

SURGERY

**USER MANUAL**

Version 3.0

July 1993

(Revised June 2007)

Department of Veterans Affairs

VistA Health Systems Design & Development

**Revision History**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Revised Pages** | **Patch Number** | **Description** |
| 06/07 | 35, 210, 212b | SR\*3\*159 | Updated screens to reflect change of the environmental indicator “Environmental Contaminant” to “SWAC” (e.g., Southwest Asia).  REDACTED |
| 06/07 | 176-180, 180a, 184c-d,  327c-d, 372, 375-376,  446, 449-450, 452-453,  455-456, 458, 461, 468,  470, 472, 479-479a,  482-484, 486a, 489,  491, 493, 495, 497, 499,  501, 502a-d, 504-506,  509-512, 519 | SR\*3\*160 | Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the *Surgery NSQIP-CICSP Enhancements 2007 Release Notes.*  Updated data entry screens to match software; changes are unrelated to this patch.  REDACTED |
| 11/06 | 10-12, 14, 21-22, 139-  141, 145-150, 152, 219,  438 | SR\*3\*157 | Updated data entry options to display new fields for collecting sterility information for the Prosthesis Installed field; updated the Nurse Intraoperative Report section with these required new fields. For more details, see the *Surgery-Tracking Prosthesis Items Release Notes*.  Updated data entry screens to match software; changes are unrelated to this patch.  REDACTED |
| 08/06 | 6-9, 14, 109-112, 122-  124, 141-149, 151-152,  176, 178-180, 180a-b,  181-184, 184a-d, 185-  186, 218-219, 326-327,  327a-d, 328-329, 373,  377, 449-450, 452-456,  459, 461-462, 467-468,  468b, 469-470, 470a,  473-474, 474a-474b,  475, 477, 481-486,  486a-b, 489-502, 502a-  b, 503-504, 509-512 | SR\*3\*153 | Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software.  Updated data entry options to incorporate renamed/new Hair Removal documentation fields. Updated the Nurse Intraoperative Report and Quarterly Report to include these fields.  For more details, see the *Surgery NSQIP/CICSP Enhancements 2006 Release Notes.*  REDACTED |

June 2007 Surgery V. 3.0 User Manual i SR\*3\*160, SR\*3\*159

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Revised Pages** | **Patch Number** | **Description** |
| 06/06 | 28-32, 40-50, 64-80,  101-102 | SR\*3\*144 | Updated options to reflect new required fields (Attending Surgeon and Principal Preoperative Diagnosis) for creating a surgery case.  REDACTED |
| 06/06 | vi, 34-35, 125, 210, 212b, 522a-b | SR\*3\*152 | Updated Service Classification screen example to display new PROJ 112/SHAD prompt.  This patch will prevent the PRIN PRE-OP ICD DIAGNOSIS CODE field of the Surgery file from being sent to the Patient Care Encounter (PCE) package.  Added the new *Alert Coder Regarding Coding Issues*  option to the Surgery Risk Assessment Menu option.  REDACTED |
| 04/06 | 445, 464a-b, 465,  480a-b | SR\*3\*146 | Added the new *Alert Coder Regarding Coding Issues*  option to the Assessing Surgical Risk chapter.  REDACTED |
| 04/06 | 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 | SR\*3\*142 | 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.  REDACTED |
| 10/05 | 9, 109-110, 144, 151,  218 | SR\*3\*147 | Updated data entry screens to reflect renaming of the Preop Shave By field to Preop Hair Clipping By field.  REDACTED |
| 08/05 | 10, 14, 99-100, 114,  119-120, 124, 153-154,  162-164, 164a-b, 190,  192, 209-212f, 238-242 | SR\*3\*119 | 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.  REDACTED |

ii Surgery V. 3.0 User Manual June 2007 SR\*3\*160, SR\*3\*159

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Revised Pages** | **Patch Number** | **Description** |
| 08/04 | iv-vi, 187-189, 195,  195a-195b, 196, 207-  208, 219a-b, 527-528 | SR\*3\*132 | Updated the Table of Contents and Index to reflect added options. Added the new *Non-OR Procedure Information* option and the *Tissue Examination Report* option (unrelated to this patch) to the Non-OR Procedures section. |
| 08/04 | 31, 43, 46, 66, 71-72,  75-76, 311 | SR\*3\*127 | Updated screen captures to display new text for ICD-9 and CPT codes. |
| 08/04 | vi, 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 | SR\*3\*125 | Updated the Table of Contents and Index. Clarified the location of the national centers for NSQIP and CICSP. Updated the data entry options for the non- cardiac and cardiac risk management sections; these options have been changed to match the software and new options have been added. For an overview of the data entry changes, see the *Surgery NSQIP/CICSP Enhancements 2004 Release Notes.* Added the *Laboratory Test Result (Enter/Edit)* option and the *Outcome Information (Enter/Edit)* option to the *Cardiac Risk Assessment Information (Enter/Edit)* menu section. Changed the name of the *Cardiac Procedures Requiring CPB (Enter/Edit*) option to *Cardiac Procedures Operative Data (Enter/Edit)* option. Removed the *Update Operations as Unrelated/Related to Death* option from the *Surgery Risk Assessment Menu*. |
| 08/04 | 6-10, 14, 103, 105-107,  109-112, 114-120, 122-  124, 141-152, 218-219,  284-287, 324, 370-377 | SR\*3\*129 | Updated examples to include the new levels for the Attending Code (or Resident Supervision). Also updated examples to include the new fields for ensuring Correct Surgery. For specific options affected by each of these updates, please see the *Resident Supervision/Ensuring Correct Surgery Phase II Release Notes.* |
| 04/04 | All | SR\*3\*100 | All pages were updated to reflect the most recent Clinical Ancillary Local Documentation Standards and the changes resulting from the Surgery Electronic Signature for Operative Reports project, SR\*3\*100. For more information about the specific changes, see the patch description or the *Surgery Electronic Signature for Operative Reports Release Notes*. |

June 2007 Surgery V. 3.0 User Manual iia SR\*3\*160, SR\*3\*159

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

iib Surgery V. 3.0 User Manual June 2007 SR\*3\*160, SR\*3\*159

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

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

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

SURPATIENT,TEN (000-12-3456)

ALLIED VETERAN

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

Primary Eligibility: SERVICE CONNECTED 50% to 100% Combat Vet: NO A/O Exp.: YES M/S Trauma: NO ION Rad.: YES SWAC: YES H/N Cancer: NO PROJ 112/SHAD: YES

SC Percent: 100%

Rated Disabilities: NONE STATED

Please supply the following required information about this operation:

Treatment related to Service Connected condition (Y/N): **N** NO Treatment related to Agent Orange (Y/N): **N** NO

Treatment related to Ionizing Radiation Exposure (Y/N): **N** NO Treatment related to SW Asia (Y/N): **N** NO

Treatment related to PROJ 112/SHAD (Y/N): **YES** YES

Update all ‘OTHER POSTOP DIAGNOSIS' Eligibility and

Service Connected Conditions with these values? Enter YES or NO. <NO> **Y**

Press RETURN to continue

June 2007 Surgery V. 3.0 User Manual 35

SR\*3\*159

**Delete or Update Operation Requests**

### [SRSUPRQ]

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

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

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

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

36 Surgery V. 3.0 User Manual April 2004

# Perioperative Occurrences Menu

### [SRO COMPLICATIONS MENU]

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

This option is locked with the SROCOMP key.



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

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

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

|  |  |
| --- | --- |
| **Shortcut** | **Option Name** |
| I | *Intraoperative Occurrences (Enter/Edit)* |
| P | *Postoperative Occurrences (Enter/Edit)* |
| N | *Non-Operative Occurrences (Enter/Edit)* |
| U | *Update Status of Returns Within 30 Days* |
| M | *Morbidity & Mortality Reports* |

**Key Vocabulary**

The following terms are used in this section.

|  |  |
| --- | --- |
| **Term** | **Definition** |
| Intraoperative Occurrence | Occurrence that occurs during the procedure. |
| Postoperative Occurrence | Occurrence that occurs after the procedure. |
| Non-Operative Occurrence | Occurrence that develops before a surgical procedure is performed. |

April 2004 Surgery V. 3.0 User Manual 175

## Intraoperative Occurrences (Enter/Edit)

### [SRO INTRAOP COMP]

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

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

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

##### Example: Entering Intraoperative Occurrences

Select Perioperative Occurrences Menu Option: **I** Intraoperative Occurrences (Enter/Edit)

Select Patient: **SURPATIENT,FIFTY**

10-28-45

000459999

SURPATIENT,FIFTY 000-45-9999

1. 06-30-06 CHOLECYSTECTOMY (COMPLETED)
2. 03-10-07 HEMORRHOIDECTOMY (COMPLETED)

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 ARR**EST REQUIRING CPR NSQIP Definition (2006):

The absence of cardiac rhythm or presence of chaotic cardiac rhythm that results in loss of consciousness requiring the initiation of any component of basic and/or advanced cardiac life support. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

CICSP Definition (2004):

Indicate if there was any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) occurring in the operating room, ICU, ward, or out-of-hospital after the chest had been completely closed and within 30 days of surgery.

Press RETURN to continue: **<Enter>**

176 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

|  |  |
| --- | --- |
| SURPATIENT,FIFTY (000-45-9999) Case #213  JUN 30,2006 CHOLECYSTECTOMY |  |
| 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,FIFTY (000-45-9999)

Type of Treatment Instituted: **CPR**

Outcome to Date: **?**

CHOOSE FROM:

U UNRESOLVED

I IMPROVED

D DEATH

W WORSE

Outcome to Date: **I** IMPROVED

|  |  |
| --- | --- |
| SURPATIENT,FIFTY (000-45-9999) Case #213  JUN 30,2006 CHOLECYSTECTOMY |  |
| 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: |

June 2007 Surgery V. 3.0 User Manual 177

SR\*3\*160

## Postoperative Occurrences (Enter/Edit)

### [SRO POSTOP COMP]

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

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

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

##### Example: Entering a Postoperative Occurrence

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

Select Patient: **SURPATIENT,SEVENTEEN**

09-13-28

000455119

SURPATIENT,SEVENTEEN R. 000-45-5119

1. 04-18-07 CRANIOTOMY (COMPLETED)
2. 03-18-07 REPAIR INCARCERATED INGUINAL HERNIA (COMPLETED)

Select Operation: **2**

SURPATIENT,SEVENTEEN (000-45-5119)

Case #202

MAR 18,2007 REPAIR INCARCERATED INGUINAL HERNIA

There are no Postoperative Occurrences entered for this case. Enter a New Postoperative Occurrence: **ACUTE RENAL FAILURE**

NSQIP Definition (2007):

In a patient who did not require dialysis preoperatively, worsening of renal dysfunction postoperatively requiring hemodialysis, peritoneal dialysis, hemofiltration, hemodiafiltration or ultrafiltration.

TIP: If the patient refuses dialysis the answer is Yes to this variable, because he/she did require dialysis.

CICSP Definition (2004):

Indicate if the patient developed new renal failure requiring dialysis or experienced an exacerbation of preoperative renal failure requiring initiation of dialysis (not on dialysis preoperatively) within 30 days postoperatively.

Press RETURN to continue: **<Enter>**

178 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

|  |  |
| --- | --- |
| SURPATIENT,SEVENTEEN (000-45-5119) Case #202 MAR 18,2007 REPAIR INCARCERATED INGUINAL HERNIA |  |
| 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: **4:6** |

SURPATIENT,SEVENTEEN (000-45-5119)

Case #202

MAR 18,2007 REPAIR INCARCERATED INGUINAL HERNIA

Treatment Instituted: **ANTIBIOTICS**

Outcome to Date: **I** IMPROVED

Date/Time the Occurrence was Noted: **3/20** (MAR 20, 2007)

|  |  |
| --- | --- |
| SURPATIENT,SEVENTEEN R. (000-45-5119) Case #202 MAR 18,2007 REPAIR INCARCERATED INGUINAL HERNIA |  |
| 1. Occurrence: ACUTE RENAL FAILURE 2. Occurrence Category: ACUTE RENAL FAILURE 3. ICD Diagnosis Code: 4. Treatment Instituted: DIALYSIS 5. Outcome to Date: IMPROVED 6. Date Noted: 03/20/07 7. Occurrence Comments: |
| Select Occurrence Information: |

June 2007 Surgery V. 3.0 User Manual 179

SR\*3\*160

## Non-Operative Occurrence (Enter/Edit)

### [SROCOMP]

The *Non-Operative Occurrence (Enter/Edit)* option is used to enter or edit occurrences that are not related to surgical procedures. A non-operative occurrence is an occurrence that develops before a surgical procedure is performed.

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

##### Example: Entering a Non-Operative Occurrence

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

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

Select PATIENT NAME: **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 Surgeon Treating the Complication: **SURSURGEON,ONE**

Name of the Attending Surgeon: **SURSURGEON,TWO** Surgical Specialty: **GEN**ERAL(OR WHEN NOT DEFINED BELOW) Select NON-OPERATIVE OCCURRENCES: **SYSTEMIC SEPSIS**

Occurrence Category: **SYSTEMIC SEPSIS**

NSQIP Definition (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

180 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

2. Severe Sepsis/Septic Shock: Sepsis is considered severe when it is associated with organ and/or circulatory dysfunction. Report this variable if the patient has the clinical signs and symptoms of SIRS or sepsis AND documented organ and/or circulatory dysfunction. Examples of organ dysfunction include: oliguria, acute alteration in mental status, acute respiratory distress. Examples of circulatory dysfunction include: hypotension, requirement of inotropic or vasopressor agents.

\* For the patient that had sepsis preoperatively, worsening of any of the above signs postoperatively would be reported as a postoperative sepsis.

