RAT  RIGHT ANT THIGH
Electroground Position (2):<Enter>
```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 1
      SURGERY POSITION

1  SURGERY POSITION:      SUPINE
2  NEW ENTRY

Enter Screen Server Function:  2
Select SURGERY POSITION:  SEMISUPINE
ARE YOU ADDING 'SEMISUPINE' AS A NEW SURGERY POSITION (THE 2ND FOR THIS SURGERY)? Y  (YES)
SURGERY POSITION: SEMISUPINE// <Enter>
```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 1
      SURGERY POSITION (SEMISUPINE)

1  SURGERY POSITION:      SEMISUPINE
2  TIME PLACED:

Enter Screen Server Function:  <Enter>
```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 1 OF 1
      SURGERY POSITION

1  SURGERY POSITION:      SUPINE
2  SURGERY POSITION:      SEMISUPINE
3  NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 1 OF 1
      RESTR & POSITION AIDS

1  RESTR & POSITION AIDS: SAFETY STRAP
2  NEW ENTRY

Enter Screen Server Function:  2
Select RESTR & POSITION AIDS:  FOAM PADS
RESTR & POSITION AIDS: FOAM PADS// <Enter>
```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 1 OF 1
      RESTR & POSITION AIDS (FOAM PADS)

1  RESTR & POSITION AIDS: FOAM PADS
2  APPLIED BY:

Enter Screen Server Function:  2
Applied By:  DENVER, DONNA
```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 1 OF 1
      RESTR & POSITION AIDS  (FOAM PADS)

1  RESTR & POSITION AIDS: FOAM PADS
2  APPLIED BY:           DENVER,DONNA

Enter Screen Server Function:  <Enter>
```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 1 OF 1
      RESTR & POSITION AIDS

1  RESTR & POSITION AIDS: SAFETY STRAP
2  RESTR & POSITION AIDS: FOAM PADS
3  NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
** STARTUP **      CASE #159  MONTANA,JOHNNY          PAGE 3 OF 3

1  SECOND SKIN PREP AGENT:
2  SURGERY POSITION:      (MULTIPLE)(DATA)
3  RESTR & POSITION AIDS: (MULTIPLE)(DATA)
4  ELECTROGROUND POSITION: RIGHT ANT THIGH
5  ELECTROGROUND POSITION (2):

Enter Screen Server Function:
```

## Operation [SR0MEN-OP]

Surgeons and nurses use the *Operation* option to enter data relating to the operation during or immediately following the actual procedure. It is very important to record the time of the patient's entrance into the hold area and operating room, the time anesthesia is administered, and the operation start time.

Many of the data fields are "multiple fields" and can have more than one value. For example, a patient can have more than one diagnosis or procedure done per operation. When a multiple field is selected, a new screen is generated so that the user can enter data related to that multiple. The up-arrow (^) can be used to exit from any multiple field. Enter a question mark (?) for software- assisted instruction.

### Field Information

The following are fields that correspond to the Operation entries.

Field Name	Definition
TIME OPERATION BEGAN	The user should check his or her institution's policy concerning an operation's start time. In some institutions, this may be the time of first incision.



If entering times on a day other than the day of surgery, enter both the date and the time. Entering only a time will default the date to the current date.

---

## Example: Operation Option: Entering Information

Select Operation Menu Option: **O** Operation

```
** OPERATION **      CASE #173  CALIFORNIA,JAMES      PAGE 1 OF 3

1  TIME PAT IN HOLD AREA:
2  TIME PAT IN OR:
3  MARKED SITE CONFIRMED:
4  PREOPERATIVE IMAGING CONFIRMED:
5  TIME OUT VERIFIED:
6  MARKED SITE COMMENTS: (WORD PROCESSING)
7  IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
8  TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
9  ANES CARE START TIME:
10 TIME OPERATION BEGAN:
```

Enter Screen Server Function: **A**

```
Time Patient Arrived in Holding Area: 8:50 (MAR 12, 1999@08:50)
Time Patient In the O.R.: 9:00 (MAR 12, 1999@09:00)
Mark on Surgical Site Confirmed: Y YES
Preoperative Imaging Confirmed: Y YES
Time Out Verification Completed (Y/N): Y YES
Correct Surgery Comments:
  No existing text
  Edit? NO// <Enter>
Anesthesia Care Start Time: 9:10 (MAR 12, 1999@09:10) (MAR 12, 1999@09:10)
Time the Operation Began: 9:20 (MAR 12, 1999@09:20)
```

```
** OPERATION **      CASE #173  CALIFORNIA,JAMES      PAGE 1 OF 3

1  TIME PAT IN HOLD AREA: MAR 12, 1999 AT 08:50
2  TIME PAT IN OR:      MAR 12, 1999 AT 09:00
3  MARKED SITE CONFIRMED: YES
4  PREOPERATIVE IMAGING CONFIRMED: YES
5  TIME OUT VERIFIED:  YES
6  MARKED SITE COMMENTS: (WORD PROCESSING)
7  IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
8  TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
9  ANES CARE START TIME:  MAR 12, 1999 AT 09:10
10 TIME OPERATION BEGAN:  MAR 12, 1999 AT 09:20
```

Enter Screen Server Function: **<Enter>**

```
** OPERATION **      CASE #173 CALIFORNIA,JAMES      PAGE 2 OF 3

1  SPECIMENS:          (WORD PROCESSING)
2  CULTURES:          (WORD PROCESSING)
3  THERMAL UNIT:      (MULTIPLE)
4  ELECTROCAUTERY UNIT:
5  ESU COAG RANGE:
6  ESU CUTTING RANGE:
7  TIME TOURNIQUET APPLIED: (MULTIPLE)
8  PROSTHESIS INSTALLED: (MULTIPLE)(DATA)
9  REPLACEMENT FLUID TYPE: (MULTIPLE)
10 IRRIGATION:        (MULTIPLE)
11 MEDICATIONS:       (MULTIPLE)
12 SPONGE COUNT CORRECT (Y/N):
13 SHARPS COUNT CORRECT (Y/N):
14 INSTRUMENT COUNT CORRECT (Y/N):
15 SPONGE, SHARPS, & INST COUNTER:

Enter Screen Server Function:  9:10;12:15
```

```
Final Sponge Count Correct (Y/N): Y YES
Final Sharps Count Correct (Y/N): Y YES
Final Instrument Count Correct (Y/N): Y YES
Person Responsible for Final Counts: LANSING,EMILY
```

```
** OPERATION **      CASE #173 CALIFORNIA,JAMES      PAGE 1 OF 1
      REPLACEMENT FLUID TYPE

1  NEW ENTRY

Enter Screen Server Function:  1
Select REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION// <Enter>
```

```
** OPERATION **      CASE #173 CALIFORNIA,JAMES      PAGE 1 OF 1
      REPLACEMENT FLUID TYPE (RINGERS LACTATED SOLUTION)

1  REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2  QTY OF FLUID (ml):
3  SOURCE ID:
4  VA IDENT:
5  REPLACEMENT FLUID COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  2;3
Quantity of Fluid (ml): 1000
Source Identification Number: TRAVENOL
```

```
** OPERATION **      CASE #173 CALIFORNIA,JAMES      PAGE 1 OF 1
      REPLACEMENT FLUID TYPE (RINGERS LACTATED SOLUTION)

1  REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2  QTY OF FLUID (ml):      1000
3  SOURCE ID:              TRAVENOL
4  VA IDENT:
5  REPLACEMENT FLUID COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

```
** OPERATION **      CASE #173 CALIFORNIA,JAMES      PAGE 1 OF 1
      REPLACEMENT FLUID TYPE

1  REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2  NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
** OPERATION ** CASE #173 CALIFORNIA,JAMES PAGE 1 OF 1
IRRIGATION

1 NEW ENTRY

Enter Screen Server Function: 1
Select IRRIGATION: NORMAL SALINE
IRRIGATION: NORMAL SALINE// <Enter>
```

```
** OPERATION ** CASE #173 CALIFORNIA,JAMES PAGE 1 OF 1
IRRIGATION (NORMAL SALINE)

1 IRRIGATION: NORMAL SALINE
2 TIME: (MULTIPLE)

Enter Screen Server Function: 2
```

```
** OPERATION ** CASE #173 CALIFORNIA,JAMES PAGE 1
IRRIGATION (NORMAL SALINE)
TIME

1 NEW ENTRY

Enter Screen Server Function: 1
Select TIME: 9:40 MAR 12, 1999@09:40
TIME: MAR 12, 1999@09:40// <Enter>
```

```
** OPERATION ** CASE #173 CALIFORNIA,JAMES PAGE 1
IRRIGATION (NORMAL SALINE)
TIME (2930601.094)

1 TIME: MAR 12, 1999 AT 09:40
2 AMOUNT USED:
3 PROVIDER:

Enter Screen Server Function: 2:3
Amount of Solution Used: 1000
Person Responsible: LANSING,EMILY
```

```
** OPERATION ** CASE #173 CALIFORNIA,JAMES PAGE 1 OF 1
IRRIGATION (NORMAL SALINE)
TIME (2930601.094)

1 TIME: MAR 12, 1999 AT 09:40
2 AMOUNT USED: 1000
3 PROVIDER: LANSING,EMILY

Enter Screen Server Function: <Enter>
```

```
** OPERATION ** CASE #173 CALIFORNIA,JAMES PAGE 1 OF 1
IRRIGATION (NORMAL SALINE)
TIME

1 TIME: MAR 12, 1999 AT 09:40
2 NEW ENTRY

Enter Screen Server Function: <Enter>
```

```
** OPERATION **      CASE #173  CALIFORNIA,JAMES      PAGE 1 OF 1
      IRRIGATION    (NORMAL SALINE)

1  IRRIGATION:      NORMAL SALINE
2  TIME:            (MULTIPLE)(DATA)

Enter Screen Server Function:  <Enter>
```

```
** OPERATION **      CASE #173  CALIFORNIA,JAMES      PAGE 1 OF 1
      IRRIGATION

1  IRRIGATION:      NORMAL SALINE
2  NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
** OPERATION **      CASE #173  CALIFORNIA,JAMES      PAGE 2 OF 3

1  SPECIMENS:      (WORD PROCESSING)
2  CULTURES:      (WORD PROCESSING)
3  THERMAL UNIT:   (MULTIPLE)
4  ELECTROCAUTERY UNIT:
5  ESU COAG RANGE:
6  ESU CUTTING RANGE:
7  TIME TOURNIQUET APPLIED: (MULTIPLE)
8  PROSTHESIS INSTALLED: (MULTIPLE)(DATA)
9  REPLACEMENT FLUID TYPE: (MULTIPLE) (DATA)
10 IRRIGATION:     (MULTIPLE) (DATA)
11 MEDICATIONS:   (MULTIPLE)
12 SPONGE COUNT CORRECT (Y/N): YES
13 SHARPS COUNT CORRECT (Y/N): YES
14 INSTRUMENT COUNT CORRECT (Y/N): YES
15 SPONGE, SHARPS, & INST COUNTER: LANSING,EMILY

Enter Screen Server Function:  <Enter>
```

```
** OPERATION **      CASE #173  CALIFORNIA,JAMES      PAGE 3 OF 3

1  COUNT VERIFIER:
2  SEQUENTIAL COMPRESSION DEVICE:
3  LASER UNIT:     (MULTIPLE)
4  CELL SAVER:    (MULTIPLE)
5  NURSING CARE COMMENTS: (WORD PROCESSING)
6  PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
7  PRIN DIAGNOSIS CODE:  574.01
8  PRINCIPAL PROCEDURE:  CHOLECYSTECTOMY
9  PRINCIPAL PROCEDURE CODE:
10 OTHER PROCEDURES:   (MULTIPLE)
11 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
12 BRIEF CLIN HISTORY:  (WORD PROCESSING)

Enter Screen Server Function:  5
```

NURSING CARE COMMENTS:

1>Admitted with prosthesis in place, left eye is artificial eye.  
2>Foam pads applied to elbows and knees. Pillow placed  
3>under knees.  
4><Enter>

EDIT Option: <Enter>

\*\* OPERATION \*\* CASE #173 CALIFORNIA,JAMES PAGE 3 OF 3

1 COUNT VERIFIER:  
2 SEQUENTIAL COMPRESSION DEVICE:  
3 LASER UNIT: (MULTIPLE)  
4 CELL SAVER: (MULTIPLE)  
5 NURSING CARE COMMENTS: (WORD PROCESSING)(DATA)  
6 PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS  
7 PRIN DIAGNOSIS CODE: 574.01  
8 PRINCIPAL PROCEDURE: CHOLECYSTECTOMY  
9 PRINCIPAL PROCEDURE CODE:  
10 OTHER PROCEDURES: (MULTIPLE)  
11 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)  
12 BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function:

## Post Operation [SRROMEN-POST]

The *Post Operation* option concerns the close of the operation, discharge, and post anesthesia recovery. It is important to enter the operation and anesthesia end times, as well as the time the patient leaves the operation room, as these fields affect many reports.

### Field Information

The following are fields that correspond to the *Post Operation* option entries.

Field Name	Definition
PRINCIPAL POST-OP DIAGNOSIS	The software will automatically default to the diagnosis that was entered at the preoperative stage.
TIME PAT OUT OR	Entry of this field generates an alert notifying the circulating nurse that the Nurse Intraoperative Report is ready for signature.
ANES CARE END TIME	Entry of the this field generates an alert notifying the anesthetist that the Anesthesia Report is ready for signature.

### Example: Post Operation

Select Operation Menu Option: **PO** Post Operation

\*\* POST OPERATION \*\*    CASE #145    HAWAII, LOU    PAGE 1 OF 2

```

1  DRESSING:
2  PACKING:
3  TUBES AND DRAINS:
4  BLOOD LOSS (ML):
5  TOTAL URINE OUTPUT (ML):
6  GASTRIC OUTPUT:
7  WOUND CLASSIFICATION:
8  POSTOP MOOD:
9  POSTOP CONSCIOUS:
10 POSTOP SKIN INTEG:
11 TIME OPERATION ENDS:
12 ANES CARE END TIME:
13 TIME PAT OUT OR:
14 OP DISPOSITION:
15 DISCHARGED VIA:

```

```

Enter Screen Server Function:  A
Dressing(s):  TELFA
Packing Type:  <Enter>
Tubes and Drains:  PENROSE
Intraoperative Blood Loss (ml):  200
Total Urine Output (ml):  600
Gastric Output (cc's):  150
Wound Classification:  CC  CLEAN/CONTAMINATED
Postoperative Mood:  RELAXED          R
Postoperative Consciousness:  RESTING          R
Postoperative Skin Integrity:  INTACT          I
Time the Operation Ends:  12:30  (APR 26, 1999@12:30)
Anesthesia Care End Time:  12:40  (APR 26, 1999@12:40)
Time Patient Out of the O.R.:  12:50  (APR 26, 1999@12:50)
Postoperative Disposition:  PACU  (RECOVERY ROOM)          R
Patient Discharged Via:  PACU BED

```

\*\* POST OPERATION \*\*      CASE #145   HAWAII,LOU                      PAGE 1 OF 2

1      DRESSING:                      TELFA  
2      PACKING:  
3      TUBES AND DRAINS:              PENROSE  
4      BLOOD LOSS (ML):              200  
5      TOTAL URINE OUTPUT (ML):      600  
6      GASTRIC OUTPUT:                150  
7      WOUND CLASSIFICATION:        CLEAN/CONTAMINATED  
8      POSTOP MOOD:                   RELAXED  
9      POSTOP CONSCIOUS:             RESTING  
10     POSTOP SKIN INTEG:            INTACT  
11     TIME OPERATION ENDS:        APR 26, 1999 AT 12:30  
12     ANES CARE END TIME:         APR 26, 1999 AT 12:40  
13     TIME PAT OUT OR:             APR 26, 1999 AT 12:50  
14     OP DISPOSITION:              PACU (RECOVERY ROOM)  
15     DISCHARGED VIA:              PACU BED

Enter Screen Server Function: <Enter>

\*\* POST OPERATION \*\*      CASE #145   HAWAII,LOU                      PAGE 2 OF 2

1      PRINCIPAL POST-OP DIAG:      CHOLELITHIASIS  
2      PRIN DIAGNOSIS CODE:  
3      OTHER POSTOP DIAGS:         (MULTIPLE)  
4      PRINCIPAL PROCEDURE:        CHOLECYSTECTOMY  
5      PRINCIPAL PROCEDURE CODE:    47480  
6      OTHER PROCEDURES:           (MULTIPLE)(DATA)  
7      ATTENDING CODE:             LEVEL C: ATTENDING IN O.R., NOT SCRUBBED

Enter Screen Server Function:

## Enter PAC(U) Information [SR0MEN-PACU]

Personnel in the Post Anesthesia Care Unit (PACU) use the *Enter PAC(U) Information* option to enter the admission and discharge times and scores.

### Example: Entering PAC(U) Information

Select Operation Menu Option: **PAC** Enter PAC(U) Information

```
** PACU **      CASE #145  HAWAII,LOU                PAGE 1 OF 1

1  ADMIT PAC(U) TIME:
2  PAC(U) ADMIT SCORE:
3  PAC(U) DISCH TIME:
4  PAC(U) DISCH SCORE:

Enter Screen Server Function: 1:4
PAC(U) Admission Time: 13:00 (APR 26, 1999@13:00)
PAC(U) Admission Score: 10
PAC(U) Discharge Date/Time: 14:00 (APR 26, 1999@14:00)
PAC(U) Discharge Score: 10
```

```
** PACU **      CASE #145  HAWAII,LOU                PAGE 1 OF 1

1  ADMIT PAC(U) TIME:      APR 26, 1999 AT 13:00
2  PAC(U) ADMIT SCORE:    10
3  PAC(U) DISCH TIME:     APR 26, 1999 AT 14:00
4  PAC(U) DISCH SCORE:    10

Enter Screen Server Function:
```

## Operation (Short Screen) [SROMEN-OUT]

The *Operation (Short Screen)* option provides a three-page screen of information concerning a surgical procedure performed on a patient. The *Operations (Short Screen)* option allows the nurse or surgeon to easily enter data relating to the operation during, and shortly after, the actual procedure. This time-saving option can replace the *Operation Startup* option, the *Operation* option, and the *Post Operation* option for minor surgeries.

When only one anesthesia technique is entered, the software will assume that it is the principal anesthesia technique for the case. Some data fields may be automatically pre-populated if the case was booked in advance.

### Example: Operation Short Screen

Select Operation Menu Option: **OSS** Operation (Short Screen)

```
** SHORT SCREEN **      CASE #186  IDAHO,PETER          PAGE 1 OF 3

1  DATE OF OPERATION:      MAR 09, 1992
2  IN/OUT-PATIENT STATUS:  OUTPATIENT
3  SURGEON:                RICHMOND,ARTHUR
4  PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5  PRIN DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  PRINCIPAL PROCEDURE:    REMOVE FACIAL LESIONS
8  PRINCIPAL PROCEDURE CODE: 17000
9  OTHER PROCEDURES:      (MULTIPLE)
10 TIME PAT IN OR:
11 MARKED SITE CONFIRMED:
12 PREOPERATIVE IMAGING CONFIRMED:
13 TIME OUT VERIFIED:
14 MARKED SITE COMMENTS: (WORD PROCESSING)
15 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)

Enter Screen Server Function: 10:13
Time Patient In the O.R.: 13:00 (MAR 09, 1992@13:00)
Mark on Surgical Site Confirmed: Y YES
Preoperative Imaging Confirmed: ?

Enter YES if the imaging data was confirmed, "I" if there was no imaging
required, or "NO" if the image was not viewed.
Choose from:
  Y      YES
  I      IMAGING NOT REQUIRED FOR THIS PROCEDURE
  N      NO - IMAGING REQUIRED BUT NOT VIEWED (see CORRECT SURGERY COMMEN
TS)
Preoperative Imaging Confirmed: I IMAGING NOT REQUIRED FOR THIS PROCEDURE
Time Out Verification Completed (Y/N): Y YES
```

```

** SHORT SCREEN **   CASE #186   IDAHO,PETER           PAGE 1 OF 3

1  DATE OF OPERATION:      MAR 09, 1992 AT 13:00
2  IN/OUT-PATIENT STATUS:  OUTPATIENT
3  SURGEON:                RICHMOND,ARTHUR
4  PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5  PRIN DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS:  (MULTIPLE)
7  PRINCIPAL PROCEDURE:    REMOVE FACIAL LESIONS
8  PRINCIPAL PROCEDURE CODE: 17000
9  OTHER PROCEDURES:       (MULTIPLE)
10 TIME PAT IN OR:        MAR 09, 1992 AT 13:00
11 MARKED SITE CONFIRMED:  YES
12 PREOPERATIVE IMAGING CONFIRMED:NA
13 TIME OUT VERIFIED      YES
14 MARKED SITE COMMENTS:  (WORD PROCESSING)
15 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  <Enter>

```

```

** SHORT SCREEN **   CASE #186   IDAHO,PETER           PAGE 2 OF 3

1  TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
2  TIME OPERATION BEGAN:
3  TIME OPERATION ENDS:
4  TIME PAT OUT OR:
5  IV STARTED BY:
6  OR CIRC SUPPORT:        (MULTIPLE)
7  OR SCRUB SUPPORT:       (MULTIPLE)
8  OPERATING ROOM:        OR3
9  FIRST ASST:            LANSING,EMILY
10 SPONGE COUNT CORRECT (Y/N):
11 SHARPS COUNT CORRECT (Y/N):
12 INSTRUMENT COUNT CORRECT (Y/N):
13 SPONGE, SHARPS, & INST COUNTER:
14 COUNT VERIFIER:
15 SURGERY SPECIALTY:     PLASTIC SURGERY (INCLUDES HEAD AND NECK)

Enter Screen Server Function:  2:4
Time the Operation Began: 13:10 (MAR 09, 1992@13:10)
Time the Operation Ends: 13:36 (MAR 09, 1992@13:36)
Time Patient Out of the O.R.: 13:40 (MAR 09, 1992@13:40)

```

```

** SHORT SCREEN **   CASE #186   IDAHO,PETER           PAGE 2 OF 3

1  TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
2  TIME OPERATION BEGAN:      MAR 09, 1992 AT 13:10
3  TIME OPERATION ENDS:      MAR 09, 1992 AT 13:36
4  TIME PAT OUT OR:          MAR 09, 1992 AT 13:40
5  IV STARTED BY:
6  OR CIRC SUPPORT:          (MULTIPLE)
7  OR SCRUB SUPPORT:         (MULTIPLE)
8  OPERATING ROOM:          OR3
9  FIRST ASST:              LANSING,EMILY
10 SPONGE COUNT CORRECT (Y/N):
11 SHARPS COUNT CORRECT (Y/N):
12 INSTRUMENT COUNT CORRECT (Y/N):
13 SPONGE, SHARPS, & INST COUNTER:
14 COUNT VERIFIER:
15 SURGERY SPECIALTY:       PLASTIC SURGERY (INCLUDES HEAD AND NECK)

Enter Screen Server Function:  <Enter>

```

```

** SHORT SCREEN **      CASE #186  IDAHO,PETER      PAGE 3 OF 3

1  WOUND CLASSIFICATION:
2  ATTEND SURG:          TULSA,LARRY
3  ATTENDING CODE:
4  SPECIMENS:            (WORD PROCESSING)
5  CULTURES:            (WORD PROCESSING)
6  NURSING CARE COMMENTS: (WORD PROCESSING)
7  ASA CLASS:
8  PRINC ANESTHETIST:    RICHMOND,ARTHUR
9  ANESTHESIA TECHNIQUE: (MULTIPLE)
10 ANES CARE START TIME:
11 ANES CARE END TIME:
12 DELAY CAUSE:         (MULTIPLE)
13 CANCEL DATE:
14 CANCEL REASON:

Enter Screen Server Function:  3;6
Attending Code:  A  LEVEL A: ATTENDING DOING THE OPERATION
Nursing Care Comments:
  1>PATIENT ARRIVED AMBULATORY FROM AMBULATORY
  2>SURGERY UNIT. DISCHARGED VIA WHEELCHAIR, AWAKE,
  3>ALERT, ORIENTED.
  4><Enter>
EDIT Option: <Enter>

```

```

** SHORT SCREEN **      CASE #186  IDAHO,PETER      PAGE 3 OF 3

1  WOUND CLASSIFICATION:
2  ATTEND SURG:          TULSA,LARRY
3  ATTENDING CODE:      LEVEL A: ATTENDING DOING THE OPERATION
4  SPECIMENS:            (WORD PROCESSING)
5  CULTURES:            (WORD PROCESSING)
6  NURSING CARE COMMENTS: (WORD PROCESSING) (DATA)
7  ASA CLASS:
8  PRINC ANESTHETIST:    RICHMOND,ARTHUR
9  ANESTHESIA TECHNIQUE: (MULTIPLE)
10 ANES CARE START TIME:
11 ANES CARE END TIME:
12 DELAY CAUSE:         (MULTIPLE)
13 CANCEL DATE:
14 CANCEL REASON:

Enter Screen Server Function:

```

## Surgeon's Verification of Diagnosis & Procedures [SROVER]

Surgeons use this option to verify that the stated procedure(s), diagnosis, and occurrences are correct for a case. With this option, the surgeon can update the Operation Name, CPT Code, Diagnosis, and Intraoperative Occurrences before verifying the case. If the case has already been verified, the user will be asked whether to re-verify it.

If the user responds **YES** to the prompt "Do you need to update the information above ?" the software will provide a summary for editing.



If there are no occurrences, the INTRAOP OCCURRENCES field should be left blank. Do **not** enter **NO** or **NONE**.

---

### **Service Classifications**

Information relating to a patient's status of Service Connected (SC), Non-Service Connected (NSC), Environmental Indicators (EI), Agent Orange (AO), Head & Neck Cancer (HNC), Ionizing Radiation (IR), and Military Sexual Trauma (MST) are captured during patient registration. The Surgery software receives this data from enrollment and displays it when the user creates a case.

In the Surgery software, the patient's Service Classification status is determined at the case level when the case is created. The user can further refine status designations, not only per case, but also per diagnosis.

The system defaults the case-level Service Classification indicators into each Other Postop Diagnosis field as the user adds the Other Postop Diagnoses. The system allows the user to edit these fields if the user determines that the defaulted value is incorrect.

### Example: Surgeon's Verification of Diagnosis & Procedures

Select Operation Menu Option: **V** Surgeon's Verification of Diagnosis & Procedures

OHIO,RAYMOND (123-45-6789)  
Operation Date: OCT 5, 1999

- 
1. Indications for Operation:  
Swelling in the inguinal region.
  2. Principal CPT Code: 00830
  3. Principal Procedure: REMOVE HERNIA
  4. Other Procedures:
  5. Postoperative Diagnosis: INGUINAL HERNIA
  6. Intraoperative Occurrences: NO OCCURRENCES HAVE BEEN ENTERED
- 

Do you need to update the information above ? NO// **Y**

Select Information to Edit: **2:3**

CPT Code: 00830 ANESTH, REPAIR OF HERNIA  
Description:  
ANESTHESIA FOR HERNIA REPAIRS IN LOWER ABDOMEN;  
NOT OTHERWISE SPECIFIED

-----

Principal Procedure Code (CPT): 00830 ANESTHESIA FOR HERNIA REPAIRS IN LOWER ABDOMEN; NOT  
OTHERWISE SPECIFIED  
// **49521** REPAIR INGUINAL HERNIA, REC  
REPAIR RECURRENT INGUINAL HERNIA, ANY AGE;  
INCARCERATED OR STRANGULATED

Modifier: **59** DISTINCT PROCEDURAL SERVICE  
Modifier: **<Enter>**

Principal Procedure: REMOVE HERNIA// **REPAIR INGUINAL HERNIA**

OHIO,RAYMOND (123-45-6789)  
Operation Date: OCT 5, 1999

-----  
1. Indications for Operation:  
Swelling in the inguinal region.

2. Principal CPT Code: 49521  
Modifiers: -59

3. Principal Procedure: REPAIR INGUINAL HERNIA

4. Other Procedures:

5. Postoperative Diagnosis: INGUINAL HERNIA

6. Intraoperative Occurrences: NO OCCURRENCES HAVE BEEN ENTERED  
-----

Do you need to update the information above ? NO// <Enter>

Will you verify that the information on your screen is correct ? YES// <Enter>

Press RETURN to continue

## Anesthesia for an Operation Menu [SROANES]



The *Anesthesia for an Operation Menu* option is restricted to anesthesia personnel and is locked with the SROANES key.

This option is designed for convenient entry of data pertaining to the anesthesia agents, personnel and techniques. When the user selects this option from the *Operation Menu* option, he or she is given a submenu of five options.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym that may be entered to select the option.

Shortcut	Option Name
I	<i>Anesthesia Information (Enter/Edit)</i>
T	<i>Anesthesia Technique (Enter/Edit)</i>
M	<i>Medications (Enter/Edit)</i>
R	<i>Anesthesia Report</i>
S	<i>Schedule Anesthesia Personnel</i>

### **Prerequisites**

To use any of these options, other than the *Schedule Anesthesia Personnel* option, the user must first select a patient case. For the *Schedule Anesthesia Personnel* option, a date and then an operating room must first be selected.

These options can also be accessed from the main *Surgery Menu*.

Information related to these options is contained in “Chapter Two: Tracking Clinical Procedures,” in the Anesthesia Menu section.

## Operation Report [SROS RPT]

The *Operation Report* option displays the dictated Operation Report for the patient case selected. This report contains the surgeon's dictation regarding the surgical procedure. The Operation Report is not electronically signed in the Surgery package. After the dictated Operation Report is uploaded into the Text Integration Utilities (TIU) package, it is then available for electronic signature through the Computerized Patient Record System (CPRS) Surgery tab.

When electronically signed, the Operation Report is also viewable through CPRS. The electronically signed Operation Report replaces VA Form 516. If the Operation Report has not been electronically signed, then CPRS will only display a stub for that document.



After the dictated Operation Report is transcribed and uploaded into TIU, the TIU software sends an alert to the surgeon responsible for electronically signing the report.

---

Until the Operation Report is signed, if the *Operation Report* option is selected, the following text displays:

“The Operation Report for this case is not yet available.”

If the Operation Report has been signed, the *Operation Report* option will display the signed document. (See the example.)

-----printout follows-----

## Example: A signed Operation Report

Page: 1

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

OPERATION REPORT  
-----

NOTE DATED: 07/29/2003 15:15 OPERATION REPORT  
VISIT: 07/29/2003 15:15 SURGERY OP REPORT NON-COUNT  
SUBJECT: Case #: 73285

PREOPERATIVE DIAGNOSIS: Visually significant cataract, right eye

POSTOPERATIVE DIAGNOSIS: Visually significant cataract, right eye

PROCEDURE: Phacoemulsification with intraocular lens placement, right eye

CLINICAL INDICATIONS: This 64-year-old gentleman complains of decreased vision in the right eye affecting his activities of daily living. Best corrected visual acuity is counting fingers at 6 feet, associated with a 2-3+ nuclear sclerotic and 4+ posterior subcapsular cataract in that eye.

ANESTHESIA: Local monitoring with topical Tetracaine and 1% preservative free Lidocaine.

DESCRIPTION OF THE PROCEDURE: After the risks, benefits and alternatives of the procedure were explained to the patient, informed consent was obtained. The patient's right eye was dilated with Phenylephrine, Mydriacyl and Ocufen. He was brought to the Operating Room and placed on anesthetic monitors. Topical Tetracaine was given. He was prepped and draped in the usual sterile fashion for eye surgery. A Lieberman lid speculum was placed.

A Supersharp was used to create a superior paracentesis port. The anterior chamber was irrigated with 1% preservative free Lidocaine. The anterior chamber was filled with Viscoelastic. The diamond groove maker and diamond keratome were used to create a clear corneal tunneled incision at the temporal limbus. The cystotome was used to initiate a continuous capsulorrhexis, which was then completed using Utrata forceps. Balanced salt solution was used to hydrodissect and hydrodelineate the lens.

Phacoemulsification was used to remove the lens nucleus and epinucleus in a non-stop horizontal chop fashion. Cortex was removed using irrigation and aspiration. The capsular bag was filled with Viscoelastic. The wound was enlarged with a 69 blade. An Alcon model MA60BM posterior chamber intraocular lens with a power of 24.0 diopters, serial #588502.064, was folded and inserted with the leading haptic placed into the bag. The trailing haptic was dialed into the bag with the Lester hook. The wound was hydrated. The anterior chamber was filled with balanced salt solution. The wound was tested and found to be self-sealing. Subconjunctival antibiotics were given, and an eye shield was placed. The patient was taken in good condition to the Recovery Room. There were no complications.

KJC/PSI

DATE DICTATED: 07/29/03  
DATE TRANSCRIBED: 07/29/03  
JOB: 629095

Signed by: /es/ CHARLES RICHMOND, M.D.  
07/30/2003 10:31

## Anesthesia Report [SROARPT]

The Anesthesia Report details anesthesia information for the patient case selected. This option provides the capability to view/print the report, edit information contained in the report, and electronically sign the report. This option can also be accessed from the *Anesthesia Menu* option located on the *Operation Menu*, as well as on the main *Surgery Menu*.

### Anesthesia Report (Unsigned)

Upon selecting this option, if the Anesthesia Report is not signed the report will begin displaying. The Anesthesia Report displays key fields on the first page. Several of these fields are required before the software will allow the user to electronically sign the report. If any of these fields are left blank, a warning will appear prompting the user to provide the missing information. The ANES CARE START TIME field, ANES CARE END TIME field, ANESTHESIA TECHNIQUE field, ASA CLASS field, OP DISPOSITION field, and the PRINC ANESTHETIST field must all be completed before the Anesthesia Report can be electronically signed.



Entering the information into the ANES CARE END TIME field triggers an alert that is sent to the anesthetist responsible for signing the report. By responding to the alert, the user is taken to the *Anesthesia Report* option.

At the bottom of the first screen is the prompt, "Press <return> to continue, 'A' to access Anesthesia Report functions or '^' to exit:". The *Anesthesia Report* functions, accessed by entering **A** at the prompt, allow the user to edit the report, to view or print the report, or to electronically sign the report.

### Example: First page of an Anesthesia Report

```
MEDICAL RECORD          FLORIDA,FRANK (123-45-6789)          PAGE 1
                          ANESTHESIA REPORT - CASE #267226

Operating Room: WX OR3

Anesthetist: ATHENS,DEBBIE          Relief Anesth:
Anesthesiologist: SALISBURY,DIANE    Assist Anesth: HARRISBURG,HENRY
Attending Code: LEVEL 3. ATTENDING NOT PRESENT IN O.R. SUITE, IMMEDIATE
LY AVAILABLE.

Anes Begin:  FEB 12, 2002  08:00      Anes End:  FEB 12, 2002  12:10

ASA Class:  * NOT ENTERED *

Operation Disposition:  * NOT ENTERED *

Anesthesia Technique(s):
GENERAL (PRINCIPAL)
  Agent:      ISOFLURANE FOR INHALATION 100ML
  Intubated:  YES
  Trauma:     NONE

Press <return> to continue, 'A' to access Anesthesia Report functions
or '^' to exit:  A
```

After entering an **A** at the prompt, the Anesthesia functions are displayed. The following examples demonstrate how these three functions are accessed and how they operate.

If the user enters a **1**, the Anesthesia Report data can be edited.

### Example: Edit Report Information

```
FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12, 2002
```

```
Anesthesia Report Functions:
```

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

```
Select number: 2// 1 Edit report information
```

```
** ANESTHESIA REPORT ** CASE #267226 FLORIDA,FRANK PAGE 1 OF 2
```

```
1 OPERATING ROOM: WX OR3
2 PRINC ANESTHETIST: ATHENS,DEBBIE
3 RELIEF ANESTHETIST:
4 ANESTHESIOLOGIST SUPVR: SALISBURY,DIANE
5 ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6 ASST ANESTHETIST: HARRISBURG,HENRY
7 ANES CARE START TIME: FEB 12, 2002 AT 08:00
8 ANES CARE END TIME: FEB 12, 2002 AT 12:10
9 ASA CLASS:
10 OP DISPOSITION:
11 ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
12 PRINCIPAL PROCEDURE: MVR
13 OTHER PROCEDURES: (MULTIPLE)(DATA)
14 MEDICATIONS: (MULTIPLE)
15 MIN INTRAOP TEMPERATURE (C): 35
```

```
Enter Screen Server Function: 10
```

```
Postoperative Disposition: SICU S
```

```
** ANESTHESIA REPORT ** CASE #267226 FLORIDA,FRANK PAGE 1 OF 2
```

```
1 OPERATING ROOM: WX OR3
2 PRINC ANESTHETIST: ATHENS,DEBBIE
3 RELIEF ANESTHETIST:
4 ANESTHESIOLOGIST SUPVR: SALISBURY,DIANE
5 ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6 ASST ANESTHETIST: HARRISBURG,HENRY
7 ANES CARE START TIME: FEB 12, 2002 AT 08:00
8 ANES CARE END TIME: FEB 12, 2002 AT 12:10
9 ASA CLASS:
10 OP DISPOSITION: SICU
11 ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
12 PRINCIPAL PROCEDURE: MVR
13 OTHER PROCEDURES: (MULTIPLE)(DATA)
14 MEDICATIONS: (MULTIPLE)
15 MIN INTRAOP TEMPERATURE (C): 35
```

```
Enter Screen Server Function: ^
```

If the user enters a **2**, the Anesthesia Report can be printed.

### Example: Print the Anesthesia Report

FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12, 2002

Anesthesia Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2// **2**

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

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

ANESTHESIA REPORT  
-----

NOTE DATED: 02/12/2002 08:00 ANESTHESIA REPORT

SUBJECT: Case #: 267226

Operating Room: WX OR3

Anesthetist: ATHENS,DEBBIE

Relief Anesth:

Anesthesiologist: SALISBURY,DIANE

Assist Anesth: HARRISBURG,HENRY

Attending Code: LEVEL 3. ATTENDING NOT PRESENT IN O.R. SUITE, IMMEDIATELY AVAILABLE.

Anes Begin: FEB 12, 2002 08:00

Anes End: FEB 12, 2002 12:10

ASA Class: \* NOT ENTERED \*

Operation Disposition: SICU

Anesthesia Technique(s):

GENERAL (PRINCIPAL)

Agent: ISOFLURANE FOR INHALATION 100ML

Intubated: YES

Trauma: NONE

Min Intraoperative Temp: 35

Intraoperative Blood Loss: 800 ml

Urine Output: 750 ml

Operation Disposition: SICU

PAC(U) Admit Score:

PAC(U) Discharge Score:

Postop Anesthesia Note Date/Time:

To electronically sign the report, the user enters a **3**.

### Example: Sign the Report Electronically

```
FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12, 2002
```

```
Anesthesia Report Functions:
```

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

```
Select number: 2// 3
```

In this case, a key field, the ASA CLASS field, has been omitted. The system will prompt the user to supply the missing information before allowing the report to be electronically signed.



The Anesthesia Report cannot be signed if the ASA CLASS field, or any other key field information, is missing.

Responding **YES** to the, "Do you want to enter this information?" prompt allows the user to enter or correct fields on the Anesthesia Report.

### Example: Entering or Correcting a Field on the Anesthesia Report prior to Signature

The following information is required before this report may be signed:

```
ASA CLASS
```

```
Do you want to enter this information? YES// YES
```

```
** ANESTHESIA REPORT ** CASE #267226 FLORIDA,FRANK PAGE 1 OF 2
```

```
1 OPERATING ROOM: BO OR1
2 PRINC ANESTHETIST: ATHENS,DEBBIE
3 RELIEF ANESTHETIST:
4 ANESTHESIOLOGIST SUPVR: SALISBURY,DIANE
5 ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6 ASST ANESTHETIST: HARRISBURG,HENRY
7 ANES CARE START TIME: FEB 12, 2002 AT 08:00
8 ANES CARE END TIME: FEB 12, 2002 AT 12:10
9 ASA CLASS:
10 OP DISPOSITION: SICU
11 ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
12 PRINCIPAL PROCEDURE: MVR
13 OTHER PROCEDURES: (MULTIPLE)(DATA)
14 MEDICATIONS: (MULTIPLE)
15 MIN INTRAOP TEMPERATURE (C): 35
```

```
Enter Screen Server Function: 9
ASA Class: 1 1 1-NO DISTURB.
```

\*\* ANESTHESIA REPORT \*\* CASE #267226 FLORIDA,FRANK PAGE 1 OF 2

```
1 OPERATING ROOM: BO OR1
2 PRINC ANESTHETIST: ATHENS,DEBBIE
3 RELIEF ANESTHETIST:
4 ANESTHESIOLOGIST SUPVR: SALISBURY,DIANE
5 ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6 ASST ANESTHETIST: HARRISBURG,HENRY
7 ANES CARE START TIME: FEB 12, 2002 AT 08:00
8 ANES CARE END TIME: FEB 12, 2002 AT 12:10
9 ASA CLASS: 1-NO DISTURB.
10 OP DISPOSITION: SICU
11 ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
12 PRINCIPAL PROCEDURE: MVR
13 OTHER PROCEDURES: (MULTIPLE)(DATA)
14 MEDICATIONS: (MULTIPLE)
15 MIN INTRAOP TEMPERATURE (C): 35
```

Enter Screen Server Function: ^

After any necessary edits have been made, the report can be electronically signed.

### Example: Electronically signing the Anesthesia Report

FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12, 2002

Anesthesia Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2// 3 Sign the report electronically

Enter your Current Signature Code: **xxx** SIGNATURE VERIFIED

FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12, 2002

\* \* The Anesthesia Report has been electronically signed. \* \*

When typing the electronic signature code, no characters will display on screen.

Once an Anesthesia Report has been signed, a warning informing the user that the Anesthesia Report has already been signed will display on screen and an addendum will be required for any future changes.

## **Anesthesia Report (Signed)**

After an Anesthesia Report has been signed, any changes to the signed report will require a signed addendum.

### **Example: Editing the Signed Report**

```
Select Operation Menu Option: AR Anesthesia Report
```

```
FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12, 2002
```

```
* * The Anesthesia Report has been electronically signed. * *
```

```
Anesthesia Report Functions:
```

1. Edit report information
2. Print/View report from beginning

```
Select number: 2// 1 Edit report information
```



If the Anesthesia Report and/or the Nurse Intraoperative Report has already been signed, the following warning will be displayed. If any data on either signed report is edited, an addendum to the Anesthesia Report and/or to the Nurse Intraoperative Report will be required.

### **Example: Warning**

```
FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12, 2002
```

```
>>> WARNING <<<
```

```
Electronically signed reports are associated with this case. Editing  
of data that appear on electronically signed reports will require the  
creation of addenda to the signed reports.
```

```
Enter RETURN to continue or '^' to exit: <Enter>
```

The user can proceed to edit the report and sign the required addendum or simply exit.

### **Example: Editing the Signed Report**

```
** ANESTHESIA REPORT ** CASE #267226 FLORIDA,FRANK PAGE 1 OF 2
```

```
1 OPERATING ROOM: WX OR3  
2 PRINC ANESTHETIST: ATHENS,DEBBIE  
3 RELIEF ANESTHETIST:  
4 ANESTHESIOLOGIST SUPVR: SALISBURY,DIANE  
5 ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.  
6 ASST ANESTHETIST: HARRISBURG,HENRY  
7 ANES CARE START TIME: FEB 12, 2002 AT 08:00  
8 ANES CARE END TIME: FEB 12, 2002 AT 12:10  
9 ASA CLASS: 1-NO DISTURB.  
10 OP DISPOSITION: SICU  
11 ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)  
12 PRINCIPAL PROCEDURE: MVR  
13 OTHER PROCEDURES: (MULTIPLE)(DATA)  
14 MEDICATIONS: (MULTIPLE)  
15 MIN INTRAOP TEMPERATURE (C): 35
```

```
Enter Screen Server Function: 1  
Operating Room: WX OR3// BO OR1
```

\*\* ANESTHESIA REPORT \*\* CASE #267226 FLORIDA,FRANK PAGE 1 OF 2

1 OPERATING ROOM: BO OR1  
2 PRINC ANESTHETIST: ATHENS,DEBBIE  
3 RELIEF ANESTHETIST:  
4 ANESTHESIOLOGIST SUPVR: SALISBURY,DIANE  
5 ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.  
6 ASST ANESTHETIST: HARRISBURG,HENRY  
7 ANES CARE START TIME: FEB 12, 2002 AT 08:00  
8 ANES CARE END TIME: FEB 12, 2002 AT 12:10  
9 ASA CLASS: 1-NO DISTURB.  
10 OP DISPOSITION: SICU  
11 ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)  
12 PRINCIPAL PROCEDURE: MVR  
13 OTHER PROCEDURES: (MULTIPLE)(DATA)  
14 MEDICATIONS: (MULTIPLE)  
15 MIN INTRAOP TEMPERATURE (C): 35

Enter Screen Server Function: ^

FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12,2002

An addendum to each of the following electronically signed document(s) is required:

Nurse Intraoperative Report - Case #267226  
Anesthesia Report - Case #267226

If you choose not to create an addendum, the original data will be restored to the modified fields appearing on the signed reports.

Create addendum? YES// <Enter>



If the user elects to exit these options prior to signing the addendum, all fields on the report revert back to the values entered when electronically signed.

Addendum for Case #267226 - FEB 12,2002  
Patient: FLORIDA,FRANK (123-45-6789)

-----  
The Operating Room field was changed  
from WX OR3  
to BO OR1

Enter RETURN to continue or '^' to exit: <Enter>

Do you want to add a comment for this case? NO// YES

Comment: OPERATING ROOM NUMBER WAS CORRECTED.

Addendum for Case #267226 - FEB 12,2002  
Patient: FLORIDA,FRANK (123-45-6789)

-----  
The Operating Room field was changed  
from WX OR3  
to BO OR1

Addendum Comment: OPERATING ROOM NUMBER WAS CORRECTED.

Enter RETURN to continue or '^' to exit: <Enter>

Enter your Current Signature Code: **xxx** SIGNATURE VERIFIED

Press RETURN to continue... <Enter>

When typing the electronic signature code, no characters will display on screen.

The *Print/View report from beginning* function can then be used to view or print the report with the addendum.

### Example: Print/View Report With Addendum

FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12, 2002

\* \* The Anesthesia Report has been electronically signed. \* \*

Anesthesia Report Functions:

1. Edit report information
2. Print/View report from beginning

Select number: 2// **2** Print/View report from beginning

Do you want WORK copies or CHART copies? WORK// <Enter>

DEVICE: [**Select Print Device**]

-----printout follows-----

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

ANESTHESIA REPORT  
-----

NOTE DATED: 02/12/2002 08:00 ANESTHESIA REPORT

SUBJECT: Case #: 267226

Operating Room: BO OR1

Anesthetist: ATHENS,DEBBIE                      Relief Anesth:  
Anesthesiologist: SALISBURY,DIANE              Assist Anesth: HARRISBURG,HENRY  
Attending Code: LEVEL 3. ATTENDING NOT PRESENT IN O.R. SUITE, IMMEDIATE  
LY AVAILABLE

Anes Begin: FEB 12, 2002 08:00              Anes End: FEB 12, 2002 12:10

ASA Class: 1-NO DISTURB.

Operation Disposition: SICU

Anesthesia Technique(s):  
GENERAL (PRINCIPAL)  
Agent: ISOFLURANE FOR INHALATION 100ML  
Enter RETURN to continue or '^' to exit:

Intubated: YES  
Trauma: NONE

Procedure(s) Performed:  
Principal: MVR

Min Intraoperative Temp: 35

Intraoperative Blood Loss: 800 ml              Urine Output: 750 ml  
Operation Disposition: SICU  
PAC(U) Admit Score:                      PAC(U) Discharge Score:

Postop Anesthesia Note Date/Time:

Signed by: /es/ DEBBIE ATHENS  
03/04/2002 10:59

03/04/2002 11:04              ADDENDUM

The Operating Room field was changed  
from WX OR3  
to BO OR1

Addendum Comment: OPERATING ROOM NUMBER WAS CORRECTED.  
Signed by: /es/ DEBBIE ATHENS  
03/04/2002 11:04

## **Nurse Intraoperative Report [SRONRPT]**

The Nurse Intraoperative Report details case information relating to nursing care provided for the patient during the operative case selected. This option provides the capability to view and print the report, edit information contained in the report, and electronically sign the report.

With the *Surgery Site Parameters* option located on the *Surgery Package Management Menu*, the user can select one of two different formats for this report. One format includes all field names whether or not information has been entered. The other format only includes fields that have actual data.

Electronically signed reports may be viewed through CPRS for completed operations.

## **Nurse Intraoperative Report - Before Electronic Signature**

Upon selecting the *Nurse Intraoperative Report* option, if the Nurse Intraoperative Report is not signed, the report will begin displaying on the screen. The Nurse Intraoperative Report displays key fields on the first page. Several of these fields are required before the software will allow the user to electronically sign the report. If any required fields are left blank, a warning will appear prompting the user to provide the missing information.

The Nurse Intraoperative Report must have the TIME PAT IN OR field and the TIME PAT OUT OR field entered prior to electronic signature. The MARKED SITE CONFIRMED, TIME OUT VERIFIED, and PREOPERATIVE IMAGING CONFIRMED fields are also required before this report can be electronically signed. Additionally, if the COUNT VERIFIER field has been entered, the SPONGE COUNT CORRECT (Y/N) field, SHARPS COUNT CORRECT (Y/N) field, INSTRUMENT COUNT CORRECT (Y/N) field, and the SPONGE, SHARPS, & INST COUNTER field will also be required before the Nurse Intraoperative Report can be electronically signed.



Entering the TIME PAT OUT OR field triggers an alert that is sent to the nurse responsible for signing the report. By acting on the alert, the nurse accesses the *Nurse Intraoperative Report* option to electronically sign the report.

At the bottom of the first screen is the prompt, "Press <return> to continue, 'A' to access Nurse Intraoperative Report functions or '^' to exit:". The *Nurse Intraoperative Report* functions, accessed by entering **A** at the prompt, allow the user to edit the report, to view or print the report, or to electronically sign the report.

### **Example: First page of the Nurse Intraoperative Report**

Select Operation Menu Option: **NR** Nurse Intraoperative Report

```

MEDICAL RECORD          FLORIDA,FRANK (123-45-6789)
                        NURSE INTRAOPERATIVE REPORT - CASE #267226          PAGE 1
Operating Room:  WX OR3          Surgical Priority: ELECTIVE
Patient in Hold: JUL 12, 2004 07:30    Patient in OR: JUL 12, 2004 08:00
Operation Begin: JUL 12, 2004 08:58    Operation End: JUL 12, 2004 12:10
Surgeon in OR:   JUL 12, 2004 07:55    Patient Out OR: JUL 12, 2004 12:45

Major Operations Performed:
Primary: MVR

Wound Classification: CLEAN
Operation Disposition: SICU
Discharged Via: ICU BED

Press <return> to continue, 'A' to access Nurse Intraoperative Report
functions, or '^' to exit: A
```

After the user enters an **A** at the prompt, the *Nurse Intraoperative Report* functions are displayed. The following examples demonstrate how these three functions are accessed and how they operate. If the user enters a **1**, the Nurse Intraoperative Report data can be edited.

### Example: Editing the Nurse Intraoperative Report

```
FLORIDA,FRANK (123-45-6789) Case #267226 - JUL 12, 2004
```

```
Nurse Intraoperative Report Functions:
```

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

```
Select number: 2// 1
```

```
** NURSE INTRAOP ** CASE #267226 FLORIDA,FRANK PAGE 1 OF 5
```

```
1 SPONGE COUNT CORRECT (Y/N):
2 SHARPS COUNT CORRECT (Y/N): YES
3 INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4 SPONGE, SHARPS, & INST COUNTER: PELHAM,STEVE
5 COUNT VERIFIER: LANSING,MARY
6 TIME PAT IN HOLD AREA: JUL 12, 2004 AT 07:30
7 TIME PAT IN OR: JUL 12, 2004 AT 08:00
8 MARKED SITE CONFIRMED: YES
9 PREOPERATIVE IMAGING CONFIRMED: YES
10 TIME OUT VERIFIED: YES
11 MARKED SITE COMMENTS: (WORD PROCESSING)
12 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
13 TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
14 TIME OPERATION BEGAN: JUL 12, 2004 AT 08:58
15 TIME OPERATION ENDS: JUL 12, 2004 AT 12:10
```

```
Enter Screen Server Function: <Enter>
```

```
** NURSE INTRAOP ** CASE #267226 FLORIDA,FRANK PAGE 2 OF 5
```

```
1 SURG PRESENT TIME: JUL 12, 2004 AT 07:55
2 TIME PAT OUT OR: JUL 12, 2004 AT 12:45
3 PRINCIPAL PROCEDURE: MVR
4 OTHER PROCEDURES: (MULTIPLE)
5 WOUND CLASSIFICATION: CLEAN
6 OP DISPOSITION: SICU
7 MAJOR/MINOR:
8 OPERATING ROOM: WX OR3
9 CASE SCHEDULE TYPE: ELECTIVE
10 SURGEON: SPRINGFIELD,JACK
11 ATTEND SURG: SPRINGFIELD,JACK
12 FIRST ASST: TAMPA,KAREN
13 SECOND ASST:
14 PRINC ANESTHETIST: ATHENS,DEBBIE
15 ASST ANESTHETIST:
```

```
Enter Screen Server Function: 5
```

```
Wound Classification: CLEAN// CONTAMINATED CONTAMINATED
```

\*\* NURSE INTRAOP \*\* CASE #267226 FLORIDA,FRANK PAGE 2 OF 5

```
1  SURG PRESENT TIME:  JUL 12, 2004 AT 07:55
2  TIME PAT OUT OR:    JUL 12, 2004 AT 12:45
3  PRINCIPAL PROCEDURE:  MVR
4  OTHER PROCEDURES:    (MULTIPLE)
5  WOUND CLASSIFICATION:  CONTAMINATED
6  OP DISPOSITION:      SICU
7  MAJOR/MINOR:
8  OPERATING ROOM:      WX OR3
9  CASE SCHEDULE TYPE:  ELECTIVE
10 SURGEON:              SPRINGFIELD,JACK
11 ATTEND SURG:         SPRINGFIELD,JACK
12 FIRST ASST:          TAMPA,KAREN
13 SECOND ASST:
14 PRINC ANESTHETIST:   ATHENS,DEBBIE
15 ASST ANESTHETIST:
```

Enter Screen Server Function: ^

At the *Nurse Intraoperative Report* functions, the report can be printed if the user enters a **2**.

### Example: Printing the Nurse Intraoperative Report

FLORIDA,FRANK (123-45-6789) Case #267226 - JUL 12, 2004

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2// <Enter>

-----printout follows-----

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

NURSE INTRAOPERATIVE REPORT  
-----

NOTE DATED: 07/12/2004 08:00 NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room: WX OR3 Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30 Patient in OR: JUL 12, 2004 08:00  
Operation Begin: JUL 12, 2004 08:58 Operation End: JUL 12, 2004 12:10  
Surgeon in OR: JUL 12, 2004 07:55 Patient Out OR: JUL 12, 2004 12:45

Major Operations Performed:  
Primary: MVR

Wound Classification: CONTAMINATED  
Operation Disposition: SICU  
Discharged Via: ICU BED

Surgeon: SPRINGFIELD,JACK First Assist: TAMPA,KAREN  
Attend Surg: SPRINGFIELD,JACK Second Assist: N/A  
Anesthetist: ATHENS,DEBBIE Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:  
Scrubbed Circulating  
HARRISBURG,HENRY (FULLY TRAINED) LANSING,MARY (FULLY TRAINED)  
PELHAM,STEVE (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS Preop Consc: ALERT-ORIENTED  
Preop Skin Integ: INTACT Preop Converse: N/A

Valid Consent/ID Band Confirmed By: TAMPA,KAREN  
Mark on Surgical Site Confirmed: YES  
Marked Site Comments: NO COMMENTS ENTERED

Preoperative Imaging Confirmed: YES  
Imaging Confirmed Comments: NO COMMENTS ENTERED

Time Out Verification Completed: YES  
Time Out Verified Comments: NO COMMENTS ENTERED

Skin Prep By: PELHAM,STEVE Skin Prep Agent: BETADINE SCRUB  
Skin Prep By (2): LANSING,MARY 2nd Skin Prep Agent: POVIDONE IODINE  
Preop Shave By: PELHAM,STEVE

Surgery Position(s):  
SUPINE Placed: N/A

Restraints and Position Aids:  
SAFETY STRAP Applied By: N/A  
ARMBOARD Applied By: N/A  
FOAM PADS Applied By: N/A  
KODEL PAD Applied By: N/A  
STIRRUPS Applied By: N/A

Electrocautery Unit: 8845,5512  
ESU Coagulation Range: 50-35  
ESU Cutting Range: 35-35  
Electroground Position(s): RIGHT BUTTOCK  
LEFT BUTTOCK

Material Sent to Laboratory for Analysis:  
Specimens:  
1. MITRAL VALVE  
Cultures: N/A

Anesthesia Technique(s):  
GENERAL (PRINCIPAL)

Tubes and Drains:  
#16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:

Item: MITRAL VALVE  
Vendor: BAXTER EDWARDS  
Model: 6900  
Lot/Serial Number: GY0755  
Size: 29MM

Sterile Resp: MANUFACTURER  
Quantity: 1

Medications: N/A

Irrigation Solution(s):  
HEPARINIZED SALINE  
NORMAL SALINE  
COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count:  
Sharps Count: YES  
Instrument Count: NOT APPLICABLE  
Counter: PELHAM,STEVE  
Counts Verified By: LANSING,MARY

Dressing: DSD, PAPER TAPE, MEPROM  
Packing: NONE

Blood Loss: 800 ml                      Urine Output: 750 ml

Postoperative Mood: RELAXED  
Postoperative Consciousness: ANESTHETIZED  
Postoperative Skin Integrity: SUTURED INCISION  
Postoperative Skin Color: N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:

PATIENT STATES HE IS ALLERGIC TO PCN. ALL WRVAMC INTRAOPERATIVE NURSING STANDARDS WERE MONITORED THROUGHOUT THE PROCEDURE. VANCYMYCIN PASTE WAS APPLIED TO STERNUM.

To electronically sign the report, the user enters a **3** at the *Nurse Intraoperative Report* functions prompt.

### Example: Signing the Nurse Intraoperative Report

```
FLORIDA,FRANK (123-45-6789) Case #267226 - JUL 12, 2004
```

```
Nurse Intraoperative Report Functions:
```

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

```
Select number: 2// 3
```



The Nurse Intraoperative Report may only be signed by a circulating nurse on the case. At the time of electronic signature, the software checks for data in key fields. The nurse will not be able to sign the report if the TIME PATIENT IN OR field and the TIME PATIENT OUT OF OR fields are not entered. The MARKED SITE CONFIRMED, TIME OUT VERIFIED, and PREOPERATIVE IMAGING CONFIRMED fields are also required before this report can be electronically signed. Also, if the COUNT VERIFIER field is entered, the other counts related fields must be populated. These count fields include the following:

```
SPONGE COUNT CORRECT
SHARPS COUNT CORRECT (Y/N)
INSTRUMENT COUNT CORRECT (Y/N)
SPONGE, SHARPS, & INST COUNTER
```

If any of the key fields are missing, the software will require them to be entered prior to signature. In the following example, the final sponge count must be entered before the nurse is allowed to electronically sign the report.

