

SURGERY

**USER MANUAL**

Version 3.0

July 1993

(Revised September 2011)

Department of Veterans Affairs Product 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** |
| 09/11 | i-iib, iii-iv, vi, 64, 66,  70, 98-101, 101a-101b,  109-112, 114-118, 122-  124, 124a-124b, 142-  152, 152a-152b, 176,  178, 180, 183-184,  184a-184f, 244, 246,  248, 325-326, 326a-  326b, 327, 327a-327d,  368, 394a-394b, 394c-  394d, 395-397, 397a-  397d, 432-433, 441,  449-450, 458-459, 461,  464a, 471-474, 474a-  474b, 475, 477, 480a,  482, 486-486a,  509,519, 521, 522a,  522c, 527, 534-535,  550, 552-556 | SR\*3\*175 | Updated definitions and made minor modifications to the non-cardiac, cardiac and transplant components of the VistA Surgery application. For more details, see the *Annual Surgery Updates – VASQIP 2011, Increment 1, Release Notes.*  REDACTED |
| 12/10 | i-iib, 372, 376, 449-450,  458, 467-468, 468b,  471-474, 474a-474b,  479, 479a, 482, 486,  486a, 522c-522d | SR\*3\*174 | Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the *Annual Surgery Updates – VASQIP 2010 Release Notes.*  REDACTED |
| 11/08 | vii-viii, 527-556 | SR\*3\*167 | New chapter added for transplant assessments. Changed Glossary to Chapter 10, and renumbered the Index.  REDACTED |
| 04/08 | iii-iv, vi, 160, 165, 168,  171-172, 296-298, 443,  447, 449-450, 459, 471-  473, 479-479a, 482,  486-486a, 489, 491,  493- 495, 497, 499,  501-502a, 502c, 502d-  502h, 513-517, 522c-  522d, 529, 534 | SR\*3\*166 | Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the *Surgery NSQIP-CICSP Enhancements 2008 Release Notes.*  REDACTED |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Revised Pages** | **Patch Number** | **Description** |
|  | b, 503-504, 509-512 |  |  |
| 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 |

|  |  |  |  |
| --- | --- | --- | --- |
| **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*. |

# Table Of Contents

[Introduction 1](#_TOC_250001)

Overview 1

Documentation Conventions 3

Getting Help and Exiting 3

Using Screen Server 5

Introduction 5

Navigating 5

Basics of Screen Server 6

Entering Data 7

Editing Data 8

Turning Pages 8

Entering or Editing a Range of Data Elements 9

Working with Multiples 10

Word Processing 14

Chapter One: Booking Operations 15

Introduction 15

Key Vocabulary 15

Exiting an Option or the System 16

Option Overview 16

Maintain Surgery Waiting List 17

Print Surgery Waiting List 18

Enter a Patient on the Waiting List 21

Edit a Patient on the Waiting List 22

Delete a Patient from the Waiting List 23

Request Operations Menu 25

Display Availability 26

Make Operation Requests 28

Delete or Update Operation Requests 36

Make a Request from the Waiting List 42

Make a Request for Concurrent Cases 45

Review Request Information 52

Operation Requests for a Day 53

Requests by Ward 55

List Operation Requests 57

Schedule Operations 59

Display Availability 60

Schedule Requested Operation 61

Schedule Unrequested Concurrent Cases 69

Reschedule or Update a Scheduled Operation 74

Cancel Scheduled Operation 81

Update Cancellation Reason 83

Schedule Anesthesia Personnel 84

Create Service Blockout 85

Delete Service Blockout 87

Schedule of Operations 88

List Scheduled Operations 91

Chapter Two: Tracking Clinical Procedures 93

Introduction 93

Key Vocabulary 93

Exiting an Option or the System 94

Option Overview 94

Operation Menu 95

Using the Operation Menu Options 96

[Operation Information 103](#_TOC_250000)

Surgical Staff 104

Operation Startup 108

Operation 113

Post Operation 119

Enter PAC(U) Information 121

Operation (Short Screen) 122

Time Out Verified Utilizing Checklist 124a

Surgeon’s Verification of Diagnosis & Procedures 125

Anesthesia for an Operation Menu 128

Operation Report 129

Anesthesia Report 131

Nurse Intraoperative Report 140

Tissue Examination Report 153

Enter Referring Physician Information 154

Enter Irrigations and Restraints 155

Medications (Enter/Edit) 157

Blood Product Verification 158

Anesthesia Menu 160

Prerequisites 160

Anesthesia Data Entry Menu 161

Anesthesia Information (Enter/Edit) 162

Anesthesia Technique (Enter/Edit) 165

Medications (Enter/Edit) 169

Anesthesia Report 170

Schedule Anesthesia Personnel 173

Perioperative Occurrences Menu 175

Key Vocabulary 175

Intraoperative Occurrences (Enter/Edit) 176

Postoperative Occurrences (Enter/Edit) 178

Non-Operative Occurrence (Enter/Edit) 180

Update Status of Returns Within 30 Days 181

Morbidity & Mortality Reports 183

Non-O.R. Procedures 187

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

Edit Non-O.R. Procedure 189

Procedure Report (Non-O.R.) 193

Tissue Examination Report 195a

Non-OR Procedure Information 195b

Annual Report of Non-O.R. Procedures 196

Report of Non-O.R. Procedures 198

iv Surgery V. 3.0 User Manual September 2011

Comments Option 205

CPT/ICD9 Coding Menu 207

CPT/ICD9 Update/Verify Menu 208

Update/Verify Procedure/Diagnosis Codes 209

Operation/Procedure Report 213

Nurse Intraoperative Report 217

Non-OR Procedure Information 219a

Cumulative Report of CPT Codes 220

Report of CPT Coding Accuracy 224

List Completed Cases Missing CPT Codes 230

List of Operations 232

List of Operations (by Surgical Specialty) 234

Report of Daily Operating Room Activity 236

PCE Filing Status Report 238

Report of Non-O.R. Procedures 243

Chapter Three: Generating Surgical Reports 249

Introduction 249

Exiting an Option or the System 249

Option Overview 249

Surgery Reports 251

Management Reports 252

List of Operations (by Surgical Priority) 267

Surgery Staffing Reports 283

Anesthesia Reports 296

CPT Code Reports 305

Laboratory Interim Report 319

Chapter Four: Chief of Surgery Reports 321

Introduction 321

Exiting an Option or the System 321

Option Overview 321

Chief of Surgery Menu 323

View Patient Perioperative Occurrences 324

Management Reports 325

Unlock a Case for Editing 398

Update Status of Returns Within 30 Days 399

Update Cancelled Cases 400

Update Operations as Unrelated/Related to Death 401

Update/Verify Procedure/Diagnosis Codes 402

Chapter Five: Managing the Software Package 407

Introduction 407

Exiting an Option or the System 407

Option Overview 407

Surgery Package Management Menu 409

Surgery Site Parameters (Enter/Edit) 410

Operating Room Information (Enter/Edit) 413

Surgery Utilization Menu 414

Person Field Restrictions Menu 425

Update O.R. Schedule Devices 429

Update Staff Surgeon Information 430

Flag Drugs for Use as Anesthesia Agents 431

Update Site Configurable Files 432

Surgery Interface Management Menu 434

Make Reports Viewable in CPRS 440

Chapter Six: Assessing Surgical Risk 441

Introduction 441

Exiting an Option or the System 441

Surgery Risk Assessment Menu 443

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

Creating a New Risk Assessment 445

Editing an Incomplete Risk Assessment 447

Preoperative Information (Enter/Edit) 448

Laboratory Test Results (Enter/Edit) 451

Operation Information (Enter/Edit) 455

Patient Demographics (Enter/Edit) 457

Intraoperative Occurrences (Enter/Edit) 459

Postoperative Occurrences (Enter/Edit) 461

Update Status of Returns Within 30 Days 463

Update Assessment Status to ‘Complete’ 464

Alert Coder Regarding Coding Issues 464a

Cardiac Risk Assessment Information (Enter/Edit) 465

Creating a New Risk Assessment 465

Clinical Information (Enter/Edit) 467

Laboratory Test Results (Enter/Edit) 468a

Enter Cardiac Catheterization & Angiographic Data 469

Operative Risk Summary Data (Enter/Edit) 471

Cardiac Procedures Operative Data (Enter/Edit) 473

Outcome Information (Enter/Edit) 474b

Intraoperative Occurrences (Enter/Edit) 475

Postoperative Occurrences (Enter/Edit) 477

Resource Data (Enter/Edit) 479

Update Assessment Status to ‘COMPLETE’ 480

Alert Coder Regarding Coding Issues 480a

Print a Surgery Risk Assessment 481

Update Assessment Completed/Transmitted in Error 487

List of Surgery Risk Assessments 489

Print 30 Day Follow-up Letters 503

Exclusion Criteria (Enter/Edit) 507

Monthly Surgical Case Workload Report 509

M&M Verification Report 513

Update 1-Liner Case 519

Queue Assessment Transmissions 521

##### Alert Coder Regarding Coding Issues 522a

vi Surgery V. 3.0 User Manual September 2011

Example 2: Schedule Operation for a Concurrent Case

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

Select Patient: **SURPATIENT,EIGHTEEN**

09-14-54

000223334

The following cases are requested for SURPATIENT,EIGHTEEN:

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

Select Operation Request: **1**

Case Information:

CAROTID ARTERY ENDARTERECTOMY By SURSURGEON,ONE

Case # 262 STANDBY

On SURPATIENT,EIGHTEEN

\* Concurrent Case # 263 AORTO CORONARY BYPASS GRAFT

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

Display of Available Operating Room Time

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

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

ROOM OR1 OR2 OR3 OR4 OR5

6AM

7 8 9 10 11 12 13 14 15 16 17 18 19 20

| | | | | | | | | | | | | | |

| |card|card|card|card|card|card|card|card|card| | | | |

| |orth|orth|orth|orth|orth|orth| | | | | | | |

| | | | | | | | | | | | | | |

| | | | | | | | | | | | | | |

Schedule a Case for which Operating Room ? **OR2** Reserve from what time ? (24HR:NEAREST 15 MIN): **7:15** Reserve to what time ? (24HR:NEAREST 15 MIN): **12:30**

Principal Anesthetist: **SURANESTHETIST,ONE**

Anesthesiologist Supervisor: **SURANESTHETIST,TWO**

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

Select Patient:

**Schedule Unrequested Operations**

### [SROSRES]

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

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

##### Prompts that require a response before the user can continue with this option are listed below. "Schedule Procedure for which Date ?"

"Select Patient:"

##### "Schedule a case for which operating Room ?"

"Reserve from what time ? (24HR:NEAREST 15 MIN):" "Reserve to what time ? (24HR:NEAREST 15 MIN):" “Desired Procedure Date:”

##### "Surgeon:" "Attending Surgeon:" "Surgical Specialty:"

"Principal Operative Procedure:" "Principal Preoperative Diagnosis:"

64 Surgery V. 3.0 User Manual September 2011

**Entering Preoperative Information**

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

Example: Schedule an Unrequested Operation

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

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

Select Patient: **SURPATIENT,THREE**

12-19-53

000212453

Display of Available Operating Room Time

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

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

ROOM OR1 OR2 OR3 OR4 OR5

6AM

7 8 9 10 11 12 13 14 15 16 17 18 19 20

| | | | | | | | | | | | | | |

| | | | | | | | | | | | | | |

| | | | | | | | | | | | | | |

| | | | | | | | | | | | | | |

| | | | | | | | | | | | | | |

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

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

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

SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

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

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

Desired Procedure Date: **7 18 05** (JUL 18, 2005) Surgeon: **SURSURGEON,ONE**

Attending Surgeon: **SURSURGEON,TWO**

Surgical Specialty: **54** ORTHOPEDICS ORTHOPEDICS 54

Principal Operative Procedure: **SHOULDER ARTHROPLASTY-PROSTHESIS**

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

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field.