Examples:

A patient comes into the emergency room with signs of sepsis - WBC 31, Temperature 104. CT shows an abdominal abscess. He is given antibiotics and is then taken emergently to the OR to drain the abscess. He receives antibiotics intraoperatively. Postoperatively his WBC and Temperature are trending down.

POD#1 WBC 24, Temp 102

POD#2 WBC 14, Temp 100

POD#3 WBC 10, Temp 99

This patient does not have postoperative sepsis as his WBC and Temperature are improving each postoperative day.

Patient comes into the ER with s/s of sepsis - WBC 31, Temp 104. CT shows an abdominal abscess. He is given antibiotics and is taken emergently to the OR to drain the abscess. He receives antibiotics intraoperatively. Postoperatively his WBC and Temp are as follows:

POD#1 WBC 28, Temp 103

POD#2 WBC 24, Temp 102.6

POD#3 WBC 22, Temp 102

POD#4 WBC 21, Temp 101.6

POD#5 WBC 30, Temp 104

This patient does have postoperative sepsis because on postoperative day #5, his WBC and Temperature increase. The patient is having worsening of the defined signs of sepsis.

Treatment Instituted: **ANTIBIOTICS** Outcome to Date: **U** UNRESOLVED Occurrence Comments:

**1>Cancel scheduled surgery for this week. Reschedule later. 2><Enter>**

EDIT Option: **<Enter>**

Press RETURN to continue

June 2007 Surgery V. 3.0 User Manual 180a SR\*3\*160

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

180b Surgery V. 3.0 User Manual April 2004

**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**

Start with Date: **6/1** (JUN 01, 2007) End with Date: **6/30** (JUN 30, 2007)

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**

NSQIP Definition (2007):

In a patient who did not require dialysis preoperatively, worsening of renal dysfunction postoperatively requiring hemodialysis, peritoneal dialysis, hemofiltration, hemodiafiltration or ultrafiltration.

TIP: If the patient refuses dialysis the answer is Yes to this variable, because he/she did require dialysis.

CICSP Definition (2004):

Indicate if the patient developed new renal failure requiring dialysis or experienced an exacerbation of preoperative renal failure requiring initiation of dialysis (not on dialysis preoperatively) within 30 days postoperatively.

CICSP Definition (2004):

Indicate if the patient developed new renal failure requiring dialysis or experienced an exacerbation of preoperative renal failure requiring initiation of dialysis (not on dialysis preoperatively) within 30 days postoperatively.

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

June 2007 Surgery V. 3.0 User Manual 184c SR\*3\*160

MAYBERRY, NC PAGE 1

SURGICAL SERVICE REVIEWED BY: PERIOPERATIVE OCCURRENCES DATE REVIEWED:

FROM: JUN 1,2007 TO: JUN 30,2007 DATE PRINTED: AUG 22,2007

|  |  |  |  |
| --- | --- | --- | --- |
| PATIENT | ATTENDING SURGEON | OCCURRENCE(S) - (DATE) | OUTCOME |
| ID# | SURGICAL SPECIALTY | TREATMENT |  |
| OPERATION DATE | PRINCIPAL OPERATION |  |  |

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

CATEGORY: ACUTE RENAL FAILURE

|  |  |  |  |
| --- | --- | --- | --- |
| SURPATIENT,SEVENTEEN | SURGEON,TWO | ACUTE RENAL FAILURE | I |
| 000-45-5119 | GENERAL | DIALYSIS |  |
| JUN 18, 2007@07:15 | REPAIR INCARCERATED INGUINAL HERNIA |  |  |

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

'\*' Represents Postoperative Occurrences

184d Surgery V. 3.0 User Manual June 2007 SR\*3\*160

## Update/Verify Procedure/Diagnosis Codes

### [SRCODING EDIT]

The *Update/Verify Procedure/Diagnosis Codes* option allows the user to enter the final codes and associated information required for PCE upon completion of a Surgery case.

The procedure and diagnoses codes entered/edited through this option will be the coded information that is sent to the Patient Care Encounter (PCE) package. After the case is coded, the user will select to send the information to PCE.

When the user first edits a case through this option, the values will be pre-populated, using the values for planned codes entered by the nurse or surgeon. If there is no Planned Principal Procedure Code or no Principal Pre-op Diagnosis Code, then the Surgery software will prompt for the final CPT and ICD codes.

Because a case can have more than one procedure and/or diagnosis, the user can associate one or more diagnosis with each procedure. The Surgery software displays the diagnoses in the order in which the user entered them in the case. The user can then associate and reorder the relevant diagnoses to each procedure.

The user can also edit the service classifications for the Postoperative Diagnoses.

The following examples depict using the *Update/Verify Procedure/Diagnosis Codes* option to edit a Bronchoscopy, with no planned CPT or ICD-9 codes entered by a clinician.

##### Example: Entering Required Information

Select CPT/ICD9 Update/Verify Menu Option: **UV** Update/Verify Procedure/Diagnosis Codes

|  |  |  |
| --- | --- | --- |
| SURPATIENT,TWELVE (000-41-8719) Case #10062  JUN 08, 2005 BRONCHOSCOPY | |  |
| Surgery Procedure PCE/Billing Information:   1. Principal Postop Diagnosis Code: NOT ENTERED 2. Other Postop Diagnosis Code: NOT ENTERED 3. Principal CPT Code: NOT ENTERED Assoc. DX:   NO Assoc. DX ENTERED   1. Other CPT Code: NOT ENTERED |  |
| The following information is required before continuing.  Principal Postop Diagnosis Code (ICD9):**934.0** 934.0 FOREIGN BODY IN TRACHEA  ...OK? Yes// (Yes) <Enter> | |

April 2004 Surgery V. 3.0 User Manual 209

Because the patient has a service-connected status, the Surgery software displays a service-connected prompt:

Please supply the following required information about this operation: Treatment related to Service Connected condition (Y/N): **YES**

Treatment related to Agent Orange Exposure (Y/N): **YES**

Treatment related to Ionizing Radiation Exposure (Y/N): **YES**

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

Primary Eligibility: SERVICE CONNECTED 50% TO 100% Combat Vet: NO A/O Exp.: YES M/S Trauma: NO ION Rad.: YES SWAC: NO H/N Cancer: NO PROJ 112/SHAD: NO

SC Percent: 50%

Rated Disabilities: NONE STATED

SC VETERAN

SURPATIENT,TWELVE (000-41-8719)

Note that when a Postop Diagnosis Code is entered, it is automatically associated to a Principal CPT code, even if a CPT code is not entered.

|  |  |  |
| --- | --- | --- |
| SURPATIENT,TWELVE (000-41-8719) Case #10062  JUN 08, 2005 BRONCHOSCOPY | |  |
| Surgery Procedure PCE/Billing Information: | |
| 1. Principal Postop Diagnosis Code: 934.0 FOREIGN BODY IN TRACHEA 2. Other Postop Diagnosis Code: NOT ENTERED 3. Principal CPT Code: NOT ENTERED   Assoc. DX: 934.0 -FOREIGN BODY IN TRACHEA   1. Other CPT Code: NOT ENTERED | |
| The following information is required before continuing. |  |
| Principal Procedure Code (CPT): **31622** DX BRONCHOSCOPE/WASH BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT FLUOROSCOPIC DIAGNOSTIC, WITH OR WITHOUT CELL WASHING (SEPARATE PROCEDURE)  Modifier: **<Enter>** | GUIDANCE; |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,TWELVE (000-41-8719)  JUN 08, 2005 BRONCHOSCOPY |  |  |  | | Case | #10062 |  |
| Surgery Procedure PCE/Billing Information: |  |  |  | |  |  |
| 1. Principal Postop Diagnosis Code: 934.0 FOREIGN 2. Other Postop Diagnosis Code: NOT ENTERED 3. Principal CPT Code: 31622 DX BRONCHOSCOPE/WASH Assoc. DX: 934.0 FOREIGN BODY IN TRACHEA 4. Other CPT Code: NOT ENTERED | BODY | IN | TRACHEA | |  |  |
| Enter number of item to edit (1-4): | | | |  | | |

Because all required information is now entered, the user can select to automatically send the information to PCE, or wait until other information is entered.

Is the coding of this case complete and ready to send to PCE? NO// **<Enter>**

210 Surgery V. 3.0 User Manual June 2007 SR\*3\*159

|  |  |  |
| --- | --- | --- |
| SURPATIENT,TWELVE (000-41-8719)  JUN 08, 2005 BRONCHOSCOPY | Case #10062 |  |
| Surgery Procedure PCE/Billing Information: | |
| 1. Principal Postop Diagnosis Code: 934.0 FOREIGN BODY IN TRACHEA 2. Other Postop Diagnosis Code: NOT ENTERED 3. Principal CPT Code: 31623 DX BRONCHOSCOPE/BRUSH Assoc. DX: 934.0-FOREIGN BODY IN TRACHE 4. Other CPT Code: 43200 ESOPHAGUS ENDOSCOPY Assoc. DX: 934.0-FOREIGN BODY IN TRACHE | |
| Enter number of item to edit (1-4): | |

**Example: Editing Service Connected/Environmental Indicators (SC/EIs)**

To edit service connected or environmental indicators, the user selects either the Principal Postop Diagnosis Code or the Other Postop Diagnosis Code.

|  |  |  |
| --- | --- | --- |
| SURPATIENT,TWELVE (000-41-8719)  JUN 08, 2005 BRONCHOSCOPY | Case #10062 |  |
| Surgery Procedure PCE/Billing Information: | |
| 1. Principal Postop Diagnosis Code: 934.0 FOREIGN BODY IN TRACHEA 2. Other Postop Diagnosis Code: NOT ENTERED 3. Principal CPT Code: 31623 DX BRONCHOSCOPE/BRUSH Assoc. DX: 934.0-FOREIGN BODY IN TRACHE 4. Other CPT Code: 43200 ESOPHAGUS ENDOSCOPY Assoc. DX: 934.0-FOREIGN BODY IN TRACHE | |
| Enter number of item to edit (1-4): **1** | |

The following shows an example of the Principal Postop Diagnosis Code being edited.

SURPATIENT,TWELVE (000-41-8719)

Case #10062

JUN 08, 2005 BRONCHOSCOPY

Principal Postop Diagnosis:

ICD9 Code: 934.0 FOREIGN BODY IN TRACHEA SC:Y AO:Y IR:Y

Select one of the following:

1

2

Update Principal Postop Diagnosis Code

Update Service Connected/Environmental Indicators only

Enter selection (1 or 2): 1// **2** Update Service Connected/Environmental Indicato rs only

April 2004 Surgery V. 3.0 User Manual 212a

The information displayed for this patient show Service Connected status of less than 50%, and the Agent Orange Exposure and Ionizing Radiation indicators associated with the diagnosis. The software gives the user the option to update all diagnoses with the same service-connected indicators simultaneously.

SURPATIENT,TWELVE (000-41-8719)

SC VETERAN

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

Primary Eligibility: SC LESS THAN 50%

Combat Vet: NO A/O Exp.: YES M/S Trauma: NO ION Rad.: YES SWAC: NO H/N Cancer: NO PROJ 112/SHAD: NO

SC Percent: %

Rated Disabilities: NONE STATED

Please supply the following required information about this operation: Treatment related to Service Connected condition (Y/N): YES// **<Enter>**

Treatment related to Agent Orange Exposure (Y/N): **NO**

Treatment related to Ionizing Radiation Exposure (Y/N): **YES**

Update all 'OTHER POSTOP DIAGNOSIS' Eligibility and Service Connected Conditions with these values (Y/N)? NO// **<Enter>**

|  |  |  |
| --- | --- | --- |
| SURPATIENT,TWELVE (000-41-8719)  JUN 08, 2005 BRONCHOSCOPY | Case #10062 |  |
| Surgery Procedure PCE/Billing Information: | |
| 1. Principal Postop Diagnosis Code: 934.0 FOREIGN BODY IN TRACHEA 2. Other Postop Diagnosis Code: NOT ENTERED 3. Principal CPT Code: 31623 DX BRONCHOSCOPE/BRUSH Assoc. DX: 934.0-FOREIGN BODY IN TRACHE 4. Other CPT Code: 43200 ESOPHAGUS ENDOSCOPY Assoc. DX: 934.0-FOREIGN BODY IN TRACHE | |
| Enter number of item to edit (1-4): | |

212b

Surgery V. 3.0 User Manual June 2007 SR\*3\*159

MAYBERRY, NC PAGE 1

SURGICAL SERVICE REVIEWED BY: PERIOPERATIVE OCCURRENCES DATE REVIEWED:

FROM: JUL 1,2006 TO: JUL 31,2006 DATE PRINTED: AUG 22,2006

PATIENT PRINCIPAL OPERATION OCCURRENCE(S) - (DATE) OUTCOME

ID# TREATMENT

OPERATION DATE

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

ATTENDING: SURGEON,ONE

|  |  |  |  |
| --- | --- | --- | --- |
| SURPATIENT,TWELVE  000-41-8719 | REPAIR DIAPHRAGMATIC HERNIA | MYOCARDIAL INFARCTION  ASPIRIN THERAPY | I |
| JUL 07, 2006@07:15 |  | URINARY TRACT INFECTION \* (07/09/06) | I |
|  |  | IV ANTBIOTICS |  |
| SURPATIENT,THREE 000-21-2453  JUL 22, 2006@10:00 | CARDIAC SURGERY CABG | REPEAT VENTILATOR SUPPORT W/IN 30 DAYS \* | I |
| SURPATIENT,FOURTEEN 000-45-7212  JUL 31, 2006@09:00 | CHOLECYSTECTOMY, APPENDECTOMY | SUPERFICIAL WOUND INFECTION \* (08/02/06) ANTIBIOTICS | I |

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

'\*' Represents Postoperative Occurrences

April 2004 Surgery V. 3.0 User Manual 327b

**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**

Start with Date: **6/1/07** (JUN 01, 2007) End with Date: **6/30/07** (JUN 30, 2007)

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**

NSQIP Definition (2007):

In a patient who did not require dialysis preoperatively, worsening of renal dysfunction postoperatively requiring hemodialysis, peritoneal dialysis, hemofiltration, hemodiafiltration or ultrafiltration.