### Example: Missing Field Warning

```
The following information is required before this report may be signed:
```

```
Final Sponge Count Correct (Y/N)
```

```
Do you want to enter this information? YES// YES
```

```
** NURSE INTRAOP ** CASE #267226 FLORIDA,FRANK PAGE 1 OF 5
```

```
1 SPONGE COUNT CORRECT (Y/N):
2 SHARPS COUNT CORRECT (Y/N): YES
3 INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4 SPONGE, SHARPS, & INST COUNTER: PELHAM,STEVE
5 COUNT VERIFIER: LANSING,MARY
6 TIME PAT IN HOLD AREA: JUL 12, 2004 AT 07:30
7 TIME PAT IN OR: JUL 12, 2004 AT 08:00
8 MARKED SITE CONFIRMED: YES
9 PREOPERATIVE IMAGING CONFIRMED: YES
10 TIME OUT VERIFIED: YES
11 MARKED SITE COMMENTS: (WORD PROCESSING)
12 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
13 TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
14 TIME OPERATION BEGAN: JUL 12, 2004 AT 08:58
15 TIME OPERATION ENDS: JUL 12, 2004 AT 12:10
```

```
Enter Screen Server Function: 1
Final Sponge Count Correct (Y/N): Y YES
```

\*\* NURSE INTRAOP \*\* CASE #267226 FLORIDA,FRANK PAGE 1 OF 5

```
1 SPONGE COUNT CORRECT (Y/N): YES
2 SHARPS COUNT CORRECT (Y/N): YES
3 INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4 SPONGE, SHARPS, & INST COUNTER: PELHAM,STEVE
5 COUNT VERIFIER: LANSING,MARY
6 TIME PAT IN HOLD AREA: JUL 12, 2004 AT 07:30
7 TIME PAT IN OR: JUL 12, 2004 AT 08:00
8 MARKED SITE CONFIRMED: YES
9 PREOPERATIVE IMAGING CONFIRMED: YES
10 TIME OUT VERIFIED: YES
11 MARKED SITE COMMENTS: (WORD PROCESSING)
12 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)
13 TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)
14 TIME OPERATION BEGAN: JUL 12, 2004 AT 08:58
15 TIME OPERATION ENDS: JUL 12, 2004 AT 12:10
```

Enter Screen Server Function: ^



If any of the correct surgery fields – MARKED SITE CONFIRMED, PREOPERATIVE IMAGING CONFIRMED, and TIME OUT VERIFIED – are answered with “NO”, then the user is prompted to enter information in the respective comments field. Entry in the comments field is required, in such cases where “NO” has been entered, before the user can electronically sign the Nurse Intraoperative Report.

FLORIDA,FRANK (123-45-6789) Case #267226 - JUL 12, 2004

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2// 3 Sign the report electronically

Enter your Current Signature Code: **XXX** SIGNATURE VERIFIED

Press RETURN to continue... <Enter>

When typing the electronic signature code, no characters will display on screen.

FLORIDA,FRANK (123-45-6789) Case #267226 - JUL 12, 2004

\* \* The Nurse Intraoperative Report has been electronically signed. \* \*

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning

Select number: 2// ^

## Nurse Intraoperative Report - After Electronic Signature

After the report has been signed, any changes to the report will require a signed addendum.

### Example: Editing the Signed Nurse Intraoperative Report

```
FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12, 2002
* * The Nurse Intraoperative Report has been electronically signed. * *
Nurse Intraoperative Report Functions:
1. Edit report information
2. Print/View report from beginning
Select number: 2// 1 Edit report information
```



If the Anesthesia Report and/or the Nurse Intraoperative Report is already signed, the following warning will be displayed. If any data on either signed report is edited, an addendum to the Anesthesia Report and/or to the Nurse Intraoperative Report will be required.

```
FLORIDA,FRANK (123-45-6789) Case #267226 - FEB 12,2002
>>> WARNING <<<
Electronically signed reports are associated with this case. Editing
of data that appear on electronically signed reports will require the
creation of addenda to the signed reports.
Enter RETURN to continue or '^' to exit: <Enter>
```

First, the user makes the edits to the desired field.

```
** NURSE INTRAOB ** CASE #267226 FLORIDA,FRANK PAGE 1 OF 5
1 SPONGE COUNT CORRECT (Y/N): YES
2 SHARPS COUNT CORRECT (Y/N): YES
3 INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE
4 SPONGE, SHARPS, & INST COUNTER: PELHAM,STEVE
5 COUNT VERIFIER: LANSING,MARY
6 TIME PAT IN HOLD AREA: FEB 12, 2002 AT 07:30
7 TIME PAT IN OR: FEB 12, 2002 AT 08:00
8 MARKED SITE CONFIRMED: YES
9 PREOPERATIVE IMAGING CONFIRMED: YES
10 TIME OUT VERIFIED: YES
11 CORRECT SURGERY COMMENTS: (WORD PROCESSING)
12 TIME OPERATION BEGAN: FEB 12, 2002 AT 08:58
13 TIME OPERATION ENDS: FEB 12, 2002 AT 12:10
14 SURG PRESENT TIME: FEB 12, 2002 AT 07:55
15 TIME PAT OUT OR: FEB 12, 2002 AT 12:45
Enter Screen Server Function: 13
Time the Operation Ends: FEB 12,2002@12:10// 1230 (FEB 12, 2002@12:30)
```

\*\* NURSE INTRAOP \*\* CASE #267226 FLORIDA,FRANK PAGE 1 OF 5

1 SPONGE COUNT CORRECT (Y/N): YES  
2 SHARPS COUNT CORRECT (Y/N): YES  
3 INSTRUMENT COUNT CORRECT (Y/N): NOT APPLICABLE  
4 SPONGE, SHARPS, & INST COUNTER: PELHAM,STEVE  
5 COUNT VERIFIER: LANSING,MARY  
6 TIME PAT IN HOLD AREA: JUL 12, 2004 AT 07:30  
7 TIME PAT IN OR: JUL 12, 2004 AT 08:00  
8 MARKED SITE CONFIRMED: YES  
9 PREOPERATIVE IMAGING CONFIRMED: YES  
10 TIME OUT VERIFIED: YES  
11 MARKED SITE COMMENTS: (WORD PROCESSING)  
12 IMAGING CONFIRMED COMMENTS: (WORD PROCESSING)  
13 TIME OUT VERIFIED COMMENTS: (WORD PROCESSING)  
14 TIME OPERATION BEGAN: JUL 12, 2004 AT 08:58  
15 TIME OPERATION ENDS: JUL 12, 2004 AT 12:30

Enter Screen Server Function: <Enter>

An addendum is required before the edit can be made to the signed report.

FLORIDA,FRANK (123-45-6789) Case #267226 - JUL 12, 2004

An addendum to each of the following electronically signed document(s) is required:

Nurse Intraoperative Report - Case #267226

If you choose not to create an addendum, the original data will be restored to the modified fields appearing on the signed reports.

Create addendum? YES// <Enter>

Addendum for Case #267226 - JUL 12,2004  
Patient: FLORIDA,FRANK (123-45-6789)

-----  
The Time the Operation Ends field was changed  
from JUL 12, 2004@12:10  
to JUL 12, 2004@12:30

Enter RETURN to continue or '^' to exit: <Enter>

Before the addendum is signed, comments may be added.

### Example: Signing the Addendum

Comment: OPERATION END TIME WAS CORRECTED.

Addendum for Case #267226 - JUL 12,2004  
Patient: FLORIDA,FRANK (123-45-6789)

-----  
The Time the Operation Ends field was changed  
from JUL 12, 2004@12:10  
to JUL 12, 2004@12:30

Addendum Comment: OPERATION END TIME WAS CORRECTED.

Enter RETURN to continue or '^' to exit:

Enter your Current Signature Code: **xxx** SIGNATURE VERIFIED..

Press RETURN to continue... <Enter>

When typing the electronic signature code, no characters will display on screen.

### Example: Printing the Nurse Intraoperative Report

FLORIDA,FRANK (123-45-6789) Case #267226 - JUL 12, 2004

\* \* The Nurse Intraoperative Report has been electronically signed. \* \*

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning

Select number: 2// **2** Print/View report from beginning

Do you want WORK copies or CHART copies? WORK// **<Enter>**

DEVICE: HOME// **[Select Print Device]**

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

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

NURSE INTRAOPERATIVE REPORT  
-----

NOTE DATED: 07/12/2004 08:00 NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room: WX OR3 Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30 Patient in OR: JUL 12, 2004 08:00  
Operation Begin: JUL 12, 2004 08:58 Operation End: JUL 12, 2004 12:30  
Surgeon in OR: JUL 12, 2004 07:55 Patient Out OR: JUL 12, 2004 12:45

Major Operations Performed:  
Primary: MVR

Wound Classification: CONTAMINATED  
Operation Disposition: SICU  
Discharged Via: ICU BED

Surgeon: SPRINGFIELD,JACK First Assist: TAMPA,KAREN  
Attend Surg: SPRINGFIELD,JACK Second Assist: N/A  
Anesthetist: ATHENS,DEBBIE Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:  
Scrubbed Circulating  
HARRISBURG,HENRY (FULLY TRAINED) LANSING,MARY (FULLY TRAINED)  
PELHAM,STEVE (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS Preop Consc: ALERT-ORIENTED  
Preop Skin Integ: INTACT Preop Converse: N/A

Valid Consent/ID Band Confirmed By: TAMPA,KAREN  
Mark on Surgical Site Confirmed: YES  
Marked Site Comments: NO COMMENTS ENTERED

Preoperative Imaging Confirmed: YES  
Imaging Confirmed Comments: NO COMMENTS ENTERED

Time Out Verification Completed: YES  
Time Out Verified Comments: NO COMMENTS ENTERED

Skin Prep By: PELHAM,STEVE Skin Prep Agent: BETADINE SCRUB  
Skin Prep By (2): LANSING,MARY 2nd Skin Prep Agent: POVIDONE IODINE  
Preop Shave By: PELHAM,STEVE

Surgery Position(s):  
SUPINE Placed: N/A

Restraints and Position Aids:  
SAFETY STRAP Applied By: N/A  
ARMBOARD Applied By: N/A  
FOAM PADS Applied By: N/A  
KODEL PAD Applied By: N/A  
STIRRUPS Applied By: N/A

Electrocautery Unit: 8845,5512  
ESU Coagulation Range: 50-35  
ESU Cutting Range: 35-35  
Electroground Position(s): RIGHT BUTTOCK  
LEFT BUTTOCK

Material Sent to Laboratory for Analysis:  
Specimens:  
1. MITRAL VALVE  
Cultures: N/A

Anesthesia Technique(s):  
GENERAL (PRINCIPAL)

Tubes and Drains:  
#16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:

Item: MITRAL VALVE  
Vendor: BAXTER EDWARDS  
Model: 6900  
Lot/Serial Number: GY0755  
Size: 29MM

Sterile Resp: MANUFACTURER  
Quantity: 1

Medications: N/A

Irrigation Solution(s):

HEPARINIZED SALINE  
NORMAL SALINE  
COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count: YES  
Sharps Count: YES  
Instrument Count: NOT APPLICABLE  
Counter: PELHAM,STEVE  
Counts Verified By: LANSING,MARY

Dressing: DSD, PAPER TAPE, MEPROM  
Packing: NONE

Blood Loss: 800 ml                      Urine Output: 750 ml

Postoperative Mood: RELAXED  
Postoperative Consciousness: ANESTHETIZED  
Postoperative Skin Integrity: SUTURED INCISION  
Postoperative Skin Color: N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:

PATIENT STATES HE IS ALLERGIC TO PCN. ALL WRVAMC INTRAOPERATIVE NURSING  
STANDARDS WERE MONITORED THROUGHOUT THE PROCEDURE. VANCYMYCIN PASTE WAS  
APPLIED TO STERNUM.

Signed by: /es/ MARY A LANSING  
03/04/2002 10:41

04/17/2002 16:42              ADDENDUM

The Time the Operation Ends field was changed  
from JUL 12, 2004@12:10  
to JUL 12, 2004@12:30

Addendum Comment: OPERATION END TIME WAS CORRECTED.

Signed by: /es/ MARY A LANSING  
07/17/2004 16:42

# Tissue Examination Report [SROTRPT]

The *Tissue Examination Report* option is used to generate the Tissue Examination Report that contains information about cultures and specimens sent to the laboratory.

This report prints in an 80-column format and can be viewed on the screen.

## Example: Tissue Examination Report

Select Operation Menu Option: T Tissue Examination Report  
DEVICE: [Select Print Device]

-----printout follows-----

```
-----
MEDICAL RECORD | TISSUE EXAMINATION
-----
Specimen Submitted By:          Obtained: MAR 09, 1999
OR1, SURGERY CASE # 187
-----
Specimen(s):
-----
Brief Clinical History:
Subscapular pain for 3 days. Nausea and vomiting.
Increased serum amylase.
-----
Operative Procedure(s):
CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM
-----
Preoperative Diagnosis:
CHOLECYSTITIS
-----
Operative Findings:
THE GALLBLADDER HAD A FEW ADHESIONS EASILY REMOVED
AND WAS FOUND TO BE FIRMLY DISTENDED WITH STONES.
-----
Postoperative Diagnosis:          Signature and Title
CHOLECYSTITIS                    TULSA,LARRY
-----
Attending Surgeon: TOPEKA,MARK
-----
```

PATHOLOGY REPORT

```
-----
Name of Laboratory              Accession Number(s)
-----
Gross Description, Histologic Examination and Diagnosis
-----
```

(Continue on reverse side)

```
-----
PATHOLOGIST'S SIGNATURE          DATE:
-----
HAWAII,LOU                      AGE: 49   SEX: MALE   ID # 123-45-6789
ETHNICITY: NOT HISPANIC         REGISTER NO.
RACE: WHITE, ASIAN
WARD:                            ROOM-BED:
-----
VAMC: MAYBERRY, NC              REPLACEMENT FORM 515
-----
```

## Enter Referring Physician Information [SR0MEN-REFER]

The *Enter Referring Physician Information* option allows the surgical staff to enter the name, address and phone number of the individual or institution that referred the patient. Referring physician information is usually entered by the scheduling manager when the operation is booked. This information displays on many reports.

### Example: Enter Referring Physician Information

```
Select Operation Menu Option: R Enter Referring Physician Information
```

```
Select REFERRING PHYSICIAN: DR. WILLIAM MILWAUKEE  
Street Address: 1600 ANYWHERE AVE.  
City: GALVESTON  
State: TX TEXAS  
Zip Code: <Enter>  
Phone Number: 555-2873
```

## Enter Irrigations and Restraints [SR0MEN-REST]

The *Enter Irrigations and Restraints* option is designed to allow the nurse to quickly document the irrigation solutions or the restraint and positioning devices used in a case. The list of solutions or devices can be different at each facility.

At the "Select Number:" prompt, the user should choose the number corresponding to the solution or device. For more than one choice, numbers are separated with a comma. If an item has been selected before, a default prompt will appear. The user can enter an at-sign (@) to delete the selection, as in Example 3.

### Example 1: Entering Irrigations

```
Select Operation Menu Option: RP Enter Irrigations or Restraints
```

```
Enter/Edit Irrigations or Restraints and Positioning Aids:
```

```
1. Irrigations
2. Restraints and Positioning Aids
Select Number: 1
```

#### IRRIGATION SOLUTIONS

```
=====
1.      AEROSP/PXYN          2.      BACITRACIN SOLUTION
3.      BETADINE SOLUTION   4.      HEPARIN
5.      HEPARINIZED SALINE  6.      ICED SALINE
7.      KANTREX SOLUTION    8.      KEFLEX SOLUTION
9.      NEOMYCIN            10.     NEOMYCIN SOLUTION
11.     NORMAL SALINE      12.     POVODINE
13.     SORBITAL           14.     STERILE WATER
15.     VEIN GRAFT SOLUTION 16.     THROMBIN
```

```
Select the number(s) corresponding to your choice: 2,15
```

```
Entering BACITRACIN SOLUTION ...
Entering VEIN GRAFT SOLUTION ...
```

```
Press <Enter> to continue      <Enter>
```

### Example 2: Restraints and Positioning Aids

```
Select Operation Menu Option: RP Enter Irrigations or Restraints
```

```
Enter/Edit Irrigations or Restraints and Positioning Aids:
```

```
1. Irrigations
2. Restraints and Positioning Aids
Select Number: 2
```

```

                                Restraints and Positioning Aids
=====
1.  ARMSHEET                    2.  SAFETY STRAP
3.  ARMBOARD                    4.  VAC PAC
5.  FOAM PADS                   6.  PILLOW
7.  AXILLARY ROLL               8.  ADHESIVE TAPE
9.  SURGERY ARMBOARD           10. KIDNEY REST
11. SANDBAG                     12. OVERHEAD ARMREST
13. ROLLED SHEET               14. LEG HOLDER
15. FOOT EXTENSION             16. STIRRUPS
17. FRACTURE TABLE            18. OTHER

Select the number(s) corresponding to your choice: 3,6,9
Entering ARMBOARD ...

Entering PILLOW ...

Entering SURGERY ARMBOARD ...

Press <Enter> to continue  <Enter>

```

**Example 3: Deleting Restraints and Positioning Aids**

```

Select Operation Menu Option: RP Enter Irrigations or Restraints

```

```

Enter/Edit Irrigations or Restraints and Positioning Aids:
1. Irrigations
2. Restraints and Positioning Aids

Select Number: 2

```

```

                                Restraints and Positioning Aids
=====
1.  ARMSHEET                    2.  SAFETY STRAP
3.  ARMBOARD                    4.  VAC PAC
5.  FOAM PADS                   6.  PILLOW
7.  AXILLARY ROLL               8.  ADHESIVE TAPE
9.  SURGERY ARMBOARD           10. KIDNEY REST
11. SANDBAG                     12. OVERHEAD ARMREST
13. ROLLED SHEET               14. LEG HOLDER
15. FOOT EXTENSION             16. STIRRUPS
17. FRACTURE TABLE            18. OTHER

Select the number(s) corresponding to your choice: 3
Entering ARMBOARD ...
  RESTR & POSITION AIDS: ARMBOARD// @
  SURE YOU WANT TO DELETE THE ENTIRE RESTR & POSITION AIDS? Y (YES)

Press <Enter> to continue

```

## Medications (Enter/Edit) [SROANES MED]

The *Medications (Enter/Edit)* option allows the user to enter all the medications administered on a case. It is designed to aid in quickly entering many different medications for a case.

In one entry, the user can enter the medication, dosage, route, and time given with the use of slashes between these categories. After one medication has been entered, the software will return the cursor to the beginning prompt so that the user can enter another medication for the case. When the user is finished entering medications for the case, he or she should press the <Enter> key to return to the menu.

### About the prompts

"ENTER MEDICATION/DOSE(MG)/ROUTE/TIME:" Respond to this prompt with the medication, dosage, route, and time given separated by slashes. If the software needs more specific information about the medication, the user will be prompted. In the example below, the software reads "Valium" and then asks the user to select from the Valiums on file. A question mark can be entered in place of one of the categories in order to get help or more information. In the example, a question mark was entered in place of the route. Then, in response to the question mark, the software offered a list of acceptable routes.

### Example: Entering Medication

```
Select Operation Menu Option: Medications (Enter/Edit)

ENTER MEDICATION/DOSE(MG)/ROUTE/TIME: DIAZEPAM/5MG/?/8:00

      1  DIAZEPAM 10MG S.R. CAP                N/F      ***NOT MANUFACTURED***
      2  DIAZEPAM 10MG S.T.                   NOTE RESTRICTIONS (ON OPTS ONLY)
      3  DIAZEPAM 15 MG S.R. CAP                N/F      NOTE RESTRICTIONS
      4  DIAZEPAM 2MG S.T.                     N/F
      5  DIAZEPAM 5MG S.T.                     NOTE RESTRICTIONS (ON OPTS ONLY)

Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 5

Route entered is not one of the available choices.
Please enter medication route again.

Choose from:
IV      INTRAVENOUS
T       TOPICAL
IR      IRRIGATION
IM      INTRAMUSCULAR
R       RECTAL
S       SUBLINGUAL
SC      SUBCUTANEOUS
IN      INFILTRATE
O       OTHER
P       PREPUMP
OR      ORAL

Enter ROUTE: IV INTRAVENOUS

MEDICATION ENTERED ...

ENTER MEDICATION/DOSE(MG)/ROUTE/TIME:
```

## Blood Product Verification

### [SR BLOOD PRODUCT VERIFICATION]

The *Blood Product Verification* option is used for transfusion error risk management. This option is used in conjunction with a bar code reader to confirm that the blood product is assigned to the patient. The functionality provided by this option is meant as an additional check for proper patient identification and should never be relied upon as the primary check.

This option prompts the user to scan the blood product unit ID, after which the software checks the Blood Bank files for an association with the patient identified. If there are multiple entries with the unit ID scanned, these entries will be listed along with the Blood Component, Patient Associated, and Expiration Date. The user will then be prompted to select the one that matches the blood product about to be administered. If the selected product is not associated with the patient identified, a warning message will be displayed.

There are certain valid scenarios that are internal to the Blood Bank that may result in a blood component not being readable using the scanner and therefore may give an unexpected response. There will be some rare instances in which this option may not produce an expected result. After verifying proper patient identification, the option may be attempted again; however, it is recommended that the unit ID be typed in manually rather than be scanned in these cases.

Blood product manufacturers are required to label all units of blood in a consistent manner. The barcode that is to be scanned at the "Enter Blood Product Identifier:" prompt will always be the barcode in the upper-left portion of the blood product label. Since this label can be in close proximity to the ABO/Rh label, care should be taken not to read both labels during a scan. One way to accomplish this would be to use a finger or some other convenient object to cover the label that the user does not wish to have read during the scanning process. The light emitted from the scanner itself will cause no harm to skin, latex, or any other object with which it comes in contact.

#### Example: Option displayed with no discrepancies

```
Select Operation Menu Option: BLOOD PRODUCT VERIFICATION
To use BAR CODE READER
    Pass reader wand over a GROUP-TYPE ( ABO/Rh) label
    =>
Enter Blood Product Identifier: KW10945

1) Unit ID: KW10945                CPDA-1 RED BLOOD CELLS
   Patient: KANSAS,THOMAS 123-45-6789  Expiration Date: NOV 27, 2004

2) Unit ID: KW10945                FRESH FROZEN PLASMA, ACD-A
   Patient: KANSAS,THOMAS 123-45-6789  Expiration Date: MAY 19, 2004

3) Unit ID: KW10945                PLATELETS, POOLED, IRRADIATED
   Patient: KANSAS,THOMAS 123-45-6789  Expiration Date: MAR 24, 2004

Select the blood product matching the unit label: (1-3): 2

No Discrepancies Found
```

### Example: Option displayed with discrepancies

```
Select Operation Menu Option: BLOOD PRODUCT VERIFICATION

To use BAR CODE READER
    Pass reader wand over a GROUP-TYPE ( ABO/Rh) label
    =>
Enter Blood Product Identifier: KW10945

1) Unit ID: KW10945                CPDA-1 RED BLOOD CELLS
   Patient: KANSAS,THOMAS 123-45-6789    Expiration Date: NOV 27, 2004

2) Unit ID: KW10945                FRESH FROZEN PLASMA, ACD-A
   Patient: KANSAS,THOMAS 123-45-6789    Expiration Date: MAY 19, 2004

3) Unit ID: KW10945                PLATELETS, POOLED, IRRADIATED
   Patient: KANSAS,THOMAS 123-45-6789    Expiration Date: MAR 24,2004

Select the blood product matching the unit label: (1-3): 1

                **WARNING**

Blood Product Expiration Date is later than today's date.
```

# Anesthesia Menu

[SROANES1]



The *Anesthesia Menu* is restricted to Anesthesia personnel and is locked with the SROANES key. It is designed for the convenient entry of data pertaining to the anesthesia agents and techniques used in a surgery.

The main options included in this menu are listed below. The *Anesthesia Data Entry Menu* contains sub-options. To the left of the option name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
E	<i>Anesthesia Data Entry Menu</i>
R	<i>Anesthesia Report</i>
A	<i>Anesthesia AMIS</i>
S	<i>Schedule Anesthesia Personnel</i>

## Prerequisites

To use the *Anesthesia Data Entry Menu* or the *Anesthesia Report* option, the user must first select a patient case. The user does not need to select a case to use the *Anesthesia AMIS* option, as it generates a report that is a compilation of statistics for all cases. However, the user must select an operating room to use the *Schedule Anesthesia Personnel* option.

## Anesthesia Data Entry Menu [SROANES-D]

The *Anesthesia Data Entry Menu* allows the user to enter anesthesia data pertinent to a selected case. The information entered in these sub-options is reflected on the Anesthesia Report.

To use any option within the *Anesthesia Data Entry Menu*, the user must first enter a patient name and choose a patient case, as shown below.

### Example: How to Select a Case for the Data Entry Menu

```
Select Surgery Menu Option:  A  Anesthesia Menu

  E   Anesthesia Data Entry Menu
  R   Anesthesia Report
  A   Anesthesia AMIS
  S   Schedule Anesthesia Personnel

Select Anesthesia Menu Option: E  Anesthesia Data Entry Menu
Select Patient: HAWAII, LOU      12-09-51      123456789      NSC VETERAN

HAWAII, LOU      123-45-6789

1. 04-26-99      CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)
2. 11-20-98      Release of Hammer Toes (REQUESTED)
3. ENTER NEW SURGICAL CASE

Select Operation:  1

HAWAII, LOU (123-45-6789)      Case #145 - APR 26, 1999

  I   Anesthesia Information (Enter/Edit)
  T   Anesthesia Technique (Enter/Edit)
  M   Medications (Enter/Edit)

Select Anesthesia Data Entry Menu Option:
```

## Anesthesia Information (Enter/Edit) [SRROMEN-ANES]

Anesthesia staff uses this option to enter anesthesia related information for a given case. The first group of prompts affects the Anesthesia AMIS Report. Some of the data fields may be automatically filled in from previous responses.

At the "Enter Screen Server Function:" prompt, the user can choose the field(s) to be edited, or press the <Enter> key to continue. Some of the data fields are "multiple" and may contain more than one value. When a multiple field is selected, a new screen is generated so that the user can enter data related to that multiple. For instance, the MONITORS field generates a new screen for adding the device, time installed, and time removed. The TIME INSTALLED field and TIME REMOVED field generate additional screens so that the user may enter more than one time installed/removed for the same operation.

### About the prompts

"Is this the Principal Technique (Y/N):" This prompt asks whether or not the technique being entered is the primary anesthesia technique for the case. It is advisable to establish the principal technique as this information affects many reports.

"Would you like to enter additional anesthesia related information ?" If the user wishes to enter more detailed information concerning the case, he or she should answer **YES** to this prompt. Two Screen Server-formatted pages will then be provided for entering more anesthesia information for the case.

### **Example: Entering Anesthesia Information**

```
Select Anesthesia Data Entry Menu Option: I Anesthesia Information (Enter/Edit)
```

```
The following information is required for the Anesthesia AMIS.
```

```
Principal Anesthetist: COLUMBIA,CAROLINE// <Enter>
Select ANESTHESIA TECHNIQUE: G (G GENERAL)
  Is this the Principal Technique (Y/N): YES// <Enter>
  Was the Patient Intubated ? (Y/N): Y YES
  Trauma Resulting from Intubation Process: NONE// <Enter>
  Select ANESTHESIA AGENTS: ENFLURANE N/F
    Dose (mg): 125
Diagnostic/Therapeutic (Y/N): NO// <Enter>

ASA Class: 2 2-MILD DISTURB.

Would you like to enter additional anesthesia related information ? NO//Y
```

\*\* ANESTHESIA INFO \*\* CASE #145 HAWAII,LOU PAGE 1 OF 2

1 ANESTHESIOLOGIST SUPVR:  
2 ANES SUPERVISE CODE:  
3 PRINC ANESTHETIST: COLUMBIA,CAROLINE  
4 RELIEF ANESTHETIST:  
5 ASST ANESTHETIST:  
6 ANES CARE START TIME: APR 26, 1999 AT 09:10  
7 INDUCTION COMPLETE:  
8 ANES CARE END TIME: APR 26, 1999 AT 12:50  
9 ASA CLASS: 2-MILD DISTURB.  
10 BLOOD LOSS (ML): 200  
11 MIN INTRAOP TEMPERATURE (C):  
12 FINAL ANESTHESIA TEMP (C):  
13 TOTAL URINE OUTPUT (ML): 1  
14 OP DISPOSITION: PACU (RECOVERY ROOM)  
15 POSTOP ANES NOTE:

Enter Screen Server Function: **10:13**  
Intraoperative Blood Loss (ml): 200// **500**  
Lowest Intraoperative Temperature (C): **28**  
Final Anesthesia Temperature (C): **37**  
Total Urine Output (ml): 1// **1800**

\*\* ANESTHESIA INFO \*\* CASE #145 HAWAII,LOU PAGE 1 OF 2

1 ANESTHESIOLOGIST SUPVR:  
2 ANES SUPERVISE CODE:  
3 PRINC ANESTHETIST: COLUMBIA,CAROLINE  
4 RELIEF ANESTHETIST:  
5 ASST ANESTHETIST:  
6 ANES CARE START TIME: APR 26, 1999 AT 09:10  
7 INDUCTION COMPLETE:  
8 ANES CARE END TIME: APR 26, 1999 AT 12:50  
9 ASA CLASS: 2-MILD DISTURB.  
10 BLOOD LOSS (ML): 500  
11 MIN INTRAOP TEMPERATURE (C): 28  
12 FINAL ANESTHESIA TEMP (C): 37  
13 TOTAL URINE OUTPUT (ML): 1800  
14 OP DISPOSITION: PACU (RECOVERY ROOM)  
15 POSTOP ANES NOTE:

Enter Screen Server Function: **<Enter>**

\*\* ANESTHESIA INFO \*\* CASE #145 HAWAII,LOU PAGE 2 OF 2

1 ORAL-PHARYNGEAL SCORE: CLASS 2  
2 MANDIBULAR SPACE: 80  
3 REPLACEMENT FLUID TYPE: (MULTIPLE)(DATA)  
4 MEDICATIONS: (MULTIPLE)(DATA)  
5 MONITORS: (MULTIPLE)  
6 GENERAL COMMENTS: (WORD PROCESSING)  
7 THERMAL UNIT: (MULTIPLE)(DATA)  
8 ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)

Enter Screen Server Function: **5**

\*\* ANESTHESIA INFO \*\* CASE #145 HAWAII,LOU PAGE 1  
MONITORS

1 NEW ENTRY

Enter Screen Server Function: **1**  
Select MONITORS: **ECG**  
MONITORS: ECG// **<Enter>**

```
** ANESTHESIA INFO ** CASE #145 HAWAII,LOU PAGE 1
MONITORS (ECG)
1 MONITORS: ECG
2 TIME INSTALLED:
3 TIME REMOVED:
4 APPLIED BY:

Enter Screen Server Function: 2:4
Time Applied: 4/26@9:20 (APR 26, 1999@09:20)
Time Removed: 4/26@12:45 (APR 26, 1999@12:45)
Person Applying the Monitor: MONTPELIER,MELINDA
```

```
** ANESTHESIA INFO ** CASE #145 HAWAII,LOU PAGE 1 OF 1
MONITORS (ECG)
1 MONITORS: ECG
2 TIME INSTALLED: APR 26, 1999 AT 09:20
3 TIME REMOVED: APR 26, 1999 AT 12:45
4 APPLIED BY: MONTPELIER,MELINDA

Enter Screen Server Function: <Enter>
```

```
** ANESTHESIA INFO ** CASE #145 HAWAII,LOU PAGE 1 OF 1
MONITORS
1 MONITORS: ECG
2 NEW ENTRY

Enter Screen Server Function: <Enter>
```

```
** ANESTHESIA INFO ** CASE #145 HAWAII,LOU PAGE 2 OF 2
1 ORAL-PHARYNGEAL SCORE: CLASS 2
2 MANDIBULAR SPACE: 80
3 REPLACEMENT FLUID TYPE: (MULTIPLE)(DATA)
4 MEDICATIONS: (MULTIPLE)(DATA)
5 MONITORS: (MULTIPLE)(DATA)
6 GENERAL COMMENTS: (WORD PROCESSING)
7 THERMAL UNIT: (MULTIPLE)(DATA)
8 ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)

Enter Screen Server Function:
```

## **Anesthesia Technique (Enter/Edit)** **[SRROMEN-ANES TECH]**

The *Anesthesia Technique (Enter/Edit)* option is used to enter information concerning the anesthesia technique. More than one anesthesia technique can be entered for a case. When the user is finished entering the first technique, he or she should select this option again to start entering another anesthesia technique.

The Surgery software recognizes six different anesthesia techniques, each with different sets of prompts.

G	<i>GENERAL</i>
M	<i>MONITORED ANESTHESIA CARE</i>
S	<i>SPINAL</i>
E	<i>EPIDURAL</i>
O	<i>OTHER</i>
L	<i>LOCAL</i>

A seventh choice for anesthesia technique is NO ANESTHESIA. This selection does not include any additional prompts.

### **About the prompts**

"Diagnostic/ Therapeutic (Y/N):" The user should answer **Y** or **YES** if the anesthesia procedure is itself a surgical procedure. The user will then have an opportunity to define the surgical (operative) procedure.

"Is this the Principal Technique (Y/N):" This prompt asks the user whether or not the technique being entered is the primary anesthesia technique for the case. For the technique being entered to appear on the Anesthesia AMIS Report, answer this prompt with a **Y** or **YES**.

"Select ANESTHESIA AGENTS:" The user can enter more than one anesthesia agent for a case by using the up-arrow (^) to jump to the "Select ANESTHESIA AGENTS:" prompt.

### Example 1: General Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: G (GENERAL)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): Y YES
  Trauma Resulting from Intubation Process: NONE// <Enter> NONE
Select ANESTHESIA AGENTS: ?
```

More than one anesthesia agent may be entered for each technique.



The ANESTHESIA AGENT field uses entries from the institution's local DRUG file. Prior to using the Surgery package, drugs that will be used as anesthesia agents must be flagged (using the Chief of Surgery Menu) by the user's package coordinator. If the user experiences problems entering an agent, it is likely that the drug being chosen has not been flagged.

```
Select ANESTHESIA AGENTS: ENFLURANE
  Dose (mg): <Enter>
Approach Technique: D DIRECT VISION LARYNGOSCOPY
Endotracheal Tube Route: O ORAL
Type of Laryngoscope: M MACINTOSH
Laryngoscope Size: 3
Was a Stylet Used ? (Y/N): Y YES
Was Topical Lidocaine Used ? (Y/N): Y YES
Was Intravenous Lidocaine Administered ? (Y/N): N NO
Type of Endotracheal Tube: P PVC LOW PRESSURE
Endotracheal Tube Size: 3
Location where the Endotracheal Tube was Removed: O OR
Who Removed the Endotracheal Tube ? : MONTPELIER,MELINDA
Was Reintubation Required within 8 Hours ? (Y/N): N NO
Was a Heat and Moisture Exchanger Used ? (Y/N): N NO
Was a Bacterial Filter Used ? (Y/N): N NO
Oral-Pharyngeal (OP) Score: 1 CLASS 1
Mandibular Space (length in mm): 65
Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// No (No Editing)
GENERAL COMMENTS:
1> <Enter>
```

### Example 2: Monitored Anesthesia Care Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: M (MONITORED ANESTHESIA CARE)
  Is this the Principal Technique (Y/N): YES//<Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: VALIUM
    Dose (mg): 5
Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
Mandibular Space (length in mm): 65// <Enter>
Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0//NO (No Editing)
GENERAL COMMENTS:
1> <Enter>
```

### Example 3: Spinal Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: S (SPINAL)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: PONTOCAINE
  Dose (mg): 5
  Was the Catheter placed for Continuous Administration ? (Y/N): NO
  // <Enter> NO
  Baricity: 1// <Enter> HYPERBARIC
  Puncture Site: 2 L3-4
  Needle Size: 25G 25G
  Neurodermatone Anesthesia Sensory Level: T6 T6
  Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
  Mandibular Space (length in mm): 65// <Enter>
  Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
  GENERAL COMMENTS:
  1><Enter>
```

### Example 4: Epidural Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: E (EPIDURAL)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: LIDOCAINE
  Dose (mg): 5
  Was the Catheter placed for Continuous Administration ? (Y/N): YES
  // <Enter> YES
  Puncture Site: 2 L3-4
  Dural Puncture ? (Y/N): NO// Y YES
  Who Removed the Catheter ? : 213 DES MOINES,DIANE
  Date/Time that the Catheter was Removed: 5/4@2:30 (MAY 04, 1999@14:30)
  Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
  Mandibular Space (length in mm): 65// <Enter>
  Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
  GENERAL COMMENTS:
  1>LOSS OF RESISTANCE TECHNIQUE
  2><Enter>
  EDIT Option: <Enter>
```

### Example 5: Other Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: O (OTHER)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: LIDOCAINE
  Dose (mg): 5
  Select BLOCK SITE: ABDOMINAL WALL Y4300
  ARE YOU ADDING 'ABDOMINAL WALL' AS A NEW BLOCK SITE (THE 1ST FOR THIS ANESTHESIA TECHNIQUE)? Y
  (YES)
  Length of Needle (cm): 3
  Gauge Size of the Needle: 22
  Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
  Mandibular Space (length in mm): 65// <Enter>
  Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
  GENERAL COMMENTS:
  1> <Enter>
```

### Example 6: Local Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: L (LOCAL)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: LIDOCAINE
    Dose (mg): 5
  Select BLOCK SITE: OROPHARYNX          60200
  ARE YOU ADDING 'OROPHARYNX' AS A NEW BLOCK SITE (THE 1ST FOR THIS ANESTHESIA TECHNIQUE)? Y
  (YES)
    Length of Needle (cm): <Enter>
    Gauge Size of the Needle: <Enter>
  Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
  Mandibular Space (length in mm): 65// <Enter>
  Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
  GENERAL COMMENTS:
  1>
```

## Medications (Enter/Edit) [SROANES MED]

Anesthesia staff members use the *Medications (Enter/Edit)* option to enter medications administered on a case. This is the last sub-option of the *Anesthesia Data Entry Menu*.

This option is designed to help the user quickly enter many different medications for a case. In one entry, the user can enter the medication, dosage, route, and time given with the use of slashes between these categories. (This is a different type of prompt response from what has been used elsewhere). After the user has finished entering one medication, the software will return the cursor to the beginning prompt so that he or she can enter another medication for the case. When the user finishes entering medications for the case, he or she should press the <Enter> key to return to the *Anesthesia Data Entry Menu*.

### About the prompts

"ENTER MEDICATION/DOSE(MG)/ROUTE/TIME:" Respond to this prompt with the medication, dosage, route, and time given separated by slashes. If the software needs more specific information about the medication, the user will be prompted. In the example, the software reads "Valium" and then asks the user to select from the Valiums on file. A question mark can be entered in place of one of the categories in order to get help or more information. In the following example, a question mark was entered in place of the route. Then, in response to the question mark, the software offered a list of acceptable routes.

### Example: Entering a Medication

```
Select Anesthesia Data Entry Menu Option: M Medications (Enter/Edit)
```

```
ENTER MEDICATION/DOSE(MG)/ROUTE/TIME: VALIUM/5MG/?/7:50
```

```
  1  VALIUM 5MG          N/F
  2  VALIUM DIAZEPAM 10MG S.T.      N/F      RESTRICTED TO
ENT/ANESTHESIA/PSYCHIATRY/PARAPLEGICS
  3  VALIUM DIAZEPAM 2MG S.T.      N/F      RESTRICTED TO
ENT/ANESTHESIA/PSYCHIATRY/PARAPLEGICS
TYPE '^' TO STOP, OR
CHOOSE 1-3: 1      (JAN 13, 1999 07:50)
```

```
Route entered is not one of the available choices.
Please enter medication route again.
```

```
Choose from:
```

```
IV      INTRAVENOUS
T       TOPICAL
IR      IRRIGATION
IM      INTRAMUSCULAR
R       RECTAL
S       SUBLINGUAL
SC      SUBCUTANEOUS
IN      INFILTRATE
O       OTHER
P       PREPUMP
OR      ORAL
```

```
ENTER ROUTE: IV
```

```
MEDICATION ENTERED ....
```

```
ENTER MEDICATION/DOSE(MG)/ROUTE/TIME:
```

## **Anesthesia Report [SROARPT]**

Anesthesia staff uses the *Anesthesia Report* option to print all the anesthesia information entered for a case. When a hard copy of this report is made, space is provided for the Anesthetist's signature. This option is located on the *Anesthesia Menu* option. It can also be accessed from the *Operation Menu* option.

For more information, see the Anesthesia Report section in the Operation Menu section of this manual.

## Anesthesia AMIS [SROAMIS]

The *Anesthesia AMIS* option compiles statistics for all surgical cases and non-O.R. procedures within the date range selected and generates the Anesthesia AMIS Report.



This option is locked with the SROAAMIS key.

The Anesthesia AMIS Report prints in a 132-column format and must be copied to a printer.

### Example: Printing the Anesthesia AMIS Report

```
Select Anesthesia Menu Option: A Anesthesia AMIS
```

```
Anesthesia AMIS
```

```
Start with Date: 1 1 99 (JAN 01, 1999)
```

```
End with Date: 1 31 99 (JAN 31, 1999)
```

```
Do you want to print all divisions? YES// <Enter>
```

```
This report is designed to use a 132 column format, and must be run  
on a printer.
```

```
DEVICE: [Select Print Device]
```

-----*report follows*-----

MAYBERRY, NC - ALL DIVISIONS  
 ANESTHESIA SERVICE  
 ANESTHESIA AMIS  
 FROM: JAN 1,1999 TO: JAN 31,1999

REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: FEB 7,1999

ANESTHETICS ADMINISTERED BY PRINCIPAL TECHNIQUE USED

TOTAL NO OF ANES- THETICS ADMINISTERED	GENERAL	MAC	SPINAL	EPIDURAL	OTHER	LOCAL
54	8	1	3	1	0	41

ANESTHETICS FOR PROCEDURES ADMINISTERED BY:

\*\* ANESTHETICS FOR DIAG. & THERA. PROCEDURES ADMINISTERED BY:

ANESTHESIOLOGIST		NURSE ANESTHETIST		OTHER		** ANESTHESIOLOGIST		NURSE ANESTHETIST		OTHER	
NUMBER OF ANESTHETICS	NO. OF DEATHS										
9	0	3	0	40	1	** 1	0	0	0	1	0

DEATHS WITHIN 24 HOURS OF INDUCTION OF ANESTHETIC

TOTAL NUMBER OF DEATHS	GENERAL	MAC	SPINAL	EPIDURAL	OTHER	LOCAL
1	0	0	0	0	0	1

## Schedule Anesthesia Personnel [SRSCHDA]

Anesthesia staff uses the *Schedule Anesthesia Personnel* option to assign or change anesthesia personnel for surgery cases. The Scheduling Manager can also assign personnel to the selected case using other menu options.



This *Schedule Anesthesia Personnel* option is locked with the SROANES key and will not appear on the menu if the user does not have this key.

With this option, the user can enter an anesthesia technique and the names of the principal anesthetist and supervisor. When an operating room is selected, the software will present all cases scheduled for that room. After scheduling personnel for cases in one operating room, the user can do the same for other operating rooms without leaving this option. For convenience, the software will default to the anesthetist and anesthesiologist supervisor previously scheduled for that room.

### Example: Scheduling Anesthesia Personnel

```
Select Anesthesia Menu Option: S Schedule Anesthesia Personnel
Schedule Anesthesia Personnel for which Date ? 4/26 (APR 26,1999)
```

```
Schedule Anesthesia Personnel for which Operating Room ? OR2
```

```
Scheduled Operations for OR2
```

```
-----
Case # 145 Patient: HAWAII,LOU
From: 09:00 To: 12:00
CHOLECYSTECTOMY
```

```
Requested Anesthesia Technique: GENERAL// <Enter>
Principal Anesthetist: COLUMBIA,CAROLINE CC
Anesthesiologist Supervisor: AUGUSTA,DON// <Enter>
```

```
Press <Enter> to continue, or '^' to quit <Enter>
```

```
Scheduled Operations for OR2
```

```
-----
Case # 148 Patient: MONTANA,JOHNNY
From: 13:00 To: 18:00
SHOULDER ARTHROPLASTY
```

```
Requested Anesthesia Technique: GENERAL// <Enter>
Principal Anesthetist: COLUMBIA,CAROLINE// <Enter> CC
Anesthesiologist Supervisor: AUGUSTA,DON// <Enter> DA
```

```
Press <Enter> to continue, or '^' to quit <Enter>
```

```
Would you like to continue with another operating room ? YES// <Enter>
```

```
Schedule Anesthesia Personnel for which Operating Room ? OR3
```

Scheduled Operations for OR3

-----  
Case # 136 Patient: MAINE,JOE  
From: 07:00 To: 10:30  
CHOLECYSECTOMY

Requested Anesthesia Technique: GENERAL// <Enter>  
Principal Anesthetist: JACKSON,R CH  
Anesthesiologist Supervisor: AUGUSTA,DON// <Enter>  
Press <Enter> to continue, or '^' to quit <Enter>

Would you like to continue with another operating room ? YES// Y

Schedule Anesthesia Personnel for which Operating Room ? OR1

There are no cases scheduled for this operating room.

Press RETURN to continue <Enter>

Would you like to continue with another operating room ? YES// N

# Perioperative Occurrences Menu

## [SRO COMPLICATIONS MENU]

Surgeons use options within the *Perioperative Occurrences Menu* option to enter or edit occurrences that occur before, during, and/or after a surgical procedure. It is also possible to enter occurrences for a patient who did not have a surgical procedure performed. The user can enter more than one occurrence per patient.



This option is locked with the SROCOMP key.

Occurrences will be included on the Chief of Surgery's Morbidity & Mortality Reports.

---



Please review specific institution policy to determine what is considered an occurrence for any category.

---

The options included in this menu are listed below. To the left of the option name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
I	<i>Intraoperative Occurrences (Enter/Edit)</i>
P	<i>Postoperative Occurrences (Enter/Edit)</i>
N	<i>Non-Operative Occurrences (Enter/Edit)</i>
U	<i>Update Status of Returns Within 30 Days</i>
M	<i>Morbidity &amp; Mortality Reports</i>

## Key Vocabulary

The following terms are used in this section.

Term	Definition
Intraoperative Occurrence	Occurrence that occurs during the procedure.
Postoperative Occurrence	Occurrence that occurs after the procedure.
Non-Operative Occurrence	Occurrence that develops before a surgical procedure is performed.

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

The *Intraoperative Occurrences (Enter/Edit)* option is used to add information about an occurrence that occurs during the procedure. The user can also use this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, the user should select an operation. The software will then list any occurrences already entered for that operation. The user may edit a previously entered occurrence or can type the word **NEW** and press the **<Enter>** key to enter a new occurrence.

At the prompt "Enter a New Intraoperative Occurrence:" the user can enter two question marks (??) to get a list of categories. Be sure to enter a category for all occurrences to satisfy Surgery Central Office reporting needs.

### Example: Entering Intraoperative Occurrences

```
Select Perioperative Occurrences Menu Option: I Intraoperative Occurrences (Enter/Edit)
```

```
Select Patient: ILLINOIS,ANNE      10-28-45      123456789
```

```
ILLINOIS,ANNE  123-45-6789
```

1. 06-30-99 CHOLECYSTECTOMY (COMPLETED)
2. 03-10-99 HEMORRHOIDECTOMY (COMPLETED)

```
Select Operation: 1
```

```
ILLINOIS,ANNE (123-45-6789)      Case #213  
JUN 30,1999  CHOLECYSTECTOMY (CPT MISSING)
```

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

```
Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR  
Any cardiac arrest requiring external or open cardiopulmonary  
resuscitation (CPR) of any duration occurring in the operating room, ICU,  
ward, or out-of-hospital after the chest has been completely closed and  
within 30 days following surgery. Exclude intentional arrests during  
cardiac surgery.
```

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

ILLINOIS, ANNE (123-45-6789) Case #213  
JUN 30, 1999 CHOLECYSTECTOMY (CPT MISSING)

---

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

ILLINOIS, ANNE (123-45-6789)

---

Type of Treatment Instituted: CPR  
Outcome to Date: ?

CHOOSE FROM:

U	UNRESOLVED
I	IMPROVED
D	DEATH
W	WORSE

Outcome to Date: I IMPROVED

ILLINOIS, ANNE (123-45-6789) Case #213  
JUN 30, 1999 CHOLECYSTECTOMY (CPT MISSING)

---

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:

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

The *Postoperative Occurrences (Enter/Edit)* option is used to add information about an occurrence that occurs after the procedure. The user can also utilize this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, the user selects an operation. The software will then list any occurrences already entered for that operation. The user can choose to edit a previously entered occurrence or type the word **NEW** and press the **<Enter>** key to enter a new occurrence.

At the prompt "Enter a New Postoperative Complication:" the user can enter two question marks (??) to get a list of categories. Be sure to enter a category for all occurrences in order to satisfy Surgery Central Office reporting needs.

### Example: Entering a Postoperative Occurrence

```
Select Perioperative Occurrences Menu Option: P Postoperative Occurrence (Enter/Edit)
```

```
Select Patient: MICHIGAN,MATTHEW R. 09-13-28 123456789
```

```
MICHIGAN,MATTHEW R. 123-45-6789
```

1. 04-18-99 CRANIOTOMY (COMPLETED)
2. 03-18-99 REPAIR INCARCERATED INGUINAL HERNIA (COMPLETED)

```
Select Operation: 2
```

```
MICHIGAN,MATTHEW R. (123-45-6789) Case #202  
MAR 18,1999 REPAIR INCARCERATED INGUINAL HERNIA (49505)
```

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

```
Enter a New Postoperative Occurrence: URINARY TRACT INFECTION  
[CDC Definition] Symptomatic urinary tract infection must meet one of the  
following TWO criteria:
```

1. One of the following: fever (>38 degrees C), urgency, frequency, dysuria, or suprapubic tenderness AND a urine culture of >100,000 colonies/ml urine with no more than two species of organisms.
2. Two of the following: fever (>38 degrees C), urgency, frequency, dysuria, or suprapubic tenderness AND any of the following:
  - a. Dipstick test positive for leukocyte esterase and/or nitrate.
  - b. Pyuria (>10 WBCs/cc or >3 WBC/hpf of unspun urine).
  - c. Organisms seen on Gram stain of unspun urine.
  - d. Two urine cultures with repeated isolation of the same uropathogen with >100 colonies/ml urine in non-voided specimen.
  - e. Urine culture with <100,000 colonies/ml urine of single uropathogen in patient being treated with appropriate antimicrobial therapy.
  - f. Physician's diagnosis.
  - g. Physician institutes appropriate antimicrobial therapy.

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

MICHIGAN, MATTHEW R. (123-45-6789) Case #202  
MAR 18, 1999 REPAIR INCARCERATED INGUINAL HERNIA (49505)

---

1. Occurrence: URINARY TRACT INFECTION
  2. Occurrence Category: URINARY TRACT INFECTION
  3. ICD Diagnosis Code:
  4. Treatment Instituted:
  5. Outcome to Date:
  6. Date Noted:
  7. Occurrence Comments:
- 

Select Occurrence Information: 4:6

MICHIGAN, MATTHEW R. (123-45-6789) Case #202  
MAR 18, 1999 REPAIR INCARCERATED INGUINAL HERNIA (49505)

---

Treatment Instituted: **ANTIBIOTICS**  
Outcome to Date: **I** IMPROVED  
Date/Time the Complication was Noted: **3/20** (MAR 20, 1999)

MICHIGAN, MATTHEW R. (123-45-6789) Case #202  
MAR 18, 1999 REPAIR INCARCERATED INGUINAL HERNIA (49505)

---

1. Occurrence: URINARY TRACT INFECTION
  2. Occurrence Category: URINARY TRACT INFECTION
  3. ICD Diagnosis Code:
  4. Treatment Instituted: ANTIBIOTICS
  5. Outcome to Date: IMPROVED
  6. Date Noted: 03/20/92
  7. Occurrence Comments:
- 

Select Occurrence Information:

## Non-Operative Occurrence (Enter/Edit) [SROCOMP]

The *Non-Operative Occurrence (Enter/Edit)* option is used to enter or edit occurrences that are not related to surgical procedures. A non-operative occurrence is an occurrence that develops before a surgical procedure is performed.

At the "Occurrence Category:" prompt, the user can enter two question marks (??) to get a list of categories. Be sure to enter a category for each occurrence in order to satisfy Surgery Central Office reporting needs.

### Example: Entering a Non-Operative Occurrence

```
Select Perioperative Occurrences Menu Option: N Non-Operative Occurrences (Enter/Edit)
```

```
NOTE: You are about to enter an occurrence for a patient that has not had an
operation during this admission. If this patient has a surgical procedure
during the current admission, use the option to enter or edit intraoperative
and postoperative occurrences.
```

```
Select PATIENT NAME: MICHIGAN, MATTHEW R.          09-13-28      123456789
```

```
MICHIGAN, MATTHEW R.
```

```
1.          ENTER A NEW NON-OPERATIVE OCCURRENCE
```

```
Select Number:  1
```

```
Select the Date of Occurrence: T-2 (JUN 30, 1999)
Name of the Surgeon Treating the Complication: TOPEKA, MARK
Name of the Attending Surgeon: TULSA, LARRY
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)
```

```
Select NON-OPERATIVE OCCURRENCES: SYSTEMIC SEPSIS
```

```
Occurrence Category: SYSTEMIC SEPSIS
```

```
This is defined as a patient noted to be acutely ill, usually febrile,
resulting from the presence of microorganisms or their poisonous
products in the blood stream.
```

```
Treatment Instituted: ANTIBIOTICS
```

```
Outcome to Date: U UNRESOLVED
```

```
Occurrence Comments:
```

```
1>Cancel scheduled surgery for this week. Reschedule later.
```

```
2><Enter>
```

```
EDIT Option: <Enter>
```

```
Press RETURN to continue
```

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

The *Update Status of Returns Within 30 Days* option will define a case as related or unrelated to another case. When a new surgical case is entered into the software, the user is asked whether it is related to any previous cases within the past 30 days. This option is designed to update that information.

The user should first enter the patient name and select a case. The software will list any cases that occurred within 30 days prior to the selected case and will indicate if the listed cases have been flagged as related or unrelated. At this point the user may update the status of the cases listed.

### Example: Updating Status of Returns Within 30 days

```
Select Perioperative Occurrences Menu Option: Update Status of Returns Within 30 Days
```

```
Select Patient: INDIANA, SUSAN          03-03-59      123456789      NO      NO
N-VETERAN (OTHER)
```

```
INDIANA, SUSAN  123-45-6789
```

1. 07-06-99 REPAIR INGUINAL HERNIA (COMPLETED)
2. 06-25-99 CHOLECYSTECTOMY, APPENDECTOMY (COMPLETED)
3. 06-23-99 CHOLEDOCHOTOMY (COMPLETED)
4. 04-10-98 CRANIOTOMY (COMPLETED)

```
Select Operation: 3
```

```
INDIANA, SUSAN (123-45-6789)      Case #62192      RETURNS TO SURGERY
JUN 23, 1999  CHOLEDOCHOTOMY (47420-58,62,22,78)
```

- 
1. 07/06/99 REPAIR INGUINAL HERNIA (49521-59) - UNRELATED
  2. 06/25/99 CHOLECYSTECTOMY (47610-59,20,66,78) - UNRELATED
- 

```
Select Number: 2
```

```
INDIANA, SUSAN (123-45-6789)      Case #62192      RETURNS TO SURGERY
JUN 23, 1999  CHOLEDOCHOTOMY (47420-58,62,22,78)
```

- 
2. 06/25/99 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, 1999 CHOLEDOCHOTOMY (47420-58,62,22,78)

- 
1. 07/06/99 REPAIR INGUINAL HERNIA (49521-59) - UNRELATED
  2. 06/25/99 CHOLECYSTECTOMY (47610-59,20,66,78) - RELATED
- 

Select Number:

## Morbidity & Mortality Reports [SROMM]

The *Morbidity & Mortality Reports* option generates two reports: the Perioperative Occurrences Report and the Mortality Report. The Perioperative Occurrences Report includes all cases that have occurrences, both intraoperatively and postoperatively. The Mortality Report includes all cases performed within the selected date range that had a death within 30 days after surgery. These reports sort by specialty within a date range. Each surgical specialty will begin on a separate page.

After the user enters the date range, the software will ask whether to generate both reports. If the user answers **NO**, the software will ask the user to select from the Perioperative Occurrences Report or the Mortality Report.

These reports have a 132-column format and are designed to be copied to a printer.

### Example 1: Printing the Perioperative Occurrences Report

```
Select Perioperative Occurrences Menu Option: M Morbidity & Mortality Reports
```

```
The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.
```

```
Do you want to generate both reports ? YES// N
```

```
1. Perioperative Occurrences Report  
2. Mortality Report
```

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

```
Start with Date: 8/1 (AUG 01, 1999)  
End with Date: 8/31 (AUG 31, 1999)
```

```
Do you want to print this report for all Surgical Specialties ? YES// N
```

```
Print the report for which Specialty ? GENERAL(OR WHEN NOT DEFINED BE LOW)  
Select an Additional Specialty <Enter>
```

```
This report is designed to use a 132 column format.
```

```
Print the Report on which Device: [Select Print Device]
```

-----report follows-----

MAYBERRY, NC  
 SURGICAL SERVICE  
 PERIOPERATIVE OCCURRENCES  
 FROM: AUG 1,1999 TO: AUG 31,1999

PAGE 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: SEP 22,1999

PATIENT ID# OPERATION DATE	PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) TREATMENT	OUTCOME
=====			
GENERAL (OR WHEN NOT DEFINED BELOW)			
-----			
IDAHO, PETER 123-45-6789 AUG 07, 1999@07:15	REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (08/09/99) IV ANTBIOTICS	I
KANSAS, THOMAS 123-45-6789 AUG 31, 1999@09:00	CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (09/02/99) ANTIBIOTICS	I

-----  
 OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH  
 '\* ' Represents Postoperative Occurrences  
 -----

## Example 2: Printing the *Mortality Report*

Select Perioperative Occurrences Menu Option: **M** Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.

Do you want to generate both reports ? YES// **N**

1. Perioperative Occurrences Report
2. Mortality Report

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

Start with Date: **1/1/99** (JAN 01, 1999)

End with Date: **12/31/99** (DEC 31, 1999)

This report is designed to use a 132 column format.

Print the Report on which Device: [**Select Print Device**]

-----*report follows*-----

MAYBERRY, NC  
 SURGICAL SERVICE  
 MORTALITY REPORT  
 FROM: JAN 1,1999 TO: DEC 31,1999

PAGE 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: SEP 22,1999

OPERATION DATE	PATIENT ID#	PRINCIPAL OPERATIVE PROCEDURE	DATE OF DEATH AUTOPSY (Y/N)
=====			
OTORHINOLARYNGOLOGY (ENT)			
-----			
JAN 22, 1999	MINNESOTA, RONALD 123-45-6789	LARYNGOSCOPY, BRONCHOSCOPY, ESOPHAGOGASTROSCOPY	FEB 09, 1999 NO
JAN 27, 1999	COLORADO, ALBERT 123-45-6789	BRONCHOSCOPY	FEB 26, 1999 NOT AVAILABLE
JAN 29, 1999	MINNESOTA, RONALD 123-45-6789	BILATERAL NECK DISECTION, LARYNGECTOMY	FEB 09, 1999 NO
FEB 08, 1999	MINNESOTA, RONALD 123-45-6789	LIGATION LT INTERNAL JUGLAR , EXPLORATORY LAPARATOMY	FEB 09, 1999 NO
FEB 19, 1999	IOWA, LUKE 123-45-6789	TRACH	FEB 21, 1999 NO
OCT 20, 1999	MAINE, JAMES 123-45-6789	LARYNGOSCOPY W/ BX, ESOPHAGOSCOPY	NOV 01, 1999 NOT AVAILABLE

# Non-O.R. Procedures

[SRONOP]



The *Non-O.R. Procedures* option, located in the main *Surgery Menu* and locked with the SROPER key, is designed for documenting and reviewing Non-O.R. Procedures.

A Non-O.R. Procedure is any procedure not performed in an operating room, but which still involves surgical or anesthesia providers. Any procedures involving anesthesia providers will display on the Anesthesia AMIS Report.

The main options included in this menu are listed below. The first option, *Non-O.R.. Procedures (Enter Edit)*, contains options to enter or update cases. To the left of the option name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
E	<i>Non-O.R.. Procedures (Enter/Edit)</i>
A	<i>Annual Report of Non-O.R.. Procedures</i>
R	<i>Report of Non-O.R.. Procedures</i>

## Non-O.R. Procedures (Enter/Edit) [SRONOP-ENTER]

The *Non-O.R. Procedures (Enter/Edit)* option allows the user to enter, edit, or delete information related to a Non-O.R. Procedure. The editing feature branches to another submenu that allows the user to enter or edit anesthesia information for a procedure. To use one of the *Non-O.R. Procedures (Enter/Edit)* options, the user must first identify the patient on which he or she is working.

