SURGERY

**USER MANUAL**

Version 3.0

July 1993

(Revised April 2008)

Department of Veterans Affairs Veterans Health Information Technology

 **Revision History**

Each time this manual is updated, the Title Page lists the new revised date and this page describes the changes. If the Revised Pages column lists “All,” replace the existing manual with the reissued manual. If the Revised Pages column lists individual entries (e.g., 25, 32), either update the existing manual with the Change Pages Document or print the entire new manual.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Revised Pages** | **Patch Number** | **Description** |
| 04/08 | iii-iv, vi, 160, 165, 168,171-172, 296-298, 443,447, 449-450, 459, 471-473, 479-479a, 482,486-486a, 489, 491,493-495, 497, 499, 501-502a, 502c, 502d-502h,513-517, 522c-522d,529, 534 | SR\*3\*166 | Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the *Surgery NSQIP-CICSP Enhancements 2008 Release Notes.*REDACTED |
| 11/07 | 479-479a, 486a | SR\*3\*164 | Updated the *Resource Data Enter/Edit* and the *Print a Surgery Risk Assessment* options to reflect the new cardiac field for CT Surgery Consult Date.REDACTED |
| 09/07 | 125, 371, 375, 382 | SR\*3\*163 | Updated the Service Classification section regarding environmental indicators, unrelated to this patch.Updated the Quarterly Report to reflect updates to the numbers and names of specific specialties in the NATIONAL SURGICAL SPECIALTY file.REDACTED |
| 06/07 | 35, 210, 212b | SR\*3\*159 | Updated screens to reflect change of the environmental indicator “Environmental Contaminant” to “SWAC” (e.g., Southwest Asia).REDACTED |
| 06/07 | 176-180, 180a, 184c-d,327c-d, 372, 375-376,446, 449-450, 452-453,455-456, 458, 461, 468,470, 472, 479-479a,482-484, 486a, 489,491, 493, 495, 497, 499,501, 502a-d, 504-506,509-512, 519 | SR\*3\*160 | Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the *Surgery NSQIP-CICSP Enhancements 2007 Release Notes.*Updated data entry screens to match software; changes are unrelated to this patch.REDACTED |

April 2008 Surgery V. 3.0 User Manual i SR\*3\*166

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Revised Pages** | **Patch Number** | **Description** |
| 11/06 | 10-12, 14, 21-22, 139-141, 145-150, 152, 219,438 | SR\*3\*157 | Updated data entry options to display new fields for collecting sterility information for the Prosthesis Installed field; updated the Nurse Intraoperative Report section with these required new fields. For more details, see the *Surgery-Tracking Prosthesis Items Release Notes*.Updated data entry screens to match software; changes are unrelated to this patch.REDACTED |
| 08/06 | 6-9, 14, 109-112, 122-124, 141-149, 151-152,176, 178-180, 180a-b,181-184, 184a-d, 185-186, 218-219, 326-327,327a-d, 328-329, 373,377, 449-450, 452-456,459, 461-462, 467-468,468b, 469-470, 470a,473-474, 474a-474b,475, 477, 481-486,486a-b, 489-502, 502a-b, 503-504, 509-512 | SR\*3\*153 | Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software.Updated data entry options to incorporate renamed/new Hair Removal documentation fields. Updated the Nurse Intraoperative Report and Quarterly Report to include these fields.For more details, see the *Surgery NSQIP/CICSP Enhancements 2006 Release Notes.*REDACTED |
| 06/06 | 28-32, 40-50, 64-80,101-102 | SR\*3\*144 | Updated options to reflect new required fields (Attending Surgeon and Principal Preoperative Diagnosis) for creating a surgery case.REDACTED |
| 06/06 | vi, 34-35, 125, 210, 212b, 522a-b | SR\*3\*152 | Updated Service Classification screen example to display new PROJ 112/SHAD prompt.This patch will prevent the PRIN PRE-OP ICD DIAGNOSIS CODE field of the Surgery file from being sent to the Patient Care Encounter (PCE) package.Added the new *Alert Coder Regarding Coding Issues* option to the Surgery Risk Assessment Menu option. REDACTED |
| 04/06 | 445, 464a-b, 465,480a-b | SR\*3\*146 | Added the new *Alert Coder Regarding Coding Issues*option to the Assessing Surgical Risk chapter.REDACTED |

ii Surgery V. 3.0 User Manual April 2008 SR\*3\*166

# Table Of Contents

Introduction 1

Overview 1

Documentation Conventions 3

Getting Help and Exiting 3

Using Screen Server 5

Introduction 5

Navigating 5

Basics of Screen Server 6

Entering Data 7

Editing Data 8

Turning Pages 8

Entering or Editing a Range of Data Elements 9

Working with Multiples 10

Word Processing 14

Chapter One: Booking Operations 15

Introduction 15

Key Vocabulary 15

Exiting an Option or the System 16

Option Overview 16

Maintain Surgery Waiting List 17

Print Surgery Waiting List 18

Enter a Patient on the Waiting List 21

Edit a Patient on the Waiting List 22

Delete a Patient from the Waiting List. 23

Request Operations Menu 25

Display Availability 26

Make Operation Requests 28

Delete or Update Operation Requests 36

Make a Request from the Waiting List 42

Make a Request for Concurrent Cases 45

Review Request Information 52

Operation Requests for a Day 53

Requests by Ward 55

List Operation Requests 57

Schedule Operations 59

Display Availability 60

Schedule Requested Operation 61

Schedule Unrequested Operations 64

Schedule Unrequested Concurrent Cases 69

Reschedule or Update a Scheduled Operation 74

Cancel Scheduled Operation 81

Update Cancellation Reason 83

Schedule Anesthesia Personnel 84

Create Service Blockout 85

Delete Service Blockout 87

April 2008 Surgery V. 3.0 User Manual iii

[SR\*3\*166](#_TOC_250007)

Schedule of Operations 88

List Scheduled Operations 91

Chapter Two: Tracking Clinical Procedures 93

Introduction 93

Key Vocabulary 93

Exiting an Option or the System 94

Option Overview 94

Operation Menu 95

Using the Operation Menu Options 96

Operation Information 103

Surgical Staff 104

Operation Startup 108

Operation 113

Post Operation 119

Enter PAC(U) Information 121

Operation (Short Screen) 122

Surgeon’s Verification of Diagnosis & Procedures 125

Anesthesia for an Operation Menu 128

Operation Report 129

Anesthesia Report 131

Nurse Intraoperative Report 140

Tissue Examination Report 153

Enter Referring Physician Information 154

Enter Irrigations and Restraints 155

Medications (Enter/Edit) 157

Blood Product Verification 158

Anesthesia Menu 160

Prerequisites 160

Anesthesia Data Entry Menu 161

Anesthesia Information (Enter/Edit) 162

Anesthesia Technique (Enter/Edit) 165

Medications (Enter/Edit) 169

Anesthesia Report 170

Schedule Anesthesia Personnel 173

Perioperative Occurrences Menu 175

Key Vocabulary 175

[Intraoperative Occurrences (Enter/Edit) 176](#_TOC_250006)

Postoperative Occurrences (Enter/Edit) 178

Non-Operative Occurrence (Enter/Edit) 180

Update Status of Returns Within 30 Days 181

Morbidity & Mortality Reports 183

Non-O.R. Procedures 187

Non-O.R. Procedures (Enter/Edit) 188

Edit Non-O.R. Procedure 189

Procedure Report (Non-O.R.) 193

Tissue Examination Report 196

Non-OR Procedure Information 197

Annual Report of Non-O.R. Procedures 196

iv Surgery V. 3.0 User Manual April 2004

Report of Non-O.R. Procedures 198

Comments Option 205

CPT/ICD9 Coding Menu 207

CPT/ICD9 Update/Verify Menu 208

Update/Verify Procedure/Diagnosis Codes 209

Operation/Procedure Report 213

Nurse Intraoperative Report 217

Non-OR Procedure Information 220

Cumulative Report of CPT Codes 220

Report of CPT Coding Accuracy 224

List Completed Cases Missing CPT Codes 230

List of Operations 232

List of Operations (by Surgical Specialty) 234

Report of Daily Operating Room Activity 236

PCE Filing Status Report 238

Report of Non-O.R. Procedures 243

Chapter Three: Generating Surgical Reports 249

Introduction 249

Exiting an Option or the System 249

Option Overview 249

Surgery Reports 251

Management Reports 252

List of Operations (by Surgical Priority) 267

Surgery Staffing Reports. 283

Anesthesia Reports. 296

CPT Code Reports 305

Laboratory Interim Report 319

Chapter Four: Chief of Surgery Reports 321

Introduction 321

Exiting an Option or the System 321

Option Overview 321

Chief of Surgery Menu 323

View Patient Perioperative Occurrences 324

Management Reports 325

Unlock a Case for Editing 398

Update Status of Returns Within 30 Days 399

Update Cancelled Cases 400

Update Operations as Unrelated/Related to Death 401

Update/Verify Procedure/Diagnosis Codes 402

Chapter Five: Managing the Software Package 407

Introduction 407

Exiting an Option or the System 407

Option Overview 407

Surgery Package Management Menu 409

Surgery Site Parameters (Enter/Edit) 410

Operating Room Information (Enter/Edit) 413

April 2004 Surgery V. 3.0 User Manual v

Surgery Utilization Menu 414

Person Field Restrictions Menu 425

Update O.R. Schedule Devices 429

Update Staff Surgeon Information 430

Flag Drugs for Use as Anesthesia Agents 431

Update Site Configurable Files 432

Surgery Interface Management Menu 434

Make Reports Viewable in CPRS 440

Chapter Six: Assessing Surgical Risk 441

Introduction 441

Exiting an Option or the System 441

Surgery Risk Assessment Menu 443

Non-Cardiac Risk Assessment Information (Enter/Edit) 445

Creating a New Risk Assessment 445

Editing an Incomplete Risk Assessment 447

Preoperative Information (Enter/Edit) 448

Laboratory Test Results (Enter/Edit) 451

Operation Information (Enter/Edit) 455

Patient Demographics (Enter/Edit) 457

Intraoperative Occurrences (Enter/Edit) 459

Postoperative Occurrences (Enter/Edit) 461

Update Status of Returns Within 30 Days 463

Update Assessment Status to ‘Complete’ 464

Alert Coder Regarding Coding Issues 465

Cardiac Risk Assessment Information (Enter/Edit) 465

Creating a New Risk Assessment 465

Clinical Information (Enter/Edit) 467

Enter Cardiac Catheterization & Angiographic Data 469

[Operative Risk Summary Data (Enter/Edit) 471](#_TOC_250005)