TIP: If the patient refuses dialysis the answer is Yes to this variable, because he/she did require dialysis.

CICSP Definition (2004):

Indicate if the patient developed new renal failure requiring dialysis or experienced an exacerbation of preoperative renal failure requiring initiation of dialysis (not on dialysis preoperatively) within 30 days postoperatively.

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*

327c

Surgery V. 3.0 User Manual June 2007 SR\*3\*160

MAYBERRY, NC PAGE 1

SURGICAL SERVICE REVIEWED BY: PERIOPERATIVE OCCURRENCES DATE REVIEWED:

FROM: JUN 1,2007 TO: JUN 30,2007 DATE PRINTED: AUG 22,2007

|  |  |  |  |
| --- | --- | --- | --- |
| PATIENT | ATTENDING SURGEON | OCCURRENCE(S) - (DATE) | OUTCOME |
| ID# | SURGICAL SPECIALTY | TREATMENT |  |
| OPERATION DATE | PRINCIPAL OPERATION |  |  |

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

CATEGORY: ACUTE RENAL FAILURE

|  |  |  |  |
| --- | --- | --- | --- |
| SURPATIENT,SEVENTEEN | SURGEON,TWO | ACUTE RENAL FAILURE | I |
| 000-45-5119 | GENERAL | DIALYSIS |  |
| JUN 18, 2007@07:15 | REPAIR INCARCERATED INGUINAL HERNIA |  |  |

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

'\*' Represents Postoperative Occurrences

June 2007 Surgery V. 3.0 User Manual 327d SR\*3\*160

**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

328 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

SUMMARY REPORT - SURGICAL SERVICE PAGE VERSION 3.0 1

Hospital: MAYBERRY, NC Station Number: 999

For Dates: JUN 01, 2004 to: JUN 30, 2004

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

Total Cases % of Total

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical Cases | 315 |  | 100.0 |
| Major Procedures | 203 |  | 64.4 |
| ASA Class (1) | 10 |  | 4.9 |
| ASA Class (2) | 70 |  | 34.5 |
| ASA Class (3) | 120 |  | 59.1 |
| ASA Class (4) | 3 |  | 1.5 |
| ASA Class (5) | 0 |  | 0.0 |
| ASA Class (6) | 0 |  | 0.0 |
| Postoperative Deaths | 2 |  | 0.6 |
| Ambulatory: 0 |  |  |  |
| Postoperative Occurrences | 18 |  | 5.7 |
| Ambulatory Procedures | 201 |  | 63.8 |
| Admitted Within 14 Days: 0  Invasive Diagnostic: 1 |  |  |  |
| Inpatient Procedures | 114 | 36.2 | |
| Emergency Procedures | 14 | 4.4 | |
| Age>60 Years | 141 | 44.8 | |

SPECIALTY PROCEDURES

---DEATHS--- PATIENTS CASES MAJOR MINOR TOTAL %

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 50 | GENERAL | 63 |  | 64 |  | 54 |  | 10 |  | 1 |  | 1.6 |
| 51 | GYNECOLOGY | 7 |  | 7 |  | 7 |  | 0 |  | 0 |  | 0.0 |
| 52 | NEUROSURGERY | 12 |  | 14 |  | 13 |  | 1 |  | 0 |  | 0.0 |
| 53 | OPHTHALMOLOGY | 57 |  | 59 |  | 0 |  | 59 |  | 0 |  | 0.0 |
| 54 | ORTHOPEDICS | 53 |  | 56 |  | 46 |  | 10 |  | 0 |  | 0.0 |
| 55 | OTORHINOLARYNGOLOGY | 35 |  | 35 |  | 32 |  | 3 |  | 0 |  | 0.0 |
| 56 | PLASTIC SURGERY | 8 |  | 8 |  | 4 |  | 4 |  | 0 |  | 0.0 |
| 57 | PROCTOLOGY | 0 |  | 0 |  | 0 |  | 0 |  | 0 |  | 0.0 |
| 58 | THORACIC SURGERY | 3 |  | 3 |  | 3 |  | 0 |  | 0 |  | 0.0 |
| 59 | UROLOGY | 19 |  | 20 |  | 20 |  | 0 |  | 0 |  | 0.0 |
| 60 | ORAL SURGERY | 1 |  | 1 |  | 1 |  | 0 |  | 0 |  | 0.0 |
| 61 | PODIATRY | 25 |  | 25 |  | 3 |  | 22 |  | 0 |  | 0.0 |
| 62 | PERIPHERAL VASCULAR | 21 |  | 23 |  | 20 |  | 3 |  | 1 |  | 4.3 |
| 500 | CARDIAC SURGERY | 0 |  | 0 |  | 0 |  | 0 |  | 0 |  | 0.0 |
| 501 | TRANSPLANTATION | 0 |  | 0 |  | 0 |  | 0 |  | 0 |  | 0.0 |
| 502 | ANESTHESIOLOGY | 0 |  | 0 |  | 0 |  | 0 |  | 0 |  | 0.0 |

LEVEL OF RESIDENT SUPERVISION (%)

LEVEL OF RESIDENT SUPERVISION (%)

|  |  |  |
| --- | --- | --- |
|  | MAJOR | MINOR |
| Level A | 0.0 | 100.0 |
| Level B | 66.7 | 0.0 |
| Level C | 0.0 | 0.0 |
| Level D | 0.0 | 0.0 |
| Level E | 33.3 | 0.0 |
| Level F | 0.0 | 0.0 |
| Level Not Entered | 0.0 | 0.0 |

April 2004 Surgery V. 3.0 User Manual 371

SUMMARY REPORT - SURGICAL SERVICE PAGE VERSION 3.0 2

Hospital: MAYBERRY, NC Station Number: 999

For Dates: JUN 01, 2004 to: JUN 30, 2004

================================================================================ INDEX PROCEDURES

|  |  |  |  |
| --- | --- | --- | --- |
|  | CASES | DEATHS | CASES WITH OCCURRENCES |
| ----- | ------- | ----------- |
| Inguinal Hernia | 13 | 0 | 0 |
| Cholecystectomy | 3 | 0 | 0 |
| Coronary Artery Bypass | 0 | 0 | 0 |
| Colon Resection (L & R) | 5 | 0 | 1 |
| Fem-Pop Bypass | 2 | 0 | 1 |
| Pulmonary Lobectomy | 0 | 0 | 0 |
| Hip Replacement |  |  |  |
| - Elective | 7 | 0 | 2 |
| - Acute Fracture | 0 | 0 | 0 |
| TURP | 0 | 0 | 0 |
| Laryngectomy | 0 | 0 | 0 |
| Craniotomy | 0 | 0 | 0 |
| Intraoccular Lens | 44 | 0 | 0 |

PERIOPERATIVE OCCURRENCE CATEGORIES

|  |  |  |  |
| --- | --- | --- | --- |
| Wound Occurrences  A. Superficial Infection | Total  6 | Urinary Occurrences  A. Renal Insufficiency | Total  2 |
| B. Deep Wound Infection | 0 | B. Acute Renal Failure | 0 |
| C. Wound Disruption | 0 | C. Urinary Tract Infection | 2 |
| D. Other | 0 | D. Other | 0 |
| Respiratory Occurrences | Total | CNS Occurrences | Total |
| A. Pneumonia | 7 | A. CVA/Stroke | 0 |
| B. Unplanned Intubation | 3 | B. Coma >24 Hours | 0 |
| C. Pulmonary Embolism | 0 | C. Peripheral Nerve Injury | 1 |
| D. On Ventilator >48 Hours | 4 | D. Other | 0 |
| E. Tracheostomy | 0 |  |  |
| F. Repeat Vent w/in 30 Days | 0 |  |  |
| G. Other | 0 |  |  |
|  |  | Other Occurrences | Total |
| Cardiac Occurrences | Total | A. Organ/Space SSI | 0 |
| A. Cardiac Arrest Req. CPR | 0 | B. Bleeding/Transfusions | 1 |
| B. Myocardial Infarction | 1 | C. Graft/Prosthesis/Flap |  |
| C. Endocarditis | 0 | Failure | 0 |
| D. Low Cardiac Output >6 Hrs. | 0 | D. DVT/Thrombophlebitis | 0 |
| E. Mediastinitis | 0 | E. Systemic Sepsis | 2 |
| F. Repeat Card Surg Proc | 0 | F. Reoperation for Bleeding | 0 |
| G. New Mech Circulatory Sup | 1 | G. C. difficile Colitis | 2 |
| H. Other | 0 | H. Other | 1 |

Clean Wound Infection Rate: 2.1

372 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

QUARTERLY REPORT - SURGICAL SERVICE PAGE VERSION 3.0 1

Hospital: MAYBERRY, NC Station Number: 999 For Dates: APR 01, 2004 to: JUN 30, 2004 Fiscal Year: 2004

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

Total Cases % of Total

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical Cases | 1315 |  | 100.0 |
| Major Procedures | 973 |  | 74.0 |
| ASA Class (1) | 34 |  | 3.5 |
| ASA Class (2) | 305 |  | 31.3 |
| ASA Class (3) | 579 |  | 59.5 |
| ASA Class (4) | 54 |  | 5.5 |
| ASA Class (5) | 0 |  | 0.0 |
| ASA Class (6) | 0 |  | 0.0 |
| ASA Class (Not Entered) | 1 |  | 0.1 |
| Postoperative Deaths | 10 |  | 0.8 |
| Ambulatory: 3 |  |  |  |
| Postoperative Occurrences | 17 |  | 1.3 |
| Ambulatory Procedures | 794 |  | 60.4 |
| Admitted Within 14 Days: 2  Invasive Diagnostic: 146 |  |  |  |
| Inpatient Procedures | 521 | 39.6 | |
| Emergency Procedures | 45 | 3.4 | |
| Age>60 Years | 729 | 55.4 | |

SPECIALTY PROCEDURES

---DEATHS--- PATIENTS CASES MAJOR MINOR TOTAL %

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 50 | GENERAL | 140 |  | 147 |  | 147 |  | 0 |  | 4 |  | 2.7 |
| 51 | GYNECOLOGY | 9 |  | 9 |  | 9 |  | 0 |  | 0 |  | 0.0 |
| 52 | NEUROSURGERY | 53 |  | 56 |  | 56 |  | 0 |  | 1 |  | 1.8 |
| 53 | OPHTHALMOLOGY | 186 |  | 208 |  | 204 |  | 4 |  | 0 |  | 0.0 |
| 54 | ORTHOPEDICS | 156 |  | 162 |  | 159 |  | 3 |  | 1 |  | 0.6 |
| 55 | OTORHINOLARYNGOLOGY | 90 |  | 95 |  | 93 |  | 2 |  | 0 |  | 0.0 |
| 56 | PLASTIC SURGERY | 40 |  | 44 |  | 44 |  | 0 |  | 0 |  | 0.0 |
| 57 | PROCTOLOGY | 0 |  | 0 |  | 0 |  | 0 |  | 0 |  | 0.0 |
| 58 | THORACIC SURGERY | 19 |  | 22 |  | 22 |  | 0 |  | 0 |  | 0.0 |
| 59 | UROLOGY | 279 |  | 321 |  | 102 |  | 219 |  | 3 |  | 0.9 |
| 60 | ORAL SURGERY | 14 |  | 14 |  | 14 |  | 0 |  | 0 |  | 0.0 |
| 61 | PODIATRY | 36 |  | 42 |  | 42 |  | 0 |  | 0 |  | 0.0 |
| 62 | PERIPHERAL VASCULAR | 39 |  | 41 |  | 41 |  | 0 |  | 1 |  | 2.4 |
| 500 | CARDIAC SURGERY | 40 |  | 40 |  | 40 |  | 0 |  | 0 |  | 0.0 |
| 501 | TRANSPLANTATION | 0 |  | 0 |  | 0 |  | 0 |  | 0 |  | 0.0 |
| 502 | ANESTHESIOLOGY | 99 |  | 114 |  | 0 |  | 114 |  | 0 |  | 0.0 |

LEVEL OF RESIDENT SUPERVISION (%)

|  |  |  |  |
| --- | --- | --- | --- |
|  | | MAJOR | MINOR |
| Level | A | 0.2 | 53.5 |
| Level | B | 95.4 | 36.3 |
| Level | C | 2.1 | 0.0 |
| Level | D | 2.4 | 0.3 |
| Level | E | 0.0 | 0.0 |
| Level | F | 0.0 | 0.0 |
| Level | Not Entered | 0.0 | 9.9 |

June 2007 Surgery V. 3.0 User Manual 375

SR\*3\*160

QUARTERLY REPORT - SURGICAL SERVICE PAGE VERSION 3.0 2

Hospital: MAYBERRY, NC Station Number: 999 For Dates: APR 01, 2004 to: JUN 30, 2004 Fiscal Year: 2004

================================================================================ INDEX PROCEDURES

|  |  |  |  |
| --- | --- | --- | --- |
|  | CASES | DEATHS | CASES WITH OCCURRENCES |
| ----- | ------ | ----------- |
| Inguinal Hernia | 31 | 0 | 1 |
| Cholecystectomy | 6 | 0 | 0 |
| Coronary Artery Bypass | 34 | 0 | 2 |
| Colon Resection (L & R) | 8 | 1 | 2 |
| Fem-Pop Bypass | 4 | 0 | 0 |
| Pulmonary Lobectomy | 3 | 0 | 0 |
| Hip Replacement |  |  |  |
| - Elective | 14 | 0 | 0 |
| - Acute Fracture | 2 | 0 | 1 |
| TURP | 21 | 0 | 0 |
| Laryngectomy | 0 | 0 | 0 |
| Craniotomy | 4 | 0 | 0 |
| Intraoccular Lens | 135 | 0 | 0 |