The Indications for Operation field can be updated later if necessary.

Press RETURN to continue **<Enter>**

SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

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

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

Principal Anesthetist: **SURANESTHETIST,ONE**

Anesthesiologist Supervisor: **SURANESTHETIST,TWO**

SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION

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

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

Principal Procedure: SHOULDER ARTHROPLASTY-PROSTHESIS

Planned Principal Procedure Code (CPT): **23470** ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIART Brief Clinical History:

1>**CHRONIC DEBILITATING PAIN. X-RAY SHOWS SEVERE**

2>**DEGENERATIVE OSTEOARTHRITIS.**

3>**<Enter>**

EDIT Option: **<Enter>**

66 Surgery V. 3.0 User Manual September 2011

## Schedule Unrequested Concurrent Cases

### [SRSCHDC]

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

**Required Prompts**

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

#### Storing the Request Information

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

#### Updating the Preoperative Information Later

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

Example: Schedule Unrequested Concurrent Cases

Select Schedule Operations Option: **CON** Schedule Unrequested Concurrent Cases

Schedule Concurrent Cases for which Patient ? **SURPATIENT,EIGHT**

000370555

06-04-35

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

Display of Available Operating Room Time

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

Schedule a case for which operating Room ? **OR2**

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

FIRST CONCURRENT CASE

SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

SURPATIENT,EIGHT (000-37-0555) JUL 25, 2005

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

Desired Procedure Date: **07 25 2005** (JUL 25, 2005) Surgeon: **SURSURGEON,ONE**

Attending Surgeon: **SURSURGEON,ONE**

Surgical Specialty: **62** PERIPHERAL VASCULAR PERIPHERAL VASCULAR 62

Principal Operative Procedure: **CAROTID ARTERY ENDARTERECTOMY**

Principal Preoperative Diagnosis: **CAROTID ARTERY STENOSIS**

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field.

The Indications for Operation field can be updated later if necessary.

Press RETURN to continue **<Enter>**

SECOND CONCURRENT CASE

SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

SURPATIENT,EIGHT (000-37-0555) JUL 25, 2005

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

Desired Procedure Date: **07 25 2005** (JUL 25, 2005) Surgeon: **SURSURGEON,TWO**

Attending Surgeon: **SURSURGEON,ONE**

Surgical Specialty: **58** THORACIC SURGERY (INC. CARDIAC SURG.) THORACIC SURGERY (INC. CARDIAC SURG.) 58

Principal Operative Procedure: **AORTO CORONARY BYPASS GRAFT**

Principal Preoperative Diagnosis: **UNSTABLE ANGINA**

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field.

The Indications for Operation field can be updated later if necessary.

Press RETURN to continue **<Enter>**

70 Surgery V. 3.0 User Manual September 2011

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

Select Surgery Menu Option: **O** Operation Menu

Select Patient: **SURPATIENT,SIX** 04-04-30 000098797

NSC VETERAN

SURPATIENT,SIX 000-09-8797

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

Select Operation: **<Enter>**

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

##### enter information for the case,

1. review the information already entered, or
2. delete the case.

SURPATIENT,SIX 000-09-8797

01-25-92

ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)

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

Select Number: 1//

#### Entering Information

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

Example: Enter Information

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

000212453

SURPATIENT,THREE 000-21-2453

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

Select Operation: **2**

SURPATIENT,THREE 000-21-2453

08-15-88

SHOULDER ARTHROPLASTY (NOT COMPLETE)

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

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

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

SURPATIENT,THREE (000-21-2453) Case #14 – MAR 12,1999

I Operation Information

SS Surgical Staff

OS Operation Startup

O Operation

PO Post Operation

PAC Enter PAC(U) Information OSS Operation (Short Screen)

TO Time Out Verified Utilizing Checklist

V Surgeon's Verification of Diagnosis & Procedures A Anesthesia for an Operation Menu ...

OR Operation Report

AR Anesthesia Report

NR Nurse Intraoperative Report TR Tissue Examination Report

R Enter Referring Physician Information RP Enter Irrigations and Restraints

M Medications (Enter/Edit) B Blood Product Verification

Select Operation Menu Option:

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

#### Reviewing Information

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

Example: Review Information

Select Surgery Menu Option: **O**peration Menu Select Patient: **SURPATIENT,THREE**

12-19-53

000212453

SURPATIENT,THREE 000-21-2453

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

SURPATIENT,THREE 000-21-2453

08-15-88

SHOULDER ARTHROPLASTY (NOT COMPLETE)

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

Select Number: 1// **2**

\*\* REVIEW \*\* CASE #14 SURPATIENT,THREE

PAGE 1 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

TIME PAT IN HOLD AREA: AUG 15, 1999 AT 07:40

TIME PAT IN OR:

AUG 15, 1999 AT 08:00

ANES CARE TIME BLOCK: (MULTIPLE)

TIME OPERATION BEGAN: AUG 15, 1999 AT 09:00

SPECIMENS: CULTURES: THERMAL UNIT:

ELECTROCAUTERY UNIT: ESU COAG RANGE:

ESU CUTTING RANGE:

(WORD PROCESSING) (WORD PROCESSING) (MULTIPLE)

TIME TOURNIQUET APPLIED: (MULTIPLE) PROSTHESIS INSTALLED: (MULTIPLE) REPLACEMENT FLUID TYPE: (MULTIPLE)

IRRIGATION: MEDICATIONS:

(MULTIPLE) (MULTIPLE)

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

\*\* REVIEW \*\* CASE #14 SURPATIENT,THREE

PAGE 2 OF 3

1

2

3

4

5

6

7

8

9

10

11

SPONGE COUNT CORRECT (Y/N): YES SHARPS COUNT CORRECT (Y/N): YES INSTRUMENT COUNT CORRECT (Y/N): SPONGE, SHARPS, & INST COUNTER: YES COUNT VERIFIER:

SEQUENTIAL COMPRESSION DEVICE:

LASER UNIT: CELL SAVER:

(MULTIPLE) (MULTIPLE)

NURSING CARE COMMENTS: (WORD PROCESSING) (DATA)

PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE L SHOULDER PRIN PRE-OP ICD DIAGNOSIS CODE:

12

13

14

15

PRINCIPAL PROCEDURE:

SHOULDER ARTHROPLASTY

PLANNED PRIN PROCEDURE CODE :

OTHER PROCEDURES:

(MULTIPLE)

INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

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

\*\* REVIEW \*\* CASE #14 SURPATIENT,THREE

PAGE 3 OF 3

1 BRIEF CLIN HISTORY:

(WORD PROCESSING)

Enter Screen Server Function:

#### Deleting a Surgery Case

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

Example: How to Delete A Case

Select Surgery Menu Option: **O**peration Menu Select Patient: **SURPATIENT,NINE** 12-09-51

000345555

NSC VETERAN

SURPATIENT,NINE 000-34-5555

1. 04-26-05 CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)
2. 12-20-05 REMOVE FACIAL LESIONS (NOT COMPLETE)
3. ENTER NEW SURGICAL CASE Select Operation: **2**

SURPATIENT,NINE 000-34-5555

12-20-05

REMOVE FACIAL LESIONS (NOT COMPLETE)

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

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

Deleting Operation...

#### Entering a New Surgical Case

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

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

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

#### Prompts that require a response include:

##### "Select the Date of Operation:" “Desired Procedure Date:”

"Enter the Principal Operative Procedure:" "Principal Preoperative Diagnosis:" "Select Surgeon:"

##### "Attending Surgeon:" "Select Surgical Specialty:"

**Example: Entering a New Surgical Case**

Select Surgery Menu Option: **O** Operation Menu Select Patient: **SURPATIENT,SIX** 04-04-30

000098797

SURPATIENT,SIX 000-09-8797

1. ENTER NEW SURGICAL CASE Select Operation: **1**

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

Enter the Principal Operative Procedure: **APPENDECTOMY**

Principal Preoperative Diagnosis: **APPENDICITIS**

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field.

The Indications for Operation field can be updated later if necessary.

Press Return to continue **<Enter>**

Select Surgeon: **SURSURGEON,ONE** Attending Surgeon: **SURSURGEON,TWO** Select Surgical Specialty: **50**

GENERAL(OR WHEN NOT DEFINED BELOW)

Brief Clinical History:

**1>PATIENT WITH 5-DAY HISTORY OF INCREASING ABDOMINAL**

**2>PAIN, ONSET OF FEVER IN LAST 24 HOURS. REBOUND**

**3>TENDERNESS IN RIGHT LOWER QUAD. NAUSEA AND**

**4>VOMITING FOR 3 DAYS.**

**5><Enter>**

EDIT Option: **<Enter>**

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

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH// **<Enter>** TYPE & CROSSMATCH Select REQ BLOOD KIND: CPDA-1 RED BLOOD CELLS// **<Enter>**

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

Units Required: **2**

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

**Principal Preoperative Diagnosis: APPENDICITIS//** <Enter>

Prin Pre-OP ICD Diagnosis Code: **540.9** 540.9 ACUTE APPENDICITIS NOS

COM

PLICATION/COMORBIDITY ACTIVE

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

Hospital Admission Status: I// **<Enter>** INPATIENT Case Schedule Type: **EM** EMERGENCY

First Assistant: **SURSURGEON,ONE** Second Assistant: **SURSURGEON,FOUR** Requested Postoperative Care: **W** WARD Case Schedule Order: **<Enter>**

Select SURGERY POSITION: SUPINE// **<Enter>**

Surgery Position: SUPINE// **<Enter>** Requested Anesthesia Technique: **G** GENERAL Request Frozen Section Tests (Y/N): **N** NO Requested Preoperative X-Rays: **<Enter>** Intraoperative X-Rays (Y/N): **N** NO

Request Medical Media: **N** NO

Request Clean or Contaminated: **C** CLEAN Select REFERRING PHYSICIAN: **<Enter>**

General Comments: 1> **<Enter>**

SPD Comments:

No existing text Edit? NO// **<Enter>**

\*\* NEW SURGERY \*\* CASE #185 SURPATIENT,SIX

PAGE 1 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

PRINCIPAL PROCEDURE: APPENDECTOMY OTHER PROCEDURES: (MULTIPLE) PLANNED PRIN PROCEDURE CODE:

PRINCIPAL PRE-OP DIAGNOSIS: APPENDICITIS PRIN PRE-OP ICD DIAGNOSIS CODE: 540.9 OTHER PREOP DIAGNOSIS: (MULTIPLE)

IN/OUT-PATIENT STATUS: INPATIENT PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: EMERGENCY

SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

SURGEON: FIRST ASST: SECOND ASST: ATTEND SURG:

REQ POSTOP CARE:

SURSURGEON,ONE SURSURGEON,ONE SURSURGEON,FOUR SURSURGEON,TWO WARD

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

\*\* NEW SURGERY \*\* CASE #185 SURPATIENT,SIX

PAGE 2 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

CASE SCHEDULE ORDER: SURGERY POSITION:

(MULTIPLE)(DATA)

REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT: REQ PREOP X-RAY:

NO

INTRAOPERATIVE X-RAYS: NO REQUEST BLOOD AVAILABILITY: YES

CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH REQ BLOOD KIND: (MULTIPLE)(DATA)

REQ PHOTO:

NO

REQ CLEAN OR CONTAMINATED: CLEAN REFERRING PHYSICIAN: (MULTIPLE)

GENERAL COMMENTS:

(WORD PROCESSING)

INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA) BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)

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

\*\* NEW SURGERY \*\* CASE #185 SURPATIENT,SIX

PAGE 3 OF 3

1 SPD COMMENTS

Enter Screen Server Function:

**Example: Operation Startup**

Select Operation Menu Option: **OS** Operation Startup

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 1 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

DATE OF OPERATION:

DEC 06, 2004 AT 08:00

PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER PRIN PRE-OP ICD DIAGNOSIS CODE:

OTHER PREOP DIAGNOSIS: (MULTIPLE)

OPERATING ROOM: SURGERY SPECIALTY: MAJOR/MINOR:

REQ POSTOP CARE:

OR2 ORTHOPEDICS

WARD

CASE SCHEDULE TYPE:

ELECTIVE

REQ ANESTHESIA TECHNIQUE: GENERAL PATIENT EDUCATION/ASSESSMENT: CANCEL DATE:

CANCEL REASON: CANCELLATION AVOIDABLE:

DELAY CAUSE:

(MULTIPLE)

Enter Screen Server Function: **7;11**

Major or Minor: **J** MAJOR

Preoperative Patient Education: **Y** YES

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 1 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

DATE OF OPERATION:

DEC 06, 2004 AT 08:00

PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER PRIN PRE-OP ICD DIAGNOSIS CODE:

OTHER PREOP DIAGNOSIS: (MULTIPLE)

OPERATING ROOM: SURGERY SPECIALTY: MAJOR/MINOR:

REQ POSTOP CARE: CASE SCHEDULE TYPE:

OR2 ORTHOPEDICS MAJOR

WARD ELECTIVE

REQ ANESTHESIA TECHNIQUE: GENERAL PATIENT EDUCATION/ASSESSMENT: YES CANCEL DATE:

CANCEL REASON: CANCELLATION AVOIDABLE:

DELAY CAUSE:

(MULTIPLE)

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

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 2 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

ASA CLASS:

PREOP MOOD:

PREOP CONSCIOUS:

PREOP SKIN INTEG:

TRANS TO OR BY:

HAIR REMOVAL BY:

HAIR REMOVAL METHOD:

HAIR REMOVAL COMMENTS: (WORD PROCESSING) SKIN PREPPED BY (1):

SKIN PREPPED BY (2): SKIN PREP AGENTS: SECOND SKIN PREP AGENT:

SURGERY POSITION:

(MULTIPLE)(DATA)

RESTR & POSITION AIDS: (MULTIPLE)(DATA) ELECTROGROUND POSITION:

Enter Screen Server Function: **A**

ASA Class: **2** 2

2-MILD DISTURB.

Preoperative Mood: **?**

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

Screen prevents selection of inactive entries.

Answer with PATIENT MOOD NAME, or CODE Choose from:

AGITATED ANGRY ANXIOUS APATHETIC DEPRESSED RELAXED

AG

ANG

ANX

AP D

R

TESTY AND IRRATE, SLEEPY

BUF

Preoperative Mood: **ANX**IOUS ANX

Preoperative Consciousness: **AO** ALERT-ORIENTED AO Preoperative Skin Integrity: **INT**ACT I Transported to O.R. By: **PACU** BED

Preop Surgical Site Hair Removal by: **SURNURSE,TWO** Surgical Site Hair Removal Method: **N** NO HAIR REMOVED Hair Removal Comments:

No existing text Edit? NO// **<Enter>**

Skin Prepped By: **<Enter>**

Skin Prepped By (2): **<Enter>**

Skin Preparation Agent: **HIB**ICLENS HI Second Skin Preparation Agent: **<Enter>** Electroground Placement: **RAT** RIGHT ANT THIGH

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 1

SURGERY POSITION

1

2

SURGERY POSITION: NEW ENTRY

SUPINE

Enter Screen Server Function: **2**

Select SURGERY POSITION: **SEMISUPINE**

SURGERY POSITION: SEMISUPINE// **<Enter>**

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 1

SURGERY POSITION (SEMISUPINE)

1

2

SURGERY POSITION: TIME PLACED:

SEMISUPINE

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

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 1 OF 1

SURGERY POSITION

1

2

3

SURGERY POSITION: SURGERY POSITION: NEW ENTRY

SUPINE SEMISUPINE

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

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 1 OF 1

RESTR & POSITION AIDS

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

Enter Screen Server Function: **2**

Select RESTR & POSITION AIDS: **FOAM PADS**

RESTR & POSITION AIDS: FOAM PADS// **<Enter>**

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 1 OF 1

RESTR & POSITION AIDS (FOAM PADS)

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

Enter Screen Server Function: **2**

Applied By: **SURNURSE,TWO**

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 2 OF 3

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

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

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 3 OF 3

1 ELECTROGROUND POSITION (2):

Enter Screen Server Function: **1**

Electroground Position (2): **LF** LEFT FLANK

\*\* STARTUP \*\* CASE #159 SURPATIENT,THREE

PAGE 3 OF 3

1 ELECTROGROUND POSITION (2):

Enter Screen Server Function:

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

## Operation

### [SROMEN-OP]

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

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

**Field Information**

##### The following are fields that correspond to the Operation entries.

|  |  |
| --- | --- |
| **Field Name** | **Definition** |
| TIME OPERATION BEGAN | The user should check his or her institution’s policy concerning an operation’s start time. In some institutions, this may be the  time of first incision. |

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

Example: Operation Option: Entering Information

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

TIME PAT IN HOLD AREA: TIME PAT IN OR:

ANES CARE TIME BLOCK: TIME OPERATION BEGAN: SPECIMENS:

CULTURES: THERMAL UNIT:

ELECTROCAUTERY UNIT: ESU COAG RANGE:

ESU CUTTING RANGE:

(MULTIPLE)

(WORD PROCESSING) (WORD PROCESSING) (MULTIPLE)

TIME TOURNIQUET APPLIED: (MULTIPLE) PROSTHESIS INSTALLED: (MULTIPLE) REPLACEMENT FLUID TYPE: (MULTIPLE)

IRRIGATION: MEDICATIONS:

(MULTIPLE) (MULTIPLE)

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

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

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 1

REPLACEMENT FLUID TYPE

1 NEW ENTRY

Enter Screen Server Function: **1**

Select REPLACEMENT FLUID TYPE: **RINGERS LACTATED SOLUTION**

REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION// **<Enter>**

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 1

REPLACEMENT FLUID TYPE (RINGERS LACTATED SOLUTION)

1. REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2. QTY OF FLUID (ml):
3. SOURCE ID:
4. VA IDENT:
5. REPLACEMENT FLUID COMMENTS: (WORD PROCESSING)

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

Quantity of Fluid (ml): **1000**

Source Identification Number: **TRAVENOL**

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 1

REPLACEMENT FLUID TYPE (RINGERS LACTATED SOLUTION)

1

2

3

4

5

REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION

QTY OF FLUID (ml): SOURCE ID:

VA IDENT:

1000

TRAVENOL

REPLACEMENT FLUID COMMENTS: (WORD PROCESSING)

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

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 1

REPLACEMENT FLUID TYPE

1. REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2. NEW ENTRY

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

\*\* OPERATION \*\*

IRRIGATION

CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 1

1 NEW ENTRY

Enter Screen Server Function: **1**

Select IRRIGATION: **NORMAL** SALINE IRRIGATION: NORMAL SALINE// **<Enter>**

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 1

IRRIGATION (NORMAL SALINE)

1. IRRIGATION:
2. TIME:

NORMAL SALINE (MULTIPLE)

Enter Screen Server Function: **2**

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1

IRRIGATION (NORMAL SALINE) TIME

1 NEW ENTRY

Enter Screen Server Function: **1**

Select TIME: **9:40** MAR 12, 1999@09:40 TIME: MAR 12, 1999@09:40// **<Enter>**

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1

IRRIGATION (NORMAL SALINE) TIME (2930601.094)

1

2

3

TIME:

AMOUNT USED: PROVIDER:

MAR 12, 1999 AT 09:40

Enter Screen Server Function: **2:3** Amount of Solution Used: **1000** Person Responsible: **SURNURSE,THREE**

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 1

IRRIGATION (NORMAL SALINE) TIME (2930601.094)

1. TIME:
2. AMOUNT USED:
3. PROVIDER:

MAR 12, 1999 AT 09:40

1000

SURNURSE,THREE

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

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 1

IRRIGATION (NORMAL SALINE) TIME

1

2

TIME:

NEW ENTRY

MAR 12, 1999 AT 09:40

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

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 1

IRRIGATION (NORMAL SALINE)

1. IRRIGATION:
2. TIME:

NORMAL SALINE (MULTIPLE)(DATA)

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

\*\* OPERATION \*\*

IRRIGATION

CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 1

1

2

IRRIGATION: NEW ENTRY

NORMAL SALINE

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

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 1 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

TIME PAT IN HOLD AREA: TIME PAT IN OR:

ANES CARE TIME BLOCK: TIME OPERATION BEGAN: SPECIMENS:

CULTURES: THERMAL UNIT:

ELECTROCAUTERY UNIT: ESU COAG RANGE:

ESU CUTTING RANGE:

MAR 12, 1999 AT 08:50

MAR 12, 1999 AT 09:00 (MULTIPLE)

(WORD PROCESSING) (WORD PROCESSING) (MULTIPLE)

TIME TOURNIQUET APPLIED: (MULTIPLE) PROSTHESIS INSTALLED: (MULTIPLE) REPLACEMENT FLUID TYPE: (MULTIPLE)

IRRIGATION: MEDICATIONS:

(MULTIPLE) (MULTIPLE)

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

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 2 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

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

SEQUENTIAL COMPRESSION DEVICE:

LASER UNIT: CELL SAVER:

(MULTIPLE) (MULTIPLE)

NURSING CARE COMMENTS: (WORD PROCESSING) PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS PRIN PRE-OP ICD DIAGNOSIS CODE:

PRINCIPAL PROCEDURE:

CHOLECYSTECTOMY

PLANNED PRIN PROCEDURE CODE :

OTHER PROCEDURES:

(MULTIPLE)

INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function: **1:4**

Final Sponge Count Correct (Y/N): **Y** YES Final Sharps Count Correct (Y/N): **Y** YES Final Instrument Count Correct (Y/N): **Y** YES

Person Responsible for Final Counts: **SURNURSE,THREE**

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 2 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

SPONGE COUNT CORRECT (Y/N): YES SHARPS COUNT CORRECT (Y/N): YES INSTRUMENT COUNT CORRECT (Y/N): YES

SPONGE, SHARPS, & INST COUNTER: **SURNURSE,THREE**

COUNT VERIFIER:

SEQUENTIAL COMPRESSION DEVICE:

LASER UNIT:

CELL SAVER:

NURSING CARE COMMENTS:

(MULTIPLE) (MULTIPLE)

(WORD PROCESSING)

PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS PRIN PRE-OP ICD DIAGNOSIS CODE:

PRINCIPAL PROCEDURE:

CHOLECYSTECTOMY

PLANNED PRIN PROCEDURE CODE :

OTHER PROCEDURES:

(MULTIPLE)

INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function: **9**

NURSING CARE COMMENTS:

**1>Admitted with prosthesis in place, left eye is artificial eye. 2>Foam pads applied to elbows and knees. Pillow placed**

**3>under knees.**

**4><Enter>**

EDIT Option: **<Enter>**

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 2 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

SPONGE COUNT CORRECT (Y/N): YES SHARPS COUNT CORRECT (Y/N): YES INSTRUMENT COUNT CORRECT (Y/N): YES

SPONGE, SHARPS, & INST COUNTER: **SURNURSE,THREE**

COUNT VERIFIER:

SEQUENTIAL COMPRESSION DEVICE:

LASER UNIT: CELL SAVER:

(MULTIPLE) (MULTIPLE)

NURSING CARE COMMENTS: (WORD PROCESSING)(DATA) PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS

PRIN PRE-OP ICD DIAGNOSIS CODE:

PRINCIPAL PROCEDURE:

CHOLECYSTECTOMY

PLANNED PRIN PROCEDURE CODE :

OTHER PROCEDURES:

(MULTIPLE)

INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

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

\*\* OPERATION \*\* CASE #173 SURPATIENT,TWENTY

PAGE 3 OF 3

1 BRIEF CLIN HISTORY:

(WORD PROCESSING)

Enter Screen Server Function:

## Enter PAC(U) Information

### [SROMEN-PACU]

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

Example: Entering PAC(U) Information

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

\*\* PACU \*\* CASE #145 SURPATIENT,NINE

PAGE 1 OF 1

1. ADMIT PAC(U) TIME:
2. PAC(U) ADMIT SCORE:
3. PAC(U) DISCH TIME:
4. PAC(U) DISCH SCORE:

Enter Screen Server Function: **1:4**

PAC(U) Admission Time: **13:00** (APR 26, 1999@13:00)

PAC(U) Admission Score: **10**

PAC(U) Discharge Date/Time: **14:00** (APR 26, 1999@14:00) PAC(U) Discharge Score: **10**

\*\* PACU \*\* CASE #145 SURPATIENT,NINE

PAGE 1 OF 1

1. ADMIT PAC(U) TIME: APR 26, 1999 AT 13:00
2. PAC(U) ADMIT SCORE: 10
3. PAC(U) DISCH TIME: APR 26, 1999 AT 14:00
4. PAC(U) DISCH SCORE: 10

Enter Screen Server Function:

## Operation (Short Screen)

### [SROMEN-OUT]

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

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

Example: Operation Short Screen

Select Operation Menu Option: **OSS** Operation (Short Screen)

\*\* SHORT SCREEN \*\* CASE #186 SURPATIENT,TWELVE

PAGE 1 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

DATE OF OPERATION:

MAR 09, 2005

IN/OUT-PATIENT STATUS: OUTPATIENT

SURGEON:

SURSURGEON,FOUR

PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE PRIN PRE-OP ICD DIAGNOSIS CODE:

OTHER PREOP DIAGNOSIS: (MULTIPLE)

PRINCIPAL PROCEDURE:

REMOVE FACIAL LESIONS

PLANNED PRIN PROCEDURE CODE: 17000

OTHER PROCEDURES: HAIR REMOVAL BY: HAIR REMOVAL METHOD:

HAIR REMOVAL COMMENTS: TIME PAT IN OR:

TIME OPERATION BEGAN: TIME OPERATION ENDS:

(MULTIPLE)

(WORD PROCESSING)

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

Time Patient In the O.R.: **13:00** (MAR 09, 2005@13:00) Time the Operation Began: **13:10** (MAR 09, 2005@13:10) Time the Operation Ends: **13:36** (MAR 09, 2005@13:36)

\*\* SHORT SCREEN \*\* CASE #186 SURPATIENT,TWELVE

PAGE 1 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

DATE OF OPERATION:

MAR 09, 2005

IN/OUT-PATIENT STATUS: OUTPATIENT

SURGEON:

SURSURGEON,FOUR

PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE PRIN PRE-OP ICD DIAGNOSIS CODE:

OTHER PREOP DIAGNOSIS: (MULTIPLE)

PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS PLANNED PRIN PROCEDURE CODE: 17000

OTHER PROCEDURES: HAIR REMOVAL BY: HAIR REMOVAL METHOD:

HAIR REMOVAL COMMENTS: TIME PAT IN OR:

(MULTIPLE)

(WORD PROCESSING) MAR 09, 2005 AT 13:00

TIME OPERATION BEGAN: MAR 09, 2005 at 13:10

TIME OPERATION ENDS: MAR 09, 2005 AT 13:36

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

\*\* SHORT SCREEN \*\* CASE #186 SURPATIENT,TWELVE

PAGE 2 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

TIME PAT OUT OR: IV STARTED BY: OR CIRC SUPPORT:

OR SCRUB SUPPORT: OPERATING ROOM:

(MULTIPLE) (MULTIPLE)

FIRST ASST:

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

SURGERY SPECIALTY: WOUND CLASSIFICATION: ATTEND SURG: ATTENDING CODE:

GENERAL(OR WHEN NOT DEFINED BELOW)

SURSURGEON,TWO

Enter Screen Server Function: **1**;5;15

Time Patient Out of the O.R.: **13:40** (MAR 09, 2005@13:40) Operating Room: **OR1**

Attending Code: **A** LEVEL A: ATTENDING DOING THE OPERATION A

The staff practitioner performs the case, but may be assisted by a resident.

\*\* SHORT SCREEN \*\* CASE #186 SURPATIENT,TWELVE

PAGE 2 OF 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

TIME PAT OUT OR: IV STARTED BY: OR CIRC SUPPORT:

OR SCRUB SUPPORT: OPERATING ROOM: FIRST ASST:

MAR 12, 2006 AT 13:40

(MULTIPLE) (MULTIPLE) OR1

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

SURGERY SPECIALTY: WOUND CLASSIFICATION: ATTEND SURG: ATTENDING CODE:

GENERAL(OR WHEN NOT DEFINED BELOW)

SURSURGEON,TWO

LEVEL A: ATTENDING DOING THE OPERATION

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

\*\* SHORT SCREEN \*\* CASE #186 SURPATIENT,TWELVE

PAGE 3 OF 3

1

2

3

4

5

6

7

8

9

10

11

SPECIMENS: CULTURES:

NURSING CARE COMMENTS: ASA CLASS:

PRINC ANESTHETIST: ANESTHESIA TECHNIQUE: ANES CARE TIME BLOCK: DELAY CAUSE:

CANCEL DATE: CANCEL REASON:

CANCELLATION COMMENTS:

(WORD PROCESSING) (WORD PROCESSING)

(WORD PROCESSING) (DATA)

SURANESTHETIST,FOUR (MULTIPLE) (MULTIPLE) (MULTIPLE)

Enter Screen Server Function: **3:4**

Nursing Care Comments:

**1>PATIENT ARRIVED AMBULATORY FROM AMBULATORY**

**2>SURGERY UNIT. DISCHARGED VIA WHEELCHAIR, AWAKE,**

**3>ALERT, ORIENTED.**

**4><Enter>**

EDIT Option: **<Enter>**

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

\*\* SHORT SCREEN \*\* CASE #186 SURPATIENT,TWELVE

PAGE 3 OF 3

1

2

3

4

5

6

7

8

9

10

11

SPECIMENS: CULTURES:

NURSING CARE COMMENTS: ASA CLASS:

PRINC ANESTHETIST: ANESTHESIA TECHNIQUE: ANES CARE TIME BLOCK: DELAY CAUSE:

CANCEL DATE: CANCEL REASON:

CANCELLATION COMMENTS:

(WORD PROCESSING) (WORD PROCESSING)

(WORD PROCESSING) (DATA) 3-SEVERE DISTURB.

SURANESTHETIST,FOUR (MULTIPLE) (MULTIPLE) (MULTIPLE)

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

## Time Out Verified Utilizing Checklist

### [SROMEN-VERF]

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

Example: Time Out Verified Utilizing Checklist

Select Operation Menu Option: **Time Out Verified Utilizing Checklist**

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

1

2

3

4

5

6

7

8

9

10

11

12

13

14

CONFIRM PATIENT IDENTITY: PROCEDURE TO BE PERFORMED: SITE OF PROCEDURE:

VALID CONSENT FORM: CONFIRM PATIENT POSITION: MARKED SITE CONFIRMED:

PREOPERATIVE IMAGES CONFIRMED: CORRECT MEDICAL IMPLANTS: AVAILABILITY OF SPECIAL EQUIP: ANTIBIOTIC PROPHYLAXIS: APPROPRIATE DVT PROPHYLAXIS: BLOOD AVAILABILITY:

CHECKLIST COMMENT: CHECKLIST CONFIRMED BY:

(WORD PROCESSING)

Enter Screen Server Function: **A**

Confirm Correct Patient Identity: **Y** YES Confirm Procedure To Be Performed: **Y** YES

Confirm Site of Procedure, Including Laterality: **Y** YES Confirm Valid Consent Form: **Y** YES

Confirm Patient Position: N **NO**

Confirm Proc. Site has been Marked Appropriately and the Site of the Mark is Vis ible After Prep: **Y** YES

Pertinent Medical Images Have Been Confirmed: **Y** YES Correct Medical Implant(s) is Available: **Y** YES Availability of Special Equipment: **Y** YES Appropriate Antibiotic Prophylaxis: **Y** YES Appropriate Deep Vein Thrombosis Prophylaxis: **Y** YES Blood Availability: **Y** YES

Checklist Comment: No existing text Edit? NO// **<Enter>**

Checklist Confirmed By: **SURNURSE,FIVE**

Checklist Comments should be entered when a "NO" response is entered for any of the Time Out Verified Utilizing Checklist fields.

Do you want to enter Checklist Comment ? YES//

Checklist Comment: No existing text Edit? NO//

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

1

2

3

4

5

6

7

8

9

10

11

12

CONFIRM PATIENT IDENTITY: YES PROCEDURE TO BE PERFORMED: YES

SITE OF PROCEDURE: VALID CONSENT FORM:

YES YES

CONFIRM PATIENT POSITION: YES MARKED SITE CONFIRMED: YES PREOPERATIVE IMAGES CONFIRMED: YES CORRECT MEDICAL IMPLANTS: YES AVAILABILITY OF SPECIAL EQUIP: YES ANTIBIOTIC PROPHYLAXIS: YES APPROPRIATE DVT PROPHYLAXIS: YES

BLOOD AVAILABILITY:

YES

13

14

CHECKLIST COMMENT:

(WORD PROCESSING)

CHECKLIST CONFIRMED BY: **SURNURSE,FIVE**

Enter Screen Server Function:

##### At the bottom of the first screen is the prompt, "Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit:". The *Nurse Intraoperative Report* functions, accessed by entering **A** at the prompt, allow the user to edit the report, to view or print the report, or to electronically sign the report.