[Cardiac Procedures Operative Data (Enter/Edit) 473](#_TOC_250004)

Outcome Information (Enter/Edit) 468

Lab Test Results (Enter/Edit) 468a

Intraoperative Occurrences (Enter/Edit) 475

Postoperative Occurrences (Enter/Edit) 477

[Resource Data (Enter/Edit) 479](#_TOC_250003)

Update Assessment Status to ‘COMPLETE’. 478

Alert Coder Regarding Coding Issues 477

[Print a Surgery Risk Assessment 481](#_TOC_250002)

Update Assessment Completed/Transmitted in Error 487

[List of Surgery Risk Assessments 489](#_TOC_250001)

Print 30 Day Follow-up Letters 503

Exclusion Criteria (Enter/Edit) 507

Monthly Surgical Case Workload Report 509

[M&M Verification Report 513](#_TOC_250000)

Update 1-Liner Case 519

Queue Assessment Transmissions 521

Alert Coder Regarding Coding Issues 522a

Risk Model Lab Test 522c

vi Surgery V. 3.0 User Manual April 2008 SR\*3\*166

**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: SURPATIENT,FOURTEEN 000-45-7212 Expiration Date: NOV 27,1997

1. Unit ID: KW10945 FRESH FROZEN PLASMA, ACD-A Patient: SURPATIENT,FOURTEEN 000-45-7212 Expiration Date: MAY 19,1998
2. Unit ID: KW10945 PLATELETS, POOLED, IRRADIATED Patient: SURPATIENT,FOURTEEN 000-45-7212 Expiration Date: MAR 24,1998

Select the blood product matching the unit label: (1-3): **3**

\*\*WARNING\*\*

Blood Product Expiration Date is later than today's date.

April 2004 Surgery V. 3.0 User Manual 159

**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 | *Anesthesia Data Entry Menu* |
| R | *Anesthesia Report* |
| S | *Schedule Anesthesia Personnel* |

**Prerequisites**

To use the *Anesthesia Data Entry Menu* or the *Anesthesia Report* option, the user must first select a patient case. The user must select an operating room to use the *Schedule Anesthesia Personnel* option.

160 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

## Anesthesia Technique (Enter/Edit)

### [SROMEN-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 the following different anesthesia techniques, each with different sets of prompts.

G *GENERAL*

##### M MONITORED ANESTHESIA CARE

S *SPINAL*

##### E EPIDURAL

O *OTHER*

L *LOCAL*

R *REGIONAL*

Another choice for an 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.

April 2008 Surgery V. 3.0 User Manual 165

SR\*3\*166

**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 ?: **SURANESTHETIST,SIX** 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>**

166 Surgery V. 3.0 User Manual April 2004

###### 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** SURANESTHETIST,SIX

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>**

April 2004 Surgery V. 3.0 User Manual 167

###### 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>**

**Example 7: Regional Technique**

Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit) Diagnostic/Therapeutic (Y/N): NO//

Select ANESTHESIA TECHNIQUE: LOCAL// **R** (R REGIONAL)

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>**

168 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

Page 171 has been deleted. The *Anesthesia AMIS* option has been removed.

April 2008 Surgery V.3.0 User Manual 171

SR\*3\*166

Page 172 has been deleted. The Anesthesia AMIS option has been removed.

172 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

MAYBERRY, NC PAGE: 1

SURGICAL SERVICE REVIEWED BY: CIRCULATING NURSE STAFFING REPORT DATE REVIEWED:

FROM: MAR 2,2001 TO: MAR 31,2001 DATE PRINTED: APR 21,2001

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DATE | PATIENT | OPERATION(S) | SCRUB NURSE | CIRC. NURSE | TIME IN |
| CASE # | ID# |  |  |  | TIME OUT |

ELAPSED (MINS)

====================================================================================================================================

\*\* SURNURSE,SEVEN \*\*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 03/10/01 | SURPATIENT,FIFTYONE | DRAINAGE OF OVARIAN CYST | SURNURSE,THREE | SURNURSE,SEVEN | 07:00 |
| 189 | 000-23-3221 |  |  |  | 08:54114 |
|  |  | \*\* SURNURSE,ONE \*\* |  |  |  |
| 03/09/01 | SURPATIENT,NINE | CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM | SURNURSE,THREE | SURNURSE,ONE | 09:15 |
| 187 | 000-34-5555 |  |  |  | 12:40205 |
| 03/10/01 | SURPATIENT,FIFTY | HEMORRHOIDECTOMY | SURNURSE,THREE | SURNURSE,ONE | 14:00 |
| 200 | 000-45-9999 |  |  |  | 14:5555 |
| 03/17/01 | SURPATIENT,FOURTEEN | CHOLECYSTECTOMY | SURNURSE,THREE | SURNURSE,ONE | 12:55 |
| 203 | 000-45-7212 |  |  |  | 14:3095 |
| 03/18/01 | SURPATIENT,SEVENTEEN | REPAIR INCARCERATED INGUINAL HERNIA | SURNURSE,THREE | SURNURSE,ONE | 07:30 |
| 202 | 000-45-5119 |  | SURNURSE,SEVEN |  | 09:0393 |
|  |  | \*\* SURNURSE,TWO \*\* |  |  |  |
| 03/03/01 | SURPATIENT,SIXTY | REMOVE CATARACTS, RETRO BULBAR BLOCK | SURNURSE,THREE | SURNURSE,TWO | 09:00 |
| 205 | 000-56-7821 |  |  |  | 09:20 |

April 2004 Surgery V. 3.0 User Manual 295

## 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:

|  |  |
| --- | --- |
| **Shortcut** | **Option Name** |
| P | *List of Anesthetic Procedures* |
| D | *Anesthesia Provider Report* |

296 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

Page 297 has been deleted. The *Anesthesia AMIS* option has been removed.

April 2008 Surgery V. 3.0 User Manual SR\*3\*166

297

Page 298 has been deleted. The *Anesthesia AMIS* option has been removed.

298 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

# 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 | *Non-Cardiac Assessment Information (Enter/Edit) ...* |
| C | *Cardiac Risk Assessment Information (Enter/Edit) ...* |
| P | *Print a Surgery Risk Assessment* |
| U | *Update Assessment Completed/Transmitted in Error* |
| L | *List of Surgery Risk Assessments* |
| F | *Print 30 Day Follow-up Letters* |
| R | *Exclusion Criteria (Enter/Edit)* |
| M | *Monthly Surgical Case Workload Report* |
| V | *M&M Verification Report* |
| O | *Update 1-Liner Case* |
| T | *Queue Assessment Transmissions* |
| CODE | *Alert Coder Regarding Coding Issues* |
| ERM | *Risk Model Lab Test (Enter/Edit)* |

April 2008 Surgery V. 3.0 User Manual 443

SR\*3\*166

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

444 Surgery V. 3.0 User Manual April 2004

**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**

SURPATIENT,TEN 000-12-3456

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)

SURPATIENT,TEN 000-12-3456 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' CODE Alert Coder Regarding Coding Issues

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

These options are described in the following sections.

April 2008 Surgery V. 3.0 User Manual 447

SR\*3\*166

## 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**

448 Surgery V. 3.0 User Manual April 2004

|  |  |
| --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 1 OF 2JUN 23,1998 CHOLEDOCHOTOMY |  |
| 1. GENERAL: 4. GASTROINTESTINAL:
	1. Height: A. Esophageal Varices:
	2. Weight:
	3. Diabetes Mellitus: 5. CARDIAC:
	4. Current Smoker W/I 1 Year: A. CHF Within 1 Month:
	5. ETOH > 2 Drinks/Day: B. MI Within 6 Months:
	6. Dyspnea: C. Previous PCI:
	7. DNR Status: D. Previous Cardiac Surgery:
	8. Preop Funct Status: E. Angina Within 1 Month:

F. Hypertension Requiring Meds:1. PULMONARY:
	1. Ventilator Dependent: 6. VASCULAR:
	2. History of Severe COPD: A. Revascularization/Amputation:
	3. Current Pneumonia: B. Rest Pain/Gangrene:
2. HEPATOBILIARY:
	1. Ascites:
 |
| Select Preoperative Information to Edit: **1:3** |

SURPATIENT,SIXTY (000-56-7821)

JUN 23,1998 CHOLEDOCHOTOMY

Case #63592

GENERAL: **YES**

Patient's Height 65 INCHES//: **62**

Patient's Weight 140 POUNDS//: **175**

Diabetes Mellitus Requiring Therapy With Oral Agents or Insulin: **I** INSULIN Current Smoker: **Y** YES