PERIOPERATIVE OCCURRENCE CATEGORIES

|  |  |  |  |
| --- | --- | --- | --- |
| Wound Occurrences  A. Superficial Infection | Total  9 | Urinary Occurrences  A. Renal Insufficiency | Total  0 |
| B. Deep Wound Infection | 1 | B. Acute Renal Failure | 0 |
| C. Wound Disruption | 1 | C. Urinary Tract Infection | 2 |
| D. Other | 0 | D. Other | 0 |
| Respiratory Occurrences | Total | CNS Occurrences | Total |
| A. Pneumonia | 4 | A. CVA/Stroke | 0 |
| B. Unplanned Intubation | 2 | B. Coma >24 Hours | 0 |
| C. Pulmonary Embolism | 0 | C. Peripheral Nerve Injury | 0 |
| D. On Ventilator >48 Hours | 3 | D. Other | 0 |
| E. Tracheostomy | 0 |  |  |
| F. Repeat Vent w/in 30 Days | 0 |  |  |
| G. Other | 0 |  |  |
|  |  | Other Occurrences | Total |
| Cardiac Occurrences | Total | A. Organ/Space SSI | 0 |
| A. Cardiac Arrest Req. CPR | 0 | B. Bleeding/Transfusions | 0 |
| B. Myocardial Infarction | 0 | C. Graft/Prosthesis/Flap |  |
| C. Endocarditis | 0 | Failure | 0 |
| D. Low Cardiac Output >6 Hrs. | 0 | D. DVT/Thrombophlebitis | 0 |
| E. Mediastinitis | 0 | E. Systemic Sepsis | 1 |
| F. Repeat Card Surg Proc | 0 | F. Reoperation for Bleeding | 0 |
| G. New Mech Circulatory Sup | 0 | G. C. difficile Colitis | 1 |
| H. Other | 0 | H. Other | 0 |
| Clean Wound Infection Rate: | 1.0% |  |  |

376 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

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

### [SROA ENTER/EDIT]

The nurse reviewer uses the *Non-Cardiac Risk Assessment Information (Enter/Edit)* option to enter a new risk assessment for a non-cardiac patient. This option is also used to make changes to an assessment that has already been entered. Cardiac cases are evaluated differently from non-cardiac cases and are entered into the software from different options. See the section, “Cardiac Risk Assessment Information (Enter/Edit)” for more information about risk assessments for cardiac cases.

The following options are available from this option, and let the user add in-depth data for a case. To the left is the shortcut synonym that the user can enter to select the option.

|  |  |
| --- | --- |
| **Shortcut** | **Option Name** |
| PRE | *Preoperative Information (Enter/Edit)* |
| LAB | *Laboratory Test Results (Enter/Edit)* |
| O | *Operation Information (Enter/Edit)* |
| D | *Patient Demographics (Enter/Edit)* |
| IO | *Intraoperative Occurrences (Enter/Edit)* |
| PO | *Postoperative Occurrences (Enter/Edit)* |
| RET | *Update Status of Returns Within 30 Days* |
| U | *Update Assessment Status to 'COMPLETE'* |
| CODE | *Alert Coder Regarding Coding Issues* |

The following example demonstrates how to create a new risk assessment for non-cardiac patients and how to get to the sub-option menu below.

**Creating a New Risk Assessment**

1. The user is prompted to select either a patient name or a case. Selecting by case lets the user enter a specific surgery case number. Selecting by patient will display any previously entered assessments for a patient. An asterisk (\*) indicates cardiac cases. The user can then choose to create a new assessment or edit one of the previously entered assessments.
2. After choosing an operation on which to report, the user should respond **YES** to the prompt, "Are you sure that you want to create a Risk Assessment for this surgical case ? " The user must answer **YES** (or press the **<Enter>** key to accept the **YES** default) to get to any of the sub-options. If the answer is **NO**, the case created in step 1 will not be considered an assessment, although it can appear on some lists, and the software will return the user to the "Select Patient:" prompt.
3. Preoperative, operative, postoperative, and lab information is entered and edited using the sub- option(s).

If assistance is needed while interacting with the software, the user should enter one or two question marks (**??**) to access the on-line help.

April 2004 Surgery V. 3.0 User Manual 445

**Example: Creating a New Risk Assessment (Non-Cardiac)**

Select Surgery Risk Assessment Menu Option: **N** Non-Cardiac Assessment Information (Enter/Edit) Select Patient: **?**

To lookup by patient, enter patient name or patient ID. To lookup by surgical case/assessment number, enter the number preceded by "#", e.g., for case 12345 enter "#12345" (no spaces).

Select Patient**: SURPATIENT,THREE** 01-01-45 000212453

NSC VETERAN

SURPATIENT,THREE 000-21-2453

1. 02-01-95 INTRAOCCULAR LENS (INCOMPLETE)
2. 02-01-95 HIP REPLACEMENT (INCOMPLETE)
3. 09-18-91 FEMORAL POPLITEAL BYPASS GRAFT (INCOMPLETE)

4. ----

CREATE NEW ASSESSMENT

Select Surgical Case: **4**

SURPATIENT,THREE 000-21-2453

1. 10-03-91 ABDOMINAL AORTIC ANEURYSM RESECTION (NOT COMPLETE)

Select Operation: **1**

When selecting a case to be assessed, if coding is completed for the case, and only excluded CPT codes are assigned, the software warns the Nurse Reviewer with the message:

“Based on the CPT Codes assigned for this case, this case should be excluded.” This is only a warning. The Nurse Reviewer may still create the assessment.

When selecting a case to be assessed, if no CPT codes have been assigned to the case, the software warns the Nurse Reviewer with the message:

“No CPT Codes have been assigned for this case.”

This is only a warning. The Nurse Reviewer may still create the assessment.

Are you sure that you want to create a Risk Assessment for this surgical case ? YES// **<Enter>**

To enter information for the risk assessment, use the sub-options from this menu option. These options are described in the following sections. For example, to enter operation information, select the *Operation Information Enter/Edit* option.

446 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

|  |  |
| --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 1 OF 2  JUN 23,1998 CHOLEDOCHOTOMY |  |
| 1. GENERAL: 3. HEPATOBILIARY:    1. Height: 65 INCHES A. Ascites:    2. Weight: 140 LBS.    3. Diabetes Mellitus: 4. GASTROINTESTINAL:    4. Current Smoker W/I 1 Year: A. Esophageal Varices:    5. Pack/Years:    6. ETOH > 2 Drinks/Day: 5. CARDIAC:    7. Dyspnea: A. CHF Within 1 Month:    8. DNR Status: B. MI Within 6 Months:    9. Pre-illness Funct C. Previous PCI:   Status: D. Previous Cardiac Surgery:   * 1. Preop Funct Status: E. Angina Within 1 Month:   F. Hypertension Requiring Meds:   1. PULMONARY:    1. Ventilator Dependent: 6. VASCULAR:    2. History of Severe COPD: A. Revascularization/Amputation:    3. Current Pneumonia: B. Rest Pain/Gangrene: |
| Select Preoperative Information to Edit: **1:3** |

SURPATIENT,SIXTY (000-56-7821)

JUN 23,1998 CHOLEDOCHOTOMY

Case #63592

GENERAL: **YES**

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

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

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

Pack/Year Cigarette History: **??**

NSQIP Definition (2004):

If the patient has ever been a smoker, enter the total number of pack/years of smoking for this patient. Pack-years are defined as the number of packs of cigarettes smoked per day times the number of years the patient has smoked. If the patient has never been a smoker, enter "0". If pack-years are >200, just enter 200. If smoking history cannot be determined, enter "NS". The possible range for number of pack-years is 0 to 200. If the chart documents differing values for pack year cigarette history, or ranges for either packs/day or number of years patient has smoked, select the highest value documented, unless you are confident in a particular documenter's assessment (e.g., preoperative anesthesia evaluation often includes a more accurate assessment of this value because of the impact it may have on the patient's response to anesthesia).

Pack/Year Cigarette History: **25**

ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: **N** NO Dyspnea: **N**

1. NO
2. NO STUDY Choose 1-2: **1** NO

DNR Status (Y/N): **N** NO

Functional Health Status Prior to Current Illness: **1** INDEPENDENT Functional Health Status at Evaluation for Surgery: **1** INDEPENDENT

PULMONARY: **NO**

HEPATOBILIARY: **NO**

June 2007 Surgery V. 3.0 User Manual 449

SR\*3\*160

|  |  |
| --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 1 OF 2  JUN 23,1998 CHOLEDOCHOTOMY |  |
| 1. GENERAL: YES 3. HEPATOBILIARY: NO    1. Height: 62 INCHES A. Ascites: NO    2. Weight: 175 LBS.    3. Diabetes Mellitus: INSULIN 4. GASTROINTESTINAL:    4. Current Smoker W/I 1 Year: YES A. Esophageal Varices:    5. Pack/Years: 25    6. ETOH > 2 Drinks/Day: NO 5. CARDIAC:    7. Dyspnea: NO A. CHF Within 1 Month:    8. DNR Status: NO B. MI Within 6 Months:    9. Pre-illness Funct C. Previous PCI:   Status: INDEPENDENT D. Previous Cardiac Surgery:   * 1. Preop Funct Status: INDEPENDENT E. Angina Within 1 Month:   F. Hypertension Requiring Meds:   1. PULMONARY: NO    1. Ventilator Dependent: NO 6. VASCULAR:    2. History of Severe COPD: NO A. Revascularization/Amputation:    3. Current Pneumonia: NO B. Rest Pain/Gangrene: |
| Select Preoperative Information to Edit: **<Enter>** |

|  |  |
| --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 2 OF 2  JUN 23,1998 CHOLEDOCHOTOMY |  |
| 1. RENAL: 3. NUTRITIONAL/IMMUNE/OTHER:    1. Acute Renal Failure: A. Disseminated Cancer:    2. Currently on Dialysis: B. Open Wound:    3. Steroid Use for Chronic Cond.: 2. CENTRAL NERVOUS SYSTEM: D. Weight Loss > 10%:    1. Impaired Sensorium: E. Bleeding Disorders:    2. Coma: F. Transfusion > 4 RBC Units:    3. Hemiplegia: G. Chemotherapy W/I 30 Days:    4. History of TIAs: H. Radiotherapy W/I 90 Days:    5. CVA/Stroke w. Neuro Deficit: I. Preoperative Sepsis:    6. CVA/Stroke w/o Neuro Deficit: J. Pregnancy:    7. Tumor Involving CNS:    8. Paraplegia:    9. Quadriplegia: |
| Select Preoperative Information to Edit: **3E** |

SURPATIENT,SIXTY (000-56-7821)

Case #63592

JUN 23,1998 CHOLEDOCHOTOMY

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

|  |  |
| --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 2 OF 2  JUN 23,1998 CHOLEDOCHOTOMY |  |
| 1. RENAL: 3. NUTRITIONAL/IMMUNE/OTHER:    1. Acute Renal Failure: A. Disseminated Cancer:    2. Currently on Dialysis: B. Open Wound:    3. Steroid Use for Chronic Cond.: 2. CENTRAL NERVOUS SYSTEM: D. Weight Loss > 10%:    1. Impaired Sensorium: E. Bleeding Disorders: YES    2. Coma: F. Transfusion > 4 RBC Units:    3. Hemiplegia: G. Chemotherapy W/I 30 Days:    4. History of TIAs: H. Radiotherapy W/I 90 Days:    5. CVA/Stroke w. Neuro Deficit: I. Preoperative Sepsis:    6. CVA/Stroke w/o Neuro Deficit: J. Pregnancy:    7. Tumor Involving CNS:    8. Paraplegia:    9. Quadriplegia: |
| Select Preoperative Information to Edit: |

450 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

## Laboratory Test Results (Enter/Edit)

### [SROA LAB]

Use the *Laboratory Test Results (Enter/Edit)* option to enter or edit preoperative and postoperative lab information for an individual risk assessment. The option is divided into the three features listed below. The first two features allow the user to merge (also called “capture” or “load”) lab information into the risk assessment from the VistA software. The third feature provides a two-page summary of the lab profile and allows direct editing of the information.

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results

To “capture” preoperative lab data, the user must provide both the date and time the operation began. Likewise, to capture postoperative lab data, the user must provide both the date and time the operation was completed. If this information has already been entered, the system will not prompt for it again.

If assistance is needed while interacting with the software, entering one or two question marks (**??**) will access the on-line help.

##### Example 1: Capture Preoperative Laboratory Information

Select Non-Cardiac Assessment Information (Enter/Edit) Option: **LAB** Laboratory Test Results (Enter/Edit)

SURPATIENT,FORTY (000-77-7777)

Case #68112

SEP 19, 2003 CHOLEDOCHOTOMY

Enter/Edit Laboratory Test Results

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results Select Number: **1**

This selection loads the most recent lab data for tests performed within 90 days before the operation.

Do you want to automatically load preoperative lab data ? YES// **<Enter>**

The ‘Time Operation Began’ must be entered before continuing.

Do you want to enter ‘Time Operation Began’ at this time ? YES// **<Enter>**

Time the Operation Began: **8:00** (SEP 25, 2003@08:00)

..Searching lab record for latest preoperative test data….

..Moving preoperative lab test data to Surgery Risk Assessment file…. Press <RET> to continue **<Enter>**

April 2004 Surgery V. 3.0 User Manual 451

##### Example 2: Capture Postoperative Laboratory Information

Select Non-Cardiac Assessment Information (Enter/Edit) Option: **LAB** Laboratory Test Results (Enter/Edit)

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results

Select Number: **2**

This selection loads highest or lowest lab data for tests performed within 30 days after the operation.

