## 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.

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| 09/11 | i-ib, iii-iv, vi, 64, 66, 70, 98-101, 101a-101b, 109-112, 114-118, 122-124, 124a-124b, 142-152, 152a-152b, 176, 178, 180, 183-184, 184a-184f, 244, 246, 248, 325-326, 326a-326b, 327, 327a-327d, 368, 394a-394b, 394c-394d, 395-397, 397a-397d, 432-433, 441, 449-450, 458-459, 461, 464a, 471-474, 474a-474b, 475, 477, 480a, 482, 486-486a, 509, 519, 521, 522a, 522c, 527, 534-535, 550, 552-556 | SR*3*175     | Updated definitions and made minor modifications to the non-cardiac, cardiac and transplant components of the VistA Surgery application. For more details, see the *Annual Surgery Updates – VASQIP 2011, Increment 1, Release Notes.*  
(T. Leggett, PM; B. Thomas, Tech Writer) |
| 12/10 | i-ib, 372, 376, 449-450, 458, 467-468, 468b, 471-474, 474a-474b, 479, 479a, 482, 486, 486a, 522c-522d | SR*3*174     | 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 *Annual Surgery Updates – VASQIP 2010 Release Notes.*  
(T. Leggett, PM; B. Thomas, Tech Writer) |
| 11/08 | vii-viii, 527-556                                                              | SR*3*167     | New chapter added for transplant assessments. Changed Glossary to Chapter 10, and renumbered the Index.  
(M. Montali, PM; G. O'Connor, Tech Writer) |
| 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.*  
(M. Montali, PM; G. O’Connor, Tech Writer) |
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<td>11/07</td>
<td>479-479a, 486a</td>
<td>SR<em>3</em>164</td>
<td>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. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<tr>
<td>09/07</td>
<td>125, 371, 375, 382</td>
<td>SR<em>3</em>163</td>
<td>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. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>06/07</td>
<td>35, 210, 212b</td>
<td>SR<em>3</em>159</td>
<td>Updated screens to reflect change of the environmental indicator “Environmental Contaminant” to “SWAC” (e.g., SouthWest Asia). (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>06/07</td>
<td>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</td>
<td>SR<em>3</em>160</td>
<td>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. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>11/06</td>
<td>10-12, 14, 21-22, 139-141, 145-150, 152, 219, 438</td>
<td>SR<em>3</em>157</td>
<td>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. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>08/06</td>
<td>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-</td>
<td>SR<em>3</em>153</td>
<td>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. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>06/06</td>
<td>28-32, 40-50, 64-80, 101-102</td>
<td>SR<em>3</em>144</td>
<td>Updated options to reflect new required fields (Attending Surgeon and Principal Preoperative Diagnosis) for creating a surgery case. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>06/06</td>
<td>vi, 34-35, 125, 210, 212b, 522a-b</td>
<td>SR<em>3</em>152</td>
<td>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. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<tr>
<td>04/06</td>
<td>445, 464a-b, 465, 480a-b</td>
<td>SR<em>3</em>146</td>
<td>Added the new Alert Coder Regarding Coding Issues option to the Assessing Surgical Risk chapter. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>6-8, 29, 31-32, 37-38, 40, 43-44, 46-48, 50, 52, 65-67, 71-73, 75-77, 79, 100, 102, 109-112, 117-120, 122-123, 125-127, 189-191, 195b, 209-212, 212a-h, 219a, 224-231, 238-242, 273-277, 311-313, 315-317, 369, 379-392, 410, 449-464, 467-468, 468a-b, 469-470, 470a, 471-474, 474a-b, 475-479, 479a-b, 480, 483-484, 489-502, 507, 519</td>
<td>SR<em>3</em>142</td>
<td>Updated the data entry screens to reflect renaming of the Planned Principal CPT Code field and the Principal Pre-op ICD Diagnosis Code field. Updated the Update/Verify Procedure/Diagnosis Coding option to reflect new functionality. Updated Risk Assessment options to remove CPT codes from headers of cases displayed. Updated reports related to the coding option to reflect final CPT codes. For more specific information on changes, see the Patient Financial Services System (PFSS) – Surgery Release Notes for this patch. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>10/05</td>
<td>9, 109-110, 144, 151, 218</td>
<td>SR<em>3</em>147</td>
<td>Updated data entry screens to reflect renaming of the Preop Shave By field to Preop Hair Clipping By field. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>SR<em>3</em>119</td>
<td>Updated the Anesthesia Data Entry Menu section (and other data entry options) to reflect new functionality for entering multiple start and end times for anesthesia. Updated examples for Referring Physician updates (e.g., capability to automatically look up physician by name). Updated the PCE Filing Status Report section. (J. Podolec, PM; B. Manies, Tech Writer)</td>
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<td>iv-vi, 187-189, 195, 195a-195b, 196, 207-208, 219a-b, 527-528</td>
<td>SR<em>3</em>132</td>
<td>Updated the Table of Contents and Index to reflect added options. Added the new <strong>Non-OR Procedure Information</strong> option and the <strong>Tissue Examination Report</strong> option (unrelated to this patch) to the Non-OR Procedures section.</td>
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<td>08/04</td>
<td>31, 43, 46, 66, 71-72, 75-76, 311</td>
<td>SR<em>3</em>127</td>
<td>Updated screen captures to display new text for ICD-9 and CPT codes.</td>
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<td>vi, 441, 443, 445-456, 458-459, 461 463, 465, 467-468, 468a-b, 469-470, 470a-b, 471, 473-474, 474a-b, 474-479, 479a-b, 480-486, 486a-b, 519, 531-534</td>
<td>SR<em>3</em>125</td>
<td>Updated the Table of Contents and Index. Clarified the location of the national centers for NSQIP and CICSP. Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software and new options have been added. For an overview of the data entry changes, see the Surgery NSQIP/CICSP Enhancements 2004 Release Notes. Added the <strong>Laboratory Test Result (Enter/Edit)</strong> option and the <strong>Outcome Information (Enter/Edit)</strong> option to the <strong>Cardiac Risk Assessment Information (Enter/Edit)</strong> menu section. Changed the name of the <strong>Cardiac Procedures Requiring CPB (Enter/Edit)</strong> option to <strong>Cardiac Procedures Operative Data (Enter/Edit)</strong> option. Removed the <strong>Update Operations as Unrelated/Related to Death</strong> option from the Surgery Risk Assessment Menu.</td>
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<td>08/04</td>
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<td>SR<em>3</em>129</td>
<td>Updated examples to include the new levels for the Attending Code (or Resident Supervision). Also updated examples to include the new fields for ensuring Correct Surgery. For specific options affected by each of these updates, please see the Resident Supervision/Ensuring Correct Surgery Phase II Release Notes.</td>
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<td>04/04</td>
<td>All</td>
<td>SR<em>3</em>100</td>
<td>All pages were updated to reflect the most recent Clinical Ancillary Local Documentation Standards and the changes resulting from the Surgery Electronic Signature for Operative Reports project, SR<em>3</em>100. For more information about the specific changes, see the patch description or the Surgery Electronic Signature for Operative Reports Release Notes.</td>
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Select Schedule Operations Option: SR  Schedule Requested Operations

Select Patient: SURPATIENT,EIGHTEEN 09-14-54 000223334

The following cases are requested for SURPATIENT,EIGHTEEN:

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

Select Operation Request: 1

Case Information:
CAROTID ARTERY ENDARTERECTOMY
By SURSURGEON,ONE  On SURPATIENT,EIGHTEEN
Case # 262
STANDBY
* Concurrent Case # 263  AORTO CORONARY BYPASS GRAFT

Is this the correct operation? YES/<Enter>

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

Select Number: 2/<Enter>

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

Schedule a Case for which Operating Room? OR2

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

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

Principal Anesthetist: SURANESTHETIST,ONE
Anesthesiologist Supervisor: SURANESTHETIST,TWO

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

Select Patient:
Schedule Unrequested Operations
[SROSRES]

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

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

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

"Schedule Procedure for which Date ?"
"Select Patient:"
"Schedule a case for which operating Room ?"
"Reserve from what time ? (24HR:NEAREST 15 MIN):"
"Reserve to what time ? (24HR:NEAREST 15 MIN):"
“Desired Procedure Date:”
"Surgeon:"
"Attending Surgeon:"
"Surgical Specialty:"
"Principal Operative Procedure:"
"Principal Preoperative Diagnosis:"
**Entering Preoperative Information**

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

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

Schedule a Procedure for which Date?  **7 18 05** (JUL 18, 2005)

Select Patient: **SURPATIENT,THREE**  12-19-53  000212453

Display of Available Operating Room Time

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

Select Number: 2/\n
ROOM  6AM  7  8  9  10  11  12  13  14  15  16  17  18  19  20
OR1   |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR2   |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR3   |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR4   |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR5   |____|____|____|____|____|____|____|____|____|____|____|____|____|____|

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

 Reserve from what time? (24HR:NEAREST 15 MIN): **8:00**
 Reserve to what time? (24HR:NEAREST 15 MIN): **13:00**

**SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION**

**SURPATIENT,THREE (000-21-2453) JUL 18, 2005**

---

**Desired Procedure Date:** **7 18 05** (JUL 18, 2005)
**Surgeon:** **SURSURGEON,ONE**
**Attending Surgeon:** **SURSURGEON,TWO**
**Surgical Specialty:** **54 ORTHOPEDICS ORTHOPEDICS**
**Principal Operative Procedure:** **SHOULDER ARTHROPLASTY-PROSTHESIS**
**Principal Preoperative Diagnosis:** **DEGENERATIVE JOINT DISEASE, L SHOULDER**

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field. The Indications for Operation field can be updated later if necessary.

Press RETURN to continue

**SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL**

**SURPATIENT,THREE (000-21-2453) JUL 18, 2005**

---

**Principal Anesthetist:** **SURANESTHETIST,ONE**
**Anesthesiologist Supervisor:** **SURANESTHETIST,TWO**

**SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION**

**SURPATIENT,THREE (000-21-2453) JUL 18, 2005**

---

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

**EDIT Option:** **<Enter>**
Schedule Unrequested Concurrent Cases
[SRSCHDC]

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

Required Prompts

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

Storing the Request Information

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

Updating the Preoperative Information Later

Use the Reschedule or Update a Scheduled Operation option to change or update any of the information entered for either of the concurrent cases.
Example: Schedule Unrequested Concurrent Cases

Select Schedule Operations Option: CON Schedule Unrequested Concurrent Cases

Schedule Concurrent Cases for which Patient? SURPATIENT,EIGHT 06-04-35
000370555

Schedule Concurrent Procedures for which Date? 07 25 2005 (JUL 25, 2005)

Display of Available Operating Room Time

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

Select Number: 2// 4

Schedule a case for which operating Room? OR2

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

FIRST CONCURRENT CASE
SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

SURPATIENT,EIGHT (000-37-0555) JUL 25, 2005
================================================================================
Desired Procedure Date: 07 25 2005 (JUL 25, 2005)
Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,ONE
Surgical Specialty: 62 PERIPHERAL VASCULAR PERIPHERAL VASCULAR 62
Principal Operative Procedure: CAROTID ARTERY ENDARTERECTOMY
Principal Preoperative Diagnosis: CAROTID ARTERY STENOSIS

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field. The Indications for Operation field can be updated later if necessary.

Press RETURN to continue <Enter>

SECOND CONCURRENT CASE
SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

SURPATIENT,EIGHT (000-37-0555) JUL 25, 2005
================================================================================
Desired Procedure Date: 07 25 2005 (JUL 25, 2005)
Surgeon: SURSURGEON,TWO
Attending Surgeon: SURSURGEON,ONE
Surgical Specialty: 58 THORACIC SURGERY (INC. CARDIAC SURG.) THORACIC SURGERY (INC. CARDIAC SURG.) 58
Principal Operative Procedure: AORTO CORONARY BYPASS GRAFT
Principal Preoperative Diagnosis: UNSTABLE ANGINA

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field. The Indications for Operation field can be updated later if necessary.

Press RETURN to continue <Enter>
Following is an example of how the software lists existing cases on record for a patient.

Select Surgery Menu Option: O  Operation Menu
Select Patient: SURPATIENT,SIX  04-04-30  000098797  NSC VETERAN

SURPATIENT,SIX  000-09-8797
1. 01-25-92  ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)
2. 01-05-92  CORONARY BYPASS (REQUESTED)
3. ENTER NEW SURGICAL CASE

Select Operation: <Enter>

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

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

SURPATIENT,SIX  000-09-8797
01-25-92  ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)
1. Enter Information
2. Review Information
3. Delete Surgery Case

Select Number: 1//
**Entering Information**

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

Example: Enter Information

Select Surgery Menu Option: O  Operation Menu
Select Patient: **SURPATIENT,THREE**  12-19-53  000212453

<table>
<thead>
<tr>
<th>Surgeon's Name</th>
<th>Date</th>
<th>Operation Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURPATIENT,THREE</td>
<td>000-21-2453</td>
<td>1. 03-12-92    SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 08-15-88    SHOULDER ARTHROPLASTY (NOT COMPLETE)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. ENTER NEW SURGICAL CASE</td>
</tr>
</tbody>
</table>

Select Operation: 2

<table>
<thead>
<tr>
<th>Surgeon's Name</th>
<th>Date</th>
<th>Operation Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURPATIENT,THREE</td>
<td>000-21-2453</td>
<td>08-15-88    SHOULDER ARTHROPLASTY (NOT COMPLETE)</td>
</tr>
</tbody>
</table>

Select Number: 1/ <Enter>

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

<table>
<thead>
<tr>
<th>Surgeon's Name</th>
<th>Date</th>
<th>Operation Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURPATIENT,THREE (000-21-2453)</td>
<td>Case #14 – MAR 12,1999</td>
<td>I  Operation Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SS  Surgical Staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GS  Operation Startup</td>
</tr>
<tr>
<td></td>
<td></td>
<td>O   Operation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO  Post Operation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PAC Enter PAC(U) Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OSS Operation (Short Screen)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TO  Time Out Verified Utilizing Checklist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>V    Surgeon's Verification of Diagnosis &amp; Procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A    Anesthesia for an Operation Menu ...</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR  Operation Report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AR  Anesthesia Report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NR  Nurse Intraoperative Report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TR  Tissue Examination Report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R   Enter Referring Physician Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RP  Enter Irrigations and Restraints</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M    Medications (Enter/Edit)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B    Blood Product Verification</td>
</tr>
</tbody>
</table>

Select Operation Menu Option:

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

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

Example: Review Information

Select Surgery Menu Option: Operation Menu
Select Patient: SURPATIENT,THREE 12-19-53 000212453

SURPATIENT,THREE 000-21-2453
1. 08-15-99 SHOULDER ARTHROPLASTY (NOT COMPLETE)
2. 03-12-92 SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)
3. ENTER NEW SURGICAL CASE
Select Operation: 2

SURPATIENT,THREE 000-21-2453
08-15-88 SHOULDER ARTHROPLASTY (NOT COMPLETE)

1. Enter Information
2. Review Information
3. Delete Surgery Case
Select Number: 1// 2

** REVIEW ** CASE #14 SURPATIENT,THREE PAGE 1 OF 3
1 TIME PAT IN HOLD AREA: AUG 15, 1999 AT 07:40
2 TIME PAT IN OR: AUG 15, 1999 AT 08:00
3 ANES CARE TIME BLOCK: (MULTIPLE)
4 TIME OPERATION BEGAN: AUG 15, 1999 AT 09:00
5 SPECIMENS: (WORD PROCESSING)
6 CULTURES: (WORD PROCESSING)
7 THERMAL UNIT: (MULTIPLE)
8 ELECTROCAUTERY UNIT: 
9 ECU COAG RANGE: 
10 ECU CUTTING RANGE: 
11 TIME Tourniquet Applied: (MULTIPLE)
12 PROSTHESIS INSTALLED: (MULTIPLE)
13 REPLACEMENT FLUID TYPE: (MULTIPLE)
14 IRRIGATION: (MULTIPLE)
15 MEDICATIONS: (MULTIPLE)

Enter Screen Server Function: <Enter>

** REVIEW ** CASE #14 SURPATIENT,THREE PAGE 2 OF 3
1 SPONGE COUNT CORRECT (Y/N): YES
2 SHARPS COUNT CORRECT (Y/N): YES
3 INSTRUMENT COUNT CORRECT (Y/N):
4 SPONGE, SHARPS, & INST COUNTER: YES
5 COUNT VERIFIER:
6 SEQUENTIAL COMPRESSION DEVICE:
7 LASER UNIT: (MULTIPLE)
8 CELL SAVER: (MULTIPLE)
9 NURSING CARE COMMENTS: (WORD PROCESSING) (DATA)
10 PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE L SHOULDER
11 PRINCIPAL PRE-OP ICD DIAGNOSIS CODE:
Deleting a Surgery Case

The user enters the number 3 to access this feature. The Delete Surgery Case feature will permanently remove all information on the operative procedure from the records; however, only cases that are not completed can be deleted.

Example: How to Delete A Case

Select Surgery Menu Option: Operation Menu
Select Patient: SURPATIENT,NINE 12-09-51 000345555 NSC VETERAN

SURPATIENT,NINE 000-34-5555
1. 04-26-05 CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)
2. 12-20-05 REMOVE FACIAL LESIONS (NOT COMPLETE)
3. ENTER NEW SURGICAL CASE

Select Operation: 2

SURPATIENT,NINE 000-34-5555
12-20-05 REMOVE FACIAL LESIONS (NOT COMPLETE)
1. Enter Information
2. Review Information
3. Delete Surgery Case

Select Number: 1/// 3

Are you sure that you want to delete this case? NO/// Y
Deleting Operation...
**Entering a New Surgical Case**

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

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

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

**Prompts that require a response include:**

- "Select the Date of Operation:"
- "Desired Procedure Date:"
- "Enter the Principal Operative Procedure:"
- "Principal Preoperative Diagnosis:"
- "Select Surgeon:"
- "Attending Surgeon:"
- "Select Surgical Specialty:"

**Example: Entering a New Surgical Case**

<table>
<thead>
<tr>
<th>Select Surgery Menu Option:</th>
<th>O Operation Menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select Patient:</td>
<td>SURPATIENT,SIX</td>
</tr>
<tr>
<td></td>
<td>04-04-30</td>
</tr>
<tr>
<td></td>
<td>000098797</td>
</tr>
<tr>
<td>SURPATIENT,SIX</td>
<td>000-09-8797</td>
</tr>
</tbody>
</table>

1. ENTER NEW SURGICAL CASE

Select Operation: 1

Select the Date of Operation: T (JAN 14, 2006)
Desired Procedure Date: T (JAN 14, 2006)

Enter the Principal Operative Procedure: APPENDECTOMY
Principal Preoperative Diagnosis: APPENDICITIS

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field. The Indications for Operation field can be updated later if necessary.

Press Return to continue <Enter>

Select Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,TWO
Select Surgical Specialty: 50 GENERAL (OR WHEN NOT DEFINED BELOW)

Brief Clinical History:
1>PATIENT WITH 5-DAY HISTORY OF INCREASING ABDOMINAL
2>PAIN, ONSET OF FEVER IN LAST 24 HOURS. REBOUND
3>TENDERNESS IN RIGHT LOWER QUAD. NAUSEA AND
4>VOMITING FOR 3 DAYS.
5><Enter>

EDIT Option: <Enter>

Request Blood Availability (Y/N): N// YES

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

Select REQ BLOOD KIND: CPDA-1 RED BLOOD CELLS// <Enter>
Required Blood Product: CPDA-1 RED BLOOD CELLS
Units Required: 2
Principal Preoperative Diagnosis: APPENDICITIS

Prin Pre-OP ICD Diagnosis Code: 540.9 540.9 ACUTE APPENDICITIS NOS COM
PLICATION/COMORBIDITY ACTIVE

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

Hospital Admission Status: I// <Enter> INPATIENT
Case Schedule Type: EM EMERGENCY
First Assistant: SURSURGEON,ONE
Second Assistant: SURSURGEON,FOUR
Requested Postoperative Care: W WARD
Case Schedule Order: <Enter>
Select SURGERY POSITION: SUPINE// <Enter>
Requested Anesthesia Technique: G GENERAL
Request Frozen Section Tests (Y/N): N NO
Requested Preoperative X-Rays: <Enter>
Intraoperative X-Rays (Y/N): N NO
Request Medical Media: N NO
Request Clean or Contaminated: C CLEAN
Select REFERRING PHYSICIAN: <Enter>

General Comments:
1> <Enter>
SPD Comments:
No existing text
Edit? NO// <Enter>

** NEW SURGERY ** CASE #185 SURPATIENT, SIX PAGE 1 OF 3

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

Enter Screen Server Function: <Enter>

** NEW SURGERY ** CASE #185 SURPATIENT, SIX PAGE 2 OF 3

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

Enter Screen Server Function: <Enter>

** NEW SURGERY ** CASE #185 SURPATIENT, SIX PAGE 3 OF 3

1 SPD COMMENTS
Enter Screen Server Function:
** STARTUP **  CASE #159  SURPATIENT,THREE             PAGE 1 OF 3

1  DATE OF OPERATION:  DEC 06, 2004 AT 08:00
2  PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
3  PRIN PRE-OP ICD DIAGNOSIS CODE:
4  OTHER PREOP DIAGNOSIS: (MULTIPLE)
5  OPERATING ROOM: OR2
6  SURGERY SPECIALTY: ORTHOPEDICS
7  MAJOR/MINOR: MAJOR
8  REQ POSTOP CARE: WARD
9  CASE SCHEDULE TYPE: ELECTIVE
10  REQ ANESTHESIA TECHNIQUE: GENERAL
11  PATIENT EDUCATION/ASSESSMENT: YES
12  CANCEL DATE: 
13  CANCEL REASON: 
14  CANCELLATION AVOIDABLE: 
15  DELAY CAUSE: (MULTIPLE)

Enter Screen Server Function: 7/11
Major or Minor: J  MAJOR

Preoperative Patient Education: YES

** STARTUP **  CASE #159  SURPATIENT,THREE             PAGE 2 OF 3

1  ASA CLASS: 
2  PREOP MOOD: 
3  PREOP CONSCIOUS: 
4  PREOP SKIN INTEG: 
5  TRANS TO OR BY: 
6  HAIR REMOVAL BY: 
7  HAIR REMOVAL METHOD: 
8  HAIR REMOVAL COMMENTS: (WORD PROCESSING)
9  SKIN PREPPED BY (1): 
10  SKIN PREPPED BY (2): 
11  SKIN PREP AGENTS: 
12  SECOND SKIN PREP AGENT: 
13  SURGERY POSITION: (MULTIPLE)(DATA) 
14  RESTR & POSITION AIDS: (MULTIPLE)(DATA)
15  ELECTROGROUND POSITION:

Enter Screen Server Function: A
ASA Class: 2 2 2-MILD DISTURB.