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 PULMONARY: **NO**

HEPATOBILIARY: **NO**

April 2008 Surgery V. 3.0 User Manual 449

SR\*3\*166

|  |  |
| --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 1 OF 2JUN 23,1998 CHOLEDOCHOTOMY |  |
| 1. GENERAL: YES 4. GASTROINTESTINAL:
	1. Height: 62 INCHES A. Esophageal Varices:
	2. Weight: 175 LBS.
	3. Diabetes Mellitus: INSULIN 5. CARDIAC:
	4. Current Smoker W/I 1 Year: YES A. CHF Within 1 Month:
	5. ETOH > 2 Drinks/Day: NO B. MI Within 6 Months:
	6. Dyspnea: NO C. Previous PCI:
	7. DNR Status: NO D. Previous Cardiac Surgery:
	8. Preop Funct Status: INDEPENDENT E. Angina Within 1 Month:

F. Hypertension Requiring Meds:1. PULMONARY: NO
	1. Ventilator Dependent: NO 6. VASCULAR:
	2. History of Severe COPD: NO A. Revascularization/Amputation:
	3. Current Pneumonia: NO B. Rest Pain/Gangrene:
2. HEPATOBILIARY: NO
	1. Ascites: NO
 |
| Select Preoperative Information to Edit: **<Enter>** |

|  |  |
| --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 2 OF 2JUN 23,1998 CHOLEDOCHOTOMY |  |
| 1. RENAL: 3. NUTRITIONAL/IMMUNE/OTHER:
	1. Acute Renal Failure: A. Disseminated Cancer:
	2. Currently on Dialysis: B. Open Wound:
	3. Steroid Use for Chronic Cond.:
2. CENTRAL NERVOUS SYSTEM: D. Weight Loss > 10%:
	1. Impaired Sensorium: E. Bleeding Disorders:
	2. Coma: F. Transfusion > 4 RBC Units:
	3. Hemiplegia: G. Chemotherapy W/I 30 Days:
	4. History of TIAs: H. Radiotherapy W/I 90 Days:
	5. CVA/Stroke w. Neuro Deficit: I. Preoperative Sepsis:
	6. CVA/Stroke w/o Neuro Deficit: J. Pregnancy: NOT APPLICABLE
	7. Tumor Involving CNS:
 |
| Select Preoperative Information to Edit: **3E** |

SURPATIENT,SIXTY (000-56-7821)

Case #63592

JUN 23,1998 CHOLEDOCHOTOMY

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

|  |  |
| --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 2 OF 2JUN 23,1998 CHOLEDOCHOTOMY |  |
| . RENAL: 3. NUTRITIONAL/IMMUNE/OTHER:1. Acute Renal Failure: A. Disseminated Cancer:
2. Currently on Dialysis: B. Open Wound:
3. Steroid Use for Chronic Cond.:
4. CENTRAL NERVOUS SYSTEM: D. Weight Loss > 10%:
	1. Impaired Sensorium: E. Bleeding Disorders: YES
	2. Coma: F. Transfusion > 4 RBC Units:
	3. Hemiplegia: G. Chemotherapy W/I 30 Days:
	4. History of TIAs: H. Radiotherapy W/I 90 Days:
	5. CVA/Stroke w. Neuro Deficit: I. Preoperative Sepsis:
	6. CVA/Stroke w/o Neuro Deficit: J. Pregnancy: NOT APPLICABLE
	7. Tumor Involving CNS:
 |
| Select Preoperative Information to Edit: |

450 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

SURPATIENT,EIGHT (000-37-0555)

Case #264

JUN 7,2005 ARTHROSCOPY, LEFT KNEE

1. Transfer Status:
2. Observation Admission Date/Time:
3. Observation Discharge Date/Time:
4. Observation Treating Specialty:
5. Hospital Admission Date/Time:
6. Hospital Discharge Date/Time:
7. Admit/Transfer to Surgical Svc.:
8. Discharge/Transfer to Chronic Care:
9. Length of Postop Hospital Stay:
10. In/Out-Patient Status:
11. Patient's Ethnicity:
12. Patient's Race:
13. Date of Death:
14. Date Surgery Consult Requested:
15. Surgery Consult Date:

INPATIENT UNANSWERED UNANSWERED

JAN 12, 2005

Select number of item to edit:

April 2008 Surgery V. 3.0 User Manual 459

SR\*3\*166

## 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)

SURPATIENT,EIGHT (000-37-0555)

Case #264

JUN 7,2005 ARTHROSCOPY, LEFT KNEE

There are no Intraoperative Occurrences entered for this case.

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

NSQIP Definition (2006):

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. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

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>**

|  |  |
| --- | --- |
| SURPATIENT,EIGHT (000-37-0555) Case #264 |  |
| JUN 7,2005 ARTHROSCOPY, LEFT KNEE |
| 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** |
| SURPATIENT,EIGHT (000-37-0555) Case #264 |
| JUN 7,2005 ARTHROSCOPY, LEFT KNEE |
| Type of Treatment Instituted: **CPR** |
| Outcome to Date: **I** IMPROVED |

460 Surgery V. 3.0 User Manual April 2004

## Operative Risk Summary Data (Enter/Edit)

### [SROA CARDIAC OPERATIVE RISK]

The *Operative Risk Summary Data* option is used to enter or edit operative risk summary data for the cardiac surgery risk assessments. 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 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)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 JUN 18,2005 CORONARY ARTERY BYPASS |  | PAGE: | 1 |  |
| 1. Physician's Preoperative Estimate of Operative

A. Date/Time Collected1. ASA Classification: 1-NO DISTURB.
2. Surgical Priority:
3. Date/Time Operation Began: JUN 18,2005 07:00
4. Date/Time Operation Ended: JUN 18,2005 09:00
5. Preoperative Risk Factors: NONE
6. CPT Codes (view only): 33510
 | Mortality: 78This information cannot be edited. |  |  |
| Select Operative Risk Summary Information to Edit: | **1:3** |  |  |

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

JUN 18,2005 CORONARY ARTERY BYPASS

Physician's Preoperative Estimate of Operative Mortality: **32**

Date/Time of Estimate of Operative Mortality: JUN 17,2005@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 17,2005@13:29

// **<Enter>**

April 2008 Surgery V. 3.0 User Manual 471

SR\*3\*166

|  |  |
| --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 JUN 18,2005 CORONARY ARTERY BYPASS |  |
| 1. Physician's Preoperative Estimate of Operative Mortality: 32%
	1. Date/Time Collected: JUN 17,2005 18:15
2. ASA Classification: 3-SEVERE DISTURB.
3. Surgical Priority: EMERGENT (ONGOING ISCHEMIA)
	1. Date/Time Collected: JUN 17,2005 09:46
4. Date/Time Operation Began: JUN 18,2005 08:45
5. Date/Time Operation Ended: JUN 18,2005 14:25
6. Preoperative Risk Factors: NONE
7. CPT Codes (view only): 33510

\*\*\* NOTE: D/Time of Surgical Priority should be < the D/Time Patient in OR.\*\*\*\*\*\* NOTE: D/Time of Estimate of Mortality should be < the D/Time PT in OR. \*\*\* |
| Select Operative Risk Summary Information to Edit: |

The Surgery software performs data checks on the following fields:

The Date/Time Collected field for Physician's Preoperative Estimate of Operative Mortality should be earlier than the Time Pat In OR field. This field is no longer auto- populated.

The Date/Time Collected field for Surgical Priority should be earlier than the Time Pat In OR field. This field is no longer auto-populated.

If the date entered does not conform to the specifications, then the Surgery software displays a warning at the bottom of the screen.

472 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

## 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.

The user can also enter of **N** shall allow the user to **Set All to No** for the 22 Cardiac Procedures fields. A verification prompt will follow to ensure that user understands the entry.

Fields that do not have YES/NO responses will be updated as follows.

* Items #1-#5 are numeric and their values will be set to 0.
* #9 Valve Repair will be set to NONE
* #13 Maze Procedure will be set to NO MAZE PERFORMED

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)SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 OF 2 JUN 18,2005 CORONARY ARTERY BYPASS |  |
| Cardiac surgical procedures with or without cardiopulmonary bypassCABG distal anastomoses: 11. Bridge to transplant/Device:1. Number with vein: 12. TMR:
2. Number with IMA: 13. Maze procedure:
3. Number with Radial Artery: 14. ASD repair:
4. Number with Other Artery: 15. VSD repair:
5. Number with Other Conduit: 16. Myectomy for IHSS:

17. Myxoma resection:1. Aortic Valve Replacement: 18. Other tumor resection:
2. Mitral Valve Replacement: 19. Cardiac transplant:
3. Tricuspid Valve Replacement: 20. Great Vessel Repair:
4. Valve Repair: 21. Endovascular Repair:
5. LV Aneurysmectomy: 22. Other cardiac procedures:
 |
| Select Cardiac Procedures Operative Information to Edit: **A** |

April 2008 Surgery V. 3.0 User Manual 473

SR\*3\*166

|  |  |  |
| --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) JUN 18,2005 CORONARY ARTERY BYPASS | Case #60183 |  |
| 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 (2006):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** AORTICLV Aneurysmectomy (Y/N): **N** NODevice for bridge to cardiac transplant / Destination therapy:**??**CICSP Definition (2006):Indicate if patient received a mechanical support device (excluding IABP) as a bridge to cardiac transplant during the sameadmission as the transplant procedure; 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 YESN NODevice for bridge to cardiac transplant / Destination therapy: **N** NO Transmyocardial Laser Revascularization: **N** NOMaze Procedure: **N** NO MAZE PERFORMED ASD Repair (Y/N): **N** NOVSD Repair (Y/N): **N** NO Myectomy for IHSS (Y/N): **N** NO Myxoma Resection (Y/N): **N** NOOther Tumor Resection (Y/N): **N** NO Cardiac Transplant (Y/N): **N** NO Great Vessel Repair (Y/N): **N** NOEndovascular Repair of Descending Thoracic Aorta: **N** NO Other Cardiac Procedures (Y/N): **N** NO |

474 Surgery V. 3.0 User Manual April 2004

## 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

SURPATIENT,TEN (000-12-3456)

Case #49413

OCT 18,2007 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD

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...