Do you want to automatically load postoperative lab data ? YES// **<Enter>**

‘Time the Operation Ends’ must be entered before continuing.

Do you want to enter the time that the operation was completed at this time ? YES// **<Enter>**

Time the Operation Ends: 12:00 (SEP 25, 2003@12:00)

..Searching lab record for postoperative lab test data….

..Moving postoperative lab data to Surgery Risk Assessment file…. Press <RET> to continue

**Example 3: Enter, Edit, or Review Laboratory Test Results**

Select Non-Cardiac Assessment Information (Enter/Edit) Option: **LAB** Laboratory Test Results (Enter/Edit)

Enter/Edit Laboratory Test Results

1. Capture Preoperative Laboratory Information
2. Capture Postoperative Laboratory Information
3. Enter, Edit, or Review Laboratory Test Results

Select Number: **3**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SURPATIENT,FORTY (000-77-7777) LATEST PREOP LAB RESULTS IN 90 SEP 19,2003 CHOLEDOCHOTOMY | Case #68112  DAYS PRIOR TO SURGERY UNLESS | | PAGE: 1 OF 2 OTHERWISE SPECIFIED | |
| 1. Anion Gap (in 48 hrs.): | 12 (SEP | 18,2003) | |  |
| 2. Serum Sodium: | 139 (SEP | 18,2003) | |
| 3. BUN: | 13 (SEP | 18,2003) | |
| 4. Serum Creatinine: | 1 (SEP | 18,2003) | |
| 5. Serum Albumin: | 4 (SEP | 18,2003) | |
| 6. Total Bilirubin: | .8 (SEP | 18,2003) | |
| 7. SGOT: | 29 (SEP | 18,2003) | |
| 8. Alkaline Phosphatase: | 120 (SEP | 18,2003) | |
| 9. WBC: | 12.8 (SEP | 18,2003) | |
| 10. Hematocrit: | 45.7 (SEP | 18,2003) | |
| 11. Platelet Count: | NS |  | |
| 12. PTT: | NS |  | |
| 13. PT: | NS |  | |
| 14. INR: | NS |  | |
| 15. Hemoglobin A1c (1000 days): | NS |  | |
| Select Preoperative Laboratory | Information to | Edit: **11:13** | |

452 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

SURPATIENT,FORTY (000-77-7777)

Case #68112

SEP 19,2003 CHOLEDOCHOTOMY

Preoperative Platelet Count (X 1000/mm3): **289**

Date Preoperative Platelet Count was Performed: **9/18/03** (SEP 18, 2003) Preoperative PTT (seconds): **33.7**

Date Preoperative PTT was Performed: **9/18/03** (SEP 18, 2003) Preoperative PT (seconds): **11.8**

Date Preoperative PT was Performed: **9/18/03** (SEP 18, 2003)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SURPATIENT,FORTY (000-77-7777) LATEST PREOP LAB RESULTS IN 90 SEP 19,2003 CHOLEDOCHOTOMY | Case #68112  DAYS PRIOR TO SURGERY UNLESS | | PAGE: 1 OF 2 OTHERWISE SPECIFIED | |
| 1. Anion Gap (in 48 hrs.): | 12 (SEP | 18,2003) | |  |
| 2. Serum Sodium: | 139 (SEP | 18,2003) | |
| 3. BUN: | 13 (SEP | 18,2003) | |
| 4. Serum Creatinine: | 1 (SEP | 18,2003) | |
| 5. Serum Albumin: | 4 (SEP | 18,2003) | |
| 6. Total Bilirubin: | .8 (SEP | 18,2003) | |
| 7. SGOT: | 29 (SEP | 18,2003) | |
| 8. Alkaline Phosphatase: | 120 (SEP | 18,2003) | |
| 9. WBC: | 12.8 (SEP | 18,2003) | |
| 10. Hematocrit: | 45.7 (SEP | 18,2003) | |
| 11. Platelet Count: | 289 (SEP | 18,2003) | |
| 12. PTT: | 33.7 (SEP | 18,2003) | |
| 13. PT: | 11.8 (SEP | 18,2003) | |
| 14. INR: | NS |  | |
| 15. Hemoglobin A1c (1000 days): | NS |  | |
| Select Preoperative Laboratory | Information to | Edit: **<Enter>** | |

|  |  |
| --- | --- |
| SURPATIENT,FORTY (000-77-7777) Case #68112 PAGE: 2 OF 2 POSTOP LAB RESULTS WITHIN 30 DAYS AFTER SURGERY  SEP 19,2003 CHOLEDOCHOTOMY | |
| 1. Highest Anion Gap: 12 (SEP 20,2003) 2. Highest Serum Sodium: 139 (SEP 20,2003) 3. Lowest Serum Sodium: 135 (SEP 20,2003) 4. Highest Potassium: 4.4 (SEP 20,2003) 5. Lowest Potassium: 3.4 (SEP 20,2003) 6. Highest Serum Creatinine: 1.2 (SEP 20,2003) 7. Highest CPK: NS 8. Highest CPK-MB Band: NS 9. Highest Total Bilirubin: NS   10. Highest WBC: 11.8 (SEP 20,2003)   1. Lowest Hematocrit: 40.3 (SEP 20,2003) 2. Highest Troponin I: 10.18 (SEP 24,2003) 3. Highest Troponin T: 12.13 (SEP 24,2003) |  |
| Select Postoperative Laboratory Information to Edit: **2** |

June 2007 Surgery V. 3.0 User Manual 453

SR\*3\*160

SURPATIENT,FORTY (000-77-7777)

Case #68112

SEP 19,1998 CHOLEDOCHOTOMY

Highest Postoperative Serum Sodium: 139// **144**

Date Highest Serum Sodium was Recorded: **9/21/03** (SEP 21, 2003)

|  |  |
| --- | --- |
| SURPATIENT,FORTY (000-77-7777) Case #68112 PAGE: 2 OF 2 POSTOP LAB RESULTS WITHIN 30 DAYS AFTER SURGERY  SEP 19,2003 CHOLEDOCHOTOMY | |
| 1. Highest Anion Gap: 12 (SEP 20,2003) 2. Highest Serum Sodium: 144 (SEP 21,2003) 3. Lowest Serum Sodium: 135 (SEP 20,2003) 4. Highest Potassium: 4.4 (SEP 20,2003) 5. Lowest Potassium: 3.4 (SEP 20,2003) 6. Highest Serum Creatinine: 1.2 (SEP 20,2003) 7. Highest CPK: NS 8. Highest CPK-MB Band: NS 9. Highest Total Bilirubin: NS   10. Highest WBC: 11.8 (SEP 20,2003)   1. Lowest Hematocrit: 40.3 (SEP 20,2003) 2. Highest Troponin I: 10.18 (SEP 24,2003) 3. Highest Troponin T: 12.13 (SEP 24,2003) |  |
| Select Postoperative Laboratory Information to Edit: |

454 Surgery V. 3.0 User Manual April 2004

## Operation Information (Enter/Edit)

### [SROA OPERATION DATA]

The *Operation Information (Enter/Edit)* option is used to enter or edit information related to the operation. At the bottom of each page is a prompt to select one or more operative items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will exit the option. If they are not already there, it is important that the operation’s beginning and ending times be entered so that the user can later enter postoperative information.

**About the** "**Select Operative Information to Edit:**" **Prompt**

The user should first enter the item number to edit at the "Select Operative Information to Edit:" prompt. To respond to every item on the page, the user should enter **A** for **ALL** or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information has been entered or edited, the display will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data. If information has been entered for the OTHER PROCEDURES field or the CONCURRENT PROCEDURES field, the summary will display \*\*\*INFORMATION ENTERED\*\*\* to the right of the items.

If assistance is needed while interacting with the software, the user should enter one or two question marks (**??**) to receive on-line help.

##### Example: Enter/Edit Operation Information

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

SURPATIENT,EIGHT (000-37-0555) Surgeon: SURSURGEON,ONE

Case #264

PAGE: 1 OF 2

>> Coding Complete <<

JUN 7,2005 ARTHROSCOPY, LEFT KNEE

Postop Diagnosis Code (ICD9): NOT ENTERED

1. Surgical Specialty:
2. Principal Operation:
3. CPT Codes (view only):
4. Other Procedures:
5. Concurrent Procedure:
6. PGY of Primary Surgeon:
7. Surgical Priority:
8. Wound Classification:
9. ASA Classification:

ORTHOPEDICS ARTHROSCOPY, LEFT KNEE 29873-LT

ELECTIVE CLEAN

1-NO DISTURB.

1. Princ. Anesthesia Technique: GENERAL
2. RBC Units Transfused:
3. Intraop Disseminated Cancer: NO
4. Intraoperative Ascites NO

Select Operative Information to Edit: **8:9**

This information cannot be edited.

--------

|  |  |  |
| --- | --- | --- |
| SURPATIENT,EIGHT (000-37-0555) | Case #264 |  |
| Surgeon: SURSURGEON,ONE |  |
| JUN 7,2005 ARTHROSCOPY, LEFT KNEE |  |
| Wound Classification: CLEAN// **CL** | |
| 1 CLEAN | |
| 2 CLEAN/CONTAMINATED | |
| Choose 1-2: **2** CLEAN/CONTAMINATED | |

June 2007 Surgery V. 3.0 User Manual 455

SR\*3\*160

ASA Class: 1-NO DISTURB.// **2** 2 2-MILD DISTURB.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SURPATIENT,EIGHT (000-37-0555) Case #264 Surgeon: SURSURGEON,ONE  JUN 7,2005 ARTHROSCOPY, LEFT KNEE |  | >> | PAGE: 1 OF  Coding Complete | 2  << |  |
| Postop Diagnosis Code (ICD9): NOT ENTERED   1. Surgical Specialty: ORTHOPEDICS 2. Principal Operation: ARTHROSCOPY, LEFT KNEE 3. CPT Codes (view only): 29873-LT 4. Other Procedures: 5. Concurrent Procedure: 6. PGY of Primary Surgeon: 7. Surgical Priority: ELECTIVE 8. Wound Classification: CLEAN/CONTAMINATED 9. ASA Classification: 2-MILD DISTURB. 10. Princ. Anesthesia Technique: GENERAL 11. RBC Units Transfused: 12. Intraop Disseminated Cancer: NO 13. Intraoperative Ascites NO | | | | |
| Select Operative Information to Edit: **<Enter>** | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,EIGHT (000-37-0555) | Case | #264 |  |  | PAGE: | 2 | OF | 2 |  |
| Surgeon: SURSURGEON,ONE |  |  |  |  |  |  |
| JUN 7,2005 ARTHROSCOPY, LEFT KNEE |  |  |  |  |  |  |
| 1. Patient in Room (PIR): | JUN | 07, | 2005 | 07:00 |  |  |  |  |
| 2. Procedure/Surgery Start Time (PST): | JUN | 07, | 2005 | 07:10 |
| 3. Procedure/Surgery Finish (PF): | JUN | 07, | 2005 | 08:15 |
| 4. Patient Out of Room (POR): | JUN | 07, | 2005 | 08:40 |
| 5. Anesthesia Start (AS): | JUN | 07, | 2005 | 06:30 |
| 6. Anesthesia Finish (AF): | JUN | 07, | 2005 | 09:00 |
| 7. Discharge from PACU (DPACU): |  |  |  |  |
| Select Operative Information to Edit: | | | | | | | | |

456 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

## Patient Demographics (Enter/Edit)

### [SROA DEMOGRAPHICS]

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

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

##### Example: Entering Patient Demographics

Select Non-Cardiac Assessment Information (Enter/Edit) Option: **D** Patient Demogr aphics (Enter/Edit)

SURPATIENT,EIGHT (000-37-0555)

Case #264

JUN 7,2005 ARTHROSCOPY, LEFT KNEE

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...

SURPATIENT,EIGHT (000-37-0555)

Case #264

JUN 7,2005 ARTHROSCOPY, LEFT KNEE

Enter/Edit Patient Demographic Information

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

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

April 2004 Surgery V. 3.0 User Manual 457

|  |  |
| --- | --- |
| SURPATIENT,EIGHT (000-37-0555) Case #264 |  |
| JUN 7,2005 ARTHROSCOPY, LEFT KNEE |
| 1. Transfer Status: NOT TRANSFERRED |
| 2. Observation Admission Date/Time: NA |
| 3. Observation Discharge Date/Time: NA |
| 4. Observation Treating Specialty: NA |
| 5. Hospital Admission Date/Time: JUN 2, 2005@10:15 |
| 6. Hospital Discharge Date/Time: JUN 4, 2005@15:10 |
| 7. Admit/Transfer to Surgical Svc.: JUN 3, 2005@14:20 |
| 8. Discharge/Transfer to Chronic Care: |
| 9. Length of Postop Hospital Stay: 1 Day |
| 10. In/Out-Patient Status: INPATIENT |
| 11. Patient’s Ethnicity NOT HISPANIC |
| 12. Patient’s Race: WHITE,ASIAN |
| 13. Date/Time of Death: NA |
| Select number of item to edit: |

458 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

## 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**

NSQIP Definition (2007):

In a patient who did not require dialysis preoperatively, worsening of renal dysfunction postoperatively requiring hemodialysis, peritoneal dialysis, hemofiltration, hemodiafiltration or ultrafiltration.

TIP: If the patient refuses dialysis the answer is Yes to this variable, because he/she did require dialysis.

CICSP Definition (2004):

Indicate if the patient developed new renal failure requiring dialysis or experienced an exacerbation of preoperative renal failure requiring initiation of dialysis (not on dialysis preoperatively) within 30 days postoperatively.