Preoperative Mood: ?

Enter the code corresponding to the preoperative assessment of the patient's emotional status upon arrival to the operating room.

Screen prevents selection of inactive entries.

Answer with PATIENT MOOD NAME, or CODE

Choose from:
AGITATED AG
ANGRY ANG
ANXIOUS ANX
APATHETIC AP
DEPRESSED D
RELAXED R
TESTY AND IRRATE, SLEEPY BUF

Preoperative Mood: ANXIOUS ANX
Preoperative Consciousness: AO ALERT-ORIENTED AO
Preoperative Skin Integrity: INTACT I
Transported to O.R. By: PACU BED
Preop Surgical Site Hair Removal by: SURNURSE, TWO
Surgical Site Hair Removal Method: N NO HAIR REMOVED
Hair Removal Comments:
No existing text
Edit? NO/<Enter>
Skin Prepped By: <Enter>
Skin Prepped By (2): <Enter>
Skin Preparation Agent: HIIBICLENS HI
Second Skin Preparation Agent: <Enter>
Electroground Placement: RAT RIGHT ANT THIGH

** STARTUP ** CASE #159 SURPATIENT,THREE PAGE 1

SURGERY POSITION
1 SURGERY POSITION: SUPINE
2 NEW ENTRY

Enter Screen Server Function: 2
Select SURGERY POSITION: SEMISUPINE
SURGERY POSITION: SEMISUPINE// <Enter>

** STARTUP ** CASE #159 SURPATIENT,THREE PAGE 1

SURGERY POSITION (SEMISUPINE)
1 SURGERY POSITION: SEMISUPINE
2 TIME PLACED:

Enter Screen Server Function: <Enter>

** STARTUP ** CASE #159 SURPATIENT,THREE PAGE 1 OF 1

SURGERY POSITION
1 SURGERY POSITION: SUPINE
2 SURGERY POSITION: SEMISUPINE
3 NEW ENTRY

Enter Screen Server Function: <Enter>

** STARTUP ** CASE #159 SURPATIENT,THREE PAGE 1 OF 1

RESTR & POSITION AIDS
1 RESTR & POSITION AIDS: SAFETY STRAP
2 NEW ENTRY

Enter Screen Server Function: 2
Select RESTR & POSITION AIDS: FOAM PADS
RESTR & POSITION AIDS: FOAM PADS// <Enter>
** STARTUP **  CASE #159  SURPATIENT,THREE  PAGE 1 OF 1

1  RESTR & POSITION AIDS: FOAM PADS
2  APPLIED BY:

Enter Screen Server Function: 2
Applied By: SURNURSE, TWO

** STARTUP **  CASE #159  SURPATIENT,THREE  PAGE 2 OF 3

1  ASA CLASS:   2-MILD DISTURB.
2  PREOP MOOD:  ANXIOUS
3  PREOP CONSCIOUS:  ALERT-ORIENTED
4  PREOP SKIN INTEG:  INTACT
5  TRANS TO OR BY:  PACU BED
6  HAIR REMOVAL BY:  MONOSKY, ALAN
7  HAIR REMOVAL METHOD:  NO HAIR REMOVED
8  HAIR REMOVAL COMMENTS:  (WORD PROCESSING)
9  SKIN PREPPLIED BY (1):
10  SKIN PREPPLIED BY (2):
11  SKIN PREP AGENTS:  HIBICLENS
12  SECOND SKIN PREP AGENT:
13  SURGERY POSITION:  (MULTIPLE) (DATA)
14  RESTR & POSITION AIDS:  (MULTIPLE) (DATA)
15  ELECTROGROUND POSITION:  RIGHT ANT THIGH

Enter Screen Server Function: <Enter>

** STARTUP **  CASE #159  SURPATIENT,THREE  PAGE 3 OF 3

1  ELECTROGROUND POSITION (2):

Enter Screen Server Function: 1
Eletroground Position (2): LF  LEFT FLANK

** STARTUP **  CASE #159  SURPATIENT,THREE  PAGE 3 OF 3

1  ELECTROGROUND POSITION (2):

Enter Screen Server Function:
**Operation [SROMEN-OP]**

Surgeons and nurses use the *Operation* option to enter data relating to the operation during or immediately following the actual procedure. It is very important to record the time of the patient’s entrance into the hold area and operating room, the time anesthesia is administered, and the operation start time.

Many of the data fields are "multiple fields" and can have more than one value. For example, a patient can have more than one diagnosis or procedure done per operation. When a multiple field is selected, a new screen is generated so that the user can enter data related to that multiple. The up-arrow (^) can be used to exit from any multiple field. Enter a question mark (?) for software- assisted instruction.

**Field Information**

The following are fields that correspond to the Operation entries.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME OPERATION BEGAN</td>
<td>The user should check his or her institution’s policy concerning an operation’s start time. In some institutions, this may be the time of first incision.</td>
</tr>
</tbody>
</table>

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

```
** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 3
1  TIME PAT IN HOLD AREA:  
2  TIME PAT IN OR:       
3  ANES CARE TIME BLOCK:  (MULTIPLE) 
4  TIME OPERATION BEGAN:  
5  SPECIMENS:            (WORD PROCESSING)  
6  CULTURES:             (WORD PROCESSING)  
7  THERMAL UNIT:         (MULTIPLE) 
8  ELECTROCAUTERY UNIT:  
9  ESU COAG RANGE:       
10 ESU CUTTING RANGE:    
11 TIME Tourniquet Applied:  (MULTIPLE) 
12 PROSTHESIS INSTALLED: (MULTIPLE)  
13 REPLACEMENT FLUID TYPE: (MULTIPLE)  
14 IRRIGATION:           (MULTIPLE)  
15 MEDICATIONS:          (MULTIPLE)  

Enter Screen Server Function:  1;2;13:14

Time Patient Arrived in Holding Area:  8:50  (MAR 12, 1999@08:50)  
Time Patient In the O.R.:  9:00  (MAR 12, 1999@09:00)  

** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
REPLACEMENT FLUID TYPE
1  NEW ENTRY  

Enter Screen Server Function:  1
Select REPLACEMENT FLUID TYPE:  RINGERS LACTATED SOLUTION  
REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION//  <Enter>

** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
REPLACEMENT FLUID TYPE  (RINGERS LACTATED SOLUTION)
1  REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2  QTY OF FLUID (ml):     1000
3  SOURCE ID:             TRAVENOL
4  VA IDENT:              
5  REPLACEMENT FLUID COMMENTS: (WORD PROCESSING)  

Enter Screen Server Function:  2;3
Quantity of Fluid (ml): 1000
Source Identification Number:  TRAVENOL

** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
REPLACEMENT FLUID TYPE  (RINGERS LACTATED SOLUTION)
1  REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2  QTY OF FLUID (ml):     1000
3  SOURCE ID:             TRAVENOL
4  VA IDENT:              
5  REPLACEMENT FLUID COMMENTS: (WORD PROCESSING)  

Enter Screen Server Function:  <Enter>

** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
REPLACEMENT FLUID TYPE
1  REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2  NEW ENTRY  

Enter Screen Server Function:  <Enter>
```
** OPERATION ** CASE #173 SURPATIENT,TWENTY PAGE 1 OF 1
IRRIGATION

1 NEW ENTRY
Enter Screen Server Function: 1
Select IRRIGATION: NORMAL SALINE
IRRIGATION: NORMAL SALINE// <Enter>

** OPERATION ** CASE #173 SURPATIENT,TWENTY PAGE 1 OF 1
IRRIGATION (NORMAL SALINE)

1 IRRIGATION: NORMAL SALINE
2 TIME: (MULTIPLE)
Enter Screen Server Function: 2

** OPERATION ** CASE #173 SURPATIENT,TWENTY PAGE 1 OF 1
IRRIGATION (NORMAL SALINE)

1 TIME: MAR 12, 1999@09:40
TIME: MAR 12, 1999@09:40// <Enter>

** OPERATION ** CASE #173 SURPATIENT,TWENTY PAGE 1 OF 1
IRRIGATION (NORMAL SALINE)
TIME

1 TIME: MAR 12, 1999 AT 09:40
2 AMOUNT USED:
3 PROVIDER:
Enter Screen Server Function: 2:3
Amount of Solution Used: 1000
Person Responsible: SURNURSE,THREE

** OPERATION ** CASE #173 SURPATIENT,TWENTY PAGE 1 OF 1
IRRIGATION (NORMAL SALINE)
TIME

1 TIME: MAR 12, 1999 AT 09:40
2 AMOUNT USED: 1000
3 PROVIDER: SURNURSE,THREE
Enter Screen Server Function: <Enter>

** OPERATION ** CASE #173 SURPATIENT,TWENTY PAGE 1 OF 1
IRRIGATION (NORMAL SALINE)
TIME

1 TIME: MAR 12, 1999 AT 09:40
2 NEW ENTRY
Enter Screen Server Function: <Enter>
** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 2 OF 3

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): YES
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,THREE
5    COUNT VERIFIER:
6    SEQUENTIAL COMPRESSION DEVICE:
7    LASER UNIT: (MULTIPLE)
8    CELL SAVER: (MULTIPLE)
9    NURSING CARE COMMENTS: (WORD PROCESSING)
10   PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
11   PRIN PRE-OP ICD DIAGNOSIS CODE:
12   PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
13   PLANNED PRIN PROCEDURE CODE :
14   OTHER PROCEDURES: (MULTIPLE)
15   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function: 1:4

Final Sponge Count Correct (Y/N): Y YES
Final Sharps Count Correct (Y/N): Y YES
Final Instrument Count Correct (Y/N): Y YES
Person Responsible for Final Counts: SURNURSE,THREE

** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 2 OF 3

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): YES
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,THREE
5    COUNT VERIFIER:
6    SEQUENTIAL COMPRESSION DEVICE:
7    LASER UNIT: (MULTIPLE)
8    CELL SAVER: (MULTIPLE)
9    NURSING CARE COMMENTS: (WORD PROCESSING)
10   PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
11   PRIN PRE-OP ICD DIAGNOSIS CODE:
12   PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
13   PLANNED PRIN PROCEDURE CODE :
14   OTHER PROCEDURES: (MULTIPLE)
15   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function: 9

NURSING CARE COMMENTS:
1>Admitted with prosthesis in place, left eye is artificial eye.
2>Foam pads applied to elbows and knees. Pillow placed under knees.
3><Enter>
EDIT Option: <Enter>
** OPERATION ** CASE #173 SURPATIENT,TWENTY  PAGE 2 OF 3

1 SPONGE COUNT CORRECT (Y/N): YES
2 SHARPS COUNT CORRECT (Y/N): YES
3 INSTRUMENT COUNT CORRECT (Y/N): YES
4 SPONGE, SHARPS, & INST COUNTER: SURNURSE,THREE
5 COUNT VERIFIER:
6 SEQUENTIAL COMPRESSION DEVICE:
7 LASER UNIT: (MULTIPLE)
8 CELL SAVER: (MULTIPLE)
9 NURSING CARE COMMENTS: (WORD PROCESSING)(DATA)
10 PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
11 PRIN PRE-OP ICD DIAGNOSIS CODE:
12 PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
13 PLANNED PRIN PROCEDURE CODE:
14 OTHER PROCEDURES: (MULTIPLE)
15 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function: <Enter>

** OPERATION ** CASE #173 SURPATIENT,TWENTY  PAGE 3 OF 3

1 BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function:
Enter PAC(U) Information
[SROMEN-PACU]

Personnel in the Post Anesthesia Care Unit (PACU) use the Enter PAC(U) Information option to enter the admission and discharge times and scores.

Example: Entering PAC(U) Information

Select Operation Menu Option: PAC Enter PAC(U) Information

** PACU ** CASE #145 SURPATIENT,NINE PAGE 1 OF 1
1 ADMIT PAC(U) TIME: 
2 PAC(U) ADMIT SCORE: 
3 PAC(U) DISCH TIME: 
4 PAC(U) DISCH SCORE: 

Enter Screen Server Function: 1:4
PAC(U) Admission Time: 13:00 (APR 26, 1999@13:00)
PAC(U) Admission Score: 10
PAC(U) Discharge Date/Time: 14:00 (APR 26, 1999@14:00)
PAC(U) Discharge Score: 10

** PACU ** CASE #145 SURPATIENT,NINE PAGE 1 OF 1
1 ADMIT PAC(U) TIME: APR 26, 1999 AT 13:00
2 PAC(U) ADMIT SCORE: 10
3 PAC(U) DISCH TIME: APR 26, 1999 AT 14:00
4 PAC(U) DISCH SCORE: 10

Enter Screen Server Function:
Operation (Short Screen)
[SROMEN-OUT]

The Operation (Short Screen) option provides a three-page screen of information concerning a surgical procedure performed on a patient. The Operation (Short Screen) option allows the nurse or surgeon to easily enter data relating to the operation during, and shortly after, the actual procedure. This time-saving option can replace the Operation Startup option, the Operation option, and the Post Operation option for minor surgeries.

When only one anesthesia technique is entered, the software will assume that it is the principal anesthesia technique for the case. Some data fields may be automatically pre-populated if the case was booked in advance.

Example: Operation Short Screen

Select Operation Menu Option: OSS  Operation (Short Screen)

** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE       PAGE 1 OF 3
1    DATE OF OPERATION:     MAR 09, 2005
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,FOUR
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:  
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE: 17000
9    OTHER PROCEDURES: (MULTIPLE)
10   HAIR REMOVAL BY:      
11   HAIR REMOVAL METHOD:  
12   HAIR REMOVAL COMMENTS: (WORD PROCESSING)
13   TIME PAT IN OR:      
14   TIME OPERATION BEGAN: 
15   TIME OPERATION ENDS:  

Enter Screen Server Function: 13:15
Time Patient In the O.R.: 13:00 (MAR 09, 2005@13:00)
Time the Operation Began: 13:10 (MAR 09, 2005@13:10)
Time the Operation Ends: 13:36 (MAR 09, 2005@13:36)
DATE OF OPERATION: MAR 09, 2005
IN/OUT-PATIENT STATUS: OUTPATIENT
SURGEON: SURSURGEON, FOUR
PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
PRIN PRE-OP ICD DIAGNOSIS CODE:
OTHER PREOP DIAGNOSIS: (MULTIPLE)
PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
PLANNED PRIN PROCEDURE CODE: 17000
OTHER PROCEDURES: (MULTIPLE)
HAIR REMOVAL BY:
HAIR REMOVAL METHOD:
HAIR REMOVAL COMMENTS: (WORD PROCESSING)
TIME PAT IN OR: MAR 09, 2005 AT 13:00
TIME OPERATION BEGAN: MAR 09, 2005 at 13:10
TIME OPERATION ENDS: MAR 09, 2005 AT 13:36

Enter Screen Server Function: <Enter>

TIME PAT OUT OR:
IV STARTED BY:
OR CIRC SUPPORT: (MULTIPLE)
OR SCRUB SUPPORT: (MULTIPLE)
OPERATING ROOM:
FIRST ASST:
SPONGE COUNT CORRECT (Y/N):
SHARPS COUNT CORRECT (Y/N):
INSTRUMENT COUNT CORRECT (Y/N):
SPONGE, SHARPS, & INST COUNTER:
COUNT VERIFIER:
SURGERY SPECIALTY: GENERAL (OR WHEN NOT DEFINED BELOW)
WOUND CLASSIFICATION:
ATTEND SURG:
ATTENDING CODE:

Enter Screen Server Function: 1;5;15

Time Patient Out of the O.R.: 13:40 (MAR 09, 2005@13:40)
Operating Room: OR1
Attending Code: A LEVEL A: ATTENDING DOING THE OPERATION A
The staff practitioner performs the case, but may be assisted by a resident.

TIME PAT OUT OR: MAR 12, 2006 AT 13:40
IV STARTED BY:
OR CIRC SUPPORT: (MULTIPLE)
OR SCRUB SUPPORT: (MULTIPLE)
OPERATING ROOM: OR1
FIRST ASST:
SPONGE COUNT CORRECT (Y/N):
SHARPS COUNT CORRECT (Y/N):
INSTRUMENT COUNT CORRECT (Y/N):
SPONGE, SHARPS, & INST COUNTER:
COUNT VERIFIER:
SURGERY SPECIALTY: GENERAL (OR WHEN NOT DEFINED BELOW)
WOUND CLASSIFICATION:
ATTEND SURG:
ATTENDING CODE:

Enter Screen Server Function: <Enter>
** SHORT SCREEN **  CASE #186 SURPATIENT,TWELVE  PAGE 3 OF 3

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SPECIMENS: (WORD PROCESSING)</td>
</tr>
<tr>
<td>2</td>
<td>CULTURES: (WORD PROCESSING)</td>
</tr>
<tr>
<td>3</td>
<td>NURSING CARE COMMENTS: (WORD PROCESSING) (DATA)</td>
</tr>
<tr>
<td>4</td>
<td>ASA CLASS:</td>
</tr>
<tr>
<td>5</td>
<td>PRINC ANESTHETIST: SURANESTHETIST,FOUR</td>
</tr>
<tr>
<td>6</td>
<td>ANESTHESIA TECHNIQUE: (MULTIPLE)</td>
</tr>
<tr>
<td>7</td>
<td>ANES CARE TIME BLOCK: (MULTIPLE)</td>
</tr>
<tr>
<td>8</td>
<td>DELAY CAUSE: (MULTIPLE)</td>
</tr>
<tr>
<td>9</td>
<td>CANCEL DATE:</td>
</tr>
<tr>
<td>10</td>
<td>CANCEL REASON:</td>
</tr>
<tr>
<td>11</td>
<td>CANCELLATION COMMENTS:</td>
</tr>
</tbody>
</table>

Enter Screen Server Function: 3:4

Nursing Care Comments:
1>PATIENT ARRIVED AMBULATORY FROM AMBULATORY
2>SURGERY UNIT. DISCHARGED VIA WHEELCHAIR, AWAKE,
3>ALERT, ORIENTED.

EDIT Option: <Enter>

ASA Class: 3

Enter Screen Server Function: <Enter>
Time Out Verified Utilizing Checklist
[SROMEN-VERF]

This option is used to enter information related to the Time Out Verified Utilizing Checklist.

Example: Time Out Verified Utilizing Checklist

Select Operation Menu Option: Time Out Verified Utilizing Checklist

** TIME OUT CHECKLIST **  CASE #145  SURPATIENT,NINE  PAGE 1 OF 1

1 CONFIRM PATIENT IDENTITY:
2 PROCEDURE TO BE PERFORMED:
3 SITE OF PROCEDURE:
4 VALID CONSENT FORM:
5 CONFIRM PATIENT POSITION:
6 MARKED SITE CONFIRMED:
7 PREOPERATIVE IMAGES CONFIRMED:
8 CORRECT MEDICAL IMPLANTS:
9 AVAILABILITY OF SPECIAL EQUIP:
10 ANTIBIOTIC PROPHYLAXIS:
11 APPROPRIATE DVT PROPHYLAXIS:
12 BLOOD AVAILABILITY:
13 CHECKLIST COMMENT:       (WORD PROCESSING)
14 CHECKLIST CONFIRMED BY:

Enter Screen Server Function: A
Confirm Correct Patient Identity: Y YES
Confirm Procedure To Be Performed: Y YES
Confirm Site of Procedure, Including Laterality: Y YES
Confirm Valid Consent Form: Y YES
Confirm Patient Position: N NO
Confirm Proc. Site has been Marked Appropriately and the Site of the Mark is Visible After Prep: Y YES
Pertinent Medical Images Have Been Confirmed: Y YES
Correct Medical Implant(s) is Available: Y YES
Availability of Special Equipment: Y YES
Appropriate Antibiotic Prophylaxis: Y YES
Appropriate Deep Vein Thrombosis Prophylaxis: Y YES
Blood Availability: Y YES
Checklist Comment:
  No existing text
Edit? NO// <Enter>
Checklist Confirmed By: SURNURSE,FIVE

Checklist Comments should be entered when a "NO" response is entered for any of the Time Out Verified Utilizing Checklist fields.
Do you want to enter Checklist Comment ? YES//

Checklist Comment:
  No existing text
Edit? NO//

** TIME OUT CHECKLIST **  CASE #145  SURPATIENT,NINE  PAGE 1 OF 1

1 CONFIRM PATIENT IDENTITY: YES
2 PROCEDURE TO BE PERFORMED: YES
3 SITE OF PROCEDURE: YES
4 VALID CONSENT FORM: YES
5 CONFIRM PATIENT POSITION: YES
6 MARKED SITE CONFIRMED: YES
7 PREOPERATIVE IMAGES CONFIRMED: YES
8 CORRECT MEDICAL IMPLANTS: YES
9 AVAILABILITY OF SPECIAL EQUIP: YES
10 ANTIBIOTIC PROPHYLAXIS: YES
11 APPROPRIATE DVT PROPHYLAXIS: YES
12 BLOOD AVAILABILITY: YES
Enter Screen Server Function:
At the bottom of the first screen is the prompt, "Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit." The Nurse Intraoperative Report functions, accessed by entering A at the prompt, allow the user to edit the report, to view or print the report, or to electronically sign the report.