SURPATIENT,TEN (000-12-3456)

Case #49413

OCT 18,2007 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD

Enter/Edit Patient Resource Data

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

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

|  |  |
| --- | --- |
| SURPATIENT,TEN (000-12-3456) Case #49413OCT 18,2007 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD |  |
| 1. Hospital Admission Date: FEB 11, 2007@15:39
2. Hospital Discharge Date: FEB 16, 2007@13:44
3. Cardiac Catheterization Date:
4. Time Patient In OR: FEB 12, 2007@06:30
5. Time Patient Out OR: FEB 12, 2007@08:40
6. Date/Time Patient Extubated:
7. Date/Time Discharged from ICU: FEB 16, 2007@13:44
8. Homeless: NO
9. Surg Performed at Non-VA Facility: NO
10. Resource Data Comments:
11. Employment Status Preoperatively: EMPLOYED PART TIME
12. CT Surgery Consult Date:
13. Cause for Delay for Surgery:
 |
| Select number of item to edit: **11** |

April 2008 Surgery V. 3.0 User Manual 479

SR\*3\*166

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

|  |  |
| --- | --- |
| SURPATIENT,TEN (000-12-3456) Case #49413OCT 18,2007 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD |  |
| 1. Hospital Admission Date: FEB 11, 2007@15:39
2. Hospital Discharge Date: FEB 16, 2007@13:44
3. Cardiac Catheterization Date:
4. Time Patient In OR: FEB 12, 2007@06:30
5. Time Patient Out OR: FEB 12, 2007@08:40
6. Date/Time Patient Extubated:
7. Date/Time Discharged from ICU: FEB 16, 2007@13:44
8. Homeless: NO
9. Surg Performed at Non-VA Facility: NO
10. Resource Data Comments:
11. Employment Status Preoperatively: EMPLOYED PART TIME
12. CT Surgery Consult Date:
13. Cause for Delay for Surgery:
 |
| Select number of item to edit: |

The Surgery software performs data checks on the following fields:

The Date/Time Patient Extubated field should be later than the Time Patient Out OR field, and earlier than the Date/Time Discharged from ICU field.

The Date/Time Discharged from ICU field should be later than the Date/Time Patient Extubated field, and equal to or earlier than the Hospital Discharge Date field.

If the date entered does not conform to the specifications, then the Surgery software displays a warning at the bottom of the screen.

479a Surgery V. 3.0 User Manual April 2008 SR\*3\*166

# 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: **SURPATIENT,FORTY**

ERAN

05-07-23

000777777

NO

NSC VET

SURPATIENT,FORTY 000-77-7777

1. 02-10-04 \* CABG (INCOMPLETE)
2. 01-09-06 APPENDECTOMY (COMPLETED)

Select Surgical Case: **2**

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

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

April 2004 Surgery V. 3.0 User Manual 481

|  |  |
| --- | --- |
| VA NON-CARDIAC RISK ASSESSMENT Assessment: 236 PAGE 1 FOR SURPATIENT,FORTY 000-77-7777 (COMPLETED)================================================================================ |  |
| Medical Center: ALBANYAge: 81 Operation Date: JAN 09, 2006Sex: MALE Ethnicity: NOT HISPANIC OR LATINO Race: AMERICAN INDIAN OR ALASKANATIVE, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, WHITETransfer Status: NOT TRANSFERREDObservation Admission Date: NAObservation Discharge Date: NAObservation Treating Specialty: NAHospital Admission Date: JAN 7,2006 11:15Hospital Discharge Date: JAN 12,2006 10:30 Admitted/Transferred to Surgical Service: JAN 7,2006 11:15 Discharged/Transferred to Chronic Care: JAN 12,2006 10:30 In/Out-Patient Status: INPATIENTDate Surgery Consult Requested: JAN 7,2006Surgery Consult Date: JAN 8,2006 |
| PREOPERATIVE INFORMATION |
| GENERAL: GASTROINTESTINAL:Height: 176 CENTIMETERS Esophageal Varices: Weight: 89 KILOGRAMSDiabetes Mellitus: CARDIAC:Current Smoker W/I 1 Year: CHF Within 1 Month:ETOH > 2 Drinks/Day: MI Within 6 Months:Dyspnea: Previous PCI:DNR Status: Previous Cardiac Surgery:Preop Funct Status: Angina Within 1 Month: Hypertension Requiring Meds:PULMONARY:Ventilator Dependent: VASCULAR:History of Severe COPD: NO Revascularization/Amputation: Current Pneumonia: Rest Pain/Gangrene: |
| HEPATOBILIARY:Ascites: |
| RENAL: YES NUTRITIONAL/IMMUNE/OTHER: YESAcute Renal Failure: NO Disseminated Cancer: NO Currently on Dialysis: NO Open Wound: NOSteroid Use for Chronic Cond.: NO CENTRAL NERVOUS SYSTEM: YES Weight Loss > 10%: NOImpaired Sensorium: NO Bleeding Disorders: NO Coma: NO Transfusion > 4 RBC Units: NOHemiplegia: NO Chemotherapy W/I 30 Days: NOHistory 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 Pregnancy: NOT APPLICABLE Tumor Involving CNS: NO |
| OPERATION DATE/TIMES INFORMATION |
| Patient in Room (PIR): JAN 9,2006 07:25 Procedure/Surgery Start Time (PST): JAN 9,2006 07:25 Procedure/Surgery Finish (PF): JAN 9,2006 08:00 Patient Out of Room (POR): JAN 9,2006 08:10 Anesthesia Start (AS): JAN 9,2006 07:15Anesthesia Finish (AF): JAN 9,2006 08:08Discharge from PACU (DPACU): JAN 9,2006 09:15 |

482 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

**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** SURPATIENT,NINE VETERAN

12-19-51

000345555

NO

SC

SURPATIENT,NINE 000-34-5555

1. 07-01-06 \* CABG X3 (1A,2V), ARTERIAL GRAFTING (TRANSMITTED)
2. 03-27-05 INGUINAL HERNIA (TRANSMITTED)
3. 07-03-04 PULMONARY LOBECTOMY (TRANSMITTED)

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

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

##### ---------------------------------------------------------printout follows--------------------------------------------------

April 2004 Surgery V. 3.0 User Manual 485

|  |
| --- |
| VA CONTINUOUS IMPROVEMENT IN CARDIAC SURGERY PROGRAM (CICSP/CICSP-X)================================================================================1. IDENTIFYING DATA

Patient: SURPATIENT,NINE 000-34-5555 Case #: 238 Fac./Div. #: 500Surgery Date: 07/01/06 Address: Anyplace WayPhone: NS/Unknown Zip Code: 33445-1234 Date of Birth: 12/19/51================================================================================1. CLINICAL DATA

Gender: MALE PCI: >72 hrs - 7 daysAge: 55 Prior MI: > 7 DAYS OF SURGHeight: 72 in # of prior heart surgeries: NONEWeight: 120 kg Prior heart surgeries:Diabetes: DIET Peripheral Vascular Disease: NOCOPD: NO Cerebral Vascular Disease: NOFEV1: NS Angina (use CCS Class): IIICardiomegaly (X-ray): YES CHF (use NYHA Class): IPulmonary 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: NO1. DETAILED LABORATORY INFO - PREOPERATIVE VALUES

Creatinine: 1.1 mg/dl 06/28/06 T. Bilirubin: .9 mg/dl 06/28/06 Hemoglobin: 15.6 mg/dl 06/28/06 T. Cholesterol: 230 mg/dl 06/28/06 Albumin: 4.4 g/dl 06/28/06 HDL: 90 mg/dl 06/28/06 Triglyceride: 77 mg/dl 06/28/06 LDL: 125 mg/dl 06/28/06 Potassium: 4.6 mg/L 06/28/06 Hemoglobin A1c: 205 mg/dl 06/28/061. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA Cardiac Catheterization Date: 06/28/06

Procedure: NS Native Coronaries:LVEDP: NS Left Main Stenosis: NS Aortic Systolic Pressure: NS LAD Stenosis: NSRight Coronary Stenosis: NS For patients having right heart cath: Circumflex Stenosis: NS PA Systolic Pressure: NSPAW Mean Pressure: NS If a Re-do, indicate stenosisin graft to:LAD: NSRight coronary (include PDA): NS Circumflex: NS |
| LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo): Grade Ejection Fraction Range DefinitionNO LV STUDY |  |
| Mitral Regurgitation: NS Aortic stenosis: NSV. OPERATIVE RISK SUMMARY DATA (Operation Began: 07/01/06 10:10) Physician's Preoperative (Operation Ended: 07/01/06 12:20) Estimate of Operative Mortality: NS 07/28/06 15:30)ASA Classification: 3-SEVERE DISTURB.Surgical Priority: ELECTIVE 07/28/06 15:31) Principal CPT Code: 33517Other Procedures CPT Codes: 33510Preoperative Risk Factors: |

486 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

SURPATIENT,NINE 000-34-5555

================================================================================

1. 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 MAZE PERFORMED 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 Great Vessel Repair: NO LV Aneurysmectomy: NO Endovascular Repair: NO

Other Cardiac procedure(s): YES

\* Other Cardiac procedures (Specify): OTHER CT PROCEDURE #1, OTHER CT PROCEDURE #2, OTHER CT PROC

Indicate other cardiac procedures only if done with cardiopulmonary bypass Foreign body removal: YES

Pericardiectomy: YES

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)

1. OUTCOMES

Operative Death: NO Date of Death:

Perioperative (30 day) Occurrences:

Perioperative MI: NO Repeat cardiac Surg procedure: YES

Endocarditis: NO Tracheostomy: YES Renal Failure Requiring Dialysis: NO Ventilator supp within 30 days: YES Mediastinitis: YES Stroke/CVA: NO Cardiac Arrest Requiring CPR: YES Coma > or = 24 Hours: NO Reoperation for Bleeding: NO New Mech Circulatory Support: YES On ventilator > or = 48 hr: NO