### Accessing the Non-O.R. Procedures Menu

When the *Non-O.R. Procedures (Enter/Edit)* option is selected, the user will be prompted to enter a patient name. The Surgery software will then list all non-O.R. procedures on record for the patient.

```
NEBRASKA,NICK 123-45-6789
1. APR 22, 2002 BRONCHOSCOPY
2. NEW PROCEDURE
Select Procedure: 1
```

The user can select from the procedure(s) listed or enter a new procedure. When selecting an existing procedure, the software will ask whether the user wants to 1) edit information for the case, or 2) delete the procedure, as follows.

```
NEBRASKA,NICK 123-45-6789
APR 22, 2002 BRONCHOSCOPY
Do you want to edit or delete this procedure ?
1. Edit
2. Delete
Select Number: 1// 1
```

If the user enters **2** to delete, the software will permanently remove the procedure from the records. On the other hand, if the user accepts the default answer, **1**, to edit the existing procedure, the software will display the *Non-O.R. Procedures (Enter/Edit)* menu option. The user will see the following options.

```
NEBRASKA,NICK (123-45-6789) Case #267260 - APR 22,2002
E Edit Non-O.R. Procedure
AI Anesthesia Information (Enter/Edit)
AM Medications (Enter/Edit)
AT Anesthesia Technique (Enter/Edit)
PR Procedure Report (Non-O.R.)
TR Tissue Examination Report
I Non-OR Procedure Information
Select Non-O.R. Procedures (Enter/Edit) Option:
```

Three of these sub-options, the *Anesthesia Information (Enter/Edit)* option, the *Medications (Enter/Edit)* option, and the *Anesthesia Technique (Enter/Edit)* option, are the same as the sub-options of the same name on the *Anesthesia Menu* option.

## Edit Non-O.R. Procedure [SRONOP-EDIT]

The *Edit Non-O.R. Procedure* option on the *Non-O.R. Procedures* menu allows the user to enter or edit data on the selected procedure.

The DICTATED SUMMARY EXPECTED field is used to determine whether a dictated summary will be required for this Non-O.R. Procedure case. If **NO** is entered into the DICTATED SUMMARY EXPECTED field, no alerts will be generated and no report information will be displayed. If **YES** is entered into the DICTATED SUMMARY EXPECTED field, an alert will be sent to the appropriate provider informing him or her that the Procedure Summary is ready for signature.



The DICTATED SUMMARY EXPECTED field is used to determine whether a dictated summary will be required for a Non-O.R. Procedure case.

### Example: Setting the DICTATED SUMMARY EXPECTED field to YES

```
NEBRASKA,NICK (123-45-6789) Case #267260 - APR 22,2002
```

```
E      Edit Non-O.R. Procedure
AI     Anesthesia Information (Enter/Edit)
AM     Medications (Enter/Edit)
AT     Anesthesia Technique (Enter/Edit)
PR     Procedure Report (Non-O.R.)
TR     Tissue Examination Report
I      Non-OR Procedure Information
```

```
Select Non-O.R. Procedures (Enter/Edit) Option: E Edit Non-O.R. Procedure
```

```
** NON-O.R. PROCEDURE ** CASE #267260 NEBRASKA,NICK PAGE 1 OF 3
```

```
1  DATE OF PROCEDURE: APR 22, 2002
2  PRINCIPAL PROCEDURE: BRONCHOSCOPY
3  PRINCIPAL PROCEDURE CODE:
4  MEDICAL SPECIALTY: GENERAL SURGERY
5  DICTATED SUMMARY EXPECTED:
6  IN/OUT-PATIENT STATUS:
7  TIME PROCEDURE BEGAN:
8  TIME PROCEDURE ENDED:
9  PROVIDER: MIAMI,STEVE
10 NON-OR LOCATION:
11 ASSOCIATED CLINIC:
12 PRINCIPAL DIAGNOSIS:
13 PRIN DIAGNOSIS CODE:
14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
15 BRIEF CLIN HISTORY: (WORD PROCESSING)
```

```
Enter Screen Server Function: 5
Dictated Summary Expected: YES YES
```

\*\* NON-O.R. PROCEDURE \*\* CASE #267260 NEBRASKA,NICK PAGE 1 OF 3

1 DATE OF PROCEDURE: APRIL 22, 2002  
2 PRINCIPAL PROCEDURE: BRONCHOSCOPY  
3 PRINCIPAL PROCEDURE CODE:  
4 MEDICAL SPECIALTY: GENERAL SURGERY  
5 DICTATED SUMMARY EXPECTED: YES  
6 IN/OUT-PATIENT STATUS:  
7 TIME PROCEDURE BEGAN:  
8 TIME PROCEDURE ENDED:  
9 PROVIDER: MIAMI, STEVE  
10 NON-OR LOCATION:  
11 ASSOCIATED CLINIC:  
12 PRINCIPAL DIAGNOSIS:  
13 PRIN DIAGNOSIS CODE:  
14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)  
15 BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function: <Enter>

\*\* NON-O.R. PROCEDURE \*\* CASE #267260 NEBRASKA,NICK PAGE 2 OF 3

1 OPERATIVE FINDINGS: (WORD PROCESSING)  
2 ATTEND PROVIDER:  
3 ATTENDING CODE:  
4 PRINC ANESTHETIST:  
5 ANESTHESIOLOGIST SUPVR:  
6 ANES CARE START TIME:  
7 ANES CARE END TIME:  
8 ANESTHESIA TECHNIQUE: (MULTIPLE)  
9 ANES SUPERVISE CODE:  
10 DIAGNOSTIC/THERAPEUTIC (Y/N):  
11 ASA CLASS:  
12 OTHER PROCEDURES: (MULTIPLE)  
13 OTHER POSTOP DIAGS: (MULTIPLE)  
14 PROCEDURE OCCURRENCE: (MULTIPLE)  
15 SPECIMENS: (WORD PROCESSING)

Enter Screen Server Function: <Enter>

\*\* NON-O.R. PROCEDURE \*\* CASE #267260 NEBRASKA,NICK PAGE 3 OF 3

1 GENERAL COMMENTS: (WORD PROCESSING)  
2 CANCEL DATE:  
3 CANCEL REASON:

Enter Screen Server Function:

If the user wishes to edit information in the Procedure Report (Non-O.R.), the *Edit Non-O.R.. Procedure* option on the *Non-O.R.. Procedures* menu can be used.

**Example: Using the Edit Non-O.R. Procedure option**

```
NEBRASKA,NICK (123-45-6789) Case #267260 - APR 22,2002

E      Edit Non-O.R. Procedure
AI     Anesthesia Information (Enter/Edit)
AM     Medications (Enter/Edit)
AT     Anesthesia Technique (Enter/Edit)
PR     Procedure Report (Non-O.R.)
TR     Tissue Examination Report

Select Non-O.R. Procedures (Enter/Edit) Option: E Edit Non-O.R. Procedure
```

```
** NON-O.R. PROCEDURE ** CASE #267260 NEBRASKA,NICK PAGE 1 OF 3

1 DATE OF PROCEDURE: APR 22, 2002
2 PRINCIPAL PROCEDURE: BRONCHOSCOPY
3 PRINCIPAL PROCEDURE CODE:
4 MEDICAL SPECIALTY: GENERAL SURGERY
5 DICTATED SUMMARY EXPECTED: YES
6 IN/OUT-PATIENT STATUS:
7 TIME PROCEDURE BEGAN: APR 22, 2002 AT 08:50
8 TIME PROCEDURE ENDED: APR 22, 2002 AT 09:27
9 PROVIDER: MIAMI,STEVE
10 NON-OR LOCATION:
11 ASSOCIATED CLINIC:
12 PRINCIPAL DIAGNOSIS:
13 PRIN DIAGNOSIS CODE:
14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
15 BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function: 8
Time Procedure Ended: APR 22,2002@09:27// 917 (APR 22, 2002@09:17)
```

```
** NON-O.R. PROCEDURE ** CASE #267260 NEBRASKA,NICK PAGE 1 OF 3

1 DATE OF PROCEDURE: APR 22, 2002
2 PRINCIPAL PROCEDURE: BRONCHOSCOPY
3 PRINCIPAL PROCEDURE CODE:
4 MEDICAL SPECIALTY: GENERAL SURGERY
5 DICTATED SUMMARY EXPECTED: YES
6 IN/OUT-PATIENT STATUS:
7 TIME PROCEDURE BEGAN: APR 22, 2002 AT 08:50
8 TIME PROCEDURE ENDED: APR 22, 2002 AT 09:17
9 PROVIDER: MIAMI,STEVE
10 NON-OR LOCATION:
11 ASSOCIATED CLINIC:
12 PRINCIPAL DIAGNOSIS:
13 PRIN DIAGNOSIS CODE:
14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
15 BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

\*\* NON-O.R. PROCEDURE \*\* CASE #267260 NEBRASKA,NICK PAGE 2 OF 3

1 OPERATIVE FINDINGS: (WORD PROCESSING)  
2 ATTEND PROVIDER:  
3 ATTENDING CODE:  
4 PRINC ANESTHETIST:  
5 ANESTHESIOLOGIST SUPVR:  
6 ANES CARE START TIME:  
7 ANES CARE END TIME:  
8 ANESTHESIA TECHNIQUE: (MULTIPLE)  
9 ANES SUPERVISE CODE:  
10 DIAGNOSTIC/THERAPEUTIC (Y/N):  
11 ASA CLASS:  
12 OTHER PROCEDURES: (MULTIPLE)  
13 OTHER POSTOP DIAGS: (MULTIPLE)  
14 PROCEDURE OCCURRENCE: (MULTIPLE)  
15 SPECIMENS: (WORD PROCESSING)

Enter Screen Server Function: <Enter>

\*\* NON-O.R. PROCEDURE \*\* CASE #267260 NEBRASKA,NICK PAGE 3 OF 3

1 GENERAL COMMENTS: (WORD PROCESSING)  
2 CANCEL DATE:  
3 CANCEL REASON:

Enter Screen Server Function: ^

## Procedure Report (Non-O.R.) [SR NON-OR REPORT]

The *Procedure Report (Non-O.R.)* option details operation information for the patient case selected. This report includes the Procedure Summary section. The Procedure Summary is dictated by the provider after completing the Non-O.R. procedure and then is electronically signed.

### **Prior to Signature**

The *Edit Non-O.R. Procedure* option on the *Non-O.R. Procedures* menu is used to enter the non-O.R. procedure data. The DICTATED SUMMARY EXPECTED field is used to determine whether a dictated summary will be required for this non-O.R. procedure. This field is a required entry when creating a new non-O.R. procedure and may be edited using the *Edit Non-O.R. Procedure* option. Entering YES in this field allows a Procedure Summary to be uploaded and signed in TIU, making a Procedure Report (Non-O.R.) available for this procedure.



The DICTATED SUMMARY EXPECTED field is used to determine whether a dictated summary will be required for a Non-O.R. Procedure case.

---

After the Procedure Summary has been electronically signed, the Procedure Report (Non-O.R..) is viewable through CPRS. If the Procedure Summary has not been electronically signed, the following displays:

“\* \* A Non-O.R. Procedure Summary is not available. \* \*”



After the Procedure Summary is transcribed and uploaded into TIU, the TIU software sends an alert to the provider responsible for electronically signing the report. The provider can then sign using CPRS options or the List Manager.

---

## **After Electronic Signature**

After electronic signature, the report is available for viewing.

### **Example 1: Printing a Procedure (Non-O.R.) Report when the Procedure Summary has been signed**

```
OHIO,RAYMOND (123-45-6789) Case #267236 - FEB 13, 2002
```

```
Select Non-O.R. Procedures (Enter/Edit) Option: PR Procedure Report (Non-O.R.)
```

```
Do you want WORK copies or CHART copies? WORK// <Enter>
```

```
DEVICE: HOME// [Select Print Device]
```

```
-----report follows-----
```

-----  
OHIO, RAYMOND 123-45-6789

PROCEDURE REPORT  
-----

NOTE DATED: 02/13/2002 00:00 PROCEDURE REPORT

SUBJECT: Case #: 267236

PREOPERATIVE DIAGNOSIS: RESPIRATORY FAILURE, PROLONGED TRACHEAL INTUBATION  
AND FAILURE TO WEAN

POSTOPERATIVE DIAGNOSIS: SAME

PROCEDURE PERFORMED: OPEN TRACHEOSTOMY

PROVIDER: DR. SPRINGFIELD

ASSISTANT PROVIDER:

ANESTHESIA: GENERAL ENDOTRACHEAL ANESTHESIA

ESTIMATED BLOOD LOSS: MINIMAL

COMPLICATIONS: NONE

INDICATIONS FOR PROCEDURE: The patient is a sixty-four-year-old gentleman with a rather extensive past surgical history, mostly significant for status post esophagogastrectomy and presented to the hospital approximately three weeks ago with abdominal pain. Diagnostic evaluation consisted of an abdominal CT scan, liver function tests and right upper quadrant ultrasound, all of which were consistent with a diagnosis of acalculus cholecystitis. Because of these findings, the patient was brought to the operating room approximately three weeks ago where an open cholecystectomy was performed. The patient subsequent to that has had a very rocky postoperative course, most significantly focusing around persistently spiking fevers with sources significant for an E-coli sinusitis as well as a Staphylococcus E-coli pneumonia with no evidence of bacteremia. As a result of all of this sepsis and persistent spiking fevers, the patient has had a pneumonia, the patient has had a rather difficult time weaning from the ventilator and because of the almost three week period since his last operation with persistent endotracheal tube in place, the patient was brought to the operating room for an open tracheostomy procedure.

DESCRIPTION OF PROCEDURE: After appropriate consent was obtained from the patient's next of kin and the risks and benefits were explained to her, the patient was then brought to the operating room where general endotracheal anesthesia was induced. The area was prepped and draped in the usual fashion with a towel roll under the patient's scapula and the neck extended.

A longitudinal incision of approximately 2 cm was made just below the cricoid cartilage. The strap muscles were taken down using Bovie electrocautery. The isthmus of the thyroid was clamped and tied off using 2-0 silk x two. Hemostasis was assured. The thyroid cartilage was carefully dissected directly onto it. The window in the third ring of the trachea was opened after placement of retraction sutures of 0 silk. The hatch was cut open using a hatch box shape. This opening was then dilated using the tracheal dilator. The endotracheal tube was pulled back. A #7 Tracheostomy tube was placed with ease. Breath sounds were assured. The patient was oxygenating well and the stay sutures were placed. The patient tolerated the procedure well. The skin was closed with 0 silk and trachea tip was applied. The patient tolerated the procedure well. The endotracheal tube was finally removed. He was brought to the Surgical Intensive Care Unit in stable, but critical condition.

Jack Springfield, M.D.

JS/jer:jw J#: 514 DD: 02-13-02 DT: 02-13-02

Signed by: /es/ JACK SPRINGFIELD  
02/13/2002 16:40

Enter RETURN to continue or '^' to exit: ^

# Tissue Examination Report [SROTRPT]

The *Tissue Examination Report* option is used to generate the Tissue Examination Report that contains information about cultures and specimens sent to the laboratory for a non-OR procedure.

This report prints in an 80-column format and can be viewed on the screen.

## Example: Tissue Examination Report

```
Select Non-O.R. Procedures (Enter/Edit) Option: TR Tissue Examination Report
DEVICE: [Select Print Device]
```

-----printout follows-----

```
-----
MEDICAL RECORD | TISSUE EXAMINATION
-----
Specimen Submitted By: OR1, SURGERY CASE # 267260 Obtained: AUG 13, 2004
-----
Specimen(s): BIOPSY OF STOMACH LINING
-----
Brief Clinical History:
The patient has had a pneumonia, and had a rather difficult time weaning
from the ventilator and because of the almost three week period since
his last operation with persistent endotracheal tube in place, the
patient was brought to the operating room for an open tracheostomy procedure.
-----
Operative Procedure(s):
OPEN TRACHEOSTOMY
-----
Preoperative Diagnosis:
RESPIRATORY FAILURE, PROLONGED TRACHEAL INTUBATION
AND FAILURE TO WEAN
-----
Operative Findings:
-----
Postoperative Diagnosis: FOREIGN BODY IN TRACHEA Signature and Title
TULSA, LARRY
-----
Attending Surgeon: TOPEKA, MARK
```

```
-----
PATHOLOGY REPORT
-----
Name of Laboratory Accession Number(s)
-----
Gross Description, Histologic Examination and Diagnosis
```

(Continue on reverse side)

```
-----
PATHOLOGIST'S SIGNATURE DATE:
-----
NEBRASKA, NICK (123-45-6789) Age: 64 SEX: MALE ID # 123-45-6789
ETHNICITY: NOT HISPANIC REGISTER NO.
RACE: WHITE, ASIAN
WARD: ROOM-BED:
-----
VAMC: MAYBERRY, NC REPLACEMENT FORM 515
```

Press RETURN to continue

## Non-OR Procedure Information [SR NON-OR INFO]

The *Non-OR Procedure Information* option displays information on the selected non-OR procedure, with the exception of the provider's dictated summary.

This report prints in an 80-column format and can be viewed on the screen.

### Example: Non-OR Procedure Information Report

```
NEBRASKA,NICK (123-45-6789) Case #267260 - APR 22,2002
Select Non-O.R. Procedures (Enter/Edit) Option: I Non-O.R. Procedure Information
DEVICE: HOME// [Select Print Device]T
```

-----printout follows-----

```
NEBRASKA,NICK (123-45-6789) Age: 64 PAGE 1
NON-O.R. PROCEDURE - CASE #267260 Printed: AUG 13, 2004@14:40
-----
```

Med. Specialty: PULMONARY, NON-TB Location: NON OR

Principal Diagnosis: FAILURE TO WEAN ICD9 Code: 934.0

Provider: TULSA,LARRY Patient Status: INPATIENT  
Attending: MIAMI,STEVE  
Attending Code: LEVEL F: NON-OR PROCEDURE DONE IN THE OR, ATTENDING IDENTIFIED

Attend Anesth: N/A  
Anesthesia Supervisor Code: N/A  
Anesthetist: N/A

Anesthesia Technique(s): N/A

Proc Begin: AUG 13, 2004 09:00 Proc End: AUG 13, 2004 10:00

Procedure(s) Performed:  
Principal: OPEN TRACHEOSTOMY  
CPT Code: 31600 INCISION OF WINDPIPE

Indications for Procedure:  
FOREIGN BODY IN TRACHEA.

Brief Clinical History:  
The patient is a sixty-four-year-old gentleman with a rather extensive past surgical history, mostly significant for status post esophagogastrectomy and presented to the hospital approximately three weeks ago with abdominal pain. Diagnostic evaluation consisted of an abdominal CT scan, liver function tests and right upper quadrant ultrasound, all of which were consistent with a diagnosis of acalculus cholecystitis. Because of these findings, the patient was brought to the operating room approximately three weeks ago where an open cholecystectomy was performed.

Specimens: BIOPSY OF STOMACH LINING.

Dictated Summary Expected: YES

Enter RETURN to continue or '^' to exit:

## Annual Report of Non-O.R. Procedures [SRONOP-ANNUAL]

The *Annual Report of Non-O.R. Procedures* option generates the Annual Report of Non-O.R. Procedures. It displays the total number of non-O.R. procedures within the selected date range based on CPT code.

This report prints in an 80-column format and can be viewed on the screen.

### Example: Annual Report of Non-O.R. Procedures

```
Select Non-O.R. Procedures Option:  A  Annual Report of Non-O.R. Procedures
```

```
Annual Report of Non-O.R. Procedures
```

```
Starting with Date: 3/2  (MAR 02, 1999)
```

```
Ending with Date: 3/30  (MAR 30, 1999)
```

```
Print the report on which Device: [Select Print Device]
```

-----report follows-----

ANNUAL REPORT OF NON-O.R. PROCEDURES  
FROM: MAR 2,1999 TO: MAR 30,1999

=====

CARDIOLOGY

92960 HEART ELECTROCONVERSION 2

Press RETURN to continue, or '^' to quit: <Enter>

ANNUAL REPORT OF NON-O.R. PROCEDURES  
FROM: MAR 2,1999 TO: MAR 30,1999

=====

GENERAL SURGERY

11404 REMOVAL OF SKIN LESION 1

Press RETURN to continue, or '^' to quit: <Enter>

ANNUAL REPORT OF NON-O.R. PROCEDURES  
FROM: MAR 2,1999 TO: MAR 30,1999

=====

GENERAL (ACUTE MEDICINE)

11423 REMOVAL OF SKIN LESION 1  
64510 INJECTION FOR NERVE BLOCK 1

Press RETURN to continue, or '^' to quit: <Enter>

ANNUAL REPORT OF NON-O.R. PROCEDURES  
FROM: MAR 2,1999 TO: MAR 30,1999

=====

PSYCHIATRY

90870 ELECTROCONVULSIVE THERAPY 3

Press RETURN to continue, or '^' to quit: <Enter>

ANNUAL REPORT OF NON-O.R. PROCEDURES  
SUMMARY OF ALL SPECIALTIES  
FROM: MAR 2,1999 TO: MAR 30,1999

=====

CARDIOLOGY	TOTAL NON-O.R. PROCEDURES: 2
GENERAL SURGERY	TOTAL NON-O.R. PROCEDURES: 1
GENERAL (ACUTE MEDICINE)	TOTAL NON-O.R. PROCEDURES: 2
PSYCHIATRY	TOTAL NON-O.R. PROCEDURES: 3

TOTAL NON-O.R. PROCEDURES FOR THIS MEDICAL CENTER: 8

Press RETURN to continue

## Report of Non-O.R. Procedures [SRONOR]

This report chronologically lists non-O.R. procedures sorted by surgical specialty or surgeon. This report can be sorted by specialty, provider, or location.

This report prints in a 132-column format and must be copied to a printer.

### Example 1: Report of Non-O.R. Procedures by Specialty

Select Non-O.R. Procedures Option: **Report of Non-O.R. Procedures**

Report of Non-OR Procedures

Start with Date: **3/1** (MAR 01, 1999)  
End with Date: **3/31** (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

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

Do you want to print the report for all Specialties ? YES// **N**

Print the Report for which Specialty ? **Cardiology**

This report is designed to use a 132 column format.

Print on Device: **[Select Print Device]**

-----*report follows*-----

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF NON-O.R. PROCEDURES  
 FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:  
 DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	PROVIDER PROCEDURE(S)	START TIME FINISH TIME
=====			
*** SPECIALTY: CARDIOLOGY ***			
03/02/92 501	IDAHO,PETER (123-45-6789) AMBULATORY SURGERY (OUTPATIENT)	BISMARK,ANDREW CARDIOVERSION	03/02/92 13:05 03/02/92 14:10
03/13/92 500	ARKANSAS,MARY (123-45-6789) ICU (INPATIENT)	TULSA,LARRY CARDIOVERSION	03/13/92 14:00 03/13/92 14:25

## Example 2: Report of Non-O.R. Procedures by Provider

Select Non-O.R. Procedures Option: **Report of Non-O.R. Procedures**

Report of Non-OR Procedures

Start with Date: **3/1** (MAR 01, 1999)

End with Date: **3/31** (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number: 2// **<Enter>**

Do you want to print the report for all Providers ? YES// **N**

Print the Report for which Provider ? **PITTSBURGH,ANTHONY** AP

This report is designed to use a 132 column format.

Print on Device: **[Select Print Device]**

-----report follows-----

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF NON-O.R. PROCEDURES  
 FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:  
 DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	SPECIALTY PROCEDURE(S)	START TIME FINISH TIME
----- *** PROVIDER PITTSBURGH, ANTHONY *** -----			
03/12/92 195	PENNSYLVANIA, PHILLIP (123-45-6789) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY ELECTROCONVULSIVE THERAPY	03/12/92 08:00 03/12/92 09:00
03/23/92 240	HAWAII, LOU (123-45-6789) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY ELECTROCONVULSIVE THERAPY	03/23/92 08:10 03/23/92 08:40
03/25/92 266	KANSAS, THOMAS (123-45-6789) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY ELECTROCONVULSIVE THERAPY	03/12/92 09:30 03/12/92 10:15

### Example 3: Report of Non-O.R. Procedures by Location

Select Non-O.R. Procedures Option: **Report of Non-O.R. Procedures**

Report of Non-OR Procedures

Start with Date: 3/1 (MAR 01, 1999)

End with Date: 3/31 (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number: 2// **<Enter>**

Do you want to print the report for all Locations ? YES// **N**

Print the Report for which location ? **AMBULATORY SURGERY**

This report is designed to use a 132 column format.

Print the report on which Device: [Select Print Device]

-----*report follows*-----

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF NON-O.R. PROCEDURES  
 FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:  
 DATE REVIEWED:

DATE CASE #	PATIENT (ID#) SPECIALTY (IN/OUT-PAT STATUS)	PROVIDER PROCEDURE(S)	START TIME FINISH TIME
=====			
*** LOCATION: AMBULATORY SURGERY ***			
03/02/92 201	IDAHO,PETER (123-45-6789) CARDIOLOGY (OUTPATIENT)	BISMARCK,ANDREW CARDIOVERSION	03/02/92 13:05 03/02/92 14:10
03/06/92 198	CALIFORNIA,JAMES (123-45-6789) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	RICHMOND,ARTHUR EXCISION OF SKIN LESION	03/07/92 16:30 03/07/92 17:08
03/09/92 193	ILLINOIS,ANNE (123-45-6789) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	PHOENIX,SALLY STELLATE NERVE BLOCK	03/09/92 09:45 03/09/92 10:21
03/13/92 200	ARKANSAS,MARY (123-45-6789) CARDIOLOGY (INPATIENT)	TULSA,LARRY CARDIOVERSION	03/13/92 14:00 03/13/92 14:25
03/17/92 194	GEORGIA,PAUL (123-45-6789) GENERAL SURGERY (OUTPATIENT)	RICHMOND,ARTHUR EXCISION OF SKIN LESION	03/17/92 13:30 03/17/92 14:42

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

# Comments Option

## [SROMEN-COM]

Surgeons use the *Comments* option to respond to the GENERAL COMMENTS field for a surgical case or non-O.R. procedure. This option is designed to give surgeons an opportunity to directly add general comments after a case has been booked. The GENERAL COMMENTS field may already contain information added by the person booking the operation.

After selecting the patient case, the surgeon can add the general comments using the VA FileMan word-processing device, demonstrated below. The surgeon must press the <Enter> key at the end of each line with this type of word processing. The surgeon would press the <Enter> key again when he or she is through with the comments.

### Example: Enter General Comments

```
Select Surgery Menu Option:  C  Comments

Select Patient:  UTAH,JOHNNY      08-15-42      123456789

1. 11/20/99  CAROTID ARTERY ENDARTERECTOMY  (COMPLETED)
2. 11/20/99  AORTO CORONARY BYPASS GRAFT  (CANCELLED)

Select Number:  1

General Comments:
 1>Patient at high risk due to severe hypertension. Pre-operative
 2>evaluation recommended treatment by other than surgical means.
 3>This treatment, however, was unsuccessful necessitating
 4>surgery. Patient should be monitored closely & anesthesia time
 5>kept to a minimum.
 6> <Enter>
EDIT Option: <Enter>

Select Surgery Menu Option:
```

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

# CPT/ICD9 Coding Menu

## [SRCODING MENU]

The Surgery *CPT/ICD9 Coding Menu* option was developed to help assure access to the most accurate source documentation and to provide a means for efficient coding entry and validation. It provides coders with special, limited access to the **VISTA** Surgery package.

From the menu, coders have ready access to the Operation Report, which is dictated by the surgeon postoperatively and contains the most comprehensive and accurate description of the procedure(s) actually performed. Coders can also view the Nurse Intraoperative Report, which is often an important supplementary source of data.

Using the same menu, coders can add and edit procedures, CPT codes, diagnoses, and International Classification of Diseases 9<sup>th</sup> Edition (ICD-9) codes, without having to rely on a paper-based system. Options are available to assist surgery staff and others who perform coding validation, as are several commonly used reports.

The *Surgery CPT/ICD9 Coding Menu* contains the following options. To the left is the shortcut synonym the user can enter to select the option:

Shortcut	Option Name
EDIT CPT/ICD9	<i>Update/Verify Menu ...</i>
C	<i>Cumulative Report of CPT Codes</i>
A	<i>Report of CPT Coding Accuracy</i>
M	<i>List Completed Cases Missing CPT Codes</i>
L	<i>List of Operations</i>
LS	<i>List of Operations (by Surgical Specialty)</i>
U	<i>List of Undictated Operations</i>
D	<i>Report of Daily Operating Room Activity</i>
PS	<i>PCE Filing Status Report</i>
R	<i>Report of Non-O.R. Procedures</i>

## CPT/ICD9 Update/Verify Menu [SRCODING UPDATE/VERIFY MENU]



The *CPT/ICD9 Update/Verify Menu* is locked with the SR CODER security key.

This option provides coding personnel with access to review and edit procedure and diagnosis information. It also provides access to the Operation Report and Nurse Intraoperative Report for operations and to the Procedure Report (Non-O.R.) for non-O.R. procedures.

The *CPT/ICD9 Update/Verify Menu* contains the following options. To the left is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
UV	<i>Update/Verify Procedure/Diagnosis Codes</i>
OR	<i>Operation/Procedure Report</i>
NR	<i>Nurse Intraoperative Report</i>
PI	<i>Non-OR Procedure Information</i>

To access the *CPT/ICD9 Update/Verify Menu*, the user must first identify the patient and case. When the user selects **EDIT** for the *CPT/ICD9 Update/Verify Menu* from the *CPT/ICD9 Coding Menu*, the user will be prompted to enter a patient name. The software will then list all the cases on record for the patient, including any operations that are completed or are in progress and any non-O.R. procedures.

Select CPT/ICD9 Coding Menu Option: **EDIT** CPT/ICD9 Update/Verify Menu

Select Patient: **IDAHO, PETER** 02-12-28 123456789 YES S  
C VETERAN

IDAHO, PETER 123-45-6789

1. 08-07-99 REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)
2. 02-24-99 CYSTOSCOPY (NON-OR PROCEDURE)
3. 02-18-03 TRACHEOSTOMY (COMPLETED)
4. 09-04-97 CHOLECYSTECTOMY (COMPLETED)
5. 09-28-95 INGUINAL HERNIA (COMPLETED)
6. 08-31-95 HIP REPLACEMENT (COMPLETED)

Select Case: **3**

IDAHO, PETER (123-45-6789) Case #124 - FEB 18, 1999

UV Update/Verify Procedure/Diagnosis Codes  
OR Operation/Procedure Report  
NR Nurse Intraoperative Report  
PI Non-OR Procedure Information

Select CPT/ICD9 Update/Verify Menu Option:

From this point, the user can select any of the *CPT/ICD9 Update/Verify Menu* options.

## Update/Verify Procedure/Diagnosis Codes [SRCODING EDIT]

Coders may use the *Update/Verify Procedure/Diagnosis Codes* option to review and update procedure and diagnosis information for a case. The option provides access to the free-text description of the procedure performed and the postoperative diagnosis, as well as the related CPT and ICD-9 codes.

### Example: Update/Verify Procedure/Diagnosis Codes Option

```
Select CPT/ICD9 Update/Verify Menu Option: UV Update/Verify Procedure/Diagnosis Codes
```

```
IDAHO,PETER (123-45-6789)
Operation Date: FEB 18, 2003@08:45 Case #124
```

- ```
-----
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code: NOT ENTERED

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-----
```

```
Select Information to Edit: ?
```

```
Enter the number corresponding to the information you want to update. You may
enter 'ALL' to update all the information displayed on this screen, or a
range of numbers separated by a ':' to update more than one item.
```

```
Select Information to Edit: 2
```

```
IDAHO,PETER (123-45-6789)
Operation Date: FEB 18, 1999@08:45 Case #124
```

```
-----
Principal Procedure Code (CPT): 31600 INCISION OF WINDPIPE
TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
Modifier: 59 DISTINCT PROCEDURAL SERVICE
Modifier: <Enter>
Assoc DX: <Enter>
```

```
IDAHO,PETER (123-45-6789)
Operation Date: FEB 18, 1999@08:45 Case #124
```

- ```
-----
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code: 31600 INCISION OF WINDPIPE
TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
Modifiers: -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-----
```

```
Select Information to Edit: 3
```

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----  
Other Procedures:

1. BRONCHOSCOPY  
CPT Code: NOT ENTERED
2. Enter NEW Other Procedure

Enter selection: (1-2): 1

BRONCHOSCOPY  
CPT Code: NOT ENTERED

OTHER PROCEDURE: BRONCHOSCOPY// <Enter>  
OTHER PROCEDURE CPT CODE: 31622 DX BRONCHOSCOPE/WASH  
BRONCHOSCOPY; DIAGNOSTIC, (FLEXIBLE OR RIGID), WITH OR WITHOUT CELL  
WASHING  
Modifier: <Enter>

Press RETURN to continue <Enter>

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----  
Other Procedures:

1. BRONCHOSCOPY  
CPT Code: 31622 DX BRONCHOSCOPE/WASH
2. Enter NEW Other Procedure

Enter selection: (1-2): 2

Enter new OTHER PROCEDURE: ESOPHAGOSCOPY  
OTHER PROCEDURE CPT CODE: 43200 ESOPHAGUS ENDOSCOPY  
ESOPHAGOSCOPY, RIGID OR FLEXIBLE;  
DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR  
WASHING (SEPARATE PROCEDURE)

Modifier: <Enter>

Press RETURN to continue <Enter>

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----  
Other Procedures:

1. BRONCHOSCOPY  
CPT Code: 31622 DX BRONCHOSCOPE/WASH
2. ESOPHAGOSCOPY  
CPT Code: 43200 ESOPHAGUS ENDOSCOPY
3. Enter NEW Other Procedure

Enter selection: (1-3): <Enter>

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

- 
1. Principal Procedure: TRACHEOSTOMY
  2. Principal CPT Code: 31600 INCISION OF WINDPIPE  
TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);  
Modifiers: -59
  3. Other Procedures: \*\* INFORMATION ENTERED \*\*
  4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
  5. Principal Diagnosis Code: NOT ENTERED
  6. Other Postop Diagnosis: \*\* INFORMATION ENTERED \*\*
- 

Select Information to Edit: 5

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----

Principal Diagnosis Code (ICD9): 934.0 934.0 FOREIGN BODY IN TRACHEA  
...OK? Yes// <Enter>

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

- 
1. Principal Procedure: TRACHEOSTOMY
  2. Principal CPT Code: 31600 INCISION OF WINDPIPE  
TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);  
Modifiers: -59
  3. Other Procedures: \*\* INFORMATION ENTERED \*\*
  4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
  5. Principal Diagnosis Code: 934.0 FOREIGN BODY IN TRACHEA
  6. Other Postop Diagnosis: \*\* INFORMATION ENTERED \*\*
- 

Select Information to Edit: 6

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----

Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis

Enter selection: (1-1): 1

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----

Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis

Enter selection: (1-1): 1

```
Enter new OTHER POSTOP DIAGNOSIS: LARYNGEAL/TRACHEAL BURN
ICD DIAGNOSIS CODE: 947.1 947.1 BURN LARYNX/TRACHEA/LUNG
...OK? Yes// <Enter>
```

```
IDAHO,PETER (123-45-6789)
Operation Date: FEB 18, 1999@08:45 Case #124
```

-----  
Other Postop Diagnosis:

1. LARYNGEAL/TRACHEAL BURN  
ICD9 Code: 947.1 BURN LARYNX/TRACHEA/LUNG
2. Enter NEW Other Postop Diagnosis

Enter selection: (1-2): <Enter>

```
IDAHO,PETER (123-45-6789)
Operation Date: FEB 18, 1999@08:45 Case #124
```

- 
1. Principal Procedure: TRACHEOSTOMY
  2. Principal CPT Code: 31600 INCISION OF WINDPIPE  
TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);  
Modifiers: -59
  3. Other Procedures: \*\* INFORMATION ENTERED \*\*
  4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
  5. Principal Diagnosis Code: 934.0 FOREIGN BODY IN TRACHEA
  6. Other Postop Diagnosis: \*\* INFORMATION ENTERED \*\*
- 

Select Information to Edit:

## Operation/Procedure Report [SRCODING OP REPORT]

The *Operation/Procedure Report* option is used by the coders to print the Operation Report for an operation or the Procedure Report (Non-O.R.) for a non-O.R. procedure.

Any user may print this report, which prints in an 80-column format and can be viewed on the screen or copied to a printer.

### Example 1: Operation Report

```
Select CPT/ICD9 Update/Verify Menu Option: OR Operation/Procedure Report  
DEVICE: [Select Print Device]
```

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

FLORIDA, FRANK 123-45-6789

OPERATION REPORT

NOTE DATED: 07/29/2003 15:15 OPERATION REPORT  
VISIT: 07/29/2003 15:15 SURGERY OP REPORT NON-COUNT  
SUBJECT: Case #: 73285

PREOPERATIVE DIAGNOSIS: Visually significant cataract, right eye

POSTOPERATIVE DIAGNOSIS: Visually significant cataract, right eye

PROCEDURE: Phacoemulsification with intraocular lens placement, right eye

CLINICAL INDICATIONS: This 64-year-old gentleman complains of decreased vision in the right eye affecting his activities of daily living. Best corrected visual acuity is counting fingers at 6 feet, associated with a 2-3+ nuclear sclerotic and 4+ posterior subcapsular cataract in that eye.

ANESTHESIA: Local monitoring with topical Tetracaine and 1% preservative free Lidocaine.

DESCRIPTION OF THE PROCEDURE: After the risks, benefits and alternatives of the procedure were explained to the patient, informed consent was obtained. The patient's right eye was dilated with Phenylephrine, Mydriacyl and Ocufen. He was brought to the Operating Room and placed on anesthetic monitors. Topical Tetracaine was given. He was prepped and draped in the usual sterile fashion for eye surgery. A Lieberman lid speculum was placed.

A Supersharps was used to create a superior paracentesis port. The anterior chamber was irrigated with 1% preservative free Lidocaine. The anterior chamber was filled with Viscoelastic. The diamond groove maker and diamond keratome were used to create a clear corneal tunneled incision at the temporal limbus. The cystotome was used to initiate a continuous capsulorrhexis, which was then completed using Utrata forceps. Balanced salt solution was used to hydrodissect and hydrodelineate the lens.

Phacoemulsification was used to remove the lens nucleus and epinucleus in a non-stop horizontal chop fashion. Cortex was removed using irrigation and aspiration. The capsular bag was filled with Viscoelastic. The wound was enlarged with a 69 blade. An Alcon model MA60BM posterior chamber intraocular lens with a power of 24.0 diopters, serial #588502.064, was folded and inserted with the leading haptic placed into the bag. The trailing haptic was dialed into the bag with the Lester hook. The wound was hydrated. The anterior chamber was filled with balanced salt solution. The wound was tested and found to be self-sealing. Subconjunctival antibiotics were given, and an eye shield was placed. The patient was taken in good condition to the Recovery Room. There were no complications.

KJC/PSI

DATE DICTATED: 07/29/03

DATE TRANSCRIBED: 07/29/03

JOB: 629095

Signed by: /es/ CHARLES RICHMOND, M.D.  
07/30/2003 10:31

**Example 2: Procedure Report (Non-OR)**

Select CPT/ICD9 Update/Verify Menu Option: **OR** Operation/Procedure Report  
DEVICE: [Select Print Device]

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

-----  
OHIO, RAYMOND 123-45-6789

PROCEDURE REPORT  
-----

NOTE DATED: 02/13/2002 00:00 PROCEDURE REPORT

SUBJECT: Case #: 267236

PREOPERATIVE DIAGNOSIS: RESPIRATORY FAILURE, PROLONGED TRACHEAL INTUBATION  
AND FAILURE TO WEAN

POSTOPERATIVE DIAGNOSIS: SAME

PROCEDURE PERFORMED: OPEN TRACHEOSTOMY

SURGEON: DR. SPRINGFIELD

ASSISTANT SURGEON:

ANESTHESIA: GENERAL ENDOTRACHEAL ANESTHESIA

ESTIMATED BLOOD LOSS: MINIMAL

COMPLICATIONS: NONE

INDICATIONS FOR PROCEDURE: The patient is a sixty-four-year-old gentleman with a rather extensive past surgical history, mostly significant for status post esophagogastrectomy and presented to the hospital approximately three weeks ago with abdominal pain. Diagnostic evaluation consisted of an abdominal CT scan, liver function tests and right upper quadrant ultrasound, all of which were consistent with a diagnosis of acalculus cholecystitis. Because of these findings, the patient was brought to the operating room approximately three weeks ago where an open cholecystectomy was performed. The patient subsequent to that has had a very rocky postoperative course, most significantly focusing around persistently spiking fevers with sources significant for an E-coli sinusitis as well as a Staphylococcus E-coli pneumonia with no evidence of bacteremia. As a result of all of this sepsis and persistent spiking fevers, the patient has had a pneumonia, the patient has had a rather difficult time weaning from the ventilator and because of the almost three week period since his last operation with persistent endotracheal tube in place, the patient was brought to the operating room for an open tracheostomy procedure.

DESCRIPTION OF PROCEDURE: After appropriate consent was obtained from the patient's next of kin and the risks and benefits were explained to her, the patient was then brought to the operating room where general endotracheal anesthesia was induced. The area was prepped and draped in the usual fashion with a towel roll under the patient's scapula and the neck extended.

A longitudinal incision of approximately 2 cm was made just below the cricoid cartilage. The strap muscles were taken down using Bovie electrocautery. The isthmus of the thyroid was clamped and tied off using 2-0 silk x two. Hemostasis was assured. The thyroid cartilage was carefully dissected directly onto it. The window in the third ring of the trachea was opened after placement of retraction sutures of 0 silk. The hatch was cut open using a hatch box shape. This opening was then dilated using the tracheal dilator. The endotracheal tube was pulled back. A #7 Tracheostomy tube was placed with ease. Breath sounds were assured. The patient was oxygenating well and the stay sutures were placed. The patient tolerated the procedure well. The skin was closed with 0 silk and trachea tip was applied. The patient tolerated the procedure well. The endotracheal tube was finally removed. He was brought to the Surgical Intensive Care Unit in stable, but critical condition.

Jack Springfield, M.D.

JS/jer:jw J#: 514 DD: 02-13-02 DT: 02-13-02

Signed by: /es/ JACK SPRINGFIELD  
02/13/2002 16:40

Enter RETURN to continue or '^' to exit: ^

## Nurse Intraoperative Report [SRCODING NURSE REPORT]

The *Nurse Intraoperative Report* option is used by the coders to print the Nurse Intraoperative Report for an operation. This report is not available for non-O.R. procedures.

This report prints in an 80-column format and can be viewed on the screen or copied to a printer.

### Example: Nurse Intraoperative Report

```
Select CPT/ICD9 Update/Verify Menu Option: NR Nurse Intraoperative Report  
DEVICE: [Select Print Device]
```

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

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

NURSE INTRAOPERATIVE REPORT  
-----

NOTE DATED: 02/12/2002 08:00 NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room: WX OR3 Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30 Patient in OR: JUL 12, 2004 08:00  
Operation Begin: JUL 12, 2004 08:58 Operation End: JUL 12, 2004 12:10  
Surgeon in OR: JUL 12, 2004 07:55 Patient Out OR: JUL 12, 2004 12:15

Major Operations Performed:

Primary: MVR

CPT Code: 33430 REPLAC MITRAL VALV W/CP BYPA

Other: ATRIAL SEPTAL DEFECT REPAIR

CPT Code: 33641 REPR ATRIAL SEPTAL DEFECT W/

Other: TEE

CPT Code: 76986 US GUID INTRAOPERATIVE

Wound Classification: CONTAMINATED

Operation Disposition: SICU

Discharged Via: ICU BED

Surgeon: SPRINGFIELD,JACK  
Attend Surg: SPRINGFIELD,JACK  
Anesthetist: ATHENS,DEBBIE

First Assist: TAMPA,KAREN  
Second Assist: N/A  
Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:

Scrubbed  
HARRISBURG,HENRY (FULLY TRAINED)

Circulating  
LANSING,MARY (FULLY TRAINED)  
PELHAM,STEVE (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS Preop Consc: ALERT-ORIENTED  
Preop Skin Integ: INTACT Preop Converse: N/A

Valid Consent/ID Band Confirmed By: TAMPA,KAREN

Mark on Surgical Site Confirmed: YES

Marked Site Comments: NO COMMENTS ENTERED

Preoperative Imaging Confirmed: YES

Imaging Confirmed Comments: NO COMMENTS ENTERED

Time Out Verification Completed: YES

Time Out Verified Comments: NO COMMENTS ENTERED

Skin Prep By: PELHAM,STEVE  
Skin Prep By (2): LANSING,MARY  
Preop Shave By: PELHAM,STEVE

Skin Prep Agent: BETADINE SCRUB  
2nd Skin Prep Agent: POVIDONE IODINE

Surgery Position(s):

SUPINE Placed: N/A

Restraints and Position Aids:

SAFETY STRAP Applied By: N/A  
ARMBOARD Applied By: N/A  
FOAM PADS Applied By: N/A  
KODEL PAD Applied By: N/A  
STIRRUPS Applied By: N/A

Electrocautery Unit: 8845,5512

ESU Coagulation Range: 50-35

Enter RETURN to continue or '^' to exit:

ESU Cutting Range: 35-35  
Electroground Position(s): RIGHT BUTTOCK  
LEFT BUTTOCK

Material Sent to Laboratory for Analysis:  
Specimens:  
1. MITRAL VALVE  
Cultures: N/A

Anesthesia Technique(s):  
GENERAL (PRINCIPAL)

Tubes and Drains:  
#16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:  
Item: MITRAL VALVE  
Vendor: BAXTER EDWARDS  
Model: 6900  
Lot/Serial Number: GY0755  
Size: 29MM  
Sterile Resp: MANUFACTURER  
Quantity: 1

Medications: N/A

Irrigation Solution(s):  
HEPARINIZED SALINE  
NORMAL SALINE  
COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count: YES  
Sharps Count: YES  
Instrument Count: NOT APPLICABLE  
Counter: PELHAM,STEVE  
Counts Verified By: LANSING,MARY

Dressing: DSD, PAPER TAPE, MEPORE  
Packing: NONE

Blood Loss: 800 ml  
Urine Output: 750 ml

Postoperative Mood: RELAXED  
Postoperative Consciousness: ANESTHETIZED  
Postoperative Skin Integrity: SUTURED INCISION  
Postoperative Skin Color: N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Signed by: /es/ MARY A LANSING  
03/04/2002 10:41

## Non-OR Procedure Information [SR NON-OR INFO]

The *Non-OR Procedure Information* option displays information on the selected non-OR procedure, with the exception of the provider's dictated summary.

This report prints in an 80-column format and can be viewed on the screen.

### Example: Non-OR Procedure Information

```
NEBRASKA,NICK (123-45-6789) Case #267260 - APR 22,2002
```

```
UV Update/Verify Procedure/Diagnosis Codes
OR Operation/Procedure Report
NR Nurse Intraoperative Report
I Non-OR Procedure Information
```

```
Select CPT/ICD9 Update/Verify Menu Option: I Non-O.R. Procedure Information
```

```
DEVICE: HOME// [Select Print Device]T
```

-----printout follows-----

```
NEBRASKA,NICK (123-45-6789) Age: 83 PAGE 1
NON-O.R. PROCEDURE - CASE #267260 Printed: AUG 04, 2004@14:40
-----
```

```
Med. Specialty: GENERAL Location: NON OR
```

```
Principal Diagnosis: LARYNGEAL/TRACHEAL BURN
```

```
Provider: MIAMI,STEVE Patient Status: NOT ENTERED
```

```
Attending:
Attending Code:
```

```
Attend Anesth: N/A
Anesthesia Supervisor Code: N/A
Anesthetist: N/A
```

```
Anesthesia Technique(s): N/A
```

```
Proc Begin: JAN 14, 2004 08:00 Proc End: JAN 14, 2004 09:00
```

```
Procedure(s) Performed:
Principal: BRONCHOSCOPY
CPT Code: 31622 DX BRONCHOSCOPE/WASH
```

```
Dictated Summary Expected: YES
```

```
Enter RETURN to continue or '^' to exit:
```

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

## Cumulative Report of CPT Codes [SROACCT]

The *Cumulative Report of CPT Codes* option counts and reports the number of times a procedure was performed (based on CPT codes) during a specified date range. There is also a column showing how many times it was in the Other Operative Procedure category.

After the user enters the date range, the software will ask if the user wants the Cumulative Report of CPT Codes to include only operating room surgical procedures, non-O.R. procedures, or both.

These reports have a 132-column format and are designed to be copied to a printer.

### Example 1: Print the Cumulative Report of CPT Codes for only OR Surgical Procedures

```
Select CPT/ICD9 Coding Menu Option: C Cumulative Report of CPT Codes
```

```
Cumulative Report of CPT Codes
```

```
Start with Date: 3/28 (MAR 28, 1999)
```

```
End with Date: 4/3 (APR 03, 1999)
```

```
Include which cases on the Cumulative Report of CPT Codes ?
```

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

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

```
This report is designed to use a 132 column format.
```

```
Select Device: [Select Print Device]
```

-----printout follows-----

MAYBERRY, NC  
 SURGICAL SERVICE  
 CUMULATIVE REPORT OF CPT CODES  
 FROM: MAR 28,1999 TO: APR 3,1999

REVIEWED BY  
 DATE REVIEWED:

O.R. SURGICAL PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	1	1	0
11440 REMOVAL OF SKIN LESION	1	1	0
11441 REMOVAL OF SKIN LESION	4	4	0
11641 REMOVAL OF SKIN LESION	4	2	2
24075 REMOVE ARM/ELBOW LESION	1	1	0
26989 HAND/FINGER SURGERY	1	1	0
30520 REPAIR OF NASAL SEPTUM	1	1	0
31231 NASAL ENDOSCOPY, DX	1	0	1
45315 PROCTOSIGMOIDOSCOPY	1	0	1
45330 SIGMOIDOSCOPY, DIAGNOSTIC	7	7	0
45333 SIGMOIDOSCOPY & POLYPECTOMY	1	1	0
45378 DIAGNOSTIC COLONOSCOPY	2	2	0
45385 COLONOSCOPY, LESION REMOVAL	3	3	0
47600 REMOVAL OF GALLBLADDER	1	0	1
49000 EXPLORATION OF ABDOMEN	1	1	0
49505 REPAIR INGUINAL HERNIA	2	1	1
66984 REMOVE CATARACT, INSERT LENS	4	3	1
68801 DILATE TEAR DUCT OPENING	1	1	0

## Example 2: Print the Cumulative Report of CPT Codes for only Non-OR Procedures

Select CPT/ICD9 Coding Menu Option: **C** Cumulative Report of CPT Codes

Cumulative Report of CPT Codes

Start with Date: 7 1 99 (JUL 01, 1999)  
End with Date: 12 31 99 (DEC 31, 1999)

Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number: 1// 2

This report is designed to use a 132 column format.

Select Device: **[Select Print Device]**

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 CUMULATIVE REPORT OF CPT CODES  
 FROM: JUL 1,1999 TO: DEC 31,1999

REVIEWED BY  
 DATE REVIEWED:

NON-O.R. PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	2	2	0
10061 DRAINAGE OF SKIN ABSCESS	1	1	0
11040 DEBRIDE SKIN PARTIAL	8	8	0
11042 DEBRIDE SKIN/TISSUE	1	1	0
11100 BIOPSY OF SKIN LESION	11	11	0
11402 REMOVAL OF SKIN LESION	1	1	0
11420 REMOVAL OF SKIN LESION	1	1	0
11620 REMOVAL OF SKIN LESION	1	1	0
11640 REMOVAL OF SKIN LESION	1	1	0
11730 REMOVAL OF NAIL PLATE	1	1	0
11750 REMOVAL OF NAIL BED	1	1	0
12001 REPAIR SUPERFICIAL WOUND(S)	3	3	0
12011 REPAIR SUPERFICIAL WOUND(S)	2	2	0
14060 SKIN TISSUE REARRANGEMENT	1	1	0
15782 ABRASION TREATMENT OF SKIN	1	1	0
17340 CRYOTHERAPY OF SKIN	1	1	0
20550 INJ TENDON/LIGAMENT/CYST	23	23	0
29799 CASTING/STRAPPING PROCEDURE	1	1	0
46083 INCISE EXTERNAL HEMORRHOID	2	2	0

## Report of CPT Coding Accuracy

The Report of CPT Coding Accuracy lists cases sorted by the CPT code used in the PRINCIPAL PROCEDURES field and OTHER OPERATIVE PROCEDURES field. This option is designed to help check the accuracy of the coding procedures.

### About the prompts

"Do you want to print the Report of CPT Coding Accuracy for all CPT Codes ?" The user should reply **NO** to this prompt to produce the report for only one CPT code. The user will then be prompted to enter the CPT code or category.

"Do you want to sort the Report of CPT Coding Accuracy by Surgical Specialty ?" The user should press the **<Enter>** key if he or she wants to sort the report by specialty. Enter **NO** to sort the report by date only.

"Do you want to print the Report to Check Coding Accuracy for all Surgical Specialties ?" The user can enter the code or name of the surgical service he or she wants the report to be based on. Or, the user can press the **<Enter>** key to print the report for all surgical specialties.

### **Example 1: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Surgical Specialty**

```
Select CPT/ICD9 Coding Menu Option: A Report of CPT Coding Accuracy
```

```
Report to Check CPT Coding Accuracy
```

```
Start with Date: 10 8 96 (OCT 08, 1999)  
End with Date: 10 8 96 (OCT 08, 1999)
```

```
Print the Report of CPT Coding Accuracy for which cases ?
```

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

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

```
Do you want to print the Report of CPT Coding Accuracy for all  
CPT Codes ? YES// <Enter>
```

```
Do you want to sort the Report of CPT Coding Accuracy by  
Surgical Specialty ? YES// <Enter>
```

```
Do you want to print the Report to Check Coding Accuracy for all  
Surgical Specialties ? YES// NO
```

```
Print the Coding Accuracy Report for which Surgical Specialty ? 50      GENERA  
L(OR WHEN NOT DEFINED BELOW) GENERAL(OR WHEN NOT DEFINED BELOW)      50
```

```
This report is designed to use a 132 column format.
```

```
Select Device: [Select Print Device]
```

-----printout follows-----

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF CPT CODING ACCURACY  
 FOR GENERAL (OR WHEN NOT DEFINED BELOW)  
 FROM: OCT 8, 1999 TO: OCT 8, 1999

REVIEWED BY:  
 DATE REVIEWED:

O.R. SURGICAL PROCEDURES

PROCEDURE DATE CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
===== 47600 REMOVAL OF GALLBLADDER PRINCIPAL PROCEDURES DESCRIPTION: CHOLECYSTECTOMY; -----			
10/08/96 07:00 63072	GEORGIA, PAUL 123-45-6789	CHOLECYSTECTOMY (47600-22)	TULSA, LARRY MIAMI, STEVE
===== 47605 REMOVAL OF GALLBLADDER OTHER PROCEDURES DESCRIPTION: CHOLECYSTECTOMY; WITH CHOLANGIOGRAPHY -----			
10/08/96 10:00 63077	BOISE, WILLIAM 123-45-6789	INGUINAL HERNIA (49521), OTHER OPERATIONS: CHOLECYSTECTOMY (47605-22)	RICHMOND, ARTHUR MIAMI, STEVE
===== 49505 REPAIR INGUINAL HERNIA PRINCIPAL PROCEDURES DESCRIPTION: REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE -----			
10/08/96 06:00 63071	KENTUCKY, KENNETH 123-45-6789	INGUINAL HERNIA (49505)	MIAMI, STEVE PITTSBURGH, ANTHONY
=====			

## Example 2: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Date

Select CPT/ICD9 Coding Menu Option: **A** Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: 10 1 96 (OCT 08, 1999)

End with Date: 10 7 96 (OCT 08, 1999)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

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

Do you want to print the Report of CPT Coding Accuracy for all  
CPT Codes ? YES// **<Enter>**

Do you want to sort the Report of CPT Coding Accuracy by  
Surgical Specialty ? YES// **N**

This report is designed to use a 132 column format.

Select Device: [**Select Print Device**]

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF CPT CODING ACCURACY  
 FROM: OCT 1,1999 TO: OCT 7,1999

REVIEWED BY:  
 DATE REVIEWED:

O.R. SURGICAL PROCEDURES

PROCEDURE DATE CASE #	PATIENT ID# SPECIALTY	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
--------------------------	-----------------------------	------------	--------------------------------------

31365 REMOVAL OF LARYNX  
 PRINCIPAL PROCEDURES  
 DESCRIPTION: LARYNGECTOMY;  
 TOTAL, WITH RADICAL NECK DISSECTION

10/03/96 07:00 63059	DELAWARE, ANDREW 123-45-6789 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY (31365)	DENVER, DONNA RICHMOND, ARTHUR
-------------------------	--------------------------------------------------------------------------	-----------------------------	-----------------------------------

32440 REMOVAL OF LUNG  
 PRINCIPAL PROCEDURES  
 DESCRIPTION: REMOVAL OF LUNG, TOTAL PNEUMONECTOMY;

10/03/96 10:00 63060	ARKANSAS, JAMES 123-45-6789 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY (32440)	MIAMI, STEVE RICHMOND, ARTHUR
10/04/96 06:00 63069	IOWA, LUKE 123-45-6789 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY (32440)	AUGUSTA, DON AUGUSTA, DON

32480 PARTIAL REMOVAL OF LUNG  
 PRINCIPAL PROCEDURES  
 DESCRIPTION: REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY;  
 SINGLE LOBE (LOBECTOMY)

10/03/96 06:00 63049	IDAHO, PETER 123-45-6789 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY (32480)	TULSA, LARRY TOPEKA, MARK
10/03/96 07:00 63050	WISCONSIN, MARK 123-45-6789 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY (32480)	TULSA, LARRY TULSA, LARRY

### Example 3: Print the Report of CPT Coding Accuracy for Non-OR Procedures, sorted by CPT Code and Medical Specialty

Select CPT/ICD9 Coding Menu Option: **A** Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: **1 1 99** (JAN 01, 1999)

End with Date: **8 31 99** (AUG 31, 1999)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number: 1// 2

Do you want to print the Report of CPT Coding Accuracy for all CPT Codes ? YES// **N**

Print the Coding Accuracy Report for which CPT Code ? **92960**

HEART ELECTROCONVERSION  
CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF  
ARRHYTHMIA, EXTERNAL

Do you want to sort the Report of CPT Coding Accuracy by Medical Specialty ? YES// **<Enter>**

Do you want to print the Report to Check Coding Accuracy for all Medical Specialties ? YES// **N**

Print the Coding Accuracy Report for which Medical Specialty ? **MEDICINE**

This report is designed to use a 132 column format.

Select Device: **[Select Print Device]**

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF CPT CODING ACCURACY  
 FOR MEDICINE  
 FROM: JAN 1,1999 TO: AUG 31,1999

REVIEWED BY:  
 DATE REVIEWED:

NON-O.R. PROCEDURES

PROCEDURE CASE #	DATE	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
===== 92960 HEART ELECTROCONVERSION PRINCIPAL PROCEDURES DESCRIPTION: CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF ARRHYTHMIA, EXTERNAL -----				
01/24/99 15499		MICHIGAN, MATHEW R. 123-45-6789	CARDIOVERSION (92960)	TULSA, LARRY TULSA, LARRY
02/09/99 15701		HAWAII, LOU 123-45-6789	CARDIOVERSION (92960)	TOPEKA, MARK TULSA, LARRY
03/29/99 15912		IDAHO, MICHAEL 123-45-6789	CARDIOVERSION (92960)	SPRINGFIELD, JACK
08/04/99 16669		MISSOURI, ROY 123-45-6789	CARDIOVERSION (92960)	AUGUSTA, DON MIAMI, STEVE
08/25/99 16828		COLORADO, ALBERT 123-45-6789	CARDIOVERSION (92960)	TULSA, LARRY TULSA, LARRY

## List Completed Cases Missing CPT Codes [SRSCPT

The *List Completed Cases Missing CPT Codes* option generates a report of completed cases that are missing a CPT code for the principal or secondary operation(s) within a specified date range.

CPT codes need to be attributed to each procedure; only procedures that have CPT codes are included in the Annual Report of Surgical Procedures. The user can use the *Operation Menu* option or the *Operation* option to add a CPT code to a case.

After the user enters the date range, the software will ask whether the user wants the Cumulative Report of CPT Codes to include 1) only operating room surgical procedures, 2) non-O.R. procedures, or 3) both.

This report is in an 80-column format and can be viewed on the screen.

### Example: List Completed Cases Missing CPT Codes

```
Select CPT/ICD9 Coding Menu Option: M List Completed Cases Missing CPT Codes
```

```
Print list of Completed Cases Missing CPT Codes for
```

1. OR Surgical Procedures.
2. Non-OR Procedures.
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

```
Select Number: 1// 1
```

```
Do you want the list for all Surgical Specialties ? YES// <Enter>
```

```
Start with Date: 2/1 (APR 01, 1999)
```

```
End with Date: 4/30 (APR 20, 1999)
```

```
Print the List of Cases Missing CPT codes to which Printer ? [Select Print Device]
```

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

MAYBERRY, NC  
 Completed Cases Missing CPT Codes  
 O.R. Surgical Procedures  
 From: FEB 1,1999 To: APR 30,1999  
 Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Operation Date Case #	Patient (ID#)	Surgeon/Provider
FEB 01, 1999 53708	JACKSON, THOMAS J. (123-45-6789)	AUGUSTA, DON
	* EXC LEFT PREAURICULAR LESION (CPT: MISSING)	
FEB 08, 1999 53747	VERMONT, JONATHAN (123-45-6789)	TOPEKA, MARK
	* EXCISION LESIONS SCALP (CPT: 11420)	
	* N/A (CPT: MISSING)	
MAR 12, 1999 53973	VIRGINIA, MARK (123-45-6789)	TULSA, LARRY
	* COLONOSCOPY (CPT: MISSING)	
MAR 23, 1999 54030	MISSISSIPPI, RANDALL (123-45-6789)	TOPEKA, MARK
	* COLONOSCOPY/ATTEMPTED (CPT: MISSING)	
APR 27, 1999 54325	ALASKA, FREDERICK (123-45-6789)	WISCONSIN, ROBERT
	* EXCISION RT FOREARM LESIONS (CPT: MISSING)	
	* EXC LESION, RT EAR (CPT: MISSING)	
	* EXC LESION, RT FOREHEAD (CPT: MISSING)	
	* EXC LESION RT SCALP (CPT: MISSING)	
	* RXC LESION, NOSE (CPT: MISSING)	
	* EXC LESION, LEFT EAR (CPT: MISSING)	
	* EXC LESION, LEFT FOREARM (CPT: MISSING)	
	* EXC LESION, TOP OF HEAD (CPT: MISSING)	
	* EXC LESION, LEFT NECK (CPT: MISSING)	

## List of Operations [SROPLIST]

The List of Operations report contains general information for completed cases within a specified date range. It sorts the cases by date and includes the procedure(s), surgical service, length of actual operation, surgeons, and anesthesia technique. This report also includes aborted cases.

This report has a 132-column format and is designed to be copied to a printer.

### Example: List of Operations

```
Select CPT/ICD9 Coding Menu Option: L List of Operations
```

```
List of Operations
```

```
Start with Date: 10/8 (OCT 08, 1999)
```

```
End with Date: 10/8 (OCT 08, 1999)
```

```
This report is designed to use a 132 column format.
```

```
Print to device: [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 LIST OF OPERATIONS  
 FROM: OCT 8,1999 TO: OCT 8,1999

PAGE 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: OCT 20,1999

DATE CASE #	PATIENT ID# PRIORITY	SERVICE OPERATION(S)	SURGEON 1ST ASSISTANT 2ND ASSISTANT	ANESTHESIA TECH
10/08/99 63071	KENTUCKY, KENNETH 123-45-6789 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA	MIAMI, STEVE TOPEKA, MARK TULSA, LARRY	GENERAL OP TIME: 50 MIN.
10/08/99 63072	GEORGIA, PAUL 123-45-6789 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) CHOLECYSTECTOMY	TULSA, LARRY MIAMI, STEVE	GENERAL OP TIME: 50 MIN.
10/08/99 63073	OKLAHOMA, SHANNON 123-45-6789 URGENT, ADD TODAY	OPHTHALMOLOGY INTRAOCULAR LENS, CHOLECYSTECTOMY	MIAMI, STEVE SPRINGFIELD, JACK RICHMOND, ARTHUR	SPINAL OP TIME: 50 MIN.
10/08/99 63074	VIRGINIA, SAMUEL 123-45-6789 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) HIP REPLACEMENT	MIAMI, STEVE RICHMOND, ARTHUR KNOXVILLE, THOMAS	NOT ENTERED OP TIME: 50 MIN.
10/08/99 63075	CONNECTICUT, CARL 123-45-6789 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) PULMONARY LOBECTOMY	AUGUSTA, DON SPRINGFIELD, JACK TULSA, LARRY	NOT ENTERED OP TIME: 45 MIN.
10/08/99 63077	BOISE, WILLIAM 123-45-6789 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA, CHOLECYSTECTOMY	RICHMOND, ARTHUR SPRINGFIELD, JACK RALEIGH, RICHARDETTE	GENERAL OP TIME: 63 MIN.
10/08/99 63076	KANSAS, THOMAS 123-45-6789 ELECTIVE	UROLOGY TURP	BISMARCK, ANDREW RICHMOND, ARTHUR TULSA, LARRY	GENERAL OP TIME: 45 MIN.