Example: First page of the Nurse Intraoperative Report

<table>
<thead>
<tr>
<th>Medical Record</th>
<th>Nurse Intraoperative Report - Case #267226</th>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURPATIENT,TEN (000-12-3456)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Room: BO OR1</td>
<td>Surgical Priority: ELECTIVE</td>
<td></td>
</tr>
<tr>
<td>Patient in Hold: JUL 12, 2004 07:30</td>
<td>Patient in OR: JUL 12, 2004 08:00</td>
<td></td>
</tr>
<tr>
<td>Operation Begin: JUL 12, 2004 08:58</td>
<td>Operation End: JUL 12, 2004 12:10</td>
<td></td>
</tr>
<tr>
<td>Surgeon in OR: JUL 12, 2004 07:55</td>
<td>Patient Out OR: JUL 12, 2004 12:45</td>
<td></td>
</tr>
<tr>
<td>Major Operations Performed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary: MVR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound Classification: CLEAN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operation Disposition: SICU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharged Via: ICU BED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon: SURSURGEON,THREE</td>
<td>First Assist: SURSURGEON,FOUR</td>
<td></td>
</tr>
<tr>
<td>Attend Surg: SURSURGEON,THREE</td>
<td>Second Assist: N/A</td>
<td></td>
</tr>
<tr>
<td>Anesthetist: SURANESTHETIST,SEVEN</td>
<td>Assistant Anesth: N/A</td>
<td></td>
</tr>
</tbody>
</table>

Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit: A
After the user enters an A at the prompt, the Nurse Intraoperative Report functions are displayed. The following examples demonstrate how these three functions are accessed and how they operate. If the user enters a 1, the Nurse Intraoperative Report data can be edited.

Example: Editing the Nurse Intraoperative Report

SURPATIENT,TEN (000-12-3456)   Case #267226 - JUL 12, 2004

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2 // 1

** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

1  CONFIRM PATIENT IDENTITY: YES
2  PROCEDURE TO BE PERFORMED: YES
3  SITE OF PROCEDURE:       YES
4  VALID CONSENT FORM:      YES
5  CONFIRM PATIENT POSITION: YES
6  MARKED SITE CONFIRMED:
7  PREOPERATIVE IMAGING CONFIRMED:
8  CORRECT MEDICAL IMPLANTS: YES
9  AVAILABILITY OF SPECIAL EQUIP: YES
10  ANTIBIOTIC PROPHYLAXIS: YES
11  APPROPRIATE DVT PROPHYLAXIS: YES
12  BLOOD AVAILABILITY:      YES
13  CHECKLIST COMMENT:       (WORD PROCESSING)
14  CHECKLIST CONFIRMED BY:  SURNURSE,FIVE

Enter Screen Server Function: <Enter>

** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 2 OF 6

1  SPONGE COUNT CORRECT (Y/N): YES
2  SHARPS COUNT CORRECT (Y/N): YES
3  INSTRUMENT COUNT CORRECT (Y/N): YES
4  SPONGE, SHARPS, & INST COUNTER: SURNURSE,FIVE
5  COUNT VERIFIER:
6  TIME PAT IN HOLD AREA:   JUL 12, 2004 AT 07:30
7  TIME PAT IN OR:          JUL 12, 2004 AT 08:00
8  TIME OPERATION BEGAN:    JUL 12, 2004 at 08:58
9  TIME OPERATION ENDS:     JUL 12, 2004 AT 12:30
10  SURG PRESENT TIME:
11  TIME PAT OUT OR:
12  PRINCIPAL PROCEDURE:     CHOLECYSTECTOMY
13  OTHER PROCEDURES:        (MULTIPLE)
14  WOUND CLASSIFICATION:    CLEAN

Enter Screen Server Function: 14
Wound Classification: CLEAN// CONTAMINATED CONTAMINATED

** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 2 OF 6

1  SPONGE COUNT CORRECT (Y/N): YES
2  SHARPS COUNT CORRECT (Y/N): YES
3  INSTRUMENT COUNT CORRECT (Y/N): YES
4  SPONGE, SHARPS, & INST COUNTER: SURNURSE,FIVE
5  COUNT VERIFIER:
6  TIME PAT IN HOLD AREA:   JUL 12, 2004 AT 07:30
7  TIME PAT IN OR:          JUL 12, 2004 AT 08:00
8  TIME OPERATION BEGAN:    JUL 12, 2004 at 08:58
9  TIME OPERATION ENDS:     JUL 12, 2004 AT 12:30
10  SURG PRESENT TIME:
** NURSE INTRAOP ** CASE #267226 SURPATIENT,TEN PAGE 3 OF 6

1 MAJOR/MINOR: MAJOR
2 OPERATING ROOM: OR1
3 CASE SCHEDULE TYPE: ELECTIVE
4 SURGEON: SURSURGEON,THREE
5 ATTEND SURG: SURSURGEON,THREE
6 FIRST ASST: SURSURGEON,FOUR
7 SECOND ASST:
8 PRINC ANESTHETIST: SURANESTHETIST,SEVEN
9 ASST ANESTHETIST:
10 OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
11 OR SCRUB SUPPORT: (MULTIPLE) (DATA)
12 OR CIRC SUPPORT: (MULTIPLE) (DATA)
13 OTHER PERSONS IN OR: (MULTIPLE)
14 PREOP MOOD: RELAXED
15 PREOP CONSCIOUS: RESTING

Enter Screen Server Function: <Enter>

** NURSE INTRAOP ** CASE #267226 SURPATIENT,TEN PAGE 4 OF 6

1 PREOP SKIN INTEG: INTACT
2 PREOP CONVERSE: NOT ANSWER QUESTIONS
3 HAIR REMOVAL BY: SURNURSE,FIVE
4 HAIR REMOVAL METHOD: OTHER
5 HAIR REMOVAL COMMENTS: (WORD PROCESSING) (DATA)
6 SKIN PREPPED BY (1): SURNURSE,FIVE
7 SKIN PREPPED BY (2):
8 SKIN PREP AGENTS: BETADINE
9 SECOND SKIN PREP AGENT: POVIDONE IODINE
10 SURGERY POSITION: (MULTIPLE) (DATA)
11 RESTR & POSITION AIDS: (MULTIPLE) (DATA)
12 ELECTROCAUTERY UNIT:
13 ESU COAG RANGE:
14 ESU CUTTING RANGE:
15 ELECTROGROUND POSITION:

Enter Screen Server Function: ^

At the Nurse Intraoperative Report functions, the report can be printed if the user enters a 2.

Example: Printing the Nurse Intraoperative Report

SURPATIENT,TEN (000-12-3456) Case #267226 - JUL 12, 2004

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2// <Enter>

---printout follows---
SRPATIENT,TEN  000-12-3456                         NURSE INTRAOPERATIVE REPORT
--------------------------------------------------------------------------------
NOTE DATED: 07/12/2004 08:00  NURSE INTRAOPERATIVE REPORT
--------------------------------------------------------------------------------
SUBJECT: Case #: 267226
Operating Room: BO OR1  Surgical Priority: ELECTIVE
Patient in Hold: JUL 12, 2004 07:30  Patient in OR: JUL 12, 2004 08:00
Operation Begin: JUL 12, 2004 08:58  Operation End: JUL 12, 2004 12:10
Surgeon in OR: JUL 12, 2004 07:55  Patient Out OR: JUL 12, 2004 12:45

Major Operations Performed:
Primary: MVR

Wound Classification: CONTAMINATED
Operation Disposition: SICU
Discharged Via: ICU BED

Surgeon: SURSURGEON,THREE  First Assist: SURSURGEON,FOUR
Attend Surg: SURSURGEON,THREE  Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN  Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:

- Scrubbed
  - SURNURSE,ONE (FULLY TRAINED)
  - SURNURSE,FOUR (FULLY TRAINED)

- Circulating
  - SURNURSE,FIVE (FULLY TRAINED)
  - SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

- Preop Mood: ANXIOUS
- Preop Conc: ALERT-ORIENTED
- Preop Skin Integ: INTACT
- Preop Converse: N/A

Confirm Correct Patient Identity: YES
Confirm Procedure to be Performed: YES
Confirm Site of the Procedure, including laterality: YES
Confirm Valid Consent Form: YES
Confirm Patient Position: YES
Confirm Proc. Site has been Marked Appropriately and that the Site of the
Mark is Visible After Prep and Draping: YES
Pertinent Medical Images have been Confirmed: YES
Correct Medical Implant(s) is available: YES
Availability of Special Equipment: YES
Appropriate Antibiotic Prophylaxis: YES
Appropriate Deep Vein Thrombosis Prophylaxis: YES
Blood Availability: YES

Checklist Comment: NO COMMENTS ENTERED

Checklist Confirmed By: SURNURSE,FIVE

Skin Prep By: SURNURSE,FOUR  Skin Prep Agent: BETADINE SCRUB
Skin Prep By (2): SURNURSE,FIVE  2nd Skin Prep Agent: Povidone Iodine

Preop Surgical Site Hair Removal by: SURNURSE,FIVE

Preop Surgical Site Hair Removal Method: OTHER
- Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):
- SUPINE
  - Placed: N/A

Restraints and Position Aids:
- SAFETY STRAP  Applied By: N/A
- ARMBOARD  Applied By: N/A
- FOAM PADS  Applied By: N/A
- KODEL PAD  Applied By: N/A
- STIRRUPS  Applied By: N/A

Electrocautery Unit: 8845,5512
ESU Coagulation Range: 50-35
ESU Cutting Range: 35-35
Electroground Position(s): RIGHT BUTTOCK
LEFT BUTTOCK

Material Sent to Laboratory for Analysis:
Specimens:
1. MITRAL VALVE
Cultures: N/A

Anesthesia Technique(s):
GENERAL (PRINCIPAL)

Tubes and Drains:
#16FOLEY, #18NGTUBE, #36 & #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
Item: MITRAL VALVE
Implant Sterility Checked (Y/N): YES
Sterility Expiration Date: DEC 15, 2004
RN Verifier: SURNURSE, ONE
Vendor: BAXTER EDWARDS
Model: 6900
Lot/Serial Number: GY0755
Size: 29MM
Sterile Resp: MANUFACTURER
Quantity: 1

Medications: N/A

Irrigation Solution(s):
HEPARINIZED SALINE
NORMAL SALINE
COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count:
Sharps Count: YES
Instrument Count: NOT APPLICABLE
Counter: SURNURSE, FOUR
Counts Verified By: SURNURSE, FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing: NONE

Blood Loss: 800 ml Urine Output: 750 ml

Postoperative Mood: RELAXED
Postoperative Consciousness: ANESTHETIZED
Postoperative Skin Integrity: SUTURED INCISION
Postoperative Skin Color: N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:
PATIENT STATES HE IS ALLERGIC TO PCN. ALL WRVAMC INTRAOPERATIVE NURSING STANDARDS WERE MONITORED THROUGHOUT THE PROCEDURE. VANCYMYCIN PASTE WAS APPLIED TO STERNUM.
To electronically sign the report, the user enters a 3 at the Nurse Intraoperative Report functions prompt.

Example: Signing the Nurse Intraoperative Report

```
SURPATIENT,TEN (000-12-3456)   Case #267226 - JUL 12, 2004

Nurse Intraoperative Report Functions:
1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2// 3
```

The Nurse Intraoperative Report may only be signed by a circulating nurse on the case. At the time of electronic signature, the software checks for data in key fields. The nurse will not be able to sign the report if the following fields are not entered:

- TIME PATIENT IN OR MARKED SITE CONFIRMED
- PREOPERATIVE IMAGING CONFIRMED
- PROCEDURE TO BE PERFORMED
- VALID CONSENT FORM
- CORRECT MEDICAL IMPLANTS
- APPROPRIATE DVT PROPHYLAXIS
- AVAILABILITY OF SPECIAL EQUIP
- TIME PATIENT OUT OF OR
- CORRECT PATIENT IDENTITY
- HAIR REMOVAL METHOD
- SITE OF THE PROCEDURE
- PATIENT POSITION
- ANTIBIOTIC PROPHYLAXIS
- BLOOD AVAILABILITY
- CHECKLIST COMMENT

If the COUNT VERIFIER field is entered, the other counts related fields must be populated. These count fields include the following:

- SPONGE COUNT CORRECT
- INSTRUMENT COUNT CORRECT (Y/N)
- SHARPS COUNT CORRECT (Y/N)
- SPONGE, SHARPS, & INST COUNTER

If the PROSTHESIS INSTALLED field has an item (or items) entered, the following fields are required for each item:

- IMPLANT STERILITY CHECKED (Y/N)
- RN VERIFIER
- STERILITY EXPIRATION DATE

If any of the key fields are missing, the software will require them to be entered prior to signature. In the following example, the final sponge count must be entered before the nurse is allowed to electronically sign the report.

Example: Missing Field Warning

```
The following information is required before this report may be signed:

ANTIBIOTIC PROPHYLAXIS
CHECKLIST COMMENT

Do you want to enter this information? YES// YES
```
If any of the Time Out Verified Utilizing Checklist fields is answered with “NO”, then the user is prompted to enter information in the CHECKLIST COMMENT field. Entry in the CHECKLIST COMMENT field is required in such cases where “NO” has been entered before the user can electronically sign the Nurse Intraoperative Report.
**Nurse Intraoperative Report - After Electronic Signature**

After the report has been signed, any changes to the report will require a signed addendum.

Example: Editing the Signed Nurse Intraoperative Report

<table>
<thead>
<tr>
<th>SURPATIENT,TEN (000-12-3456)</th>
<th>Case #267226 - JUL 12, 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>* * The Nurse Intraoperative Report has been electronically signed. * *</td>
<td></td>
</tr>
<tr>
<td>Nurse Intraoperative Report Functions:</td>
<td></td>
</tr>
<tr>
<td>1. Edit report information</td>
<td></td>
</tr>
<tr>
<td>2. Print/View report from beginning</td>
<td></td>
</tr>
<tr>
<td>Select number: 2// 1 Edit report information</td>
<td></td>
</tr>
</tbody>
</table>

___

If the Anesthesia Report and/or the Nurse Intraoperative Report is already signed, the following warning will be displayed. If any data on either signed report is edited, an addendum to the Anesthesia Report and/or to the Nurse Intraoperative Report will be required.

<table>
<thead>
<tr>
<th>SURPATIENT,TEN (000-12-3456)</th>
<th>Case #267226 - JUL 12, 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;&gt;&gt; WARNING &lt;&lt;&lt;</td>
<td></td>
</tr>
<tr>
<td>Electronically signed reports are associated with this case. Editing of data that appear on electronically signed reports will require the creation of addenda to the signed reports.</td>
<td></td>
</tr>
</tbody>
</table>

Enter RETURN to continue or ‘^^’ to exit: <Enter>
First, the user makes the edits to the desired field.

An addendum is required before the edit can be made to the signed report.

Create addendum? YES// <Enter>

Addendum for Case #267226 - JUL 12, 2004
Patient: SURPATIENT,TEN (000-12-3456)

The Checklist Confirmed By field was changed
from SURNURSE,FOUR
to SURNURSE,FIVE

Before the addendum is signed, comments may be added.
Example: Signing the Addendum

Comment: **OPERATION END TIME WAS CORRECTED.**

Addendum for Case #267226 - JUL 12, 2004
Patient: SURPATIENT, TEN (000-12-3456)
-------------------------------------------------------------

The Checklist Confirmed By field was changed
from SURNURSE, FOUR
to SURNURSE, FIVE

Addendum Comment: **OPERATION END TIME WAS CORRECTED.**

Enter RETURN to continue or '' to exit:
Enter your Current Signature Code: Xxxxxx SIGNATURE VERIFIED.
Press RETURN to continue... <Enter>

Example: Printing the Nurse Intraoperative Report

SURPATIENT, TEN (000-12-3456)  Case #267226 - JUL 12, 2004
  * * The Nurse Intraoperative Report has been electronically signed. * *

Nurse Intraoperative Report Functions:
  1. Edit report information
  2. Print/View report from beginning

Select number: 2// 2  Print/View report from beginning

Do you want WORK copies or CHART copies? WORK// <Enter>

DEVICE: HOME//  [Select Print Device]
-------------------------------------------------------------printout follows-------------------------------------------------------------
SURPATIENT, TEN 000-12-3456
NOTE DATED: 07/12/2004 08:00

SUBJECT: Case #: 267226

Operating Room: BO OR1
Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30
Operation Begin: JUL 12, 2004 08:58
Surgeon in OR: JUL 12, 2004 07:55

Patient in OR: JUL 12, 2004 08:00
Operation End: JUL 12, 2004 12:30
Surgeon Out OR: JUL 12, 2004 12:45

Major Operations Performed:
Primary: MVR

Wound Classification: CONTAMINATED
Operation Disposition: SICU
Discharged Via: ICU BED

Surgeon: SURGEON, THREE
First Assist: SURGEON, FOUR
Attend Surg: SURGEON, THREE
Second Assist: N/A
Anesthetist: ANESTHETIST, SEVEN
Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:
Scrubbed: SURNURSE, ONE (FULLY TRAINED)
Circulating: SURNURSE, FIVE (FULLY TRAINED)
SURNURSE, FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS
Preop Consc: ALERT-ORIENTED
Preop Skin Integ: INTACT
Preop Converse: N/A

Confirm Correct Patient Identity: YES
Confirm Procedure to be Performed: YES
Confirm Site of the Procedure, including laterality: YES
Confirm Valid Consent Form: YES
Confirm Patient Position: YES
Confirm Proc. Site has been Marked Appropriately and that the Site of the
Mark is Visible After Prep and Draping: YES
Pertinent Medical Images have been Confirmed: YES
Correct Medical Implant(s) Is Available: YES
Availability of Special Equipment: YES
Appropriate Antibiotic Prophylaxis: YES
Appropriate Deep Vein Thrombosis Prophylaxis: YES
Blood Availability: YES
Checklist Comment: NO COMMENTS ENTERED

Checklist Confirmed By: SURNURSE, FOUR
Skin Prep By: SURNURSE, FOUR
Skin Prep Agent: BETADINE SCRUB
Skin Prep By (2): SURNURSE, FIVE
2nd Skin Prep Agent: POVIDONE IODINE

Surgical Site Hair Removal Method: OTHER
Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):
SUPINE
Placed: N/A

Restraints and Position Aids:
SAFETY STRAP
ARMBOARD
FOAM PADS
KODEL PAD
STIRRUPS
Applied By: N/A
Applied By: N/A
Applied By: N/A
Applied By: N/A
Applied By: N/A

Electrocautery Unit: 8845, 5512
ESU Coagulation Range: 50-35
ESU Cutting Range: 35-35
Electroground Position(s): RIGHT BUTTOCK
LEFT BUTTOCK

Material Sent to Laboratory for Analysis:
Specimens:
1. MITRAL VALVE
Cultures: N/A
Anesthesia Technique(s):
GENERAL (PRINCIPAL)

Tubes and Drains:
#16FOLEY, #18NGTUBE, #36 & #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
Item: MITRAL VALVE
Implant Sterility Checked (Y/N): YES
Sterility Expiration Date: DEC 15, 2004
RN Verifier: SURNURSE, ONE
Vendor: BAXTER EDWARDS
Model: 6900
Lot/Serial Number: GY0755 Sterile Resp: MANUFACTURER
Size: 29MM Quantity: 1

Medications: N/A

Irrigation Solution(s):
HEPARINIZED SALINE
NORMAL SALINE
COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count: YES
Sharps Count: YES
Instrument Count: NOT APPLICABLE
Counter: SURNURSE, FOUR
Counts Verified By: SURNURSE, FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Pack: NONE

Blood Loss: 800 ml Urine Output: 750 ml

Postoperative Mood: RELAXED
Postoperative Consciousness: ANESTHETIZED
Postoperative Skin Integrity: SUTURED INCISION
Postoperative Skin Color: N/A

Laser Unit(s): N/A
Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:
PATIENT STATES HE IS ALLERGIC TO PCN. ALL WRVAMC INTRAOPERATIVE NURSING STANDARDS WERE MONITORED THROUGHOUT THE PROCEDURE. VANCYMYCIN PASTE WAS APPLIED TO STERNUM.

Signed by: /es/ FIVE SURNURSE
07/13/2004 10:41

07/17/2004 16:42 ADDENDUM

The Checklist Confirmed By field was changed from SURNURSE, FOUR
to SURNURSE, FIVE

Addendum Comment: OPERATION END TIME WAS CORRECTED.
Signed by: /es/ FIVE SURNURSE
07/17/2004 16:42
Perioperative Occurrences Menu
[SRO COMPLICATIONS MENU]

Surgeons use options within the *Perioperative Occurrences Menu* option to enter or edit occurrences that occur before, during, and/or after a surgical procedure. It is also possible to enter occurrences for a patient who did not have a surgical procedure performed. The user can enter more than one occurrence per patient.