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** |

June 2007 Surgery V. 3.0 User Manual 461

SR\*3\*160

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SURPATIENT,EIGHT (000-37-0555) JUN 7,2005 ARTHROSCOPY, LEFT | KNEE | Case | #264 |  |
| Treatment Instituted: **DIALYSIS** | | | |

|  |  |
| --- | --- |
| 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: DIALYSIS 5. Outcome to Date: 6. Date Noted: 7. Occurrence Comments: |
| Select Occurrence Information: **<Enter>** |

|  |  |  |
| --- | --- | --- |
| SURPATIENT,EIGHT (000-37-0555) | Case #264 |  |
| JUN 7,2005 ARTHROSCOPY, LEFT KNEE |  |
| Enter/Edit Postoperative Occurrences | |
| 1. ACUTE RENAL FAILURE | |
| Category: ACUTE RENAL FAILURE | |
| Select a number (1), or type 'NEW' to enter another occurrence: | |

462 Surgery V. 3.0 User Manual April 2004

## Clinical Information (Enter/Edit)

### [SROA CLINICAL INFORMATION]

The *Clinical Information (Enter/Edit)* option is used to enter the clinical information required for a cardiac risk assessment. The software will present one page; at the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the

**<Enter>** key will advance the user to another option.

**About the** "**Select Clinical Information to Edit:**" **Prompt**

At the "Select Clinical Information to Edit:" prompt, the user should enter the item number to edit. The user can then enter an **A** for **ALL** to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data. If assistance is needed while interacting with the software, the user can enter one or two question marks (**??**) to receive on-line help.

##### Example: Enter Clinical Information

Select Cardiac Risk Assessment Information (Enter/Edit) Option: **CLIN** Clinical Information (Enter/Edit)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 JUN 18,2005 CORONARY ARTERY BYPASS | | | | | | |
| 1. Height: | 63 in |  | 13. | Prior MI: | NONE |  |
| 2. Weight: | 170 lb | 14. | Number prior heart surgeries: |  |
| 3. Diabetes: |  | 15. | Prior heart surgeries: |  |
| 4. COPD: |  | 16. | Peripheral Vascular Disease: |  |
| 5. FEV1: |  | 17. | Cerebral Vascular Disease: |  |
| 6. Cardiomegaly (X-ray): |  | 18. | Angina (use CCS Class): |  |
| 7. Pulmonary Rales: |  | 19. | CHF (use NYHA Class): |  |
| 8. Current Smoker: |  | 20. | Current Diuretic Use: |  |
| 9. Active Endocarditis: |  | 21. | Current Digoxin Use: |  |
| 10. Resting ST Depression: |  | 22. | IV NTG within 48 Hours: |  |
| 11. Functional Status: |  | 23. | Preop circulatory Device: |  |
| 12. PCI: |  | 24. | Hypertension (Y/N): |  |
| Select Clinical Information | to Edit: | **A** |  |  |  |

April 2004 Surgery V. 3.0 User Manual 467

|  |  |  |
| --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) | Case #60183 |  |
| JUN 18,2005 CORONARY ARTERY BYPASS |  |
| Patient's Height 63 INCHES//: **76** | |
| Patient's Weight170 LBS.//: **210** | |
| Diabetes: **O** ORAL | |
| History of Severe COPD (Y/N): **Y** YES | |
| FEV1 : **NS** | |
| Cardiomegaly on Chest X-Ray (Y/N): **Y** YES | |
| Pulmonary Rales (Y/N): **Y** YES | |
| Current Smoker: **2** WITHIN 2 WEEKS OF SURGERY | |
| Active Endocarditis (Y/N): **N** NO | |
| Resting ST Depression (Y/N): **N** NO | |
| Functional Status: **I** INDEPENDENT | |
| PCI: **0** NONE | |
| Prior Myocardial Infarction: **1** LESS THAN OR EQUAL TO 7 DAYS PRIOR TO SURGERY | |
| Number of Prior Heart Surgeries: **1** 1 | |

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

PAGE: 1

JUN 18,2005 CORONARY ARTERY BYPASS

Prior heart surgeries:

1. None
2. CABG-only
3. Valve-only
4. CABG/Valve
5. Other
6. CABG/Other

Enter your choice(s) separated by commas (0-5): // **2**

2 - Valve-only

Peripheral Vascular Disease (Y/N): **Y** YES Cerebral Vascular Disease (Y/N): **N** NO

Angina (use CCS Functional Class): **IV** CLASS IV

Congestive Heart Failure (use NYHA Functional Class): **II** SLIGHT LIMITATION Current Diuretic Use (Y/N): **Y** YES

Current Digoxin Use (Y/N): **N** NO

IV NTG within 48 Hours Preceding Surgery (Y/N): **Y** YES Preop use of circulatory Device: **N** NONE

History of Hypertension (Y/N): **Y** YES

|  |  |
| --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 JUN 18,2005 CORONARY ARTERY BYPASS | |
| 1. Height: 76 in 13. Prior MI: < OR = 7 DAYS 2. Weight: 210 lb 14. Number prior heart surgeries: 1 3. Diabetes: ORAL 15. Prior heart surgeries: VALVE-ONLY 4. COPD: YES 16. Peripheral Vascular Disease: YES 5. FEV1: NS 17. Cerebral Vascular Disease: NO 6. Cardiomegaly (X-ray): YES 18. Angina (use CCS Class): IV 7. Pulmonary Rales: YES 19. CHF (use NYHA Class): II 8. Current Smoker: WITHIN 2 WEEKS OF S 20. Current Diuretic Use: YES 9. Active Endocarditis: NO 21. Current Digoxin Use: NO 10. Resting ST Depression: NO 22. IV NTG within 48 Hours: YES 11. Functional Status: INDEPENDENT 23. Preop circulatory Device: NONE 12. PCI: NONE 24. Hypertension (Y/N): YES |  |
| Select Clinical Information to Edit: |

468 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

## Enter Cardiac Catheterization & Angiographic Data

### [SROA CATHETERIZATION]

The *Enter Cardiac Catheterization & Angiographic Data* option is used to enter or edit cardiac catheterization and angiographic information for a cardiac risk assessment. The software will present one page. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance the user to another option.

**About the** "**Select Cardiac Catheterization and Angiographic Information to Edit:**" **Prompt**

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

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

##### Example: Enter Cardiac Catheterization & Angiographic Data

Select Cardiac Risk Assessment Information (Enter/Edit) Option: **CATH** Enter Cardiac Catheterization & Angiographic Data

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 JUN 18,2005 CORONARY ARTERY BYPASS |  |  |  | PAGE: | 1 | OF 2 |
| 1. Procedure: 2. LVEDP: 3. Aortic Systolic Pressure:   For patients having right heart cath   1. PA Systolic Pressure: 2. PAW Mean Pressure: 3. LV Contraction Grade (from contrast   or radionuclide angiogram or 2D echo):   1. Mitral Regurgitation: 2. Aortic Stenosis: | | | | | |
| Select Cardiac Catheterization and Angiographic Information | to | Edit: | **A** |  |  |

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

PAGE: 1 OF 2

JUN 18,2005 CORONARY ARTERY BYPASS

Procedure Type: **NS** NO STUDY/UNKNOWN

Do you want to automatically enter 'NS' for NO STUDY for all other fields within this option ? YES// **<Enter>**

April 2004 Surgery V. 3.0 User Manual 469

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 JUN 18,2005 CORONARY ARTERY BYPASS |  |  |  | PAGE: | 1 | OF 2 |
| 1. Procedure: NS 2. LVEDP: NS 3. Aortic Systolic Pressure: NS   For patients having right heart cath   1. PA Systolic Pressure: NS 2. PAW Mean Pressure: NS 3. LV Contraction Grade (from contrast   or radionuclide angiogram or 2D echo): NO LV STUDY   1. Mitral Regurgitation: NS 2. Aortic Stenosis: NS | | | | | |
| Select Cardiac Catheterization and Angiographic Information | to | Edit: | **A** |  |  |

Procedure Type: NO STUDY/UNKNOWN// **CATH** CATH You have changed the answer from "NS".

Do you want to clear 'NS' from all other fields within this option ? NO// **N** NO

Left Ventricular End-Diastolic Pressure: NS// **56**

Aortic Systolic Pressure: NS// **120**

PA Systolic Pressure: NS//**30** PAW Mean Pressure: NS//**15** LV Contraction Grade: NS//**?**

Enter the grade that best describes left ventricular function.

Screen prevents selection of code III. Choose from:

1. > EQUAL 0.55 NORMAL
2. 0.45-0.54 MILD DYSFUNC. IIIa 0.40-0.44 MOD. DYSFUNC. A IIIb 0.35-0.39 MOD. DYSFUNC. B IV 0.25-0.34 SEVERE DYSFUNC.

V <0.25 VERY SEVERE DYSFUNC.

NS NO STUDY

LV Contraction Grade: NO STUDY//**IIIa** 0.40-0.44 MOD. DYSFUNC. A Mitral Regurgitation: NO STUDY//**?**

Enter the code describing presence/severity of mitral regurgitation. Choose from:

1. NONE
2. MILD
3. MODERATE
4. SEVERE

NS NO STUDY

Mitral Regurgitation: NO STUDY//**2** MODERATE Aortic Stenosis: NO STUDY//**1** MILD

470 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

## Operative Risk Summary Data (Enter/Edit)

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

### [SROA CARDIAC OPERATIVE RISK]

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

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

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

##### Example: Operative Risk Summary Data

Select Cardiac Risk Assessment Information (Enter/Edit) Option: **OP** Operative Risk Summary Data (Enter/Edit)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 JUN 18,2005 CORONARY ARTERY BYPASS |  | |  | PAGE: | | 1 |  |
| 1. Physician's Preoperative Estimate of Operative 2. ASA Classification: 1-NO DISTURB. 3. Surgical Priority: 4. Date/Time Operation Began: JUN 18,2005 07:00 5. Date/Time Operation Ended: JUN 18,2005 09:00 | Mortality: | | 78 |  | |  |
| 1. Preoperative Risk Factors: NONE 2. CPT Codes (view only): 33510 | | This information cannot be edited. | | |  | |
| Select Operative Risk Summary Information to Edit: | **1:3** | |  |  | |  |

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

JUN 18,2005 CORONARY ARTERY BYPASS

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

Date/Time of Estimate of Operative Mortality: JUN 17,2005@18:15

// **<Enter>**

ASA Class: **3** 3-SEVERE DISTURB.

Cardiac Surgical Priority: **?**

Enter the surgical priority that most accurately reflects the acuity of patient’s cardiovascular condition at the time of transport to the operating room.

CHOOSE FROM:

1. ELECTIVE
2. URGENT
3. EMERGENT (ONGOING ISCHEMIA)
4. EMERGENT (HEMODYNAMIC COMPROMISE)
5. EMERGENT (ARREST WITH CPR)

Cardiac Surgical Priority: **3** EMERGENT (ONGOING ISCHEMIA) Date/Time of Cardiac Surgical Priority: JUN 17,2005@13:29

// **<Enter>**

April 2004 Surgery V. 3.0 User Manual 471

|  |  |
| --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 JUN 18,2005 CORONARY ARTERY BYPASS |  |
| Principal CPT Code: 33510  Other CPT Codes: NOT ENTERED   1. Physician's Preoperative Estimate of Operative Mortality: 32%    1. Date/Time Collected: JUN 17,2005 18:15 2. ASA Classification: 3-SEVERE DISTURB. 3. Surgical Priority: EMERGENT (ONGOING ISCHEMIA)    1. Date/Time Collected: JUN 17,2005 09:46 4. Date/Time Operation Began: JUN 18,2005 08:45 5. Date/Time Operation Ended: JUN 18,2005 14:25 6. Preoperative Risk Factors: 7. CPT Codes (view only): 33510   \*\*\* NOTE: D/Time of Surgical Priority should be < the D/Time Patient in OR.\*\*\*  \*\*\* NOTE: D/Time of Estimate of Mortality should be < the D/Time PT in OR. \*\*\* |
| Select Operative Risk Summary Information to Edit: |

The Surgery software performs data checks on the following fields:

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

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

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

472 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

## Resource Data (Enter/Edit)

### [SROA CARDIAC RESOURCE]

The nurse reviewer uses the *Resource Data (Enter/Edit)* option to enter, edit, or review risk assessment and cardiac patient demographic information such as hospital admission, discharge dates, and other information related to the surgical episode.

##### Example: Resource Data (Enter/Edit)

Select Cardiac Risk Assessment Information (Enter/Edit) Option: **R** Resource Data

SURPATIENT,TEN (000-12-3456)

Case #49413

JUN 18,2005 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD

Enter/Edit Patient Resource Data

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information Select Number: (1-2): **1**

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

...HMMM, I'M WORKING AS FAST AS I CAN...