TOTAL CASES: 7

## List of Operations (by Surgical Specialty) [SROPLIST1]

The List of Operations (by Surgical Specialty) report contains general information for completed cases within a selected date range. It sorts the cases by surgical specialty and case number.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique. The user can request a list for all specialties or a selected specialty.

This report has a 132-column format and is designed to be copied to a printer.

### Example: List of Operations by Surgical Specialty

```
Select CPT/ICD9 Coding Menu Option: LS List of Operations (by Surgical Specialty)
```

```
List of Operations sorted by Surgical Specialty
```

```
Start with Date: 10/4 (OCT 04, 1999)
```

```
End with Date: 10/8 (OCT 08, 1999)
```

```
Do you want to print the report for all Specialties ? YES// N
```

```
Print the report for which Surgical Specialty ? GENERAL (OR WHEN NOT DEFINED BELOW)
```

```
This report is designed to use a 132 column format.
```

```
Print the Report on which Device: [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 LIST OF OPERATIONS BY SERVICE  
 FROM: OCT 4,1999 TO: OCT 8,1999

DATE REVIEWED:  
 REVIEWED BY:  
 DATE PRINTED: SEP 20,1999

DATE CASE #	PATIENT ID# PRIORITY	OPERATION(S)	SURGEON FIRST ASSISTANT SECOND ASSISTANT	ANESTHESIA TECHNIQUE
-----				
*GENERAL(OR WHEN NOT DEFINED BELOW)*				
10/04/99 63066	UTAH, JOHNNY 123-45-6789 STANDBY	INGUINAL HERNIA	SPRINGFIELD, JACK TULSA, LARRY TOPEKA, MARK	GENERAL OP TIME: 40 MIN.
10/04/99 63067	NEVADA, NORMAN 123-45-6789 ELECTIVE	INGUINAL HERNIA	MIAMI, STEVE TOPEKA, MARK TULSA, LARRY	GENERAL OP TIME: 50 MIN.
10/04/99 63068	MONTANA, MICHEAL 123-45-6789 ELECTIVE	INGUINAL HERNIA	SPRINGFIELD, JACK TOPEKA, MARK TULSA, LARRY	GENERAL OP TIME: 45 MIN.
10/07/99 63070	INDIANA, SUSAN 123-45-6789 ELECTIVE	INGUINAL HERNIA	AUGUSTA, DON MIAMI, STEVE	GENERAL OP TIME: 45 MIN.
10/08/99 63071	KENTUCKY, KENNETH 123-45-6789 ELECTIVE	INGUINAL HERNIA	MIAMI, STEVE TOPEKA, MARK TULSA, LARRY	GENERAL OP TIME: 50 MIN.
10/08/99 63072	GEORGIA, PAUL 123-45-6789 ELECTIVE	CHOLECYSTECTOMY	TULSA, LARRY MIAMI, STEVE	GENERAL OP TIME: 50 MIN.
10/08/99 63077	BOISE, WILLIAM 123-45-6789 ELECTIVE	INGUINAL HERNIA, CHOLECYSTECTOMY	RICHMOND, ARTHUR SPRINGFIELD, JACK RALEIGH, RICHARDETTE	GENERAL OP TIME: 63 MIN.

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 7

## Report of Daily Operating Room Activity [SROPACT]

The *Report of Daily Operating Room Activity* option generates a report listing cases started between 6:00 AM on the date selected and 5:59 AM of the following day for all operating rooms.

This report has a 132-column format and is designed to be copied to a printer.

### Example: Print the Report of Daily Operating Room Activity

```
Select CPT/ICD9 Coding Menu Option: D Report of Daily Operating Room Activity
```

```
Print the Report of Daily Activity for which Date ? 3/9 (MAR 09, 1999)
```

```
This report will include all cases started between MAR 9, 1999 at 6:00 AM  
and MAR 10, 1999 at 5:59 AM.
```

```
It is designed to use a 132 column format.
```

```
Print the Report to which Device ? [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 DAILY REPORT OF OPERATING ROOM ACTIVITY  
 FOR: MAR 09, 1999

PATIENT ID # WARD	AGE	TIME IN OR TIME OUT OR CASE NUMBER	POSTOPERATIVE DIAGNOSIS PROCEDURE(S)	ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
=====					
OPERATING ROOM: OR1					
IDAHO,PETER 123-45-6789 1 NORTH 161-1	61	03/09 08:00 03/09 09:10 194	INGUINAL HERNIA INGUINAL HERNIA	LANSING,E HARRISBURG,H	ALBANY,A NASHVILLE,N TULSA,L
OPERATING ROOM: OR3					
HAWAII,LOU 123-45-6789 OUTPATIENT	49	03/09 09:15 03/09 12:40 187	CHOLECYSTITIS CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	AUGUSTA,D PHOENIX,S	TULSA,L RICHMOND,A TULSA,LARRY
OPERATING ROOM: OR5					
MISSOURI,ROY 123-45-6789 1 WEST 101-1	50	03/09 19:56 03/09 21:05 188	APPENDICITIS APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY, CRAIN	AUGUSTA,D NASHVILLE,N	PITTSBURGH,A RICHMOND,A MIAMI,S

## **PCE Filing Status Report [SRO PCE STATUS]**

The *PCE Filing Status Report* option provides a report of the Patient Care Encounter (PCE) filing status of completed cases performed during the selected date range in accordance with the site parameter controlling PCE updates. If this site parameter is turned off, the report will show no cases. The report may be printed for O.R. surgical cases, non-O.R. procedures or both. The report may also be printed for all specialties or for a single specialty only.

This report is intended to be used as a tool in the review of Surgery case information that is passed automatically to PCE. The report uses 5 status categories:

- (1) **FILED** - This status indicates that case information has already been filed with PCE.
- (2) **QUEUED TO FILE** - This status indicates the case is queued to file with PCE next time the Surgery nightly maintenance job runs.
- (3) **UPDATE QUEUED** - This status indicates that information passed to PCE has been updated after the case was filed with PCE and PCE will be updated the next time the Surgery nightly maintenance job runs.
- (4) **NOT QUEUED** - This status indicates the case is missing information required for filing with PCE.
- (5) **UNCERTAIN** - If the UPDATES TO PCE site parameter is set to file outpatient cases only, this status indicates the IN/OUT-PATIENT STATUS field is null.

Two forms of the report are available, the long and the short. The long form uses a 132- column format and prints case information including the surgeon/provider, the attending, the specialty, the principal post-op diagnosis, and the principal procedure. If the PCE filing status is **FILED**, **QUEUED TO FILE** or **UPDATE QUEUED**, the CPT codes and ICD diagnosis codes will be printed. If the filing status is **NOT QUEUED** or **UNCERTAIN**, information fields needed for PCE filing that do not contain data will be printed. At the end of the report, the number of cases in each PCE filing status will be printed, plus the number of CPT and ICD-9 codes for cases with a status of **FILED**, **QUEUED TO FILE**, and **UPDATE QUEUED**.

The short form uses an 80-column format and does not include Surgeon/Provider, Attending, Principal Post-Op Diagnosis and CPT and ICD-9 code information. The totals printed at the end will show only the total cases for each status.

### Example 1: PCE Filing Status Report (Short Form)

Select CPT/ICD9 Coding Menu Option: **PS** PCE Filing Status Report

#### Report of PCE Filing Status

This report displays the filing status of completed cases performed during the selected date range.

Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// **<Enter>**

Do you want the report for all Surgical Specialties ? YES// **NO**

Select Surgical Specialty: **50** GENERAL(OR WHEN NOT DEFINED BELOW) GENERAL(  
OR WHEN NOT DEFINED BELOW) 50

Start with Date: 10/3/99 (OCT 03, 1999)

End with Date: 10/3/99 (OCT 03, 1999)

Print the long form or the short form ? SHORT// **<Enter>**

Print the PCE Filing Status Report to which Printer ? **[Select Print Device]**

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

MAYBERRY, NC  
PCE FILING STATUS REPORT PAGE 1  
For Completed O.R. Surgical Procedures  
From: OCT 3,1999 To: OCT 3,1999  
Report Printed: OCT 15,1999@10:29

DATE OF OPERATION CASE #	PATIENT NAME SPECIALTY PRINCIPAL PROCEDURE	PATIENT ID (AGE)	FILING STATUS SCHED STATUS
OCT 3,1999@06:00 63052	KANSAS, THOMAS GENERAL (OR WHEN NOT INGUINAL HERNIA	123-45-6789 (76)	FILED CHECKED OUT
OCT 3,1999@06:00 63062	IOWA, LUKE GENERAL (OR WHEN NOT CHOLECYSTECTOMY	123-45-6789 (39)	FILED CHECKED OUT
OCT 3,1999@08:00 63054	TEXAS, THOMAS GENERAL (OR WHEN NOT INGUINAL HERNIA	123-45-6789 (60)	FILED CHECKED OUT
OCT 3,1999@11:00 63061	LOUISIANA, DOUG GENERAL (OR WHEN NOT INGUINAL HERNIA	123-45-6789 (54)	FILED CHECKED OUT
OCT 3,1999@13:00 63064	OHIO, RAYMOND GENERAL (OR WHEN NOT APPENDECTOMY	123-45-6789 (85)	UPDATE QUEUED CHECKED OUT

```

      FILED:      4
    QUEUED TO FILE:  0
      UPDATE QUEUED:  1
      NOT QUEUED:    0
      -----
    TOTAL CASES:    5

```

## Example 2: PCE Filing Status Report (Long Form)

Select CPT/ICD9 Coding Menu Option: **PS** PCE Filing Status Report

### Report of PCE Filing Status

This report displays the filing status of completed cases performed during the selected date range.

Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// **<Enter>**

Do you want the report for all Surgical Specialties ? YES// **NO**

Select Surgical Specialty: **50** GENERAL(OR WHEN NOT DEFINED BELOW) GENERAL(  
OR WHEN NOT DEFINED BELOW) 50

Start with Date: 10/3/99 (OCT 03, 1999)

End with Date: 10/3/99 (OCT 03, 1999)

Print the long form or the short form ? SHORT// **LONG**

Print the PCE Filing Status Report to which Printer ? **[Select Print Device]**

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

MAYBERRY, NC  
PCE FILING STATUS REPORT  
For Completed O.R. Surgical Procedures  
From: OCT 3,1999 To: OCT 3,1999  
Report Printed: OCT 15,1999@10:33

DATE OF OPERATION CASE #	PATIENT NAME PATIENT ID (AGE) PRINCIPAL PROCEDURE	SURGEON ATTENDING	SPECIALTY PRINCIPAL POST-OP DIAGNOSIS	PCE FILING STATUS SCHED STATUS
OCT 3,1999@06:00 63052	KANSAS, THOMAS 123-45-6789 (76) INGUINAL HERNIA	TULSA, LARRY RICHMOND, ARTHUR	GENERAL (OR WHEN NOT DEFINED BELOW) BILATERAL INGUINAL HERNIA	UPDATE QUEUED CHECKED OUT
CPT Code: 49505 REPAIR INGUINAL HERNIA Modifiers: -76 REPEAT PROCEDURE BY SAME PHYSICIAN		ICD Diagnosis Code: 550.02 BILAT ING HERNIA W GANG		
OCT 3,1999@06:00 63062	IOWA, LUKE 123-45-6789 (39) CHOLECYSTECTOMY	BISMARK, ANDREW AUGUSTA, DON	GENERAL (OR WHEN NOT DEFINED BELOW) GALLSTONES	UPDATE QUEUED CHECKED OUT
CPT Code: 47605 REMOVAL OF GALLBLADDER Modifiers: -66 SURGICAL TEAM CPT Code: 44960 APPENDECTOMY Modifiers: -32 MANDATED SERVICES		ICD Diagnosis Code: 575.2 OBSTRUCTION GALLBLADDER ICD Diagnosis Code: 540.1 ABSCESS OF APPENDIX		
OCT 3,1999@08:00 63054	TEXAS, THOMAS 123-45-6789 (60) INGUINAL HERNIA	BISMARK, ANDREW RICHMOND, ARTHUR	GENERAL (OR WHEN NOT DEFINED BELOW) NOT ENTERED	FILED CHECKED OUT
CPT Code: 49505 REPAIR INGUINAL HERNIA		ICD Diagnosis Code: 550.02 BILAT ING HERNIA W GANG		
OCT 3,1999@11:00 63061	LOUISIANA, DOUG 123-45-6789 (54) INGUINAL HERNIA	RICHMOND, ARTHUR BISMARK, ANDREW	GENERAL (OR WHEN NOT DEFINED BELOW) NOT ENTERED	FILED CHECKED OUT
CPT Code: 49507 REPAIR, INGUINAL HERNIA		ICD Diagnosis Code: 550.92 BILAT INGUINAL HERNIA		

	CPT CASES	CPT CODES	ICD CODES
FILED:	2	2	2
QUEUED TO FILE:	0	0	0
UPDATE QUEUED:	2	3	3
NOT QUEUED:	0		
TOTAL:	4	5	5

## Report of Non-O.R. Procedures [SRONOR]

The *Report of Non-O.R. Procedures* option chronologically lists non-O.R. procedures sorted by surgical specialty or surgeon. This report can be sorted by specialty, provider, or location.

This report prints in a 132-column format and must be copied to a printer.

### Example 1: Report of Non-O.R. Procedures by Specialty

```
Select CPT/ICD9 Coding Menu Option: R Report of Non-O.R. Procedures
```

```
Report of Non-OR Procedures
```

```
Start with Date: 3/1 (MAR 01, 1999)  
End with Date: 3/31 (MAR 31, 1999)
```

```
How do you want the report sorted ?
```

1. By Specialty
2. By Provider
3. By Location

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

```
Do you want to print the report for all Specialties ? YES// N
```

```
Print the Report for which Specialty ? CARDIOLOGY
```

```
This report is designed to use a 132 column format.
```

```
Print on Device: [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF NON-O.R. PROCEDURES  
 FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:  
 DATE REVIEWED:

DATE	PATIENT (ID#)	PROVIDER	START TIME
CASE #	LOCATION (IN/OUT-PAT STATUS)	PROCEDURE(S)	FINISH TIME
=====			
*** SPECIALTY: CARDIOLOGY ***			
03/02/99	IDAHO,PETER (123-45-6789)	BISMARK,ANDREW	03/02/92 13:05
501	AMBULATORY SURGERY (OUTPATIENT)	CARDIOVERSION	03/02/92 14:10
03/13/99	ARKANSAS,MARY (123-45-6789)	TULSA,LARRY	03/13/92 14:00
500	ICU (INPATIENT)	CARDIOVERSION	03/13/92 14:25

## Example 2: Report of Non-O.R. Procedures by Provider

Select CPT/ICD9 Coding Menu Option: **R** Report of Non-O.R. Procedures

Report of Non-OR Procedures

Start with Date: **3/1** (MAR 01, 1999)

End with Date: **3/31** (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number: 1// 2

Do you want to print the report for all Providers ? YES// **N**

Print the Report for which Provider ? **PITTSBURGH,ANTHONY**

This report is designed to use a 132 column format.

Print on Device: [**Select Print Device**]

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF NON-O.R. PROCEDURES  
 FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:  
 DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	SPECIALTY PROCEDURE(S)	START TIME FINISH TIME
=====			
*** PROVIDER PITTSBURGH, ANTHONY ***			
03/12/99 195	PENNSYLVANIA, PHILLIP (123-45-6789) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY ELECTROCONVULSIVE THERAPY	03/12/99 08:00 03/12/99 09:00
03/23/99 240	HAWAII, LOU (123-45-6789) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY ELECTROCONVULSIVE THERAPY	03/23/99 08:10 03/23/99 08:40
03/25/99 266	KANSAS, THOMAS (123-45-6789) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY ELECTROCONVULSIVE THERAPY	03/12/99 09:30 03/12/99 10:15

### Example 3: Report of Non-O.R. Procedures by Location

Select CPT/ICD9 Coding Menu Option: **R** Report of Non-O.R. Procedures

Report of Non-OR Procedures

Start with Date: **3/1** (MAR 01, 1999)

End with Date: **3/31** (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number: 1// 3

Do you want to print the report for all Locations ? YES// **N**

Print the Report for which Location ? **AMBULATORY SURGERY**

This report is designed to use a 132 column format.

Print on Device: [**Select Print Device**]

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF NON-O.R. PROCEDURES  
 FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:  
 DATE REVIEWED:

DATE CASE #	PATIENT (ID#) SPECIALTY (IN/OUT-PAT STATUS)	PROVIDER PROCEDURE(S)	START TIME FINISH TIME
=====			
*** LOCATION: AMBULATORY SURGERY ***			
03/02/99 201	IDAHO,PETER (123-45-6789) CARDIOLOGY (OUTPATIENT)	BISMARK,ANDREW CARDIOVERSION	03/02/99 13:05 03/02/99 14:10
03/06/99 198	CALIFORNIA,JAMES (123-45-6789) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	RICHMOND,ARTHUR EXCISION OF SKIN LESION	03/07/99 16:30 03/07/99 17:08
03/09/99 193	ILLINOIS,ANNE (123-45-6789) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	PHOENIX,SALLY STELLATE NERVE BLOCK	03/09/99 09:45 03/09/99 10:21
03/13/99 200	ARKANSAS,MARY (123-45-6789) CARDIOLOGY (INPATIENT)	TULSA,LARRY CARDIOVERSION	03/13/99 14:00 03/13/99 14:25
03/17/99 194	GEORGIA,PAUL (123-45-6789) GENERAL SURGERY (OUTPATIENT)	RICHMOND,ARTHUR EXCISION OF SKIN LESION	03/17/99 13:30 03/17/99 14:42

# Chapter Three: Generating Surgical Reports

---

## Introduction

The Surgery package integrates clinical and patient data to provide a variety of reports for Surgery Service management. This chapter describes reports that are generated for Surgical Service staff. Among the reports generated are the Annual Report of Surgical Procedures, Anesthesia AMIS, Attending Surgeons Report, and Nurse Staffing Report.

## Exiting an Option or the System

The user can enter an up-arrow (^) to stop what he or she is doing. The up-arrow can be used at almost any prompt to stop the line of questioning and return to the previous level in the option. The user should continue entering up-arrows to completely exit the system.

## Option Overview

The main options included in this chapter are listed below. The *Surgery Reports* menu contains submenus. To the left of the option name is the shortcut synonym the user can enter to select the option. A restricted option (such as the *Surgery Reports* menu) will not display if the user does not have security clearance for that option.

Shortcut	Option Name
SR	<i>Surgery Reports</i>
L	<i>Laboratory Interim Report</i>

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

# Surgery Reports

## [SRORPTS]

The Chief of Surgery and staff members use the *Surgery Reports* menu to select various reports for the Surgical Service. Among the reports generated are the Annual Report of Surgical Procedures, Anesthesia AMIS, Attending Surgeons Report, and Nurse Staffing Report.



This menu is locked with the SROREP key.

All of the menu items below contain sub-options. To the left of the menu name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
M	<i>Management Reports</i>
S	<i>Surgery Staffing Reports</i>
A	<i>Anesthesia Reports</i>
CPT	<i>CPT Code Reports</i>

## Management Reports [SR MANAGE REPORTS]

The *Management Reports* menu provides access to several *Management Reports* options. These options generate reports on completed cases, meaning cases that have an entry for the TIME PAT OUT OR field.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
S	<i>Schedule of Operations</i>
A	<i>Annual Report of Surgical Procedures</i>
L	<i>List of Operations</i>
LD	<i>List of Operations (by Postoperative Disposition)</i>
LS	<i>List of Operations (by Surgical Specialty)</i>
LP	<i>List of Operations (by Surgical Priority)</i>
P	<i>Report of Surgical Priorities</i>
U	<i>List of Undictated Operations</i>
D	<i>Report of Daily Operating Room Activity</i>
PS	<i>PCE Filing Status Report</i>
NOX	<i>Outpatient Encounters Not Transmitted to NPCD</i>

## Schedule of Operations

### [SROSCH]

The *Schedule of Operations* option generates the Operating Room Schedule used by the operating room nurses, surgeons, anesthesiologists, and other hospital services. The report lists operations and patients scheduled for a particular date. It sorts by operating room and includes the procedure(s), blood products requested, and any preoperative x-rays requested. The schedule also provides anesthesia information and surgeon names.

This report can be printed on multiple printers simultaneously. Use the options included within the *Surgery Package Management Menu* option to enter the name of all printers on which the schedule will print.

This report has a 132-column format and is designed to be copied to a printer with wide paper.

### **Example: Print Schedule of Operations**

```
Select Management Reports Option:  S  Schedule of Operations
```

```
Print Schedule of Operations for which date ?  9/8  (SEP 08, 1999)
```

```
This report is designed to use a 132 column format.
```

```
Print the Report on which device:  [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 SCHEDULE OF OPERATIONS  
 FOR: SEP 08, 1999

PAGE 1

PRINTED: SEP 07, 1999 11:12

SIGNATURE OF CHIEF: DR. MOE HOWARD

PATIENT ID#	AGE	DISPOSITION START TIME END TIME	PREOPERATIVE DIAGNOSIS OPERATION(S)	REQ ANESTHESIA ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
----------------	-----	---------------------------------------	----------------------------------------	---------------------------------------------------------	---------------------------------------

OPERATING ROOM: OR1

OHIO, RAYMOND 123-45-6789 TO BE ADMITTED Case # 143	46	WARD 07:30 09:30	CARPAL TUNNEL SYNDROME REVISE MEDIAN NERVE	GENERAL SPRINGFIELD, J BISMARK, A	JACKSON, R MIAMI, S JACKSON, R
--------------------------------------------------------------	----	------------------------	-----------------------------------------------	-----------------------------------------	--------------------------------------

PREOPERATIVE XRAYS: CARPAL TUNNEL, R WRIST

OPERATING ROOM: OR2

KANSAS, THOMAS 123-45-6789 HICU 212-B Case # 141	36	WARD 06:30 08:00	CHOLELITHIASIS CHOLECYSTECTOMY	GENERAL AUGUSTA, D PHOENIX, S	JACKSON, R TULSA, L JACKSON, R
-----------------------------------------------------------	----	------------------------	-----------------------------------	-------------------------------------	--------------------------------------

REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH  
 CPDA-1 RED BLOOD CELLS - 2 UNITS  
 PREOPERATIVE XRAYS: ABDOMIN

IDAHO, PETER 123-45-6789 TO BE ADMITTED Case # 142	71	WARD 08:00 09:30	ACUTE DIAPHRAGMATIC HERNIA REPAIR DIAPHRAGMATIC HERNIA	GENERAL AUGUSTA, D PHOENIX, S	TULSA, L JACKSON, R TULSA, L
-------------------------------------------------------------	----	------------------------	-----------------------------------------------------------	-------------------------------------	------------------------------------

REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH  
 CPDA-1 RED BLOOD CELLS - 2 UNITS  
 PREOPERATIVE XRAYS: ABDOMEN

ALASKA, FRED 123-45-6789 TO BE ADMITTED Case # 150	48	WARD 11:15 16:00	CAROTID ARTERY STENOSIS CAROTID ARTERY ENDARTERECTOMY	GENERAL AUGUSTA, D PHOENIX, S	JACKSON, R RICHMOND, A JACKSON, R
-------------------------------------------------------------	----	------------------------	----------------------------------------------------------	-------------------------------------	-----------------------------------------

\*\* Concurrent Case #157 AORTO CORONARY BYPASS GRAFT  
 REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH  
 CPDA-1 RED BLOOD CELLS - UNITS NOT ENTERED  
 CPDA-1 WHOLE BLOOD - 2 UNITS  
 PREOPERATIVE XRAYS: DOPPLER STUDIES

ALASKA, FRED 123-45-6789 TO BE ADMITTED Case # 157	48	WARD 11:15 16:00	CORONARY ARTERY DISEASE AORTO CORONARY BYPASS GRAFT	GENERAL AUGUSTA, D PHOENIX, S	TULSA, L TOPEKA, D TULSA, L
-------------------------------------------------------------	----	------------------------	--------------------------------------------------------	-------------------------------------	-----------------------------------

\*\* Concurrent Case #150 CAROTID ARTERY ENDARTERECTOMY

TOTAL CASES SCHEDULED: 5

## Annual Report of Surgical Procedures

### [SROARSP]

The *Annual Report of Surgical Procedures* option is used to generate the Annual Report of Surgical Procedures required by VA Central Office. This report counts the number of times a procedure was performed, based on the CPT code entry, within a surgical specialty.

The report includes only cases that have not been cancelled and that have an entry for the TIME PAT OUT OR field. Procedures without CPT codes are not included in this report.

This report can be generated for any date range, not only annually.

The report has a 132-column format and is designed to be copied to a printer.

### **Example: Annual Report of Surgical Procedures**

```
Select Management Reports Option:  A  Annual Report of Surgical Procedures
```

```
Annual Report of Surgical Procedures
```

```
Start with Date:  9/1  (SEP 01, 2001)
```

```
End with Date:   9/30 (SEP 30, 2001)
```

```
Do you want to print the Annual Report of Surgical Procedures for all Surgical Specialties?  
YES// <Enter>
```

```
This report is designed to use a 132 column format, and must be run on a printer.
```

```
Select Printer:  [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 ANNUAL REPORT OF SURGICAL PROCEDURES  
 FROM: SEP 1,2001 TO: SEP 30,2001

PAGE: 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: OCT 20,2001

CPT CODE - OPERATION	TOTAL	STAFF	MAJOR RESIDENT	TOTAL	STAFF	MINOR RESIDENT	TOTAL
----- NEUROSURGERY -----							
61304 OPEN SKULL FOR EXPLORATION	1	1	0	1	0	0	0
61680 INTRACRANIAL VESSEL SURGERY	1	0	0	0	1	0	1
-----							
TOTALS FOR NEUROSURGERY:	2	1	0	1	1	0	1
-----							
ORTHOPEDECS -----							
27130 TOTAL HIP REPLACEMENT	2	0	0	0	1	1	2
27236 REPAIR OF THIGH FRACTURE	1	0	0	0	0	1	1
-----							
TOTALS FOR ORTHOPEDICS:	3	0	0	0	1	2	3
-----							
OTORHINOLARYNGOLOGY (ENT) -----							
31365 REMOVAL OF LARYNX	2	0	0	0	2	0	2
-----							
TOTALS FOR OTORHINOLARYNGOLOGY (ENT):	2	0	0	0	2	0	2
-----							
THORACIC SURGERY (INC. CARDIAC SURG.) -----							
32480 PARTIAL REMOVAL OF LUNG	2	0	0	0	1	1	2
32500 PARTIAL REMOVAL OF LUNG	1	0	0	0	1	0	1
33510 CABG, VEIN, SINGLE	1	0	0	0	0	1	1
-----							
TOTALS FOR THORACIC SURGERY (INC. CARDIAC SURG.):	4	0	0	0	2	2	4
-----							
=====							
TOTAL OPERATIONS:	11	1	0	1	6	4	10
=====							

## **List of Operations**

### **[SROPLIST]**

The *List of Operations* option contains general information for completed cases within a specified date range. It sorts the cases by date and includes the procedure(s), surgical service, length of actual operation, surgeons, and anesthesia technique. This report also includes aborted cases.

This report has a 132-column format and is designed to be copied to a printer.

### **Example: List of Operations**

```
Select Management Reports Option:  L  List of Operations
```

```
List of Operations
```

```
Start with Date:  10/8  (OCT 08, 2001)
```

```
End with Date:   10/8  (OCT 08, 2001)
```

```
This report is designed to use a 132 column format.
```

```
Print to device:  [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 LIST OF OPERATIONS  
 FROM: OCT 8,2001 TO: OCT 8,2001

PAGE 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: SEP 20,2001

DATE CASE #	PATIENT ID# PRIORITY	SERVICE OPERATION(S)	SURGEON 1ST ASSISTANT 2ND ASSISTANT	ANESTHESIA TECH
10/08/01 63071	KENTUCKY, KENNETH 123-45-6789 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA	MIAMI, STEVE TOPEKA, MARK TULSA, LARRY	GENERAL OP TIME: 50 MIN.
10/08/01 63072	GEORGIA, PAUL 123-45-6789 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) CHOLECYSTECTOMY	TULSA, LARRY MIAMI, STEVE	GENERAL OP TIME: 50 MIN.
10/08/01 63073	OKLAHOMA, SHANNON 123-45-6789 URGENT, ADD TODAY	OPHTHALMOLOGY INTRAOCULAR LENS, CHOLECYSTECTOMY	MIAMI, STEVE SPRINGFIELD, JACK RICHMOND, ARTHUR	SPINAL OP TIME: 50 MIN.
10/08/01 63074	VIRGINIA, SAMUEL 123-45-6789 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) HIP REPLACEMENT	MIAMI, STEVE RICHMOND, ARTHUR KNOXVILLE, THOMAS	NOT ENTERED OP TIME: 50 MIN.
10/08/01 63075	CONNECTICUT, CARL 123-45-6789 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) PULMONARY LOBECTOMY	AUGUSTA, DON SPRINGFIELD, JACK TULSA, LARRY	NOT ENTERED OP TIME: 45 MIN.
10/08/01 63077	BOISE, WILLIAM 123-45-6789 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA, CHOLECYSTECTOMY	RICHMOND, ARTHUR SPRINGFIELD, JACK RALEIGH, RICHARDETTE	GENERAL OP TIME: 63 MIN.
10/08/01 63076	KANSAS, THOMAS 123-45-6789 ELECTIVE	UROLOGY TURP	BISMARCK, ANDREW RICHMOND, ARTHUR TULSA, LARRY	GENERAL OP TIME: 45 MIN.

TOTAL CASES: 7

## List of Operations (by Postoperative Disposition)

The *List of Operations (by Postoperative Disposition)* option contains general information for completed cases within a selected date range. It sorts the cases by postoperative disposition and by case number. Reports may also be sorted by specialty.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique.

This report has a 132-column format and is designed to be copied to a printer.

### Example 1: List of Operations by Postoperative Disposition (All Dispositions)

```
Select Management Reports Option: LD List of Operations (by Postoperative Disposition)
```

```
List of Operations by Postoperative Disposition:
```

```
Start with Date: 10/8 (OCT 08, 2001)  
End with Date: 10/8 (OCT 08, 2001)
```

```
Print the List of Operations for which of the following ?
```

1. All Dispositions
2. A Specific Disposition
3. No Disposition Entered

```
Enter selection: 1// 1 All Dispositions
```

```
Do you want the report sorted by surgical specialty ? Y//<Enter>
```

```
Print for all surgical specialties ? Y// N
```

```
Print the report for which Specialty ? GENERAL(OR WHEN NOT DEFINED BELOW)
```

```
Select An Additional Specialty: <Enter>
```

```
This report is designed to use a 132 column format.
```

```
Print the Report on which Device: [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 LIST OF OPERATIONS BY POSTOP DISPOSITION  
 FROM: OCT 8,2001 TO: OCT 8,2001  
 POSTOP DISPOSITION: WARD

PAGE  
 1

DATE PRINTED: OCT 20,2001  
 REVIEWED BY:  
 DATE REVIEWED:

DATE CASE #	PATIENT ID#	OPERATION(S)	SURGEON 1ST ASST 2ND ASST	ANESTHESIA TECH IN/OUT-PAT STATUS OP TIME
-----				
>> GENERAL(OR WHEN NOT DEFINED BELOW) <<				
10/08/01 63072	GEORGIA, PAUL 123-45-6789	CHOLECYSTECTOMY	TULSA, LARRY MIAMI, STEVE	GENERAL OUTPATIENT 50 MIN.
10/08/01 63077	BOISE, WILLIAM 123-45-6789	INGUINAL HERNIA, CHOLECYSTECTOMY	RICHMOND, ARTHUR SPRINGFIELD, JACK RALEIGH, RICHARDETTE	GENERAL OUTPATIENT 63 MIN.
10/08/01 63071	KENTUCKY, KENNETH 123-45-6789	INGUINAL HERNIA	MIAMI, STEVE TOPEKA, MARK TULSA, LARRY	GENERAL OUTPATIENT 50 MIN.

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 3

## Example 2: List of Operations by Postoperative Disposition (A Specific Disposition)

Select Management Reports Option: **LD** List of Operations (by Postoperative Disposition)

List of Operations by Postoperative Disposition:

Start with Date: **10/4** (OCT 04, 2001)  
End with Date: **10/8** (OCT 08, 2001)

Print the List of Operations for which of the following ?

1. All Dispositions
2. A Specific Disposition
3. No Disposition Entered

Enter selection: 1// **2** A Specific Disposition

Print the report for which Disposition ? **OUTPATIENT**           O

Do you want the report sorted by surgical specialty ? Y// **N**

This report is designed to use a 132 column format.

Print the Report on which Device: [**Select Print Device**]

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 LIST OF OPERATIONS BY POSTOP DISPOSITION  
 FROM: OCT 4,2001 TO: OCT 8,2001  
 POSTOP DISPOSITION: OUTPATIENT

PAGE  
1

DATE PRINTED: OCT 20,2001  
 REVIEWED BY:  
 DATE REVIEWED:

DATE CASE #	PATIENT ID#	OPERATION(S)	SURGEON 1ST ASST 2ND ASST	ANESTHESIA TECH IN/OUT-PAT STATUS OP TIME
10/04/01 63066	UTAH, JOHNNY 123-45-6789 (GENERAL)	INGUINAL HERNIA	SPRINGFIELD, JACK TULSA, LARRY TOPEKA, MARK	GENERAL OUTPATIENT 40 MIN.
10/04/01 63067	NEVADA, NORMAN 123-45-6789 (GENERAL)	INGUINAL HERNIA	MIAMI, STEVE TOPEKA, MARK TULSA, LARRY	GENERAL OUTPATIENT 50 MIN.
10/04/01 63068	ILLINOIS, MICHAEL 123-45-6789 (GENERAL)	INGUINAL HERNIA	SPRINGFIELD, JACK TOPEKA, MARK TULSA, LARRY	GENERAL OUTPATIENT 45 MIN.
10/07/01 63070	INDIANA, SUSAN 123-45-6789 (GENERAL)	INGUINAL HERNIA	AUGUSTA, DON MIAMI, STEVE	GENERAL OUTPATIENT 45 MIN.
10/08/01 63071	KENTUCKY, KENNETH 123-45-6789 (GENERAL)	INGUINAL HERNIA	MIAMI, STEVE TOPEKA, MARK TULSA, LARRY	GENERAL OUTPATIENT 50 MIN.

TOTAL OUTPATIENT: 5

### Example 3: List of Operations by Postoperative Disposition (No Disposition Entered)

Select Management Reports Option: **LD** List of Operations (by Postoperative Disposition)

List of Operations by Postoperative Disposition:

Start with Date: **10/4** (OCT 04, 2001)  
End with Date: **10/8** (OCT 08, 2001)

Print the List of Operations for which of the following ?

1. All Dispositions
2. A Specific Disposition
3. No Disposition Entered

Enter selection: 1// **3** No Disposition Entered

Do you want the report sorted by surgical specialty ? Y// **N**

This report is designed to use a 132 column format.

Print the Report on which Device: [**Select Print Device**]

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 LIST OF OPERATIONS BY POSTOP DISPOSITION  
 FROM: OCT 4,2001 TO: OCT 8,2001  
 POSTOP DISPOSITION: DISPOSITION NOT ENTERED

PAGE  
1

DATE PRINTED: SEP 20,2001  
 REVIEWED BY:  
 DATE REVIEWED:

DATE CASE #	PATIENT ID#	OPERATION(S)	SURGEON 1ST ASST 2ND ASST	ANESTHESIA TECH IN/OUT-PAT STATUS OP TIME
10/04/01 63069	IOWA, LUKE 123-45-6789 (THORACIC SURGERY )	PULMONARY LOBECTOMY	AUGUSTA, DON COLUMBIA, ALLEN TOPEKA, JAMES	GENERAL OUTPATIENT 60 MIN.
10/08/01 63073	OKLAHOMA, SHANNON 123-45-6789 (OPHTHALMOLOGY)	INTRAOCULAR LENS, CHOLECYSTECTOMY	MIAMI, STEVE SPRINGFIELD, JACK RICHMOND, ARTHUR	SPINAL OUTPATIENT 50 MIN.
10/08/01 63076	KANSAS, THOMAS 123-45-6789 (UROLOGY)	TURP	BISMARCK, ANDREW RICHMOND, ARTHUR TULSA, LARRY	GENERAL OUTPATIENT 45 MIN.

TOTAL DISPOSITION NOT ENTERED: 3

## List of Operations (by Surgical Specialty)

The *List of Operations (by Surgical Specialty)* option contains general information for completed cases within a selected date range. It sorts the cases by surgical specialty and case number.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique. The user can request a list for all specialties or a selected specialty.

This report has a 132-column format and is designed to be copied to a printer.

### Example: List of Operations by Surgical Specialty

```
Select Management Reports Option: LS List of Operations (by Surgical Specialty)
```

```
List of Operations sorted by Surgical Specialty
```

```
Start with Date: 10/4 (OCT 04, 2001)  
End with Date: 10/8 (OCT 08, 2001)
```

```
Do you want to print the report for all Specialties ? YES// N
```

```
Print the report for which Surgical Specialty ? GENERAL (OR WHEN NOT DEFINED BELOW)
```

```
This report is designed to use a 132 column format.
```

```
Print the Report on which Device: [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 LIST OF OPERATIONS BY SERVICE  
 FROM: OCT 4,2001 TO: OCT 8,2001

PAGE 1

DATE REVIEWED:  
 REVIEWED BY:  
 DATE PRINTED: SEP 20,2001

DATE CASE #	PATIENT ID# PRIORITY	OPERATION(S)	SURGEON FIRST ASSISTANT SECOND ASSISTANT	ANESTHESIA TECHNIQUE
=====				
*GENERAL(OR WHEN NOT DEFINED BELOW)*				
10/04/01 63066	UTAH,JOHNNY 123-45-6789 STANDBY	INGUINAL HERNIA	SPRINGFIELD,JACK TULSA,LARRY TOPEKA,MARK	GENERAL OP TIME: 40 MIN.
10/04/01 63067	NEVADA,NORMAN 123-45-6789 ELECTIVE	INGUINAL HERNIA	MIAMI,STEVE TOPEKA,MARK TULSA,LARRY	GENERAL OP TIME: 50 MIN.
10/04/01 63068	IOWA,MICHEAL 123-45-6789 ELECTIVE	INGUINAL HERNIA	SPRINGFIELD,JACK TOPEKA,MARK TULSA,LARRY	GENERAL OP TIME: 45 MIN.
10/07/01 63070	INDIANA,SUSAN 123-45-6789 ELECTIVE	INGUINAL HERNIA	AUGUSTA,DON MIAMI,STEVE	GENERAL OP TIME: 45 MIN.
10/08/01 63071	KENTUCKY,KENNETH 123-45-6789 ELECTIVE	INGUINAL HERNIA	MIAMI,STEVE TOPEKA,MARK TULSA,LARRY	GENERAL OP TIME: 50 MIN.
10/08/01 63072	GEORGIA,PAUL 123-45-6789 ELECTIVE	CHOLECYSTECTOMY	TULSA,LARRY MIAMI,STEVE	GENERAL OP TIME: 50 MIN.
10/08/01 63077	IDAHO,WILLIAM 123-45-6789 ELECTIVE	INGUINAL HERNIA, CHOLECYSTECTOMY	RICHMOND,ARTHUR SPRINGFIELD,JACK RALEIGH,RICHARD	GENERAL OP TIME: 63 MIN.

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 7

## List of Operations (by Surgical Priority)

The *List of Operations (by Surgical Priority)* option generates a report containing general information for completed cases within a selected date range. It sorts the cases by surgical priority and surgical specialty.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique. The user can request a list for all priorities or a selected priority. One or more surgical specialties can also be specified.

This report has a 132-column format and is designed to be copied to a printer.

### Example: List of Operations by Surgical Priority

```
Select Management Reports Option: LP List of Operations (by Surgical Priority)
```

```
List of Operations by Surgical Priority:
```

```
Start with Date: 8/1 (AUG 01, 2001)  
End with Date: 9/30 (SEP 30, 2001)
```

```
Print List of Operations for all priorities ? Y// N
```

```
Print report for which Priority ?
```

1. EMERGENCY
2. ELECTIVE
3. ADD ON TODAY (NONEMERGENT)
4. STANDBY
5. URGENT ADD TODAY
6. PRIORITY NOT ENTERED

```
Select Number: 1// 4
```

```
Do you want the report sorted by surgical specialty ? Y// <Enter>
```

```
Print for all surgical specialties ? Y// <Enter>
```

```
This report is designed to use a 132 column format.
```

```
Print the Report on which Device: [Select Print Device]
```

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

ISC-BIRMINGHAM, AL  
 SURGICAL SERVICE  
 LIST OF OPERATIONS BY SURGICAL PRIORITY  
 FROM: AUG 1,2001 TO: SEP 30,2001  
 SURGICAL PRIORITY: STANDBY

PAGE:  
 1

DATE PRINTED: OCT 20,2001  
 REVIEWED BY:  
 DATE REVIEWED:

DATE CASE #	PATIENT ID#	OPERATION(S)	SURGEON 1ST ASST 2ND ASST	ANESTHESIA TECH
-----				
>> THORACIC SURGERY (INC. CARDIAC SURG.) <<				
08/21/01 62901	MONTANA, JOHNNY 123-45-6789	PULMONARY LOBECTOMY	MIAMI, STEVE AUGUSTA, DON RICHMOND, ARTHUR	GENERAL OP TIME: 170 MIN.
09/02/01 63002	HAWAII, LOU 123-45-6789	PULMONARY LOBECTOMY	TULSA, LARRY AUGUSTA, DON	GENERAL OP TIME: 95 MIN.
09/29/01 63042	KANSAS, THOMAS 123-45-6789	PULMONARY LOBECTOMY	BISMARCK, ANDREW RICHMOND, ARTHUR	GENERAL OP TIME: 90 MIN.

TOTAL THORACIC SURGERY (INC. CARDIAC SURG.): 3

## Report of Surgical Priorities

The *Report of Surgical Priorities* option provides the total number of completed surgical cases for each surgical priority, such as elective, emergency, and urgent within a date range. The user can sort the report by all surgical specialties, one surgical specialty (Example 1), or by all operations within a date range (Example 2).

This report has an 80-column format and can be viewed on your terminal display screen.

### Example 1: Print Report of Surgical Priorities for a specialty

```
Select Management Reports Option: P Report of Surgical Priorities
```

```
Report of Surgical Priorities
```

```
Start with Date: 3/1 (MAR 01, 2001)
End with Date: T (MAR 26, 2001)
```

```
Do you want to review this information sorted by Surgical Specialty ? YES// <Enter>
```

```
Do you want to print this report for all Surgical Specialties ? YES// N
```

```
Print the report for which Surgical Specialty ? 50          GENERAL(OR WHEN NOT DEFINED BELOW)
GENERAL(OR WHEN NOT DEFINED BELOW)          50
```

```
Print the Report on which Device: [Select Print Device]
```

-----printout follows-----

```
                MAYBERRY, NC
                SURGICAL SERVICE
TOTAL OPERATIONS BY SURGICAL PRIORITY
FROM: MAR 1,2001 TO: MAR 26,2001
```

---

```
GENERAL(OR WHEN NOT DEFINED BELOW)
```

```
1. ELECTIVE                1
2. URGENT                   1
3. EMERGENCY                2
4. ADD ON (NON-EMERGENT)   0
5. STANDBY                  1
```

```
TOTAL SURGICAL CASES:      5
```

## Example 2: Print Report of Surgical Priorities for all Operations

Select Management Reports Option: **P** Report of Surgical Priorities

Report of Surgical Priorities

Start with Date: **3/1** (MAR 01, 2001)

End with Date: **T** (MAR 26, 2001)

Do you want to review this information sorted by Surgical Specialty ? YES// **N**

Print the Report on which Device: [**Select Print Device**]

-----printout follows-----

MAYBERRY, NC  
SURGICAL SERVICE  
TOTAL OPERATIONS BY SURGICAL PRIORITY  
FROM: MAR 1,2001 TO: MAR 26,2001

---

1. ELECTIVE	3
2. URGENT	2
3. EMERGENCY	2
4. ADD ON (NON-EMERGENT)	0
5. STANDBY	4
6. PRIORITY NOT ENTERED	4

TOTAL SURGICAL CASES:	15
-----------------------	----

## Report of Daily Operating Room Activity

The *Report of Daily Operating Room Activity* option generates a report listing cases started between 6:00 AM on the date selected and 5:59 AM of the following day for all operating rooms.

This report has a 132-column format and is designed to be copied to a printer.

### Example: Print the Report of Daily Operating Room Activity

```
Select Management Reports Option: D Report of Daily Operating Room Activity
```

```
Print the Report of Daily Activity for which Date ? 3/9 (MAR 09, 2001)
```

```
This report will include all cases started between MAR 9, 2001 at 6:00 AM  
and MAR 10, 2001 at 5:59 AM.
```

```
It is designed to use a 132 column format.
```

```
Print the Report to which Device ? [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 DAILY REPORT OF OPERATING ROOM ACTIVITY  
 FOR: MAR 09, 2001

PATIENT ID # WARD	AGE	TIME IN OR TIME OUT OR CASE NUMBER	POSTOPERATIVE DIAGNOSIS PROCEDURE(S)	ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
=====					
OPERATING ROOM: OR1					
IDAHO, PETER 123-45-6789 1 NORTH 161-1	61	03/09 08:00 03/09 09:10 194	INGUINAL HERNIA INGUINAL HERNIA	LANSING, E HARRISBURG, H	ALBANY, A NASHVILLE, N TULSA, L
OPERATING ROOM: OR3					
HAWAII, LOU 123-45-6789 OUTPATIENT	49	03/09 09:15 03/09 12:40 187	CHOLECYSTITIS CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	AUGUSTA, D PHOENIX, S	TULSA, L RICHMOND, A TULSA, LARRY
OPERATING ROOM: OR5					
MISSOURI, ROY 123-45-6789 1 WEST 101-1	50	03/09 19:56 03/09 21:05 188	APPENDICITIS APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY, CRAIN	AUGUSTA, D NASHVILLE, N	PITTSBURGH, A RICHMOND, A MIAMI, S

## PCE Filing Status Report

The *PCE Filing Status Report* option provides a report of the PCE filing status of completed cases performed during the selected date range in accordance with the site parameter controlling PCE updates. If this site parameter is turned off, the report will show no cases. The report may be printed for OR surgical cases, non-O.R. procedures or both. Also, the report may be printed for all specialties or for a single specialty only.

This report is intended to be used as a tool in the review of Surgery case information that is passed automatically to Patient Care Encounters (PCE). The report uses five status categories.

- (1) FILED - This status indicates that case information has already been filed with PCE.
- (2) QUEUED TO FILE - This status indicates the case is queued to file with PCE next time the Surgery nightly maintenance job runs.
- (3) UPDATE QUEUED - This status indicates that information passed to PCE has been updated after the case was filed with PCE and PCE will be updated the next time the Surgery nightly maintenance job runs.
- (4) NOT QUEUED - This status indicates the case is missing information required for filing with PCE.
- (5) UNCERTAIN - If the UPDATES TO PCE site parameter is set to file outpatient cases only, this status indicates the IN/OUT-PATIENT STATUS field is null.

Two forms of the report are available: the short and the long forms. The short form uses an 80-column format and does not include surgeon/provider, attending, principal post-op diagnosis, and CPT and ICD-9 code information. The totals printed at the end will show only the total cases for each status.

The long form uses a 132-column format and prints case information including the surgeon/provider, the attending, the specialty, the principal post-op diagnosis, and the principal procedure. If the PCE filing status is FILED, QUEUED TO FILE, or UPDATE QUEUED the CPT codes and ICD diagnosis codes will be printed. If the filing status is NOT QUEUED or UNCERTAIN, information fields needed for PCE filing not containing data will be printed. At the end of the report, the number of cases in each PCE filing status will be printed, plus the number of CPT and ICD-9 codes for cases with a status of FILED, QUEUED TO FILE, and UPDATE QUEUED.

### Example 1: PCE Filing Status Report (Short Form)

Select Management Reports Option: **PS** PCE Filing Status Report

#### Report of PCE Filing Status

This report displays the filing status of completed cases performed during the selected date range.

Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// **<Enter>**

Do you want the report for all Surgical Specialties ? YES// **NO**

Select Surgical Specialty: **50** GENERAL(OR WHEN NOT DEFINED BELOW) GENERAL(  
OR WHEN NOT DEFINED BELOW) 50

Start with Date: **10/3/01** (OCT 03, 2001)

End with Date: **10/3/01** (OCT 03, 2001)

Print the long form or the short form ? SHORT// **<Enter>**

Print the PCE Filing Status Report to which Printer ? **[Select Print Device]**

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

MAYBERRY, NC  
PCE FILING STATUS REPORT  
For Completed O.R. Surgical Procedures  
From: OCT 3,2001 To: OCT 3,2001  
Report Printed: OCT 15,2001@10:29

PAGE 1

DATE OF OPERATION CASE #	PATIENT NAME SPECIALTY PRINCIPAL PROCEDURE	PATIENT ID (AGE)	FILING STATUS SCHED STATUS
OCT 3,2001@06:00 63052	KANSAS,THOMAS GENERAL(OR WHEN NOT INGUINAL HERNIA	123-45-6789 (76)	FILED CHECKED OUT
OCT 3,2001@06:00 63062	IOWA,LUKE GENERAL(OR WHEN NOT CHOLECYSTECTOMY	123-45-6789 (39)	FILED CHECKED OUT
OCT 3,2001@08:00 63054	TEXAS,THOMAS GENERAL(OR WHEN NOT INGUINAL HERNIA	123-45-6789 (60)	FILED CHECKED OUT
OCT 3,2001@11:00 63061	LOUISIANA,DOUG GENERAL(OR WHEN NOT INGUINAL HERNIA	123-45-6789 (54)	FILED CHECKED OUT
OCT 3,2001@13:00 63064	OHIO,RAYMOND GENERAL(OR WHEN NOT APPENDECTOMY	123-45-6789 (85)	UPDATE QUEUED CHECKED OUT

FILED: 4  
QUEUED TO FILE: 0  
UPDATE QUEUED: 1  
NOT QUEUED: 0  
-----  
TOTAL CASES: 5

## Example 2: PCE Filing Status Report (Long Form)

Select Management Reports Option: **PS** PCE Filing Status Report

### Report of PCE Filing Status

This report displays the filing status of completed cases performed during the selected date range.

Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// **<Enter>**

Do you want the report for all Surgical Specialties ? YES// **NO**

Select Surgical Specialty: **50** GENERAL(OR WHEN NOT DEFINED BELOW) GENERAL(  
OR WHEN NOT DEFINED BELOW) 50

Start with Date: **10/3/01** (OCT 03, 2001)

End with Date: **10/3/01** (OCT 03, 2001)

Print the long form or the short form ? SHORT// **LONG**

Print the PCE Filing Status Report to which Printer ? **[Select Print Device]**

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

MAYBERRY, NC  
PCE FILING STATUS REPORT  
For Completed O.R. Surgical Procedures  
From: OCT 3,2001 To: OCT 3,2001  
Report Printed: OCT 15,2001@10:33

DATE OF OPERATION CASE #	PATIENT NAME PATIENT ID (AGE) PRINCIPAL PROCEDURE	SURGEON ATTENDING	SPECIALTY PRINCIPAL POST-OP DIAGNOSIS	PCE FILING STATUS SCHED STATUS
OCT 3,2001@06:00 63052	KANSAS, THOMAS 123-45-6789 (76) INGUINAL HERNIA	TULSA, LARRY RICHMOND, ARTHUR	GENERAL (OR WHEN NOT DEFINED BELOW) BILATERAL INGUINAL HERNIA	UPDATE QUEUED CHECKED OUT
CPT Code: 49505 REPAIR INGUINAL HERNIA Modifiers: -76 REPEAT PROCEDURE BY SAME PHYSICIAN		ICD Diagnosis Code: 550.02 BILAT ING HERNIA W GANG		
OCT 3,2001@06:00 63062	IOWA, LUKE 123-45-6789 (39) CHOLECYSTECTOMY	BISMARK, ANDREW AUGUSTA, DON	GENERAL (OR WHEN NOT DEFINED BELOW) GALLSTONES	UPDATE QUEUED CHECKED OUT
CPT Code: 47605 REMOVAL OF GALLBLADDER Modifiers: -32 MANDATED SERVICES CPT Code: 44960 APPENDECTOMY		ICD Diagnosis Code: 575.2 OBSTRUCTION GALLBLADDER ICD Diagnosis Code: 540.1 ABSCESS OF APPENDIX		
OCT 3,2001@08:00 63054	TEXAS, THOMAS 123-45-6789 (60) INGUINAL HERNIA	BISMARK, ANDREW RICHMOND, ARTHUR	GENERAL (OR WHEN NOT DEFINED BELOW) NOT ENTERED	FILED CHECKED OUT
CPT Code: 49505 REPAIR INGUINAL HERNIA		ICD Diagnosis Code: 550.02 BILAT ING HERNIA W GANG		
OCT 3,2001@11:00 63061	LOUISIANA, DOUG 123-45-6789 (54) INGUINAL HERNIA	RICHMOND, ARTHUR BISMARK, ANDREW	GENERAL (OR WHEN NOT DEFINED BELOW) NOT ENTERED	FILED CHECKED OUT
CPT Code: 49507 REPAIR, INGUINAL HERNIA		ICD Diagnosis Code: 550.92 BILAT INGUINAL HERNIA		
OCT 3,2001@13:00 63064	OHIO, RAYMOND 123-45-6789 (85) APPENDECTOMY	RICHMOND, ARTHUR DENVER, DONNA	GENERAL (OR WHEN NOT DEFINED BELOW) ACUTE APPENDICITIS	UPDATE QUEUED CHECKED OUT
CPT Code: 44950 APPENDECTOMY		ICD Diagnosis Code: 540.9 ACUTE APPENDICITIS NOS		

	CASES	CPT CODES	ICD CODES
FILED:	2	2	2
QUEUED TO FILE:	0	0	0
UPDATE QUEUED:	3	4	4
NOT QUEUED:	0		
TOTAL:	5	6	6

## Outpatient Encounters Not Transmitted to NPCD

Outpatient surgical and non-O.R. procedures that are filed as encounters in the PCE package without an active count clinic identified for each encounter are not transmitted to the National Patient Care Database (NPCD) as workload. The *Outpatient Encounters Not Transmitted to NPCD* option may be used as a tool for identifying these encounters that represent uncounted workload so that corrective actions may be taken in the Surgery package to insure these procedures are associated with an active count clinic. After corrections are made, these encounters may be re-filed with PCE to be transmitted to NPCD.

This option provides functionality:

- To count and/or list surgical cases and non-O.R. procedures that have entries in PCE but have no matching entries in the OUTPATIENT ENCOUNTER file or have matching entries that are non-count encounters or encounters requiring action.
- To re-file with PCE the cases identified as having no matching entries in the OUTPATIENT ENCOUNTER file or having matching entries that are non-count encounters or encounters requiring action.

Both the report and the re-filing process may be run for O.R. surgical cases, non-O.R. procedures or both. The report and the re-filing process may be run for a specific specialty or for all specialties and may be run for a selected date range.

### Example 1: Print List of Cases

```
Select Management Reports Option: NOX Outpatient Encounters Not Transmitted to NPCD
```

```
Outpatient Surgery Encounters Not Transmitted to NPCD
```

```
Surgical cases filed with PCE that have no Scheduling appointment status or that have an appointment status of ACTION REQUIRED or NON-COUNT indicate surgical encounters that have not transmitted to the National Patient Care Database. This option is intended as a tool to identify these encounters and, after taking appropriate corrective measures, to reinitiate the encounter transmission process.
```

1. Print list of cases.
2. Print total number of cases only.
3. Re-file cases in PCE.

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

```
Print the list for the following.
```

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

```
Select Number (1, 2 or 3): 1// <Enter>
```

```
Do you want the report for all Surgical Specialties ? YES// NO
```

```
Select Surgical Specialty: 50 GENERAL(OR WHEN NOT DEFINED BELOW) GENERAL(OR WHEN NOT DEFINED BELOW) 50
```