This option is locked with the SROCOMP key.

Occurrences will be included on the Chief of Surgery’s Morbidity & Mortality Reports.

Please review specific institution policy to determine what is considered an occurrence for any category.

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

<table>
<thead>
<tr>
<th>Shortcut</th>
<th>Option Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td><em>Intraoperative Occurrences (Enter/Edit)</em></td>
</tr>
<tr>
<td>P</td>
<td><em>Postoperative Occurrences (Enter/Edit)</em></td>
</tr>
<tr>
<td>N</td>
<td><em>Non-Operative Occurrences (Enter/Edit)</em></td>
</tr>
<tr>
<td>U</td>
<td><em>Update Status of Returns Within 30 Days</em></td>
</tr>
<tr>
<td>M</td>
<td><em>Morbidity &amp; Mortality Reports</em></td>
</tr>
</tbody>
</table>

**Key Vocabulary**

The following terms are used in this section.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intraoperative Occurrence</td>
<td>Occurrence that occurs during the procedure.</td>
</tr>
<tr>
<td>Postoperative Occurrence</td>
<td>Occurrence that occurs after the procedure.</td>
</tr>
<tr>
<td>Non-Operative Occurrence</td>
<td>Occurrence that develops before a surgical procedure is performed.</td>
</tr>
</tbody>
</table>
**Intraoperative Occurrences (Enter/Edit)**

The *Intraoperative Occurrences (Enter/Edit)* option is used to add information about an occurrence that occurs during the procedure. The user can also use this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, the user should select an operation. The software will then list any occurrences already entered for that operation. The user may edit a previously entered occurrence or can type the word **NEW** and press the `<Enter>` key to enter a new occurrence.

At the prompt "Enter a New Intraoperative Occurrence:" the user can enter two question marks (??) to get a list of categories. Be sure to enter a category for all occurrences to satisfy Surgery Central Office reporting needs.

Example: Entering Intraoperative Occurrences

Select Patient: **SURPATIENT,FIFTY** 10-28-45 000459999

<table>
<thead>
<tr>
<th>SURPATIENT,FIFTY 000-45-9999</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 06-30-06 CHOLECYSTECTOMY (COMPLETED)</td>
</tr>
<tr>
<td>2. 03-10-07 HEMORRHIOIDENTOMY (COMPLETED)</td>
</tr>
</tbody>
</table>

Select Operation: 1

SurPatient,Fifty (000-45-9999) Case #213
JUN 30,2006 CHOLECYSTECTOMY

There are no Intraoperative Occurrences entered for this case.

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

Definition Revised (2011): 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. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

If patient had cardiac arrest requiring CPR, indicate whether the arrest occurred intraoperatively or postoperatively. Indicate the one appropriate response:
- intraoperatively: occurring while patient was in the operating room
- postoperatively: occurring after patient left the operating room

Press RETURN to continue: `<Enter>`
1. Occurrence: CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted: CPR
5. Outcome to Date: IMPROVED
6. Occurrence Comments:
**Postoperative Occurrences (Enter/Edit)**

[SRO POSTOP COMP]

The *Postoperative Occurrences (Enter/Edit)* option is used to add information about an occurrence that occurs after the procedure. The user can also utilize this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, the user selects an operation. The software will then list any occurrences already entered for that operation. The user can choose to edit a previously entered occurrence or type the word **NEW** and press the `<Enter>` key to enter a new occurrence.

At the prompt "Enter a New Postoperative Complication:" the user can enter two question marks (??) to get a list of categories. Be sure to enter a category for all occurrences in order to satisfy Surgery Central Office reporting needs.

**Example: Entering a Postoperative Occurrence**

Select Perioperative Occurrences Menu Option: **P** Postoperative Occurrence (Enter/Edit)

<table>
<thead>
<tr>
<th>Select Patient: SURPATIENT,SEVENTEEN</th>
<th>09-13-28</th>
<th>000455119</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURPATIENT,SEVENTEEN R. 000-45-5119</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. 04-18-07 CRANIOTOMY (COMPLETED)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. 03-18-07 REPAIR INCARCERATED INGUINAL HERNIA (COMPLETED)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select Operation: **2**

<table>
<thead>
<tr>
<th>SURPATIENT,SEVENTEEN (000-45-5119)</th>
<th>Case #202</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAR 18,2007 REPAIR INCARCERATED INGUINAL HERNIA</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>There are no Postoperative Occurrences entered for this case.</td>
<td></td>
</tr>
</tbody>
</table>

Enter a New Postoperative Occurrence: **ACUTE RENAL FAILURE**

Definition Revised (2011): Indicate if the patient developed new renal failure requiring renal replacement therapy or experienced an exacerbation of preoperative renal failure requiring initiation of renal replacement therapy (not on renal replacement therapy preoperatively) within 30 days postoperatively.

**TIP:** If the patient refuses dialysis report as an occurrence because he/she did require dialysis.

Press RETURN to continue: <Enter>
<table>
<thead>
<tr>
<th>Occurrence</th>
<th>ACUTE RENAL FAILURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occurrence Category</td>
<td>ACUTE RENAL FAILURE</td>
</tr>
<tr>
<td>ICD Diagnosis Code</td>
<td></td>
</tr>
<tr>
<td>Treatment Instituted</td>
<td>ANTIBIOTICS</td>
</tr>
<tr>
<td>Outcome to Date</td>
<td>IMPROVED</td>
</tr>
<tr>
<td>Date Noted</td>
<td>03/20/07</td>
</tr>
</tbody>
</table>

Outcome to Date: IMPROVED
Date/Time the Occurrence was Noted: 3/20 (MAR 20, 2007)
The Non-Operative Occurrence (Enter/Edit) option is used to enter or edit occurrences that are not related to surgical procedures. A non-operative occurrence is an occurrence that develops before a surgical procedure is performed.

At the "Occurrence Category:" prompt, the user can enter two question marks (??) to get a list of categories. Be sure to enter a category for each occurrence in order to satisfy Surgery Central Office reporting needs.

Example: Entering a Non-Operative Occurrence

Select Perioperative Occurrences Menu Option: N Non-Operative Occurrences (Enter/Edit)

NOTE: You are about to enter an occurrence for a patient that has not had an operation during this admission. If this patient has a surgical procedure during the current admission, use the option to enter or edit intraoperative and postoperative occurrences.

Select PATIENT NAME: SURPATIENT, SEVENTEEN 09-13-28 000455119

SURPATIENT, SEVENTEEN

1. ENTER A NEW NON-OPERATIVE OCCURRENCE

Select Number: 1

Select the Date of Occurrence: 063007 (JUN 30, 2007)

Name of the Attending Surgeon: SURSURGEON, ONE

Surgical Specialty: GENERAL (OR WHEN NOT DEFINED BELOW)

Select NON-OPERATIVE OCCURRENCES: SYSTEMIC SEPSIS

Occurrence Category: SYSTEMIC SEPSIS

Definition Revised (2007):
Sepsis is a vast clinical entity that takes a variety of forms. The spectrum of disorders spans from relatively mild physiologic abnormalities to septic shock. Please report the most significant level using the criteria below:

1. Sepsis: Sepsis is the systemic response to infection. Report this variable if the patient has clinical signs and symptoms of SIRS. SIRS is a widespread inflammatory response to a variety of severe clinical insults. This syndrome is clinically recognized by the presence of two or more of the following:
   - Temp >38 degrees C or <36 degrees C
   - HR >90 bpm
   - RR >20 breaths/min or PaCO2 <32 mmHg (<4.3 kPa)
   - WBC >12,000 cell/mm3, <4000 cells/mm3, or >10% immature (band) forms
   - Anion gap acidosis: this is defined by either:
     [Na + K] - [Cl + HCO3 (or serum CO2)]. If this number is greater than 16, then an anion gap acidosis is present.
   - or
     Na - [Cl + HCO3 (or serum CO2)]. If this number is greater than 12, then an anion gap acidosis is present.
   and one of the following:
   - positive blood culture
   - clinical documentation of purulence or positive culture from any site thought to be causative
**Morbidity & Mortality Reports**  
[SROMM]

The *Morbidity & Mortality Reports* option generates two reports: the Perioperative Occurrences Report and the Mortality Report. The Perioperative Occurrences Report includes all cases that have occurrences, both intraoperatively and postoperatively, and can be sorted by specialty, attending surgeon, or occurrence category. The Mortality Report includes all cases performed within the selected date range that had a death within 30 days after surgery, and sort by specialty within a date range. Each surgical specialty will begin on a separate page.

After the user enters the date range, the software will ask whether to generate both reports. If the user answers **NO**, the software will ask the user to select from the Perioperative Occurrences Report or the Mortality Report.

These reports have a 132-column format and are designed to be copied to a printer.

**Example 1: Printing the Perioperative Occurrences Report – Sorted by Specialty**

<table>
<thead>
<tr>
<th>Select Perioperative Occurrences Menu Option:</th>
<th>Morbidity &amp; Mortality Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.</td>
<td></td>
</tr>
<tr>
<td>Do you want to generate both reports? YES// N</td>
<td></td>
</tr>
<tr>
<td>1. Perioperative Occurrences Report</td>
<td></td>
</tr>
<tr>
<td>2. Mortality Report</td>
<td></td>
</tr>
<tr>
<td>Select Number: (1-2): 1</td>
<td></td>
</tr>
<tr>
<td>Print Report for:</td>
<td></td>
</tr>
<tr>
<td>1. Intraoperative Occurrences</td>
<td></td>
</tr>
<tr>
<td>2. Postoperative Occurrences</td>
<td></td>
</tr>
<tr>
<td>3. Intraoperative and Postoperative Occurrences</td>
<td></td>
</tr>
<tr>
<td>Select Number: (1-3): 3</td>
<td></td>
</tr>
<tr>
<td>Start with Date: 7/1 (JUL 01, 2006)</td>
<td></td>
</tr>
<tr>
<td>End with Date: 7/31 (JUL 31, 2006)</td>
<td></td>
</tr>
<tr>
<td>Do you want to print all divisions? YES// &lt;Enter&gt;</td>
<td></td>
</tr>
<tr>
<td>Print report by</td>
<td></td>
</tr>
<tr>
<td>1. Surgical Specialty</td>
<td></td>
</tr>
<tr>
<td>2. Attending Surgeon</td>
<td></td>
</tr>
<tr>
<td>3. Occurrence Category</td>
<td></td>
</tr>
<tr>
<td>Select 1, 2 or 3: (1-3): 1// &lt;Enter&gt;</td>
<td></td>
</tr>
</tbody>
</table>
Do you want to print this report for all Surgical Specialties? YES/\ N

Print the report for which Specialty? GENERAL (OR WHEN NOT DEFINED BELOW)
Select an Additional Specialty <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]

------------------------------------------report follows------------------------------------------
<table>
<thead>
<tr>
<th>PATIENT ID#</th>
<th>ATTENDING SURGEON</th>
<th>PRINCIPAL OPERATION</th>
<th>OCCURRENCE(S) - (DATE)</th>
<th>TREATMENT</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURPATIENT,TWELVE 000-41-8719</td>
<td>SURSURGEON,THREE  JUL 07, 2006@07:15</td>
<td>REPAIR DIAPHRAGMATIC HERNIA</td>
<td>MYOCARDIAL INFARCTION</td>
<td>ASPIRIN THERAPY</td>
<td>I</td>
</tr>
<tr>
<td>SURPATIENT,FOURTEEN 000-45-7212</td>
<td>SURLSURGEON,FIVE JUL 31, 2006@09:00</td>
<td>CHOLECYSTECTOMY, APPENDECTOMY</td>
<td>SUPERFICIAL WOUND INFECTION * (08/02/06)</td>
<td>ANTIBIOTICS</td>
<td>I</td>
</tr>
</tbody>
</table>

OUTCOMES: 
U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences
Example 2: Printing the Perioperative Occurrences Report – Sorted by Attending Surgeon

Select Perioperative Occurrences Menu Option: M Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.

Do you want to generate both reports? YES// N

1. Perioperative Occurrences Report
2. Mortality Report

Select Number: (1-2): 1

Print Report for:
1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): 3

Start with Date: 7/1 (JUL 01, 2006)
End with Date: 7/31 (JUL 31, 2006)

Do you want to print all divisions? YES// Enter

Print report by
1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

Select 1, 2 or 3: (1-3): 1// 2

Do you want to print this report for all Attending Surgeons? YES// N

Print the report for which Attending Surgeon? SURGEON,ONE

Select an Additional Attending Surgeon: Enter

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]

----------------------------------------------------------report follows--------------------------------------------------
<table>
<thead>
<tr>
<th>PATIENT</th>
<th>SURGICAL SPECIALTY</th>
<th>OCCURRENCE(S) - (DATE)</th>
<th>TREATMENT</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURPATIENT, TWELVE</td>
<td>GENERAL (OR WHEN NOT DEFINED BELOW)</td>
<td>MYOCARDIAL INFARCTION</td>
<td>ASPIRIN THERAPY</td>
<td>I</td>
</tr>
<tr>
<td>ID# 000-41-8719</td>
<td>REPAIR DIAPHRAGMATIC HERNIA</td>
<td>URINARY TRACT INFECTION <em>(07/09/06)</em></td>
<td>IV ANTIBIOTICS</td>
<td>I</td>
</tr>
<tr>
<td>JUL 07, 2006@07:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SURPATIENT, THREE</td>
<td>CARDIAC SURGERY</td>
<td>REPEAT VENTILATOR SUPPORT W/IN 30 DAYS *</td>
<td></td>
<td>I</td>
</tr>
<tr>
<td>ID# 000-21-2453</td>
<td>CABG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JUL 22, 2006@10:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SURPATIENT, FOURTEEN</td>
<td>GENERAL (OR WHEN NOT DEFINED BELOW)</td>
<td>SUPERFICIAL WOUND INFECTION <em>(08/02/06)</em></td>
<td>ANTIBIOTICS</td>
<td>I</td>
</tr>
<tr>
<td>ID# 000-45-7212</td>
<td>CHOLECYSTECTOMY, APPENDECTOMY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JUL 31, 2006@09:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OUTCOMES:  U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences
Example 3: Printing the Perioperative Occurrences Report – Sorted by Occurrence Category

Select Perioperative Occurrences Menu Option: M Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.

Do you want to generate both reports? YES// N

1. Perioperative Occurrences Report
2. Mortality Report

Select Number: (1-2): 1

Print Report for:
1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): 3

Start with Date: 7/1 (JUL 01, 2006)
End with Date: 7/31 (JUL 31, 2006)

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

Print report by
1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

Select 1, 2 or 3: (1-3): 1// 3

Do you want to print this report for all occurrence categories? YES// NO

Print the report for which Occurrence Category? ACUTE RENAL FAILURE
Definition Revised (2011): Indicate if the patient developed new renal failure requiring renal replacement therapy or experienced an exacerbation of preoperative renal failure requiring initiation of renal replacement therapy (not on renal replacement therapy preoperatively) within 30 days postoperatively.

TIP: If the patient refuses dialysis report as an occurrence because he/she did require dialysis.

Select an Additional Occurrence Category: <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
<table>
<thead>
<tr>
<th>PATIENT</th>
<th>ATTENDING SURGEON</th>
<th>OCCURRENCE(S) - (DATE)</th>
<th>TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID#</td>
<td>SURGICAL SPECIALTY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPERATION DATE</td>
<td>PRINCIPAL OPERATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SURPATIENT, SEVENTEEN</td>
<td>SURGEON, TWO</td>
<td>ACUTE RENAL FAILURE</td>
<td>I</td>
</tr>
<tr>
<td>000-45-5119</td>
<td>GENERAL</td>
<td>DIALYSIS</td>
<td></td>
</tr>
<tr>
<td>JUN 18, 2007@07:15</td>
<td>REPAIR INCARCERATED INGUINAL HERNIA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OUTCOMES:  U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH

'**' Represents Postoperative Occurrences
[SRONOR]

The Report of Non-O.R. Procedures option chronologically lists non-O.R. procedures sorted by surgical specialty or surgeon. This report can be sorted by specialty, provider, or location.

This report prints in a 132-column format and must be copied to a printer.


Select CPT/ICD9 Coding Menu Option: R Report of Non-O.R. Procedures

Report of Non-OR Procedures

Start with Date: 3/1 (MAR 01, 1999)
End with Date: 3/31 (MAR 31, 1999)

How do you want the report sorted?

1. By Specialty
2. By Provider
3. By Location

Select Number: 1// <Enter>

Do you want to print the report for all Specialties? YES// N

Print the Report for which Specialty? CARDIOLOGY

This report is designed to use a 132 column format.

Print on Device: [Select Print Device]

printout follows-----------------------------------------------
### **SPECIALTY: CARDIOLOGY**

<table>
<thead>
<tr>
<th>DATE</th>
<th>PATIENT (ID#)</th>
<th>PROVIDER</th>
<th>PROCEDURE(S)</th>
<th>START TIME</th>
<th>FINISH TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/02/99</td>
<td>SURPATIENT,TWELVE (000-41-8719)</td>
<td>SURSURGEON, TWO</td>
<td>CARDIOVERSION</td>
<td>03/02/99 13:05</td>
<td></td>
</tr>
<tr>
<td>03/13/99</td>
<td>SURPATIENT,SIXTY (000-56-7821)</td>
<td>Sursurgeon, TWO</td>
<td>CARDIOVERSION</td>
<td>03/13/99 14:00</td>
<td></td>
</tr>
<tr>
<td>03/13/99</td>
<td>SURPATIENT,SIXTY (000-56-7821)</td>
<td>Sursurgeon, TWO</td>
<td>CARDIOVERSION</td>
<td>03/13/99 14:25</td>
<td></td>
</tr>
</tbody>
</table>

Select CPT/ICD9 Coding Menu Option: R Report of Non-O.R. Procedures

Report of Non-OR Procedures

Start with Date: 3/1 (MAR 01, 1999)
End with Date: 3/31 (MAR 31, 1999)

How do you want the report sorted?

1. By Specialty
2. By Provider
3. By Location

Select Number: 1// 2

Do you want to print the report for all Providers? YES// N

Print the Report for which Provider? SURSURGEON,SIXTEEN

This report is designed to use a 132 column format.

Print on Device: [Select Print Device]

-----------------------------------------printout follows-----------------------------------------
<table>
<thead>
<tr>
<th>DATE</th>
<th>PATIENT (ID#)</th>
<th>SPECIALTY</th>
<th>START TIME</th>
<th>FINISH TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/12/99</td>
<td>SURPATIENT,TWO (000-45-1982)</td>
<td>PSYCHIATRY</td>
<td>03/12/99 08:00</td>
<td></td>
</tr>
<tr>
<td>195</td>
<td>PAC(U) - ANESTHESIA (INPATIENT)</td>
<td>SURANESTHETIST, TWO</td>
<td>03/12/99 09:00</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ANESTHESIOLOGIST, ONE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03/23/99</td>
<td>SURPATIENT,NINE (000-34-5555)</td>
<td>PSYCHIATRY</td>
<td>03/23/99 08:10</td>
<td></td>
</tr>
<tr>
<td>240</td>
<td>PAC(U) - ANESTHESIA (INPATIENT)</td>
<td>SURANESTHETIST, SIX</td>
<td>03/23/99 08:40</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ANESTHESIOLOGIST, ONE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03/25/99</td>
<td>SURPATIENT,FOURTEEN (000-45-7212)</td>
<td>PSYCHIATRY</td>
<td>03/12/99 09:30</td>
<td></td>
</tr>
<tr>
<td>266</td>
<td>PAC(U) - ANESTHESIA (INPATIENT)</td>
<td>SURANESTHETIST, TWO</td>
<td>03/12/99 10:15</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ANESTHESIOLOGIST, ONE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROCEDURE(S)**

- ELECTROCONVULSIVE THERAPY
Example 3: Report of Non-O.R. Procedures by Location

Select CPT/ICD9 Coding Menu Option: R  Report of Non-O.R. Procedures

Report of Non-OR Procedures

Start with Date: 3/1  (MAR 01, 1999)
End with Date: 3/31  (MAR 31, 1999)

How do you want the report sorted?

1. By Specialty
2. By Provider
3. By Location

Select Number: 1// 3

Do you want to print the report for all Locations?  YES// N

Print the Report for which Location?  AMBULATORY SURGERY

This report is designed to use a 132 column format.