1. RESOURCE DATA

Hospital Admission Date: 06/30/06 06:05

Hospital Discharge Date: 07/10/06 08:50

Time Patient In OR: 07/10/06 10:00

Time Patient Out OR: 07/10/06 12:30

Date and Time Patient Extubated: 07/10/06 13:13 Postop Intubation Hrs: +1.9

Date and Time Patient Discharged from ICU: 07/10/06 08:00 Patient is Homeless: NS

Cardiac Surg Performed at Non-VA Facility: UNKNOWN CT Surgery Consult Date: 06/29/06

Cause for Delay for Surgery: NONE Resource Data Comments:

================================================================================

1. 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

1. 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 SURPATIENT,NINE 000-34-5555 assessment #238 \*\*\*

April 2008 Surgery V. 3.0 User Manual 486a SR\*3\*166

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

486b Surgery V. 3.0 User Manual April 2004

# 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, or 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. The examples in this section illustrate printing assessments in 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
	8. List of 1-Liner Cases Missing Information
	9. List of Eligible Cases
	10. List of Cases With No CPT Codes
	11. Summary List of Assessed Cases

###### 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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **1**

Start with Date: **1 1 06** (JAN 01, 2006)

End with Date: **6 30 06** (JUN 30, 2006)

Print by Surgical Specialty ? YES// **<Enter>** Print report for ALL specialties ? YES// **<Enter>** Do you want to print all divisions? YES// **NO**

1. MAYBERRY, NC

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

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------------------------------------------------*

April 2008 Surgery V. 3.0 User Manual SR\*3\*166

489

INCOMPLETE RISK ASSESSMENTS PAGE 1

MAYBERRY, NC

SURGERY SERVICE DATE REVIEWED: FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

ASSESSMENT # PATIENT OPERATIVE PROCEDURE(S) ANESTHESIA TECHNIQUE OPERATION DATE SURGEON

====================================================================================================================================

\*\* SURGICAL SPECIALTY: CARDIAC SURGERY \*\*

28519 SURPATIENT,NINE 000-34-5555 \* CABG X3 (2V,1A) GENERAL JAN 05, 2006 SURSURGEON,ONE

CPT Codes: 33736

\*\* SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) \*\*

63063 SURPATIENT,ONE 000-44-7629 INGUINAL HERNIA SPINAL

JUN 09, 2006 SURSURGEON,TWO

CPT Codes: 49521

\*\* SURGICAL SPECIALTY: NEUROSURGERY \*\*

63154 SURPATIENT,EIGHT 000-37-0555 CRANIOTOMY NOT ENTERED

JUN 24, 2006 SURSURGEON,FOUR

CPT Codes: NOT ENTERED

490 Surgery V. 3.0 User Manual April 2004

**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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **2**

Start with Date: **1 1 06** (JAN 01, 2006)

End with Date: **6 30 06** (JUN 30, 2006)

Print by Surgical Specialty ? YES// **<Enter>** Print report for ALL specialties ? YES// **<Enter>** Do you want to print all divisions? YES// **NO**

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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--------------------------------------------------

April 2008 Surgery V. 3.0 User Manual SR\*3\*166

491

COMPLETED RISK ASSESSMENTS PAGE 1

MAYBERRY, NC

SURGERY SERVICE DATE REVIEWED: FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

ASSESSMENT # PATIENT DATE COMPLETED ANESTHESIA TECHNIQUE OPERATION DATE OPERATIVE PROCEDURE

====================================================================================================================================

\*\* SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) \*\*

|  |  |  |  |
| --- | --- | --- | --- |
| 92FEB 23, 2006 | SURPATIENT,SIXTY 000-56-7821CHOLEDOCHOTOMY | FEB 28, 2006 | GENERAL |
|  | CPT Code: 47420 |  |  |
| 63045MAR 01, 2006 | SURPATIENT,FORTYONE 000-43-2109 INGUINAL HERNIACPT Code: 49521 | MAR 29, 2006 | GENERAL |

\*\* SURGICAL SPECIALTY: OPHTHALMOLOGY \*\*

1898 SURPATIENT,FORTYONE 000-43-2109 MAY 28, 2006 GENERAL

APR 28, 2006 INTRAOCCULAR LENS

CPT Codes: NOT ENTERED

492 Surgery V. 3.0 User Manual April 2004

**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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **3**

Print by Date of Operation or by Date of Transmission ?

1. Date of Operation
2. Date of Transmission

Select Number: (1-2): 1// **<Enter>**

Start with Date: **1 1 06** (JAN 01, 2006)

End with Date: **6 30 06** (JUN 30, 2006)

Print which Transmitted Cases ?

1. Assessed Cases Only
2. Excluded Cases Only
3. Both Assessed and Excluded Select Number: (1-3): 1// **<Enter>**

Print by Surgical Specialty ? YES// **<Enter>**

Print report for ALL specialties ? YES// **N**

Print the Report for which Surgical Specialty: **GENERAL** SURGERY SURGERY

50

GENERAL

1

2

3

50 GENERAL SURGERY 50

50 GASTROENTEROLOGY 50

50 TWO GENERAL 50 TG

GASTR

CHOOSE 1-3: **<Enter>** SURGERY GENERAL SURGERY 50

Do you want to print all divisions? YES// **NO**

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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--------------------------------------------------

April 2008 Surgery V. 3.0 User Manual SR\*3\*166

493

TRANSMITTED RISK ASSESSMENTS PAGE 1

MAYBERRY, NC

SURGERY SERVICE DATE REVIEWED: OPERATION DATES FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

ASSESSMENT # PATIENT TRANSMISSION DATE ANESTHESIA TECHNIQUE OPERATION DATE PRINCIPAL OPERATIVE PROCEDURE

====================================================================================================================================

\*\* SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) \*\*

|  |  |  |  |
| --- | --- | --- | --- |
| 63076JAN 08, 2006 | SURPATIENT,FOURTEEN 000-45-7212INGUINAL HERNIA | FEB 12, 2006 | GENERAL |
|  | CPT Codes: 49521 |  |  |
| 63077FEB 08, 2006 | SURPATIENT,FIVE 000-58-7963 INGUINAL HERNIA, OTHER PROC1 CPT Codes: NOT ENTERED | FEB 30, 2006 | GENERAL |
| 63103MAR 27, 2006 | SURPATIENT,NINE 000-34-5555 INGUINAL HERNIACPT Codes: 49521 | APR 09, 2006 | GENERAL |
| 63171MAY 17, 2006 | SURPATIENT,FIFTYTWO 000-99-8888 CHOLECYSTECTOMYCPT Codes: 47600 | JUN 05, 2006 | GENERAL |

494 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

**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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **4**

Start with Date: **1 1 06** (JAN 01, 2006)

End with Date: **6 30 06** (JUN 30, 2006)

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(OR WHEN NOT DEFINED BELOW) 50

Do you want to print all divisions? YES// **NO**

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

April 2008 Surgery V. 3.0 User Manual SR\*3\*166

495

NON-ASSESSED MAJOR SURGICAL CASES BY SURGICAL SPECIALTY PAGE 1 MAYBERRY, NC

SURGERY SERVICE DATE REVIEWED: FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

CASE # PATIENT ANESTHESIA TECHNIQUE

OPERATION DATE OPERATIVE PROCEDURE(S) SURGEON

==================================================================================================================================== SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

|  |  |  |
| --- | --- | --- |
| 63071FEB 08, 2006 | SURPATIENT,FOUR 000-17-0555INGUINAL HERNIA | GENERALSURSURGEON,TWO |
|  | CPT Codes: 49505 |  |
| 63136 | SURPATIENT,EIGHT 000-34-5555 | GENERAL |
| MAR 07, 2006 | CHOLECYSTECTOMY CPT Codes: 47605 | SURSURGEON,TWO |

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 2

496 Surgery V. 3.0 User Manual April 2004

**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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **5**

Start with Date: **1 1 06** (JAN 01, 2006)

End with Date: **6 30 06** (JUN 30, 2006)

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(OR WHEN NOT DEFINED BELOW) 50

Do you want to print all divisions? YES// **NO**

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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--------------------------------------------------

April 2008 Surgery V. 3.0 User Manual SR\*3\*166

497

ALL MAJOR SURGICAL CASES BY SURGICAL SPECIALTY PAGE 1 MAYBERRY, NC

SURGERY SERVICE DATE REVIEWED: FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

|  |  |  |  |
| --- | --- | --- | --- |
| CASE # | PATIENT | ASSESSMENT STATUS | ANESTHESIA TECHNIQUE |
| OPERATION DATE | OPERATIVE PROCEDURE(S) | EXCLUSION CRITERIA | SURGEON |

====================================================================================================================================

|  |  |  |  |
| --- | --- | --- | --- |
| SURGICAL SPECIALTY:63110JAN 23, 2006 | GENERAL(OR WHEN NOT DEFINED BELOW)SURPATIENT,SIXTY 000-56-7821 CHOLEDOCHOTOMY | COMPLETEDSCNR WAS ON A/L | GENERAL SURSURGEON,TWO |
|  | CPT Codes: 47420 |  |  |
| 63131APR 21, 2006 | SURPATIENT,FIFTYTWO 000-99-8888 PERINEAL WOUND EXPLORATIONCPT Codes: NOT ENTERED | NO ASSESSMENT | GENERAL SURSURGEON,NINE |
| 63136JUN 07, 2006 | SURPATIENT,EIGHT 000-34-5555 CHOLECYSTECTOMYCPT Codes: 47600 | NO ASSESSMENT | GENERAL SURSURGEON,ONE |