Example: First page of the Nurse Intraoperative Report

Select Operation Menu Option: **NR** Nurse Intraoperative Report

MEDICAL RECORD

SURPATIENT,TEN (000-12-3456)

NURSE INTRAOPERATIVE REPORT - CASE #267226

PAGE 1

Operating Room: BO OR1

Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30 Patient in OR: JUL 12, 2004 08:00

Operation Begin: JUL 12, 2004 08:58 Operation End: JUL 12, 2004 12:10

Surgeon in OR: JUL 12, 2004 07:55 Patient Out OR: JUL 12, 2004 12:45

Major Operations Performed: Primary: MVR

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

Surgeon: SURSURGEON,THREE Attend Surg: SURSURGEON,THREE

Anesthetist: SURANESTHETIST,SEVEN

First Assist: SURSURGEON,FOUR Second Assist: N/A

Assistant Anesth: N/A

Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit: **A**

##### After the user enters an **A** at the prompt, the *Nurse Intraoperative Report* functions are displayed. The following examples demonstrate how these three functions are accessed and how they operate.

If the user enters a **1**, the Nurse Intraoperative Report data can be edited.

Example: Editing the Nurse Intraoperative Report

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

Nurse Intraoperative Report Functions:

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

Select number: 2// **1**

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

1

2

3

4

5

6

7

8

9

10

11

12

13

14

CONFIRM PATIENT IDENTITY: YES PROCEDURE TO BE PERFORMED: YES

SITE OF PROCEDURE: VALID CONSENT FORM:

YES YES

CONFIRM PATIENT POSITION: YES MARKED SITE CONFIRMED: PREOPERATIVE IMAGING CONFIRMED: CORRECT MEDICAL IMPLANTS: YES AVAILABILITY OF SPECIAL EQUIP: YES ANTIBIOTIC PROPHYLAXIS: YES APPROPRIATE DVT PROPHYLAXIS: YES

BLOOD AVAILABILITY: CHECKLIST COMMENT:

YES

(WORD PROCESSING)

CHECKLIST CONFIRMED BY: SURNURSE,FIVE

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

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

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

SPONGE COUNT CORRECT (Y/N): YES SHARPS COUNT CORRECT (Y/N): YES INSTRUMENT COUNT CORRECT (Y/N): YES

SPONGE, SHARPS, & INST COUNTER: SURNURSE,FIVE COUNT VERIFIER:

TIME PAT IN HOLD AREA: TIME PAT IN OR:

TIME OPERATION BEGAN: TIME OPERATION ENDS: SURG PRESENT TIME: TIME PAT OUT OR: PRINCIPAL PROCEDURE: OTHER PROCEDURES: WOUND CLASSIFICATION: OP DISPOSITION:

JUL 12, 2004 AT 07:30

JUL 12, 2004 AT 08:00

JUL 12, 2004 at 08:58

JUL 12, 2004 AT 12:30

CHOLECYSTECTOMY (MULTIPLE) CLEAN

Enter Screen Server Function: **14**

Wound Classification: CLEAN// **CONTAMINATED** CONTAMINATED

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

1

2

3

4

5

6

7

8

9

10

SPONGE COUNT CORRECT (Y/N): YES SHARPS COUNT CORRECT (Y/N): YES INSTRUMENT COUNT CORRECT (Y/N): YES

SPONGE, SHARPS, & INST COUNTER: SURNURSE,FIVE COUNT VERIFIER:

TIME PAT IN HOLD AREA: TIME PAT IN OR:

TIME OPERATION BEGAN: TIME OPERATION ENDS: SURG PRESENT TIME:

JUL 12, 2004 AT 07:30

JUL 12, 2004 AT 08:00

JUL 12, 2004 at 08:58

JUL 12, 2004 AT 12:30

11

12

13

14

15

TIME PAT OUT OR: PRINCIPAL PROCEDURE: OTHER PROCEDURES: WOUND CLASSIFICATION: OP DISPOSITION:

CHOLECYSTECTOMY (MULTIPLE) CONTAMINATED

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

\*\* NURSE INTRAOP \*\* CASE #267226 SURPATIENT,TEN PAGE 3 OF 6

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

MAJOR/MINOR: OPERATING ROOM: CASE SCHEDULE TYPE: SURGEON:

ATTEND SURG: FIRST ASST: SECOND ASST:

PRINC ANESTHETIST: ASST ANESTHETIST:

MAJOR OR1 ELECTIVE

SURSURGEON,THREE SURSURGEON,THREE SURSURGEON,FOUR

SURANESTHETIST,SEVEN

OTHER SCRUBBED ASSISTANTS: (MULTIPLE)

OR SCRUB SUPPORT: OR CIRC SUPPORT:

OTHER PERSONS IN OR: PREOP MOOD:

PREOP CONSCIOUS:

(MULTIPLE)(DATA)

(MULTIPLE)(DATA) (MULTIPLE) RELAXED

RESTING

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

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

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

PREOP SKIN INTEG: PREOP CONVERSE: HAIR REMOVAL BY:

HAIR REMOVAL METHOD: HAIR REMOVAL COMMENTS: SKIN PREPPED BY (1): SKIN PREPPED BY (2): SKIN PREP AGENTS: SECOND SKIN PREP AGENT: SURGERY POSITION:

RESTR & POSITION AIDS: ELECTROCAUTERY UNIT: ESU COAG RANGE:

ESU CUTTING RANGE: ELECTROGROUND POSITION:

INTACT

NOT ANSWER QUESTIONS SURNURSE,FIVE

OTHER

(WORD PROCESSING)(DATA) SURNURSE,FIVE

If SHAVING or OTHER is entered as the Hair Removal Method, then Hair Removal Comments must be entered before the report can be electronically signed.

BETADINE POVIDONE IODINE (MULTIPLE)(DATA) (MULTIPLE)(DATA)

Enter Screen Server Function: **^**

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

Example: Printing the Nurse Intraoperative Report

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

Nurse Intraoperative Report Functions:

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

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

*-printout follows*

SURPATIENT,TEN 000-12-3456 NURSE INTRAOPERATIVE REPORT NOTE DATED: 07/12/2004 08:00 NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room: BO OR1 Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30 Patient in OR: JUL 12, 2004 08:00

Operation Begin: JUL 12, 2004 08:58 Operation End: JUL 12, 2004 12:10

Surgeon in OR: JUL 12, 2004 07:55 Patient Out OR: JUL 12, 2004 12:45

Major Operations Performed:

Primary: MVR

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

Surgeon: SURSURGEON,THREE First Assist: SURSURGEON,FOUR

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

Other Scrubbed Assistants: N/A OR Support Personnel:

Scrubbed Circulating

SURNURSE,ONE (FULLY TRAINED) SURNURSE,FIVE (FULLY TRAINED)

SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS Preop Consc: ALERT-ORIENTED

Preop Skin Integ: INTACT Preop Converse: N/A Confirm Correct Patient Identity: YES

Confirm Procedure to be Performed: YES

Confirm Site of the Procedure, including laterality: YES Confirm Valid Consent Form: YES

Confirm Patient Position: YES

Confirm Proc. Site has been Marked Appropriately and that the Site of the Mark is Visible After Prep and Draping: YES

Pertinent Medical Images have been Confirmed: YES Correct Medical Implant(s) is available: YES Availability of Special Equipment: YES Appropriate Antibiotic Prophylaxis: YES Appropriate Deep Vein Thrombosis ProphylAxis: YES Blood Availability: YES

Checklist Comment: NO COMMENTS ENTERED Checklist Confirmed By: SURNURSE,FIVE

Skin Prep By: SURNURSE,FOUR Skin Prep Agent: BETADINE SCRUB

Skin Prep By (2): SURNURSE,FIVE 2nd Skin Prep Agent: POVIDONE IODINE

Preop Surgical Site Hair Removal by: SURNURSE,FIVE Surgical Site Hair Removal Method: OTHER

Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):

SUPINE Placed: N/A

Restraints and Position Aids:

SAFETY STRAP Applied By: N/A

ARMBOARD Applied By: N/A

FOAM PADS Applied By: N/A

KODEL PAD Applied By: N/A

STIRRUPS Applied By: N/A

Electrocautery Unit: 8845,5512 ESU Coagulation Range: 50-35

ESU Cutting Range: 35-35

Electroground Position(s): RIGHT BUTTOCK

LEFT BUTTOCK

Material Sent to Laboratory for Analysis:

Specimens:

1. MITRAL VALVE Cultures: N/A

Anesthesia Technique(s):

GENERAL (PRINCIPAL)

Tubes and Drains:

#16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A Thermal Unit: N/A Prosthesis Installed:

Item: MITRAL VALVE

Implant Sterility Checked (Y/N): YES Sterility Expiration Date: DEC 15, 2004 RN Verifier: SURNURSE,ONE

Vendor: BAXTER EDWARDS

Model: 6900

Lot/Serial Number: GY0755 Sterile Resp: MANUFACTURER

Size: 29MM Quantity: 1

Medications: N/A

Irrigation Solution(s): HEPARINIZED SALINE NORMAL SALINE

COLD SALINE

Blood Replacement Fluids: N/A Sponge Count:

Sharps Count: YES

Instrument Count: NOT APPLICABLE Counter: SURNURSE,FOUR

Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE

Packing: NONE

Blood Loss: 800 ml Urine Output: 750 ml Postoperative Mood: RELAXED

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

Laser Unit(s): N/A

Sequential Compression Device: NO Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:

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

To electronically sign the report, the user enters a **3** at the *Nurse Intraoperative Report* functions prompt.

Example: Signing the Nurse Intraoperative Report

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

Nurse Intraoperative Report Functions:

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

Select number: 2// **3**

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

TIME PATIENT IN OR TIME PATIENT OUT OF OR

##### MARKED SITE CONFIRMED CORRECT PATIENT IDENTITY PREOPERATIVE IMAGING CONFIRMED HAIR REMOVAL METHOD PROCEDURE TO BE PERFORMED SITE OF THE PROCEDURE VALID CONSENT FORM PATIENT POSITION

CORRECT MEDICAL IMPLANTS ANTIBIOTIC PROPHYLAXIS APPROPRIATE DVT PROPHYLAXIS BLOOD AVAILABILITY AVAILABILITY OF SPECIAL EQUIP CHECKLIST COMMENT

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

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

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

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

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

Example: Missing Field Warning

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

ANTIBIOTIC PROPHYLAXIS CHECKLIST COMMENT

Do you want to enter this information? YES// **YES**

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

1

2

3

4

5

6

7

8

9

10

11

12

13

14

CONFIRM PATIENT IDENTITY: YES PROCEDURE TO BE PERFORMED: YES

SITE OF PROCEDURE: VALID CONSENT FORM:

YES YES

CONFIRM PATIENT POSITION: YES

MARKED SITE CONFIRMED:

YES

PREOPERATIVE IMAGES CONFIRMED: YES CORRECT MEDICAL IMPLANTS: YES AVAILABILITY OF SPECIAL EQUIP: YES ANTIBIOTIC PROPHYLAXIS: APPROPRIATE DVT PROPHYLAXIS: YES

BLOOD AVAILABILITY: CHECKLIST COMMENT: CHECKLIST CONFIRMED BY:

YES

(WORD PROCESSING) SURNURSE,FIVE

Enter Screen Server Function: **10**

Appropriate Antibiotic Prophylaxis: **Y** YES

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

1

2

3

4

5

6

7

8

9

10

11

12

13

14

CONFIRM PATIENT IDENTITY: YES PROCEDURE TO BE PERFORMED: YES

SITE OF PROCEDURE: VALID CONSENT FORM:

YES YES

CONFIRM PATIENT POSITION: YES

MARKED SITE CONFIRMED:

YES

PREOPERATIVE IMAGES CONFIRMED: YES CORRECT MEDICAL IMPLANTS: YES AVAILABILITY OF SPECIAL EQUIP: YES ANTIBIOTIC PROPHYLAXIS: YES APPROPRIATE DVT PROPHYLAXIS: YES

BLOOD AVAILABILITY: CHECKLIST COMMENT:

YES

(WORD PROCESSING)

CHECKLIST CONFIRMED BY: SURNURSE,FIVE

Enter Screen Server Function: **^**

If any of the Time Out Verified Utilizing Checklist fields is answered with “NO”, then the user is prompted to enter information in the CHECKLIST COMMENT field. Entry in the CHECKLIST COMMENT field is required in such cases where “NO” has been entered before the user can electronically sign the Nurse Intraoperative Report.