```
Start with Date: 5/1 (MAY 01, 2001)
```

```
End with Date: 5/15 (MAY 15, 2001)
```

```
Print report on which printer ? [Select Print Device]
```

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

MAYBERRY, NC  
 Outpatient Surgery Encounters Not Transmitted to NPCD  
 For Completed O.R. Surgical Procedures  
 From: MAY 1,2001 To: MAY 15,2001  
 Report Printed: MAY 20,2001@06:44

DATE OF OPERATION PATIENT NAME PATIENT ID (AGE)	CASE # PRINCIPAL PROCEDURE	SPECIALTY	SCHED STATUS
MAY 1,2001@09:00 KANSAS, THOMAS 123-45-6789 (55)	63028 CHOLECYSTECTOMY	GENERAL(OR WHEN NOT	<NONE>
MAY 3,2001@05:45 INDIANA, SUSAN 123-45-6789 (39)	63092 CHOLEDOCHOTOMY	GENERAL(OR WHEN NOT	<NONE>
MAY 7,2001@07:15 IDAHO, PETER 123-45-6789 (71)	63142 REPAIR DIAPHRAGMATIC HERNIA	GENERAL(OR WHEN NOT	<NONE>
MAY 12,2001@06:00 GEORGIA, PAUL 123-45-6789 (64)	63191 INGUINAL HERNIA	GENERAL(OR WHEN NOT	<NONE>
MAY 14,2001@06:00 IDAHO, PETER 123-45-6789 (69)	63208 CHOLECYSTECTOMY	GENERAL(OR WHEN NOT	ACTION REQUIRED
MAY 15,2001@06:01 INDIANA, SUSAN 123-45-6789 (39)	63180 CHOLECYSTECTOMY	GENERAL(OR WHEN NOT	<NONE>

SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

Total with NO status: 5  
 Total with NON-COUNT: 0  
 Total with ACTION REQUIRED: 1  
 -----  
 Total cases identified: 6

## Example 2: Print Total Number of Cases Only

Select Management Reports Option: **NOX** Outpatient Encounters Not Transmitted to NPCD

### Outpatient Surgery Encounters Not Transmitted to NPCD

Surgical cases filed with PCE that have no Scheduling appointment status or that have an appointment status of ACTION REQUIRED or NON-COUNT indicate surgical encounters that have not transmitted to the National Patient Care Database. This option is intended as a tool to identify these encounters and, after taking appropriate corrective measures, to reinitiate the encounter transmission process.

1. Print list of cases.
2. Print total number of cases only.
3. Re-file cases in PCE.

Select Number: 1// **2**

Print the list for the following.

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// **<Enter>**

Do you want the report for all Surgical Specialties ? YES// **NO**

Select Surgical Specialty: **50** GENERAL(OR WHEN NOT DEFINED BELOW) GENERAL(  
OR WHEN NOT DEFINED BELOW) 50

Start with Date: **5/1** (MAY 01, 2001)

End with Date: **5/15** (MAY 15, 2001)

Print report on which printer ? **[Select Print Device]**

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

MAYBERRY, NC  
Outpatient Surgery Encounters Not Transmitted to NPCD Page 1  
For Completed O.R. Surgical Procedures  
From: MAY 1,2001 To: MAY 15,2001  
Report Printed: MAY 20,2001@07:25

=====

SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

Total with NO status:	5
Total with NON-COUNT:	0
Total with ACTION REQUIRED:	1
	-----
Total cases identified:	6

### Example 3: Re-File Cases in PCE

Select Management Reports Option: **NOX** Outpatient Encounters Not Transmitted to NPCD

Outpatient Surgery Encounters Not Transmitted to NPCD

Surgical cases filed with PCE that have no Scheduling appointment status or that have an appointment status of ACTION REQUIRED or NON-COUNT indicate surgical encounters that have not transmitted to the National Patient Care Database. This option is intended as a tool to identify these encounters and, after taking appropriate corrective measures, to reinitiate the encounter transmission process.

1. Print list of cases.
2. Print total number of cases only.
3. Re-file cases in PCE.

Select Number: 1// **3**

Re-file the following.

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// **1**

Do you want re-filing for all Surgical Specialties ? YES// **NO**

Select Surgical Specialty: **50** GENERAL(OR WHEN NOT DEFINED BELOW) GENERAL(  
OR WHEN NOT DEFINED BELOW) 50

Start with Date: **5/1** (MAY 01, 2001)  
End with Date: **5/15** (MAY 15, 2001)  
Requested Start Time: NOW// (MAY 20, 2001@07:37:32)  
(Task #652379)

Press RETURN to continue **<Enter>**

## **Surgery Staffing Reports**

### **[SR STAFFING REPORTS]**

The *Surgery Staffing Reports* menu provides access to several staffing related report options.

The options included in this submenu are listed below. To the left of the option name is the shortcut synonym the user can enter to select the option.

<b>Shortcut</b>	<b>Option Name</b>
A	<i>Attending Surgeon Reports</i>
S	<i>Surgeon Staffing Report</i>
N	<i>Surgical Nurse Staffing Report</i>
NS	<i>Scrub Nurse Staffing Report</i>
NC	<i>Circulating Nurse Staffing Report</i>

## Attending Surgeon Reports

### [SROATT]

The *Attending Surgeon Reports* option generates the Attending Surgeon Report, which provides staffing information for completed cases (Example 1). The Attending Surgeon Cumulative Report is a table with cumulative totals for each attending code (Example 2). You can print these reports separately or you can print both reports at one time.

The Attending Surgeon Report can be sorted by surgical specialty. They can also be generated for an individual surgeon, or for all attending surgeons.

The Attending Surgeon Report has a 132-column format and is designed to be copied to a printer. The Attending Surgeon Cumulative Report has an 80-column format and can be viewed on the screen.

#### Example 1: Print the Attending Surgeon Report

```
Select Surgery Staffing Reports Option: A Attending Surgeon Reports
```

```
Attending Surgeon Report
```

```
Starting with which Date ? 6/9 (JUN 09, 2004)  
Ending with which Date ? 6/18 (JUN 18, 2004)
```

```
Do you want to print the report for all Attending Surgeons ? YES// <Enter>
```

```
Attending Surgeon Reports
```

1. Attending Surgeon Report
2. Attending Surgeon Cumulative Report
3. Attending Surgeon Report and Attending Surgeon Cumulative Report

```
Select the number corresponding with the desired report(s): 1
```

```
Start report for each attending surgeon on a new page ? NO// <Enter>
```

```
Do you want the report for all Surgical Specialties ? YES// N
```

```
Print the Report for which Surgical Specialty ? 50 GENERAL(OR WHEN NOT DE  
FINED BELOW) GENERAL(OR WHEN NOT DEFINED BELOW) 50
```

```
The Attending Surgeon Report was designed to use a 132 column format.
```

```
Print the report on which Device ? [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 ATTENDING SURGEON REPORT  
 FROM: JUN 9,2004 TO: JUN 18,2004

PAGE: 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: JUN 20,2004

DATE CASE #	PATIENT ID# ATTENDING CODE	PRINCIPAL DIAGNOSIS PRINCIPAL OPERATIVE PROCEDURE	SURGEON 1ST ASST 2ND ASST
=====			
GENERAL (OR WHEN NOT DEFINED BELOW) =====			
ATTENDING SURGEON: TULSA, LARRY -----			
06/17/04 203	KANSAS, THOMAS 123-45-6789 LEVEL B: ATTENDING IN O.R., SCRUBBED	CHOLELITHIASIS CHOLECYSTECTOMY	TOPEKA, MARK RICHMOND, ARTHUR
06/18/04 202	MICHIGAN, MATTHEW R. 123-45-6789 LEVEL B: ATTENDING IN O.R., SCRUBBED	INCARCERATED INGUINAL HERNIA REPAIR INCARCERATED INGUINAL HERNIA	TOPEKA, MARK RICHMOND, ARTHUR
03/09/04 494	IDAHO, PETER 123-45-6789 ATTENDING CODE NOT ENTERED	INCARCERATED INGUINAL HERNIA INGUINAL HERNIA	SPRINGFIELD, JACK NASHVILLE, N
ATTENDING SURGEON: TOPEKA, MARK -----			
06/10/04 189	CALIFORNIA, ELIZABETH 123-45-6789 LEVEL E: EMERGENCY CARE, ATTENDING CONTACTED ASAP	RUPTURED TUBOOVARIAN ABSCESS DRAINAGE OF OVARIAN CYST	RICHMOND, ARTHUR
06/09/04 187	HAWAII, LOU 123-45-6789 LEVEL C: ATTENDING IN O.R., NOT SCRUBBED	CHOLECYSTITIS CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	TULSA, LARRY RICHMOND, ARTHUR DALLAS, LARRY
ATTENDING SURGEON: RICHMOND, ARTHUR -----			
06/09/04 188	MISSOURI, ROY 123-45-6789 LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE	APPENDICITIS APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY	PITTSBURGH, A RICHMOND, ARTHUR

## Example 2: Print the Attending Surgeon Cumulative Report

Select Surgery Staffing Reports Option: **A** Attending Surgeon Reports

Attending Surgeon Report

Starting with which Date ? **6/9** (JUN 09, 2004)

Ending with which Date ? **6/18** (JUN 18, 2004)

Do you want to print the report for all Attending Surgeons ? YES// **<Enter>**

Attending Surgeon Reports

1. Attending Surgeon Report
2. Attending Surgeon Cumulative Report
3. Attending Surgeon Report and Attending Surgeon Cumulative Report

Select the number corresponding with the desired report(s): **2**

Do you want the report for all Surgical Specialties ? YES// **N**

Print the Report for which Surgical Specialty ? **50** GENERAL(OR WHEN NOT DE  
FINED BELOW) GENERAL(OR WHEN NOT DEFINED BELOW) 50

The Attending Surgeon Cumulative Report was designed to use a 80 column format.

Print the report on which Device ? **[Select Print Device]**

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

MAYBERRY, NC  
SURGICAL SERVICE  
ATTENDING SURGEON CUMULATIVE REPORT  
FROM: JUN 9,2004 TO: JUN 18,2004

=====

GENERAL (OR WHEN NOT DEFINED BELOW)

ATTENDING CODE	TOTAL CASES
-----	-----
LEVEL B: ATTENDING IN O.R., SCRUBBED	2
LEVEL C: ATTENDING IN O.R., NOT SCRUBBED	1
LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE	1
LEVEL E: EMERGENCY CARE, ATTENDING CONTACTED ASAP	1
* ATTENDING CODE NOT ENTERED	1
TOTAL CASES FROM 06/09/04 TO 06/18/04	6

## **Surgeon Staffing Report**

### **[SROSUR]**

The *Surgeon Staffing Report* option lists completed cases sorted by the surgeon and his or her role (i.e., attending, first assistant) for each case. The report provides the procedure, diagnosis and operation date/time.

This report has a 132-column format and is designed to be copied to a printer.

### **Example: Print Surgeon Staffing Report**

```
Select Surgery Staffing Reports Option: S Surgeon Staffing Report
```

```
Surgeon Staffing Report
```

```
Start with Date: 3/2 (MAR 02, 2001)
```

```
End with Date: 3/31 (MAR 31, 2001)
```

```
Do you want to print this report for an individual surgeon ? YES// <Enter>
```

```
Select Surgeon: TOPEKA,MARK
```

```
This report is designed to use a 132 column format.
```

```
Print the report on which Device ? [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 SURGEON STAFFING REPORT  
 FROM: MAR 2,2001 TO: MAR 31,2001

PAGE: 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: APR 20,2001

DATE/TIME CASE #	PATIENT ID #	OPERATION(S)	DIAGNOSIS
=====			
** TOPEKA,MARK **			
ROLE: ATTENDING SURGEON			
MAR 09, 2001@09:15 187	HAWAII,LOU 123-45-6789	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	CHOLECYSTITIS
MAR 10, 2001@07:00 189	CALIFORNIA,BETH 123-45-6789	DRAINAGE OF OVARIAN CYST	APPENDICITIS
MAR 10, 2001@14:00 200	ILLINOIS,ANNE 123-45-6789	HEMORRHOIDECTOMY	EXTERNAL HEMORRHOIDS
ROLE: SURGEON			
MAR 10, 2001@08:00 199	MARYLAND,MARK 123-45-6789	CHOLECYSTECTOMY WITH CHOLANGIOGRAM	CHOLELITHIASIS WITH BILIARY COLIC
MAR 17, 2001@12:55 203	KANSAS,THOMAS 123-45-6789	CHOLECYSTECTOMY	CHOLELITHIASIS
MAR 18, 2001@07:30 202	MICHIGAN,MATTHEW R. 123-45-6789	REPAIR INCARCERATED INGUINAL HERNIA	INCARCERATED INGUINAL HERNIA

## **Surgical Nurse Staffing Report**

### **[SRONSR]**

This option generates the Surgical Nurse Staffing Report that lists completed cases within a specified date range. It provides the names of the scrub nurse, the circulating nurse, and the operation times.

This report has a 132-column format and is designed to be copied to a printer.

### **Example: Print Surgical Nurse Staffing Report**

```
Select Surgery Staffing Reports Option: N Surgical Nurse Staffing Report
```

```
Surgical Nurse Staffing Report
```

```
Do you want the report for all nurses ? YES// <Enter>
```

```
Start with Date: 3/9 (MAR 09, 2001)
```

```
End with Date: 3/10 (MAR 10, 2001)
```

```
This report is designed to use a 132 column format.
```

```
Print the report on which Device: [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 SURGICAL NURSE STAFFING REPORT  
 FROM: MAR 9,2001 TO: MAR 10,2001

REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: MAR 20,2001

PAGE: 1

DATE CASE #	PATIENT ID#	OPERATION(S)	SCRUB NURSE	CIRC. NURSE	TIME IN TIME OUT ELAPSED (MINS)
03/09/01 194	IDAHO,PETER 123-45-6789	INGUINAL HERNIA	HOUSTON,ALICE	TRENTON,PATRICIA	08:00 09:10 70
03/09/01 187	HAWAII,LOU 123-45-6789	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	LANSING,EMILY	ALBANY,ROSE	09:15 12:40 205
03/09/01 188	MISSOURI,ROY 123-45-6789	APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY	LANSING,EMILY	NASHVILLE,NANCY	19:56 21:05 69
03/10/01 189	CALIFORNIA,ELIZABETH 123-45-6789	DRAINAGE OF OVARIAN CYST	LANSING,EMILY	TAMPA,ANNETTE	07:00 08:54 114
03/10/01 199	MARYLAND,MARK 123-45-6789	CHOLECYSTECTOMY WITH CHOLANGIOGRAM	HOUSTON,ALICE	LANSING,JAMES	08:00 10:08 128
03/10/01 200	ILLINOIS,ANNE 123-45-6789	HEMORRHOIDECTOMY	LANSING,EMILY	ALBANY,ROSE	14:00 14:55 55

## **Scrub Nurse Staffing Report**

### **[SROSNR]**

The *Scrub Nurse Staffing Report* option lists each operating room scrub nurse and the completed cases they are assigned to within a specified date range. It also provides the circulating nurses, other scrub nurses, and operation times.

This report has a 132-column format and is designed to be copied to a printer.

### **Example: Print Scrub Nurse Staffing Report**

```
Select Surgery Staffing Reports Option: NS Scrub Nurse Staffing Report
```

```
Scrub Nurse Staffing Report
```

```
Do you want the report for all nurses ? YES//<Enter>
```

```
Start with Date: 3/8 (MAR 08, 2001)
```

```
End with Date: 3/20 (MAR 20, 2001)
```

```
This report is designed to use a 132 column format.
```

```
Print the report on which Device: [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 SCRUB NURSE STAFFING REPORT  
 FROM: MAR 8,2001 TO: MAR 20,2001

REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: MAR 22,2001

DATE CASE #	PATIENT ID#	OPERATION(S)	SCRUB NURSE	CIRC. NURSE	TIME IN TIME OUT ELAPSED (MINS)
=====					
** TAMPA, ANNETTE **					
03/18/01 202	MICHIGAN, MATTHEW R. 123-45-6789	REPAIR INCARCERATED INGUINAL HERNIA	LANSING, EMILY TAMPA, ANNETTE	ALBANY, ROSE	07:30 09:03 93
** LANSING, EMILY **					
03/09/01 187	HAWAII, LOU 123-45-6789	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	LANSING, EMILY	ALBANY, ROSE	09:15 12:40 205
03/09/01 188	MISSOURI, ROY 123-45-6789	APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY, CRAIN	LANSING, EMILY		19:56 21:05 69
03/10/01 189	CALIFORNIA, ELIZABETH 123-45-6789	DRAINAGE OF OVARIAN CYST	LANSING, EMILY	TAMPA, ANNETTE	07:00 08:54 114
03/10/01 200	ILLINOIS, ANNE 123-45-6789	HEMORRHOIDECTOMY	LANSING, EMILY	ALBANY, ROSE	14:00 14:55 55
03/17/01 203	KANSAS, THOMAS 123-45-6789	CHOLECYSTECTOMY	LANSING, EMILY	ALBANY, ROSE	12:55 14:30 95
03/18/01 202	MICHIGAN, MATTHEW R. 123-45-6789	REPAIR INCARCERATED INGUINAL HERNIA	LANSING, EMILY TAMPA, ANNETTE	ALBANY, ROSE	07:30 09:03 93

## Circulating Nurse Staffing Report

### [SROCNR]

The *Circulating Nurse Staffing Report* option provides nurse staffing information, sorted by the circulating nurse's name. It lists the circulating nurses and the completed cases they are assigned to within a specified date range. The report includes the scrub nurse, other circulating nurses, and operation times.

This report has a 132-column format and is designed to be copied to a printer.

### **Example: Print Circulating Nurse Staffing Report**

```
Select Surgery Staffing Reports Option: NC Circulating Nurse Staffing Report
```

```
Circulating Nurse Staffing Report
```

```
Do you want the report for all nurses ? YES// <Enter>
```

```
Start with Date: 3/2 (MAR 02, 2001)
```

```
End with Date: 3/31 (MAR 31, 2001)
```

```
This report is designed to use a 132 column format.
```

```
Print the report on which Device: [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 CIRCULATING NURSE STAFFING REPORT  
 FROM: MAR 2,2001 TO: MAR 31,2001

PAGE: 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: APR 21,2001

DATE CASE #	PATIENT ID#	OPERATION(S)	SCRUB NURSE	CIRC. NURSE	TIME IN TIME OUT ELAPSED (MINS)
=====					
** TAMPA,ANNETTE **					
03/10/01 189	CALIFORNIA,ELIZABETH 123-45-6789	DRAINAGE OF OVARIAN CYST	LANSING,EMILY	TAMPA,ANNETTE	07:00 08:54 114
** ALBANY,ROSE **					
03/09/01 187	HAWAII,LOU 123-45-6789	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	LANSING,EMILY	ALBANY,ROSE	09:15 12:40 205
03/10/01 200	ILLINOIS,ANNE 123-45-6789	HEMORRHOIDECTOMY	LANSING,EMILY	ALBANY,ROSE	14:00 14:55 55
03/17/01 203	KANSAS,THOMAS 123-45-6789	CHOLECYSTECTOMY	LANSING,EMILY	ALBANY,ROSE	12:55 14:30 95
03/18/01 202	MICHIGAN,MATTHEW R. 123-45-6789	REPAIR INCARCERATED INGUINAL HERNIA	LANSING,EMILY TAMPA,ANNETTE	ALBANY,ROSE	07:30 09:03 93
** DENVER,KELLY D **					
03/03/01 205	ARKANSAS,MARY 123-45-6789	REMOVE CATARACTS, RETRO BULBAR BLOCK	LANSING,EMILY	DENVER,KELLY D	09:00 09:20

## **Anesthesia Reports** **[SR ANESTH REPORTS]**

The *Anesthesia Reports* menu provides options for printing various anesthesia reports.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym the user can enter to select the option:

<b>Shortcut</b>	<b>Option Name</b>
A	<i>Anesthesia AMIS</i>
P	<i>List of Anesthetic Procedures</i>
D	<i>Anesthesia Provider Report</i>

## Anesthesia AMIS

### [SROAMIS]

The *Anesthesia AMIS* option compiles statistics for all surgical cases and non-O.R. procedures within the date range selected and then generates a report.

 This option is locked with the SROAAMIS key.

The Anesthesia AMIS Report prints in a 132-column format and must be copied to a printer.

#### **Example: Printing the Anesthesia AMIS Report**

```
Select Anesthesia Menu Option: A Anesthesia AMIS
```

```
Anesthesia AMIS
```

```
Start with Date: 1 1 01 (JAN 01, 2001)  
End with Date: 1 31 01 (JAN 31, 2001)
```

```
Do you want to print all divisions? YES// <Enter>
```

```
This report is designed to use a 132 column format, and must be run  
on a printer.
```

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

MAYBERRY, NC  
 ANESTHESIA SERVICE  
 ANESTHESIA AMIS  
 FROM: JAN 1,2001 TO: JAN 31,2001

REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: FEB 7,2001

```

=====
ANESTHETICS ADMINISTERED BY PRINCIPAL TECHNIQUE USED
=====
TOTAL NO OF ANES-
THETICS ADMINISTERED | GENERAL | MAC | SPINAL | EPIDURAL | OTHER | LOCAL
-----
54 | 8 | 1 | 3 | 1 | 0 | 41
=====
  
```

```

=====
ANESTHETICS FOR PROCEDURES ADMINISTERED BY: ** ANESTHETICS FOR DIAG. & THERA. PROCEDURES ADMINISTERED BY:
=====
ANESTHESIOLOGIST | NURSE ANESTHETIST | OTHER ** ANESTHESIOLOGIST | NURSE ANESTHETIST | OTHER
-----
NUMBER OF | NO. OF | NUMBER OF | NO. OF | NUMBER OF | NO. OF ** NUMBER OF | NO. OF | NUMBER OF | NO. OF | NUMBER OF | NO. OF
ANESTHETICS | DEATHS | ANESTHETICS | DEATHS | ANESTHETICS | DEATHS ** ANESTHETICS | DEATHS | ANESTHETICS | DEATHS | ANESTHETICS | DEATHS
-----
9 | 0 | 3 | 0 | 40 | 1 ** 1 | 0 | 0 | 0 | 1 | 0
=====
  
```

```

=====
DEATHS WITHIN 24 HOURS OF INDUCTION OF ANESTHETIC
=====
TOTAL NUMBER
OF DEATHS | GENERAL | MAC | SPINAL | EPIDURAL | OTHER | LOCAL
-----
1 | 0 | 0 | 0 | 0 | 0 | 1
=====
  
```

## List of Anesthetic Procedures

### [SROANP]

The *List of Anesthetic Procedures* option generates a report listing each completed case within the date range selected. It sorts by date order and provides the anesthesia personnel. This report also provides the anesthesia start, end, and elapsed times for each case.

After the user enters the date range, the software will ask whether the user wants the List of Anesthetic Procedures to include 1) only operating room surgical procedures, 2) non-O.R. procedures, or 3) both.

These reports have a 132-column format and are designed to be copied to a printer.

### **Example 1: Print the List of Anesthetic Procedures for only O.R. Surgical Procedures**

```
Select Anesthesia Reports Option: P List of Anesthetic Procedures
```

```
List of Anesthetic Procedures
```

```
Start with Date: 8/8 (AUG 08, 2001)
End with Date: 8/25 (AUG 25, 2001)
```

```
Print List of Anesthetic Procedures for
```

1. O.R. Surgical Procedures.
2. Non-O.R. Procedures.
3. Both O.R. Surgical Procedures and Non-O.R. Procedures.

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

```
This report is designed to use a 132 column format.
```

```
Print the Report on which Device: [Select Print Device]
```

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

MAYBERRY, NC  
SURGICAL SERVICE  
LIST OF ANESTHETIC PROCEDURES  
FROM: AUG 8,2001 TO: AUG 25,2001

PAGE: 1

REVIEWED BY:  
DATE REVIEWED:  
DATE PRINTED: SEP 21,2001

O.R. SURGICAL PROCEDURES

DATE CASE #	PATIENT ID# ASA CLASS	PRINCIPAL DIAGNOSIS PROCEDURE(S)	PRIN ANESTHETIST ANESTH TECHNIQUE ANESTH AGENT	START TIME END TIME ELAPSED
08/08/01 08:00 63085	HAWAII, LOU 123-45-6789 MILD DISTURB.	ABDOMINAL WOUND DEHISCENSE CLOSURE ABDOMINAL DEHISCENSE	TOPEKA, MARK GENERAL DESFLURANE 240ML BTL	08:00 10:30 90
08/12/01 08:30 63090	MISSOURI, ROY 123-45-6789 SEVERE DISTURB.	CA OF LARYNX LARYNGECTOMY	MIAMI, STEVE GENERAL SUFENTANIL CITRATE 5 120	08:35 10:35 120
08/16/01 08:00 63094	KANSAS, THOMAS 123-45-6789 NO DISTURB.	LESION RT EAR LOBE EXC LESION LESIO RT EAR LOBE	NASHVILLE, NANCY LOCAL LIDOCAINE 2% (20MG/M 25	08:05 08:30 25
08/21/01 06:00 63100	MISSISSIPPI, RANDALL 123-45-6789 MILD DISTURB.	DIAGNOSTIC COLONOSCOPY COLONOSCOPY	TOPEKA, MARK GENERAL PROPOFOL 20ML INJ	06:00 07:05 65
08/21/01 07:00 63104	MONTANA, JOHNNY 123-45-6789 SEVERE DISTURB.	PARATHYROID ADENOMA PARATHYROID EXPLORATION AND EXCISION ADENOMA	NASHVILLE, NANCY GENERAL SUFENTANIL CITRATE 5 120	07:00 09:00 120
08/22/01 10:10 63106	NEBRASKA, NICHOLAS 123-45-6789 MILD DISTURB.	HX OF POLYP COLONOSCOPY, POLYPECTOMY	TOPEKA, MARK GENERAL PROPOFOL 20ML INJ	10:15 11:15 60
08/22/01 09:56 63110	INDIANA, SUSAN 123-45-6789 MILD DISTURB.	CHOLECYSTITIS LAP CHOLE	MIAMI, STEVE GENERAL DESFLURANE 240ML BTL	10:00 11:55 115
08/24/01 14:55 63115	KANSAS, THOMAS 123-45-6789 MILD DISTURB.	INGUINAL HERNIA INGUINAL HERNIA REPAIR	NASHVILLE, NANCY GENERAL PROPOFOL 20ML INJ	14:55 16:05 70

## Example 2: Print the List of Anesthetic Procedures for only Non-OR Procedures

Select Anesthesia Reports Option: **P** List of Anesthetic Procedures

List of Anesthetic Procedures

Start with Date: **1/1** (JAN 01, 2001)  
End with Date: **1/7** (JAN 07, 2001)

Print List of Anesthetic Procedures for

1. O.R. Surgical Procedures.
2. Non-O.R. Procedures.
3. Both O.R. Surgical Procedures and Non-O.R. Procedures.

Select Number: 1// **2**

This report is designed to use a 132 column format.

Print the Report on which Device: **[Select Print Device]**

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 LIST OF ANESTHETIC PROCEDURES  
 FROM: JAN 1,2001 TO: JAN 7,2001

PAGE: 1

REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: JAN 15,2001

NON-O.R. PROCEDURES

DATE CASE #	PATIENT ID# ASA CLASS	PRINCIPAL DIAGNOSIS PROCEDURE(S)	PRIN ANESTHETIST ANESTH TECHNIQUE ANESTH AGENT	START TIME END TIME ELAPSED
01/02/01 51051	MINNESOTA, RONALD 123-45-6789 MILD DISTURB.	TB BRONCHOSCOPY	TOPEKA, MARK GENERAL PHENOBARBITAL SODIUM	09:43 10:25 42
01/02/01 51053	MINNESOTA, RONALD 123-45-6789 MILD DISTURB.	ILEITIS COLONOSCOPY	MIAMI, STEVE OTHER FENTANYL 250MCG/5ML	10:00 11:10 70
01/02/01 51057	OREGON, ROBERT 123-45-6789 NO DISTURB.	ESOPHAGEAL VARICES ESOPHAGOSCOPY	TAMPA, ANNETTE GENERAL PROPOFOL 20ML INJ	13:10 13:45 35
01/04/01 51169	ARKANSAS, MARY 123-45-6789 MILD DISTURB.	HISTOPLASMOSIS BRONCHOSCOPY	TAMPA, ANNETTE OTHER FENTANYL 250MCG/5ML	08:20 09:15 55
01/04/01 88	MAINE, JOHN 123-45-6789 NO DISTURB.	CARDIAC ARRHYTHMIA CARDIOVERSION	BOISE, WILLIAM GENERAL PHENOBARBITAL 30MG/7	18:50 19:25 35
01/07/01 51181	ARKANSAS, MARY 123-45-6789 MILD DISTURB.	HISTOPLASMOSIS BRONCHOSCOPY	TAMPA, ANNETTE OTHER FENTANYL 250MCG/5ML	10:05 11:05 60
01/07/01 51185	NEVADA, NORMAN 123-45-6789 MILD DISTURB.	CHRONIC DEPRESSION ELECTROCONVULSIVE THERAPY	BOISE, WILLIAM OTHER MIDAZOLAM 1MG/1ML 2M	13:10 13:35 25

## Anesthesia Provider Report

### [SROADOC]

The *Anesthesia Provider Report* option provides information concerning the anesthesia staff and techniques for completed cases within a selected date range. This report can be generated for all anesthesia providers or the user can specify one. It sorts the cases by the principal anesthetist and includes information on anesthesia personnel, technique, agent, level of supervision, and elapsed anesthesia time.

This report has a 132-column format and is designed to be copied to a printer.

#### **Example: Print the Anesthesia Provider Report**

```
Select Anesthesia Reports Option: D Anesthesia Provider Report
```

```
Anesthesia Provider Report
```

```
Start with Date: 3/2 (MAR 02, 2001)  
End with Date: 3/15 (MAR 15, 2001)
```

```
Do you want to print the report for all Anesthesia Providers ? YES// N
```

```
Print the report for which Anesthesia Provider ? PHOENIX,SALLY
```

```
This report is designed to use a 132 column format.
```

```
Print the Report on which Device: [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 ANESTHESIA PROVIDER REPORT  
 FROM: MAR 23,2001 TO: MAR 24,2001

PAGE: 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: MAR 29,2001

DATE CASE #	PATIENT ID#	PROCEDURE(S)	SUPERVISOR RELIEF ANESTH ASST ANESTH	ASA CLASS PRINCIPAL TECHNIQUE ANESTHESIA AGENT	LEVEL OF SUPERVISION ELAPSED ANES TIME
***** PHOENIX, SALLY *****					
03/23/01 54014	OHIO, R 123-45-6789	ESS, SEPTO, WITH LEFT TURBINECTOMY SCAR REVISION	AUGUSTA, D HOUSTON F	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 105 MINS.
03/23/01 54020	KANSAS, T 123-45-6789	COLONOSCOPY/ATTEMPTED	AUGUSTA, D NASHVILLE, N	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 55 MINS.
03/23/01 54050	GEORGIA, G 123-45-6789	CYSTO, RETROGRADE, STENT	AUGUSTA, D HOUSTON F	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 45 MINS.
03/24/01 54023	ALASKA, F 123-45-6789	COLONOSCOPY/POLYPECTOMY	AUGUSTA, D NASHVILLE, N	SEVERE DISTURB. GENERAL PROPOFOL 20ML INJ	1 50 MINS.
03/24/01 54025	NEVADA, N 123-45-6789	COLONOSCOPY	AUGUSTA, D HOUSTON F	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 65 MINS.
03/24/01 54024 NON-OR	INDIANA, S 123-45-6789	CARDIOVERSION	AUGUSTA, D NASHVILLE, N	SEVERE DISTURB. GENERAL MIDAZOLAM 1MG/1ML 2M	1 35 MINS.
03/24/01 54058	MICHIGAN, M 123-45-6789	HEMORRHOIDECTOMY	AUGUSTA, D HOUSTON F	SEVERE DISTURB. SPINAL BUPIVACAINE 0.25%	1 45 MINS.
03/24/01 54079	WISCONSIN, S 123-45-6789	EXPL LAP, LYSIS OF ADHESIONS	AUGUSTA, D HOUSTON F NASHVILLE, N	SEVERE DIST.-EMERG GENERAL DESFLURANE 240ML BTL	1 120 MINS.

## CPT Code Reports [SR CPT REPORTS]

The *CPT Code Reports* menu contains reports based on CPT codes.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym the user can enter to select the option.

<b>Shortcut</b>	<b>Option Name</b>
C	<i>Cumulative Report of CPT Codes</i>
A	<i>Report of CPT Coding Accuracy</i>
M	<i>List Completed Cases Missing CPT Codes</i>

## Cumulative Report of CPT Codes

### [SROACCT]

The *Cumulative Report of CPT Codes* option counts and reports the number of times a procedure was performed (based on CPT codes) during a specified date range. There is also a column showing how many times the procedure was in the Principal Procedure category, and how many times it was in the Other Operative Procedure category.

After the date range is entered, the software will ask if the user wants the Cumulative Report of CPT Codes to include 1) only operating room surgical procedures, 2) non-O.R. procedures, or 3) both.

These reports have a 132-column format and are designed to be copied to a printer.

#### **Example 1: Print the Cumulative Report of CPT Codes for only OR Surgical Procedures**

```
Select CPT Code Reports Option: C Cumulative Report of CPT Codes
```

```
Cumulative Report of CPT Codes
```

```
Start with Date: 3/28 (MAR 28, 2001)
End with Date: 4/3 (APR 03, 2001)
```

```
Include which cases on the Cumulative Report of CPT Codes ?
```

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

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

```
This report is designed to use a 132 column format.
```

```
Select Device: [Select Print Device]
```

-----printout follows-----

MAYBERRY, NC  
 SURGICAL SERVICE  
 CUMULATIVE REPORT OF CPT CODES  
 FROM: MAR 28,2001 TO: APR 3,2001

REVIEWED BY  
 DATE REVIEWED:

O.R. SURGICAL PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	1	1	0
11440 REMOVAL OF SKIN LESION	1	1	0
11441 REMOVAL OF SKIN LESION	4	4	0
11641 REMOVAL OF SKIN LESION	4	2	2
24075 REMOVE ARM/ELBOW LESION	1	1	0
26989 HAND/FINGER SURGERY	1	1	0
30520 REPAIR OF NASAL SEPTUM	1	1	0
31231 NASAL ENDOSCOPY, DX	1	0	1
45315 PROCTOSIGMOIDOSCOPY	1	0	1
45330 SIGMOIDOSCOPY, DIAGNOSTIC	7	7	0
45333 SIGMOIDOSCOPY & POLYPECTOMY	1	1	0
45378 DIAGNOSTIC COLONOSCOPY	2	2	0
45385 COLONOSCOPY, LESION REMOVAL	3	3	0
47600 REMOVAL OF GALLBLADDER	1	0	1
49000 EXPLORATION OF ABDOMEN	1	1	0
49505 REPAIR INGUINAL HERNIA	2	1	1
66984 REMOVE CATARACT, INSERT LENS	4	3	1
68801 DILATE TEAR DUCT OPENING	1	1	0

## Example 2: Print the Cumulative Report of CPT Codes for only Non-O.R. Procedures

Select CPT Code Reports Option: **C** Cumulative Report of CPT Codes

Cumulative Report of CPT Codes

Start with Date: **7 1 01** (JUL 01, 2001)

End with Date: **12 31 01** (DEC 31, 2001)

Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number: 1// 2

This report is designed to use a 132 column format.

Select Device: [**Select Print Device**]

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 CUMULATIVE REPORT OF CPT CODES  
 FROM: JUL 1,2001 TO: DEC 31,2001

REVIEWED BY  
 DATE REVIEWED:

NON-O.R. PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	2	2	0
10061 DRAINAGE OF SKIN ABSCESS	1	1	0
11040 DEBRIDE SKIN PARTIAL	8	8	0
11042 DEBRIDE SKIN/TISSUE	1	1	0
11100 BIOPSY OF SKIN LESION	11	11	0
11402 REMOVAL OF SKIN LESION	1	1	0
11420 REMOVAL OF SKIN LESION	1	1	0
11620 REMOVAL OF SKIN LESION	1	1	0
11640 REMOVAL OF SKIN LESION	1	1	0
11730 REMOVAL OF NAIL PLATE	1	1	0
11750 REMOVAL OF NAIL BED	1	1	0
12001 REPAIR SUPERFICIAL WOUND(S)	3	3	0
12011 REPAIR SUPERFICIAL WOUND(S)	2	2	0
14060 SKIN TISSUE REARRANGEMENT	1	1	0
15782 ABRASION TREATMENT OF SKIN	1	1	0
17340 CRYOTHERAPY OF SKIN	1	1	0
20550 INJ TENDON/LIGAMENT/CYST	23	23	0
29799 CASTING/STRAPPING PROCEDURE	1	1	0
46083 INCISE EXTERNAL HEMORRHOID	2	2	0

## Report of CPT Coding Accuracy

### [SR CPT ACCURACY]

The *Report of CPT Coding Accuracy* option lists cases sorted by the CPT code used in the PRINCIPAL PROCEDURES field and OTHER OPERATIVE PROCEDURES field. This option is designed to help check the accuracy of the coding procedures.

#### About the prompts

"Do you want to print the Report of CPT Coding Accuracy for all CPT Codes ?" The user should reply **NO** to this prompt to produce the report for only one CPT code. The software will then prompt the user to enter the CPT code or category.

"Do you want to sort the Report of CPT Coding Accuracy by Surgical Specialty ?" The user should press the **<Enter>** key if he or she wants to sort the report by specialty. The user would enter **NO** to sort the report by date only.

"Do you want to print the Report to Check Coding Accuracy for all Surgical Specialties ?" The user can enter the code or name of the surgical service he or she wants the report to be based on or can press the **<Enter>** key to print the report for all surgical specialties.

#### Example 1: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Surgical Specialty

```
Select CPT Code Reports Option: A Report of CPT Coding Accuracy
```

```
Report to Check CPT Coding Accuracy
```

```
Start with Date: 10 8 01 (OCT 08, 2001)  
End with Date: 10 8 01 (OCT 08, 2001)
```

```
Print the Report of CPT Coding Accuracy for which cases ?
```

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

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

```
Do you want to print the Report of CPT Coding Accuracy for all  
CPT Codes ? YES// <Enter>
```

```
Do you want to sort the Report of CPT Coding Accuracy by  
Surgical Specialty ? YES// <Enter>
```

```
Do you want to print the Report to Check Coding Accuracy for all  
Surgical Specialties ? YES// NO
```

```
Print the Coding Accuracy Report for which Surgical Specialty ? 50      GENERA  
L(OR WHEN NOT DEFINED BELOW) GENERAL(OR WHEN NOT DEFINED BELOW)      50
```

```
This report is designed to use a 132 column format.
```

```
Select Device: [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF CPT CODING ACCURACY  
 FOR GENERAL (OR WHEN NOT DEFINED BELOW)  
 FROM: OCT 8, 2001 TO: OCT 8, 2001

PAGE  
 1

REVIEWED BY:  
 DATE REVIEWED:

O.R. SURGICAL PROCEDURES

PROCEDURE CASE #	DATE TIME	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
===== 47600 REMOVAL OF GALLBLADDER PRINCIPAL PROCEDURES DESCRIPTION: CHOLECYSTECTOMY; =====				
10/08/01 63072	07:00	GEORGIA, PAUL 123-45-6789	CHOLECYSTECTOMY (47600-22)	TULSA, LARRY MIAMI, STEVE
===== 47605 REMOVAL OF GALLBLADDER OTHER PROCEDURES DESCRIPTION: CHOLECYSTECTOMY; WITH CHOLANGIOGRAPHY =====				
10/08/01 63077	10:00	BOISE, WILLIAM 123-45-6789	INGUINAL HERNIA (49521), OTHER OPERATIONS: CHOLECYSTECTOMY (47605-22)	RICHMOND, ARTHUR MIAMI, STEVE
===== 49505 REPAIR INGUINAL HERNIA PRINCIPAL PROCEDURES DESCRIPTION: REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE =====				
10/08/01 63071	06:00	KENTUCKY, KENNETH 123-45-6789	INGUINAL HERNIA (49505)	MIAMI, STEVE PITTSBURGH, ANTHONY
=====				

## Example 2: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Date

Select CPT Code Reports Option: **A** Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: **10 1 01** (OCT 08, 2001)

End with Date: **10 7 01** (OCT 08, 2001)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

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

Do you want to print the Report of CPT Coding Accuracy for all  
CPT Codes ? YES// **<Enter>**

Do you want to sort the Report of CPT Coding Accuracy by  
Surgical Specialty ? YES// **N**

This report is designed to use a 132 column format.

Select Device: **[Select Print Device]**

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF CPT CODING ACCURACY  
 FROM: OCT 1,2001 TO: OCT 7,2001

REVIEWED BY:  
 DATE REVIEWED:

O.R. SURGICAL PROCEDURES

PROCEDURE CASE #	DATE	PATIENT ID#	PROCEDURES SPECIALTY	SURGEON/PROVIDER ATTEND SURG/PROV
---------------------	------	----------------	-------------------------	--------------------------------------

31365 REMOVAL OF LARYNX  
 PRINCIPAL PROCEDURES  
 DESCRIPTION: LARYNGECTOMY;  
 TOTAL, WITH RADICAL NECK DISSECTION

10/03/01 63059	07:00	DELAWARE, ANDREW 123-45-6789	PULMONARY LOBECTOMY (31365) THORACIC SURGERY (INC. CARDIAC SURG.)	DENVER, DONNA RICHMOND, ARTHUR
-------------------	-------	---------------------------------	----------------------------------------------------------------------	-----------------------------------

32440 REMOVAL OF LUNG  
 PRINCIPAL PROCEDURES  
 DESCRIPTION: REMOVAL OF LUNG, TOTAL PNEUMONECTOMY;

10/03/01 63060	10:00	ARKANSAS, JAMES 123-45-6789	PULMONARY LOBECTOMY (32440) THORACIC SURGERY (INC. CARDIAC SURG.)	MIAMI, STEVE RICHMOND, ARTHUR
-------------------	-------	--------------------------------	----------------------------------------------------------------------	----------------------------------

10/04/01 63069	06:00	IOWA, LUKE 123-45-6789	PULMONARY LOBECTOMY (32440) THORACIC SURGERY (INC. CARDIAC SURG.)	AUGUSTA, DON AUGUSTA, DON
-------------------	-------	---------------------------	----------------------------------------------------------------------	------------------------------

32480 PARTIAL REMOVAL OF LUNG  
 PRINCIPAL PROCEDURES  
 DESCRIPTION: REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY;  
 SINGLE LOBE (LOBECTOMY)

10/03/01 63049	06:00	IDAHO, PETER 123-45-6789	PULMONARY LOBECTOMY (32480) THORACIC SURGERY (INC. CARDIAC SURG.)	TULSA, LARRY TOPEKA, MARK
-------------------	-------	-----------------------------	----------------------------------------------------------------------	------------------------------

10/03/01 63050	07:00	WISCONSIN, MARK 123-45-6789	PULMONARY LOBECTOMY (32480) THORACIC SURGERY (INC. CARDIAC SURG.)	TULSA, LARRY TULSA, LARRY
-------------------	-------	--------------------------------	----------------------------------------------------------------------	------------------------------

**Example 3: Print the Report of CPT Coding Accuracy for Non-O.R. Procedures, sorted by CPT Code and Medical Specialty**

Select CPT Code Reports Option: **A** Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: **1 1 01** (JAN 01, 2001)  
End with Date: **8 31 01** (AUG 31, 2001)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number: 1// **2**

Do you want to print the Report of CPT Coding Accuracy for all CPT Codes ? YES// **N**

Print the Coding Accuracy Report for which CPT Code ? **92960**  
HEART ELECTROCONVERSION  
CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF  
ARRHYTHMIA, EXTERNAL

Do you want to sort the Report of CPT Coding Accuracy by Medical Specialty ? YES// **<Enter>**

Do you want to print the Report to Check Coding Accuracy for all Medical Specialties ? YES// **N**

Print the Coding Accuracy Report for which Medical Specialty ? **MEDICINE**

This report is designed to use a 132 column format.

Select Device: **[Select Print Device]**

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF CPT CODING ACCURACY  
 FOR MEDICINE  
 FROM: JAN 1,2001 TO: AUG 31,2001

PAGE  
 1

REVIEWED BY:  
 DATE REVIEWED:

NON-O.R. PROCEDURES

PROCEDURE CASE #	DATE	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
===== 92960 HEART ELECTROCONVERSION PRINCIPAL PROCEDURES DESCRIPTION: CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF ARRHYTHMIA, EXTERNAL -----				
01/24/95 15499		MICHIGAN, MATTHEW R. 123-45-6789	CARDIOVERSION (92960)	TULSA, LARRY TULSA, LARRY
02/09/95 15701		HAWAII, LOU 123-45-6789	CARDIOVERSION (92960)	TOPEKA, MARK TULSA, LARRY
03/29/95 15912		IDAHO, MICHAEL 123-45-6789	CARDIOVERSION (92960)	SPRINGFIELD, JACK
08/04/95 16669		MISSOURI, ROY 123-45-6789	CARDIOVERSION (92960)	AUGUSTA, DON MIAMI, STEVE
08/25/95 16828		COLORADO, ALBERT 123-45-6789	CARDIOVERSION (92960)	TULSA, LARRY TULSA, LARRY

## List Completed Cases Missing CPT Codes

### [SRSCPT]

The *List Completed Cases Missing CPT Codes* option generates a report of completed cases that are missing a CPT code for the principal or secondary operation(s) within a specified date range.

CPT codes need to be attributed to each procedure; only procedures that have CPT codes are included in the Annual Report of Surgical Procedures. The user can use the *Operation Menu* option or the *Operation* option to add a CPT code to a case.

After the date range has been entered, the software will ask if the user wants the Cumulative Report of CPT Codes to include 1) only operating room surgical procedures, 2) non-O.R. procedures, or 3) both.

This report is in an 80-column format and can be viewed on the screen.

### **Example: List Completed Cases Missing CPT Codes**

```
Select CPT Code Reports Option: M List Completed Cases Missing CPT Codes
```

```
Print list of Completed Cases Missing CPT Codes for
```

1. OR Surgical Procedures.
2. Non-OR Procedures.
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

```
Select Number: 1// 1
```

```
Do you want the list for all Surgical Specialties ? YES// <Enter>
```

```
Start with Date: 2/1 (APR 01, 2001)
```

```
End with Date: 4/30 (APR 20, 2001)
```

```
Print the List of Cases Missing CPT codes to which Printer ? [Select Print Device]
```

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

MAYBERRY, NC  
 Completed Cases Missing CPT Codes  
 O.R. Surgical Procedures  
 From: FEB 1,2001 To: APR 30,2001  
 Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Operation Date Case #	Patient (ID#)	Surgeon/Provider
FEB 01, 2001 53708	JACKSON,THOMAS J. (123-45-6789)	AUGUSTA,DON
	* EXC LEFT PREAURICULAR LESION (CPT: MISSING)	
FEB 08, 2001 53747	VERMONT,JONATHAN (123-45-6789)	TOPEKA,MARK
	* EXCISION LESIONS SCALP (CPT: 11420)	
	* N/A (CPT: MISSING)	
MAR 12, 2001 53973	VIRGINIA,MARK (123-45-6789)	TULSA,LARRY
	* COLONOSCOPY (CPT: MISSING)	
MAR 23, 2001 54030	MISSISSIPPI,RANDALL (123-45-6789)	TOPEKA,MARK
	* COLONOSCOPY/ATTEMPTED (CPT: MISSING)	
APR 27, 2001 54325	ALASKA,FREDERICK (123-45-6789)	WISCONSIN,ROBERT
	* EXCISION RT FOREARM LESIONS (CPT: MISSING)	
	* EXC LESION, RT EAR (CPT: MISSING)	
	* EXC LESION, RT FOREHEAD (CPT: MISSING)	
	* EXC LESION RT SCALP (CPT: MISSING)	
	* RXC LESION, NOSE (CPT: MISSING)	
	* EXC LESION, LEFT EAR (CPT: MISSING)	
	* EXC LESION, LEFT FOREARM (CPT: MISSING)	
	* EXC LESION, TOP OF HEAD (CPT: MISSING)	
	* EXC LESION, LEFT NECK (CPT: MISSING)	

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

# Laboratory Interim Report

[SRO-LRRP]

The *Laboratory Interim Report* option accesses the Laboratory Package to show what lab tests the patient has had. This option will print or display interim reports for a selected patient, within a given time period. The printout will go in inverse date order. This report will output all tests for the time period specified. This option only prints verified results and does not output the microbiology reports.

## Example: Print Laboratory Interim Report

```
Select Surgery Menu Option: L   Laboratory Interim Report

Select Patient Name: INDIANA,SUSAN      03-03-59      123456789      NO
NON-VETERAN (OTHER)
Date to START with: TODAY//5 15 01 (MAY 15, 2001)
Date to END with: T-7//5 1 01 (MAY 01, 2001)
DEVICE: [Select Print Device]
-----printout follows-----
```

INDIANA,SUSAN 09/21/2001 1:21 pm  
SSN: 123-45-6789 SEX: F AGE: 40 LOC: LRC

Provider: MIAMI,STEVE  
Specimen: SERUM  
Accession [UID]: CH 0513 1 [3471330001]

05/13/1997 07:00

Test name	Result	units	Ref.	range
GLUCOSE	87	mg/dL	60	- 123
UREA NITROGEN	22	mg/dL	11	- 24
CREATININE	1.8	mg/dl	1	- 2.1
POTASSIUM	4.4	meq/L	3.5	- 4.8
SODIUM	143	meq/L	135	- 145
CHLORIDE	103	meq/L	95	- 105
CO2	27.0	meq/L	20	- 32
CALCIUM	8.7	mg/dL	8.5	- 11

=====  
KEY: "L"=Abnormal low, "H"=Abnormal high, "\*"=Critical value

INDIANA,SUSAN 123-45-6789 09/21/2001 1:21 pm PRESS '^' TO STOP

# Chapter Four: Chief of Surgery Reports

---

## Introduction

This chapter describes options and reports for the exclusive use of the Surgical Service Chief, or his or her designee. The Chief has access to lists of cancellations, the Morbidity and Mortality Report, and Patient Occurrences.

## Exiting an Option or the System

The user should enter an up-arrow (^) to stop what he or she is doing. The up-arrow can be used at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continuing to enter up-arrows will cause the user to completely exit the system.

## Option Overview

The main options included in this chapter are listed below. To the left of the option name is the shortcut synonym that the user can enter to select the option. The *Chief of Surgery Menu* option will not display if the user does not have proper security clearance.

Shortcut	Option Name
CH	<i>Chief of Surgery Menu</i>

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

# Chief of Surgery Menu

## [SROCHIEF]

The *Chief of Surgery Menu* is a restricted option (locked with the SROCHIEF key), allowing access to various management reports and functions. It is designed for the Chief of Surgery and his or her designees. The options available from this menu are shown in the following table.

Shortcut	Option or Menu Name
V	<i>View Patient Perioperative Occurrences</i>
M	<i>Management Reports</i>
U	<i>Unlock a Case for Editing</i>
RET	<i>Update Status of Returns Within 30 Days</i>
CAN	<i>Update Cancelled Case ...</i>
D	<i>Update Operations as Unrelated/Related to Death</i>
CODE	<i>Update/Verify Procedure/Diagnosis Codes</i>

## View Patient Perioperative Occurrences [SR0MEN-M&M]

The *View Patient Perioperative Occurrences* option is designed to provide a quick view of any occurrences for a particular case. This report can be viewed on a screen.

### Example: View Patient Perioperative Occurrences

Select Chief of Surgery Menu Option: V View Patient Perioperative Occurrences

Select Patient: HAWAII,LOU 09-01-50 123456789

HAWAII,LOU 123-45-6789

1. 09-15-04 BYPASS (REQUESTED)
2. 09-15-04 CAROTID ARTERY ENDARTERECTOMY (SCHEDULED)
3. 03-09-04 CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)

Select Operation: 3

HAWAII,LOU (123-45-6789)

OCCURRENCES

-----  
Date of Operation: JUN 09, 2004 09:15  
Principal Operation: CHOLECYSTECTOMY (47480)

Surgeon: TULSA,LARRY  
Attending Surgeon: TOPEKA,MARK  
Attending Code: LEVEL B: ATTENDING IN O.R., SCRUBBED

Principal Postop Diagnosis: CHOLECYSTITIS (574.01)

Intraoperative Occurrences: PUNCTURED MESENTERIC ARTERY  
Outcome: IMPROVED

Postoperative Occurrences: EDEMA (03/10/92)  
Outcome: IMPROVED

Press RETURN to continue <Enter>

## Management Reports [SRO-CHIEF REPORTS]

The *Management Reports* menu is designed to give the Chief of Surgery various management reports. The reports contained on this menu are listed below. To the left of the option/report name is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
MM	<i>Morbidity &amp; Mortality Reports</i>
MV	<i>M&amp;M Verification Report</i>
CD	<i>Comparison of Preop and Postop Diagnosis</i>
D	<i>Delay and Cancellation Reports ...</i>
V	<i>List of Unverified Surgery Cases</i>
RET	<i>Report of Returns to Surgery</i>
A	<i>Report of Daily Operating Room Activity</i>
NS	<i>Report of Cases Without Specimens</i>
ICU	<i>Report of Unscheduled Admissions to ICU</i>
OR	<i>Operating Room Utilization Report</i>
WC	<i>Wound Classification Report</i>
QM	<i>Quarterly Report Menu ...</i>
BA	<i>Print Blood Product Verification Audit Log</i>
ECS	<i>Ensuring Correct Surgery Compliance Report</i>

## Morbidity & Mortality Reports

### [SRMMM]

The *Morbidity & Mortality Reports* option generates the Perioperative Occurrences Report and the Mortality Report. The Perioperative Occurrences Report includes all cases that have occurrences, both intraoperatively and postoperatively. These reports sort by service within a date range. Each surgical service will begin on a separate page.

After the date range has been entered, the software will ask whether the user wants to generate both reports. If the answer is **NO**, the software will ask the user to select from 1) the Perioperative Occurrences Report or 2) the Mortality Report.

These reports have a 132-column format and are designed to be copied to a printer.

#### Example 1: Printing the Perioperative Occurrences Report

```
Select Management Reports Option:  MM Morbidity & Mortality Reports
```

```
The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.
```

```
Do you want to generate both reports ?  YES//  N
```

```
1. Perioperative Occurrences Report
2. Mortality Report
```

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

```
Start with Date:  8/1  (AUG 01, 2002)
```

```
End with Date:  8/31  (AUG 31, 2002)
```

```
Do you want to print this report for all Surgical Specialties ? YES//  NO
```

```
Print the report for which Specialty ?  GENERAL(OR WHEN NOT DEFINED BELOW)  GENERAL(OR WHEN NOT
DEFINED BELOW)          50
```

```
Select an Additional Specialty:          <Enter>
```

```
This report is designed to use a 132 column format.
```

```
Print report on which Device:  [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 PERIOPERATIVE OCCURRENCES  
 FROM: AUG 1,2002 TO: AUG 31,2002

PAGE 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: SEP 22,2002

PATIENT ID# OPERATION DATE	PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) TREATMENT	OUTCOME
=====			
GENERAL (OR WHEN NOT DEFINED BELOW)			
-----			
IDAHO, PETER 123-45-6789 AUG 07, 2002@07:15	REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (08/09/02) IV ANTBIOTICS	I
KANSAS, THOMAS 123-45-6789 AUG 31, 2002@09:00	CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (09/02/02) ANTIBIOTICS	I

-----  
 OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH  
 '\*' Represents Postoperative Occurrences  
 -----

## Example 2: Print the Mortality Report

Select Management Reports Option: **MM** Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.

Do you want to generate both reports ? YES// **N**

1. Perioperative Occurrences Report
2. Mortality Report

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

Start with Date: **1/1/02** (JAN 01, 2002)

End with Date: **12/31/02** (DEC 31, 2002)

This report is designed to use a 132 column format.

Print report on which Device: [**Select Print Device**]

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 MORTALITY REPORT  
 FROM: JAN 1,2002 TO: DEC 31,2002

PAGE 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: DEC 22,1999

OPERATION DATE	PATIENT ID#	PRINCIPAL OPERATIVE PROCEDURE	DATE OF DEATH AUTOPSY (Y/N)
=====			
OTORHINOLARYNGOLOGY (ENT)			
-----			
JAN 22, 2002	MINNESOTA, RONALD 123-45-6789	LARYNGOSCOPY, BRONCHOSCOPY, ESOPHAGOGASTROSCOPY	FEB 09, 2002 NO
JAN 27, 2002	COLORADO, ALBERT 123-45-6789	BRONCHOSCOPY	FEB 26, 2002 NOT AVAILABLE
JAN 29, 2002	MINNESOTA, RONALD 123-45-6789	BILATERAL NECK DISSECTION, LARYNGECTOMY	FEB 09, 2002 NO
FEB 08, 2002	MINNESOTA, RONALD 123-45-6789	LIGATION LT INTERNAL JUGULAR , EXPLORATORY LAPARATOMY	FEB 09, 2002 NO
FEB 19, 2002	IOWA, LUKE 123-45-6789	TRACH	FEB 21, 2002 NO
OCT 20, 2002	MAINE, JAMES 123-45-6789	LARYNGOSCOPY W/ BX, ESOPHAGOSCOPY	NOV 01, 2002 NOT AVAILABLE

## M&M Verification Report

### [SRO M&M VERIFICATION REPORT]

The *M&M Verification Report* option produces the M&M Verification Report that may be useful for (1) reviewing occurrences and their assignments to operations and (2) reviewing deaths unrelated/related assignments to operations

Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range and experienced intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk-assessed operations that are in a completed state but have not yet been transmitted to the national database.

**Variety #1:** Report information is printed patient-by-patient, listing all operations for the patient that occurred during the selected date range, as well as any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that were performed prior to the selected date range, and, if printed by specialty, may include operations performed by other specialties. For every operation that is listed, the intraoperative and postoperative occurrences are also listed. The report also includes information about whether the operation was unrelated or related to death as well as the risk assessment type and status (if assessed). The report may be printed for a selected list of surgical specialties.

**Variety #2:** Report information is printed patient-by-patient in a format similar to Variety #1. This report lists all risk-assessed operations that are in a completed state but have not yet been transmitted to the national database and that have intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The report includes any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some other operations that may or may not be risk assessed, and, if risk assessed, may have any risk assessment status (incomplete, complete, or transmitted). Every patient listed on this report will have at least one operation with a risk assessment status of “complete.”

#### **Example 1: Generate an M&M Verification Report (Full Report)**

```
Select Management Reports Option: MV M&M Verification Report
```

#### M&M Verification Report

```
The M&M Verification Report is a tool to assist in the review of occurrences and their assignments to operations and in the review of death unrelated or related assignments to operations. Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk assessed operations that are in a completed state but have not yet transmitted to the national database.
```

```
Print which variety of the report ?
```

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.