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 3

498 Surgery V. 3.0 User Manual April 2004

**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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **6**

Start with Date: **1 1 06** (JAN 01, 2006)

End with Date: **6 30 06** (JUN 30, 2006)

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

Do you want to print all divisions? YES// **NO**

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

April 2008 Surgery V. 3.0 User Manual SR\*3\*166

499

ALL SURGICAL CASES BY SURGICAL SPECIALTY PAGE 1 MAYBERRY, NC

SURGERY SERVICE DATE REVIEWED: FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

|  |  |  |  |
| --- | --- | --- | --- |
| CASE # | PATIENT | ASSESSMENT STATUS | ANESTHESIA TECHNIQUE |
| OPERATION DATE | PRINCIPAL OPERATIVE PROCEDURE | EXCLUSION CRITERIA | SURGEON |

====================================================================================================================================

|  |  |  |  |
| --- | --- | --- | --- |
| SURGICAL SPECIALTY:63110JAN 23, 2006 | GENERAL(OR WHEN NOT DEFINED BELOW)SURPATIENT,SIXTY 000-56-7821 CHOLEDOCHOTOMY | COMPLETEDSCNR WAS ON A/L | GENERAL SURSURGEON,TWO |
|  | CPT Code: 47420 |  |  |
| 63079APR 02, 2006 | SURPATIENT,FIFTYTWO 000-99-8888 INGUINAL HERNIACPT Codes: NOT ENTERED | INCOMPLETE | GENERAL SURSURGEON,ONE |
| 63131APR 21, 2006 | SURPATIENT,FIFTYTWO 000-99-8888 PERINEAL WOUND EXPLORATIONCPT Codes: NOT ENTERED | NO ASSESSMENT | GENERAL SURSURGEON,NINE |
| 63180JUN 23, 2006 | SURPATIENT,SIXTY 000-56-7821 CHOLECYSTECTOMYCPT Codes: 47600 | NO ASSESSMENT | NOT ENTERED SURSURGEON,ONE |

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 4

 -

500 Surgery V. 3.0 User Manual April 2004

**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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **7**

Start with Date: **1 1 06** (JAN 01, 2006)

End with Date: **6 30 06** (JUN 30, 2006)

Print by Surgical Specialty ? YES// **<Enter>** Print report for ALL specialties ? YES// **<Enter>** Do you want to print all divisions? YES// **NO**

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

Print the List of Assessments to which Device: **[Select Print Device]**

##### ---------------------------------------------------------printout follows--------------------------------------------------

April 2008 Surgery V. 3.0 User Manual 501

SR\*3\*166

COMPLETED/TRANSMITTED ASSESSMENTS MISSING INFORMATION PAGE 1

MAYBERRY, NC

FROM: JAN 1,2006 TO: JUN 30,2006 DATE PRINTED: JUL 13,2006

\*\* GENERAL(OR WHEN NOT DEFINED BELOW)

|  |  |  |  |
| --- | --- | --- | --- |
| ASSESSMENT # | PATIENT | TYPE | STATUS |
| OPERATION DATE | OPERATION(S) |  |  |

================================================================================ 63172 SURPATIENT,FIFTYTWO 000-99-8888 NON-CARDIAC TRANSMITTED

MAY 17, 2006 REPAIR ARTERIAL BLEEDING

CPT Code: 33120

Missing information:

1. The final coding for Procedure and Diagnosis is not complete.
2. Anesthesia Technique

63185 SURPATIENT,SIXTEEN 000-11-1111 NON-CARDIAC TRANSMITTED

APR 17, 2006 INGUINAL HERNIA, CHOLECYSTECTOMY

Missing information:

1. The final coding for Procedure and Diagnosis is not complete.
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 SURPATIENT,THIRTY 000-82-9472 EXCLUDED COMPLETE

JAN 03, 2006 TURP

Missing information:

1. The final coding for Procedure and Diagnosis is not complete.

TOTAL FOR GENERAL(OR WHEN NOT DEFINED BELOW): 3 TOTAL FOR ALL SPECIALTIES: 3

502 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

**Example 8: List of 1-Liner Cases 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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **8**

Start with Date: **2 27 06** (FEB 27, 2006)

End with Date: **6 30 06** (JUN 30, 2006)

Print by Surgical Specialty ? YES// **<Enter>** Print report for ALL specialties ? YES// **<Enter>** Do you want to print all divisions? YES// **NO**

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

Print the List of Assessments to which Device: **[Select Print Device]**

##### ---------------------------------------------------------printout follows--------------------------------------------------

April 2008 Surgery V. 3.0 User Manual 502a SR\*3\*166

1-LINER CASES MISSING INFORMATION PAGE 1 MABERRY, NC

FROM: FEB 27,2006 TO: JUN 30,2006 DATE PRINTED: JUN 30,2006

\*\* UROLOGY

CASE # PATIENT TYPE STATUS OP DATE OPERATION(S)

================================================================================

317 SURPATIENT,FOURTEEN 000-45-7212 CARDIAC COMPLETE APR 10, 2006 Vasectomy

CPT Codes: NOT ENTERED

Missing information:

1. The final coding for Procedure and Diagnosis is not complete.
2. Attending Code
3. Wound Classification
4. ASA Class

TOTAL FOR UROLOGY: 1

502b Surgery V. 3.0 User Manual April 2004

**Example 9: List of Eligible 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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **9**

Start with Date: **6 1 06** (JUN 01, 2006)

End with Date: **6 30 07** (JUN 30, 2007) Print which Eligible Cases ?

1. Assessed Cases Only
2. Excluded Cases Only
3. Non-Assessed Cases only
4. All Cases

Select Number: (1-4): 1// **<Enter>**

Print by Surgical Specialty ? YES// **<Enter>**

Print report for ALL specialties ? YES// **NO** NO

Print the Report for which Surgical Specialty: **GENERAL** SURGERY 50

GENERAL SURGERY

Do you want to print all divisions? YES// **NO**

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

Print the List of Assessments to which Device: **[Select Print Device]**

##### ---------------------------------------------------------printout follows--------------------------------------------------

April 2008 Surgery V. 3.0 User Manual 502c SR\*3\*166

CASES ELIGIBLE FOR ASSESSMENT PAGE 1 MAYBERRY, NC

FROM: JUN 1,2006 TO: JUN 30,2007 DATE PRINTED: JUN 30,2007

'\*' Denotes Eligible CPT Code

>>> CARDIAC SURGERY

===

|  |  |  |  |
| --- | --- | --- | --- |
| CASE #OP DATE | PATIENTOPERATION(S) | TYPE | STATUS |
| ============================================================================= 10095 SURPATIENT,SEVENTY 000-00-0125 CARDIAC COMPLETEJUN 04, 2006 CABG, REGRAFT |

>>> Final CPT Coding is not complete. CPT Codes: \*33510, \*33511

|  |  |  |  |
| --- | --- | --- | --- |
| 10084JUL 08, 2006 | SURPATIENT,NINE 000-34-5555 CABG | CARDIAC | COMPLETE |
| CPT Codes: \*33502, 11402 |
| 10380FEB 06, 2007 | SURPATIENT,THREE 000-21-2453 CORONARY ARTERY BYPASS | NOT LOGGED | COMPLETE |
| CPT Codes: NOT ENTERED |
| 10383FEB 08, 2007 | SURPATIENT,ONE 000-44-7629 STENT | NON-CARDIAC | COMPLETE |

CPT Codes: NOT ENTERED

TOTAL FOR CARDIAC SURGERY: 4

>>> GENERAL SURGERY

|  |  |  |  |
| --- | --- | --- | --- |
| CASE #OP DATE | PATIENTOPERATION(S) | TYPE | STATUS |
| ============================================================================= 10061 SURPATIENT,FIFTEEN 666-98-1288 NON-CARDIAC COMPLETEFEB 11, 2007 APPENDECTOMY, SPLENECTOMY |

===

>>> Final CPT Coding is not complete. CPT Codes: \*44955, \*38100

|  |  |  |  |
| --- | --- | --- | --- |
| 10079 | SURPATIENT,SEVENTY 000-00-0125 | EXCLUDED | COMPLETE |
| MAR 31, 2007 | HERNIA |  |  |

>>> Final CPT Coding is not complete. CPT Codes: \*49521, \*49521

TOTAL FOR GENERAL SURGERY: 2

502d Surgery V. 3.0 User Manual April 2008 SR\*3\*166

**Example 10: List of Cases With No CPT Codes**

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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **10**

Start with Date: **1 1 07** (JAN 01, 2007) End with Date: **T** (JAN 23, 2008)

Print by Surgical Specialty ? YES// **<Enter>** Print report for ALL specialties ? YES// **<Enter>** Do you want to print all divisions? YES// **<Enter>**

Print the List of Assessments to which Device: HOME// **[Select Print Device]**

#####  printout follows

April 2008 Surgery V. 3.0 User Manual 502e SR\*3\*166

>>> CARDIAC SURGERY

CASES WITHOUT CPT CODES PAGE 1 ALBANY - ALL DIVISIONS

FROM: JAN 1,2007 TO: JAN 23,2008 DATE PRINTED: JAN 23,2008

|  |  |  |  |
| --- | --- | --- | --- |
| CASE #OP DATE | PATIENTOPERATION(S) | TYPE | STATUS |
| ================================================================================ |
| 10429FEB 12, | 2007 | SURPATIENT,TEN 666-12-3456 CABG | CARDIAC | COMPLETE |
| 10420FEB 12, | 2007 | SURPATIENT,F. 666-00-0804 CABG | CARDIAC | TRANSMITTED |
| 10423MAR 12, | 2007 | SURPATIENT,TWO 666-45-1982cabg | CARDIAC | INCOMPLETE |
| 10430MAR 18, | 2007 | SURPATIENT,EIGHT 666-37-0555 CABG X3 | CARDIAC | INCOMPLETE |
| 10374MAY 10, | 2007 | SURPATIENT,NINE 666-34-5555CABG X 3 | NOT LOGGED | NO ASSESSMENT |