Print on Device: [Select Print Device]

printout follows---------------------------------
<table>
<thead>
<tr>
<th>DATE</th>
<th>PATIENT (ID#)</th>
<th>PROVIDER</th>
<th>START TIME</th>
<th>SPECIALTY (IN/OUT-PAT STATUS)</th>
<th>PRINCIPAL ANESTHETIST</th>
<th>ANESTHESIOLOGIST SUPERVISOR</th>
<th>PROCEDURE(S)</th>
<th>FINISH TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/02/99</td>
<td>SURPATIENT, TWELVE (000-41-8719)</td>
<td>SURLPATIENT, TWO</td>
<td>03/02/99 13:05</td>
<td>CARDIOLOGY (OUTPATIENT)</td>
<td>SURLPATIENT, FOUR</td>
<td>SURLPATIENT, ONE</td>
<td>CARDIOVERSION</td>
<td>03/02/99 14:10</td>
</tr>
<tr>
<td>03/06/99</td>
<td>SURPATIENT, TWENTY (000-45-4886)</td>
<td>SURLPATIENT, FOUR</td>
<td>03/07/99 16:30</td>
<td>GENERALACUTE MEDICINE (OUTPATIENT)</td>
<td>SURLPATIENT, FIVE</td>
<td>SURLPATIENT, ONE</td>
<td>EXCISION OF SKIN LESION</td>
<td>03/07/99 17:08</td>
</tr>
<tr>
<td>03/09/99</td>
<td>SURPATIENT, FIFTY (000-45-9999)</td>
<td>SURLPATIENT, FIVE</td>
<td>03/09/99 09:45</td>
<td>GENERALACUTE MEDICINE (OUTPATIENT)</td>
<td>SURLPATIENT, Seven</td>
<td>SURLPATIENT, Seven</td>
<td>STELLATE NERVE BLOCK</td>
<td>03/09/99 10:21</td>
</tr>
<tr>
<td>03/13/99</td>
<td>SURPATIENT, SIXTY (000-56-7821)</td>
<td>SURLPATIENT, TWO</td>
<td>03/13/99 14:00</td>
<td>CARDIOLOGY (INPATIENT)</td>
<td>SURLPATIENT, Two</td>
<td>SURLPATIENT, One</td>
<td>CARDIOVERSION</td>
<td>03/13/99 14:25</td>
</tr>
<tr>
<td>03/17/99</td>
<td>SURPATIENT, EIGHTEEN (000-22-3334)</td>
<td>SURLPATIENT, FOUR</td>
<td>03/17/99 13:30</td>
<td>GENERAL SURGERY (OUTPATIENT)</td>
<td>SURLPATIENT, SIX</td>
<td>SURLPATIENT, Seven</td>
<td>EXCISION OF SKIN LESION</td>
<td>03/17/99 14:42</td>
</tr>
</tbody>
</table>
**Management Reports**

[SRO-CHIEF REPORTS]

The *Management Reports* menu is designed to give the Chief of Surgery various management reports. The reports contained on this menu are listed below. To the left of the option/report name is the shortcut synonym that the user can enter to select the option.

<table>
<thead>
<tr>
<th>Shortcut</th>
<th>Option Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM</td>
<td>Morbidity &amp; Mortality Reports</td>
</tr>
<tr>
<td>MV</td>
<td>M&amp;M Verification Report</td>
</tr>
<tr>
<td>CD</td>
<td>Comparison of Preop and Postop Diagnosis</td>
</tr>
<tr>
<td>D</td>
<td>Delay and Cancellation Reports ...</td>
</tr>
<tr>
<td>V</td>
<td>List of Unverified Surgery Cases</td>
</tr>
<tr>
<td>RET</td>
<td>Report of Returns to Surgery</td>
</tr>
<tr>
<td>A</td>
<td>Report of Daily Operating Room Activity</td>
</tr>
<tr>
<td>NS</td>
<td>Report of Cases Without Specimens</td>
</tr>
<tr>
<td>ICU</td>
<td>Report of Unscheduled Admissions to ICU</td>
</tr>
<tr>
<td>OR</td>
<td>Operating Room Utilization Report</td>
</tr>
<tr>
<td>WC</td>
<td>Wound Classification Report</td>
</tr>
<tr>
<td>BA</td>
<td>Print Blood Product Verification Audit Log</td>
</tr>
<tr>
<td>KEY</td>
<td>Key Missing Surgical Package Data</td>
</tr>
<tr>
<td>OC</td>
<td>Admitted w/in 14 days of Out Surgery If Postop Occ</td>
</tr>
<tr>
<td>DS</td>
<td>Death Within 30 Days of Surgery</td>
</tr>
</tbody>
</table>
**Morbidity & Mortality Reports**

[SROMM]

The *Morbidity & Mortality Reports* option generates two reports: the Perioperative Occurrences Report and the Mortality Report. The Perioperative Occurrences Report includes all cases that have occurrences, both intraoperatively and postoperatively, and can be sorted by specialty, attending surgeon, or occurrence category. The Mortality Report includes all cases performed within the selected date range that had a death within 30 days after surgery, and sort by specialty within a date range. Each surgical specialty will begin on a separate page.

After the user enters the date range, the software will ask whether to generate both reports. If the user answers *NO*, the software will ask the user to select from the Perioperative Occurrences Report or the Mortality Report.

These reports have a 132-column format and are designed to be copied to a printer.

**Example 1: Printing the Perioperative Occurrences Report – Sorted by Specialty**

```plaintext
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.

Do you want to generate both reports ? YES// N

1. Perioperative Occurrences Report
2. Mortality Report

Select Number:  (1-2): 1

Print Report for:
1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number:  (1-3): 3

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

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

Print report by
1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

Select 1, 2 or 3:  (1-3): 1// <Enter>
```
Do you want to print this report for all Surgical Specialties?  YES// N

Print the report for which Specialty?  GENERAL (OR WHEN NOT DEFINED BELOW)
Select an Additional Specialty  <Enter>

This report is designed to use a 132 column format.
Print the Report on which Device: [Select Print Device]

----------------------------------------------------------report follows--------------------------------------------------
(This page included for two-sided copying.)
<table>
<thead>
<tr>
<th>PATIENT ID#</th>
<th>ATTENDING SURGEON</th>
<th>PRINCIPAL OPERATION</th>
<th>OCCURRENCE(S) - (DATE)</th>
<th>TREATMENT</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURPATIENT, TWELVE</td>
<td>SURSURGEON, THREE</td>
<td>REPAIR DIAPHRAGMATIC HERNIA</td>
<td>MYOCARDIAL INFARCTION</td>
<td>ASPIRIN THERAPY</td>
<td>I</td>
</tr>
<tr>
<td>000-41-8719</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JUL 07, 2006@07:15</td>
<td></td>
<td></td>
<td>URINARY TRACT INFECTION <em>(07/09/06)</em></td>
<td>IV ANTIBIOTICS</td>
<td>I</td>
</tr>
<tr>
<td>SURPATIENT, FOURTEEN</td>
<td>SURSURGEON, FIVE</td>
<td>CHOLECYSTECTOMY, APPENDECTOMY</td>
<td>SUPERFICIAL WOUND INFECTION <em>(08/02/06)</em></td>
<td>ANTIBIOTICS</td>
<td>I</td>
</tr>
<tr>
<td>000-45-7212</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JUL 31, 2006@09:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OUTCOMES: U = UNRESOLVED, I = IMPROVED, W = WORSE, D = DEATH
*“* Represents Postoperative Occurrences
Example 2: Printing the Perioperative Occurrences Report – Sorted by Attending Surgeon

Select Perioperative Occurrences Menu Option: M Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.

Do you want to generate both reports? YES// N

1. Perioperative Occurrences Report
2. Mortality Report

Select Number: (1-2): 1

Print Report for:
1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): 3

Start with Date: 7/1 (JUL 01, 2006)
End with Date: 7/31 (JUL 31, 2006)

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

Print report by
1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

Select 1, 2 or 3: (1-3): 1// 2

Do you want to print this report for all Attending Surgeons? YES// N

Print the report for which Attending Surgeon? SURGEON,ONE

Select an Additional Attending Surgeon: <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]

----------------------------------------------------------report follows--------------------------------------------------
<table>
<thead>
<tr>
<th>PATIENT</th>
<th>SURGICAL SPECIALTY</th>
<th>OCCURRENCE(S) - (DATE)</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURPATIENT, TWELVE</td>
<td>GENERAL (OR WHEN NOT DEFINED BELOW)</td>
<td>MYOCARDIAL INFARCTION</td>
<td>I</td>
</tr>
<tr>
<td>000-41-8719</td>
<td>REPAIR DIAPHRAGMATIC HERNIA</td>
<td>ASPIRIN THERAPY</td>
<td></td>
</tr>
<tr>
<td>JUL 07, 2006@07:15</td>
<td></td>
<td>URINARY TRACT INFECTION * (07/09/06)</td>
<td>I</td>
</tr>
<tr>
<td>SURPATIENT, THREE</td>
<td>CARDIAC SURGERY</td>
<td>REPEAT VENTILATOR SUPPORT W/IN 30 DAYS *</td>
<td>I</td>
</tr>
<tr>
<td>000-21-2453</td>
<td>CABG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JUL 22, 2006@10:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SURPATIENT, FOURTEEN</td>
<td>GENERAL (OR WHEN NOT DEFINED BELOW)</td>
<td>SUPERFICIAL WOUND INFECTION * (08/02/06)</td>
<td>I</td>
</tr>
<tr>
<td>000-45-7212</td>
<td>CHOLECYSTECTOMY, APPENDECTOMY</td>
<td>ANTIBIOTICS</td>
<td></td>
</tr>
<tr>
<td>JUL 31, 2006@09:00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OUTCOMES:  U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH  
'*' Represents Postoperative Occurrences
Example 3: Printing the Perioperative Occurrences Report – Sorted by Occurrence Category

Select Perioperative Occurrences Menu Option: M Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.

Do you want to generate both reports? YES// NO

1. Perioperative Occurrences Report
2. Mortality Report

Select Number: (1-2): 1

Print Report for:
1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): 3

Start with Date: 7/1 (JUL 01, 2006)
End with Date: 7/31 (JUL 31, 2006)

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

Print report by
1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

Select 1, 2 or 3: (1-3): 1// 3

Do you want to print this report for all occurrence categories? YES// NO

Print the report for which Occurrence Category? ACUTE RENAL FAILURE
Definition Revised (2011): Indicate if the patient developed new renal failure requiring renal replacement therapy or experienced an exacerbation of preoperative renal failure requiring initiation of renal replacement therapy (not on renal replacement therapy preoperatively) within 30 days postoperatively.

TIP: If the patient refuses dialysis report as an occurrence because he/she did require dialysis.

Select an Additional Occurrence Category: <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]

--------------------------------------------------------------------------------------------------------------------------report follows--------------------------------------------------------------------------------------------------------------------------
<table>
<thead>
<tr>
<th>PATIENT ID#</th>
<th>ATTENDING SURGEON</th>
<th>OCCURRENCE(S) - (DATE)</th>
<th>TREATMENT</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>000-45-5119</td>
<td>SURGEON, TWO</td>
<td>ACUTE RENAL FAILURE</td>
<td>DIALYSIS</td>
<td>I</td>
</tr>
<tr>
<td>JUN 18, 2007@07:15</td>
<td>GENERAL</td>
<td>REPAIR INCARCERATED INGUINAL HERNIA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences
Example 4: Print the Mortality Report

Select Management Reports Option: MM Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.

Do you want to generate both reports? YES/ N

1. Perioperative Occurrences Report
2. Mortality Report

Select Number: (1-2): 2

Start with Date: 1/1/02 (JAN 01, 2002)
End with Date: 12/31/02 (DEC 31, 2002)

This report is designed to use a 132 column format.
Print report on which Device: [Select Print Device]

--------------------------------------------------------------------------------------------------------------------------printout follows--------------------------------------------------------------------------------------------------------------------------
**Example 3: Clean Wound Infection Summary**

Select Management Reports Option: WC  Wound Classification Report

Start with Date: 6/1  (JUN 01, 1999)
End with Date: 6/30  (JUN 30, 1999)

Print which of the following?
1. Wound Classification Report (Summary)
2. List of Operations by Wound Classification
3. Clean Wound Infection Summary

Select Number: 1//3

Do you want to print the report for all Surgical Specialties?  YES// <Enter>

Print on Device: [Select Print Device]

---

**MAYBERRY, NC**
**SURGICAL SERVICE**
**CLEAN WOUND INFECTION SUMMARY**
FROM: JUN 1, 1999  TO: JUN 30, 1999
DATE PRINTED: JUL 18, 1999
REVIEWED BY:  DATE REVIEWED:

<table>
<thead>
<tr>
<th>SURGICAL SERVICE</th>
<th>CLEAN WOUNDS</th>
<th>INFECTIONS</th>
<th>INFECTION RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL</td>
<td>21</td>
<td>1</td>
<td>4.8%</td>
</tr>
<tr>
<td>GYNECOLOGY</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>NEUROSURGERY</td>
<td>11</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>OPHTHALMOLOGY</td>
<td>30</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>20</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td>OTORHINOLARYNGOLOGY</td>
<td>6</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PLASTIC SURGERY</td>
<td>7</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PROCTOLOGY</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>THORACIC SURGERY</td>
<td>2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>UROLOGY</td>
<td>2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>ORAL SURGERY</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PODIATRY</td>
<td>14</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PERIPHERAL VASCULAR</td>
<td>28</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CARDIAC SURGERY</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>TRANSPLANTATION</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>ANESTHESIOLOGY</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>RHEUMATOLOGY</td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>PULMONARY</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>GASTROENTEROLOGY</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>NO SPECIALTY ENTERED</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

TOTAL 142 2 1.4%
Pages 368-392 have been deleted. The Quarterly Report Menus have been removed.
**Key Missing Surgical Package Data**

[SROQ MISSING DATA]

The *Key Missing Surgical Package Data* option generates a list of surgical cases performed within the selected date range that are missing key information. This report includes surgical cases with an entry in the TIME PAT IN OR field and does not include aborted cases.

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

Example: Key Missing Surgical Package Data

Select Management Reports Option: **KEY** Key Missing Surgical Package Data

<table>
<thead>
<tr>
<th>Report of Key Missing Surgical Package Data</th>
</tr>
</thead>
</table>

For surgical cases with an entry in the TIME PAT IN OR field and that are not aborted, this option generates a report of cases missing any of the following pieces of information:

- In/Out-Patient Status
- Major/Minor
- Case Schedule Type
- Attending Code
- Time Pat Out OR
- Wound Classification
- ASA Class
- CPT Code (Principal)

Start with Date: Start with Date: 4 1 (APR 01, 2005)
End with Date: 4 30 (APR 30, 2005)

Do you want the report for all Surgical Specialties? YES// <Enter>

This report is designed to use a 132 column format.

Print the report to which Printer? [Select Print Device]

-----------------------------------------------printout follows-----------------------------------------------
## MAYBERRY, NC
### Report of Key Missing Surgical Package Data
From: APR 1, 2005 To: APR 30, 2005
Report Printed: MAY 11, 2005 @ 15:09

<table>
<thead>
<tr>
<th>DATE OF OPERATION</th>
<th>PATIENT NAME</th>
<th>SURGICAL SPECIALTY</th>
<th>MISSING ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>APR 6, 2005@07:40</td>
<td>SURPATIENT, ONE</td>
<td>OPHTHALMOLOGY</td>
<td>D</td>
</tr>
<tr>
<td>32474</td>
<td>000-44-7629 (46)</td>
<td>PHACOEMLLSIFICATION, LENS IMPLANT OD</td>
<td></td>
</tr>
<tr>
<td>APR 12, 2005@12:00</td>
<td>SURPATIENT, FORTYONE</td>
<td>OPHTHALMOLOGY</td>
<td>D</td>
</tr>
<tr>
<td>32508</td>
<td>000-43-2109 (78)</td>
<td>PHACOEMLLSIFICATION, LENS IMPLANT OS</td>
<td></td>
</tr>
<tr>
<td>APR 12, 2005@13:50</td>
<td>SURPATIENT, ONE</td>
<td>PLASTIC SURGERY (INCLUDES HEAD AND NECK)</td>
<td>D</td>
</tr>
<tr>
<td>32534</td>
<td>000-44-7629 (46)</td>
<td>EXCISION OF RT. WRIST MASS</td>
<td></td>
</tr>
<tr>
<td>APR 12, 2005@14:00</td>
<td>SURPATIENT, THIRTY</td>
<td>OPHTHALMOLOGY</td>
<td>D</td>
</tr>
<tr>
<td>32544</td>
<td>000-82-9472 (48)</td>
<td>PHACOEMLLSIFICATION OD</td>
<td></td>
</tr>
<tr>
<td>APR 13, 2005@09:20</td>
<td>SURPATIENT, FIFTY TWO</td>
<td>OPHTHALMOLOGY</td>
<td>D</td>
</tr>
<tr>
<td>32513</td>
<td>000-99-8888 (79)</td>
<td>PHACOEMLLSIFICATION, LENS IMPLANT OD</td>
<td></td>
</tr>
<tr>
<td>APR 15, 2005@13:05</td>
<td>SURPATIENT, FIFTY</td>
<td>GENERAL (OR WHEN NOT DEFINED BELOW)</td>
<td>D</td>
</tr>
<tr>
<td>32351</td>
<td>000-45-9999 (44)</td>
<td>EXCISIONAL BIOPSY MASS RT. BREAST</td>
<td></td>
</tr>
<tr>
<td>APR 19, 2005@13:00</td>
<td>SURPATIENT, SEVENTEEN</td>
<td>OPHTHALMOLOGY</td>
<td>D</td>
</tr>
<tr>
<td>32580</td>
<td>000-45-5119 (71)</td>
<td>PHACOEMLLSIFICATION LENS IMPLANT OD</td>
<td></td>
</tr>
<tr>
<td>APR 27, 2005@13:15</td>
<td>SURPATIENT, SIXTY</td>
<td>OPHTHALMOLOGY</td>
<td>F</td>
</tr>
<tr>
<td>32684</td>
<td>000-56-7821 (40)</td>
<td>TRABECULECTOMY OD</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL CASES MISSING DATA: 8

MISSING ITEMS CODES:  
A-IN/OUT - PATIENT STATUS,  B-MAJOR/MINOR,  C-CASE SCHEDULE TYPE,  D-ATTENDING CODE,  
E-TIME PAT OUT OR,  F-WOUND CLASSIFICATION,  G-ASA CLASS,  H-CPT CODE (PRINCIPAL)
Admitted w/in 14 days of Out Surgery If Postop Occ
[SROQADM]

The Admitted w/in 14 days of Out Surgery If Postop Occ option displays a list of patients with completed outpatient surgical cases that resulted in at least one postoperative occurrence and a hospital admission within 14 days of the surgery.

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

Example:  Report of Admitted w/in 14 days of Out Surgery If Postop Occ

Select Quarterly Report Menu Option: A  Admitted w/in 14 days of Out Surgery If Postop Occ
Outpatient Cases with Postop Occurrences
and Admissions Within 14 Days

This report displays the completed outpatient surgical cases which resulted in at least one postoperative occurrence and a hospital admission within 14 days.

Start with Date: 9 1 04  (SEP 01, 2004)
End with Date: 12 31 04  (DEC 31, 2004)

Do you want the report for all Surgical Specialties ? YES// <Enter>

This report is designed to use a 132 column format.

Print the report to which Printer ? [Select Print Device]

======================================================================================================
<table>
<thead>
<tr>
<th>Date of Operation</th>
<th>Patient Name</th>
<th>Surgical Specialty</th>
<th>Anesthesia Technique</th>
<th>Date of Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep 24, 2004@12:30</td>
<td>Surpatient, Forty</td>
<td>Thoracic Surgery (Inc. Cardiac</td>
<td>General</td>
<td>Oct 3, 2004@14:11</td>
</tr>
<tr>
<td></td>
<td>30395</td>
<td>Mediastinoscopy with Node Biopsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Other Occurrence - (10/03/04)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep 25, 2004@14:30</td>
<td>Surpatient, Eighteen</td>
<td>General (Or when not defined be</td>
<td>General</td>
<td>Sep 28, 2004@10:06</td>
</tr>
<tr>
<td></td>
<td>30544</td>
<td>Left Inguinal Herniorraphy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Other Occurrence - (09/28/04)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov 18, 2004@09:45</td>
<td>Surpatient, Fifteen</td>
<td>Plastic Surgery (Includes Head</td>
<td>General</td>
<td>Nov 28, 2004@12:51</td>
</tr>
<tr>
<td></td>
<td>31034</td>
<td>Ganglion Cyst Lt. Wrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Superficial Wound Infection - (11/28/04)</td>
<td></td>
<td>Inclusion of Cyst Index Finger Lt.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Excision of Lipoma of Lt. Foot</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Application Short Arm Splint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec 9, 2004@13:35</td>
<td>Surpatient, Eight</td>
<td>Orthopedics</td>
<td>General</td>
<td>Dec 9, 2004@17:55</td>
</tr>
<tr>
<td></td>
<td>31242</td>
<td>Orif Rt Ulna</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Superficial Wound Infection - (12/29/04)</td>
<td></td>
<td>Repair Rt. Distalradioulnar Fx (</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec 31, 2004@07:30</td>
<td>Surpatient, Fiftyone</td>
<td>Otorhinolaryngology (Ent)</td>
<td>General</td>
<td>Dec 31, 2004@18:02</td>
</tr>
<tr>
<td></td>
<td>31277</td>
<td>Nasal Sinus Surgery with Bil Spenoethmoid Polypectomy (CPT Code: 31205)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Other CNS Occurrence - (01/05/03)</td>
<td></td>
<td>Bilateral Antrostomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bilateral Turbinectomy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Cases: 5
Deaths Within 30 Days of Surgery
[SROQD]

The Deaths Within 30 Days of Surgery option lists patients who had surgery within the selected date range, died within 30 days of surgery and whose deaths are included on the Quarterly/Summary Report. Three separate reports are available through this option. These reports correspond to the three sections of the Quarterly Report that include death totals.

1. **Total Cases Summary**: This report may be printed in one of three ways.

   A. **All Cases**

   The report will list all patients who had surgery within the selected date range and who died within 30 days of surgery, along with all of the patients' operations that were performed during the selected date range. These patients are included in the postoperative deaths totals on the Quarterly Report.