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

Nurse Intraoperative Report Functions:

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

Select number: 2// **3** Sign the report electronically

Enter your Current Signature Code: **XXXXXX** SIGNATURE VERIFIED Press RETURN to continue... **<Enter>**

When typing the electronic signature code, no characters will display on screen.

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

* \* The Nurse Intraoperative Report has been electronically signed. \* \* Nurse Intraoperative Report Functions:
  1. Edit report information
  2. Print/View report from beginning

Select number: 2// **^**

**Nurse Intraoperative Report - After Electronic Signature**

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

Example: Editing the Signed Nurse Intraoperative Report

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

* \* The Nurse Intraoperative Report has been electronically signed. \* \* Nurse Intraoperative Report Functions:
  1. Edit report information
  2. Print/View report from beginning

Select number: 2// **1** Edit report information

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

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

>>> WARNING <<<

Electronically signed reports are associated with this case. Editing of data that appear on electronically signed reports will require the creation of addenda to the signed reports.

Enter RETURN to continue or '^' to exit: **<Enter>**

First, the user makes the edits to the desired field.

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

1

2

3

4

5

6

7

8

9

10

11

12

13

14

CONFIRM PATIENT IDENTITY: YES PROCEDURE TO BE PERFORMED: YES

SITE OF PROCEDURE: VALID CONSENT FORM:

YES YES

CONFIRM PATIENT POSITION: YES MARKED SITE CONFIRMED: YES PREOPERATIVE IMAGES CONFIRMED: YES CORRECT MEDICAL IMPLANTS: YES AVAILABILITY OF SPECIAL EQUIP: YES ANTIBIOTIC PROPHYLAXIS: APPROPRIATE DVT PROPHYLAXIS: YES

BLOOD AVAILABILITY: CHECKLIST COMMENT:

YES

(WORD PROCESSING)

CHECKLIST CONFIRMED BY: SURNURSE,FOUR

Enter Screen Server Function: 14

Checklist Confirmed By: SURNURSE,FOUR // SURNURSE,FIVE

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

1

2

3

4

5

6

7

8

9

10

11

12

13

14

CONFIRM PATIENT IDENTITY: YES PROCEDURE TO BE PERFORMED: YES

SITE OF PROCEDURE: VALID CONSENT FORM:

YES YES

CONFIRM PATIENT POSITION: YES MARKED SITE CONFIRMED: YES PREOPERATIVE IMAGES CONFIRMED: YES CORRECT MEDICAL IMPLANTS: YES AVAILABILITY OF SPECIAL EQUIP: YES ANTIBIOTIC PROPHYLAXIS: YES APPROPRIATE DVT PROPHYLAXIS: YES

BLOOD AVAILABILITY: CHECKLIST COMMENT:

YES

(WORD PROCESSING)

CHECKLIST CONFIRMED BY: SURNURSE,FIVE

Enter Screen Server Function: **^**

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

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

An addendum to each of the following electronically signed document(s) is required:

Nurse Intraoperative Report - Case #267226

If you choose not to create an addendum, the original data will be restored to the modified fields appearing on the signed reports.

Create addendum? YES// **<Enter>**

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

The Checklist Confirmed By field was changed from SURNURSE,FOUR

to SURNURSE,FIVE

Enter RETURN to continue or '^' to exit: **<Enter>**

Before the addendum is signed, comments may be added.

Example: Signing the Addendum

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

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

The Checklist Confirmed By field was changed from SURNURSE,FOUR

to SURNURSE,FIVE

Addendum Comment: OPERATION END TIME WAS CORRECTED.

Enter RETURN to continue or '^' to exit:

Enter your Current Signature Code: **XXXXXX** SIGNATURE VERIFIED.. Press RETURN to continue... **<Enter>**

Example: Printing the Nurse Intraoperative Report

When typing the electronic signature code, no characters will display on screen.

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

* \* The Nurse Intraoperative Report has been electronically signed. \* \* Nurse Intraoperative Report Functions:
  1. Edit report information
  2. Print/View report from beginning

Select number: 2// **2** Print/View report from beginning Do you want WORK copies or CHART copies? WORK// **<Enter>** DEVICE: HOME// ***[Select Print Device]***

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

SURPATIENT,TEN 000-12-3456 NURSE INTRAOPERATIVE REPORT NOTE DATED: 07/12/2004 08:00 NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room: BO OR1 Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30 Patient in OR: JUL 12, 2004 08:00

Operation Begin: JUL 12, 2004 08:58 Operation End: JUL 12, 2004 12:30

Surgeon in OR: JUL 12, 2004 07:55 Patient Out OR: JUL 12, 2004 12:45

Major Operations Performed:

Primary: MVR

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

Surgeon: SURSURGEON,THREE First Assist: SURSURGEON,FOUR

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

Other Scrubbed Assistants: N/A OR Support Personnel:

Scrubbed Circulating

SURNURSE,ONE (FULLY TRAINED) SURNURSE,FIVE (FULLY TRAINED)

SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS Preop Consc: ALERT-ORIENTED

Preop Skin Integ: INTACT Preop Converse: N/A Confirm Correct Patient Identity: YES

Confirm Procedure to be Performed: YES

Confirm Site of the Procedure, including laterality: YES Confirm Valid Consent Form: YES

Confirm Patient Position: YES

Confirm Proc. Site has been Marked Appropriately and that the Site of the Mark is Visible After Prep and Draping: YES

Pertinent Medical Images have been Confirmed: YES Correct Medical Implant(s) Is Available: YES Availability of Special Equipment: YES Appropriate Antibiotic Prophylaxis: YES Appropriate Deep Vein Thrombosis Prophylaxis: YES Blood Availability: YES

Checklist Comment: NO COMMENTS ENTERED Checklist Confirmed By: SURNURSE,FOUR

Skin Prep By: SURNURSE,FOUR Skin Prep Agent: BETADINE SCRUB

Skin Prep By (2): SURNURSE,FIVE 2nd Skin Prep Agent: POVIDONE IODINE

Preop Surgical Site Hair Removal by: SURNURSE,FIVE Surgical Site Hair Removal Method: OTHER

Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):

SUPINE Placed: N/A

Restraints and Position Aids:

SAFETY STRAP Applied By: N/A

ARMBOARD Applied By: N/A

FOAM PADS Applied By: N/A

KODEL PAD Applied By: N/A

STIRRUPS Applied By: N/A

Electrocautery Unit: 8845,5512

ESU Coagulation Range: 50-35

ESU Cutting Range: 35-35

Electroground Position(s): RIGHT BUTTOCK

LEFT BUTTOCK

Material Sent to Laboratory for Analysis:

Specimens:

1. MITRAL VALVE Cultures: N/A Anesthesia Technique(s):

GENERAL (PRINCIPAL)

Tubes and Drains:

#16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A Thermal Unit: N/A Prosthesis Installed:

Item: MITRAL VALVE

Implant Sterility Checked (Y/N): YES Sterility Expiration Date: DEC 15, 2004 RN Verifier: SURNURSE,ONE

Vendor: BAXTER EDWARDS

Model: 6900

Lot/Serial Number: GY0755 Sterile Resp: MANUFACTURER

Size: 29MM Quantity: 1

Medications: N/A Irrigation Solution(s):

HEPARINIZED SALINE NORMAL SALINE

COLD SALINE

Blood Replacement Fluids: N/A Sponge Count: YES

Sharps Count: YES

Instrument Count: NOT APPLICABLE Counter: SURNURSE,FOUR

Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE

Packing: NONE

Blood Loss: 800 ml Urine Output: 750 ml Postoperative Mood: RELAXED

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

Laser Unit(s): N/A

Sequential Compression Device: NO Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:

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

Signed by: /es/ FIVE SURNURSE

07/13/2004 10:41

07/17/2004 16:42 ADDENDUM

The Checklist Confirmed By field was changed from SURNURSE,FOUR

to SURNURSE,FIVE

Addendum Comment: OPERATION END TIME WAS CORRECTED.

Signed by: /es/ FIVE SURNURSE

07/17/2004 16:42

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

# 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. |

## 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)

JUN 30,2006 CHOLECYSTECTOMY

Case #213

There are no Intraoperative Occurrences entered for this case.

Enter a New Intraoperative Occurrence: **CARDIAC ARR**EST REQUIRING CPR Definition Revised (2011): Indicate if there was any cardiac arrest

requiring external or open cardiopulmonary resuscitation (CPR) occurring in the operating room, ICU, ward, or out-of-hospital after the chest had been completely closed and within 30 days of surgery. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

If patient had cardiac arrest requiring CPR, indicate whether the arrest occurred intraoperatively or postoperatively. Indicate the one appropriate response:

* intraoperatively: occurring while patient was in the operating room
* postoperatively: occurring after patient left the operating room

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

176 Surgery V. 3.0 User Manual September 2011

|  |  |
| --- | --- |
| 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: |

## 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**

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

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

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

178 Surgery V. 3.0 User Manual September 2011

|  |  |
| --- | --- |
| 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: |

## 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**

Definition Revised (2007):

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

1. Sepsis: Sepsis is the systemic response to infection. Report this variable if the patient has clinical signs and symptoms of SIRS. SIRS is a widespread inflammatory response to a variety of severe clinical insults. This syndrome is clinically recognized by the presence of two or more of the following:
   * Temp >38 degrees C or <36 degrees C
   * HR >90 bpm
   * RR >20 breaths/min or PaCO2 <32 mmHg(<4.3 kPa)
   * WBC >12,000 cell/mm3, <4000 cells/mm3, or >10% immature (band) forms
   * Anion gap acidosis: this is defined by either:

[Na + K] - [Cl + HCO3 (or serum CO2)]. If this number is greater than 16, then an anion gap acidosis is present.

or

Na - [Cl + HCO3 (or serum CO2)]. If this number is greater than 12, then an anion gap acidosis is present.

and one of the following:

* + positive blood culture
  + clinical documentation of purulence or positive culture from any site thought to be causative

## Morbidity & Mortality Reports

### [SROMM]

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

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

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

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

Select Perioperative Occurrences Menu Option: **M** Morbidity & Mortality Reports

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

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

1. Perioperative Occurrences Report
2. Mortality Report

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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): 3

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

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

Print report by

1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

Select 1, 2 or 3: (1-3): 1// **<Enter>**

Do you want to print this report for all Surgical Specialties ? YES// **N**

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

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

*report follows*

MAYBERRY, NC PAGE 1

SURGICAL SERVICE REVIEWED BY: PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP DATE REVIEWED:

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

PATIENT ATTENDING SURGEON OCCURRENCE(S) - (DATE) OUTCOME

ID# PRINCIPAL OPERATION TREATMENT OPERATION DATE

==================================================================================================================================== GENERAL(OR WHEN NOT DEFINED BELOW)

|  |  |  |  |
| --- | --- | --- | --- |
| SURPATIENT,TWELVE  000-41-8719 | SURSURGEON,THREE  REPAIR DIAPHRAGMATIC HERNIA | MYOCARDIAL INFARCTION  ASPIRIN THERAPY | I |
| JUL 07, 2006@07:15 |  | URINARY TRACT INFECTION \* (07/09/06) | I |
|  |  | IV ANTBIOTICS |  |
| SURPATIENT,FOURTEEN 000-45-7212  JUL 31, 2006@09:00 | SURSURGEON,FIVE CHOLECYSTECTOMY, APPENDECTOMY | SUPERFICIAL WOUND INFECTION \* (08/02/06) ANTIBIOTICS | I |

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

'\*' Represents Postoperative Occurrences

Example 2: Printing the Perioperative Occurrences Report – Sorted by Attending Surgeon

Select Perioperative Occurrences Menu Option: **M** Morbidity & Mortality Reports

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

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

1. Perioperative Occurrences Report
2. Mortality Report

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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): 3

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

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

Print report by

1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

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

Do you want to print this report for all Attending Surgeons ? YES//**N** Print the report for which Attending Surgeon ? **SURGEON,ONE**

Select an Additional Attending Surgeon: **<Enter>**

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

###### report follows

MAYBERRY, NC PAGE 1

SURGICAL SERVICE REVIEWED BY: PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP DATE REVIEWED:

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

PATIENT SURGICAL SPECIALTY OCCURRENCE(S) - (DATE) OUTCOME

ID# PRINCIPAL OPERATION TREATMENT OPERATION DATE

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

ATTENDING: SURGEON,ONE

|  |  |  |  |
| --- | --- | --- | --- |
| SURPATIENT,TWELVE  000-41-8719 | GENERAL(OR WHEN NOT DEFINED BELOW)  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 | GENERAL(OR WHEN NOT DEFINED BELOW) CHOLECYSTECTOMY, APPENDECTOMY | SUPERFICIAL WOUND INFECTION \* (08/02/06) ANTIBIOTICS | I |

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

'\*' Represents Postoperative Occurrences

Example 3: Printing the Perioperative Occurrences Report – Sorted by Occurrence Category

Select Perioperative Occurrences Menu Option: **M** Morbidity & Mortality Reports

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

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

1. Perioperative Occurrences Report
2. Mortality Report

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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): 3

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

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

Print report by

1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

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

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

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

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

Select an Additional Occurrence Category: **<Enter>**

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

###### report follows

MAYBERRY, NC PAGE 1

SURGICAL SERVICE REVIEWED BY: PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP 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

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

## Report of Non-O.R. Procedures

### [SRONOR]

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

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

Example 1: Report of Non-O.R. Procedures by Specialty

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

Report of Non-OR Procedures

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

How do you want the report sorted ?

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

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

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

Print the Report for which Specialty ? **CARDIOLOGY**

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

*printout follows*

MAYBERRY, NC

SURGICAL SERVICE REVIEWED BY: REPORT OF NON-O.R. PROCEDURES DATE REVIEWED:

FROM: MAR 1,1999 TO: MAR 31,1999

|  |  |  |  |
| --- | --- | --- | --- |
| DATE | PATIENT (ID#) | PROVIDER | START TIME |
| CASE # | LOCATION (IN/OUT-PAT STATUS) | PRINCIPAL ANESTHETIST | FINISH TIME |

ANESTHESIOLOGIST SUPERVISOR PROCEDURE(S)

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

\*\*\* SPECIALTY: CARDIOLOGY \*\*\*

|  |  |  |  |
| --- | --- | --- | --- |
| 03/02/99 | SURPATIENT,TWELVE (000-41-8719) | SURSURGEON,TWO | 03/02/99 13:05 |
| 501 | AMBULATORY SURGERY (OUTPATIENT) | **SURANESTHETIST,TWO** | 03/02/99 14:10 |

SURANESTHETIST,ONE

CARDIOVERSION

|  |  |  |  |
| --- | --- | --- | --- |
| 03/13/99 | SURPATIENT,SIXTY (000-56-7821) | SURSURGEON,TWO | 03/13/99 14:00 |
| 500 | ICU (INPATIENT) | **SURANESTHETIST,FOUR** | 03/13/99 14:25 |

SURANESTHETIST,ONE

CARDIOVERSION

244 Surgery V. 3.0 User Manual September 2011

Example 2: Report of Non-O.R. Procedures by Provider

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

Report of Non-OR Procedures

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

How do you want the report sorted ?

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

Select Number: 1// **2**

Do you want to print the report for all Providers ? YES// **N** Print the Report for which Provider ? **SURSURGEON,SIXTEEN** This report is designed to use a 132 column format.

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

###### printout follows

MAYBERRY, NC

SURGICAL SERVICE REVIEWED BY: REPORT OF NON-O.R. PROCEDURES DATE REVIEWED:

FROM: MAR 1,1999 TO: MAR 31,1999

|  |  |  |  |
| --- | --- | --- | --- |
| DATE | PATIENT (ID#) | SPECIALTY | START TIME |
| CASE # | LOCATION (IN/OUT-PAT STATUS) | PRINCIPAL ANESTHETIST | FINISH TIME |

ANESTHESIOLOGIST SUPERVISOR PROCEDURE(S)

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

\*\*\* PROVIDER SURSURGEON,SIXTEEN \*\*\*

|  |  |  |  |
| --- | --- | --- | --- |
| 03/12/99 | SURPATIENT,TWO (000-45-1982) | PSYCHIATRY | 03/12/99 08:00 |
| 195 | PAC(U) - ANESTHESIA (INPATIENT) | SURANESTHETIST,TWO | 03/12/99 09:00 |

SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY

|  |  |  |  |
| --- | --- | --- | --- |
| 03/23/99 | SURPATIENT,NINE (000-34-5555) | PSYCHIATRY | 03/23/99 08:10 |
| 240 | PAC(U) - ANESTHESIA (INPATIENT) | SURANESTHETIST,SIX | 03/23/99 08:40 |

SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY

|  |  |  |  |
| --- | --- | --- | --- |
| 03/25/99 | SURPATIENT,FOURTEEN (000-45-7212) | PSYCHIATRY | 03/12/99 09:30 |
| 266 | PAC(U) - ANESTHESIA (INPATIENT) | SURANESTHETIST,TWO | 03/12/99 10:15 |

SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY

246 Surgery V. 3.0 User Manual September 2011

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

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

Report of Non-OR Procedures

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

How do you want the report sorted ?

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

Select Number: 1// **3**

Do you want to print the report for all Locations ? YES// **N** Print the Report for which Location ? **AMBULATORY** SURGERY This report is designed to use a 132 column format.

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

###### printout follows

MAYBERRY, NC

SURGICAL SERVICE REVIEWED BY: REPORT OF NON-O.R. PROCEDURES DATE REVIEWED:

FROM: MAR 1,1999 TO: MAR 31,1999

|  |  |  |  |
| --- | --- | --- | --- |
| DATE | PATIENT (ID#) | PROVIDER | START TIME |
| CASE # | SPECIALTY (IN/OUT-PAT STATUS) | PRINCIPAL ANESTHETIST | FINISH TIME |

ANESTHESIOLOGIST SUPERVISOR PROCEDURE(S)

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

\*\*\* LOCATION: AMBULATORY SURGERY \*\*\*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 03/02/99 | SURPATIENT,TWELVE (000-41-8719) | SURSURGEON,TWO | 03/02/99 | 13:05 |
| 201 | CARDIOLOGY (OUTPATIENT) | SURANESTHETIST,FOUR | 03/02/99 | 14:10 |

SURANESTHETIST,ONE CARDIOVERSION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 03/06/99 | SURPATIENT,TWENTY (000-45-4886) | SURSURGEON,FOUR | 03/07/99 | 16:30 |
| 198 | GENERAL(ACUTE MEDICINE) (OUTPATIENT) | SURANESTHETIST,FIVE | 03/07/99 | 17:08 |
|  |  | SURANESTHETIST,ONE EXCISION OF SKIN LESION |  |  |
| 03/09/99 | SURPATIENT,FIFTY (000-45-9999) | SURANESTHETIST,ONE | 03/09/99 | 09:45 |
| 193 | GENERAL (ACUTE MEDICINE) (OUTPATIENT) | SURANESTHETIST,FIVE | 03/09/99 | 10:21 |

SURANESTHETIST,SEVEN STELLATE NERVE BLOCK

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 03/13/99 | SURPATIENT,SIXTY (000-56-7821) | SURSURGEON,TWO | 03/13/99 | 14:00 |
| 200 | CARDIOLOGY (INPATIENT) | SURANESTHETIST,TWO | 03/13/99 | 14:25 |

SURANESTHETIST,ONE CARDIOVERSION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 03/17/99 | SURPATIENT,EIGHTEEN (000-22-3334) | SURSURGEON,FOUR | 03/17/99 | 13:30 |
| 194 | GENERAL SURGERY (OUTPATIENT) | SURANESTHETIST,SIX | 03/17/99 | 14:42 |
|  |  | SURANESTHETIST,SEVEN |  |  |

EXCISION OF SKIN LESION

## Management Reports

### [SRO-CHIEF REPORTS]

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

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

**Morbidity & Mortality Reports**

### [SROMM]

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

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

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

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

Select Perioperative Occurrences Menu Option: **M** Morbidity & Mortality Reports

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

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

1. Perioperative Occurrences Report
2. Mortality Report

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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): 3

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

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

Print report by

1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

Select 1, 2 or 3: (1-3): 1// **<Enter>**

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

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

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

*report follows*

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

MAYBERRY, NC PAGE 1

SURGICAL SERVICE REVIEWED BY: PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP DATE REVIEWED:

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

PATIENT ATTENDING SURGEON OCCURRENCE(S) - (DATE) OUTCOME

ID# PRINCIPAL OPERATION TREATMENT OPERATION DATE

==================================================================================================================================== GENERAL(OR WHEN NOT DEFINED BELOW)

|  |  |  |  |
| --- | --- | --- | --- |
| SURPATIENT,TWELVE  000-41-8719 | SURSURGEON,THREE  REPAIR DIAPHRAGMATIC HERNIA | MYOCARDIAL INFARCTION  ASPIRIN THERAPY | I |
| JUL 07, 2006@07:15 |  | URINARY TRACT INFECTION \* (07/09/06) | I |
|  |  | IV ANTBIOTICS |  |
| SURPATIENT,FOURTEEN 000-45-7212  JUL 31, 2006@09:00 | SURSURGEON,FIVE CHOLECYSTECTOMY, APPENDECTOMY | SUPERFICIAL WOUND INFECTION \* (08/02/06) ANTIBIOTICS | I |

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

'\*' Represents Postoperative Occurrences

Example 2: Printing the Perioperative Occurrences Report – Sorted by Attending Surgeon

Select Perioperative Occurrences Menu Option: **M** Morbidity & Mortality Reports