```
Enter selection (1 or 2): 1// <Enter>
```

```
Start with Date: 12 31 01 (DEC 31, 2001)
```

```
End with Date: 1 31 02 (JAN 31, 2002)
```

Do you want to print this report for all Surgical Specialties ? YES// <Enter>

This report is designed to use a 132 column format.

Print report on which Device: [**Select Print Device**]

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

Reviewed By:  
Date Reviewed:

Op Date	Specialty	Procedure(s)	Death Related	Occurrence(s) - (Date)	Assessment Type/Status
=====					
>>> ALASKA,FREDERICK (123-45-6789) - DIED 02/27/02					
01/06/02	GENERAL	TOTAL LARYNGECTOMY	NO		NON-CARD/T
12/29/01	THORACIC	CABG, VEIN, SIX+	NO		CARDIAC/I
11/20/01	PERIPHERAL	LT CAROTID ENDOARTERECTOMY	N/A	OTHER OCCURRENCE (11/20/01) ICD: 998.4 FB LEFT DURING PROCEDURE URINARY TRACT INFECTION * (12/08/01) ICD: 599.0 URIN TRACT INFECTION NOS OTHER RESPIRATORY OCCURRENCE * (11/25/01) ICD: 478.25 EDEMA PHARYNX/NASOPHARYX OTHER OCCURRENCE * (NO DATE) ICD: 530.1 ESOPHAGITIS	NON-CARD/T
11/02/01	PERIPHERAL	EVACUATION OF HEMATOMA LT.THIGH	YES	DVT/THROMBOPHLEBITIS * (11/06/01) ICD: 453.8 VENOUS THROMBOSIS NEC BLEEDING/TRANSFUSIONS * (11/04/01) BLEEDING/TRANSFUSIONS * (11/06/01) BLEEDING/TRANSFUSIONS * (11/06/01)	NON-CARD/I

-----  
Occurrences(s): '\*' Denotes Postop Occurrence

-----  
Assessment Status - I:Incomplete, C:Complete, T:Transmitted  
-----

## Example 2: Generate an M&M Verification Report (Pre-Transmission Report)

Select Management Reports Option: **MV** M&M Verification Report

### M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences and their assignments to operations and in the review of death unrelated or related assignments to operations. Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk assessed operations that are in a completed state but have not yet transmitted to the national database.

Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// 2

Do you want to print this report for all Surgical Specialties ? YES// <Enter>

This report is designed to use a 132 column format.

Print report on which Device: [**Select Print Device**]

-----printout follows-----

MAYBERRY, NC  
M&M Verification Report  
Pre-Transmission Report for Completed Assessments  
Report Generated: DEC 31,2002

Reviewed By:  
Date Reviewed:

Op Date	Specialty	Procedure(s)	Death Related	Occurrence(s) - (Date)	Assessment Type/Status
=====					
>>> KENTUCKY,KENNETH (123-45-6789) - DIED 12/30/02@07:16					
12/24/02	UROLOGY	CYSTOSCOPY	YES		EXCLUDED/C
-----					
>>> CALIFORNIA,ALBERT (123-45-6789) - DIED 03/02/02@13:20					
01/31/02	GENERAL	LEFT BKA STUMP DEBRIDEMENT & REVISION	?	URINARY TRACT INFECTION * (02/09/02) ICD: 599.0 URIN TRACT INFECTION NOS PNEUMONIA * (02/15/02) ICD: 485. BRONCOPNEUMONIA ORG NOS	EXCLUDED/C
-----					
>>> OHIO,RAYMOND (123-45-6789) - DIED 08/13/02@19:00					
08/05/02	PERIPHERAL	LEFT LEG ABOVE KNEE AMPUTATION, RIGHT LEG ABOVE KNEE AMPUTATION	NO		EXCLUDED/C
-----					
>>> OKLAHOMA,JESSE (123-45-6789) - DIED 10/01/02					
08/21/02	PERIPHERAL	OMEGAPORT PLACEMENT	?		EXCLUDED/C
-----					
>>> IDAHO, WILLIAM B (123-45-6789) - DIED 04/08/02					
03/14/02	GENERAL	HICKMAN CATH PLACMENT	NO		EXCLUDED/C
-----					

Occurrences(s): '\*' Denotes Postop Occurrence Assessment Status - I:Incomplete, C:Complete, T:Transmitted

## Comparison of Preop and Postop Diagnosis

### [SROPPC]

The *Comparison of Preop and Postop Diagnosis* option generates a list of completed cases in which the principal preoperative and principal postoperative diagnoses are different.

#### **Example: Print Comparison of Preop and Postop Diagnosis Report**

Select Management Reports Option: **CD** Comparison of Preop and Postop Diagnosis

Comparison of Preop and Postop Diagnosis

Start with Date: **3/1** (MAR 01, 2002)

End with Date: **3/31** (MAR 31, 2002)

This report is designed to use a 132 column format.

Print the Report on which device: **[Select Print Device]**

-----*report follows*-----

MAYBERRY, NC  
 SURGICAL SERVICE  
 COMPARISON OF PREOP AND POSTOP DIAGNOSIS  
 FROM: MAR 1,2002 TO: MAR 31,2002

REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: APR 22,2002

DATE CASE #	PATIENT ID # SURGICAL SPECIALTY	PREOPERATIVE DIAGNOSIS	POSTOPERATIVE DIAGNOSIS	WOUND CLASS
03/03/02 63064	OHIO, RAYMOND 123-45-6789 GENERAL	APPENDICITIS	ACUTE APPENDICITIS	D
03/04/02 63066	UTAH, JOHNNY 123-45-6789 GENERAL	BILATERAL INGUINAL HERNIA	BILATERAL INGUINAL HERNIA, WITH GANGRENE	C
03/04/02 63068	IOWA, MICHEAL 123-45-6789 GENERAL	BILATERAL INGUINAL HERNIA	BILAT INGUINAL HERNIA	C
03/08/02 63072	GEORGIA, PAUL 123-45-6789 GENERAL	CHOLECYSTITIS	CHOLECYSTITIS WITH OBSTRUCTION	C

-----  
 WOUND CLASSIFICATION CODES:  
 C: CLEAN, CC: CLEAN/CONTAMINATED, D: CONTAMINATED, I: INFECTED

## **Delay and Cancellation Reports**

### **[SRO DEL MENU]**

The *Delay and Cancellation Reports* menu provides access to various reports used to track delays and cancellations. The reports on this menu are listed below. To the left of the option/report name is the shortcut synonym the user can enter to select the option.

<b>Shortcut</b>	<b>Option Name</b>
D	<i>Report of Delayed Operations</i>
R	<i>Report of Delay Reasons</i>
T	<i>Report of Delay Time</i>
C	<i>Report of Cancellations</i>
A	<i>Report of Cancellation Rates</i>

## Report of Delayed Operations [SRODELA]

The *Report of Delayed Operations* option will list all cases that have been delayed within a specified date range. The report sorts by surgical service and includes both the delay cause and delay time.

This report is in a 132-column format and should be copied to a printer with wide paper.

### Example: Report of Delayed Operations

```
Select Delay and Cancellation Reports Option: D Report of Delayed Operations
```

```
Report of Delayed Operations
```

```
Start with which Date ? 7/1 (JUL 01, 1999)
```

```
End with which Date ? 7/31 (JUL 31, 1999)
```

```
Do you want to print the Report of Delayed Operations for all Surgical  
Specialties ? YES// <Enter>
```

```
This report is designed to use a 132 column format.
```

```
Print the Report on which device ? [Select Print Device]
```

```
-----report follows-----
```

MAYBERRY, NC  
SURGICAL SERVICE  
REPORT OF DELAYED OPERATIONS  
NEUROSURGERY  
FROM: JUL 1,1999 TO: JUL 31,1999

PAGE: 1  
REVIEWED BY:  
DATE REVIEWED:  
DATE PRINTED: AUG 13,1999

DATE DELAY TIME	PATIENT ID #	ATTENDING SURGEON OPERATION(S)	DELAY COMMENTS
=====			
OPERATING SURGEON NOT PRESENT -----			
07/13/99 30 MINS.	MICHIGAN, MATTHEW R. 123-45-6789	SPRINGFIELD, JACK L3-4 LUMBAR LAMINECTOMY WITH PARTIAL FACETECTOMY AND LEFT NEUROFORAMINOTOMY, ADDITIONAL L4-5	
STAFF SURGEON NOT PRESENT -----			
07/28/99 45 MINS.	ARKANSAS, MARY 123-45-6789	TULSA, LARRY RT. MEDIAN NERVE DECOMPRESSION AT WRIST	WEDNESDAY UNIVERSITY MEETING

## Report of Delay Reasons [SROREAS]

The *Report of Delay Reasons* option lists reasons for delays, and the number of occurrences for delayed operations, within a specified date range.

This report is in an 80-column format and can be viewed on your screen.

### Example: Report of Delay Reasons

Select Delay and Cancellation Reports Option: **R** Report of Delay Reasons

Report of Delayed Operations

Start with which Date ? 3/1 (MAR 01, 1999)

End with which Date ? 3/31 (MAR 31, 1999)

Do you want to print the Report of Delay Reasons for all Surgical  
Specialties ? YES//<Enter>

Do you want to display the totals for each Surgical Specialty ? YES// ?

Enter RETURN to display the totals for delay reasons for each specialty. If  
you want to display the totals for all delay reasons for the entire medical  
center, enter 'NO'.

Do you want to display the totals for each Surgical Specialty ? YES// <Enter>

Print the Report on which device: **[Select Print Device]**

-----printout follows-----

REPORT OF DELAY REASONS  
FROM 03/01/99 TO 03/31/99

GENERAL(OR WHEN NOT DEFINED BELOW)  
-----

ANESTHETIST NOT PRESENT	1
SPECIAL EQUIPMENT NOT READY	1
OTHER	1
TOTAL DELAYS FOR GENERAL(OR WHEN NOT DEFINED BELOW)	3

OTORHINOLARYNGOLOGY (ENT)  
-----

OPERATING SURGEON NOT PRESENT	1
TOTAL DELAYS FOR OTORHINOLARYNGOLOGY (ENT)	1

Press RETURN to continue, or '^' to quit: <Enter>

REPORT OF DELAY REASONS  
FROM 03/01/99 TO 03/31/99

=====

OPERATING SURGEON NOT PRESENT	1
ANESTHETIST NOT PRESENT	1
SPECIAL EQUIPMENT NOT READY	1
OTHER	1
TOTAL DELAY REASONS	4

Press RETURN to continue <Enter>

## Report of Delay Time [SRO DELAY TIME]

The *Report of Delay Time* option provides the total amount of delay time for each delay reason for a specified date range. The report sorts by surgical specialty.

This report is in an 80-column format and can be viewed on a screen.

### Example: Report of Delay Time

```
Select Delay and Cancellation Reports Option: T Report of Delay Time
```

```
Report of Delay Time
```

```
Start with which Date ? 3/1 (MAR 01, 1999)
```

```
End with which Date ? 3/31 (MAR 31, 1999)
```

```
Do you want to print the Report of Delay Time for all delay reasons ? YES// ?
```

```
Enter RETURN to print this report for all delay reasons, or 'NO' to select  
a specific delay reason.
```

```
Do you want to print the Report of Delay Time for all delay reasons ? YES// <Enter>
```

```
Do you want to print the Report of Delayed Operations for all Surgical  
Specialties ? YES// <Enter>
```

```
Print the Report on which device: [Select Print Device]
```

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

MAYBERRY, NC  
Report of Delay Times  
From 03/01/99 To 03/31/99

PAGE 1

SURGICAL SPECIALTY	# OF DELAYS	MINUTES DELAYED
=====		
>> Delay Reason: OPERATING SURGEON NOT PRESENT <<		
OTORHINOLARYNGOLOGY (ENT)	1	15
-----		
>> Delay Reason: ANESTHETIST NOT PRESENT <<		
GENERAL(OR WHEN NOT DEFINED BE	1	30
-----		
>> Delay Reason: SPECIAL EQUIPMENT NOT READY <<		
GENERAL(OR WHEN NOT DEFINED BE	1	10
Press RETURN to continue, or '^' to quit. <Enter>		

MAYBERRY, NC  
Report of Delay Times  
From 03/01/99 To 03/31/99

PAGE 2

SURGICAL SPECIALTY	# OF DELAYS	MINUTES DELAYED
=====		
>> Delay Reason: OTHER <<		
GENERAL(OR WHEN NOT DEFINED BE	1	15
Press RETURN to continue, or '^' to quit. <Enter>		

MAYBERRY, NC  
Report of Delay Times  
From 03/01/99 To 03/31/99

PAGE 3

DELAY REASON	# OF DELAYS	MINUTES DELAYED
OPERATING SURGEON NOT PRESENT	1	15
ANESTHETIST NOT PRESENT	1	30
SPECIAL EQUIPMENT NOT READY	1	10
OTHER	1	15
TOTAL	4	70

Press RETURN to continue <Enter>

## Report of Cancellations [SROCAN]

The *Report of Cancellations* option is designed to provide information for cases that have been scheduled and cancelled.

This report is in a 132-column format and must be copied to a printer.

### Example: Print Report of Cancellations

Select Delay and Cancellation Reports Option: **C** Report of Cancellations

Report of Cancellations

NOTE: This report contains all cancelled cases, including those that were cancelled after the patient had entered the operating room. Aborted cases are identified by an '\*' next to the procedure name.

Start with Date: **3/1** (MAR 01, 1999)  
End with Date: **3/3** (MAR 03, 1999)

Do you want to print the report for all Surgical Specialties ? YES// **<Enter>**

This report is designed to use a 132 column format.

Print the Report on which device: **[Select Print Device]**

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

MAYBERRY, NC  
 REPORT OF CANCELLATIONS  
 FROM 03/01/99 TO 03/03/99

PAGE: 1

PRINTED: MAR 23, 1999

REVIEWED BY:  
 DATE REVIEWED:

DATE CASE #	PATIENT ID#	OPERATION(S)	CANCEL DATE REASON
=====			
>> SURGICAL SPECIALTY: OPHTHALMOLOGY <<			
MAR 01, 1999 31725	IDAHO, WILLIAM B 123-45-6789	* PHACEOMULSIFICATION, LENS IMPLANT OS	MAR 01, 1999 11:00 MEDICAL
-----			
>> SURGICAL SPECIALTY: ORTHOPEDICS <<			
MAR 01, 1999 32066	IDAHO, WILLIAM 123-45-6789	LT. TOTAL KNEE ARTHROPLASTY	MAR 01, 1999 08:01 MEDICAL
MAR 03, 1999 32143	MONTANA, JOHNNY B 123-45-6789	HARDWARE REMOVAL RT. ANKLE	MAR 03, 1999 12:49 ADMINISTRATIVE CANCELLATION
-----			
>> SURGICAL SPECIALTY: PLASTIC SURGERY (INCLUDES HEAD AND NECK) <<			
MAR 01, 1999 32089	FLORIDA, FRANK 123-45-6789	DEBRIDMENT OF BACK, NECK WOUNDS, GOLDWEIGHT TO RT. EYE, RT. LATERAL CANTHOPLASTY	MAR 01, 1999 07:36 SURGEON
MAR 03, 1999 32141	IOWA, LUKE 123-45-6789	PRIMARY CLOSURE LT. CHEEK, SKIN GRAFT VS SKIN FLAP	APR 02, 1999 08:21 PATIENT NOT NPO
-----			
>> SURGICAL SPECIALTY: THORACIC SURGERY (INC. CARDIAC SURG.) <<			
MAR 01, 1999 32013	MAINE, JOE. 123-45-6789	LT. THORACOTOMY, LOBECTOMY, PNEUMONECTOMY	MAR 01, 1999 07:35 MEDICAL
-----			
>> SURGICAL SPECIALTY: UROLOGY <<			
MAR 03, 1999 32119	DELAWARE, DAVID 123-45-6789	TRANSURETHRAL RESECTION OF BLADDER TUMOR	MAR 19, 1999 08:00 PATIENT/GUARDIAN REFUSES
-----			
>> SURGICAL SPECIALTY: PODIATRY <<			
MAR 02, 1999 31865	MICHIGAN, RYAN 123-45-6789	1ST METATARSAL REMODELING RT. FOOT, REMOVAL OF SOFT TISSUE NODULE RT. FOOT	MAR 29, 1999 08:52 MEDICAL
-----			

## Report of Cancellation Rates [SROCRAT]

The *Report of Cancellation Rates* option generates a report on the calculations of cancellation rates. This report can be printed for one or a few surgical specialties (Example 1), or for all surgical specialties (Example 2). Emergency cases are not included in this report.

This report is in an 80-column format and can be viewed on your screen.

### How the Cancellation Rates Are Calculated

Cancellation Rate for Scheduled Cases =  
(Total Cancels / Total Scheduled) x 100

Avoidable Cancellation Rate for Scheduled Cases =  
(Total Avoidable Cancels / Total Scheduled) x 100

Avoidable Cancellation rate for all Cancelled Cases =  
(Total Avoidable Cancels / Total Cancels) x 100

### Example 1: View for Individual Surgical Specialties

```
Select Delay and Cancellation Reports Option: A Report of Cancellation Rates
```

```
Report of Cancellation Rates
```

```
Start with which Date ? 3/2 (MAR 02, 1999)
```

```
End with which Date ? 3/20 (MAR 20, 1999)
```

```
Do you want to print the report for all Surgical Specialties ? YES// N
```

```
Print the report for which Specialty ? 50 GENERAL (OR WHEN NOT DEFINED BELOW)
```

```
Select An Additional Specialty: ORTHOPEDICS 54 ORTHOPEDICS
```

```
Select An Additional Specialty: PLASTIC SURGERY (INCLUDES HEAD AND NECK) PROCTOLOGY 56
```

```
PLASTIC SURGERY (INCLUDES HEAD AND NECK)
```

```
Select An Additional Specialty: <Enter>
```

```
Print the Report on which device: [Select Print Device]
```

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

\*\* GENERAL(OR WHEN NOT DEFINED BELOW) \*\*

TOTAL SCHEDULED SURGICAL CASES: 18  
 CANCELLATION RATE FOR SCHEDULED CASES: 17 %  
 AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %  
 AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
PREV. CASE LENGTH	3	0
TOTAL CANCELLATIONS	3	0

Press RETURN to continue, or '^' to quit: <Enter>

\*\* ORTHOPEDICS \*\*

TOTAL SCHEDULED SURGICAL CASES: 23  
 CANCELLATION RATE FOR SCHEDULED CASES: 26 %  
 AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 9 %  
 AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 33 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
ADMINISTRATIVE CANCELLATION	1	1
MEDICAL	4	1
SCHEDULING ERROR	1	0
TOTAL CANCELLATIONS	6	2

Press RETURN to continue, or '^' to quit: <Enter>

\*\* PLASTIC SURGERY (INCLUDES HEAD AND NECK) \*\*

TOTAL SCHEDULED SURGICAL CASES: 10  
 CANCELLATION RATE FOR SCHEDULED CASES: 30 %  
 AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 20 %  
 AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 67 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
PATIENT NOT NPO	1	1
PREV. CASE LENGTH	1	0
SURGEON	1	1
TOTAL CANCELLATIONS	3	2

Press RETURN to continue, or '^' to quit: <Enter>

## Example 2: View for All Specialties

Select Delay and Cancellation Reports Option: **A** Report of Cancellation Rates

### Report of Cancellation Rates

Start with which Date ? **3/2** (MAR 02, 1999)  
End with which Date ? **3/20** (MAR 20, 1999)

Do you want to print the report for all Surgical Specialties ? YES// **<Enter>**

Do you want to display the cancellation reasons for each Surgical Specialty ? YES//**<Enter>**

Print the Report on which device: **[Select Print Device]**

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

\*\* GENERAL(OR WHEN NOT DEFINED BELOW) \*\*

TOTAL SCHEDULED SURGICAL CASES: 18  
CANCELLATION RATE FOR SCHEDULED CASES: 17 %  
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %  
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
PREV. CASE LENGTH	3	0
TOTAL CANCELLATIONS	3	0

Press RETURN to continue, or '^' to quit: **<Enter>**

\*\* NEUROSURGERY \*\*

TOTAL SCHEDULED SURGICAL CASES: 8  
CANCELLATION RATE FOR SCHEDULED CASES: 25 %  
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 13 %  
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 50 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
OPERATING ROOM	1	0
PATIENT NO-SHOW	1	1
TOTAL CANCELLATIONS	2	1

Press RETURN to continue, or '^' to quit: **<Enter>**

\*\* ORTHOPEDICS \*\*

TOTAL SCHEDULED SURGICAL CASES: 23  
CANCELLATION RATE FOR SCHEDULED CASES: 26 %  
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 9 %  
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 33 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
ADMINISTRATIVE CANCELLATION	1	1
MEDICAL	4	1
SCHEDULING ERROR	1	0
TOTAL CANCELLATIONS	6	2

Press RETURN to continue, or '^' to quit: **<Enter>**

\*\* OTORHINOLARYNGOLOGY (ENT) \*\*

TOTAL SCHEDULED SURGICAL CASES: 18  
CANCELLATION RATE FOR SCHEDULED CASES: 6 %  
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 6 %  
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 100 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
SCHEDULING ERROR	1	1
TOTAL CANCELLATIONS	1	1

Press RETURN to continue, or '^' to quit: <Enter>

\*\* PERIPHERAL VASCULAR \*\*

TOTAL SCHEDULED SURGICAL CASES: 16  
CANCELLATION RATE FOR SCHEDULED CASES: 25 %  
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 6 %  
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 25 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
MEDICAL	2	0
PREV. CASE LENGTH	1	0
SCHEDULING ERROR	1	1
TOTAL CANCELLATIONS	4	1

Press RETURN to continue, or '^' to quit: <Enter>

\*\* PLASTIC SURGERY (INCLUDES HEAD AND NECK) \*\*

TOTAL SCHEDULED SURGICAL CASES: 10  
CANCELLATION RATE FOR SCHEDULED CASES: 30 %  
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 20 %  
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 67 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
PATIENT NOT NPO	1	1
PREV. CASE LENGTH	1	0
SURGEON	1	1
TOTAL CANCELLATIONS	3	2

Press RETURN to continue, or '^' to quit: <Enter>

\*\* PODIATRY \*\*

TOTAL SCHEDULED SURGICAL CASES: 14  
CANCELLATION RATE FOR SCHEDULED CASES: 7 %  
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %  
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
MEDICAL	1	0
TOTAL CANCELLATIONS	1	0

Press RETURN to continue, or '^' to quit: <Enter>

\*\* UROLOGY \*\*

TOTAL SCHEDULED SURGICAL CASES: 11  
 CANCELLATION RATE FOR SCHEDULED CASES: 18 %  
 AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %  
 AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
MEDICAL	1	0
PATIENT/GUARDIAN REFUSES	1	0
TOTAL CANCELLATIONS	2	0

Press RETURN to continue, or '^' to quit: <Enter>

TOTAL SURGICAL CASES SCHEDULED FOR MAYBERRY, NC: 118  
 CANCELLATION RATE FOR SCHEDULED CASES: 19 %  
 AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 6 %  
 AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 32 %

CANCELLATION REASON	TOTAL CANCELS	TOTAL AVOIDABLE
ADMINISTRATIVE CANCELLATION	1	1
MEDICAL	8	1
OPERATING ROOM	1	0
PATIENT NO-SHOW	1	1
PATIENT NOT NPO	1	1
PATIENT/GUARDIAN REFUSES	1	0
PREV. CASE LENGTH	5	0
SCHEDULING ERROR	3	2
SURGEON	1	1
TOTAL CANCELLATIONS	22	7

Press RETURN to continue, or '^' to quit: <Enter>

SURGICAL SPECIALTY	PERCENT AVOIDABLE CANCELLATIONS	
	SCHEDULED CASES	CANCELLED CASES
GENERAL(OR WHEN NOT DEFINED BELOW)	0 %	0 %
NEUROSURGERY	13 %	50 %
ORTHOPEDICS	9 %	33 %
OTORHINOLARYNGOLOGY (ENT)	6 %	100 %
PERIPHERAL VASCULAR	6 %	25 %
PLASTIC SURGERY (INCLUDES HEAD AND NECK)	20 %	67 %
PODIATRY	0 %	0 %
UROLOGY	0 %	0 %

Press RETURN to continue <Enter>

## List of Unverified Surgery Cases

### [SROUNV]

The *List of Unverified Surgery Cases* option will generate a list of all completed surgery cases that have not had the procedure, diagnosis, and complications verified. The user can verify a case using the *Surgeon's Verification of Diagnosis & Procedures* option in the *Operation Menu*. This list can be compiled for one or all surgical specialties.

This report is in an 80-column format and can be viewed on your screen.

### Example: List of Unverified Surgery Cases

Select Management Reports Option: **V** List of Unverified Surgery Cases

Do you want the list for all Surgical Specialties ? YES// **N**

Select Surgical Specialty: **GENERAL**(OR WHEN NOT DEFINED BELOW) 50

Start with Date: **3/9** (MAR 09, 1999)

End with Date: **3/20** (MAR 20, 1999)

Print the List of Unverified Cases to which Printer ? [Select Print Device]

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

List of Unverified Cases for GENERAL(OR WHEN NOT DEFINED BELOW)

Operation Date	Patient (Case #) Patient ID #	Surgeon Attending Surgeon
MAR 9, 1999	MISSOURI,ROY (15188) 123-45-6789	PITTSBURGH, S RICHMOND,ARTHUR
	APPENDECTOMY * CPT CODE MISSING *	
MAR 10, 1999	CALIFORNIA,ELIZABETH (15189) 123-45-6789	RICHMOND,ARTHUR TOPEKA,MARK
	DRAINAGE OF OVARIAN CYST * CPT CODE MISSING *	
MAR 10, 1999	MARYLAND,MARK (15199) 123-45-6789	TOPEKA,MARK NOT ENTERED
	CHOLECYSTECTOMY WITH CHOLANGIOGRAM * CPT CODE MISSING *	
MAR 17, 1999	KANSAS,THOMAS (15203) 123-45-6789	TOPEKA,MARK TULSA,LARRY
	CHOLECYSTECTOMY * CPT CODE MISSING *	
MAR 18, 1999	MICHIGAN,MATHEW R. (15202) 123-45-6789	TOPEKA,MARK TULSA,LARRY
	REPAIR INCARCERATED INGUINAL HERNIA * CPT CODE MISSING *	

Press RETURN to continue, or '^' to quit: . **<Enter>**

## Report of Returns to Surgery

### [SRORET]

The *Report of Returns to Surgery* option lists cases that have had related surgical procedures performed within 30 days of the date of the operation. The user must enter the date range by which the software will sort.

This report has a 132-column format and must be copied to a printer with wide paper.

### **Example: Print the Report of Returns to Surgery**

Select Management Reports Option: **RET** Report of Returns to Surgery

Report of Returns to Surgery

Start with Date: **7/1** (JUL 01, 1999)

End with Date: **7/14** (JUL 14, 1999)

This report will list cases completed during the date range entered that have had return cases associated with them. It is designed to use a 132 column format.

Print the Report on which Device: **[Select Print Device]**

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 REPORT OF RETURNS TO SURGERY  
 FROM: JUL 1,1999 TO: JUL 14,1999

REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: AUG 27,1999

OPERATION DATE	PATIENT (ID#)	PRINCIPAL OPERATIVE PROCEDURE
JUL 03, 1999	MICHIGAN,RYAN (123-45-6789)	REPAIR GASTRIC PERFORATION
	RETURNS TO SURGERY: JUL 07, 1999	EXPLORATORY LAPAROTOMY
JUL 06, 1999	OKLAHOMA,JESSE (123-45-6789)	ATTEMPTED REVISION OF LEFT ARM A-V FISTULA WITH GRAFT
	RETURNS TO SURGERY: JUL 15, 1999	CREATION OF A-V FISTULA W/VASCULAR GRAFT, RT ARM
JUL 06, 1999	IDAHO, WILLIAM B (123-45-6789)	EXCISION OF GRANULATION TISSUE RT. FOOT
	RETURNS TO SURGERY: AUG 03, 1999	STSG FROM RT. THIGH TO RIGHT FOOT
JUL 06, 1999	MAINE,JOE (123-45-6789)	IRRIGATION AND DEBRIDEMENT OF LT. FOOT
	RETURNS TO SURGERY: JUL 14, 1999	IRRIGATION AND DEBRIDEMENT OF LT. FOOT
JUL 07, 1999	MISSISSIPPI,RANDALL (123-45-6789)	EXPLORATORY LAPAROTOMY
	RETURNS TO SURGERY: AUG 05, 1999	TRACHEOSTOMY
JUL 10, 1999	MISSISSIPPI,RANDALL (123-45-6789)	RIGHT LOWER QUADRANT EXPLORATION
	RETURNS TO SURGERY: JUL 13, 1999	SIGMOID COLECTOMY

## **Report of Daily Operating Room Activity**

### **[SROPACT]**

The *Report of Daily Operating Room Activity* option provides a list of completed cases started between 6:00 AM on the date selected and 5:59 AM of the following day for all operating rooms.

#### **Example: Print the Report of Daily Operating Room Activity**

Select Management Reports Option: **A** Report of Daily Operating Room Activity

Print the Report of Daily Activity for which Date ? **7/1** (JUL 01, 1999)

This report will include all cases started between MAR 12, 1992 at 6:00 AM and MAR 13, 1992 at 5:59 AM.

It is designed to use a 132 column format.

Print the Report to which Device ? **[Select Print Device]**

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 DAILY REPORT OF OPERATING ROOM ACTIVITY  
 FOR: JUL 01, 1999

PATIENT ID # WARD	AGE	TIME IN OR TIME OUT OR CASE NUMBER	POSTOPERATIVE DIAGNOSIS PROCEDURE(S)	ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
=====					
OPERATING ROOM: CYST01					
MISSOURI, ROY 123-45-6789 OUTPATIENT	45	07/01 14:00 07/01 16:05 33536	GROSS HEMATURIA CYSTOURETHROSCOPY WITH BLADDER BIOPSY, TRANSURETHRAL RESECTION OF BLADDER TUMOR	DALLAS, J MIAMI, S	RICHMOND, A KNOXVILLE, N
OPERATING ROOM: OR1					
DELAWARE, DAVID 123-45-6789 OUTPATIENT	56	07/01 08:00 07/01 16:30 33512	LEFT COLD FOOT LEFT FEMORO-TIB TO TIB PERONEAL TRUNK SAPHENOUS, IN-SITU, TIBIAL-PERONEAL EMBOLECTOMY, EXCLUSION OF POPLITEAL ANEURYSM, COMPLETION ANGIOGRAPHY, COMPLETION DUPLEX	TULSA, L MIAMI, S	TULSA, L HOUSTON, M KNOXVILLE, N
MICHIGAN, RYAN 123-45-6789 OUTPATIENT	71	07/01 09:10 07/01 13:00 33521	RT. CAROTID STENOSIS RT. CAROTID ENDARTERECTOMY	DALLAS, J	ATLANTA, M JACKSON, D
OPERATING ROOM: OR2					
FLORIDA, FRANK 123-45-6789 OUTPATIENT	35	07/01 06:00 07/01 07:35 33519	APPENDICITIS APPENDECTOMY	JACKSON, D JACKSON, D	ATLANTA, M JACKSON, D
OPERATING ROOM: OR4					
OKLAHOMA, JESSE 123-45-6789 OUTPATIENT	75	07/01 07:45 07/01 12:00 33409	RT. EAR, RT. EYELID BASAL CELL CA EXCISION OF RT. UPPER EYELID BASAL CELL CA, EXCISION OF RT. EAR BASAL CELL CA	JACKSON, D JACKSON, D	ATLANTA, M RICHMOND, C
OPERATING ROOM: OR5					
MINNESOTA, ROBERT 123-45-6789 OUTPATIENT	67	07/01 07:50 07/01 10:27 33399	SINUSITIS, RHINOPHYMA, NASAL OBSTRUCTION SEPTOPLASTY, TURBINECTOMY, INTERNAL INTRA NASAL SYNOIDECTOMY, LASER RESURFACE OF NOSE, NASAL POLYECTOMY RT., NASAL POLYPECTOMY LT.	JACKSON, D JACKSON, D	HOUSTON, S JACKSON, D

## **Report of Cases Without Specimens**

### **[SROSPEC]**

The *Report of Cases Without Specimens* option lists all completed cases in which there were no specimens taken from the operative site. The report can be printed for an individual surgical specialty, if it is needed.

This report is in a 132-column format and must be copied to a printer with wide paper.

### **Example: Print the Report of Cases without Specimens**

```
Select Management Reports Option: NS Report of Cases Without Specimens
```

```
Report of Cases Without Specimens
```

```
Starting with which Date ? 7/12 (JUL 12, 1999)
```

```
Ending with which Date ? 7/14 (JUL 14, 1999)
```

```
Do you want the report sorted by Surgical Specialty ? NO// <Enter>
```

```
This report is designed to use a 132 column format.
```

```
Print the Report on which Device ? [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 CASES WITHOUT SPECIMENS  
 FROM: JUL 12,1999 TO: JUL 14,1999

PAGE 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: JUL 27,1999

DATE CASE #	PATIENT PATIENT ID	SURGICAL SPECIALTY POSTOPERATIVE DIAGNOSIS OPERATIVE PROCEDURE	SURGEON ATTENDING SURGEON
07/12/99 33613	FLORIDA, FRANK 123-45-6789	PERIPHERAL VASCULAR RENAL FAILURE PLACEMENT OF LEFT FEMORAL DIALYSIS TESSIO-CATHETER	SPRINGFIELD, JACK TOPEKA, MARK
07/12/99 33616	MISSISSIPPI, RANDALL 123-45-6789	OTORHINOLARYNGOLOGY (ENT) NASAL OBSTRUCTION LEFT LATERAL RHINOTOMY WITH RECONSTRUCTION OF NASAL VESTIBULE	AUGUSTA, DON TOPEKA, MARK
07/12/99 33659	MINNESOTA, ROBERT 123-45-6789	UROLOGY SIGMOID CA CYSTOURETOROSCOPY, RETROGRADE PYELOGRAPHY, BILATERAL URETERAL STENT PLACEMENT	MIAMI, STEVE MIAMI, STEVE
07/12/99 33653	MICHIGAN, MATTHEW 123-45-6789	GENERAL (OR WHEN NOT DEFINED BELOW) PROLONGED ANTIBIOTIC THERAPY PLACEMENT OF HICKMAN CATHETER	TULSA, LARRY TAMPA, ANNETTE
07/13/99 33554	ILLINOIS, ANNE 123-45-6789	OPHTHALMOLOGY CATARACT OS PHACEOMULSIFICATION, LENS IMPLANT OS	JACKSON, ROBERT TOPEKA, MARK
07/14/99 33598	IOWA, LUKE 123-45-6789	PLASTIC SURGERY (INCLUDES HEAD AND NECK) MOH'S DEFECT LT. UPPER LIP FLAP CLOSURE OF MOHS DEFECT LEFT UPPER LIP	JACKSON, ROBERT MIAMI, STEVE
07/14/99 33645	TEXAS, SAMUEL 123-45-6789	PLASTIC SURGERY (INCLUDES HEAD AND NECK) INFECTED DIABETIC FOOT DEBRIDEMENT RIGHT FOOT, SKIN GRAFT RT THIGH TO RT FOOT	NASHVILLE, NANCY TULSA, LARRY

TOTAL CASES WITHOUT SPECIMENS: 7

## **Report of Unscheduled Admissions to ICU**

### **[SROICU]**

The *Report of Unscheduled Admissions to ICU* option lists all unscheduled admissions to the Intensive Care Unit (ICU) based on the requested (expected) postoperative care and actual postoperative disposition.

This report is in a 132-column format and must be copied to a printer with wide paper.

### **Example: Print Report of Unscheduled Admissions to ICU**

```
Select Management Reports Option: ICU Report of Unscheduled Admissions to ICU
```

```
Report of Unscheduled Admissions to the ICU
```

```
Starting with which Date ? 7/1 (JUL 01, 1999)
```

```
Ending with which Date ? 7/31 (JUL 31, 1999)
```

```
Do you want the report for a specific Surgical Specialty ? NO// <Enter>
```

```
This report is designed to use a 132 column format.
```

```
Print the Report on which Device ? [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 UNSCHEDULED ADMISSIONS TO ICU  
 FROM 07/01/99 TO 07/31/99

REVIEWED BY:  
 DATE REVIEWED:

DATE	PATIENT PATIENT ID REQ DISPOSITION/POSTOP DISPOSITION	SURGICAL SPECIALTY POSTOPERATIVE DIAGNOSIS OPERATIVE PROCEDURE(S)	SURGEON ATTENDING SURGEON
07/01/99	TEXAS, SAMUEL. 123-45-6789 PACU (RECOVERY ROOM)/SICU	GENERAL (OR WHEN NOT DEFINED BELOW) APPENDICITIS APPENDECTOMY	JACKSON, ROBERT SPRINGFIELD, JACK
07/06/99	IOWA, LUKE 123-45-6789 WARD/SICU	GENERAL (OR WHEN NOT DEFINED BELOW) INABILITY TO TAKE ORAL OR USE NG TUBE PLACEMENT OF G-TUBE	MINNEAPOLIS, SUSAN TAMPA, LEE
07/08/99	IDAHO, PETER 123-45-6789 WARD/MICU	GENERAL (OR WHEN NOT DEFINED BELOW) GANGRENE LT. FOOT LT. BELOW KNEE AMPUTATION	TOPEKA, MARK SPRINGFIELD, JACK
07/23/99	FLORIDA, FRANK 123-45-6789 WARD/SICU	PERIPHERAL VASCULAR IV ACCESS PLACEMENT OF HICKMAN CATHATER, INTRODUCTION OF DOBHOF TUBE	JACKSON, ROBERT MIAMI, STEVE
07/27/99	MAINE, JOE 123-45-6789 WARD/MICU	GENERAL (OR WHEN NOT DEFINED BELOW) RT BUTTOCK ABCESS I AND D OF RIGHT BUTTOCK ABSCESS	MINNEAPOLIS, SUSAN TULSA, LARRY
07/29/99	MISSISSIPPI, ROBERT 123-45-6789 WARD/MICU	GENERAL (OR WHEN NOT DEFINED BELOW) INCARCERATED EPIGASTRIC HERNIA REPAIR OF INCARCERATED EPIGASTRIC HERNIA	TOPEKA, MARK TULSA, LARRY

## Operating Room Utilization Report

### [SR OR UTL1]

The *Operating Room Utilization Report* option prints utilization information for a selected date range for all operating rooms or for a single operating room. The report displays the percent utilization, the number of cases, the total operation time and the time worked outside normal hours for each operating room individually and all operating rooms collectively.

### How the Percent Utilization is Derived

The percent utilization is derived by dividing the total operation time for all operations (including total time patients were in OR, plus the cleanup time allowed for each case) by the total functioning time, as defined in the SURGERY UTILIZATION file. The quotient is then multiplied by 100.

This report must be copied to a printer with wide paper

### Example: Print the Operating Room Utilization Report

```
Select Management Reports Option: OR Operating Room Utilization Report
```

```
Operating Room Utilization Report
```

```
Print utilization information starting with which date ? 3/8 (MAR 08, 1999)
```

```
Print utilization information through which date ? 3/9 (MAR 09, 1999)
```

```
Do you want to print the Operating Room Utilization Report for all  
operating rooms ? YES// <Enter>
```

```
Print the Operating Room Utilization Report on which Device ? [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 OPERATING ROOM UTILIZATION REPORT  
 FOR ALL OPERATING ROOMS FROM: MAR 8,1999 TO: MAR 9,1999  
 DATE PRINTED: MAR 17,1999

```

=====
OPERATING ROOM      PERCENT UTILIZATION      NUMBER OF CASES      TOTAL OPERATION TIME
                    (INCLUDING OR MAINTENANCE)      TIME WORKED OUTSIDE NORMAL HRS
=====
OR1                  70%                        3                    17 hrs and 35 mins      6 hrs and 20 mins
-----
OR2                  39%                        1                    7 hrs and 25 mins      1 hr and 10 mins
-----
OR3                  133%                       8                    23 hrs and 42 mins      2 hrs and 30 mins
-----
OR4                  29%                        3                    4 hrs and 41 mins      -
-----
OR5                  84%                        7                    18 hrs and 50 mins      5 hrs and 25 mins
-----
OR6                  0                          0                    -                        -
-----
OR7                  0                          0                    -                        -
-----
TOTAL UTILIZATION FOR ALL ROOMS      63%                        22                    72 hrs and 13 mins      15 hrs and 25 mins
=====
  
```

## Wound Classification Report

### [SROWC]

The *Wound Classification Report* option generates a report showing the total number of surgical cases in each of the various wound classifications for a specified date range. The report is sorted by surgical service.

After selecting a date range, the user has the choice of printing one of three reports.

- **Wound Classification Report:** The user enters the number 1 to print this summary of wound classifications entered for surgical cases performed during the date range.
- **List of Operations by Wound Classification:** The user enters the number 2 to print this list of operations sorted by wound classification and by surgical specialty performed during the date range.
- **Clean Wound Infection Summary:** The user enters the number 3 to print this summary of clean wound infections.

These reports are in an 80-column format and can be viewed on the screen.

#### **Example 1: Wound Classification Report (Summary)**

```
Select Management Reports Option: WC Wound Classification Report

Wound Classification Report

Start with Date: 7/1 (JUL 01, 1999)
End with Date: 7/15 (JUL 15, 1999)

Print which of the following ?

1. Wound Classification Report (Summary)
2. List of Operations by Wound Classification
3. Clean Wound Infection Summary

Select Number: 1// <Enter>

Do you want to print the report for all Surgical Specialties ? YES// N

Print the report for which Specialty ? GENERAL(OR WHEN NOT DEFINED BE LOW)
50
Select An Additional Specialty: ORTHOPEDICS 54
Select An Additional Specialty: <Enter>

Print on Device: [Select Print Device]

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

WOUND CLASSIFICATION REPORT  
FROM: JUL 1,1999 TO: JUL 15,1999

---

SURGICAL SERVICE	CLEAN	CLEAN CONTAMINATED	CONTAMINATED	INFECTED	NO CLASS ENTERED
GENERAL	9	10	4	3	0
ORTHOPEDICS	9	0	0	0	0
SUB TOTAL:	18	10	4	3	0

TOTAL: 35

CLEAN WOUND INFECTION RATE: 0.0%

Press RETURN to continue <Enter>

## Example 2: List of Operations by Wound Classification

Select Management Reports Option: WC Wound Classification Report

Wound Classification Report

Start with Date: 7/8 (JUL 08, 1999)

End with Date: 7/8 (JUL 08, 1999)

Print which of the following ?

1. Wound Classification Report (Summary)
2. List of Operations by Wound Classification
3. Clean Wound Infection Summary

Select Number: 1// 2

Do you want to print the report for all Wound Classifications ? YES// **N**

Print report for which Wound Classification ?

1. CLEAN
2. CLEAN/CONTAMINATED
3. CONTAMINATED
4. INFECTED
5. NO CLASS ENTERED

Select Number: 1

Do you want to print the report for all Surgical Specialties ? YES// **N**

Print the report for which Specialty ? **GENERAL**(OR WHEN NOT DEFINED BELOW) 50

Select An Additional Specialty: **PERIPHERAL VASCULAR** 62

Select An Additional Specialty: **<Enter>**

Print on Device: **[Select Print Device]**

-----printout follows-----

List of Surgical Cases by Wound Classification  
FROM: JUL 8,1999 TO: JUL 8,1999  
Wound Classification: CLEAN

Page:  
1

DATE PRINTED: JUL 27,1999

Operation Date Case #	Patient ID #	Surgeon/Provider
=====		
>> GENERAL(OR WHEN NOT DEFINED BELOW) <<		
JUL 08, 1999 33280	FLORIDA,FRANK 123-45-6789 * RT. INGUINAL HERNIA REPAIR	TOPEKA,MARK
-----		
JUL 08, 1999 33629	KENTUCKY,KENNETH 123-45-6789 * INCARCERATED UMBILICAL HERNIA REPAIR	RICHMOND,ARTHUR
-----		

Press RETURN to continue, or '^' to quit: <Enter>

List of Surgical Cases by Wound Classification  
FROM: JUL 8,1999 TO: JUL 8,1999  
Wound Classification: CLEAN

Page:  
2

DATE PRINTED: JUL 27,1999

Operation Date Case #	Patient ID #	Surgeon/Provider
=====		
>> PERIPHERAL VASCULAR <<		
JUL 08, 1999 33478	MAINE,JOE 123-45-6789 * LEFT CAROTID ENDARTERECTOMY * REOPERATION LEFT CAROTID	PHOENIX,SALLY
-----		
JUL 08, 1999 33575	COLORADO,MATTHEW 123-45-6789 * LT. A-V FISTULA WITH LOOP VEIN GRAFT	HARRISBURG,HENRY
-----		

Press RETURN to continue <Enter>

### Example 3: Clean Wound Infection Summary

Select Management Reports Option: **WC** Wound Classification Report

Wound Classification Report

Start with Date: **6/1** (JUN 01, 1999)

End with Date: **6/30** (JUN 30, 1999)

Print which of the following ?

1. Wound Classification Report (Summary)
2. List of Operations by Wound Classification
3. Clean Wound Infection Summary

Select Number: 1// 3

Do you want to print the report for all Surgical Specialties ? YES// **<Enter>**

Print on Device: **[Select Print Device]**

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 CLEAN WOUND INFECTION SUMMARY  
 FROM: JUN 1,1999 TO: JUN 30,1999  
 DATE PRINTED: JUL 18,1999  
 REVIEWED BY:                      DATE REVIEWED:

SURGICAL SERVICE	CLEAN WOUNDS	INFECTIONS	INFECTION RATE
GENERAL	21	1	4.8%
GYNECOLOGY	0	0	0.0%
NEUROSURGERY	11	0	0.0%
OPHTHALMOLOGY	30	0	0.0%
ORTHOPEDECS	20	1	5.0%
OTORHINOLARYNGOLOGY	6	0	0.0%
PLASTIC SURGERY	7	0	0.0%
PROCTOLOGY	0	0	0.0%
THORACIC SURGERY	2	0	0.0%
UROLOGY	2	0	0.0%
ORAL SURGERY	0	0	0.0%
PODIATRY	14	0	0.0%
PERIPHERAL VASCULAR	28	0	0.0%
CARDIAC SURGERY	0	0	0.0%
TRANSPLANTATION	0	0	0.0%
ANESTHESIOLOGY	0	0	0.0%
RHEUMATOLOGY	1	0	0.0%
PULMONARY	0	0	0.0%
GASTROENTEROLOGY	0	0	0.0%
NO SPECIALTY ENTERED	0	0	0.0%
TOTAL	142	2	1.4%

## Quarterly Report Menu

### [SROQ MENU]

The *Quarterly Report Menu* contains the option to generate the Quarterly Report and other associated options that may be helpful in validating information on the Quarterly Report. The options on this menu are listed below. To the left of the option name is the shortcut synonym the user can enter to select the option.

<b>Shortcut</b>	<b>Option Name</b>
Q	<i>Quarterly Report - Surgical Service</i>
D	<i>Deaths Within 30 Days of Surgery</i>
A	<i>Admissions Within 14 Days of Outpatient Surgery</i>
I	<i>List of Invasive Diagnostic Procedures</i>
L	<i>List of Operations Included on Quarterly Report</i>
M	<i>Report of Missing Quarterly Report Data</i>

## Quarterly Report — Surgical Service [SRO QUARTERLY REPORT]

This option looks at all the surgical procedures performed and provides breakdowns on different characteristics of the procedures. The breakdown is in the form of either the Quarterly Report, to be submitted to the Surgical Service at VHA Headquarters, or a Summary Report for a selected date range.

The Quarterly Report for Central Office can be printed and/or automatically transmitted to the national database. When the report is transmitted, a mail message containing the report goes to members of the SR-QUARTERLY mail group.

### Prerequisites

The Quarterly/Summary Report uses information stored in the following data fields of the SURGERY file. To produce an accurate report, these fields should be addressed when information is entered about an operation.

Field Name	Field Number
MAJOR/MINOR	.03
IN/OUT-PATIENT STATUS	.011
CASE SCHEDULE TYPE	.035
ASA CLASS	1.13
SURGERY SPECIALTY	.04
ATTENDING CODE	.165
PRINCIPAL PROCEDURE CODE	27
OTHER PROCEDURE CPT CODE	3 in OTHER PROCEDURES multiple
INTRAOPERATIVE OCCURRENCES	1.14
OCCURRENCE CATEGORY	3 in INTRAOPERATIVE OCCURRENCES multiple
POSTOP OCCURRENCE	1.16
OCCURRENCE CATEGORY	5 in POSTOP OCURRENCE multiple
WOUND CLASSIFICATION	1.09
TIME OUT VERIFIED	71
PREOPERATIVE IMAGING CONFIRMED	72

These reports are formatted in an 80-column format and can be viewed on the screen.

### Example 1: Summary Report for Surgical Service

Select Management Reports Option: **Q** Quarterly Report - Surgical Specialty

QUARTERLY/SUMMARY REPORT FOR SURGICAL SERVICE

NOTE: Listed below are the CPT codes for the index procedures on these reports.

Procedure	CPT Code(s)
Inguinal Hernia	49505,49507,49520,49521,49525
Cholecystectomy	47600,47605,47610,47562,47563,47564
Coronary Artery Bypass	33510,33511,33512,33513,33514,33516,33517,33518, 33519,33521,33522,33523,33533,33534,33535,33536
Colon Resection (L & R)	44140,44141,44143,44144,44145,44146,44147,44160
Fem-Pop Bypass	35656,35556
Pulmonary Lobectomy	32480,32500,32440
Hip Replacement	
- Elective	27125,27130,27132,27134,27137,27138
- Acute Fracture	27236
TURP	52601
Laryngectomy	31360,31365,31367,31368
Craniotomy	61304,61305,61312,61314,61510,61512,61518,61519, 61700,61680
Intraocular Lens	66983,66984

Press RETURN to continue or '^' to quit: **<Enter>**

Run which report ?

1. Summary Report for Selected Date Range
2. Quarterly Report for Central Office

Select Report Number: 1// 1

SUMMARY REPORT FOR SURGICAL SERVICE

Enter date range for data to be included on report.

Start with date: **6/1** (JUN 01, 2004)

End with date: **6/30** (JUN 30, 2004)

Print report on which Device: **[Select Print Device]**

-----printout follows-----

Hospital: MAYBERRY, NC  
Station Number: 999  
For Dates: JUN 01, 2004 to: JUN 30, 2004

```

=====

```

	Total Cases	% of Total
	-----	-----
Surgical Cases	315	100.0
Major Procedures	203	64.4
ASA Class (1)	10	4.9
ASA Class (2)	70	34.5
ASA Class (3)	120	59.1
ASA Class (4)	3	1.5
ASA Class (5)	0	0.0
ASA Class (6)	0	0.0
Postoperative Deaths	2	0.6
Ambulatory: 0		
Postoperative Occurrences	18	5.7
Ambulatory Procedures	201	63.8
Admitted Within 14 Days: 0		
Invasive Diagnostic: 1		
Inpatient Procedures	114	36.2
Emergency Procedures	14	4.4
Age>60 Years	141	44.8

SPECIALTY PROCEDURES

```

-----

```

	PATIENTS	CASES	MAJOR	MINOR	---DEATHS---	
	-----	-----	-----	-----	TOTAL	%
					-----	-----
50 GENERAL	63	64	54	10	1	1.6
51 GYNECOLOGY	7	7	7	0	0	0.0
52 NEUROSURGERY	12	14	13	1	0	0.0
53 OPHTHALMOLOGY	57	59	0	59	0	0.0
54 ORTHOPEDICS	53	56	46	10	0	0.0
55 OTORHINOLARYNGOLOGY	35	35	32	3	0	0.0
56 PLASTIC SURGERY	8	8	4	4	0	0.0
57 PROCTOLOGY	0	0	0	0	0	0.0
58 THORACIC SURGERY	3	3	3	0	0	0.0
59 UROLOGY	19	20	20	0	0	0.0
60 ORAL SURGERY	1	1	1	0	0	0.0
61 PODIATRY	25	25	3	22	0	0.0
62 PERIPHERAL VASCULAR	21	23	20	3	1	4.3
500 CARDIAC SURGERY	0	0	0	0	0	0.0
501 TRANSPLANTATION	0	0	0	0	0	0.0
502 ANESTHESIOLOGY	0	0	0	0	0	0.0

LEVEL OF RESIDENT SUPERVISION (%)

LEVEL OF RESIDENT SUPERVISION (%)