   B. **Outpatient Cases Only**

   The report will list only the surgical cases that are associated with deaths that are counted as outpatient (ambulatory) deaths on the Quarterly Report.

   C. **Inpatient Cases Only**

   The report will list only the surgical cases that are associated with deaths that are counted as inpatient deaths. Although the count of deaths associated with inpatient cases is not a part of the Quarterly Report, this report is provided to help with data validation.

2. **Specialty Procedures**: This report will list the surgical cases that are associated with deaths that are counted for the national surgical specialty linked to the local surgical specialty. Cases are listed by national surgical specialty.

3. **Index Procedures**: This report will list the surgical cases that are associated with deaths that are counted in the Index Procedures section of the Quarterly Report.

These reports have a 132-column format and are designed to be copied to a printer.
**Example 1: Deaths Within 30 Days of Surgery - Total Cases Summary**

Select Quarterly Report Menu Option: **D** Deaths Within 30 Days of Surgery

<table>
<thead>
<tr>
<th>Deaths Within 30 Days of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>This report lists patients who had surgery within the selected date range, who died within 30 days of surgery and whose deaths are included on the Quarterly/Summary Report.</td>
</tr>
<tr>
<td>Start with Date: <strong>4/1</strong> (APR 01, 2005)</td>
</tr>
<tr>
<td>End with Date: <strong>4/30</strong> (APR 30, 2005)</td>
</tr>
</tbody>
</table>

Print report for which section of Quarterly/Summary Report?

1. Total Cases Summary
2. Specialty Procedures
3. Index Procedures

Select number: **1**/1 Total Cases Summary

Print Deaths within 30 Days of Surgery for

- **A** - All cases
- **O** - Outpatient cases only
- **I** - Inpatient cases only

Select Letter (I, O or A): **A** All Cases

This report is designed to use a 132 column format.

Print the report to which Printer? **[Select Print Device]**
## Deaths Within 30 Days of Surgery

**For Surgery Performed From: Apr 1, 2005 to: Apr 30, 2005**

Report Printed: May 18, 2005 @ 12:09

<table>
<thead>
<tr>
<th>OP Date</th>
<th>Case #</th>
<th>In/Out</th>
<th>Surgical Specialty</th>
<th>Procedure(s)</th>
<th>Related</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/13/05</td>
<td>32571</td>
<td>Inpat</td>
<td>General (or when not defined below)</td>
<td>Exploratory Laparotomy, Right Hemicolectomy, Ileostomy, Mucous Fistula of Colon</td>
<td>Unrelated</td>
</tr>
<tr>
<td>04/24/05</td>
<td>32693</td>
<td>Inpat</td>
<td>General (or when not defined below)</td>
<td>Closure of Abdominal Wall Fascia</td>
<td>Unrelated</td>
</tr>
<tr>
<td>04/26/05</td>
<td>32702</td>
<td>Inpat</td>
<td>Thoracic Surgery (Inc. Cardiac Surg)</td>
<td>Right Thoracotomy with Lung Biopsy, Diaphragm Biopsy</td>
<td>Unrelated</td>
</tr>
<tr>
<td>04/20/05</td>
<td>32567</td>
<td>Inpat</td>
<td>Thoracic Surgery (Inc. Cardiac Surg)</td>
<td>Esophagectomy, Esophagoscopy, Bronchoscopy, Feeding Tube Jejunostomy</td>
<td>Related</td>
</tr>
</tbody>
</table>

**Total Deaths: 3**
Example 2: Deaths Within 30 Days of Surgery - Specialty Procedures

Select Quarterly Report Menu Option: D  Deaths Within 30 Days of Surgery

Deaths Within 30 Days of Surgery

This report lists patients who had surgery within the selected date range, who died within 30 days of surgery and whose deaths are included on the Quarterly/Summary Report.

Start with Date: 4/1  (APR 01, 2005)
End with Date: 4/30  (APR 30, 2005)

Print report for which section of Quarterly/Summary Report ?

1. Total Cases Summary
2. Specialty Procedures
3. Index Procedures

Select number: 1//2  Specialty Procedures

Do you want the report for all National Surgical Specialties? YES//<Enter>

This report is designed to use a 132 column format.

Print the report to which Printer? [Select Print Device]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~printout follows~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
<table>
<thead>
<tr>
<th>OP DATE</th>
<th>PATIENT NAME</th>
<th>DATE OF DEATH</th>
<th>LOCAL SPECIALTY</th>
<th>IN/OUT</th>
<th>DEATH RELATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/24/05</td>
<td>SURPATIENT, FORTY</td>
<td>05/12/05</td>
<td>GENERAL (OR WHEN NOT DEFINED BELOW)</td>
<td>INPAT</td>
<td>UNRELATED</td>
</tr>
<tr>
<td>32693</td>
<td>000-77-7777 (70)</td>
<td></td>
<td>CLOSURE OF ABDOMINAL WALL FASCIA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL DEATHS FOR GENERAL SURGERY: 1

<table>
<thead>
<tr>
<th>OP DATE</th>
<th>PATIENT NAME</th>
<th>DATE OF DEATH</th>
<th>LOCAL SPECIALTY</th>
<th>IN/OUT</th>
<th>DEATH RELATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/26/05</td>
<td>SURPATIENT, TEN</td>
<td>05/12/05</td>
<td>THORACIC SURGERY (INC. CARDIAC SURG.)</td>
<td>INPAT</td>
<td>UNRELATED</td>
</tr>
<tr>
<td>32702</td>
<td>000-12-3456 (68)</td>
<td></td>
<td>RIGHT THORACOTOMY WITH LUNG BIOPSY</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DIAPHRAGM BIOPSY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OP DATE</th>
<th>PATIENT NAME</th>
<th>DATE OF DEATH</th>
<th>LOCAL SPECIALTY</th>
<th>IN/OUT</th>
<th>DEATH RELATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/21/05</td>
<td>SURPATIENT, SIXTY</td>
<td>04/30/05</td>
<td>THORACIC SURGERY (INC. CARDIAC SURG)</td>
<td>INPAT</td>
<td>RELATED</td>
</tr>
<tr>
<td>32567</td>
<td>000-56-7821 (40)</td>
<td></td>
<td>ESOPHAGECTOMY</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ESOPHAGOSCOPY</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BRONCHOSCOPY</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>FEEDING TUBE JEJUNOSTOMY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL DEATHS FOR THORACIC SURGERY: 2

TOTAL FOR ALL SPECIALTIES: 3
Example 3: Deaths Within 30 Days of Surgery - Index Procedures

Select Quarterly Report Menu Option: D Deaths Within 30 Days of Surgery

<table>
<thead>
<tr>
<th>Deaths Within 30 Days of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>This report lists patients who had surgery within the selected date range, who died within 30 days of surgery and whose deaths are included on the Quarterly/Summary Report.</td>
</tr>
<tr>
<td>Start with Date: 1/1 (JAN 01, 2005)</td>
</tr>
<tr>
<td>End with Date: 3/31 (MAR 31, 2005)</td>
</tr>
<tr>
<td>Print report for which section of Quarterly/Summary Report ?</td>
</tr>
<tr>
<td>1. Total Cases Summary</td>
</tr>
<tr>
<td>2. Specialty Procedures</td>
</tr>
<tr>
<td>3. Index Procedures</td>
</tr>
<tr>
<td>Select number: 1// 3 Index Procedures</td>
</tr>
<tr>
<td>This report is designed to use a 132 column format.</td>
</tr>
<tr>
<td>Print the report to which Printer ? [Select Print Device]</td>
</tr>
</tbody>
</table>

------------------------------------------printout follows------------------------------------------
<table>
<thead>
<tr>
<th>OP DATE</th>
<th>PATIENT NAME</th>
<th>DATE OF DEATH</th>
<th>LOCAL SPECIALTY</th>
<th>IN/OUT</th>
<th>DEATH RELATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/05/05</td>
<td>SURPATIENT, SIXTY</td>
<td>03/18/05</td>
<td>GENERAL (OR WHEN NOT DEFINED BELOW)</td>
<td>INPAT</td>
<td>RELATED</td>
</tr>
<tr>
<td>32147</td>
<td>000-56-7821 (40)</td>
<td></td>
<td>LAPAROSCOPIC CHOLECYSTECTOMY</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL DEATHS FOR Cholecystectomy: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/12/05</td>
<td>SURPATIENT, TEN</td>
<td>01/18/05</td>
<td>GENERAL (OR WHEN NOT DEFINED BELOW)</td>
<td>INPAT</td>
<td>UNRELATED</td>
</tr>
<tr>
<td>31514</td>
<td>000-12-3456 (60)</td>
<td></td>
<td>RT. HEMICOLECTOMY</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL DEATHS FOR Colon Resection (L &amp; R): 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/15/05</td>
<td>SURPATIENT, SIXTEEN</td>
<td>01/19/05</td>
<td>ORTHOPEDICS</td>
<td>INPAT</td>
<td>RELATED</td>
</tr>
<tr>
<td>31576</td>
<td>000-11-1111 (93)</td>
<td></td>
<td>LT. HIP ARTHROPLASTY</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL DEATHS FOR Hip Replacement - Elective: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/23/05</td>
<td>SURPATIENT, FIFTYTWO</td>
<td>03/15/05</td>
<td>OPHTHALMOLOGY</td>
<td>OUTPAT</td>
<td>UNRELATED</td>
</tr>
<tr>
<td>32008</td>
<td>000-99-8888 (90)</td>
<td></td>
<td>CATARACT EXTRACTION WITH IOL GS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL DEATHS FOR Intraocular Lens: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL FOR ALL INDEX PROCEDURES: 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Unlock a Case for Editing
[SRO-UNLOCK]

The Chief of Surgery, or a designee, uses the Unlock a Case for Editing option to unlock a case so that it can be edited. A case that has been completed will automatically lock within a specified time after the date of operation. When a case is locked, the data cannot be edited.

With this option, the selected case will be unlocked so that the user can use another option (such as in the Operation Menu option or Anesthesia Menu option) to make changes. The case will automatically re-lock in the evening. The package coordinator has the ability to set the automatic lock times.

Although the case may be unlocked to allow editing, any field that is included in an electronically signed report, for example in the Nurse Intraoperative Report, will require the creation of an addendum to the report before the edit can be completed.

Example: Unlock a Case for Editing

Select Chief of Surgery Menu Option: Unlock a Case for Editing

Select PATIENT NAME: SURPATIENT,THREE 08-15-91 000212453

1. 05-15-91 CAROTID ARTERY ENDARTERECTOMY
2. 05-15-91 AORTO CORONARY BYPASS GRAFT

Select Number: 1
Press <Enter> to continue. <Enter>

Case #115 is now unlocked

Select Chief of Surgery Menu Option:
Flag Drugs for Use as Anesthesia Agents [SROCODE]

Surgery Service managers use the Flag Drugs for Use as Anesthesia Agents option to mark drugs for use as anesthesia agents. If the drug is not flagged, the user will not be able to select it as an entry for the ANESTHESIA AGENT data field.

To flag a drug, it must already be listed in the Pharmacy DRUG file. To add a drug to this file, the user should contact the facility’s Pharmacy Package Coordinator.

Example: Flag Drugs Used as Anesthesia Agents

Select Surgery Package Management Menu Option: D Flag Drugs for use as Anesthesia Agents

Enter the name of the drug you wish to flag: HALOTHANE

Do you want to flag this drug for SURGERY (Y/N)? YES

Enter the name of the drug you wish to flag:
Update Site Configurable Files
[SR UPDATE FILES]

The *Update Site Configurable Files* option is designed for the package coordinator to add, edit, or inactivate file entries for the site-configurable files.

The software provides a numbered list of site-configurable files. The user should enter the number corresponding to the file that he or she wishes to update. The software will default to any previously entered information on the entry and provide a chance to edit it. The last prompt asks whether the user wants to inactivate the entry; answering *Yes* or 1 will inactivate the entry.

**Example 1: Add a New Entry to a Site-Configurable File**

Select Surgery Package Management Menu Option:  \textbf{F} Update Site Configurable Files

```plaintext
Update Site Configurable Surgery Files
1. Surgery Transportation Devices
2. Prosthesis
3. Surgery Positions
4. Restraints and Positional Aids
5. Surgical Delay
6. Monitors
7. Irrigations
8. Surgery Replacement Fluids
9. Skin Prep Agents
10. Skin Integrity
11. Patient Mood
12. Patient Consciousness
13. Local Surgical Specialty
14. Electroground Positions
15. Surgery Dispositions
```

Update Information for which File? \textbf{2}

Update Information in the Prosthesis file.

Select PROSTHESIS NAME: HUMERAL

ARE YOU ADDING 'HUMERAL' AS A NEW PROSTHESIS (THE 112TH)? Y (YES)

NAME: HUMERAL // HUMERAL COMPONENT

VENDOR: AMERICAN

MODEL: NEER II

STERILE CODE: MFG

LOT/Serial NO: F19705-1087

STERILE RESP: MANUFACTURER

SIZE: STEM 150 MM, HEAD 22 MM

QUANTITY: \textbf{<Enter>}

INACTIVE?: \textbf{<Enter>}

Select PROSTHESIS NAME:
Example 2: Re-Activate an Entry

Select Surgery Package Management Menu Option: F Update Site Configurable Files

Update Site Configurable Surgery Files

1. Surgery Transportation Devices
2. Prosthesis
3. Surgery Positions
4. Restraints and Positional Aids
5. Surgical Delay
6. Monitors
7. Irrigations
8. Surgery Replacement Fluids
9. Skin Prep Agents
10. Skin Integrity
11. Patient Mood
12. Patient Consciousness
13. Local Surgical Specialty
14. Electroground Positions
15. Surgery Dispositions

Update Information for which File? 6

Update Information in the Monitors file.

Select MONITORS NAME: ECG ** INACTIVE **
NAME: ECG// <Enter>
INACTIVE?: YES// @
SURE YOU WANT TO DELETE? Y (YES)

Select MONITORS NAME:
Surgery Interface Management Menu
[SRHL INTERFACE]

The Surgery Interface Management Menu contains options that allow the user to set up certain interface parameters that control the processing of Health Level 7 (HL7) messages. The interface adheres to the HL7 protocol and forms the basis for the exchange of health care information between the VistA Surgery package and any ancillary system.

Currently, there are four options on the Surgery Interface Management Menu.

<table>
<thead>
<tr>
<th>Shortcut</th>
<th>Option Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Flag Interface Fields</td>
</tr>
<tr>
<td>F</td>
<td>File Download</td>
</tr>
<tr>
<td>T</td>
<td>Table Download</td>
</tr>
<tr>
<td>P</td>
<td>Update Interface Parameter Field</td>
</tr>
</tbody>
</table>
Chapter Six: Assessing Surgical Risk

Introduction

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

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

Exiting an Option or the System

To get out of an option, the user should enter an up-arrow (^). The up-arrow can be entered at almost any prompt to terminate the line of questioning and return to the previous level in the routine. To completely exit the system, the user continues entering up-arrows.
<table>
<thead>
<tr>
<th><strong>1. GENERAL:</strong></th>
<th><strong>3. HEPATOBILIARY:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Height:</td>
<td>A. Ascites:</td>
</tr>
<tr>
<td>B. Weight:</td>
<td></td>
</tr>
<tr>
<td>C. Diabetes Mellitus:</td>
<td></td>
</tr>
<tr>
<td>D. Current smoker W/I 1 Year:</td>
<td>A. Esophageal Varices:</td>
</tr>
<tr>
<td>E. ETOH &gt; 2 Drinks/Day:</td>
<td></td>
</tr>
<tr>
<td>F. Dyspnea:</td>
<td></td>
</tr>
<tr>
<td>G. Preop Sleep Apnea:</td>
<td></td>
</tr>
<tr>
<td>H. DNR Status:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>2. PULMONARY:</strong></th>
<th><strong>6. VASCULAR:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Ventilator Dependent:</td>
<td>A. Revascularization/Amputation:</td>
</tr>
<tr>
<td>B. History of Severe COPD:</td>
<td>F. Hypertension Requiring Meds:</td>
</tr>
<tr>
<td>C. Current Pneumonia:</td>
<td></td>
</tr>
</tbody>
</table>

Select Preoperative Information to Edit: 1:3

---

**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
Preoperative Sleep Apnea: NONE NONE - LEVEL 1
DNR Status (Y/N): N NO
Functional Health Status at Evaluation for Surgery: 1 INDEPENDENT

**PULMONARY:** NO

**HEPATOBILIARY:** NO
JUN 23,1998   CHOLEDOCHOTOMY

1. GENERAL:
   A. Height: 62 INCHES
   B. Weight: 175 LBS.
   C. Diabetes Mellitus: INSULIN
   D. Current Smoker W/I 1 Year: YES
   E. ETOH > 2 Drinks/Day: NO
   F. Dyspnea: NO
   G. Preop Sleep Apnea: LEVEL 1
   H. DNR Status: NO
   I. Preop Funct Status: INDEPENDENT

2. PULMONARY:
   A. Ventilator Dependent: NO
   B. History of Severe COPD: NO
   C. Current Pneumonia: NO

3. HEPATOBILIARY:
   A. Ascites: NO
   B. Esophageal Varices: NO

4. GASTROINTESTINAL:
   A. CHF Within 1 Month:
   B. MI Within 6 Months:

5. CARDIAC:
   A. CHF Within 1 Month:
   B. MI Within 6 Months:
   C. Previous PCI:
   D. Previous Cardiac Surgery:

6. VASCULAR:
   A. Revascularization/Amputation:
   B. Rest Pain/Gangrene:

Select Preoperative Information to Edit: <Enter>

JUN 23,1998   CHOLEDOCHOTOMY

1. RENAL:
   A. Acute Renal Failure:
   B. Currently on Dialysis:

2. CENTRAL NERVOUS SYSTEM:
   A. Impaired Sensorium:
   B. Coma:
   C. Hemiplegia:
   D. History of TIAs:
   E. CVA/Stroke w. Neuro Deficit:
   F. CVA/Stroke w/o Neuro Deficit:

3. NUTRITIONAL/IMMUNE/OTHER:
   A. Disseminated Cancer:
   B. Open Wound:
   C. Steroid Use for Chronic Cond.:
   D. Weight Loss > 10%:
   E. Bleeding Disorders:
   F. Transfusion > 4 RBC Units:
   G. Chemotherapy W/I 30 Days:
   H. Radiotherapy W/I 90 Days:
   I. Preoperative Sepsis:
   J. Pregnancy: NOT APPLICABLE

G. Tumor Involving CNS:

Select Preoperative Information to Edit: 3E

JUN 23,1998   CHOLEDOCHOTOMY

History of Bleeding Disorders (Y/N): Y

JUN 23,1998   CHOLEDOCHOTOMY

Select Preoperative Information to Edit:
Patient Demographics (Enter/Edit)
[SROA DEMOGRAPHICS]

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

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

Example: Entering Patient Demographics

Select Non-Cardiac Assessment Information (Enter/Edit) Option: D Patient Demographics (Enter/Edit)

---

Enter/Edit Patient Demographic Information

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

Select Number: (1-2): 1

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

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

---

Enter/Edit Patient Demographic Information

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

Select Number: (1-2): 2
<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transfer Status:</td>
<td>NOT TRANSFERRED</td>
</tr>
<tr>
<td>2. Observation Admission Date/Time:</td>
<td>NA</td>
</tr>
<tr>
<td>3. Observation Discharge Date/Time:</td>
<td>NA</td>
</tr>
<tr>
<td>4. Observation Treating Specialty:</td>
<td>NA</td>
</tr>
<tr>
<td>5. Hospital Admission Date/Time:</td>
<td>JUN 06, 2005@14:15</td>
</tr>
<tr>
<td>6. Hospital Discharge Date/Time:</td>
<td>JUN 21, 2005@11:32</td>
</tr>
<tr>
<td>7. Admit/Transfer to Surgical Svc.:</td>
<td>JUN 06, 2005@08:30</td>
</tr>
<tr>
<td>8. Discharge/Transfer to Chronic Care:</td>
<td>JUN 21, 2005@11:32</td>
</tr>
<tr>
<td>9. Length of Postop Hospital Stay:</td>
<td>15 Days</td>
</tr>
<tr>
<td>10. In/Out-Patient Status:</td>
<td>INPATIENT</td>
</tr>
<tr>
<td>11. Patient's Ethnicity:</td>
<td>NOT HISPANIC OR LATINO</td>
</tr>
<tr>
<td>12. Patient's Race:</td>
<td>AMERICAN INDIAN OR ALASKA NATIVE, ASIAN</td>
</tr>
<tr>
<td>13. Date of Death:</td>
<td>NA</td>
</tr>
<tr>
<td>14. 30-Day Death:</td>
<td>NO</td>
</tr>
</tbody>
</table>

Select number of item to edit:
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**

Definition Revised (2011): 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. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

If patient had cardiac arrest requiring CPR, indicate whether the arrest occurred intraoperatively or postoperatively. Indicate the one appropriate response:
- intraoperatively: occurring while patient was in the operating room
- postoperatively: occurring after patient left the operating room.

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

Select Occurrence Information: <Enter>
Postoperative Occurrences (Enter/Edit)  
[SRO POSTOP COMP]

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

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

Example: Enter a Postoperative Occurrence

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

SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------
There are no Postoperative Occurrences entered for this case.

Enter a New Postoperative Occurrence: ACUTE RENAL FAILURE  
Definition Revised (2011): Indicate if the patient developed new renal failure requiring renal replacement therapy or experienced an exacerbation of preoperative renal failure requiring initiation of renal replacement therapy (not on renal replacement therapy preoperatively) within 30 days postoperatively.