TOTAL FOR CARDIAC SURGERY: 5 TOTAL FOR ALL SPECIALTIES: 5

502f Surgery V. 3.0 User Manual April 2008 SR\*3\*166

**Example 11: Summary List of Assessed 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
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **11**

Start with Date: **01 01 08** (JAN 01, 2008)

End with Date: **01 30 08** (JAN 30, 2008) Print by Surgical Specialty ? YES// **<Enter>**

Print report for ALL specialties ? YES// **<Enter>**

Do you want to print all divisions? YES// **NO**

1. ALBANY
2. PHILADELPHIA, PA

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

Print the List of Assessments to which Device: HOME// **[Select Print Device]**

April 2008 Surgery V. 3.0 User Manual 502g SR\*3\*166

SUMMARY LIST OF ASSESSED CASES PAGE 1 ALBANY

FROM: JAN 1,2008 TO: JAN 30,2008 DATE PRINTED: JAN 30,2008

SURGICAL SPECIALTY INCOMPLETE | COMPLETE | TRANSMITTED | EXCLUDED

================================================================================

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| CARDIAC SURGERY |  | 8 | 1 | 1 | 0 |
| GENERAL SURGERY |  | 17 | 1 | 1 | 6 |
| NEUROSURGERY |  | 1 | 0 | 1 | 0 |
| OPHTHALMOLOGY |  | 2 | 0 | 0 | 0 |
| ORTHOPEDICS |  | 2 | 0 | 0 | 0 |
| OTORHINOLARYNGOLOGY | (ENT) | 1 | 0 | 0 | 0 |
| PLASTIC SURGERY (INCLUDES HEAD | 2 | 0 | 0 | 0 |
| TWO GENERAL | 1 | 0 | 0 | 0 |
| UROLOGY | 0 | 0 | 0 | 1 |

TOTAL FOR ALL SPECIALTIES: 34 2 3 7

502h Surgery V. 3.0 User Manual April 2008 SR\*3\*166

# 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 assignment to operations
* reviewing death unrelated/related assignments to operations

The full report includes all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences or death within 90 days of surgery. The pre- transmission report is similar but includes operations with completed risk assessments that have not yet transmitted to the national database.

**Full Report**:

Information is printed by patient, 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 listed, the intraoperative and postoperative occurrences are listed. The report indicates if the operation was flagged as unrelated or related to death and the risk assessment type and status. The report may be printed for a selected list of surgical specialties.

#### Pre-Transmission Report:

Information is printed in a format similar to the full report. This report lists all completed risk assessed operations that have not yet 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 operations that may or may not be risk assessed, and, if risk assessed, may have a status other than 'complete'. 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 assignment to operations and in the review of death unrelated or related assignments to operations.

The full report includes all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences or death within 90 days of surgery. The pre-transmission report is similar but includes only operations with completed risk assessments that have not yet transmitted to the national database.

April 2008 Surgery V. 3.0 User Manual 513

SR\*3\*166

Print which report ?

1. Full report for selected date range.
2. Pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// **<Enter>**

Start with Date: **03 01 07** (MAR 01, 2007)

End with Date: **03 30 07** (MAR 30, 2007)

Do you want to print all divisions? YES// **<Enter>**

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*

514 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

ALBANY - ALL DIVISIONS Page 1

M&M Verification Report

From: MAR 1,2007 To: MAR 30,2007 REVIEWED BY:

Report Generated: APR 23,2007 DATE REVIEWED:

OP DATE CASE # SURGICAL SPECIALTY ASSESSMENT TYPE STATUS DEATH RELATED PRINCIPAL PROCEDURE

====================================================================================================================================

>>> SURPATIENT,FIVE (666-58-7963)

03/01/07 10401 GENERAL SURGERY NON-CARDIAC TRANSMITTED N/A APPENDECTOMY

CPT Codes: 44970

Occurrences: ACUTE RENAL FAILURE \*\* POSTOP \*\* (03/02/07)

>>> SURPATIENT,ONE (666-44-7629)

03/07/07 10421 GENERAL SURGERY NON-CARDIAC TRANSMITTED N/A APPENDECTOMY, CHOLECYSTECTOMY

CPT Codes: 44950, 47610

Occurrences: URINARY TRACT INFECTION \*\* POSTOP \*\* (03/09/07) ACUTE RENAL FAILURE \*\* POSTOP \*\* (03/10/07)

OTHER RESPIRATORY OCCURRENCE \*\* POSTOP \*\* (03/10/07) ICD: 478.25 EDEMA PHARYNX/NASOPHARYX

>>> SURPATIENT,TWO (666-45-1982)

03/07/07 10422 NEUROSURGERY NON-CARDIAC TRANSMITTED N/A LAMINECTOMY

CPT Codes: 22630

Occurrences: OTHER OCCURRENCE (03/07/07)

ICD: 415.19 OTH PULM EMB & INFARC

>>> SURPATIENT,ELEVEN (666-00-0748) - DIED 03/10/07@14:50

03/10/07 10100 GENERAL SURGERY NON-CARDIAC INCOMPLETE NO REMOVAL OF GALLBLADDER

CPT Codes: 47600

Occurrences: PULMONARY EMBOLISM \*\* POSTOP \*\* (03/10/07)

>>> Comments:

Patient complained of chest pain and shortness of breath. Heparin was administered immediately by IV. Date of Death: 03/10/07@14:50

Review of Death Comments: Patient expired from large pulmonary embolus before anticoagulant treatment could take effect.

Patient's obesity and prolonged immobilization were likely contributing factors.

April 2008 Surgery V. 3.0 User Manual 515

SR\*3\*166

**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 assignment to operations and in the review of death unrelated or related assignments to operations.

The full report includes all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences or death within 90 days of surgery. The pre-transmission report is similar but includes only operations with completed risk assessments that have not yet transmitted to the national database.

Print which report ?

1. Full report for selected date range.
2. Pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// **2**

Do you want to print all divisions? YES// **<Enter>**

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

516 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

ALBANY - ALL DIVISIONS Page 1

M&M Verification Report

PRE-TRANSMISSION REPORT FOR COMPLETED ASSESSMENTS REVIEWED BY:

Report Generated: OCT 23,2007 DATE REVIEWED:

OP DATE CASE # SURGICAL SPECIALTY ASSESSMENT TYPE STATUS DEATH RELATED PRINCIPAL PROCEDURE

====================================================================================================================================

>>> SURPATIENT,TWELVE (666-00-0762)

09/21/07 45466 PLASTIC SURGERY NON-CARDIAC COMPLETE N/A RHINOPLASTY

CPT Codes: 30410

Occurrences: DEEP INCISIONAL SSI \*\* POSTOP \*\* (09/23/07)

>>> SURPATIENT,FIFTEEN (666-00-0194)

09/16/07 45475 EAR, NOSE, THROAT (ENT) NON-CARDIAC COMPLETE N/A LARYNGECTOMY (TOTAL)

CPT Codes: 31360

Occurrences: BLEEDING/TRANSFUSIONS \*\* POSTOP \*\* (09/17/07)

>>> Comments:

Esophageal varices were the source of bleeding.

>>> SURPATIENT,FORTY (666-00-4174)

09/19/07 45499 GENERAL SURGERY NON-CARDIAC COMPLETE N/A INGUINAL HERNIA

CPT Codes: 49505

Occurrences: URINARY TRACT INFECTION \*\* POSTOP \*\* (09/21/07)

April 2008 Surgery V. 3.0 User Manual 517

SR\*3\*166

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

518 Surgery V. 3.0 User Manual April 2004

# Risk Model Lab Test

### [SROA LAB TEST EDIT]

In order to assist the nurse reviewer, in the *Surgery Risk Assessment Menu* is the *Risk Model Lab Test (Enter/Edit)* option, which allows the nurse to map NSQIP-CICSP data in the RISK MODEL LAB TEST file (#139.2). The option synonym is ERM.

Risk Model Lab Test (Enter/Edit)

Select item to edit from list below:

1. ALBUMIN
2. ALKALINE PHOSPHATASE
3. ANION GAP
4. BUN
5. CHOLESTEROL
6. CPK
7. CPK-MB
8. CREATININE
9. HDL
10. HEMATOCRIT
11. HEMOGLOBIN
12. HEMOGLOBIN A1C
13. INR
14. LDL
15. PLATELET COUNT
16. POTASSIUM
17. PT
18. PTT
19. SGOT
20. SODIUM
21. TOTAL BILIRUBIN
22. TRIGLYCERIDE
23. TROPONIN I
24. TROPONIN T
25. WHITE BLOOD COUNT

Enter number (1-25): **5**

Risk Model Lab Test (Enter/Edit)

Test Name: CHOLESTEROL Laboratory Data Name(s): NONE ENTERED

Specimen: SERUM

Do you want to edit this test ? NO// **YES**

Select LABORATORY DATA NAME: **CHOLESTEROL**

1. CHOLESTEROL
2. CHOLESTEROL CRYSTALS CHOOSE 1-2: **1** CHOLESTEROL

Select LABORATORY DATA NAME: **<Enter>**

Specimen: SERUM// **<Enter>**

April 2008 Surgery V. 3.0 User Manual 522c SR\*3\*166

Risk Model Lab Test (Enter/Edit)

Select item to edit from list below:

1. ALBUMIN
2. ALKALINE PHOSPHATASE
3. ANION GAP
4. BUN
5. CHOLESTEROL
6. CPK
7. CPK-MB
8. CREATININE
9. HDL
10. HEMATOCRIT
11. HEMOGLOBIN
12. HEMOGLOBIN A1C
13. INR
14. LDL
15. PLATELET COUNT
16. POTASSIUM
17. PT
18. PTT
19. SGOT
20. SODIUM
21. TOTAL BILIRUBIN
22. TRIGLYCERIDE
23. TROPONIN I
24. TROPONIN T
25. WHITE BLOOD COUNT