```

-----

```

	MAJOR	MINOR
	-----	-----
Level A	0.0	100.0
Level B	66.7	0.0
Level C	0.0	0.0
Level D	0.0	0.0
Level E	33.3	0.0
Level F	0.0	0.0
Level Not Entered	0.0	0.0

Hospital: MAYBERRY, NC  
 Station Number: 999  
 For Dates: JUN 01, 2004 to: JUN 30, 2004

INDEX PROCEDURES

	CASES	DEATHS	CASES WITH OCCURRENCES
Inguinal Hernia	13	0	0
Cholecystectomy	3	0	0
Coronary Artery Bypass	0	0	0
Colon Resection (L & R)	5	0	1
Fem-Pop Bypass	2	0	1
Pulmonary Lobectomy	0	0	0
Hip Replacement			
- Elective	7	0	2
- Acute Fracture	0	0	0
TURP	0	0	0
Laryngectomy	0	0	0
Craniotomy	0	0	0
Intraocular Lens	44	0	0

PERIOPERATIVE OCCURRENCE CATEGORIES

Wound Occurrences	Total	Urinary Occurrences	Total
A. Superficial Infection	6	A. Renal Insufficiency	2
B. Deep Wound Infection	0	B. Acute Renal Failure	0
C. Wound Disruption	0	C. Urinary Tract Infection	2
		D. Other	0
Respiratory Occurrences	Total	CNS Occurrences	Total
A. Pneumonia	7	A. CVA/Stroke	0
B. Unplanned Intubation	3	B. Coma >24 Hours	0
C. Pulmonary Embolism	0	C. Peripheral Nerve Injury	1
D. On Ventilator >48 Hours	4	D. Other	0
E. Other	0		
Cardiac Occurrences	Total	Other Occurrences	Total
A. Cardiac Arrest Req. CPR	1	A. Ileus/Bowel Obstruction	0
B. Myocardial Infarction	0	B. Bleeding/Transfusions	0
C. Endocarditis	0	C. Graft/Prosthesis/Flap	
D. Low Cardiac Output >6 Hrs.	0	Failure	1
E. Mediastinitis	0	D. DVT/Thrombophlebitis	0
F. Repeat Card-Pul Bypass	0	E. Systemic Sepsis	1
G. Other	0	F. Reoperation for Bleeding	0
		G. Other	2

Clean Wound Infection Rate: 2.1

Hospital: MAYBERRY, NC  
Station Number: 999  
For Dates: JUN 01, 2004 to: JUN 30, 2004

=====

ENSURING CORRECT SURGERY - COMPLIANCE SUMMARY

-----

	CASES	% OF TOTAL
	-----	-----
TOTAL CASES PERFORMED:	315	100.0
TIME OUT VERIFIED		
YES:	308	97.8
NO:	5	1.6
NOT ENTERED:	2	0.6
PREOPERATIVE IMAGING CONFIRMED		
YES:	219	69.5
IMAGING NOT REQUIRED:	88	27.9
NO:	5	1.6
NOT ENTERED:	3	1.0
MARK ON SURGICAL SITE CONFIRMED		
YES:	219	69.5
MARKING NOT REQUIRED:	6	1.7
NO:	2	0.6
NOT ENTERED:	1	.4
OVERALL COMPLIANCE FOR THIS DATE RANGE		
-----		
TIME OUT VERIFIED:	97.8%	
PREOPERATIVE IMAGING CONFIRMED:	97.4%	
MARK ON SURGICAL SITE CONFIRMED:	97.4%	

## Example 2: Quarterly Report for Surgical Service

Select Management Reports Option: **Q** Quarterly Report - Surgical Specialty

### QUARTERLY/SUMMARY REPORT FOR SURGICAL SERVICE

NOTE: Listed below are the CPT codes for the index procedures on these reports.

Procedure	CPT Code(s)
-----	-----
Inguinal Hernia	49505,49507,49520,49521,49525
Cholecystectomy	47600,47605,47610,56340,56341,56342
Coronary Artery Bypass	33510,33511,33512,33513,33514,33516,33517,33518, 33519,33521,33522,33523,33533,33534,33535,33536
Colon Resection (L & R)	44140,44141,44143,44144,44145,44146,44147,44160
Fem-Pop Bypass	35656,35556
Pulmonary Lobectomy	32480,32500,32440
Hip Replacement	
- Elective	27125,27130,27132,27134,27137,27138
- Acute Fracture	27236
TURP	52601
Laryngectomy	31360,31365,31367,31368
Craniotomy	61304,61305,61312,61314,61510,61512,61518,61519, 61700,61680
Intraocular Lens	66983,66984

Press RETURN to continue or '^' to quit: **<Enter>**

Run which report ?

1. Summary Report for Selected Date Range
2. Quarterly Report for Central Office

Select Report Number: 1// **2**

### QUARTERLY REPORT FOR SURGICAL SERVICE

Run report for which quarter of the fiscal year ?

- (1) October 1 - December 31
- (2) January 1 - March 31
- (3) April 1 - June 30
- (4) July 1 - September 30

Select Quarter: **3**

Select FISCAL YEAR: 2004// **<Enter>**

Do you want this report to be transmitted to the Surgical Service  
central database ? NO// **<Enter>**

Print report on which Device: **[Select Print Device]**

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

Hospital: MAYBERRY, NC Station Number: 999  
For Dates: APR 01, 2004 to: JUN 30, 2004 Fiscal Year: 2004

	Total Cases	% of Total
Surgical Cases	1315	100.0
Major Procedures	973	74.0
ASA Class (1)	34	3.5
ASA Class (2)	305	31.3
ASA Class (3)	579	59.5
ASA Class (4)	54	5.5
ASA Class (5)	0	0.0
ASA Class (6)	0	0.0
ASA Class (Not Entered)	1	0.1
Postoperative Deaths	10	0.8
Ambulatory: 3		
Postoperative Occurrences	17	1.3
Ambulatory Procedures	794	60.4
Admitted Within 14 Days: 2		
Invasive Diagnostic: 146		
Inpatient Procedures	521	39.6
Emergency Procedures	45	3.4
Age>60 Years	729	55.4

SPECIALTY PROCEDURES

	PATIENTS	CASES	MAJOR	MINOR	---DEATHS---	
					TOTAL	%
50 GENERAL	140	147	147	0	4	2.7
51 GYNECOLOGY	9	9	9	0	0	0.0
52 NEUROSURGERY	53	56	56	0	1	1.8
53 OPHTHALMOLOGY	186	208	204	4	0	0.0
54 ORTHOPEDICS	156	162	159	3	1	0.6
55 OTORHINOLARYNGOLOGY	90	95	93	2	0	0.0
56 PLASTIC SURGERY	40	44	44	0	0	0.0
57 PROCTOLOGY	0	0	0	0	0	0.0
58 THORACIC SURGERY	19	22	22	0	0	0.0
59 UROLOGY	279	321	102	219	3	0.9
60 ORAL SURGERY	14	14	14	0	0	0.0
61 PODIATRY	36	42	42	0	0	0.0
62 PERIPHERAL VASCULAR	39	41	41	0	1	2.4
500 CARDIAC SURGERY	40	40	40	0	0	0.0
501 TRANSPLANTATION	0	0	0	0	0	0.0
502 ANESTHESIOLOGY	99	114	0	114	0	0.0

LEVEL OF RESIDENT SUPERVISION (%)

	MAJOR	MINOR
Level A	0.2	53.5
Level B	95.4	36.3
Level C	2.1	0.0
Level D	2.4	0.3
Level Not Entered	0.0	9.9

Hospital: MAYBERRY, NC Station Number: 999  
For Dates: APR 01, 2004 to: JUN 30, 2004 Fiscal Year: 2004

INDEX PROCEDURES

	CASES	DEATHS	CASES WITH OCCURRENCES
Inguinal Hernia	31	0	1
Cholecystectomy	6	0	0
Coronary Artery Bypass	34	0	2
Colon Resection (L & R)	8	1	2
Fem-Pop Bypass	4	0	0
Pulmonary Lobectomy	3	0	0
Hip Replacement			
- Elective	14	0	0
- Acute Fracture	2	0	1
TURP	21	0	0
Laryngectomy	0	0	0
Craniotomy	4	0	0
Intraocular Lens	135	0	0

PERIOPERATIVE OCCURRENCE CATEGORIES

Wound Occurrences	Total	Urinary Occurrences	Total
A. Superficial Infection	9	A. Renal Insufficiency	0
B. Deep Wound Infection	1	B. Acute Renal Failure	0
C. Wound Disruption	1	C. Urinary Tract Infection	2
		D. Other	0
Respiratory Occurrences	Total	CNS Occurrences	Total
A. Pneumonia	4	A. CVA/Stroke	0
B. Unplanned Intubation	2	B. Coma >24 Hours	0
C. Pulmonary Embolism	0	C. Peripheral Nerve Injury	0
D. On Ventilator >48 Hours	3	D. Other	0
E. Other	0		
Cardiac Occurrences	Total	Other Occurrences	Total
A. Cardiac Arrest Req. CPR	0	A. Ileus/Bowel Obstruction	0
B. Myocardial Infarction	0	B. Bleeding/Transfusions	1
C. Endocarditis	0	C. Graft/Prosthesis/Flap Failure	0
D. Low Cardiac Output >6 Hrs.	0	D. DVT/Thrombophlebitis	1
E. Mediastinitis	0	E. Systemic Sepsis	0
F. Repeat Card-Pul Bypass	0	F. Reoperation for Bleeding	0
G. Other	1	G. Other	2
Clean Wound Infection Rate:	1.0%		



## **Deaths Within 30 Days of Surgery [SROQD]**

The *Deaths Within 30 Days of Surgery* option lists patients who had surgery within the selected date range, died within 30 days of surgery and whose deaths are included on the Quarterly/Summary Report. Three separate reports are available through this option. These reports correspond to the three sections of the Quarterly Report that include death totals.

**1. Total Cases Summary:** This report may be printed in one of three ways.

A. All Cases

The report will list all patients who had surgery within the selected date range and who died within 30 days of surgery, along with all of the patients' operations that were performed during the selected date range. These patients are included in the postoperative deaths totals on the Quarterly Report.

B. Outpatient Cases Only

The report will list only the surgical cases that are associated with deaths that are counted as outpatient (ambulatory) deaths on the Quarterly Report.

C. Inpatient Cases Only

The report will list only the surgical cases that are associated with deaths that are counted as inpatient deaths. Although the count of deaths associated with inpatient cases is not a part of the Quarterly Report, this report is provided to help with data validation.

**2. Specialty Procedures:** This report will list the surgical cases that are associated with deaths that are counted for the national surgical specialty linked to the local surgical specialty. Cases are listed by national surgical specialty.

**3. Index Procedures:** This report will list the surgical cases that are associated with deaths that are counted in the Index Procedures section of the Quarterly Report.

These reports have a 132-column format and are designed to be copied to a printer.

### Example 1: Deaths Within 30 Days of Surgery - Total Cases Summary

Select Quarterly Report Menu Option: **D** Deaths Within 30 Days of Surgery

#### Deaths Within 30 Days of Surgery

This report lists patients who had surgery within the selected date range, who died within 30 days of surgery and whose deaths are included on the Quarterly/Summary Report.

Start with Date: **4/1** (APR 01, 1999)

End with Date: **4/30** (APR 30, 1999)

Print report for which section of Quarterly/Summary Report ?

1. Total Cases Summary
2. Specialty Procedures
3. Index Procedures

Select number: 1// **1** Total Cases Summary

Print Deaths within 30 Days of Surgery for

- A - All cases
- O - Outpatient cases only
- I - Inpatient cases only

Select Letter (I, O or A): A// **All Cases**

This report is designed to use a 132 column format.

Print the report to which Printer ? **[Select Print Device]**

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

MAYBERRY, NC  
 DEATHS WITHIN 30 DAYS OF SURGERY  
 FOR SURGERY PERFORMED FROM: APR 1,1999 TO: APR 30,1999  
 Report Printed: MAY 18,1999@12:09

OP DATE	CASE #	IN/OUT	SURGICAL SPECIALTY	PROCEDURE(S)	DEATH RELATED
=====					
>>> MAINE,JOE (123-45-6789) - DIED 05/12/99 AGE: 70					
04/13/99	32571	INPAT	GENERAL(OR WHEN NOT DEFINED BELOW)	EXPLORATORY LAPAROTOMY (CPT Code: 49000) RIGHT HEMICOLECTOMY (CPT Code: 44140) ILEOSTOMY (CPT Code: 44144) MUCOUS FISTULA OF COLON (CPT Code: 44144)	UNRELATED
04/24/99	32693	INPAT	GENERAL(OR WHEN NOT DEFINED BELOW)	CLOSURE OF ABDOMINAL WALL FASCIA (CPT Code: 13160)	UNRELATED
-----					
>>> FLORIDA,FRANK (123-45-6789) - DIED 05/12/99 AGE: 68					
04/26/99	32702	INPAT	THORACIC SURGERY (INC. CARDIAC SURG	RIGHT THORACOTOMY WITH LUNG BIOPSY (CPT Code: 32095) DIAPHRAGM BIOPSY (CPT Code: 39599)	UNRELATED
-----					
>>> MINNESOTA, SUSAN (123-45-6789) - DIED 04/30/99 AGE: 63					
04/21/99	32567	INPAT	THORACIC SURGERY (INC. CARDIAC SURG	ESOPHAGECTOMY (CPT Code: 43112-62) ESOPHAGOSCOPY (CPT Code: 43200) BRONCHOSCOPY (CPT Code: 31622) FEEDING TUBE JEJUNOSTOMY (CPT Code: B4084)	RELATED
-----					
TOTAL DEATHS: 3					

## Example 2: Deaths Within 30 Days of Surgery - Specialty Procedures

Select Quarterly Report Menu Option: **D** Deaths Within 30 Days of Surgery

### Deaths Within 30 Days of Surgery

This report lists patients who had surgery within the selected date range, who died within 30 days of surgery and whose deaths are included on the Quarterly/Summary Report.

Start with Date: **4/1** (APR 01, 1999)

End with Date: **4/30** (APR 30, 1999)

Print report for which section of Quarterly/Summary Report ?

1. Total Cases Summary
2. Specialty Procedures
3. Index Procedures

Select number: 1// **2** Specialty Procedures

Do you want the report for all National Surgical Specialties ? YES// **<Enter>**

This report is designed to use a 132 column format.

Print the report to which Printer ? [**Select Print Device**]

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

MAYBERRY, NC  
 DEATHS WITHIN 30 DAYS OF SURGERY LISTED FOR SPECIALTY PROCEDURES  
 FOR SURGERY PERFORMED FROM: APR 1,1999 TO: APR 30,1999  
 Report Printed: MAY 18,1999@12:38

OP DATE	PATIENT NAME	DATE OF DEATH	LOCAL SPECIALTY	IN/OUT	DEATH RELATED
CASE #	PATIENT ID# (AGE)	PROCEDURE(S)			
=====					
>>> GENERAL(OR WHEN NOT DEFINED BELOW) <<<					
04/24/99	MAINE,JOE	05/12/99	GENERAL(OR WHEN NOT DEFINED BELOW)	INPAT	UNRELATED
32693	123-45-6789 (70)	CLOSURE OF ABDOMINAL WALL FASCIA (CPT Code: 13160)			
TOTAL DEATHS FOR GENERAL(OR WHEN NOT DEFINED BELOW): 1					
-----					
>>> THORACIC SURGERY (INC. CARDIAC SURG.) <<<					
04/26/99	FLORIDA,FRANK	05/12/99	THORACIC SURGERY (INC. CARDIAC SURG.)	INPAT	UNRELATED
32702	123-45-6789 (68)	RIGHT THORACOTOMY WITH LUNG BIOPSY (CPT Code: 32095) DIAPHRAGM BIOPSY (CPT Code: 39599)			
04/21/99	MINNESOTA,SUSAN	04/30/99	THORACIC SURGERY (INC. CARDIAC SURG.)	INPAT	RELATED
32567	123-45-6789 (63)	ESOPHAGECTOMY (CPT Code: 43112-62) ESOPHAGOSCOPY (CPT Code: 43200) BRONCHOSCOPY (CPT Code: 31622) FEEDING TUBE JEJUNOSTOMY (CPT Code: B4084)			
TOTAL DEATHS FOR THORACIC SURGERY (INC. CARDIAC SURG.): 2					
-----					
TOTAL FOR ALL SPECIALTIES: 3					

### Example 3: Deaths Within 30 Days of Surgery - Index Procedures

Select Quarterly Report Menu Option: **D** Deaths Within 30 Days of Surgery

#### Deaths Within 30 Days of Surgery

This report lists patients who had surgery within the selected date range, who died within 30 days of surgery and whose deaths are included on the Quarterly/Summary Report.

Start with Date: **1/1** (JAN 01, 1999)

End with Date: **3/31** (MAR 31, 1999)

Print report for which section of Quarterly/Summary Report ?

1. Total Cases Summary
2. Specialty Procedures
3. Index Procedures

Select number: 1// **3** Index Procedures

This report is designed to use a 132 column format.

Print the report to which Printer ? [**Select Print Device**]

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

MAYBERRY, NC  
 DEATHS WITHIN 30 DAYS OF SURGERY LISTED FOR INDEX PROCEDURES  
 FOR SURGERY PERFORMED FROM: JAN 1,1999 TO: MAR 31,1999  
 Report Printed: APR 28,1999@13:02

OP DATE	PATIENT NAME	DATE OF DEATH	LOCAL SPECIALTY	IN/OUT	DEATH RELATED
CASE #	PATIENT ID# (AGE)	PROCEDURE(S)			

>>> Cholecystectomy <<<

03/05/99	MINNESOTA,SUSAN	03/18/99	GENERAL(OR WHEN NOT DEFINED BELOW)	INPAT	RELATED
32147	123-45-6789 (52)	LAPAROSCOPIC CHOLECYSTECTOMY	(CPT Code: 56341)		

TOTAL DEATHS FOR Cholecystectomy: 1

>>> Colon Resection (L & R) <<<

01/12/99	FLORIDA,FRANK	01/18/99	GENERAL(OR WHEN NOT DEFINED BELOW)	INPAT	UNRELATED
31514	123-45-6789 (76)	RT. HEMICOLECTOMY	(CPT Code: 44140-59)		

TOTAL DEATHS FOR Colon Resection (L & R): 1

>>> Hip Replacement - Elective <<<

01/15/99	MINNESOTA,RONALD	01/19/99	ORTHOPEDECS	INPAT	RELATED
31576	123-45-6789 (93)	LT. HIP ARTHROPLASTY	(CPT Code: 27130)		

TOTAL DEATHS FOR Hip Replacement - Elective: 1

>>> Intraocular Lens <<<

02/23/99	TEXAS,ZACHARY	03/15/99	OPHTHALMOLOGY	OUTPAT	UNRELATED
32008	123-45-6789 (90)	CATARACT EXTRACTION WITH IOL OS	(CPT Code: 66983)		

TOTAL DEATHS FOR Intraocular Lens: 1

TOTAL FOR ALL INDEX PROCEDURES: 4

## Admissions Within 14 Days of Outpatient Surgery [SROQADM]

The *Admissions Within 14 Days of Outpatient Surgery* option provides a list of patients with completed outpatient surgical cases that resulted in at least one postoperative occurrence AND a hospital admission within 14 days of the surgery. These patients are included in the "Admitted Within 14 Days" total on the Quarterly Report.

This report has a 132-column format and is designed to be copied to a printer with wide paper.

### Example: Report of Admissions Within 14 Days of Outpatient Surgery

Select Quarterly Report Menu Option: **A** Admissions Within 14 Days of Outpatient Surgery

Outpatient Cases with Postop Occurrences  
and Admissions Within 14 Days

This report displays the completed outpatient surgical cases which resulted in at least one postoperative occurrence and a hospital admission within 14 days.

Start with Date: **9 1 99** (SEP 01, 1999)

End with Date: **12 31 99** (DEC 31, 1999)

Do you want the report for all Surgical Specialties ? YES// **<Enter>**

This report is designed to use a 132 column format.

Print the report to which Printer ? **[Select Print Device]**

-----printout follows-----

MAYBERRY, NC  
 OUTPATIENT CASES WITH POSTOP OCCURRENCES AND ADMISSIONS WITHIN 14 DAYS  
 From: SEP 1,1999 To: DEC 31,1999  
 Report Printed: FEB 12,2000@13:44

DATE OF OPERATION CASE # *OCCURRENCE - (DATE)	PATIENT NAME PATIENT ID (AGE)	SURGICAL SPECIALTY PROCEDURE(S) PERFORMED	ANESTHESIA TECHNIQUE	DATE OF ADMISSION
SEP 24,1999@12:30 30395 *OTHER OCCURRENCE - (10/03/99)	MAINE,JOE 123-45-6789 (72)	THORACIC SURGERY (INC. CARDIAC MEDIASTINOSCOPY WITH NODE BIOPSY	GENERAL (CPT Code: 39400)	OCT 3,1999@14:11
SEP 25,1999@14:30 30544 *OTHER OCCURRENCE - (09/28/99)	GEORGIA,PAUL 123-45-6789 (75)	GENERAL(OB WHEN NOT DEFINED BE LEFT INGUINAL HERNIORRAPHY	GENERAL (CPT Code: 49505) HYDROCELECTOMY (CPT Code: 55040)	SEP 28,1999@10:06
NOV 18,1999@09:45 31034 *SUPERFICIAL WOUND INFECTION - (11/28/99)	NEBRASKA,NICK 123-45-6789 (50)	PLASTIC SURGERY (INCLUDES HEAD GANGLION CYST LT. WRIST	GENERAL (CPT Code: 25111) INCLUSION OF CYST INDEX FINGER LT. (CPT Code: 26210) EXCISION OF LIPOMA OF LT. FOOT (CPT Code: 28043) APPLICATION SHORT ARM SPLINT (CPT Code: 29125)	NOV 28,1999@12:51
DEC 9,1999@13:35 31242 *SUPERFICIAL WOUND INFECTION - (12/29/99)	NEVADA,NORMAN 123-45-6789 (49)	ORTHOPEDICS ORIF RT ULNA (CPT Code: 25545) REPAIR RT. DISTALRADIOULNAR FX (CPT Code: 25676)	GENERAL	DEC 9,1999@17:55
DEC 31,1999@07:30 31277 *OTHER CNS OCCURRENCE - (01/05/00)	OREGON,SALLY 123-45-6789 (31)	OTORHINOLARYNGOLOGY (ENT) NASAL SINUS SURGERY WITH BIL SPENOETHMOID POLYPECTOMY (CPT Code: 31205) BILATERAL ANTROSTOMY (CPT Code: 31256) BILATERAL TURBINECTOMY (CPT Code: 30130)	GENERAL	DEC 31,1999@18:02

TOTAL CASES: 5

## List of Invasive Diagnostic Procedures [SROQIDP]

The *List of Invasive Diagnostic Procedures* option provides a report listing the completed surgical cases that were performed during the selected date range and have a principal CPT code on the invasive diagnostic procedures list defined by Surgical Service at VHA Headquarters.

This report has a 132-column format and is designed to be copied to a printer.

### Example: List of Invasive Diagnostic Procedures Report

Select Quarterly Report Menu Option: **I** List of Invasive Diagnostic Procedures

#### List of Invasive Diagnostic Procedures

This report displays the completed surgical cases that meet the selection criteria and that have a principal CPT code on the list below defined by Surgical Service at VHA Headquarters as invasive diagnostic procedures.

Procedure Group	CPT Code(s)
Urologic	52000,52005,52007,52010,52204
ENT	31231
Pulmonary (Respiratory)	31615,31622,31625,31628,31629,31656
Upper Gastrointestinal	43200,43202,43234,43235,43239,43259,43263
Small Bowel and Stomach	44360,44361,44376,44377,44380,44382,44385,44386, 44388,44389
Colon and Rectum	45330,45331,45355,45378,45380,46600,46606

Enter RETURN to continue or '^' to exit: **<Enter>**

Print List of Invasive Diagnostic Procedures for

A - All cases  
O - Outpatient cases only  
I - Inpatient cases only

Select Letter (I, O or A): O// Outpatient Cases Only

Start with Date: **5/7** (MAY 07, 1999)  
End with Date: **5/7** (MAY 07, 1999)

Do you want the report for all Surgical Specialties ? YES// **<Enter>**

This report is designed to use a 132 column format.

Print the List of Invasive Diagnostic Procedures to which Printer ?  
**[Select Print Device]**

-----printout follows-----

MAYBERRY, NC  
 LIST OF INVASIVE DIAGNOSTIC PROCEDURES  
 From: MAY 7,1999 To: MAY 7,1999  
 Report Printed: JUN 10,1999@14:16

PAGE 1

DATE OF OPERATION CASE #	PATIENT NAME PATIENT ID (AGE)	SURGICAL SPECIALTY PROCEDURE(S) PERFORMED	ANESTHESIA TECHNIQUE	IN/OUT-PATIENT
MAY 7,1999@08:20 34398	FLORIDA,FRANK. 123-45-6789 (84)	UROLOGY CYSTO (CPT Code: 52000)	LOCAL	OUTPATIENT
MAY 7,1999@09:25 34397	GEORGIA,PAUL 123-45-6789 (57)	GENERAL(OR WHEN NOT DEFINED FLEX SIG (CPT Code: 45330)	NOT ENTERED	OUTPATIENT
MAY 7,1999@09:30 34399	MAINE,JOE 123-45-6789 (79)	UROLOGY CYSTO (CPT Code: 52000)	LOCAL	OUTPATIENT
MAY 7,1999@11:45 34440	MICHIGAN,RYAN 123-45-6789 (52)	UROLOGY CYSTOSCOPY (CPT Code: 52000)	LOCAL	OUTPATIENT
MAY 7,1999@12:20 34441	ARIZONA,JOSEPH 123-45-6789 (61)	UROLOGY CYSTOSCOPY (CPT Code: 52007)	LOCAL	OUTPATIENT

TOTAL OUTPATIENT CASES: 5

## List of Operations Included on Quarterly Report [SROQ LIST OPS]

The *List of Operations Included on Quarterly Report* option generates a list of completed operations that are included in the totals displayed on the Quarterly Report. The report displays the data fields that are checked by the Quarterly Report.

This report has a 132-column format and is designed to be copied to a printer.

### Example: List of Operations Included on Quarterly Report

```
Select Quarterly Report Menu Option: L List of Operations Included on Quarterly Report
```

```
List of Operations Included on Quarterly Report
```

```
This option generates a list of completed operations that are included on the  
Quarterly Report and displays the data fields for each case that are checked  
by the Quarterly Report.
```

```
Start with Date: 12/31 (DEC 31, 1999)  
End with Date: 12/31 (DEC 31, 1999)
```

```
Do you want the report for all Surgical Specialties ? YES// <Enter>
```

```
This report is designed to use a 132 column format.
```

```
Print the report to which Printer ? [Select Print Device]
```

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

MAYBERRY, NC  
 List of Operations Included on Quarterly Report  
 From: DEC 31,1999 To: DEC 31,1999  
 Report Printed: FEB 13,2000@14:37

PAGE 1

DATE OF OPERATION CASE # (MAJ/MIN) OCCURENCE(S)	PATIENT NAME SURGICAL SPECIALTY	PATIENT ID (AGE) CASE SCHEDULE TYPE PROCEDURE(S)	ASA CLASS WOUND CLASS	RESIDENT SUPERVISION IN/OUT-PAT STATUS
DEC 31,1999@07:30 31277 (MAJOR) POSTOP - OTHER CNS OCCURENCE	ARIZONA,JOSEPH OTORHINOLARYNGOLOGY (ENT)	123-45-6789 (31) ELECTIVE NASAL SINUS SURGERY WITH BIL SPENOETHMOID POLYPECTOMY (CPT Code: 31205) BILATERAL ANTROSTOMY (CPT Code: 31256) BILATERAL TURBINECTOMY (CPT Code: 30130)	2-MILD DISTURB. CLEAN/CONTAMINATED	LEVEL 1 OUTPATIENT
DEC 31,1999@07:35 31408 (MAJOR)	NEVADA,NORMAN OTORHINOLARYNGOLOGY (ENT)	123-45-6789 (63) ELECTIVE SEPTOPLASTY, INTRANASAL ETHMOIDECTOMY (CPT Code: 30520)	2-MILD DISTURB. CLEAN/CONTAMINATED	LEVEL 1 OUTPATIENT
DEC 31,1999@08:00 31412 (MINOR)	NEBRASKA,JUAN GENERAL(OR WHEN NOT DEFINED BE	123-45-6789 (75) URGENT A-V FISTULA LT (CPT Code: 36825)	3-SEVERE DISTURB. CLEAN	LEVEL 1 OUTPATIENT
DEC 31,1999@09:50 31278 (MAJOR)	WASHINGTON,JAMES OTORHINOLARYNGOLOGY (ENT)	123-45-6789 (51) ELECTIVE INTRANASAL SINUS SURGERY WITH NASAL POLYPECTOMY (CPT Code: 31256)	2-MILD DISTURB. CLEAN/CONTAMINATED	LEVEL 1 OUTPATIENT
DEC 31,1999@10:15 31437 (MAJOR)	INDIANA,GARRY PERIPHERAL VASCULAR	123-45-6789 (51) URGENT LT BKA (CPT Code: 27880)	3-SEVERE DISTURB. INFECTED	LEVEL 1 INPATIENT
DEC 31,1999@11:55 31362 (MAJOR)	OHIO,RAYMOND OTORHINOLARYNGOLOGY (ENT)	123-45-6789 (66) ELECTIVE BLEPHAROPLASTY LEFT LOWER LID (CPT Code: 15820) ADDITIONAL LEFT UPPER LID (CPT Code: 15823) ADDITIONAL RIGHT UPPER LID (CPT Code: 15823) ADDITIONAL RIGHT LOWER LID (CPT Code: 15820)	3-SEVERE DISTURB. CLEAN	LEVEL 1 OUTPATIENT

TOTAL CASES: 6

## Report of Missing Quarterly Report Data [SROQ MISSING DATA]

The *Report of Missing Quarterly Report Data* option generates a list of surgical cases performed within the selected date range that are missing information used by the Quarterly Report. This report includes surgical cases with an entry in the TIME PAT IN OR field but does not include aborted cases.

This report has a 132-column format and is designed to be copied to a printer.

### Example: Report of Missing Quarterly Report Data

```
Select Quarterly Report Menu Option: M Report of Missing Quarterly Report Data
```

#### Report of Missing Quarterly Report Data

For surgical cases with an entry in the TIME PAT IN OR field and that are not aborted, this option generates a report of cases missing any of the following pieces of information used by the Quarterly Report:

- In/Out-Patient Status
- Major/Minor
- Case Schedule Type
- Attending Code
- Time Pat Out OR
- Wound Classification
- ASA Class
- CPT Code (Principal)
- CPT Code (Other)

```
Start with Date: 4 1 (APR 01, 1999)
End with Date: 4 30 (APR 30, 1999)
```

```
Do you want the report for all Surgical Specialties ? YES// <Enter>
```

This report is designed to use a 132 column format.

```
Print the report to which Printer ? [Select Print Device]
```

-----printout follows-----

MAYBERRY, NC  
 Report of Missing Data for Quarterly Report  
 From: APR 1,1999 To: APR 30,1999  
 Report Printed: MAY 11,1999@15:09

DATE OF OPERATION CASE #	PATIENT NAME PATIENT ID (AGE)	SURGICAL SPECIALTY PRINCIPAL PROCEDURE	MISSING ITEMS
APR 6,1999@07:40 32474	OHIO,RAYMOND 123-45-6789 (43)	OPHTHALMOLOGY PHACOEMULSIFICATION, LENS IMPLANT OD	D
APR 12,1999@12:00 32508	MISSISSIPPI,RANDALL 123-45-6789 (78)	OPHTHALMOLOGY PHACOEMULSIFICATION, LENS IMPLANT OS	D
APR 12,1999@13:50 32534	INDIANA,GARRY 123-45-6789 (77)	PLASTIC SURGERY (INCLUDES HEAD AND NECK) EXCISION OF RT. WRIST MASS	D
APR 12,1999@14:00 32544	NEBRASKA,JUAN 123-45-6789 (81)	OPHTHALMOLOGY PHACOEMULSIFICATION OD	D
APR 13,1999@09:20 32513	TEXAS,JESSE 123-45-6789 (79)	OPHTHALMOLOGY PHACOEMULSIFICATION, LENS IMPLANT OD	D
APR 15,1999@13:05 32351	ILLINOIS,ANNE 123-45-6789 (40)	GENERAL(OR WHEN NOT DEFINED BELOW) EXCISIONAL BIOPSY MASS RT. BREAST	D
APR 19,1999@13:00 32580	WISCONSIN,MICHAEL 123-45-6789 (52)	OPHTHALMOLOGY PHACOEMULSIFICATION LENS IMPLANT OD	D
APR 27,1999@13:15 32684	COLORADO,KELLY A. 123-45-6789 (69)	OPHTHALMOLOGY TRABECULECTOMY OD	F

TOTAL CASES MISSING DATA: 8

-----  
 MISSING ITEMS CODES: A-IN/OUT-PATIENT STATUS, B-MAJOR/MINOR, C-CASE SCHEDULE TYPE, D-ATTENDING CODE,  
 E-TIME PAT OUT OR, F-WOUND CLASSIFICATION, G-ASA CLASS, H-CPT CODE (PRINCIPAL), I-CPT CODE (OTHER)

## **Print Blood Product Verification Audit Log**

### **[SR BLOOD PRODUCT VERIFY AUDIT]**

The *Blood Product Verification Audit Log* option is used to print the KERNEL audit log for the *Blood Product Verification* option.

Prior to printing entries from the KERNEL audit log for the *Blood Product Verification* option (located on the *Operation Menu*), the audit function must be turned on either through the *System Manager Menu* option or by invoking the *Establish System Audit Parameters* option in KERNEL, as shown in the following example.

#### **Example: Establish System Audit Parameters**

```
Select Systems Manager Menu Option: System Security
```

```
Select System Security Option: Audit Features
```

```
Select Audit Features Option: Maintain System Audit Options
```

```
Select Maintain System Audit Options Option: Establish System Audit Parameters
```

```
Kernel Site Parameter edit

DOMAIN: [Enter your domain here.]

OPTION AUDIT: SPECIFIC OPTIONS AUDITED      FAILED ACCESS ATTEMPTS:
INITIATE AUDIT: [Enter date here.]          TERMINATE AUDIT: [Enter date here.]

Option to audit                               Namespace to audit
SR BLOOD PRODUCT VERIFICATION

User to audit                                 Device to audit

COMMAND:                                         Press <PF1>H for help   Insert
```

## Example: Print Blood Product Verification Audit Log

Select Management Reports Option: **BA** Print Blood Product Verification Audit Log

Enter a date range to print the Blood Verification Audit Log.

\* Previous selection: DATE/TIME from Feb 21,1999

START WITH DATE/TIME: FIRST// <Enter>

DEVICE: [**Select Print Device**]

-----printout follows-----

MENU OPTION AUDIT LOG      APR 2,1999              3:04 PM              PAGE 1

-----

\*\*\* OPTION: SR BLOOD PRODUCT VERIFICATION

USER: AUSTIN,KELLY

DATE/TIME (ENTRY): MAR 5,1999 09:24      (EXIT): MAR 5,1999 09:24

CPU: VAA                      DEVICE: \_LTA8720:              JOB: 541070010

\*\*\* OPTION: SR BLOOD PRODUCT VERIFICATION

USER: HOUSTON,SHAY

DATE/TIME (ENTRY): MAR 5,1999 09:24      (EXIT): MAR 5,1999 09:24

CPU: VAA                      DEVICE: \_LTA8720:              JOB: 541070010

\*\*\* OPTION: SR BLOOD PRODUCT VERIFICATION

USER: JACKSON,ROBERT

DATE/TIME (ENTRY): MAR 6,1999 13:06      (EXIT): MAR 6,1999 13:07

CPU: VAA                      DEVICE: \_LTA1411:              JOB: 541072157

\*\*\* OPTION: SR BLOOD PRODUCT VERIFICATION

USER: JACKSON,ROBERT

DATE/TIME (ENTRY): MAR 6,1999 13:10      (EXIT): MAR 6,1999 13:11

CPU: VAA                      DEVICE: \_LTA1411:              JOB: 541072157

\*\*\* OPTION: SR BLOOD PRODUCT VERIFICATION

USER: JACKSON,ROBERT

DATE/TIME (ENTRY): MAR 6,1999 13:20      (EXIT): MAR 6,1999 13:20

CPU: VAA                      DEVICE: \_LTA1411:              JOB: 541072157

## Ensuring Correct Surgery Compliance Report

### [SRO ECS COMPLIANCE]

This option generates a two-part report, consisting of a summary of the compliance rate and a list of surgical cases that are non-compliant in documenting the process for ensuring correct surgery. The report sorts by surgical specialty within a date range. Each surgical specialty will begin on a separate page.

After you enter the date range, the computer will ask you to select from 1) the Compliance Summary Only, 2) the List of Non-Compliant Cases, or 3) Both Parts. When you choose the option to generate Both Parts of the report, the List of Non-Compliant Cases displays first, followed by the Compliance Summary.

This report is in an 80-column format and can be viewed on the screen.

The following examples show a sample Compliance Summary and a sample List of Non-Compliant Cases.

#### Example 1: Compliance Summary Report

```
Select Management Reports Option: ECS Ensuring Correct Surgery Compliance Report
```

```
Ensuring Correct Surgery Compliance Report
```

```
This two-part report includes a summary of the rate of compliance and/or a list of surgical cases that are non-compliant in documenting the process for ensuring correct surgery for operations performed by the selected surgical specialties during the selected date range.
```

```
Print which part of the report?
```

- 1. Compliance Summary Only
- 2. List of Non-Compliant Cases
- 3. Both Parts

```
Select Number (1, 2 or 3): 3// 1 Compliance Summary Only
```

```
Start with Date: 040102 (APR 01, 2002)
```

```
End with Date: 040103 (APR 01, 2003)
```

```
Print the report for all Surgical Specialties ? YES// <RET>
```

```
Do you want to print all divisions? YES// <RET>
```

```
Print the report on which Printer ? [Select Print Device]
```

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

```
=====
                CASES      % OF TOTAL
                -----
TOTAL CASES PERFORMED:    18      100.0

TIME OUT VERIFIED
    YES:      4      22.2
    NO:      4      22.2
    NOT ENTERED: 10      55.6

IMAGING CONFIRMED
    YES:      3      16.7
    NO:      3      16.7
    NOT APPLICABLE: 3      16.7
    NOT ENTERED: 9      50.0
=====
```

OVERALL COMPLIANCE FOR THIS DATE RANGE

```
=====
TIME OUT VERIFIED:  22.2%
IMAGING CONFIRMED:  33.3%
=====
```

Press RETURN to continue

### Example 2: List of Non-Compliant Cases

```
Select Management Reports Option: ECS Ensuring Correct Surgery Compliance Report

                Ensuring Correct Surgery Compliance Report

This two-part report includes a summary of the rate of compliance and/or a
list of surgical cases that are non-compliant in documenting the process
for ensuring correct surgery for operations performed by the selected
surgical specialties during the selected date range.

Print which part of the report?

1. Compliance Summary Only
2. List of Non-Compliant Cases
3. Both Parts
Select Number (1, 2 or 3): 3// 2 List of Non-Compliant Cases

Start with Date: 040102 (APR 01, 2002)
End with Date: 040103 (APR 01, 2003)

Print the report for all Surgical Specialties ? YES// <RET>

Do you want to print all divisions? YES// <RET>

Print the report on which Printer ? [Select Print Device]
```

-----printout follows-----

DATE OF OPERATION	PATIENT NAME	PATIENT ID (AGE)	CASE #	ATTENDING SURGEON	CIRCULATING NURSE	PRINCIPAL PROCEDURE	TIME OUT VERIFIED	IMAGING CONFIRMED
=====								
>>> SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) <<<								

APR 20,2002@07:30	ALASKA,FRED	123-45-6789	(36)	5	BOISE,WILLIAM	LANSING,EMILY	INGUINAL HERNIA REPAIR	YES	NO
-------------------	-------------	-------------	------	---	---------------	---------------	------------------------	-----	----

AUG 4,2002@10:00	MARYLAND,MARK	123-45-6789	(30)	18	MIAMI,STEPHEN	LANSING,EMILY	INGUINAL HERNIA	<NOT ENTERED>	NOT APPLICABLE
------------------	---------------	-------------	------	----	---------------	---------------	-----------------	---------------	----------------

NOV 22,2002@08:00	INDIANA,SUSAN	123-45-6789	(45)	34	MIAMI,STEPHEN	JACKSON,ROBERT	INGUINAL HERNIA REPAIR	<NOT ENTERED>	<NOT ENTERED>
-------------------	---------------	-------------	------	----	---------------	----------------	------------------------	---------------	---------------

DATE OF OPERATION	PATIENT NAME	PATIENT ID (AGE)	CASE #	ATTENDING SURGEON	CIRCULATING NURSE	PRINCIPAL PROCEDURE	TIME OUT VERIFIED	IMAGING CONFIRMED
=====								
>>> SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) (continued) <<<								

MAR 18,2003@09:00	OHIO,RAYMOND	123-45-6789	(61)	47	BOISE,WILLIAM	TAMPA,ANNETTE	CHOLECYSTECTOMY	<NOT ENTERED>	<NOT ENTERED>
-------------------	--------------	-------------	------	----	---------------	---------------	-----------------	---------------	---------------

MAR 18,2003@13:00	OHIO ,DEREK	123-45-6789	(27)	49	MIAMI,STEPHEN	JACKSON,ROBERT	CHOLECYSTECTOMY	<NOT ENTERED>	<NOT ENTERED>
-------------------	-------------	-------------	------	----	---------------	----------------	-----------------	---------------	---------------

DATE OF OPERATION	PATIENT NAME	PATIENT ID (AGE)	CASE #	ATTENDING SURGEON	CIRCULATING NURSE	PRINCIPAL PROCEDURE	TIME OUT VERIFIED	IMAGING CONFIRMED
=====								
>>> SPECIALTY: ORTHOPEDICS <<<								

MAY 19,2002	MISSOURI,ROY	123-45-6789	(27)	14	HARRISBURG,HENRY	PHOENIX,SALLY	HIP REPLACEMENT	<NOT ENTERED>	NO
-------------	--------------	-------------	------	----	------------------	---------------	-----------------	---------------	----

MAR 18,2003@07:00	IDAHO,PETER	123-45-6789	(43)	39	RALEIGH,RICHARD	TRENTON,PATRICIA	ARTHROPLASTY, ACETABULAR AND PROXIMAL FEMORAL PROSTHETIC REPLACEMENT (TOTAL HIP ARTHROPLASTY), WITH OR WITHOUT AUTOGRAFT OR ALLOGRAFT	<NOT ENTERED>	<NOT ENTERED>
-------------------	-------------	-------------	------	----	-----------------	------------------	---------------------------------------------------------------------------------------------------------------------------------------	---------------	---------------

## Unlock a Case for Editing [SRO-UNLOCK]

The Chief of Surgery, or a designee, uses the *Unlock a Case for Editing* option to unlock a case so that it can be edited. A case that has been completed will automatically lock within a specified time after the date of operation. When a case is locked, the data cannot be edited.

With this option, the selected case will be unlocked so that the user can use another option (such as in the *Operation Menu* option or *Anesthesia Menu* option) to make changes. The case will automatically re-lock in the evening. The package coordinator has the ability to set the automatic lock times.

Although the case may be unlocked to allow editing, any field that is included in an electronically signed report, for example in the Nurse Intraoperative Report, will require the creation of an addendum to the report before the edit can be completed.

### Example: Unlock a Case for Editing

```
Select Chief of Surgery Menu Option:  Unlock a Case for Editing
```

```
Select PATIENT NAME:  MONTANA,JOHNNY  08-15-91  123456789
```

1. 05-15-91 CAROTID ARTERY ENDARTERECTOMY
2. 05-15-91 AORTO CORONARY BYPASS GRAFT

```
Select Number:  1
```

```
Press <Enter> to continue.  <Enter>
```

```
Case #115 is now unlocked
```

```
Select Chief of Surgery Menu Option:
```

## 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 Chief of Surgery Menu Option: RET Update Status of Returns Within 30 Days
```

```
Select Patient: ILLINOIS,ANNE      10-28-45      123456789
```

```
ILLINOIS,ANNE  123-45-6789
```

1. 07-13-92 SPLENECTOMY (NOT COMPLETE)
2. 06-30-92 CHOLECYSTECTOMY (COMPLETED)
3. 03-10-92 HEMORRHOIDECTOMY (COMPLETED)

```
Select Operation: 2
```

```
ILLINOIS,ANNE (123-45-6789)      Case #213      RETURNS TO SURGERY  
JUN 30,1992  CHOLECYSTECTOMY (CPT MISSING)
```

- 
1. 07/13/92 SPLENECTOMY (CPT MISSING) - RELATED

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

```
Press RETURN to continue
```

## Update Cancelled Cases [SRO UPDATE CANCELLED CASE]



This option is locked with the SROCHIEF key and will not appear on the menu if the user does not have this key.

Normally, a cancelled case cannot be accessed for editing. However, the restricted *Update Cancelled Cases* option allows the Chief of Surgery to edit a cancelled case.

When the user enters this option, the software will allow access to the *Operations Menu* option.

### Example: Update a Cancelled Case

```
Select Chief of Surgery Menu Option: CAN Update Cancelled Case
```

```
Update Cancelled Case
```

```
Select Patient: KANSAS, THOMAS 08-16-51 123456789
```

```
KANSAS, THOMAS 123-45-6789
```

1. 09-16-99 CHOLECYSTECTOMY (CANCELLED)
2. 09-15-99 CHOLECYSTECTOMY (CANCELLED)

```
Select Operation: 2
```

```
KANSAS, THOMAS (123-45-6789) Case #15644 - SEP 15, 1992
```

```
I      Operation Information
SS     Surgical Staff
OS     Operation Startup
O      Operation
PO     Post Operation
PAC    Enter PAC(U) Information
OSS    Operation (Short Screen)
V      Surgeon's Verification of Diagnosis & Procedures
A      Anesthesia for an Operation Menu ...
OR     Operation Report
AR     Anesthesia Report
NR     Nurse Intraoperative Report
TR     Tissue Examination Report
R      Enter Referring Physician Information
RP     Enter Irrigations and Restraints
```

```
Select Update Cancelled Case Option:
```

## Update Operations as Unrelated/Related to Death [SRO DEATH RELATED]

The *Update Operations as Unrelated/Related to Death* option is used to update the status of operations performed within 90 days prior to death. The status is either UNRELATED or RELATED TO DEATH. With this option the user can add comments to further document the review of death.

### Example: Updating an Operation as Related to Death

```
Select Surgery Risk Assessment Menu Option: D Update Operations as Unrelated/Related to Death
```

```
Update Operations as Unrelated or Related to Death
```

```
Select Patient: ALASKA,FREDERICK 01-12-32 111221850 NO NON-VETERAN (OTHER)
```

```
Update Operations as Unrelated or Related to Death
```

```
ALASKA,FREDERICK 123-45-6789 * DIED 02/27/00 *
```

```
Operations in 90 Days Prior to Death:
```

1. 01/29/00 CABG, VEIN, SIX+ (33516) - UNRELATED  
>>> Died 29 days postop. <<<
2. 01/06/00 TOTAL LARYNGECTOMY (CPT MISSING) - UNRELATED  
>>> Died 52 days postop. <<<
3. 12/02/99 EVACUATION OF HEMATOMA LT.THIGH (27301) - UNRELATED  
>>> Died 87 days postop. <<<

```
Select Number of Operation to be Updated: (1-3): 1
```

```
Update Operations as Unrelated or Related to Death
```

```
ALASKA,FREDERICK 123-45-6789 * DIED 02/27/00 *
```

1. 01/29/00 CABG, VEIN, SIX+ (33516) - UNRELATED  
>>> Died 29 days postop. <<<

```
Was the Death Unrelated or Related to the Surgery?: UNRELATED
```

```
// R RELATED
```

```
Review of Death Comments:
```

```
No existing text
```

```
Edit? NO//<Enter>
```

```
Update Operations as Unrelated or Related to Death
```

```
ALASKA,FREDERICK 123-45-6789 * DIED 02/27/00 *
```

```
Operations in 90 Days Prior to Death:
```

1. 01/29/00 CABG, VEIN, SIX+ (33516) - RELATED  
>>> Died 29 days postop. <<<
2. 01/06/00 TOTAL LARYNGECTOMY (CPT MISSING) - UNRELATED  
>>> Died 52 days postop. <<<
3. 12/02/99 EVACUATION OF HEMATOMA LT.THIGH (27301) - UNRELATED  
>>> Died 87 days postop. <<<

```
Select Number of Operation to be Updated: (1-3): <Enter>
```

```
Update Operations as Unrelated or Related to Death
```

```
Select Patient:
```

## Update/Verify Procedure/Diagnosis Codes [SRCODING EDIT]

The *Update/Verify Procedure/Diagnosis Codes* option is used to edit and/or verify the CPT and ICD-9 codes for an operation or non-O.R. procedure.

Select Chief of Surgery Menu Option: **CODE** Update/Verify Procedure/Diagnosis Codes

Select Patient: **D8719** IDAHO,PETER 02-12-28 123456789  
YES SC VETERAN

IDAHO,PETER (123-45-6789)

Operation Date: FEB 18, 1999@08:45 Case #124

- 
1. Principal Procedure: TRACHEOSTOMY
  2. Principal CPT Code: NOT ENTERED
  3. Other Procedures: \*\* INFORMATION ENTERED \*\*
  4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
  5. Principal Diagnosis Code: NOT ENTERED
  6. Other Postop Diagnosis: \*\* INFORMATION ENTERED \*\*
- 

Select Information to Edit: ?

Enter the number corresponding to the information you want to update. You may enter 'ALL' to update all the information displayed on this screen, or a range of numbers separated by a ':' to update more than one item.

Select Information to Edit: 2

IDAHO,PETER (123-45-6789)

Operation Date: FEB 18, 1999@08:45 Case #124

-----

Principal Procedure Code (CPT): **31600** INCISION OF WINDPIPE  
TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);  
Modifier: **59** DISTINCT PROCEDURAL SERVICE  
Modifier: **<Enter>**

IDAHO,PETER (123-45-6789)

Operation Date: FEB 18, 1999@08:45 Case #124

- 
1. Principal Procedure: TRACHEOSTOMY
  2. Principal CPT Code: 31600 INCISION OF WINDPIPE  
TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);  
Modifiers: -59
  3. Other Procedures: \*\* INFORMATION ENTERED \*\*
  4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
  5. Principal Diagnosis Code: NOT ENTERED
  6. Other Postop Diagnosis: \*\* INFORMATION ENTERED \*\*
- 

Select Information to Edit: 3

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----  
Other Procedures:

1. BRONCHOSCOPY  
CPT Code: NOT ENTERED
2. Enter NEW Other Procedure

Enter selection: (1-2): 1

BRONCHOSCOPY  
CPT Code: NOT ENTERED

OTHER PROCEDURE: BRONCHOSCOPY// <Enter>  
OTHER PROCEDURE CPT CODE: 31622 DX BRONCHOSCOPE/WASH  
BRONCHOSCOPY; DIAGNOSTIC, (FLEXIBLE OR RIGID), WITH OR WITHOUT CELL  
WASHING  
Modifier: <Enter>

Press RETURN to continue <Enter>

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----  
Other Procedures:

1. BRONCHOSCOPY  
CPT Code: 31622 DX BRONCHOSCOPE/WASH
2. Enter NEW Other Procedure

Enter selection: (1-2): 2

Enter new OTHER PROCEDURE: ESOPHAGOSCOPY  
OTHER PROCEDURE CPT CODE: 43200 ESOPHAGUS ENDOSCOPY  
ESOPHAGOSCOPY, RIGID OR FLEXIBLE;  
DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR  
WASHING (SEPARATE PROCEDURE)

Modifier: <Enter>

Press RETURN to continue <Enter>

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----  
Other Procedures:

1. BRONCHOSCOPY  
CPT Code: 31622 DX BRONCHOSCOPE/WASH
2. ESOPHAGOSCOPY  
CPT Code: 43200 ESOPHAGUS ENDOSCOPY
3. Enter NEW Other Procedure

Enter selection: (1-3): <Enter>

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

- 
1. Principal Procedure: TRACHEOSTOMY
  2. Principal CPT Code: 31600 INCISION OF WINDPIPE  
TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);  
Modifiers: -59
  3. Other Procedures: \*\* INFORMATION ENTERED \*\*
  4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
  5. Principal Diagnosis Code: NOT ENTERED
  6. Other Postop Diagnosis: \*\* INFORMATION ENTERED \*\*
- 

Select Information to Edit: 5

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----

Principal Diagnosis Code (ICD9): 934.0 934.0 FOREIGN BODY IN TRACHEA  
...OK? Yes// <Enter>

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

- 
1. Principal Procedure: TRACHEOSTOMY
  2. Principal CPT Code: 31600 INCISION OF WINDPIPE  
TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);  
Modifiers: -59
  3. Other Procedures: \*\* INFORMATION ENTERED \*\*
  4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
  5. Principal Diagnosis Code: 934.0 FOREIGN BODY IN TRACHEA
  6. Other Postop Diagnosis: \*\* INFORMATION ENTERED \*\*
- 

Select Information to Edit: 6

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----

Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis

Enter selection: (1-1): 1

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----

Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis

Enter selection: (1-1): 1

Enter new OTHER POSTOP DIAGNOSIS: LARYNGEAL/TRACHEAL BURN  
ICD DIAGNOSIS CODE: 947.1 947.1 BURN LARYNX/TRACHEA/LUNG  
...OK? Yes// <Enter>

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

-----  
Other Postop Diagnosis:

1. LARYNGEAL/TRACHEAL BURN  
ICD9 Code: 947.1 BURN LARYNX/TRACHEA/LUNG
2. Enter NEW Other Postop Diagnosis

Enter selection: (1-2): <Enter>

IDAHO,PETER (123-45-6789)  
Operation Date: FEB 18, 1999@08:45 Case #124

- 
1. Principal Procedure: TRACHEOSTOMY
  2. Principal CPT Code: 31600 INCISION OF WINDPIPE  
TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);  
Modifiers: -59
  3. Other Procedures: \*\* INFORMATION ENTERED \*\*
  4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
  5. Principal Diagnosis Code: 934.0 FOREIGN BODY IN TRACHEA
  6. Other Postop Diagnosis: \*\* INFORMATION ENTERED \*\*
- 

Select Information to Edit:

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# Chapter Five: Managing the Software Package

---

## Introduction

This chapter describes options designed for the exclusive use of the Surgery package coordinator. The package coordinator can configure certain Surgery package fields to conform to a facility's needs.

## Exiting an Option or the System

The user should enter an up-arrow (^) to stop what he or she is doing. The up-arrow can be used at almost any prompt to terminate the line of questioning and return to the previous level in the routine. The user would continue entering up-arrows to completely exit the system.

## Option Overview

The main option included in this menu is listed below. To the left of the option name is the shortcut synonym that the user can enter to select the option. This is a restricted option and only users with the SRCOORD security key have access.

Shortcut	Option Name
M	<i>Surgery Package Management Menu</i>

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

# Surgery Package Management Menu

## [SRO PACKAGE MANAGEMENT]

The *Surgery Package Management Menu* provides access to options that are used to manage the Surgery software. Each option is discussed in the rest of this chapter.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
S	<i>Surgery Site Parameters (Enter/Edit)</i>
OR	<i>Operating Room Information (Enter/Edit)</i>
SU	<i>Surgery Utilization Menu ...</i>
KEY	<i>Person Field Restrictions Menu ...</i>
SD	<i>Update O.R. Schedule Devices</i>
U	<i>Update Staff Surgeon Information</i>
D	<i>Flag Drugs for Use as Anesthesia Agents</i>
F	<i>Update Site Configurable Files</i>
SI	<i>Surgery Interface Management Menu ...</i>
V	<i>Make Reports Viewable in CPRS</i>

## Surgery Site Parameters (Enter/Edit) [SROPARAM]

Surgical Service managers use this option to create or update local site parameters for the Surgery package.

A question mark or two can be entered to access the help text at any prompt.

### Example: Enter Surgery Site Parameters

```
Select Surgery Package Management Menu Option: S Surgery Site Parameters (Enter/Edit)
```

```
Edit Parameters for which Surgery Site: MAYBERRY, NC
```

```
MAYBERRY, NC (999) PAGE 1 OF 2
1 MAIL CODE FOR ANESTHESIA: 112G
2 CANCEL IVS: CANCEL
3 DEFAULT BLOOD COMPONENT: CPDA-1 RED BLOOD CELLS
4 CHIEF'S NAME: DR. JACK SPRINGFIELD
5 LOCK AFTER HOW MANY DAYS:
6 REQUEST DEADLINE: 15:00
7 SCHEDULE CLOSE TIME: 14:00
8 NURSE INTRAOP REPORT: PRINT TITLES WITH INFO ONLY
9 CARDIAC ASSESSMENT IN USE (Y/N): YES
10 ASK FOR RISK PREOP INFO: NO
11 UPDATES TO PCE: OUTPATIENT ONLY
12 PCE UPDATE ACTIVATION DATE: OCT 01, 1999
13 ASK CLASSIFICATION QUESTIONS: YES
14 SURGICAL RESIDENTS (Y/N): NO

Enter Screen Server Function: 5
Lock Completed Cases after How Many Days?: 14
```

```
MAYBERRY, NC (999) PAGE 1 OF 2
1 MAIL CODE FOR ANESTHESIA: 112G
2 CANCEL IVS: CANCEL
3 DEFAULT BLOOD COMPONENT: CPDA-1 RED BLOOD CELLS
4 CHIEF'S NAME: DR. JACK SPRINGFIELD
5 LOCK AFTER HOW MANY DAYS: 14
6 REQUEST DEADLINE: 15:00
7 SCHEDULE CLOSE TIME: 14:00
8 NURSE INTRAOP REPORT: PRINT TITLES WITH INFO ONLY
9 CARDIAC ASSESSMENT IN USE (Y/N): YES
10 ASK FOR RISK PREOP INFO: NO
11 UPDATES TO PCE: OUTPATIENT ONLY
12 PCE UPDATE ACTIVATION DATE: OCT 01, 1999
13 ASK CLASSIFICATION QUESTIONS: YES
14 SURGICAL RESIDENTS (Y/N): NO

Enter Screen Server Function: <Enter>
```

MAYBERRY, NC (999)

PAGE 2 OF 2

```
1  REQUIRED FIELDS FOR SCHEDULING: (MULTIPLE)(DATA)
2  REQUEST CUTOFF FOR SUNDAY: SATURDAY
3  REQUEST CUTOFF FOR MONDAY: FRIDAY
4  REQUEST CUTOFF FOR TUESDAY: MONDAY
5  REQUEST CUTOFF FOR WEDNESDAY: TUESDAY
6  REQUEST CUTOFF FOR THURSDAY: WEDNESDAY
7  REQUEST CUTOFF FOR FRIDAY: THURSDAY
8  REQUEST CUTOFF FOR SATURDAY: FRIDAY
9  HOLIDAY SCHEDULING ALLOWED: (MULTIPLE)(DATA)
10 INACTIVE?:
11 AUTOMATED CASE CART ORDERING: YES
12 ANESTHESIA REPORT IN USE: YES
13 DEFAULT CLINIC FOR DOCUMENTS:
```

Enter Screen Server Function: 1

MAYBERRY, NC (999)

PAGE 1 OF 1

REQUIRED FIELDS FOR SCHEDULING

```
1  NEW ENTRY
```

Enter Screen Server Function: 1

Select REQUIRED FIELDS FOR SCHEDULING: 27 PRINCIPAL PROCEDURE CODE

ARE YOU ADDING 'PRINCIPAL PROCEDURE CODE' AS

A NEW REQUIRED FIELDS FOR SCHEDULING (THE 1ST FOR THIS SURGERY SITE PARAMETERS)? Y (YES)

REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE

// <Enter>

MAYBERRY, NC (999)

PAGE 1 OF 1

REQUIRED FIELDS FOR SCHEDULING (PRINCIPAL PROCEDURE CODE)

```
1  REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
2  COMMENTS: (WORD PROCESSING)
```

Enter Screen Server Function: 2

Comments:

1>This field is required for the Quarterly Report.

2><Enter>

EDIT Option: <Enter>

MAYBERRY, NC (999)

PAGE 1 OF 1

REQUIRED FIELDS FOR SCHEDULING (PRINCIPAL PROCEDURE CODE)

```
1  REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
2  COMMENTS: (WORD PROCESSING)(DATA)
```

Enter Screen Server Function: <Enter>

MAYBERRY, NC (999)

PAGE 1 OF 1

REQUIRED FIELDS FOR SCHEDULING

```
1  REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
2  NEW ENTRY
```

Enter Screen Server Function: <Enter>

1 REQUIRED FIELDS FOR SCHEDULING: (MULTIPLE)(DATA)  
2 REQUEST CUTOFF FOR SUNDAY: SATURDAY  
3 REQUEST CUTOFF FOR MONDAY: FRIDAY  
4 REQUEST CUTOFF FOR TUESDAY: MONDAY  
5 REQUEST CUTOFF FOR WEDNESDAY: TUESDAY  
6 REQUEST CUTOFF FOR THURSDAY: WEDNESDAY  
7 REQUEST CUTOFF FOR FRIDAY: THURSDAY  
8 REQUEST CUTOFF FOR SATURDAY: FRIDAY  
9 HOLIDAY SCHEDULING ALLOWED: (MULTIPLE)(DATA)  
10 INACTIVE?:  
11 AUTOMATED CASE CART ORDERING: YES  
12 ANESTHESIA REPORT IN USE: YES  
13 DEFAULT CLINIC FOR DOCUMENTS:

Enter Screen Server Function:

## Operating Room Information (Enter/Edit) [SRO-ROOM]

The *Operating Room Information (Enter/Edit)* option is used to enter or edit information pertinent to a selected operating room, including start and end times, and cleaning time.

At the TYPE field, the user can enter two question marks (??) to get a list of operating room types from which to select. If an operating room is not in service, the user can enter "YES" at the INACTIVE field to make the operating room inactive and prevent its use by other people using the Surgery software.

### Example: Entering Operating Room Information

```
Select Surgery Package Management Menu Option: OR Operating Room Information (Enter/Edit)
```

```
Enter/Edit Information for which Operating Room ? OR1
```

```
OR1  ** Update O.R. **                                PAGE 1 OF 1
1  LOCATION:                1 WEST
2  PERSON RESP.:           JACKSON,ROBERT
3  TELEPHONE:              555-5555
4  TYPE:                   GENERAL PURPOSE OPERATING ROOM
5  CLEANING TIME:         15
6  REMARKS:
7  INACTIVE?:
```

```
Enter Screen Server Function: 2
```

```
Person Responsible for this Operating Room: JACKSON,ROBERT// LANSING,EMILY
```

```
OR1  ** Update O.R. **                                PAGE 1 OF 1
1  LOCATION:                1 WEST
2  PERSON RESP.:           LANSING,EMILY
3  TELEPHONE:              555-5555
4  TYPE:                   GENERAL PURPOSE OPERATING ROOM
5  CLEANING TIME:         15
6  REMARKS:
7  INACTIVE?:
```

```
Enter Screen Server Function:
```

## Surgery Utilization Menu [SR OR UTIL]

The *Surgery Utilization Menu* contains options designed to help determine operating room use. With this menu, Surgery Service managers can schedule the normal operating hours for an operating room, as well as the actual hours an operating room was in use. Operating rooms can also be inactivated. A report can be generated to see what percentage of available hours an operating room was in use and to see if an O.R. was used outside normal hours.

Shortcut	Option Name
E	<i>Operating Room Utilization (Enter/Edit)</i>
N	<i>Normal Daily Hours (Enter/Edit)</i>
R	<i>Operating Room Utilization Report</i>
H	<i>Report of Normal Operating Room Hours</i>
P	<i>Purge Utilization Information</i>

## Operating Room Utilization (Enter/Edit)

### [SR UTIL EDIT ROOM]

The *Operating Room Utilization (Enter/Edit)* option is used to update the actual start and end times for operating rooms on a selected date, one operating room at a time. This information is used when generating the operating room utilization reports.

The user first enters the date, then the name of the operating room. The software will default to the start and end times and allow the times to be edited. There is also a prompt for inactivating a room. If the user does not want to edit an entry, pressing the <Enter> key will display the next prompt.

When the user is finished entering or editing times for an operating room, he or she will be prompted for the name of the next operating room. If the user does not wish to edit times for any more operating rooms on this date, he or she should press the <Enter> key. The software will then prompt for a new date and the cycle begins again. When the user is finished editing times, he or she can press the <Enter> key or enter an up-arrow (^) to exit this option.

#### **Example: Enter and Edit Operating Room Times**

```
Select Surgery Utilization Menu Option: E Operating Room Utilization (Enter/Edit)
```

```
Update Start and End Times for Operating Rooms
```

```
Update Times for which Date ? T (NOV 03, 2003)
```

```
Operating Room Utilization on NOV 3, 2003
```

```
-----  
Update Start and End Times for which Operating Room ? OR1
```

```
Time this Operating Room Begins Functioning: 07:00
```

```
// <Enter>
```

```
Time this Operating Room Stops Functioning: 17:00
```

```
// 13:50 (NOV 03, 2003@13:50)
```

```
Has this Room been Inactivated on this Date ? (Y/N): N NO
```

```
Operating Room Utilization on NOV 3, 2003
```

```
-----  
Update Start and End Times for which Operating Room ? OR2
```

```
Time this Operating Room Begins Functioning: 07:00
```

```
// <Enter>
```

```
Time this Operating Room Stops Functioning: 17:00
```

```
// 13:30 (NOV 03, 2003@13:30)
```

```
Has this Room been Inactivated on this Date ? (Y/N): N NO
```

Operating Room Utilization on NOV 3, 2003

-----

Update Start and End Times for which Operating Room ? **OR3**

Time this Operating Room Begins Functioning: 07:00

// **<Enter>**

Time this Operating Room Stops Functioning: 17:00

// **<Enter>**

Has this Room been Inactivated on this Date ? (Y/N): **Y** YES

Operating Room Utilization on NOV 3, 2003

-----

Update Start and End Times for which Operating Room ? **<Enter>**

Update Start and End Times for Operating Rooms and Surgical Specialties

Update Times for which Date ?

## Normal Daily Hours (Enter/Edit)

### [SR NORMAL HOURS]

The *Normal Daily Hours (Enter/Edit)* option is used to schedule the normal start and end times of an operating room for each day of the week, one operating room at a time. The information is used to help determine operating room use on a weekly basis.

First, the user enters the name of the operating room. Beginning with Sunday, the software will provide an editing schedule for each day of the week and prompt for normal start and end times for each day. There is also a prompt for inactivating a room. When the schedules for the week have been completed, the user will be prompted for the name of the next operating room for which to enter times. When the user finishes editing times, he or she can press the <Enter> key or enter an up-arrow (^) to exit this option.

At the "Select information to edit:" prompt, the user can 1) enter the letter **A** to update all the information on the schedule, 2) enter a number to update information in the corresponding field, 3) enter a range of numbers separated by a colon (:), or 4) press the <Enter> key to move to the next day's schedule. To edit the schedule for a particular day, the user enters an up-arrow followed by a day of the week. For example, to edit Friday's schedule, ^**Friday** would be entered. This is demonstrated in the following example.



The start and end times must be in military time. Also, use a leading zero when the hour is a single digit (e.g., 7 AM is 07:00).

### Example: Enter Normal Start and End Times for an Operating Room

```
Select Surgery Utilization Menu Option: N Normal Daily Hours (Enter/Edit)
```

```
=====
Normal Daily Schedules for Operating Rooms
=====
```

```
Enter the name of the operating room: OR1
```

```
Editing the SUNDAY Schedule for the OR1 Operating Room
=====
```

```
1. Normal Start Time: 07:00
2. Normal End Time: 15:30
3. Inactive (Y/N):
```

```
=====
Select information to edit: <Enter>
```

```
Editing the MONDAY Schedule for the OR1 Operating Room
=====
1. Normal Start Time:
2. Normal End Time:
3. Inactive (Y/N):
=====

Select information to edit: 1:2

Normal Starting Time: 07:00
Normal Ending Time: 15:30
```

```
Editing the MONDAY Schedule for the OR1 Operating Room
=====
1. Normal Start Time: 07:00
2. Normal End Time: 15:30
3. Inactive (Y/N):
=====

Select information to edit: ^FRIDAY
```

```
Editing the FRIDAY Schedule for the OR1 Operating Room
=====
1. Normal Start Time:
2. Normal End Time:
3. Inactive (Y/N):
=====

Select information to edit: 1:2

Normal Starting Time: 07:00
Normal Ending Time: 15:30
```

```
Editing the FRIDAY Schedule for the OR1 Operating Room
=====
1. Normal Start Time: 07:00
2. Normal End Time: 15:30
3. Inactive (Y/N):
=====

Select information to edit: ^
```

```
=====
Normal Daily Schedules for Operating Rooms
=====

Enter the name of the operating room: ^
```

## Operating Room Utilization Report

### [SR OR UTL1]

The *Operating Room Utilization Report* option prints utilization information, within a selected date range, for all operating rooms or for a single operating room. The report displays the percent utilization, the number of cases, the total operation time and the time worked outside normal hours for each operating room individually and all operating rooms collectively.

### How the Percent Utilization is Derived

The percent utilization is derived by dividing the total operation time for all operations (including total time patients were in O.R., plus the cleanup time allowed for each case) by the total functioning time as defined in the SURGERY UTILIZATION file. The quotient is then multiplied by 100.

This report has a 132-column format and is designed to be copied to a printer.