TIP: If the patient refuses dialysis report as an occurrence because he/she did require dialysis.

Press RETURN to continue: <Enter>

SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------
1. Occurrence:            ACUTE RENAL FAILURE
2. Occurrence Category:   ACUTE RENAL FAILURE
3. ICD Diagnosis Code:    
4. Treatment Instituted:  
5. Outcome to Date:       
6. Date Noted:           
7. Occurrence Comments:  
------------------------------------------------------------------
Select Occurrence Information: 4
TREATMENT INSTITUTED: DIALYSIS

1. Occurrence: ACUTE RENAL FAILURE
2. Occurrence Category: ACUTE RENAL FAILURE
3. ICD Diagnosis Code:
4. Treatment Instituted: DIALYSIS
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

Select Occurrence Information: <Enter>

Enter/Edit Postoperative Occurrences

1. ACUTE RENAL FAILURE
   Category: ACUTE RENAL FAILURE

Select a number (1), or type 'NEW' to enter another occurrence:
Alert Coder Regarding Coding Issues
[SROA CODE ISSUE]

This option allows the nurse reviewer to send an alert to the coder when there may be an issue with the CPT codes or the Postoperative Diagnosis codes for a Surgery case. When this option is selected, the nurse reviewer can enter a free-text message that will be sent to the coder on record, as well as to a predefined mail group identified in the Surgery Site Parameter titled CODE ISSUE MAIL GROUP. The message will not be sent if there is no coder, or if the mail group is not defined.

Example : Alert Coder Regarding Coding Issues

Select Non-Cardiac Assessment Information (Enter/Edit) Option: CODE Alert Coder Regarding Coding Issues

Select Patient: SURPATIENT,TWO 4-3-23 000451982 YES
SC VETERAN

SURPATIENT,THREE  000-45-1982
1. 05-10-05   CHOLECYSTECTOMY (COMPLETED)
2. 01-27-06   BRONCHOSCOPY (COMPLETED)
Select Operation:  1

SURPATIENT,TWO (000-45-1982) Case #10102
MAY 10,2005   CHOLECYSTECTOMY
--------------------------------------------------------------------
The following "final" codes have been entered for the case.
Principal CPT Code: 47563   LAPARO CHOLECYSTECTOMY/GRAPH
Other CPT Codes:   NOT ENTERED
Postop Diagnosis Code (ICD9): 540.9   ACUTE APPENDICITIS NOS

If you believe that the information coded is not correct and would like to alert the coders of the potential issue, enter a brief description of your concern below.

Do you want to alert the coders (Y/N)? YES

I have reviewed this case for VASQIP. The final Principal CPT Code entered is 47563. I would like to talk to you regarding the code. I think the code should be 47562. Please call me at X2545.

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

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

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

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

Example: Operative Risk Summary Data

---

1. Physician's Preoperative Estimate of Operative Mortality: 78%  
   A. Date/Time Collected: JUN 17, 2005@18:15  
2. ASA Classification: 1-NO DISTURB.  
3. Surgical Priority:  
4. Preoperative Risk Factors: NONE  
5. CPT Codes (view only): 33510  
6. Wound Classification: CLEAN  
---

Select Operative Risk Summary Information to Edit: 1:3

---

Physician's Preoperative Estimate of Operative Mortality: 78%  
Date/Time of Estimate of Operative Mortality: JUN 18, 2005@13:29

ASA Class: 1-NO DISTURB.  
Cardiac Surgical Priority: EMERGENT (ONGOING ISCHEMIA)  
Date/Time of Cardiac Surgical Priority: JUN 18, 2005@13:29
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.
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.

Entry of N shall allow the user to Set All to No for the 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.
- Valve Procedures 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 Procedures 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 bypass
CABG distal Anastomoses: 13. Maze procedure:
1. Number with vein: 14. ASD repair:
2. Number with IMA: 15. VSD repair:
3. Number with Radial Artery: 16. Myectomy:
4. Number with Other Artery: 17. Myxoma resection:
5. Number with Other Conduit: 18. Other tumor resection:
6. LV Aneurysmectomy: 19. Cardiac transplant:
7. Bridge to transplant/Device: 20. Great Vessel Repair:
8. TMR: 21. Endovascular Repair:
9. Aortic Valve Procedure: 22. Other cardiac procedures:
10. Mitral Valve Procedure:
11. Tricuspid Valve Procedure:
12. Pulmonary Valve Procedure:
--------------------------------------------------------------------------------
Select Cardiac Procedures Operative Information to Edit: A
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------
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
LV Aneurysmectomy (Y/N): N NO
Device for bridge to cardiac transplant / Destination therapy: ??
Definition Revised (2006):
Indicate if patient received a mechanical support device
(excluding IABP) as a bridge to cardiac transplant during the same
admission 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:
N   NONE
B   BRIDGE TO
TRANSPLANT
D   DESTINATION THERAPY
Device for bridge to cardiac transplant / Destination therapy: N  NONE
Transmyocardial Laser Revascularization: N  NO
Aortic Valve Procedure: ??
VASQIP Definition (2010):
Indicate if the patient had an aortic valve replacement (either the
native or a prosthetic valve) or a repair (on the native valve to
relieve stenosis and/or correct regurgitation -annuloplasty,
commissurotomy, etc.); performed with or without additional
procedure(s); either with or without placing the patient on
cardiopulmonary bypass. (If a repair was attempted, but a replacement
occurred, indicate the details of the replacement valve.) Indicate
the one most appropriate procedure:
* None
* Mechanical Valve
* Stented Bioprosthetic Valve
* Stentless Bioprosthetic Valve
* Homograft
* Primary Valve Repair
* Primary Valve Repair and Annuloplasty Device
* Annuloplasty Device alone
* Autograft Procedure (Ross Procedure)
* Other
Choose from:
N   NONE
M   MECHANICAL
S   STENTED BIOPROSTHETIC
B   STENTLESS BIOPROSTHETIC
H   HOMOGRRAFT
PR  PRIMARY REPAIR
PA  PRIMARY REPAIR & ANNULOPLASTY DEVICE
AN  ANNULOPLASTY DEVICE ALONE
AU  AUTOGRAFT (ROSS)
O   OTHER
Aortic Valve Procedure: PR  PRIMARY REPAIR
Mitral Valve Procedure: N  NONE
Tricuspid Valve Procedure: N  NONE
Pulmonary Valve Procedure: N  NONE
Maze Procedure: N  NO MAZE PERFORMED
ASD Repair (Y/N):  N  NO
VSD Repair (Y/N):  N  NO
Myectomy (Y/N):  N  NO
Myxoma Resection (Y/N):  N  NO
Other Tumor Resection (Y/N):  N  NO
Cardiac Transplant (Y/N):  N  NO
Great Vessel Repair (Y/N):  N  NO
Endovascular Repair of Aorta:  N  NO
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Count</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CABG distal anastomoses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number with vein:</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Number with IMA:</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Number with Radial Artery:</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Number with Other Artery:</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Number with Other Conduit:</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>LV Aneurysmectomy:</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Bridge to transplant/Device:</td>
<td>NONE</td>
<td></td>
</tr>
<tr>
<td>TMR:</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Aortic Valve Procedure:</td>
<td>PRIMARY REPAIR</td>
<td></td>
</tr>
<tr>
<td>Mitral Valve Procedure:</td>
<td>NONE</td>
<td></td>
</tr>
<tr>
<td>Tricuspid Valve Procedure:</td>
<td>NONE</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Valve Procedure:</td>
<td>NONE</td>
<td></td>
</tr>
</tbody>
</table>

Select Operative Information to Edit: <Enter>
Outcome Information (Enter/Edit) [SROA CARDIAC-OUTCOMES]

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

Example: Enter Outcome Information

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

SURPATIENT,TWENTY (000-45-4886)  Case #238  PAGE: 1

OUTCOMES INFORMATION
FEB 10,2004  CABG

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

0. Operative Death: NO

Perioperative (30 day) Occurrences:

1. Perioperative MI: NO 8. Repeat cardiac surg procedure: YES
2. Endocarditis: NO 9. Tracheostomy: YES
3. Renal failure require dialysis: NO 10. Repeat ventilator w/in 30 days: YES
5. Cardiac arrest requiring CPR: YES 12. Coma >= 24 hr: NO
7. On ventilator >= 48 hr: NO 14. Postop Atrial Fibrillation: NO

15. Wound Disruption: YES

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

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

Enter NONE, ON BYPASS, or OFF BYPASS.
0  None
1  On-bypass
2  Off-bypass

Cardiopulmonary Bypass Status: 1 On-bypass

SURPATIENT,TWENTY (000-45-4886)  Case #238  PAGE: 1

OUTCOMES INFORMATION
FEB 10,2004  CABG

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

0. Operative Death: NO

Perioperative (30 day) Occurrences:

1. Perioperative MI: NO 8. Repeat cardiac surg procedure: YES
2. Endocarditis: NO 9. Tracheostomy: YES
3. Renal failure require dialysis: NO 10. Repeat ventilator w/in 30 days: YES
5. Cardiac arrest requiring CPR: YES 12. Coma >= 24 hr: NO
7. On ventilator >= 48 hr: NO 14. Postop Atrial Fibrillation: NO

15. Wound Disruption: YES

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

Select Outcomes Information to Edit:
**Intraoperative Occurrences (Enter/Edit)**

[SRO INTRAOP COMP]

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

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

**Example: Enter an Intraoperative Occurrence**

| SURPATIENT,NINETEEN (000-28-7354) | Case #60183 |
| JUN 18,2005 | CORONARY ARTERY BYPASS |
|----------------------------------------------------------|
| There are no Intraoperative Occurrences entered for this case. |

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

- **Definition Revised (2011):** 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. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

- If patient had cardiac arrest requiring CPR, indicate whether the arrest occurred intraoperatively or postoperatively. Indicate the one appropriate response:
  - intraoperatively: occurring while patient was in the operating room
  - postoperatively: occurring after patient left the operating room

Press RETURN to continue: <Enter>

| SURPATIENT,NINETEEN (000-28-7354) | Case #60183 |
| JUN 18,2005 | CORONARY ARTERY BYPASS |
|----------------------------------------------------------|
| 1. Occurrence: **CARDIAC ARREST REQUIRING CPR** |
| 2. Occurrence Category: **CARDIAC ARREST REQUIRING CPR** |
| 3. ICD Diagnosis Code: |
| 4. Treatment Instituted: |
| 5. Outcome to Date: |
| 6. Occurrence Comments: |

Select Occurrence Information: 2:5
SURPATIENT,NINETEEN (000-28-7354)  Case #60183
JUN 18,2005  CORONARY ARTERY BYPASS

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

------------------------------------------------------------------------------
Select Occurrence Information: <Enter>

SURPATIENT,NINETEEN (000-28-7354)  Case #60183
JUN 18,2005  CORONARY ARTERY BYPASS

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

Select Occurrence Information: <Enter>

SURPATIENT,NINETEEN (000-28-7354)  Case #60183
JUN 18,2005  CORONARY ARTERY BYPASS

Enter/Edit Intraoperative Occurrences

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

Select a number (1), or type 'NEW' to enter another occurrence:
Postoperative Occurrences (Enter/Edit)
[SRO POSTOP COMP]

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

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

Example: Enter a Postoperative Occurrence

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

SURPATIENT,NINETEEN (000-28-7354) Case #60183
JUN 18,2005 CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
There are no Postoperative Occurrences entered for this case.

Enter a New Postoperative Occurrence: CARDIAC ARREST REQUIRING CPR
Definition Revised (2011): 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. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

If patient had cardiac arrest requiring CPR, indicate whether the arrest occurred intraoperatively or postoperatively. Indicate the one appropriate response:
- intraoperatively: occurring while patient was in the operating room
- postoperatively: occurring after patient left the operating room

Press RETURN to continue: <Enter>

SURPATIENT,NINETEEN (000-28-7354) Case #60183
JUN 18,2005 CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
1. Occurrence: CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:
------------------------------------------------------------------------------
Select Occurrence Information: 4:6
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
Date/Time the Occurrence was Noted: 6/19/05   (JUN 19, 2005)
------------------------------------------------------------------------------
1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:    
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Date Noted:            06/19/05
7. Occurrence Comments:   
------------------------------------------------------------------------------
Select Occurrence Information: <Enter>

SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
Enter/Edit Intraoperative Occurrences
1.   CARDIAC ARREST REQUIRING CPR
     Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:
Alert Coder Regarding Coding Issues
[SROA CODE ISSUE]

This option allows the nurse reviewer to send an alert to the coder when there may be an issue with the CPT codes or the Postoperative Diagnosis codes for a Surgery case. When this option is selected, the nurse reviewer can enter a free-text message that will be sent to the coder on record, as well as to a pre-defined mail group identified in the Surgery Site Parameter titled CODE ISSUE MAIL GROUP. The message will not be sent if there is no coder, or if the mail group is not defined.

Example: Alert Coder Regarding Coding Issues

| Select Cardiac Risk Assessment Information (Enter/Edit) Option: CODE Alert Coder Regarding Coding Issues |
| Select Patient: SURPATIENT,NINETEEN 000287354 YES |
| SURPATIENT,NINETEEN 000-28-7354 |
| 1. 05-10-05 CHOLECYSTECTOMY (COMPLETED) |
| 2. 06-18-05 * CORONARY ARTERY BYPASS (COMPLETED) |
| Select Operation: 2 |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 JUN 18,2005 CORONARY ARTERY BYPASS |
| The following "final" codes have been entered for the case. |
| Principal CPT Code: 33510 |
| Other CPT Codes: NOT ENTERED |
| Postop Diagnosis Code (ICD9): 402.10 HYP HEART DIS BENING W/O FAIL |

If you believe that the information coded is not correct and would like to alert the coders of the potential issue, enter a brief description of your concern below.

Do you want to alert the coders (Y/N)? YES// <Enter>

==[ WRAP ]==[ INSERT ]-----< Coding Discrepancy Comments >----[ <PF1>H=Help ]-----
I have reviewed this case for VASQIP. The final Principal CPT Code entered is 33510. I would like to talk to you regarding the code. I think the code should be 33502. Please call me at X2545.

1. Transmit Message
2. Edit Text
Select Number: 1// <Enter>
(This page included for two-sided copying.)
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 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---------------------------------------------
VA NON-CARDIAC RISK ASSESSMENT

FOR SURPATIENT, FORTY 000-77-7777 (COMPLETED)

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

Medical Center: ALBANY

Age: 81
Sex: MALE
Operation Date: JAN 09, 2006
Race: AMERICAN INDIAN OR ALASKA NATIVE, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, WHITE

Medical Center: ALBANY

Age: 81
Sex: MALE
Operation Date: JAN 09, 2006
Race: AMERICAN INDIAN OR ALASKA NATIVE, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, WHITE

Transfer Status: NOT TRANSFERRED

Observation Admission Date: NA
Observation Discharge Date: NA
Observation Treating Specialty: NA
Hospital Admission Date: JAN 7, 2006 11:15
Hospital Discharge Date: JAN 12, 2006 10:30
Admitted/Transferred to Surgical Service: JAN 7, 2006 11:15
In/Out-Patient Status: INPATIENT
Assessment Completed by: SURNURSE, SEVEN

PREOPERATIVE INFORMATION

GENERAL: NO HEPATOBILIARY: NO
Height: 70 INCHES Ascites: NO
Weight: 180 LBS.
Diabetes Mellitus: NO GASTROINTESTINAL: NO
Current Smoker W/I 1 Year: NO Esophageal Varices: NO
ETOH > 2 Drinks/Day: NO
Dyspnea: NO CARDIAC: NO
Preop Sleep Apnea: LEVEL 1 CHF Within 1 Month: NO
DNR Status: NO MI Within 6 Months: NO
Preop Funct Status: INDEPENDENT Previous PCI: NO
PULMONARY: NO Previous Cardiac Surgery: NO
Ventilator Dependent: NO Angina Within 1 Month: NO
History of Severe COPD: NO Hypertension Requiring Meds: NO
Current Pneumonia: NO VASCULAR: NO
RENAL: YES NUTRITIONAL/IMMUNE/OTHER: YES
Acute Renal Failure: NO Disseminated Cancer: NO
Currently on Dialysis: NO Open Wound: NO
Steroid Use for Chronic Cond.: NO
CENTRAL NERVOUS SYSTEM: YES Weight Loss > 10%: NO
Impaired Sensorium: NO Bleeding Disorders: NO
Coma: NO Transfusion > 4 RBC Units: NO
Hemiplegia: NO Chemotherapy W/I 30 Days: NO
History of TIA's: NO Radiotherapy W/I 90 Days: NO
CVA/Stroke w. Neuro Deficit: YES Preoperative Sepsis: NONE
CVA/Stroke w/o Neuro Deficit: NO
Tumor Involving CNS: NO

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 07:15
Anesthesia Finish (AF): JAN 9, 2006 08:08
Discharge from PACU (DPACU): JAN 9, 2006 09:15
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 12-19-51 000345555 NO SC VETERAN

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>07-01-06</td>
<td>* CABG X3 (1A,2V), ARTERIAL GRAFTING (TRANSMITTED)</td>
</tr>
<tr>
<td>03-27-05</td>
<td>INGUINAL HERNIA (TRANSMITTED)</td>
</tr>
<tr>
<td>07-03-04</td>
<td>PULMONARY LOBECTOMY (TRANSMITTED)</td>
</tr>
</tbody>
</table>

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

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

-------------------------------------------------------------------------------------------------------------------------------------------
VA SURGICAL QUALITY IMPROVEMENT PROGRAM - CARDIAC SPECIALTY

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

II. CLINICAL DATA
Gender: MALE Prior MI: < OR = 7 DAYS OF SURG
Age: 56 # of prior heart surgeries: Valve-only
Height: 76 in Prior heart surgeries: Valve-only
Weight: 210 lb Peripheral Vascular Disease: YES
Diabetes: ORAL Cerebral Vascular Disease: NO
COPD: YES Angina (use CCS Class): IV
FEVI: NS CBF (use NYHA Class): II
Cardiomegaly (X-ray): YES Current Diuretic Use: YES
Pulmonary Rales: YES Current Digoxin Use: NO
Current Smoker: WITHIN 2 WEEKS OF SURG IV NTG 48 Hours Preceding Surgery: YES
Resting ST Depression: NO Hypertension: YES
Functional Status: INDEPENDENT Preoperative Atrial Fibrillation: NO
PCI: None

III. DETAILED LABORATORY INFO - PREOPERATIVE VALUES
Creatinine: mg/dl (NS) T. Cholesterol: mg/dl (NS)
Hemoglobin: mg/dl (NS) HDL: mg/dl (NS)
Albumin: g/dl (NS) LDL: mg/dl (NS)
Triglyceride: mg/dl (NS) Hemoglobin A1c: % (NS)
Potassium: mg/L (NS) BNP: mg/dl (NS)
T. Bilirubin: mg/dl (NS)

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA
Cardiac Catheterization Date: 06/28/06
Native Coronaries:
LVEDP: NS Left Main Stenosis: NS
Aortic Systolic Pressure: NS LAD Stenosis: NS
Right Coronary Stenosis: NS
For patients having right heart cath: Circumflex Stenosis: NS
PA Systolic Pressure: NS
PAW Mean Pressure: NS If a Re-do, indicate stenosis in graft to:
LAD: NS
Right coronary (include PDA): NS
Circumflex: NS

LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):
Grade Ejection Fraction Range Definition
NO LV STUDY

Mitrail Regurgitation: NS
Aortic stenosis: NS

V. OPERATIVE RISK SUMMARY DATA
Physician's Preoperative 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: 33517
Other Procedures CPT Codes: 33510
Preoperative Risk Factors:
Wound Classification: CLEAN
### VI. OPERATIVE DATA

Cardiac surgical procedures with or without cardiopulmonary bypass

<table>
<thead>
<tr>
<th>CABG distal anastomoses:</th>
<th>Maze procedure:</th>
<th>NO MAZE PERFORMED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number with Vein:</td>
<td>1 A. S. D. repair:</td>
<td>NO</td>
</tr>
<tr>
<td>Number with IMA:</td>
<td>1 V. S. D. repair:</td>
<td>NO</td>
</tr>
<tr>
<td>Number with Radial Artery:</td>
<td>0 Myectomy:</td>
<td>NO</td>
</tr>
<tr>
<td>Number with Other Artery:</td>
<td>1 Myxoma resection:</td>
<td>NO</td>
</tr>
<tr>
<td>Number with Other Conduit:</td>
<td>1 Other tumor resection:</td>
<td>NO</td>
</tr>
<tr>
<td>LV Aneurysmectomy:</td>
<td>NO Cardiac transplant:</td>
<td>NO</td>
</tr>
<tr>
<td>Bridge to transplant/Device:</td>
<td>NONE</td>
<td>Great Vessel Repair:</td>
</tr>
<tr>
<td>TMR:</td>
<td>NONE Endovascular Repair:</td>
<td>NO</td>
</tr>
</tbody>
</table>

* Other Cardiac procedures (Specify):

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)

### VII. OUTCOMES

Operative Death: NO

Date of Death:

Perioperative (30 day) Occurrences:

- Perioperative MI: NO Repeat cardiac Surg procedure: YES
- Endocarditis: NO Tracheostomy: YES
- Renal Failure Requiring Dialysis: NO Ventilator supp within 30 days: YES
- Mediastinitis: YES Stroke/CVA: NO
- Cardiac Arrest Requiring CPR: YES Coma > or = 24 Hours: NO
- Reoperation for Bleeding: NO New Mech Circulatory Support: YES
- On ventilator > or = 48 hr: NO Postop Atrial Fibrillation: NO
- Wound Disruption: YES

### VIII. RESOURCE DATA

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

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

Time Patient In OR: 07/01/06 10:00 Operation Began: 07/01/06 10:10

Operation Ended: 07/10/06 12:30 Time Patient Out OR: 07/01/06 12:20

Date and Time Patient Exhusted: 07/01/06 13:13

Postop Intubation Hrs: +1.9

Date and Time Patient Discharged from ICU: 07/01/06 08:00

Patient is Homeless: NS

Cardiac Surg Performed at Non-VA Facility: UNKNOWN

Resource Data Comments:

---

### IX. SOCIOECONOMIC, ETHNICITY, AND RACE

Employment Status Preoperatively: SELF EMPLOYED

Ethnicity: NOT HISPANIC OR LATINO

Race Category(ies): AMERICAN INDIAN OR ALASKA NATIVE, AMERICAN INDIAN OR ALASKA NATIVE, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, WHITE

### X. DETAILED DISCHARGE INFORMATION

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

Type of Disposition: TRANSFER

Place of Disposition: HOME-BASED PRIMARY CARE (HBPC)

Primary care or referral VAMC identification code: 526

Follow-up VAMC identification code: 526

*** End of report for SURPATIENT,NINE 000-34-5555 assessment #238 ***
Monthly Surgical Case Workload Report
[SROA MONTHLY WORKLOAD REPORT]

The Monthly Surgical Case Workload Report option generates the Monthly Surgical Case Workload Report that may be printed and/or transmitted to the VASQIP national database. The report can be printed for a specific month, or for a range of months.