SURPATIENT,TEN (000-12-3456)

Case #49413

JUN 18,2005 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD

Enter/Edit Patient Resource Data

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

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

|  |  |
| --- | --- |
| SURPATIENT,TEN (000-12-3456) Case #49413 |  |
| JUN 18,2005 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD |
| 1. Hospital Admission Date: JUN 16, 2005@08:00 |
| 2. Hospital Discharge Date: JUN 30, 2005@08:00 |
| 3. Cardiac Catheterization Date: JUN 21, 2005 |
| 4. Time Patient In OR: JUN 18, 2005@07:30 |
| 5. Time Patient Out OR: JUN 18, 2005@14:30 |
| 6. Date/Time Patient Extubated: JUN 18, 2005@08:05 |
| 7. Date/Time Discharged from ICU: |
| 8. Homeless: NO |
| 9. Surg Performed at Non-VA Facility: NO |
| 10. Resource Data Comments: |
| 11. Employment Status Preoperatively: SELF EMPLOYED |
| Select number of item to edit: **11** |

June 2007 Surgery V. 3.0 User Manual 479

Employment Status Preoperatively: EMPLOYED FULL TIME// **?**

Enter the patient's employment status preoperatively. Choose from:

1. EMPLOYED FULL TIME
2. EMPLOYED PART TIME
3. NOT EMPLOYED
4. SELF EMPLOYED
5. RETIRED
6. ACTIVE MILITARY DUTY

9 UNKNOWN

Employment Status Preoperatively: **3** NOT EMPLOYED

|  |  |
| --- | --- |
| SURPATIENT,TEN (000-12-3456) Case #49413  JUN 18,2005 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD |  |
| 1. Hospital Admission Date: JUN 16, 2005@08:00 2. Hospital Discharge Date: JUN 30, 2005@08:00 3. Cardiac Catheterization Date: JUN 21, 2005 4. Time Patient In OR: JUN 18, 2005@07:30 5. Time Patient Out OR: JUN 18, 2005@14:30 6. Date/Time Patient Extubated: JUN 18, 2005@08:05 7. Date/Time Discharged from ICU: 8. Homeless: NO 9. Surg Performed at Non-VA Facility: NO 10. Resource Data Comments: 11. Employment Status Preoperatively: NOT EMPLOYED |
| Select number of item to edit: |

The Surgery software performs data checks on the following fields:

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

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

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

479a Surgery V. 3.0 User Manual June 2007 SR\*3\*160

# Print a Surgery Risk Assessment

### [SROA PRINT ASSESSMENT]

The *Print a Surgery Risk Assessment* option prints an entire Surgery Risk Assessment Report for an individual patient. This report can be displayed temporarily on a screen. As the report fills the screen, the user will be prompted to press the **<Enter>** key to go to the next page. A permanent record can be made by copying the report to a printer. When using a printer, the report is formatted slightly differently from the way it displays on the terminal.

##### Example 1: Print Surgery Risk Assessment for a Non-Cardiac Case

Select Surgery Risk Assessment Menu Option: **P** Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO// **<Enter>**

Select Patient: **SURPATIENT,FORTY**

ERAN

05-07-23

000777777

NO

NSC VET

SURPATIENT,FORTY 000-77-7777

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

Select Surgical Case: **2**

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

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

April 2004 Surgery V. 3.0 User Manual 481

|  |  |
| --- | --- |
| VA NON-CARDIAC RISK ASSESSMENT Assessment: 236 PAGE 1 FOR SURPATIENT,FORTY 000-77-7777 (COMPLETED)  ================================================================================ |  |
| Medical Center: ALBANY  Age: 81 Operation Date: JAN 09, 2004  Sex: MALE Ethnicity: NOT HISPANIC OR LATINO Race: AMERICAN INDIAN OR ALASKA  NATIVE, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, WHITE  Transfer Status: NOT TRANSFERRED  Observation Admission Date: NA  Observation Discharge Date: NA  Observation Treating Specialty: NA  Hospital Admission Date: JAN 7,2006 11:15  Hospital Discharge Date: JAN 12,2006 10:30 Admitted/Transferred to Surgical Service: JAN 7,2006 11:15 Discharged/Transferred to Chronic Care: JAN 12,2006 10:30 In/Out-Patient Status: INPATIENT |
| PREOPERATIVE INFORMATION |
| GENERAL: YES HEPATOBILIARY: YES  Height: 176 CENTIMETERS Ascites: YES Weight: 89 KILOGRAMS  Diabetes Mellitus: INSULIN GASTROINTESTINAL: YES Current Smoker W/I 1 Year: YES Esophageal Varices: YES Pack/Years: 0  ETOH > 2 Drinks/Day: NO CARDIAC: NO  Dyspnea: NO CHF Within 1 Month: NO  DNR Status: NO MI Within 6 Months: NO Pre-illness Funct Previous PCI:  Status: INDEPENDENT Previous Cardiac Surgery: Preop Funct Status: INDEPENDENT Angina Within 1 Month:  Hypertension Requiring Meds:  PULMONARY:  Ventilator Dependent: NS VASCULAR: YES History of Severe COPD: NO Revascularization/Amputation: NO Current Pneumonia: NO Rest Pain/Gangrene: YES |
| RENAL: YES NUTRITIONAL/IMMUNE/OTHER: YES  Acute Renal Failure: NO Disseminated Cancer: NO Currently on Dialysis: NO Open Wound: NO  Steroid Use for Chronic Cond.: NO CENTRAL NERVOUS SYSTEM: YES Weight Loss > 10%: NO  Impaired Sensorium: NO Bleeding Disorders: NO Coma: NO Transfusion > 4 RBC Units: NO  Hemiplegia: NO Chemotherapy W/I 30 Days: NO  History of TIAs: NO Radiotherapy W/I 90 Days: NO CVA/Stroke w. Neuro Deficit: YES Preoperative Sepsis: NONE CVA/Stroke w/o Neuro Deficit: NO Pregnancy: NOT APPLICABLE Tumor Involving CNS: NO  Paraplegia: NO  Quadriplegia: 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 |

482 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

VA NON-CARDIAC RISK ASSESSMENT Assessment: 236 PAGE 2 FOR SURPATIENT,FORTY 000-77-7777 (COMPLETED)

================================================================================ OPERATIVE INFORMATION

Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Principal Operation: APPENDECTOMY

Procedure CPT Codes: 44950

Concurrent Procedure:

CPT Code: PGY of Primary Surgeon: 0

Emergency Case (Y/N): NO

Wound Classification: CONTAMINATED

ASA Classification: 3-SEVERE DISTURB. Principal Anesthesia Technique: GENERAL

RBC Units Transfused: 0 Intraop Disseminated Cancer: NO

Intraoperative Ascites: NO

PREOPERATIVE LABORATORY TEST RESULTS

|  |  |  |  |
| --- | --- | --- | --- |
| Anion Gap: | 12 | (JAN | 7,2006) |
| Serum Sodium: | 144.6 | (JAN | 7,2006) |
| Serum Creatinine: | .9 | (JAN | 7,2006) |
| BUN: | 18 | (JAN | 7,2006) |
| Serum Albumin: | 3.5 | (JAN | 7,2006) |
| Total Bilirubin: | .9 | (JAN | 7,2006) |
| SGOT: | 46 | (JAN | 7,2006) |
| Alkaline Phosphatase: | 34 | (JAN | 7,2006) |
| White Blood Count: | 15.9 | (JAN | 7,2006) |
| Hematocrit: | 43.4 | (JAN | 7,2006) |
| Platelet Count: | 356 | (JAN | 7,2006) |
| PTT: | 25.9 | (JAN | 7,2006) |
| PT: | 12.1 | (JAN | 7,2006) |
| INR: | 1.54 | (JAN | 7,2006) |
| Hemoglobin A1c: | NS |  |  |

POSTOPERATIVE LABORATORY RESULTS

\* Highest Value

\*\* Lowest Value

\* Anion Gap: 11 (JAN 7,2006)

\* Serum Sodium: 148 (JAN 12,2006)

\*\* Serum Sodium: 144.2 (FEB 2,2006)

\* Potassium: 4.5 (JAN 12,2006)

\*\* Potassium: 4.5 (JAN 12,2006)

\* Serum Creatinine: 1.4 (FEB 2,2006)

\* CPK: 88 (JAN 12,2006)

\* CPK-MB Band: <1 (JAN 12,2006)

\* Total Bilirubin: 1.3 (JAN 12,2006)

\* White Blood Count: 12.2 (JAN 12,2006)

\*\* Hematocrit: 42.9 (JAN 12,2006)

\* Troponin I: 1.42 (JAN 12,2006)

\* Troponin T: NS

June 2007 Surgery V. 3.0 User Manual 483

SR\*3\*160

VA NON-CARDIAC RISK ASSESSMENT Assessment: 236 PAGE 3 FOR SURPATIENT,FORTY 000-77-7777 (COMPLETED)

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

OUTCOME INFORMATION

Postoperative Diagnosis Code (ICD9): 540.1 ABSCESS OF APPENDIX Length of Postoperative Hospital Stay: 3 DAYS

Date of Death: Return to OR Within 30 Days: NO

PERIOPERATIVE OCCURRENCE INFORMATION

WOUND OCCURRENCES: YES CNS OCCURRENCES: YES

Superficial Incisional SSI: NO Stroke/CVA: NO

Deep Incisional SSI: NO Coma > 24 Hours: NO Wound Disruption: 01/10/06 Peripheral Nerve Injury: 01/10/06

\* 427.31 ATRIAL FIBRILLATI 01/10/06

URINARY TRACT OCCURRENCES: YES CARDIAC OCCURRENCES: YES

Renal Insufficiency: NO Arrest Requiring CPR: NO Acute Renal Failure: NO Myocardial Infarction: 01/09/06 Urinary Tract Infection: 01/11/06

RESPIRATORY OCCURRENCES: YES OTHER OCCURRENCES: YES

Pneumonia: NO Bleeding/Transfusions: NO Unplanned Intubation: NO Graft/Prosthesis/Flap Failure: NO Pulmonary Embolism: NO DVT/Thrombophlebitis: NO

On Ventilator > 48 Hours: NO Systemic Sepsis: SEPTIC SHOCK 01/11/06

Organ/Space SSI: 01/11/06

C. difficile Colitis: NO

* 477.0 RHINITIS DUE TO P 01/12/06
* indicates Other (ICD9)

484 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

SURPATIENT,NINE 000-34-5555

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

1. OPERATIVE DATA

Cardiac surgical procedures with or without cardiopulmonary bypass

CABG distal anastomoses: Bridge to transplant/Device: NO Number with Vein: 2 TMR: NO Number with IMA: 2 Maze procedure: NO MAZE PERFORMED Number with Radial Artery: 0 ASD repair: NO

Number with Other Artery: 0 VSD repair: NO

Number with Other Conduit: 0 Myectomy for IHSS: NO

Aortic Valve Replacement: NO Myxoma resection: NO Mitral Valve Replacement: NO Other tumor resection: NO Tricuspid Valve Replacement: NO Cardiac transplant: NO Valve Repair: NONE Great Vessel Repair: NO LV Aneurysmectomy: NO Endovascular Repair: NO

Other Cardiac procedure(s): YES

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

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

Pericardiectomy: YES

Other Operative Data details

Total CPB Time: 85 min Total Ischemic Time: 60 min Incision Type: FULL STERNOTOMY

Conversion Off Pump to CPB: N/A (began on-pump/ stayed on-pump)

1. OUTCOMES

Operative Death: NO Date of Death:

Perioperative (30 day) Occurrences:

Perioperative MI: NO Repeat cardiac Surg procedure: YES

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

1. RESOURCE DATA

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

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

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

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

Date and Time Patient Extubated: 07/10/06 13:13 Date and Time Patient Discharged from ICU: 07/10/06 08:00 Patient is Homeless: NS

Cardiac Surg Performed at Non-VA Facility: UNKNOWN

Resource Data Comments: Indicate other cardiac procedures only if done with cardiopulmonary bypass

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

1. SOCIOECONOMIC, ETHNICITY, AND RACE

Employment Status Preoperatively: SELF EMPLOYED Ethnicity: NOT HISPANIC OR LATINO

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

1. DETAILED DISCHARGE INFORMATION

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

Type of Disposition: TRANSFER

Place of Disposition: HOME-BASED PRIMARY CARE (HBPC) Primary care or referral VAMC identification code: 526 Follow-up VAMC identification code: 526

\*\*\* End of report for SURPATIENT,NINE 000-34-5555 assessment #238 \*\*\*

June 2007 Surgery V. 3.0 User Manual 486a SR\*3\*160

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

486b Surgery V. 3.0 User Manual April 2004

# List of Surgery Risk Assessments

### [SROA ASSESSMENT LIST]

The *List of Surgery Risk Assessments* option is used to print lists of assessments within a date range. Lists of assessments in different phases of completion (for example, incomplete, completed, or transmitted) or a list of all surgical cases entered in the Surgery Risk Assessment software can be printed. The user can also request that the list be sorted by surgical service. The software will prompt for a beginning date and an ending date. Examples 1-9 illustrate printing assessments in each of the following formats.