### Example: Print the Operating Room Utilization Report

```
Select Management Reports Option: OR Operating Room Utilization Report
```

```
Operating Room Utilization Report
```

```
Print utilization information starting with which date ? 3/8 (MAR 08, 2003)
```

```
Print utilization information through which date ? 3/9 (MAR 09, 2003)
```

```
Do you want to print the Operating Room Utilization Report for all  
operating rooms ? YES// <Enter>
```

```
Print the Operating Room Utilization Report on which Device ? [Select Print Device]
```

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

MAYBERRY, NC  
 SURGICAL SERVICE  
 OPERATING ROOM UTILIZATION REPORT  
 FOR ALL OPERATING ROOMS FROM: MAR 8,2003 TO: MAR 9, 2003  
 DATE PRINTED: MAR 17,2003

OPERATING ROOM	PERCENT UTILIZATION	NUMBER OF CASES	TOTAL OPERATION TIME (INCLUDING OR MAINTENANCE)	TIME WORKED OUTSIDE NORMAL HRS
OR1	70%	3	17 hrs and 35 mins	6 hrs and 20 mins
OR2	39%	1	7 hrs and 25 mins	1 hr and 10 mins
OR3	133%	8	23 hrs and 42 mins	2 hrs and 30 mins
OR4	29%	3	4 hrs and 41 mins	-
OR5	84%	7	18 hrs and 50 mins	5 hrs and 25 mins
OR6	0	0	-	-
OR7	0	0	-	-
TOTAL UTILIZATION FOR ALL ROOMS	63%	22	72 hrs and 13 mins	15 hrs and 25 mins

## Report of Normal Operating Room Hours

### [SR OR HOURS]

The *Report of Normal Operating Room Hours* option provides the start time and the end time of the normal working hours for all operating rooms or for the selected operating room for each date within the specified date range. The total time of the normal working day is displayed for each operating room for each date.

### Example: Print Operating Room Normal Working Hours Report

```
Select Surgery Utilization Menu Option: H Report of Normal Operating Room Hours
```

```
Operating Room Normal Working Hours Report
```

```
Print normal working hours starting with which date ? 3/1 (MAR 01, 1999)
```

```
Print normal working hours through which date ? 3/12 (MAR 12, 1999)
```

```
Do you want to print the Operating Room Normal Working Hours Report for all  
operating rooms ? YES// <Enter>
```

```
Print the report on which Device: [Select Print Device]
```

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

OPERATING ROOM NORMAL WORKING HOURS  
FROM 03/01/99 TO 03/12/99

OPERATING ROOM	START TIME	END TIME	TOTAL TIME
-----			
** MAR 1, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3		** INACTIVE **	
OR4		** INACTIVE **	
OR5	07:00	17:00	10 hrs
** MAR 2, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4		** INACTIVE **	
OR5	07:00	17:00	10 hrs
** MAR 3, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
** MAR 4, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
** MAR 5, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
** MAR 6, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
** MAR 7, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins

OPERATING ROOM NORMAL WORKING HOURS  
FROM 03/01/99 TO 03/12/99

OPERATING ROOM	START TIME	END TIME	TOTAL TIME
-----			
** MAR 7, 1999 **			
OR3		** INACTIVE **	
OR4		** INACTIVE **	
OR5	07:00	17:00	10 hrs
** MAR 8, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3		** INACTIVE **	
OR4		** INACTIVE **	
OR5	07:00	17:00	10 hrs
** MAR 9, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4		** INACTIVE **	
OR5	07:00	17:00	10 hrs
** MAR 10, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
** MAR 11, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
** MAR 12, 1999 **			
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs

## **Purge Utilization Information**

### **[SR PURGE UTILIZATION]**

The *Purge Utilization Information* option is used to purge utilization information for a selected date range. After selecting a starting date, the user can purge all utilization information for dates prior to, and including, that specified starting date.

#### **Example: Purge Utilization Information**

```
Select Surgery Utilization Menu Option: P Purge Utilization Information
```

```
Purge Utilization Information
```

```
Starting with Date: 2/1 (FEB 28, 1999)
```

```
This option will purge all utilization information for the dates prior to (and including) FEB 28, 1999.
```

```
Are you sure that you want to purge for this date range ? NO// Y
```

```
The option to purge utilization data has been queued.
```

```
Press RETURN to continue
```

## Person Field Restrictions Menu [SROKEY MENU]

The *Person Field Restrictions Menu* contains options used by the package coordinator to maintain restrictions applied to person-type fields (meaning a field that points to the NEW PERSON field) in files.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym the user can enter to select the option. None of these options will display if the user does not have proper security clearance.

Shortcut	Option Name
E	<i>Enter Restrictions for 'Person' Fields</i>
R	<i>Remove Restrictions on 'Person' Fields</i>

## Enter Restrictions for 'Person' Fields

### [SROKEY ENTER]

The *Enter Restrictions for 'Person' Fields* option allows IRM personnel to assign a key to a specific person-type field (meaning any field that points to the NEW PERSON field) in a file or sub-file.

A key limits the acceptable responses to a field. The Surgery software can be tailored to limit acceptable responses in the field to only those people assigned one of the keys used to restrict the field. For example, a prompt asking for the name of the attending surgeon can be modified to accept only the names of surgeons. Additionally, a field can have more than one key assigned to it; thus, the ATTENDING SURGEON field can be modified to accept the names of surgeons and other surgical staff.

Example 1 below shows how to enter the surgeon key for the SURGEON field in the SURGERY file. Example 2 shows how to enter the surgeon, nurse, and anesthetist keys for a sub-field in the SURGERY file.

Keys can be removed using the *Remove Restrictions on 'Person' Fields* option.

The user can enter one or two question marks to access the on-line help if assistance is needed while interacting with the software. A question mark can also be entered at the "Select Additional Key:" prompt for a list of keys from which to select.

### Example 1: Enter Restrictions

```
Select Person Field Restrictions Menu Option: E Enter Restrictions for 'Person' Fields
```

```
Add 'PERSON' Field Restrictions:
```

```
Select File: SURGERY
```

- 1 SURGERY
- 2 SURGERY CANCELLATION REASON
- 3 SURGERY DISPOSITION
- 4 SURGERY EXTRACT
- 5 SURGERY INTERFACE PARAMETER

```
Press <RETURN> to see more, '^' to exit this list, OR
```

```
CHOOSE 1-5: 1 SURGERY
```

```
Select FIELD: SURGEON
```

- 1 SURGEON
- 2 SURGEON'S DICTATION (word-processing)

```
CHOOSE 1-2: 1 SURGEON
```

```
There are no keys restricting entries in this field.
```

```
Do you want to add a key ? YES// <Enter>
```

```
Select Additional Key: SR SURGEON
```

```
Select Additional Key: <Enter>
```

```
Entering Keys...
```

## Example 2: Enter Restrictions

Select Person Field Restrictions Menu Option: E Enter Restrictions for 'Person' Fields

Add 'PERSON' Field Restrictions:

Select File: **SURGERY**

- 1 SURGERY
- 2 SURGERY CANCELLATION REASON
- 3 SURGERY DISPOSITION
- 4 SURGERY EXTRACT
- 5 SURGERY INTERFACE PARAMETER

Press <RETURN> to see more, '^' to exit this list, OR

CHOOSE 1-5: **1** SURGERY

Select FIELD: **RESTR** & POSITION AIDS (multiple)

Select RESTR & POSITION AIDS SUB-FIELD: **APPLIED BY**

There are no keys restricting entries in this field.

Do you want to add a key ? YES// **<Enter>**

Select Additional Key: **SR NURSE**

Select Additional Key: **SR SURGEON**

Select Additional Key: **SR ANESTHETIST**

Select Additional Key: **<Enter>**

Entering Keys...

## Remove Restrictions on 'Person' Fields

### [SROKEY REMOVE]

The *Remove Restrictions on 'Person' Fields* option allows IRM personnel to remove a key to a specific person-type field in a specific file. A key limits the acceptable responses to a field; removing a key removes a restriction on the acceptable responses.

In the example below, the key that permits the name of an anesthetist is removed from the RESTRAINTS & POSITION AIDS field, leaving the nurse and surgeon keys intact. All of the keys can be removed at one time by entering **ALL** at the "Select Number or 'ALL':" prompt.

#### Example: Remove Restrictions

```
Select Person Field Restrictions Menu Option: R Remove Restrictions on 'Person' Fields
```

```
Remove 'PERSON' field restrictions:
```

```
Select File: SURGERY
```

- 1 SURGERY
- 2 SURGERY CANCELLATION REASON
- 3 SURGERY DISPOSITION
- 4 SURGERY EXTRACT
- 5 SURGERY INTERFACE PARAMETER

```
Press <RETURN> to see more, '^' to exit this list, OR
```

```
CHOOSE 1-5: 1 SURGERY
```

```
Select FIELD: RESTR & POSITION AIDS (multiple)
```

```
Select RESTR & POSITION AIDS SUB-FIELD: APPLIED BY
```

```
Current Restrictions for this Field:
```

- 1. SR NURSE
- 2. SR SURGEON
- 3. SR ANESTHETIST

```
Do you want to remove one of these keys ? YES//<Enter>
```

```
Select Number or "ALL": 3
```

```
Select Person Field Restrictions Option:
```

## Update O.R. Schedule Devices [SR UPDATE SCHEDULE DEVICE]

The *Update O.R. Schedule Devices* option is used to update the list of devices that will print the Schedule of Operations when printing to all pre-defined printers.

### Example: Add a New Schedule Device

```
Select Surgery Package Management Menu Option: SD Update O.R. Schedule Devices
```

```
Update O.R. Schedule Devices  
-----
```

```
Select OR SCHEDULE DEVICES: SPD PTR  
  ARE YOU ADDING 'SPD PTR ' AS A NEW OR SCHEDULE DEVICES (THE 1ST FOR THIS SURGERY  
SITE PARAMETERS)? Y (YES)  
Select OR SCHEDULE DEVICES:
```

## Update Staff Surgeon Information [SROSTAFF]

The *Update Staff Surgeon Information* option allows the designation of a user as a staff surgeon by assigning a security key called SR STAFF SURGEON. The Annual Report of Surgical Procedures will count cases performed by holders of this security key as having been performed by “staff.” All other cases will be counted as performed by “resident.”

### Example 1: Designate a Staff Surgeon

```
Select Surgery Package Management Menu Option: U Update Staff Surgeon Information
```

```
Update Information for which Surgeon: TOPEKA,MARK
```

```
Do you want to designate this person as a 'Staff Surgeon' ? YES// <Enter>
```

```
TOPEKA,MARK is now designated as a staff surgeon.
```

```
Press RETURN to continue
```

### Example 2: Remove Staff Surgeon Designation

```
Select Surgery Package Management Menu Option: U Update Staff Surgeon Information
```

```
Update Information for which Surgeon: TOPEKA,MARK
```

```
This person is already designated as a staff surgeon. Do you want to remove  
that designation ? NO// Y
```

```
Removing key designating TOPEKA,MARK as a staff surgeon...
```

```
Press RETURN to continue
```

## Flag Drugs for Use as Anesthesia Agents [SROCODE]

Surgery Service managers use the *Flag Drugs for Use as Anesthesia Agents* option to mark drugs for use as anesthesia agents. If the drug is not flagged, the user will not be able to select it as an entry for the ANESTHESIA AGENT data field.

To flag a drug, it must already be listed in the Pharmacy DRUG file. To add a drug to this file, the user should contact the facility's Pharmacy Package Coordinator.

### Example: Flag Drugs Used as Anesthesia Agents

```
Select Surgery Package Management Menu Option:  D  Flag Drugs for use as Anesthesia Agents
```

```
Enter the name of the drug you wish to flag:  HALOTHANE
```

```
Do you want to flag this drug for SURGERY (Y/N)?  YES
```

```
Enter the name of the drug you wish to flag:
```

## Update Site Configurable Files [SR UPDATE FILES]

The *Update Site Configurable Files* option is designed for the package coordinator to add, edit, or inactivate file entries for the site-configurable files.

The software provides a numbered list of site-configurable files. The user should enter the number corresponding to the file that he or she wishes to update. The software will default to any previously entered information on the entry and provide a chance to edit it. The last prompt asks whether the user wants to inactivate the entry; answering **Yes** or **1** will inactivate the entry.

### Example 1: Add a New Entry to a Site-Configurable File

```
Select Surgery Package Management Menu Option: F Update Site Configurable Files
```

```
=====
                          Update Site Configurable Surgery Files
=====
1. Surgery Transportation Devices
2. Prosthesis
3. Surgery Positions
4. Restraints and Positional Aids
5. Surgical Delay
6. Monitors
7. Irrigations
8. Surgery Replacement Fluids
9. Surgery Cancellation Reasons
10. Skin Prep Agents
11. Skin Integrity
12. Patient Mood
13. Patient Consciousness
14. Local Surgical Specialty
15. Electroground Positions
16. Surgery Dispositions
=====
Update Information for which File ? 2
```

```
Update Information in the Prosthesis file.
=====
Select PROSTHESIS NAME: HUMERAL
  ARE YOU ADDING 'HUMERAL' AS A NEW PROSTHESIS (THE 112TH)? Y (YES)
NAME: HUMERAL // HUMERAL COMPONENT
VENDOR: AMERICAN
MODEL: NEER II
STERILE CODE: MFG
LOT/SERIAL NO: F19705-1087
STERILE RESP: MANUFACTURER
SIZE: STEM 150 MM, HEAD 22 MM
QUANTITY: <Enter>
INACTIVE?: <Enter>

Select PROSTHESIS NAME:
```

## Example 2: Re-Activate an Entry

Select Surgery Package Management Menu Option: **F** Update Site Configurable Files

```
=====
                          Update Site Configurable Surgery Files
=====
1. Surgery Transportation Devices
2. Prosthesis
3. Surgery Positions
4. Restraints and Positional Aids
5. Surgical Delay
6. Monitors
7. Irrigations
8. Surgery Replacement Fluids
9. Surgery Cancellation Reasons
10. Skin Prep Agents
11. Skin Integrity
12. Patient Mood
13. Patient Consciousness
14. Local Surgical Specialty
15. Electroground Positions
16. Surgery Dispositions
=====

Update Information for which File ? 6
```

Update Information in the Monitors file.

```
=====

Select MONITORS NAME: ECG                ** INACTIVE **
NAME: ECG// <Enter>
INACTIVE?: YES// @
      SURE YOU WANT TO DELETE? Y (YES)

Select MONITORS NAME:
```

## **Surgery Interface Management Menu** **[SRHL INTERFACE]**

The *Surgery Interface Management Menu* contains options that allow the user to set up certain interface parameters that control the processing of Health Level 7 (HL7) messages. The interface adheres to the HL7 protocol and forms the basis for the exchange of health care information between the **VISTA** Surgery package and any ancillary system.

Currently, there are four options on the *Surgery Interface Management Menu*.

<b>Shortcut</b>	<b>Option Name</b>
I	<i>Flag Interface Fields</i>
F	<i>File Download</i>
T	<i>Table Download</i>
P	<i>Update Interface Parameter Field</i>

## Flag Interface Fields

### [SRHL INTERFACE FLDS]

The *Flag Interface Fields* option allows the package coordinator to set the INTERFACE field in the SURGERY INTERFACE file. The categories listed on the first screen correspond to entries in SURGERY INTERFACE file. These categories are listed in the Surgery HL7 Interface Specifications document as being the OBR (Observation Request) text identifiers. Each identifier corresponds to several fields in the VISTA Surgery package. This allows the user to control the flow of data between the VISTA Surgery package and the ancillary system on a field-by-field basis.

The option lists each identifier and its current setting. To receive the data coming from the ancillary system for a category, the flag the flag should be set to **R** for receive. To ignore the data, the flag should be set to **N** for not receive. To see a second underlying layer of OBX (Observation/Result) text identifiers (the SURGERY file fields) and their settings, the OBR (Observation Request) text identifier should be set to **R** for receive. The option will allow the user to toggle the settings for a range of items or for individual items.

#### Example: Flagging Operation Information to be Received

```
Select Surgery Interface Management Menu Option: I Flag Interface Fields
```

```

Surgery Interface Setup Menu

To change the setting in one of the following categories, enter the
corresponding number.
(R - Receive)
(S - Send)
(S/R - Send and Receive)
(I - Ignore)

1. OPERATION (S/R)
2. TOURNIQUET (I)
3. MONITOR (I)
4. MEDICATION (R)
5. ANESTHESIA (R)
6. PROCEDURE (I)
7. PROCEDURE OCCURRENCE (I)
8. INTRAOPERATIVE OCCURRENCE (I)
9. POSTOPERATIVE OCCURRENCE (I)
10. NONOPERATIVE OCCURRENCE (I)

Enter a number: ?

The categories above refer to VistA Surgery data fields. Below are examples:
OPERATION -> File 130 fields.
TOURNIQUET -> TIME TOURNIQUET APPLIED (#.48) and File 130.02 fields.
MONITOR -> MONITORS (#.293) and File 130.41 fields.
MEDICATION -> MEDICATIONS (#.375) and File 130.33 fields.
ANESTHESIA -> ANESTHESIA TECHNIQUE (#.37) and File 130.06 fields.
Enter the corresponding number of the category you wish to edit. To edit
underlying fields, set the category to R for receive or S to send.

Enter a number: 1

Do you wish to change the current setting of OPERATION: IGNORE// RECEIVE

OPERATION DATA

Toggle the current setting to (R)eceive, (S)end, or (I)gnore.
```

1. TIME OPERATION BEGAN (S)	17. OR SETUP TIME (I)
2. TIME OPERATION ENDS (S)	18. ANESTHESIA TEMP (I)
3. NURSE PRESENT TIME (I)	19. HR (I)
4. TIME PATIENT IN HOLDING AREA (I)	20. RR (I)
5. ANESTHESIA AVAILABLE TIME (I)	21. BP (I)
6. TIME PATIENT IN OR (S)	22. ASA CLASS (I)
7. SURGEON PRESENT TIME (I)	23. CASE SCHEDULE TYPE (I)
8. ANESTHESIA CARE START TIME (I)	24. ATTENDING CODE (I)
9. ANESTHESIA CARE END TIME (I)	25. REPLACEMENT FLUID (R)
10. TIME PATIENT OUT OR (I)	26. INDUCTION COMPLETE (I)
11. PRIN. ANES. (I)	27. ANES. SUPERVISE CODE (I)
12. RELIEF ANESTHETIST (I)	28. SURGEON PGY (I)
13. ASSISTANT ANESTHETIST (I)	29. OR LOCATION (I)
14. ANES. SUPER. (I)	30. PAC(U) ADMIT TIME (I)
15. BLOOD LOSS (I)	31. PAC(U) DISCHARGE TIME (I)
16. TOTAL URINE OUTPUT (I)	

Enter a number: ?

The items above refer to VistA Surgery package fields. Below are examples:

```
HR -> End Pulse (#.84)
BP -> End BP      (#.85)
RR -> End Resp   (#.86)
```

To toggle the current setting of an item, enter its corresponding number.

## **File Download**

### **[SRHL DOWNLOAD INTERFACE FILES]**

The *File Download* option is used to download Surgery interface files to the Automated Anesthesia Information System (AAIS). The process is currently being done by a screen capture to a file. In the future, this will be changed to a background task that can be queued to send HL7 master file updates.

#### **Example: Downloading Interface Files**

Select Surgery Interface Management Menu Option: **F** File Download

```
Surgery Interface File Download Option

1. CPT4
2. ICD9
3. MEDICATION
4. MONITOR
5. PERSONNEL
6. REPLACEMENT FLUID
7. ANES SUPERVISE CODE
8. LOCATION

Enter file to Capture: (1-8): 4
Update the MONITOR file? YES// <Enter>
Queuing message
```

## Table Download

### [SRHL DOWNLOAD SET OF CODES]

The *Table Download* option downloads the SURGERY file set of codes to the AAIS. This process is currently being done by a screen capture to a file. In the future, this will be changed to a background task that can be queued to send HL7 master file updates.

#### Example: Downloading Surgery Set of Codes

```
Select Surgery Interface Management Menu Option: T Table Download
```

```

Surgery Interface Table Setup Menu

This option allows the users to populate table files on the Automated
Anesthesia Information System.

1. ASA CLASS                      11. TUBE TYPE
2. CASE SCHEDULE TYPE             12. EXTUBATED IN
3. ATTENDING CODE                 13. BARICITY
4. SITE TOURNIQUET APPLIED        14. EPIDURAL METHOD
5. MEDICATION ROUTE               15. ADMINISTRATION METHOD
6. PRINCIPAL ANES TECHNIQUE (Y/N) 16. PROCEDURE OCCURRENCE OUTCOME
7. PATIENT STATUS                 17. INTRAOP OCCURRENCE OUTCOME
8. ANESTHESIA ROUTE               18. POSTOP OCCURRENCE OUTCOME
9. ANESTHESIA APPROACH            19. NONOP OCCURRENCE OUTCOME
10. LARYNGOSCOPE TYPE

Enter a list or range of numbers (1-19): 3
Update the ATTENDING CODE table? YES// <Enter>
MAD Sending HL7 Master File addition message.....
```

## Update Interface Parameter Field

### [SRHL DOWNLOAD SET OF CODES]

The *Update Interface Parameter Field* option may be used to edit the parameter that determines which Surgery HL7 interface will be used, the interface compatible with HL7 V. 1.6 or the older one compatible with HL7 V. 1.5.

If applications communicating with the Surgery HL7 interface must use the interface designed for use with HL7 V. 1.5, **YES** should be entered. Otherwise, **NO** should be entered or this field should be left blank.

### **Example: Updating Interface Parameter Field**

Select Surgery Interface Management Menu Option: **P** Update Interface Parameter Field

This option may be used to edit the parameter that determines which Surgery HL7 interface will be used, the interface compatible with HL7 v1.6 or the older one compatible with HL7 v1.5.

If applications communicating with the Surgery HL7 interface must use the interface designed for HL7 v1.5, enter YES. Otherwise, enter NO or or leave this field blank.

Use Surgery Interface Compatible with VistA HL7 v1.5 (Y/N): **NO**

## Make Reports Viewable in CPRS [SR VIEW HISTORICAL REPORTS]

This option allows Operation Reports, Nurse Intraoperative Reports, Anesthesia Reports, and Procedure Reports (Non-O.R.) for historical cases to be moved into TIU as “electronically unsigned” to make them viewable on the CPRS Surgery tab. This option lets the user move reports by division, if necessary.

```
Select Surgery Package Management Menu Option: V Make Reports Viewable in CPRS
```

```
Make Reports Viewable in CPRS
```

```
This option allows Operation Reports, Nurse Intraoperative Reports, Anesthesia Reports and Procedure Reports (Non-O.R.) for historical cases to be moved into TIU as "electronically unsigned" to make them viewable within the CPRS Surgery tab. Historical cases are cases performed before the Surgery Electronic Signature for Operative Reports feature was implemented.
```

```
These "electronically unsigned" reports will contain a disclaimer stating: "This information is provided from historical files and 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."
```

```
CAUTION!! This is a system intensive process that creates new documents in TIU. Please ensure adequate disk space availability before running this process.
```

```
Enter starting date for reports to be moved: T-180 (MAR 19, 2003)
```

```
Move reports for all divisions? YES// NO
```

1. ALBANY
2. PHILADELPHIA, PA
3. SAN JUAN, PR

```
Select Number: (1-3): 1
```

```
Do you want to move the Operation Reports (Y/N)? NO// YES
```

```
Do you want to move the Nurse Intraoperative Reports (Y/N)? NO// YES
```

```
Do you want to move the Anesthesia Reports (if used) (Y/N)? NO// YES
```

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

```
The following reports for cases performed MAR 19, 2003 to the present for ALBANY will be moved.
```

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

```
Is this correct (Y/N)? NO// YES
```

```
Requested Start Time: NOW// <Enter> (SEP 15, 2003@13:13:21)
```

```
Queued as task #158943
```

```
Press RETURN to continue.
```

# 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.

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# 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&amp;M Verification Report</i>
O	<i>Update I-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: 4. GASTROINTESTINAL:  
D. Current Smoker W/I 1 Year: A. Esophageal Varices:  
E. Pack/Years:  
F. ETOH > 2 Drinks/Day: 5. CARDIAC:  
G. Dyspnea: A. CHF Within 1 Month:  
H. DNR Status: B. MI Within 6 Months:  
I. Pre-illness Funct Status: C. Previous PTCA:  
J. Preop Funct Status: D. Previous Cardiac Surgery:  
E. Angina Within 1 Month:  
F. Hypertension Requiring Meds:  
2. PULMONARY:  
A. Ventilator Dependent:  
B. History of Severe COPD: 6. VASCULAR:  
C. Current Pneumonia: 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 25, 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 &amp; Angiographic Data</i> |
| OP       | <i>Operative Risk Summary Data (Enter/Edit)</i>              |
| CARD     | <i>Cardiac Procedures Operative Data (Enter/Edit)</i>        |
| OUT      | <i>Outcome Information (Enter/Edit)</i>                      |
| IO       | <i>Intraoperative Occurrences (Enter/Edit)</i>               |
| PO       | <i>Postoperative Occurrences (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 described 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            123456789            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
```



## 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

Case #60183  
CORONARY ARTERY BYPASS (33510)

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

Case #60183  
CORONARY ARTERY BYPASS (33510)

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 dialysis: 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 dialysis: 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	Trachestomy:	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.)*

# Update Assessment Completed/Transmitted in Error

## [SROA TRANSMITTED IN ERROR]

The *Update Assessment Completed/Transmitted in Error* option is used to change the status of a completed or transmitted assessment that contains errors or has been entered in error. The status will change from Completed or Transmitted to Incomplete so that the user can edit the assessment. Transmitted assessments will be re-transmitted if they are re-completed within 14 days of the original transmission date.

### Example: Update Assessment Completed/Transmitted in Error

```
Select Surgery Risk Assessment Menu Option: U Update Assessment Completed/Transmitted in Error
```

```
Select Patient: DELAWARE, DAVID      03-03-30      123456789      SC VETERAN
```

```
DELAWARE, DAVID 123-45-6789
```

1. 02-08-95 CORONARY ARTERY BYPASS (INCOMPLETE)
2. 01-25-95 PULMONARY LOBECTOMY (TRANSMITTED)

```
Select Surgical Case: 2
```

```
Are you sure that you want to change the status of this assessment  
from 'TRANSMITTED' to 'INCOMPLETE' ? YES// <Enter>
```

```
The Assessment Status has been changed to 'INCOMPLETE'.
```

```
Press <Enter> to continue
```

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

# List of Surgery Risk Assessments

## [SROA ASSESSMENT LIST]

The *List of Surgery Risk Assessments* option is used to print lists of assessments within a date range. Lists of assessments in different phases of completion (for example, incomplete, completed, transmitted) or a list of all surgical cases entered in the Surgery Risk Assessment software can be printed. The user can also request that the list be sorted by surgical service. The software will prompt for a beginning date and an ending date. Examples 1-7 illustrate printing assessments in each of the following formats.

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information

### Example 1: List of Incomplete Assessments

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments
```

```
List of Surgery Risk Assessments
```

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information

```
Select the Number of the Report Desired: 1
```

```
Start with Date: 10 1 96 (OCT 01, 1996)
```

```
End with Date: 9 30 97 (SEP 30, 1997)
```

```
Print by Surgical Specialty ? YES// <Enter>
```

```
Print report for ALL specialties ? YES// <Enter>
```

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

```
Print the List of Assessments to which Device: [Select Print Device]
```

-----printout follows-----

INCOMPLETE RISK ASSESSMENTS  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: OCT 1,1996 TO: SEP 30,1997

PAGE 1

DATE REVIEWED:  
REVIEWED BY:

ASSESSMENT #	PATIENT	PRINCIPAL OPERATIVE PROCEDURE	ANESTHESIA TECHNIQUE
--------------	---------	-------------------------------	----------------------

=====

\*\* SURGICAL SPECIALTY: CARDIAC SURGERY \*\*

28519 AUG 05, 1997	HAWAII, LOU 123-45-6789	* CABG X3 (2V,1A)	GENERAL
-----------------------	-------------------------	-------------------	---------

-----  
\*\* SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) \*\*

63063 OCT 03, 1996	ALASKA, FRED 123-45-6789	INGUINAL HERNIA	SPINAL
-----------------------	--------------------------	-----------------	--------

-----  
\*\* SURGICAL SPECIALTY: NEUROSURGERY \*\*

63154 AUG 08, 1997	LOUISIANA, DOUG 123-45-6789	CRANIOTOMY	NOT ENTERED
-----------------------	-----------------------------	------------	-------------

-----

## Example 2: List of Completed Assessments

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information

Select the Number of the Report Desired: **2**

Start with Date: **10 1 97** (OCT 01, 1997)

End with Date: **9 30 98** (SEP 30, 1998)

Print by Surgical Specialty ? YES// **<Enter>**

Print report for ALL specialties ? YES// **<Enter>**

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

Print the List of Assessments to which Device: **[Select Print Device]**

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

COMPLETED RISK ASSESSMENTS  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: OCT 1,1997 TO: SEP 30,1998

PAGE 1

DATE REVIEWED:  
REVIEWED BY:

ASSESSMENT #	PATIENT	DATE COMPLETED	ANESTHESIA TECHNIQUE
OPERATION DATE	PRINCIPAL OPERATIVE PROCEDURE		

=====

\*\* SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) \*\*

92	INDIANA,SUSAN 123-45-6789	OCT 19, 1998	GENERAL
JUN 23, 1998	CHOLEDOCHOTOMY		

63045	ARIZONA,ANTHONY 123-45-6789	NOV 29, 1997	GENERAL
OCT 01, 1997	INGUINAL HERNIA		

-----

\*\* SURGICAL SPECIALTY: OPHTHALMOLOGY \*\*

1898	MISSISSIPPI,RANDALL 123-45-6789	JAN 28, 1998	GENERAL
DEC 28, 1997	INTRAOCULAR LENS		

-----

### Example 3: List of Transmitted Assessments

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information

Select the Number of the Report Desired: **3**

Start with Date: **10 1 96** (OCT 01, 1996)

End with Date: **9 30 98** (SEP 30, 1998)

Print by Surgical Specialty ? YES//<Enter>

Print report for ALL specialties ? YES// **N**

Print the Report for which Surgical Specialty: **GENERAL**(OR WHEN NOT DEFINED BELOW) GENERAL(O  
WHEN NOT DEFINED BELOW) 50

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [**Select Print Device**]

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

TRANSMITTED RISK ASSESSMENTS  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: OCT 1,1996 TO: SEP 30,1998

PAGE 1

DATE REVIEWED:  
REVIEWED BY:

ASSESSMENT # OPERATION DATE	PATIENT PRINCIPAL OPERATIVE PROCEDURE	TRANSMISSION DATE	ANESTHESIA TECHNIQUE
--------------------------------	------------------------------------------	-------------------	----------------------

\*\*\*\*\*  
\*\* SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) \*\*

63076 OCT 08, 1996	KANSAS, THOMAS 123-45-6789 INGUINAL HERNIA	AUG 12, 1998	GENERAL
63077 OCT 08, 1996	IDAHO, WILLIAM 123-45-6789 INGUINAL HERNIA, OTHER PROC1	JAN 30, 1997	GENERAL
63103 MAR 27, 1997	GEORGIA, PAUL 123-45-6789 INGUINAL HERNIA	JUL 09, 1997	GENERAL
63171 JUL 17, 1998	TEXAS, LUKE 123-45-6789 CHOLECYSTECTOMY	SEP 05, 1998	GENERAL

#### Example 4: List of Non-Assessed Major Surgical Cases

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information

Select the Number of the Report Desired: **4**

Start with Date: **10 1 96** (OCT 01, 1996)

End with Date: **9 30 97** (SEP 30, 1997)

Print by Surgical Specialty ? YES// **<Enter>**

Print report for ALL specialties ? YES// **N**

Print the Report for which Surgical Specialty: **GENERAL**(OR WHEN NOT  
DEFINED BELOW) GENERAL(OOR WHEN NOT DEFINED BELOW) 50

This report is designed to print to your screen or a printer. When  
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: **[Select Print Device]**

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

NON-ASSESSED MAJOR SURGICAL CASES BY SURGICAL SPECIALTY  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: OCT 1,1996 TO: SEP 30,1997

PAGE 1

DATE REVIEWED:  
REVIEWED BY:

CASE #	PATIENT		ANESTHESIA TECHNIQUE
OPERATION DATE	OPERATIVE PROCEDURE(S)		PRINCIPAL CPT CODE
=====			
SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)			
63071	KENTUCKY,KENNETH 123-45-6789		GENERAL
OCT 08, 1996	INGUINAL HERNIA		49505
63136	LOUISIANA,DOUG 123-45-6789		GENERAL
AUG 07, 1997	CHOLECYSTECTOMY		47605
TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 2			
-----			

## Example 5: List of All Major Surgical Cases

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information

Select the Number of the Report Desired: **5**

Start with Date: **8/1/97** (AUG 01, 1997)

End with Date: **9/30/98** (SEP 30, 1998)

Print by Surgical Specialty ? YES// **<Enter>**

Print report for ALL specialties ? YES// **N**

Print the Report for which Surgical Specialty: **GENERAL**(OR WHEN NOT  
DEFINED BELOW) GENERAL(OOR WHEN NOT DEFINED BELOW) 50

This report is designed to print to your screen or a printer. When  
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: **[Select Print Device]**

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

ALL MAJOR SURGICAL CASES BY SURGICAL SPECIALTY  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: AUG 1,1997 TO: SEP 30,1998

PAGE 1

DATE REVIEWED:  
REVIEWED BY:

CASE #	PATIENT	ASSESSMENT STATUS	ANESTHESIA TECHNIQUE
OPERATION DATE	OPERATIVE PROCEDURE(S)	EXCLUSION CRITERIA	

=====

SURGICAL SPECIALTY: GENERAL (OR WHEN NOT DEFINED BELOW)

63110 JUN 23, 1998	INDIANA,SUSAN 123-45-6789 CHOLEDOCHOTOMY	COMPLETED SCNR WAS ON A/L	GENERAL
63131 JUL 21, 1998	TEXAS,LUKE 123-45-6789 PERINEAL WOUND EXPLORATION	NO ASSESSMENT	GENERAL
63136 AUG 07, 1997	LOUISIANA,DOUG 123-45-6789 CHOLECYSTECTOMY	NO ASSESSMENT	GENERAL

TOTAL GENERAL (OR WHEN NOT DEFINED BELOW): 3

-----

## Example 6: List of All Surgical Cases

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information

Select the Number of the Report Desired: **6**

Start with which Date: **10/1/97** (OCT 01, 1997)

End with which Date: **9/30/98** (SEP 30, 1998)

Print by Surgical Specialty ? YES// **<Enter>**

Print report for ALL specialties ? YES// **N**

Print the Report for which Surgical Specialty: **50** GENERAL(OR WHEN NOT DEFINED BELOW)  
GENERAL(OR WHEN NOT DEFINED BELOW) 50

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

Print the List of Assessments to which Device: **[Select Print Device]**

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

ALL SURGICAL CASES BY SURGICAL SPECIALTY  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: OCT 1,1997 TO: SEP 30,1998

PAGE 1

DATE REVIEWED:  
REVIEWED BY:

CASE #	PATIENT	ASSESSMENT STATUS	ANESTHESIA TECHNIQUE
OPERATION DATE	PRINCIPAL OPERATIVE PROCEDURE	EXCLUSION CRITERIA	
=====			
SURGICAL SPECIALTY: GENERAL (OR WHEN NOT DEFINED BELOW)			
63079 APR 02, 1998	NEBRASKA, NICHOLAS 123-45-6789 INGUINAL HERNIA	INCOMPLETE	GENERAL
63110 JUN 23, 1998	INDIANA, SUSAN 123-45-6789 CHOLEDOCHOTOMY	COMPLETED SCNR WAS ON A/L	GENERAL
63131 JUL 21, 1998	TEXAS, LUKE 123-45-6789 PERINEAL WOUND EXPLORATION	NO ASSESSMENT	GENERAL
63180 JUN 23, 1998	INDIANA, SUSAN 123-45-6789 CHOLECYSTECTOMY	NO ASSESSMENT	NOT ENTERED

TOTAL GENERAL (OR WHEN NOT DEFINED BELOW): 4

-----

### Example 7: List of Completed/Transmitted Assessments Missing Information

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information

Select the Number of the Report Desired: **7**

Start with Date: **10 1 97** (OCT 01, 1997)

End with Date: **10 13 98** (OCT 13, 1998)

Print by Surgical Specialty ? YES// **<Enter>**

Print report for ALL specialties ? YES// **<Enter>**

Print the List of Assessments to which Device: **[Select Print Device]**

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

MAYBERRY, NC

FROM: OCT 1,1997 TO: OCT 13,1998

DATE PRINTED: OCT 13,1998

\*\* GENERAL(OR WHEN NOT DEFINED BELOW)

ASSESSMENT #	PATIENT	TYPE	STATUS
OPERATION DATE	OPERATION(S)		
63172	TEXAS,LUKE 123-45-6789	NON-CARDIAC	TRANSMITTED
JUL 17, 1998	REPAIR ARTERIAL BLEEDING		
	Missing information:		
	1. Principal Procedure Code (CPT)		
	2. Anesthesia Technique		
63185	MINNESOTA,BENJAMIN 123-45-6789	NON-CARDIAC	TRANSMITTED
JUN 17, 1998	INGUINAL HERNIA, CHOLECYSTECTOMY		
	Missing information:		
	1. Principal Procedure Code (CPT)		
	2. Concurrent Case		
	3. History of COPD (Y/N)		
	4. Ventilator Dependent Greater than 48 Hrs (Y/N)		
	5. Weight Loss > 10% of Usual Body Weight (Y/N)		
	6. Transfusion Greater than 4 RBC Units this Admission (Y/N)		
63080	ALASKA,FREDERICK 123-45-6789	EXCLUDED	COMPLETE
JAN 03, 1998	TURP		
	Missing information:		
	1. Major or Minor		

TOTAL FOR GENERAL(OR WHEN NOT DEFINED BELOW): 3

TOTAL FOR ALL SPECIALTIES: 3

# Print 30 Day Follow-up Letters

## [SROA REPRINT LETTERS]

The Surgical Clinical Nurse Reviewer uses the *Print 30 Day Follow-up Letters* option to automatically print a letter, or a batch of letters, addressed to a specific patient or patients.

### **About the "Do you want to print the letter for a specific assessment?" Prompt**

The user responds **YES** to this prompt in order to print a follow-up letter for a single assessment. The software will ask the user to select the patient and case for which the letter will be printed. See Example 1 below.

The user responds **NO** to this prompt if he or she wants to print a batch of follow-up letters for surgical cases within a data range. The software will ask for the beginning and ending dates of the date range for which the letters will be printed. See Example 2 on the following pages.

### **Example 1: Print a Single Follow-up Letter**

```
Do you want to edit the text of the letter? NO// <Enter>
```

```
Select Surgery Risk Assessment Menu Option: F Print 30 Day Follow-up Letters
```

```
Do you want to print the letter for a specific assessment ? YES// <Enter>
```

```
Select Patient:      DELAWARE, DAVID      03-03-30      123456789      SC VETERAN
```

```
DELAWARE, DAVID 123-45-6789
```

```
1. 06-18-97 CORONARY ARTERY BYPASS (INCOMPLETE)
```

```
2. 01-25-97 PULMONARY LOBECTOMY (TRANSMITTED)
```

```
Select Surgical Case: 1
```

```
Print 30 Day Letters on which Device: [Select Print Device]
```

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

DELAWARE, DAVID  
87 ANY STREET  
MT. PILOT, NC 65216

JUL 18, 1997

Dear Mr. Delaware,

One month ago, you had an operation at the VA Medical Center. We are interested in how you feel. Have you had any health problems since your operation? We would like to hear from you. Please take a few minutes to answer these questions and return this letter in the self-addressed stamped envelope.

Have you been to a hospital or seen a doctor for any reason since your operation?  Yes  No

If you answered NO, you do not need to answer any more questions. Please return this sheet in the self-addressed stamped envelope.

If you have answered YES, please answer the following questions.

1) Have you been seen in an outpatient clinic or doctor's office?  
 Yes  No

Why did you go to the clinic or doctor's office? \_\_\_\_\_

Where? (name and location) \_\_\_\_\_ Date? \_\_\_\_\_

Who was your doctor? \_\_\_\_\_

2) Were you admitted to a hospital?  Yes  No

Why did you go to the hospital? \_\_\_\_\_

Where? (name and location) \_\_\_\_\_ Date? \_\_\_\_\_

Who was your doctor? \_\_\_\_\_

Please return this letter whether or not you have had any medical problems. Your health and opinion are important to us. Thank you.

Sincerely,

Surgical Clinical Nurse Reviewer

## Example 2: Print Letters Within a Date Range

Select Surgery Risk Assessment Menu Option: **P** Print 30 Day Follow-up Letters

Do you want to print the letter for a specific assessment ? YES// **N**

This option will allow you to reprint the 30 day follow up letters for the date that they were originally printed. When printed automatically, the letters print 25 days after the date of operation.

Print letters for BEGINNING date: TODAY// **6/1/99** (JUN 01, 1999)

Print letters for ENDING date: TODAY// **<Enter>** (JUN 02, 1999)

Print 30 Day Letters on which Device: **[Select Print Device]**

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

RANDALL MISSISSIPPI  
87 NORTH STREET  
PHILADELPHIA, PA 91776

JUN 02, 1999

Dear Mr. Mississippi,

One month ago, you had an operation at the VA Medical Center. We are interested in how you feel. Have you had any health problems since your operation? We would like to hear from you. Please take a few minutes to answer these questions and return this letter in the self-addressed stamped envelope.

Have you been to a hospital or seen a doctor for any reason since your operation?  Yes  No

If you answered NO, you do not need to answer any more questions. Please return this sheet in the self-addressed stamped envelope.

If you have answered YES, please answer the following questions.

1) Have you been seen in an outpatient clinic or doctor's office?  
 Yes  No

Why did you go to the clinic or doctor's office? \_\_\_\_\_

Where? (name and location) \_\_\_\_\_ Date? \_\_\_\_\_

Who was your doctor? \_\_\_\_\_

2) Were you admitted to a hospital?  Yes  No

Why did you go to the hospital? \_\_\_\_\_

Where? (name and location) \_\_\_\_\_ Date? \_\_\_\_\_

Who was your doctor? \_\_\_\_\_

Please return this letter whether or not you have had any medical problems. Your health and opinion are important to us. Thank You.

Sincerely,

Surgical Clinical Nurse Reviewer

# Exclusion Criteria (Enter/Edit)

## [SR NO ASSESSMENT REASON]

The *Exclusion Criteria (Enter/Edit)* option is used to flag major cases that will not have a surgery risk assessment due to certain exclusion criteria. At the prompt "Reason an Assessment was not Created:" enter a question mark (?) to see a list of reasons.

### Example: Enter Reason for No Assessment

```
Select Surgery Risk Assessment Menu Option: R Exclusion Criteria (Enter/Edit)
Select Patient: R9922  GEORGIA, PAUL          03-03-34    123456789    NO    SC
                VETERAN

GEORGIA, PAUL    123-45-6789

1. 11-01-98    TURP (COMPLETED)
2. 08-01-97    CABG X3 (1A,2V), ARTERIAL GRAFTING (COMPLETED)
3. 07-03-90    PULMONARY LOBECTOMY, TURP (COMPLETED)

Select Operation: 1

Reason an Assessment was not Created: 6  SCNR WAS ON ANNUAL LEAVE

GEORGIA, PAUL (123-45-6789)          Case #63159
Transmission Status: QUEUED TO TRANSMIT
NOV 1,1998    TURP (52601-59)
-----
1. Exclusion Criteria:          SCNR WAS ON A/L
2. Surgical Priority:          ELECTIVE
3. Surgical Specialty:          UROLOGY
4. Principal Operation (CPT):    52601-59
5. Principal Anesthesia Technique: GENERAL
6. Major or Minor:              MAJOR
-----

Select Excluded Case Information to Edit:
```

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

# Monthly Surgical Case Workload Report

## [SROA MONTHLY WORKLOAD REPORT]

The *Monthly Surgical Case Workload Report* option generates the Monthly Surgical Case Workload Report that may be printed and/or transmitted to the NSQIP national database.

### Example: Monthly Surgical Case Workload Report

```
Select Surgery Risk Assessment Menu Option: M Monthly Surgical Case Workload Report
```

#### Report of Monthly Case Workload Totals

This option provides a report of the monthly risk assessment surgical case workload totals which include the following categories:

1. All cases performed
2. Excluded cases
3. Assessed cases
4. Non-assessed cases
5. Cardiac cases
6. Non-cardiac cases
7. Assessed cases per day (based on 20 days/month)

The second part of this report provides the total number of incomplete assessments remaining for the month selected and the prior 12 months.

Compile workload totals for which month and year? SEP 1999// 8 99

Compile totals for AUG 1999? YES// <Enter>

This report may be printed and/or transmitted to the national database.

Do you want this report to be transmitted to the central database? NO// <Enter>

Print report on which Device: [Select Print Device]

-----printout follows-----

MAYBERRY, NC  
 REPORT OF MONTHLY SURGICAL CASE WORKLOAD  
 FOR AUG 1999

-----		
TOTAL CASES PERFORMED	=	249
TOTAL MAJOR CASES	=	227
TOTAL MINOR CASES	=	22
CASES MEETING EXCLUSION CRITERIA	=	114
ANESTHESIA TYPE	=	55
EXCEEDS MAX. ASSESSMENTS	=	0
EXCEEDS MAXIMUM TURPS	=	0
STUDY CRITERIA	=	59
SCNR WAS ON A/L	=	0
CONCURRENT CASE	=	0
EXCEEDS MAXIMUM HERNIAS	=	0
ASSESSED CASES	=	135
NOT LOGGED MAJOR CASES	=	0
CARDIAC CASES	=	16
NON-CARDIAC CASES	=	119
ASSESSED CASES PER DAY	=	6.75
-----		

NUMBER OF INCOMPLETE ASSESSMENTS REMAINING FOR PAST YEAR

	CARDIAC	NON-CARDIAC	TOTAL
	-----	-----	-----
AUG 1998	0	0	0
SEP 1998	0	0	0
OCT 1998	0	0	0
NOV 1998	0	0	0
DEC 1998	0	0	0
JAN 1999	0	0	0
FEB 1999	0	0	0
MAR 1999	0	0	0
APR 1999	0	0	0
MAY 1999	0	0	0
JUN 1999	0	0	0
JUL 1999	0	0	0
AUG 1999	15	82	97
	-----	-----	-----
	15	82	97

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.

# M&M Verification Report

## [SRO M&M VERIFICATION REPORT]

The *M&M Verification Report* option produces the M&M Verification Report, which may be useful for:

- reviewing occurrences and their assignments to operations
- reviewing deaths unrelated/related assignments to operations

Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range and experienced intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk-assessed operations that are in a completed state but have not yet been transmitted to the national database.

**Variety #1:** Report information is sorted alphabetically by patient name, listing all operations for the patient that occurred during the selected date range, plus any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that were performed prior to the selected date range and, if printed by specialty, may include operations performed by other specialties. For every operation that is listed, the intraoperative and postoperative occurrences are also listed. Also, the report includes information about whether the operation was unrelated or related to death and the risk assessment type and status (if assessed). The report may be printed for a selected list of surgical specialties.

**Variety #2:** Report information is sorted alphabetically by patient name in a format like the first variety. This report lists all risk-assessed operations that are in a completed state but have not yet been transmitted to the national database and that have intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The report includes any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some other operations that may or may not be risk assessed, and, if risk assessed, may have any risk assessment status (incomplete, complete, or transmitted). However, every patient listed on this report will have at least one operation with a risk assessment status of “complete.”

### Example 1: Generate an M&M Verification Report (Full Report)

```
Select Surgery Risk Assessment Menu Option: V M&M Verification Report
```

#### M&M Verification Report

```
The M&M Verification Report is a tool to assist in the review of occurrences and their assignments to operations and in the review of death unrelated or related assignments to operations. Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk assessed operations that are in a completed state but have not yet transmitted to the national database.
```

Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// **<Enter>**

Start with Date: **12 30 95** (DEC 30, 1995)  
End with Date: **1 29 96** (JAN 29, 1996)

Do you want to print this report for all Surgical Specialties ? YES// **<Enter>**

This report is designed to use a 132 column format.

Print report on which Device: **[Select Print Device]**

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

MAYBERRY, NC  
M&M Verification Report  
From: DEC 30,1995 To: JAN 29,1996  
Report Generated: OCT 21,1997

Reviewed By:  
Date Reviewed:

Op Date	Specialty	Procedure(s)	Death Related	Occurrence(s) - (Date)	Assessment Type/Status
=====					
>>> ALASKA,FREDERICK (123-45-6789) - DIED 02/27/96					
01/06/96	GENERAL	TOTAL LARYNGECTOMY	NO		NON-CARD/T
01/29/96	THORACIC	CABG, VEIN, SIX+	NO		CARDIAC/I
11/20/95	PERIPHERAL	LT CAROTID ENDOARTERECTOMY	N/A	OTHER OCCURRENCE (11/20/95) ICD: 998.4 FB LEFT DURING PROCEDURE URINARY TRACT INFECTION * (12/08/95) ICD: 599.0 URIN TRACT INFECTION NOS OTHER RESPIRATORY OCCURRENCE * (11/25/95) ICD: 478.25 EDEMA PHARYNX/NASOPHARYX OTHER OCCURRENCE * (NO DATE) ICD: 530.1 ESOPHAGITIS	NON-CARD/T
12/02/95	PERIPHERAL	EVACUATION OF HEMATOMA LT.THIGH	YES	DVT/THROMBOPHLEBITIS * (12/06/95) ICD: 453.8 VENOUS THROMBOSIS NEC BLEEDING/TRANSFUSIONS * (12/04/95) BLEEDING/TRANSFUSIONS * (12/06/95) BLEEDING/TRANSFUSIONS * (12/06/95)	NON-CARD/I

-----  
Occurrences(s): '\*' Denotes Postop Occurrence

Assessment Status - I:Incomplete, C:Complete, T:Transmitted  
-----

## Example 2: Generate an M&M Verification Report (Pre-Transmission Report)

Select Surgery Risk Assessment Menu Option: **V** M&M Verification Report

### M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences and their assignments to operations and in the review of death unrelated or related assignments to operations. Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk assessed operations that are in a completed state but have not yet transmitted to the national database.

Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// **2**

Do you want to print this report for all Surgical Specialties ? YES// **<Enter>**

This report is designed to use a 132 column format.

Print report on which Device: **[Select Print Device]**

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

MAYBERRY, NC  
M&M Verification Report  
Pre-Transmission Report for Completed Assessments  
Report Generated: JAN 23,1998

Reviewed By:  
Date Reviewed:

Op Date	Specialty	Procedure(s)	Death Related	Occurrence(s) - (Date)	Assessment Type/Status
=====					
>>> KENTUCKY,KENNETH (123-45-6789) - DIED 12/31/97@07:16					
12/24/97	UROLOGY	CYSTOSCOPY	YES		EXCLUDED/C
-----					
>>> CALIFORNIA,ALBERT (123-45-6789) - DIED 03/02/97@13:20					
01/31/97	GENERAL	LEFT BKA STUMP DEBRIDEMENT & REVISION	?	URINARY TRACT INFECTION * (02/09/97) ICD: 599.0 URIN TRACT INFECTION NOS PNEUMONIA * (02/15/97) ICD: 485. BRONCOPNEUMONIA ORG NOS	EXCLUDED/C
-----					
>>> OHIO,RAYMOND (123-45-6789) - DIED 08/13/97@19:00					
08/05/97	PERIPHERAL	LEFT LEG ABOVE KNEE AMPUTATION, RIGHT LEG ABOVE KNEE AMPUTATION	NO		EXCLUDED/C
-----					
>>> OKLAHOMA,JESSE (123-45-6789) - DIED 10/01/97					
08/21/97	PERIPHERAL	OMEGAPORT PLACEMENT	?		EXCLUDED/C
-----					
>>> IDAHO,WILLIAM B (123-45-6789) - DIED 04/08/97					
03/14/97	GENERAL	HICKMAN CATH PLACMENT	NO		EXCLUDED/C
-----					
Occurrences(s): '*' Denotes Postop Occurrence					
Assessment Status - I:Incomplete, C:Complete, T:Transmitted					
-----					

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# 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:
```

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# Queue Assessment Transmissions

## [SROA TRANSMIT ASSESSMENTS]

The *Queue Assessment Transmissions* option may be used to manually queue the NSQIP transmission process to run at a selected time. The NSQIP transmission process is a part of the nightly maintenance and cleanup process.

### Example: Queue Assessment Transmissions

```
Select Surgery Risk Assessment Menu Option: T Queue Assessment Transmissions
Transmit Surgery Risk Assessments
Requested Start Time: NOW// <Enter>
Queued as task #2651700
Press RETURN to continue
```

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# Chapter Seven: CoreFLS/Surgery Interface

---

## Introduction

The existing Surgery interface with Integrated Funds Distribution, Control Point Activity, and Procurement (IFCAP) was replaced with a new interface to Surgery called CoreFLS. The new interface will automatically send this information from Surgery when a surgical case is scheduled so that Supply Processing and Distribution (SPD) can create the specific case carts needed for surgeries based upon the CPT code(s) associated with the procedures to be performed.

## Activating the Transmissions to SPD

Before the Surgery software can automatically send transmissions to SPD, the following must be set:

- The field AUTOMATED CASE CART ORDERING, in the SURGERY SITE PARAMETERS file, should be set to YES. (This indicates that the CoreFLS interface is in use at the facility.)



If the PRINCIPAL PROCEDURE CODE field in the SURGERY file is not defined, then the information sent to SPD to create a case cart may not contain enough information for processing.

---

## Surgery Menu Options Affected by the SPD Comments Field

The new SPD COMMENTS field is now available as a Word Processing field in the requesting and scheduling edit options in the Surgery software. These Surgery menu options include:

- *Make Operation Requests*
- *Delete or Update Operation Requests*
- *Make a Request from the Waiting List*
- *Make a Request for Concurrent Cases*
- *Schedule Unrequested Operations*
- *Schedule Unrequested Concurrent Cases*
- *Reschedule or Update a Scheduled Operation*

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## Chapter Eight: Code Set Versioning

---

The Code Set Versioning enhancement to the Surgery package ensures that only CPT codes, CPT modifiers, and ICD-9 codes that are active for the operation or procedure date will be available for selection by the user, regardless of when the CPT entry or edit is made. Also, when a future operation or procedure date is entered, only active codes will be available.

It is possible that a new code set will be loaded between the time that an operation or procedure is scheduled and the time the operation or procedure occurs. Re-validation of the codes and modifiers occurs when the date and time that a patient enters the operating room is entered in the Surgery package. If the code (CPT or ICD-9) or CPT modifier is invalid — inactive for the date of operation or procedure — the inactive codes or modifiers will be deleted. Then, these two actions transpire:

1. A warning message displays on the screen, corresponding to the specific code or modifier that is inactive.
2. A MailMan message is sent to the surgeon (or provider), attending surgeon of record, and to the user who edited the record. The MailMan message contains the patient's name, date of operation, case number, free-text operation or procedure name, CPT or ICD-9 codes, CPT modifiers deleted (if any), and the reason for deletion.

The first sample warning message shows an inactive CPT code, its modifiers, and ICD-9 codes, and the second warning message is for a Non-O.R. procedure.

### Example: Warning Message to Surgeon

```
The following codes are no longer active and will be deleted for case # 12426.
```

```
OTHER PROCEDURE CPT CODE:    99900
CPT MODIFIER:                08 - SAMPLE MODIFIER
```

```
PRINCIPAL DIAGNOSIS CODE:    600.0
```

```
New active codes must be re-entered. A MailMan message will be sent to the surgeon and attending surgeon of record and to the user who edited the record with case details for follow-up.
```

### Example: Warning Message to Provider

```
The following codes are no longer active and will be deleted for case #:242
```

```
PRINCIPAL CPT CODE:         00869
CPT MODIFIER:               23 UNUSUAL ANESTHESIA
```

```
New active codes must be re-entered. A MailMan message will be sent to the provider and attending provider of record and to the user who edited the record with case details for follow-up.
```

The following sample MailMan message is sent to the surgeon, attending surgeon of record, and to the user who edited the record. The sample shows ICD-9 codes, CPT codes, and CPT modifiers that are inactive.

### Example: MailMan Message to Surgeon

```
Subj: ICD-9 OR CPT CODE DELETION [#43805] 01/15/03@09:00
1 line
From: SURGERY PACKAGE In 'IN' basket. Page 1
```

```
-----
Patient: IDAHO,PETER          CASE #: 12426
OPERATION DATE: 1/15/03      HERNIA REPAIR
```

The following codes are no longer active and were deleted for this case when the TIME PAT IN OR field was entered.

```
PRINCIPAL CPT CODE: 99900
CPT MODIFIER: 08

PRINCIPAL DIAGNOSIS CODE: 600.0
```

New active codes must be re-entered.

Enter message action (in IN basket): Ignore//



---

For Non-O.R. procedures, the MailMan message is sent to the provider and attending provider.

---

### Example: MailMan Message to Provider

```
Subj: ICD-9 OR CPT CODE DELETION [#88073] 06/26/03@12:32 12 lines
From: SURGERY PACKAGE In 'IN' basket. Page 1 *New*
```

```
-----
Patient: TEST,ROB          CASE #: 242
OPERATION DATE: JUN 26, 2003  STELLATE NERVE BLOCK
```

The following codes are no longer active and were deleted for this case when the Time Procedure Began was entered.

```
PRINCIPAL CPT CODE: 00869
CPT MODIFIER: 23 UNUSUAL ANESTHESIA
```

New active codes must be re-entered.

Enter message action (in IN basket): Ignore//

The following options allow for re-validation of the ICD-9 and CPT codes and modifiers when the TIME PAT IN OR field or TIME PROCEDURE BEGAN field is entered.

- *Operation*
- *Operation (Short Screen)*
- *Edit Non-O.R. Procedure*
- *Operation Information (Enter/Edit)*
- *Resource Data*

## Chapter Nine: Glossary

The following table contains terms that are used throughout the *Surgery V.3.0 User Manual*, and will aid the user in understanding the use of the Surgery package.

Term	Definition
Aborted	Case status indicating the case was cancelled after the patient entered the operating room. Cases with ABORTED status must contain entries in TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232), plus CANCEL DATE field (#17) and/or CANCEL REASON field (#18).
ASA Class	This is the American Society of Anesthesiologists classification relating to the patient's physiologic status. Numbers followed by an 'E' indicate an emergency.
Attending Code	Code that corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure.
Blockout Graph	Graph showing the availability of operating rooms.
Cancelled Case	Case status indicating that an entry has been made in the CANCEL DATE field and/or the CANCEL REASON field without the patient entering the operating room.
CCSHS	VA Center for Cooperative Studies in Health Services located at Hines, Illinois.
CICSP	Continuous Improvement in Cardiac Surgery Program.
Completed Case	Case status indicating that an entry has been made in the TIME PAT OUT OR field.
Concurrent Case	A patient undergoing two operations by different surgical specialties at the same time, or back to back, in the same operating room.
CPT Code	Also called Operation Code. CPT stands for Current Procedural Terminology.
CRT	Cathode ray tube display. A display device that uses a cathode ray tube.
Intraoperative Occurrence	Perioperative occurrence during the procedure.
Major	Any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered.
Minor	All operations not designated as Major.
New Surgical Case	A surgical case that has not been previously requested or scheduled such as an emergency case. A surgical case entered in the records without being booked through scheduling will not appear on the Schedule of Operations or as an operative request.
Non-Operative Occurrence	Occurrence that develops before a surgical procedure is performed.
Not Complete	Case status indicating one of the following two situations with no entry in the TIME PAT OUT OR field (#.232).  1) Case has entry in TIME PAT IN OR field (#.205). 2) Case has not been requested or scheduled.
NSQIP	National Surgical Quality Improvement Program.
Operation Code	Identifying code for reporting medical services and procedures performed by physicians. See CPT Code.

PACU	Post Anesthesia Care Unit.
Postoperative Occurrence	Perioperative occurrence following the procedure.
Procedure Occurrence	Occurrence related to a non-O.R. procedure.
Requested	Operation has been slotted for a particular day but the time and operating room are not yet firm.
Risk Assessment	Part of the Surgery software that provides medical centers a mechanism to track information related to surgical risk and operative mortality. Completed assessments are transmitted to the NSQIP or the CICSP national database for statistical analysis.
Scheduled	Operation has both an operating room and a scheduled starting time, but the operation has not yet begun.
Screen Server	A format for displaying data on a cathode ray tube display. Screen Server is designed specifically for the Surgery Package.
Screen Server Function	The Screen Server prompt for data entry.
Service Blockouts	The reservation of an operating room for a particular service on a recurring basis. The reservation is charted on a blackout graph.

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