Example: Monthly Surgical Case Workload Report – Single Month

Select Surgery Risk Assessment Menu Option: M Monthly Surgical Case Workload Report

Report of Monthly Case Workload Totals

Print which report?

1. Report for Single Month
2. Report for Range of Months

Select Number (1 or 2): 1// <Enter>

This option provides a report of the monthly risk assessment surgical case workload totals which include the following categories:

1. All cases performed
2. Eligible cases
3. Eligible cases meeting exclusion criteria
4. Assessed cases
5. Not logged eligible cases
6. Cardiac cases
7. Non-cardiac cases
8. Assessed cases per day (based on 20 days/month)

The second part of this report provides the total number of incomplete assessments remaining for the month selected and the prior 12 months.

Compile workload totals for which month and year? MAY 2007// <Enter>

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

This report may be printed and/or transmitted to the national database.

Do you want this report to be transmitted to the central database? NO// <Enter>

Print report on which Device: [Select Print Device]

---------------------------------------------------------printout follows--------------------------------------------------
MAYBERRY, NC
REPORT OF MONTHLY SURGICAL CASE WORKLOAD
FOR MAY 2007

TOTAL CASES PERFORMED = 249
TOTAL ELIGIBLE CASES = 227
CASES MEETING EXCLUSION CRITERIA = 114
NON-SURGEON CASE = 55
EXCEEDS MAX. ASSESSMENTS = 0
EXCEEDS MAXIMUM TURPS = 0
STUDY CRITERIA = 59
SCNR WAS ON A/L = 0
CONCURRENT CASE = 0
EXCEEDS MAXIMUM HERNIAS = 0
ASSESSED CASES = 135
NOT LOGGED ELIGIBLE CASES = 0
CARDIAC CASES = 16
NON-CARDIAC CASES = 119
ASSESSED CASES PER DAY = 6.75

NUMBER OF INCOMPLETE ASSESSMENTS REMAINING FOR PAST YEAR

<table>
<thead>
<tr>
<th></th>
<th>CARDIAC</th>
<th>NON-CARDIAC</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAY 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JUN 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JUL 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>AUG 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SEP 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OCT 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NOV 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DEC 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JAN 2007</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FEB 2007</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MAR 2007</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>APR 2007</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MAY 2007</td>
<td>15</td>
<td>82</td>
<td>97</td>
</tr>
</tbody>
</table>

15 82 97
Update 1-Liner Case
[SROA ONE-LINER UPDATE]

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

Example: Update 1-Liner Case

<table>
<thead>
<tr>
<th>Select Surgery Risk Assessment Menu Option:</th>
<th>Update 1-Liner Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select Patient:</td>
<td>SURPATIENT,TWELVE</td>
</tr>
<tr>
<td></td>
<td>SC VETERAN</td>
</tr>
<tr>
<td></td>
<td>02-12-28 000418719</td>
</tr>
</tbody>
</table>

SURPATIENT,TWELVE 000-41-8719

1. 08-07-04 REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)
2. 02-18-99 TRACHEOSTOMY, BRONCHOSCOPY, ESOPHAGOSCOPY (COMPLETED)
3. 09-04-97 CHOLECYSTECTOMY (COMPLETED)

Select Case: 1

SURPATIENT,TWELVE (000-41-8719) Case #142

Transmission Status: QUEUED TO TRANSMIT >> Coding Complete <<
AUG 7,2004 REPAIR DIAPHRAGMATIC HERNIA (CPT Code: 39540)

| Select number of item to edit: | 6 |

Wound Classification: C CLEAN

SURPATIENT,TWELVE (000-41-8719) Case #142

Transmission Status: QUEUED TO TRANSMIT >> Coding Complete <<
AUG 7,2004 REPAIR DIAPHRAGMATIC HERNIA (CPT Code: 39540)

| Select number of item to edit: | |
Queue Assessment Transmissions
[SROA TRANSMIT ASSESSMENTS]

The Queue Assessment Transmissions option may be used to manually queue the VASQIP transmission process to run at a selected time. The VASQIP transmission process is a part of the nightly maintenance and cleanup process.

Example: Queue Assessment Transmissions

Select Surgery Risk Assessment Menu Option: T Queue Assessment Transmissions

Transmit Surgery Risk Assessments

Requested Start Time: NOW// <Enter>

Queued as task #2651700

Press RETURN to continue
(This page included for two-sided copying.)
Alert Coder Regarding Coding Issues
[SROA CODE ISSUE]

This option allows the nurse reviewer to send an alert to the coder when there may be an issue with the CPT codes or the Postoperative Diagnosis codes for a Surgery case. When this option is selected, the nurse reviewer can enter a free-text message that will be sent to the coder on record, as well as to a pre-defined mail group identified in the Surgery Site Parameter titled CODE ISSUE MAIL GROUP. The message will not be sent if there is no coder, or if the mail group is not defined.

Example : Alert Coder Regarding Coding Issues

Select Surgery Risk Assessment Menu Option: CODE Alert Coder Regarding Coding Issues

Select Patient: SURPATIENT,TWELVE 02-12-28 000418719 YES
SC VETERAN

SURPATIENT,TWELVE 000-41-8719
1. 08-07-04 REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)
2. 02-18-99 TRACHEOSTOMY, BRONCHOSCOPY, ESOPHAGOSCOPY (COMPLETED)
3. 09-04-97 CHOLECYSTECTOMY (COMPLETED)
Select Operation: 1

SURPATIENT,TWELVE (000-41-8719) Case #142
AUG 7,2004 REPAIR DIAPHRAGMATIC HERNIA
--------------------------------------------------------------------
The following "final" codes have been entered for the case.
Principal CPT Code: 39540 REPAIR DIAPHRAGMATIC HERNIA
Other CPT Codes: NOT ENTERED
Postop Diagnosis Code (ICD9): 551.3 DIAPHRAGM HERNIA W GANGR (w C/C)

If you believe that the information coded is not correct and would like to alert the coders of the potential issue, enter a brief description of your concern below.

Do you want to alert the coders (Y/N)? YES// <Enter>

I have reviewed this case for VASQIP. The final Principal CPT Code entered is 39540. I would like to talk to you regarding the code. I think the code should be 39541. Please call me at X2545.

1. Transmit Message
2. Edit Text
Select Number: 1// <Enter>
Transmitting message...
(This page included for two-sided copying.)
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 VASQIP data in the RISK MODEL LAB TEST file (#139.2). The option synonym is ERM.

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Laboratory Data Name(s)</th>
<th>Specimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHOLESTEROL</td>
<td>NONE ENTERED</td>
<td>SERUM</td>
</tr>
</tbody>
</table>

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>
### Risk Model Lab Test (Enter/Edit)

Select item to edit from list below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>ALBUMIN</td>
</tr>
<tr>
<td>2.</td>
<td>ALKALINE PHOSPHATASE</td>
</tr>
<tr>
<td>3.</td>
<td>ANION GAP</td>
</tr>
<tr>
<td>4.</td>
<td>B-TYPE NATRIURETIC PEPTIDE</td>
</tr>
<tr>
<td>5.</td>
<td>BUN</td>
</tr>
<tr>
<td>6.</td>
<td>CHOLESTEROL</td>
</tr>
<tr>
<td>7.</td>
<td>CPK</td>
</tr>
<tr>
<td>8.</td>
<td>CPK-MB</td>
</tr>
<tr>
<td>9.</td>
<td>CREATININE</td>
</tr>
<tr>
<td>10.</td>
<td>HDL</td>
</tr>
<tr>
<td>11.</td>
<td>HEMATOCRIT</td>
</tr>
<tr>
<td>12.</td>
<td>HEMOGLOBIN</td>
</tr>
<tr>
<td>13.</td>
<td>HEMOGLOBIN A1C</td>
</tr>
<tr>
<td>14.</td>
<td>INR</td>
</tr>
<tr>
<td>15.</td>
<td>LDL</td>
</tr>
<tr>
<td>16.</td>
<td>PLATELET COUNT</td>
</tr>
<tr>
<td>17.</td>
<td>POTASSIUM</td>
</tr>
<tr>
<td>18.</td>
<td>PT</td>
</tr>
<tr>
<td>19.</td>
<td>PTT</td>
</tr>
<tr>
<td>20.</td>
<td>SGOT</td>
</tr>
<tr>
<td>21.</td>
<td>SODIUM</td>
</tr>
<tr>
<td>22.</td>
<td>TOTAL BILIRUBIN</td>
</tr>
<tr>
<td>23.</td>
<td>TRIGLYCERIDE</td>
</tr>
<tr>
<td>24.</td>
<td>TROPONIN I</td>
</tr>
<tr>
<td>25.</td>
<td>TROPONIN T</td>
</tr>
<tr>
<td>26.</td>
<td>WHITE BLOOD COUNT</td>
</tr>
</tbody>
</table>

Enter number (1-26):
Chapter Nine: Assessing Transplants

Introduction

The Transplant Assessment module allows qualified personnel to create and manage transplant assessments. Menu options provide the ability to enter transplant assessment information for a patient and transmit the assessment to the Veterans Affairs Surgery Quality Improvement Program (VASQIP) national databases. Options are also provided to print and list transplant assessments.
JUN 17, 2008  KIDNEY TRANSPLANT

RECIPIENT INFORMATION

1. VACO ID:                  12121
2. Date Placed on Waiting:   MAY 04, 2008
3. Date Started Dialysis:    JAN 21, 2008
4. Recipient ABO Blood Type: O O
5. Recipient CMV:            + POSITIVE

Diagnosis Information

6. Calcineurin Inhibitor Toxicity:  13. Obstructive Uropathy from BPH:
7. Glomerular Sclerosis/Nephritis:   14. Polycystic Disease:
8. Graft Failure:                  15. Renal Cancer:
9. IgA Nephropathy:                16. Rejection:
10. Lithium Toxicity:
11. Membranous Nephropathy:
12. Transplant Comments:

Select Transplant Information to Edit: <Enter>
SURPATIENT, NINETYSIX (0288)   VACO ID: 12121   CASE: 482
JUN 17, 2008   KIDNEY TRANSPLANT

KIDNEY TRANSPLANT INFORMATION

1. Warm Ischemia time:
2. Cold Ischemia time:
3. Total Ischemia time:
4. Crossmatch D/R:
5. PRA at Listing:
6. PRA at Transplant:
7. IVIG Recipient:
8. Plasmapheresis:

HLA Typing (#,#,#,#)

9. Recipient HLA-A:
10. Recipient HLA-B:
11. Recipient HLA-C:
12. Recipient HLA-DR:
13. Recipient HLA-BW:
14. Recipient HLA-DQ:

Select Transplant Information to Edit: <Enter>

SURPATIENT, NINETYSIX (0288)   VACO ID: 12121   CASE: 482
JUN 17, 2008   KIDNEY TRANSPLANT

RISK ASSESSMENT

1. Diabetic Retinopathy:
2. Diabetic Neuropathy:
3. Cardiac Disease:
4. Liver Disease:
5. HIV + (positive):
6. Lung Disease:
7. Pre-Transplant Malignancy:
8. Active Infection Immediately Pre-TX req. Antibiotics:
9. Non-Compliance (Med and Diet):
10. Recipient Substance Abuse:
11. Post-TX Prophylaxis for CMV/Antiviral Treatment:
12. Post-TX Prophylaxis for PJP/Antibiotic Treatment:
13. Post-TX Prophylaxis for TB/Antimycobacterial Treatment:
14. Graft Failure Date:

Select Transplant Information to Edit: <Enter>
| 1. Donor Race:                      |
| 2. Donor Gender:                   |
| 3. Donor Height:                   |
| 4. Donor Weight:                   |
| 5. Donor DOB:                      |
| 6. Donor Age:                      |
| 7. Donor ABO Blood Type:           |
| 8. Donor CMV:                      |
| 9. Donor Substance Abuse:          |
| 10. Deceased Donor:                |
| 11. Living Donor:                  |
| 12. Donor with Malignancy:         |

Donor Race: 
Gender: 
Height: 
Weight: 
DOB: 
Age: 
ABO Blood Type: 
CMV: 
Substance Abuse: 
Deceased Donor: 
Living Donor: 
With Malignancy: 

---

Select Transplant Information to Edit: <Enter>

| 1. Pancreas (SPK/PAK):            |
| 2. Glucose at Time of Listing:    |
| 3. C-peptide at Time of Listing:  |
| 4. Pancreatic Duct Anastomosis:    |
| 5. Glucose Post Transplant:        |
| 6. Amylase Post Transplant:        |
| 7. Lipase Post Transplant:         |
| 8. Insulin Req Post transplant:    |
| 9. Oral Hypoglycemics Req Post-TX: |

Pancreas: 
Glucose at Time of Listing: 
C-peptide at Time of Listing: 
Pancreatic Duct Anastomosis: 
Glucose Post Transplant: 
Amylase Post Transplant: 
Lipase Post Transplant: 
Insulin Req Post transplant: 
Oral Hypoglycemics Req Post-TX: 

---

Select Transplant Information to Edit: <Enter>

Are you ready to complete and transmit this transplant assessment? NO// <Enter>
Edit a Transplant Assessment
When selecting an existing transplant assessment, the user has the following options.

- Enter Transplant Assessment Information
- Delete Transplant Assessment Entry
- Update Transplant Assessment Status to 'COMPLETE'
- Change VA/Non-VA Transplant Indicator

Enter Transplant Assessment Information

Example: Editing a Transplant Assessment

<table>
<thead>
<tr>
<th>Division: ALBANY (500)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E Enter/Edit Transplant Assessments</td>
</tr>
<tr>
<td>P Print Transplant Assessment</td>
</tr>
<tr>
<td>L List of Transplant Assessments</td>
</tr>
<tr>
<td>S Transplant Assessment Parameters (Enter/Edit)</td>
</tr>
</tbody>
</table>

Select Transplant Assessment Menu Option: E Enter/Edit Transplant Assessments

Select Patient: SURPATIENT,NINETYSIX 05-05-64 666000288 NSC VETERAN

SURPATIENT,NINETYSIX 666-00-0288

1. 06-17-08 KIDNEY TRANSPLANT (INCOMPLETE)
2. ---- CREATE NEW TRANSPLANT ASSESSMENT

Select Assessment: 1

SURPATIENT,NINETYSIX

06-17-06 KIDNEY TRANSPLANT (INCOMPLETE)

1. Enter Transplant Assessment Information
2. Delete Transplant Assessment Entry
3. Update Transplant Assessment Status to 'COMPLETE'
4. Change VA/Non-VA Transplant Indicator

Select Number: 1// <Enter>

SURPATIENT,NINETYSIX (0288) VACO ID: 12121 CASE: 482 PAGE: 1 OF 5
JUN 17,2008 KIDNEY TRANSPLANT RECIPIENT INFORMATION

1. VACO ID: 12121
2. Date Placed on Waiting: MAY 04, 2008
3. Date Started Dialysis: JAN 21, 2008
4. Recipient ABO Blood Type: O
5. Recipient CMV: POSITIVE

Diagnosis Information

6. Calcineurin Inhibitor Toxicity: 13. Obstructive Uropathy from BPH:
7. Glomerular Sclerosis/Nephritis: 14. Polycistic Disease:
8. Graft Failure: 15. Renal Cancer:
9. IgA Nephropathy: 16. Rejection:
10. Lithium Toxicity:
11. Membranous Nephropathy:
12. Transplant Comments:

Select Transplant Information to Edit: 6
Chapter Ten: Glossary

The following table contains terms that are used throughout the Surgery V.3.0 User Manual, and will aid the user in understanding the use of the Surgery package.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aborted</td>
<td>Case status indicating the case was cancelled after the patient entered the operating room. Cases with ABORTED status must contain entries in TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232), plus CANCEL DATE field (#17) and/or CANCEL REASON field (#18).</td>
</tr>
<tr>
<td>ASA Class</td>
<td>This is the American Society of Anesthesiologists classification relating to the patient’s physiologic status. Numbers followed by an ‘E’ indicate an emergency.</td>
</tr>
<tr>
<td>Attending Code</td>
<td>Code that corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure.</td>
</tr>
<tr>
<td>Blockout Graph</td>
<td>Graph showing the availability of operating rooms.</td>
</tr>
<tr>
<td>Cancelled Case</td>
<td>Case status indicating that an entry has been made in the CANCEL DATE field and/or the CANCEL REASON field without the patient entering the operating room.</td>
</tr>
<tr>
<td>CCSHS</td>
<td>VA Center for Cooperative Studies in Health Services located at Hines, Illinois.</td>
</tr>
<tr>
<td>CICSP</td>
<td>Continuous Improvement in Cardiac Surgery Program.</td>
</tr>
<tr>
<td>Completed Case</td>
<td>Case status indicating that an entry has been made in the TIME PAT OUT OR field.</td>
</tr>
<tr>
<td>Concurrent Case</td>
<td>A patient undergoing two operations by different surgical specialties at the same time, or back to back, in the same operating room.</td>
</tr>
<tr>
<td>CRT</td>
<td>Cathode ray tube display. A display device that uses a cathode ray tube.</td>
</tr>
<tr>
<td>Intraoperative Occurrence</td>
<td>Perioperative occurrence during the procedure.</td>
</tr>
<tr>
<td>Major</td>
<td>Any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered.</td>
</tr>
<tr>
<td>Minor</td>
<td>All operations not designated as Major.</td>
</tr>
<tr>
<td>New Surgical Case</td>
<td>A surgical case that has not been previously requested or scheduled such as an emergency case. A surgical case entered in the records without being booked through scheduling will not appear on the Schedule of Operations or as an operative request.</td>
</tr>
<tr>
<td>Non-Operative Occurrence</td>
<td>Occurrence that develops before a surgical procedure is performed.</td>
</tr>
<tr>
<td>Not Complete</td>
<td>Case status indicating one of the following two situations with no entry in the TIME PAT OUT OR field (#.232).</td>
</tr>
<tr>
<td></td>
<td>1) Case has entry in TIME PAT IN OR field (#.205).</td>
</tr>
<tr>
<td></td>
<td>2) Case has not been requested or scheduled.</td>
</tr>
<tr>
<td>NSQIP</td>
<td>National Surgical Quality Improvement Program.</td>
</tr>
<tr>
<td>Operation Code</td>
<td>Identifying code for reporting medical services and procedures performed by physicians. See CPT Code.</td>
</tr>
<tr>
<td>PACU</td>
<td>Post Anesthesia Care Unit.</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Postoperative Occurrence</td>
<td>Perioperative occurrence following the procedure.</td>
</tr>
<tr>
<td>Procedure Occurrence</td>
<td>Occurrence related to a non-O.R. procedure.</td>
</tr>
<tr>
<td>Requested</td>
<td>Operation has been slotted for a particular day but the time and operating room are not yet firm.</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>Part of the Surgery software that provides medical centers a mechanism to track information related to surgical risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical analysis.</td>
</tr>
<tr>
<td>Scheduled</td>
<td>Operation has both an operating room and a scheduled starting time, but the operation has not yet begun.</td>
</tr>
<tr>
<td>Screen Server</td>
<td>A format for displaying data on a cathode ray tube display. Screen Server is designed specifically for the Surgery Package.</td>
</tr>
<tr>
<td>Screen Server Function</td>
<td>The Screen Server prompt for data entry.</td>
</tr>
<tr>
<td>Service Blockouts</td>
<td>The reservation of an operating room for a particular service on a recurring basis. The reservation is charted on a blockout graph.</td>
</tr>
<tr>
<td>Transplant Assessments</td>
<td>Part of the Surgery software that provides medical centers a mechanism to track information related to transplant risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical analysis.</td>
</tr>
<tr>
<td>VASQIP</td>
<td>Veterans Affairs Surgery Quality Improvement Program.</td>
</tr>
</tbody>
</table>
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