Enter number (1-25):

Select Surgery Risk Assessment Menu Option:

522d Surgery V. 3.0 User Manual April 2008 SR\*3\*166

# Index

#### A

AAIS, 437, 438

anesthesia

agents, 128, 160

entering data, 161

printing information, 170

staff, 162

techniques, 160 anesthesia agents

flagging a drug, 431 anesthesia personnel, 61, 128

assigning, 173

scheduling, 84 anesthesia technique

entering information, 165, 173 assessment

changing existing, 465 changing status of, 487 creating new, 465 upgrading status of, 464

Automated Anesthesia Information System (AAIS), 437, 438

#### B

bar code reader, 158

blockout an operating room, 85 blockout graph, 60

Blood Bank, 158 blood product

label, 158

verification, 158 book an operation, 25

book concurrent operation, 45

#### C

cancellation rates calculations, 347

cardiac risk assessment

entering operative risk summary data, 471 case

cancelled, 345

cardiac, 465

delayed, 338

designation, 96

editing cancelled, 400 list of requested, 57

scheduled, 96, 345

updating the cancellation date, 83 updating the cancellation reason, 83 verifying, 352

Chief of Surgery, 178, 251, 398 Code Set Versioning, 525 coding

checking accuracy of procedures, 310 entry, 207

validation, 207 comments

adding, 205

completed cases, 355, 357

PCE filing status of, 238, 273

report of, 232, 234, 257, 265, 267

reports on, 252

staffing information for, 284 surgical priority, 269

complications, 93, 459

concurrent case, 93

adding, 74

defined, 15

scheduling, 61

scheduling unrequested operations, 69 condensed characters, 26

count clinic active, 278

CPT codes, 59, 207, 220, 224, 255, 525

CPT modifiers, 525

cultures, 153, 196

cutoff time, 15, 42

#### D

death totals, 378 deaths

reviewing, 330

within 30 days of surgery, 183, 326

within 90 days of surgery, 330 delays

reasons for, 340

devices, 155

updating list of, 429 diagnosis, 113, 208, 238, 273

dosage, 157, 169

downloading Surgery set of codes, 438

April 2008 Surgery V. 3.0 User Manual 529

SR\*3\*166

#### E

electronically signing a report Anesthesia Report,

nurse staffing information, 294 nursing care, 140

131, 134 **O**

Nurse Intraoperative Report, 146

#### F

flag a drug, 431

#### G

occurrence, 180

adding information about a postoperative, 178 editing, 176

entering, 176

intraoperative, 330, 459, 475 adding information about an, 176

Glossary, 527 M&M Verification Report, 330

#### H

HL7, 434, 435, 439

master file updates, 437, 438

hospital admission, 385

number of for delayed operations, 340 postoperative, 330, 461

reviewing, 330

viewing, 324 Operating Room

determining use of, 414

**I** entering information, 413

ICD9 codes, 207, 525

interim reports, 319 intraoperative occurrence

entering, 459, 475

irrigation solutions, 155

#### K

KERNEL audit log, 393

#### L

percent utilization, 361

rescheduling, 74

reserving on a recurring basis, 85 utilization reports, 415

viewing availability of, 26 viewing availability of, 60

Operating Room Schedule, 88, 253 operation

book concurrent, 45

booking, 25, 59

canceling scheduled, 81

laboratory information, 95 close of, 119

entering, 451 delayed, 108, 338, 340

Laboratory Package, 319 discharge, 119

list of requested cases, 57 outstanding requests, 28

patient preparation, 108

1. post anesthesia recovery, 119

medical administration, 95

medications, 157, 169

mortality and morbidity rates, 183, 326

multiple fields, 108

requesting, 25

rescheduling, 74

scheduled, 26

scheduled by surgical specialty, 91 scheduling requested, 59

1. scheduling unrequested, 64

new surgical case, 101 non-count encounters, 278

non-O.R. procedure, 187

deleting data, 188

editing data, 188

entering data, 188

NSQIP, 509, 519, 528

NSQIP transmission process, 521

starting time, 113 operation information

entering or editing, 455 operation request

deleting, 36 printing a list, 53

Options

Admissions Within 14 Days of Outpatient Surgery, 385

530 Surgery V. 3.0 User Manual April 2008 SR\*3\*166

preoperative assessment entering information, 448

preoperative information, 15

editing, 52

entering, 29, 65

reviewing, 52

updating, 74

Preoperative Information (Enter/Edit), 448 principal diagnosis, 103

procedure deleting, 23

dictating a summary, 189 editing data for non-O.R., 189 entering data for non-O.R., 189 filed as encounters, 278 summary for non-O.R., 193

purging utilization information, 424

#### Q

Quarterly Report, 368

quick reference on a case, 103

#### R

Referring physician information, 154 reporting

tracking cancellations, 337

tracking delays, 337 reports

Admissions Within 14 Days of Outpatient Surgery Report, 385

Anesthesia Provider Report, 303 Anesthesia Report, 131

Annual Report of Non-O.R. Procedures, 196 Annual Report of Surgical Procedures, 255 Attending Surgeon Cumulative Report, 284,

286

Attending Surgeon Report, 284 Cases Without Specimens, 357

Circulating Nurse Staffing Report, 294 Clean Wound Infection Summary, 367 Comparison of Preop and Postop Diagnosis,

335

Completed Cases Missing CPT Codes, 230, 316

Cumulative Report of CPT Codes, 220, 222, 306, 308

Daily Operating Room Activity, 236 Daily Operating Room Activity, 271 Daily Operating Room Activity, 325 Daily Operating Room Activity, 355

Daily Operating Room Activity, 355

Deaths Within 30 Days of Surgery, 379, 381,

383

Ensuring Correct Surgery Compliance Report, 395, 396

Laboratory Interim Report, 319

List of Anesthetic Procedures, 299, 301 List of Invasive Diagnostic Procedures, 387 List of Operations, 232, 257

List of Operations (by Surgical Specialty), 234

List of Operations by Postoperative Disposition, 259, 261, 263

List of Operations by Surgical Priority, 267 List of Operations by Surgical Specialty, 265 List of Operations by Wound Classification,

365

List of Operations Included on Quarterly Report, 389

List of Unverified Cases, 352

M&M Verification Report, 330, 333, 513, 516 Missing Quarterly Report Data, 391

Monthly Surgical Case Workload Report, 509, 511

Mortality Report, 183, 326, 328 Nurse Intraoperative Report, 141

Operating Room Normal Working Hours Report, 421

Operating Room Utilization Report, 419 Operation Report, 130, 213

Operation Requests, 57 Operation Requests for a Day, 53

Outpatient Surgery Encounters Not Transmitted to NPCD, 278, 280

PCE Filing Status Report, 239, 241, 274, 276

Perioperative Occurrences Report, 183, 326

Procedure Report (Non-O.R.), 195, 216 Procedure Report (Non-OR), 215 Quarterly Report - Surgical Service, 374 Quarterly Report - Surgical Specialty, 370 Re-Filing Cases in PCE, 282

Report of Cancellation Rates, 347, 349 Report of Cancellations, 345

Report of CPT Coding Accuracy, 224, 310, 312, 314

Report of CPT Coding Accuracy for OR Surgical Procedures, 226, 228

Report of Daily Operating Room Activity, 271

Report of Delay Time, 342

Report of Delayed Operations, 338

April 2004 Surgery V.3.0 User Manual 533

Report of Non-O.R. Procedures, 198, 200,

202, 243, 245, 247

Report of Returns to Surgery, 353 Report of Surgical Priorities, 269, 270 Requests by Ward, 55

Schedule of Operations, 88 Scheduled Operations, 91

Scrub Nurse Staffing Report, 292 Surgeon Staffing Report, 288 Surgery Risk Assessment, 481, 485 Surgery Waiting List, 18

Surgical Nurse Staffing Report, 290 Tissue Examination Report, 153, 196 Unscheduled Admissions to ICU, 359 Wound Classification Report, 363

request an operation, 25 restraint, 108, 155

risk assessment, 330

changing, 445

creating, 445

creating cardiac, 465

entering non-cardiac patient, 445

entering the clinical information for cardiac case, 467

Risk Assessment, 481, 528 Risk Assessment module, 443 Risk Model Lab Test, 522c route, 157, 169

#### S

schedule an unrequested operation, 64 scheduled, 79, 84, 98, 528

scheduling a concurrent case, 61 Screen Server, 93

data elements, 6

Defined, 5

editing data, 8

entering a range of elements, 9 entering data, 7

header, 6

multiple screen shortcut, 12 multiples, 10

Navigation, 5

prompt, 6

turning pages, 8

word processing, 14

service blockout, 60

creating, 85

removing, 87

short form listing of scheduled cases, 91

site-configurable files, 432

specimens, 155, 197 staff surgeon

designating a user as, 430 surgeon key, 426

Surgery

major,defined, 110

minor,defined, 110 Surgery case

cancelled, 400

unlocking, 398

Surgery package coordinator, 407 Surgery Site parameters

entering, 410

Surgical Service Chief, 322 Surgical Service managers, 410 surgical specialty, 21, 57, 74, 234

Surgical staff, 106

#### T

time given, 159, 169 transfusion

error risk management, 160

#### U

utilization information, 361, 419

purging, 424

#### V

VA Central Office, 255

#### W

Waiting List

adding a new case, 21 deleting a procedure, 23 editing a patient on the, 22 entering a patient, 21 printing, 18

waiting lists, 17 workload

report, 509

uncounted, 278

wound classification, 363

534 Surgery V. 3.0 User Manual April 2008 SR\*3\*166