* 1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases

##### Example 1: List of Incomplete Assessments

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases

Select the Number of the Report Desired: **1**

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

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

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

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

June 2007 Surgery V. 3.0 User Manual SR\*3\*160

489

INCOMPLETE RISK ASSESSMENTS PAGE 1

MAYBERRY, NC

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

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

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

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

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

CPT Codes: 33736

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

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

JUN 09, 2006 SURSURGEON,TWO

CPT Codes: 49521

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

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

JUN 24, 2006 SURSURGEON,FOUR

CPT Codes: NOT ENTERED

490 Surgery V. 3.0 User Manual April 2004

**Example 2: List of Completed Assessments**

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases

Select the Number of the Report Desired: **2**

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

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

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

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

June 2007 Surgery V. 3.0 User Manual SR\*3\*160

491

COMPLETED RISK ASSESSMENTS PAGE 1

MAYBERRY, NC

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

ASSESSMENT # PATIENT DATE COMPLETED ANESTHESIA TECHNIQUE OPERATION DATE OPERATIVE PROCEDURE

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

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

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

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

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

APR 28, 2006 INTRAOCCULAR LENS

CPT Codes: NOT ENTERED

492 Surgery V. 3.0 User Manual April 2004

**Example 3: List of Transmitted Assessments**

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases

Select the Number of the Report Desired: **3**

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

End with Date: **6 30 06** (JUN 30, 2006) Print by Surgical Specialty ? YES// <Enter> Print report for ALL specialties ? YES// **N**

Print the Report for which Surgical Specialty: **GENERAL**(OR WHEN NOT DEFINED BELOW) GENERAL(OR WHEN NOT DEFINED BELOW) 50

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

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

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

June 2007 Surgery V. 3.0 User Manual SR\*3\*160

493

TRANSMITTED RISK ASSESSMENTS PAGE 1

MAYBERRY, NC

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

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

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

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

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

494 Surgery V. 3.0 User Manual April 2004

**Example 4: List of Non-Assessed Major Surgical Cases**

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases

Select the Number of the Report Desired: **4**

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

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

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

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

Print the Report for which Surgical Specialty: **GENERAL**(OR WHEN NOT DEFINED BELOW) GENERAL(OR WHEN NOT DEFINED BELOW) 50

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

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

#### printout follows

June 2007 Surgery V. 3.0 User Manual SR\*3\*160

495

NON-ASSESSED MAJOR SURGICAL CASES BY SURGICAL SPECIALTY PAGE 1

MAYBERRY, NC

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

CASE # PATIENT ANESTHESIA TECHNIQUE

OPERATION DATE OPERATIVE PROCEDURE(S) SURGEON

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

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

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 2

496 Surgery V. 3.0 User Manual April 2004

**Example 5: List of All Major Surgical Cases**

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases

Select the Number of the Report Desired: **5**

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

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

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

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

Print the Report for which Surgical Specialty: **GENERAL**(OR WHEN NOT DEFINED BELOW) GENERAL(OR WHEN NOT DEFINED BELOW) 50

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

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

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

June 2007 Surgery V. 3.0 User Manual SR\*3\*160

497

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

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

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

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

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

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 3

498 Surgery V. 3.0 User Manual April 2004

**Example 6: List of All Surgical Cases**

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases

Select the Number of the Report Desired: **6**

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

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

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

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

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

GENERAL(OR WHEN NOT DEFINED BELOW)

GENERAL(OR WHEN NOT DEFINED BELOW) 50

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

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

#### printout follows

June 2007 Surgery V. 3.0 User Manual SR\*3\*160

499

ALL SURGICAL CASES BY SURGICAL SPECIALTY PAGE 1 MAYBERRY, NC

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

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

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

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

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 4

500 Surgery V. 3.0 User Manual April 2004

**Example 7: List of Completed/Transmitted Assessments Missing Information**

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases

Select the Number of the Report Desired: **7**

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

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

June 2007 Surgery V. 3.0 User Manual 501

SR\*3\*160

COMPLETED/TRANSMITTED ASSESSMENTS MISSING INFORMATION PAGE 1

MAYBERRY, NC

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

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

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

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

MAY 17, 2006 REPAIR ARTERIAL BLEEDING

CPT Code: 33120

Missing information:

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

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

APR 17, 2006 INGUINAL HERNIA, CHOLECYSTECTOMY

Missing information:

1. The final coding for Procedure and Diagnosis is not complete.
2. Concurrent Case
3. History of COPD (Y/N)
4. Ventilator Dependent Greater than 48 Hrs (Y/N)
5. Weight Loss > 10% of Usual Body Weight (Y/N)
6. Transfusion Greater than 4 RBC Units this Admission (Y/N)

63080 SURPATIENT,THIRTY 000-82-9472 EXCLUDED COMPLETE

JAN 03, 2006 TURP

Missing information:

1. The final coding for Procedure and Diagnosis is not complete.
2. Major or Minor

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

502 Surgery V. 3.0 User Manual April 2004

**Example 8: List of Completed/Transmitted Assessments Missing Information**

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases

Select the Number of the Report Desired: **8**

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

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

June 2007 Surgery V. 3.0 User Manual 502a SR\*3\*160

|  |  |  |
| --- | --- | --- |
|  | 1-LINER CASES MISSING INFORMATION  ALBANY | PAGE 1 |
| FROM: FEB 27,2006 TO: JUN 30,2006 DATE PRINTED: JUN 30,2006 |  |
| \*\* UROLOGY |  |  |
| CASE # OP DATE | PATIENT TYPE  OPERATION(S) | STATUS |
| ================================================================================ | | |
| 317 | SURPATIENT,FOURTEEN 000-45-7212 CARDIAC | COMPLETE |
| APR 10, 2006 | Vasectomy |  |
|  | CPT Codes: NOT ENTERED |  |
| Missing information: | | |

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

TOTAL FOR UROLOGY: 1

502b Surgery V. 3.0 User Manual June 2007 SR\*3\*160

**Example 9: List of Eligible Cases**

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases

Select the Number of the Report Desired: **9**

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

End with Date: **6 30 07** (JUN 30, 2007)

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

June 2007 Surgery V. 3.0 User Manual 502c SR\*3\*160

CASES ELIGIBLE FOR ASSESSMENT PAGE 1 FROM: JUN 1,2006 TO: JUN 30,2007

'\*' Denotes Eligible CPT Code

>>> CARDIAC SURGERY

===

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

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

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

CPT Codes: NOT ENTERED

TOTAL FOR CARDIAC SURGERY: 4

>>> GENERAL SURGERY

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

===

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

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

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

TOTAL FOR GENERAL SURGERY: 2

502d Surgery V. 3.0 User Manual June 2007 SR\*3\*160

# Print 30 Day Follow-up Letters

### [SROA REPRINT LETTERS]

The Surgical Clinical Nurse Reviewer uses the *Print 30 Day Follow-up Letters* option to automatically print a letter, or a batch of letters, addressed to a specific patient or patients.

**About the "Do you want to print the letter for a specific assessment?" Prompt**

The user responds **YES** to this prompt in order to print a follow-up letter for a single assessment. The software will ask the user to select the patient and case for which the letter will be printed. See Example 1 below.

The user responds **NO** to this prompt if he or she wants to print a batch of follow-up letters for surgical cases within a data range. The software will ask for the beginning and ending dates of the date range for which the letters will be printed. See Example 2 on the following pages.

If the patient has died, the software notifies the user of the death, and will not print the letter. Also, if a patient has not been discharged, the follow up letter will not print.

**Example 1: Print a Single Follow-up Letter**

Select Surgery Risk Assessment Menu Option: **F** Print 30 Day Follow-up Letters

Do you want to edit the text of the letter? NO// **<Enter>**

Do you want to print the letter for a specific assessment ? YES// **<Enter>**

Select Patient:

**SURPATIENT,NINETEEN**

03-03-30

000287354

SC VETERAN

SURPATIENT,NINETEEN 000-28-7354

1. 06-18-06 CORONARY ARTERY BYPASS (INCOMPLETE)
2. 01-25-06 PULMONARY LOBECTOMY (TRANSMITTED)

Select Surgical Case: **1**

Print 30 Day Letters on which Device: ***[Select Print Device]***

*printout follows*

April 2004 Surgery V. 3.0 User Manual 503

NINETEEN SURPATIENT JUL 18, 2006

Operation Date: 06/18/06 Specialty: GENERAL SURGERY

Dear Mr. Surpatient,

One month ago, you had an operation at the VA Medical Center. We are interested in how you feel. Have you had any health problems since your operation ? We would like to hear from you. Please take a few minutes to answer these questions and return this letter in the self-addressed stamped envelope.

Have you been to a hospital or seen a doctor for any reason since your operation ? Yes No

If you answered NO, you do not need to answer any more questions. Please return this sheet in the self-addressed stamped envelope.

If you have answered YES, please answer the following questions.

* 1. Have you been seen in an outpatient clinic or doctor's office ?

Yes No

Why did you go to the clinic or doctor's office ?

Where ? (name and location) Date ?

Who was your doctor ?

* 1. Were you admitted to a hospital ? Yes No

Why did you go to the hospital ?

Where ? (name and location) Date ?

Who was your doctor ?

Please return this letter whether or not you have had any medical problems. Your health and opinion are important to us. Thank you.

Sincerely,

Surgical Clinical Nurse Reviewer

504 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

**Example 2: Print Letters Within a Date Range**

Select Surgery Risk Assessment Menu Option: **P** Print 30 Day Follow-up Letters

Do you want to print the letter for a specific assessment ? YES// **N**

This option will allow you to reprint the 30 day follow up letters for the date that they were originally printed. When printed automatically, the letters print 25 days after the date of operation.

Print letters for BEGINNING date: TODAY// **6/1/07** (JUN 01, 2007) Print letters for ENDING date: TODAY// **<Enter>** (JUN 02, 2007)

Print 30 Day Letters on which Device: ***[Select Print Device]***

#### printout follows

June 2007 Surgery V. 3.0 User Manual 505

SR\*3\*160

FORTYONE SURPATIENT JUN 02, 2007

87 NORTH STREET Operation Date: 05/08/07

PHILADELPHIA, PA 91776 Specialty: GENERAL SURGERY

Dear Mr. Surpatient,

One month ago, you had an operation at the VA Medical Center. We are interested in how you feel. Have you had any health problems since your operation ? We would like to hear from you. Please take a few minutes to answer these questions and return this letter in the self-addressed stamped envelope.

Have you been to a hospital or seen a doctor for any reason since your operation ? Yes No

If you answered NO, you do not need to answer any more questions. Please return this sheet in the self-addressed stamped envelope.

If you have answered YES, please answer the following questions.

1. Have you been seen in an outpatient clinic or doctor's office ?

Yes No

Why did you go to the clinic or doctor's office ?

Where ? (name and location) Date ?

Who was your doctor ?

1. Were you admitted to a hospital ? Yes No

Why did you go to the hospital ?

Where ? (name and location) Date ?

Who was your doctor ?

Please return this letter whether or not you have had any medical problems. Your health and opinion are important to us. Thank You.

Sincerely,

Surgical Clinical Nurse Reviewer

506 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

# Monthly Surgical Case Workload Report

### [SROA MONTHLY WORKLOAD REPORT]

The *Monthly Surgical Case Workload Report* option generates the Monthly Surgical Case Workload Report that may be printed and/or transmitted to the NSQIP national database. 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*

June 2007 Surgery V. 3.0 User Manual 509

SR\*3\*160

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

CARDIAC NON-CARDIAC TOTAL

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| MAY | 2006 | 0 |  | 0 |  | 0 |
| JUN | 2006 | 0 |  | 0 |  | 0 |
| JUL | 2006 | 0 |  | 0 |  | 0 |
| AUG | 2006 | 0 |  | 0 |  | 0 |
| SEP | 2006 | 0 |  | 0 |  | 0 |
| OCT | 2006 | 0 |  | 0 |  | 0 |
| NOV | 2006 | 0 |  | 0 |  | 0 |
| DEC | 2006 | 0 |  | 0 |  | 0 |
| JAN | 2007 | 0 |  | 0 |  | 0 |
| FEB | 2007 | 0 |  | 0 |  | 0 |
| MAR | 2007 | 0 |  | 0 |  | 0 |
| APR | 2007 | 0 |  | 0 |  | 0 |
| MAY | 2007 | 15 |  | 82 |  | 97 |

15 82 97

510 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

**Example: Monthly Surgical Case Workload Report – Range of Months**

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// **2**

Start with which month and year? OCT 2006// (OCT 2006) **<Enter>** End with which month and year? MAY 2007// (MAY 2007) **<Enter>** Do you want to print all divisions? YES// **<Enter>**

Print report on which Device: ***[Select Print Device]***

#### printout follows

June 2007 Surgery V. 3.0 User Manual 511

SR\*3\*160

ALBANY - ALL DIVISIONS REPORT OF SURGICAL CASE WORKLOAD

FOR OCT 2005 THROUGH MAY 2006

|  |  |  |
| --- | --- | --- |
| TOTAL CASES PERFORMED | = | 30 |
| TOTAL ELIGIBLE CASES | = | 5 |
| CASES MEETING EXCLUSION CRITERIA | = | 1 |
| NON-SURGEON CASE | = | 0 |
| ANESTHESIA TYPE | = | 0 |
| EXCEEDS MAX. ASSESSMENTS | = | 0 |
| EXCEEDS MAXIMUM TURPS | = | 0 |
| STUDY CRITERIA | = | 0 |
| SCNR WAS ON A/L | = | 1 |
| CONCURRENT CASE | = | 0 |
| EXCEEDS MAXIMUM HERNIAS | = | 0 |
| ASSESSED CASES | = | 20 |
| NOT LOGGED ELIGIBLE CASES | = | 0 |
| CARDIAC CASES | = | 4 |
| NON-CARDIAC CASES | = | 16 |

512 Surgery V. 3.0 User Manual June 2007 SR\*3\*160

# Update 1-Liner Case

### [SROA ONE-LINER UPDATE]

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

##### Example: Update 1-Liner Case

Select Surgery Risk Assessment Menu Option: **O** Update 1-Liner Case

Select Patient: **SURPATIENT,TWELVE**

SC VETERAN

02-12-28

000418719

YES

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) |  |
| 1. In/Out-Patient Status: OUTPATIENT 2. Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW) 3. Surgical Priority: STANDBY 4. Attending Code: LEVEL A. ATTENDING DOING THE OPERATION 5. ASA Class: 2-MILD DISTURB. 6. Wound Classification: 7. Anesthesia Technique: GENERAL 8. CPT Codes (view only): 39540 9. Other Procedures: \*\*\*NONE ENTERED\*\*\* |
| 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) |
| 1. In/Out-Patient Status: OUTPATIENT |
| 2. Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW) |
| 3. Surgical Priority: STANDBY |
| 4. Attending Code: LEVEL A. ATTENDING DOING THE OPERATION |
| 5. ASA Class: 2-MILD DISTURB. |
| 6. Wound Classification: CLEAN |
| 7. Anesthesia Technique: GENERAL |
| 8. CPT Codes (view only): 39540 |
| 9. Other Procedures: \*\*\*NONE ENTERED\*\*\* |
| Select number of item to edit: |

June 2007 Surgery V. 3.0 User Manual 519

SR\*3\*160

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

520 Surgery V. 3.0 User Manual April 2004