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

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

1. Perioperative Occurrences Report
2. Mortality Report

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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): 3

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

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

Print report by

1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

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

Do you want to print this report for all Attending Surgeons ? YES//**N** Print the report for which Attending Surgeon ? **SURGEON,ONE**

Select an Additional Attending Surgeon: **<Enter>**

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

###### report follows

MAYBERRY, NC PAGE 1

SURGICAL SERVICE REVIEWED BY: PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP DATE REVIEWED:

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

PATIENT SURGICAL SPECIALTY OCCURRENCE(S) - (DATE) OUTCOME

ID# PRINCIPAL OPERATION TREATMENT OPERATION DATE

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

ATTENDING: SURGEON,ONE

|  |  |  |  |
| --- | --- | --- | --- |
| SURPATIENT,TWELVE  000-41-8719 | GENERAL(OR WHEN NOT DEFINED BELOW)  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 | GENERAL(OR WHEN NOT DEFINED BELOW) CHOLECYSTECTOMY, APPENDECTOMY | SUPERFICIAL WOUND INFECTION \* (08/02/06) ANTIBIOTICS | I |

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

'\*' Represents Postoperative Occurrences

Example 3: Printing the Perioperative Occurrences Report – Sorted by Occurrence Category

Select Perioperative Occurrences Menu Option: **M** Morbidity & Mortality Reports

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

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

1. Perioperative Occurrences Report
2. Mortality Report

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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): 3

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

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

Print report by

1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

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

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

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

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

Select an Additional Occurrence Category: **<Enter>**

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

###### report follows

MAYBERRY, NC PAGE 1

SURGICAL SERVICE REVIEWED BY: PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP 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

Example 4: Print the Mortality Report

Select Management Reports Option: **MM** Morbidity & Mortality Reports

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

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

1. Perioperative Occurrences Report
2. Mortality Report

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

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

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

###### printout follows

Example 3: Clean Wound Infection Summary

Select Management Reports Option: **WC** Wound Classification Report

Wound Classification Report

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

Print which of the following ?

1. Wound Classification Report (Summary)
2. List of Operations by Wound Classification
3. Clean Wound Infection Summary Select Number: 1// **3**

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

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

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

MAYBERRY, NC SURGICAL SERVICE

CLEAN WOUND INFECTION SUMMARY FROM: JUN 1,1999 TO: JUN 30,1999 DATE PRINTED: JUL 18,1999

REVIEWED BY: DATE REVIEWED:

SURGICAL SERVICE CLEAN WOUNDS INFECTIONS INFECTION RATE

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

|  |  |  |  |
| --- | --- | --- | --- |
| GENERAL | 21 | 1 | 4.8% |
| GYNECOLOGY | 0 | 0 | 0.0% |
| NEUROSURGERY | 11 | 0 | 0.0% |
| OPHTHALMOLOGY | 30 | 0 | 0.0% |
| ORTHOPEDICS | 20 | 1 | 5.0% |
| OTORHINOLARYNGOLOGY | 6 | 0 | 0.0% |
| PLASTIC SURGERY | 7 | 0 | 0.0% |
| PROCTOLOGY | 0 | 0 | 0.0% |
| THORACIC SURGERY | 2 | 0 | 0.0% |
| UROLOGY | 2 | 0 | 0.0% |
| ORAL SURGERY | 0 | 0 | 0.0% |
| PODIATRY | 14 | 0 | 0.0% |
| PERIPHERAL VASCULAR | 28 | 0 | 0.0% |
| CARDIAC SURGERY | 0 | 0 | 0.0% |
| TRANSPLANTATION | 0 | 0 | 0.0% |
| ANESTHESIOLOGY | 0 | 0 | 0.0% |
| RHEUMATOLOGY | 1 | 0 | 0.0% |
| PULMONARY | 0 | 0 | 0.0% |
| GASTROENTEROLOGY | 0 | 0 | 0.0% |
| NO SPECIALTY ENTERED | 0 | 0 | 0.0% |
| TOTAL | 142 | 2 | 1.4% |

Pages 368-392 have been deleted. The Quarterly Report Menus have been removed.

**Key Missing Surgical Package Data**

### [SROQ MISSING DATA]

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

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

Example: Key Missing Surgical Package Data

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

Report of Key Missing Surgical Package Data

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

In/Out-Patient Status Major/Minor

Case Schedule Type Attending Code Time Pat Out OR

Wound Classification ASA Class

CPT Code (Principal)

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

End with Date: **4 30** (APR 30, 2005)

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

This report is designed to use a 132 column format.

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

*printout follows*

MAYBERRY, NC

Report of Key Missing Surgical Package Data PAGE 1

From: APR 1,2005 To: APR 30,2005

Report Printed: MAY 11,2005@15:09

|  |  |  |  |
| --- | --- | --- | --- |
| DATE OF OPERATION | PATIENT NAME | SURGICAL SPECIALTY | MISSING ITEMS |
| CASE # | PATIENT ID (AGE) | PRINCIPAL PROCEDURE |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| APR 6,2005@07:40 32474 | SURPATIENT,ONE 000-44-7629 (46) | OPHTHALMOLOGY  PHACHOEMULSIFICATION, LENS IMPLANT OD | D |
| APR 12,2005@12:00 32508 | SURPATIENT,FORTYONE 000-43-2109 (78) | OPHTHALMOLOGY  PHACOEMULSIFICATION, LENS IMPLANT OS | D |
| APR 12,2005@13:50 32534 | SURPATIENT,ONE 000-44-7629 (46) | PLASTIC SURGERY (INCLUDES HEAD AND NECK) EXCISION OF RT. WRIST MASS | D |
| APR 12,2005@14:00 32544 | SURPATIENT,THIRTY 000-82-9472 (48) | OPHTHALMOLOGY PHACOEMULSIFICATION OD | D |
| APR 13,2005@09:20 32513 | SURPATIENT,FIFTYTWO 000-99-8888 (79) | OPHTHALMOLOGY  PHACOEMULSIFICATION, LENS IMPLANT OD | D |
| APR 15,2005@13:05 32351 | SURPATIENT,FIFTY 000-45-9999 (44) | GENERAL(OR WHEN NOT DEFINED BELOW) EXCISIONAL BIOPSY MASS RT. BREAST | D |
| APR 19,2005@13:00 32580 | SURPATIENT,SEVENTEEN 000-45-5119 (71) | OPHTHALMOLOGY  PHACOEMULSIFICATION LENS IMPLANT OD | D |
| APR 27,2005@13:15 32684 | SURPATIENT,SIXTY 000-56-7821 (40) | OPHTHALMOLOGY TRABECULECTOMY OD | F |

TOTAL CASES MISSING DATA: 8

|  |  |  |  |
| --- | --- | --- | --- |
| MISSING ITEMS CODES: A-IN/OUT-PATIENT STATUS, | B-MAJOR/MINOR, | C-CASE SCHEDULE TYPE, | D-ATTENDING CODE, |
| E-TIME PAT OUT OR, F-WOUND CLASSIFICATION, | G-ASA CLASS, | H-CPT CODE (PRINCIPAL) |  |

**Admitted w/in 14 days of Out Surgery If Postop Occ**

### [SROQADM]

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

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

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

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

and Admissions Within 14 Days

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

Start with Date: **9 1 04** (SEP 01, 2004)

End with Date: **12 31 04** (DEC 31, 2004)

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

This report is designed to use a 132 column format.

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

*printout follows*

MAYBERRY, NC

OUTPATIENT CASES WITH POSTOP OCCURRENCES AND ADMISSIONS WITHIN 14 DAYS PAGE 1

From: SEP 1,2004 To: DEC 31,2004

Report Printed: FEB 12,2005@13:44

DATE OF OPERATION PATIENT NAME SURGICAL SPECIALTY ANESTHESIA TECHNIQUE DATE OF ADMISSION CASE # PATIENT ID (AGE) PROCEDURE(S) PERFORMED

\*OCCURRENCE - (DATE)

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SEP 24,2004@12:30 | SURPATIENT,FORTY | THORACIC SURGERY (INC. CARDIAC | GENERAL | OCT 3,2004@14:11 |
| 30395 | 000-77-7777 (72) | MEDIASTINOSCOPY WITH NODE BIOPSY |  |  |
| \*OTHER OCCURRENCE - | (10/03/04) |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SEP 25,2004@14:30 | SURPATIENT,EIGHTEEN | GENERAL(OR WHEN NOT DEFINED BE | GENERAL | SEP 28, 2004@10:06 |
| 30544 | 000-22-3334 (71) | LEFT INGUINAL HERNIORRAPHY |  |  |
| \*OTHER OCCURRENCE - | (09/28/04) | HYDROCELECTOMY |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NOV 18,2004@09:45 | SURPATIENT,FIFTEEN | PLASTIC SURGERY (INCLUDES HEAD | GENERAL | NOV 28, 2004@12:51 |
| 31034 | 000-98-1234 (55) | GANGLION CYST LT. WRIST |  |  |

\*SUPERFICIAL WOUND INFECTION - (11/28/04) INCLUSION OF CYST INDEX FINGER LT.

EXCISION OF LIPOMA OF LT. FOOT APPLICATION SHORT ARM SPLINT

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DEC 9,2004@13:35 | SURPATIENT,EIGHT | ORTHOPEDICS | GENERAL | DEC 9, 2004@17:55 |
| 31242 | 000-37-0555 (64) | ORIF RT ULNA |  |  |

\*SUPERFICIAL WOUND INFECTION - (12/29/04) REPAIR RT. DISTALRADIOULNAR FX (

DEC 31,2004@07:30 SURPATIENT,FIFTYONE OTORHINOLARYNGOLOGY (ENT) GENERAL DEC 31, 2004@18:02

|  |  |  |
| --- | --- | --- |
| 31277 | 000-23-3221 (31) | NASAL SINUS SURGERY WITH BIL SPENOETHMOID POLYPECTOMY (CPT Code: 31205) |
| \*OTHER CNS OCCURRENCE | - (01/05/03) | BILATERAL ANTROSTOMY |
| TOTAL CASES: 5 |  | BILATERAL TURBINECTOMY |

### Deaths Within 30 Days of Surgery

**[SROQD]**

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

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

##### All Cases

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

##### Outpatient Cases Only

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

##### Inpatient Cases Only

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

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

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

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

Example 1: Deaths Within 30 Days of Surgery - Total Cases Summary

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

Deaths Within 30 Days of Surgery

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

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

Print report for which section of Quarterly/Summary Report ?

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

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

Print Deaths within 30 Days of Surgery for

A - All cases

O - Outpatient cases only I - Inpatient cases only

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

This report is designed to use a 132 column format.

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

*printout follows*

MAYBERRY, NC

DEATHS WITHIN 30 DAYS OF SURGERY PAGE 1

FOR SURGERY PERFORMED FROM: APR 1,2005 TO: APR 30,2005

Report Printed: MAY 18,2005@12:09

DEATH

OP DATE CASE # IN/OUT SURGICAL SPECIALTY PROCEDURE(S) RELATED

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

>>> SURPATIENT,FORTY (000-77-7777) - DIED 05/12/05 AGE: 70

04/13/05 32571 INPAT GENERAL(OR WHEN NOT DEFINED BELOW) EXPLORATORY LAPAROTOMY UNRELATED

RIGHT HEMICOLECTOMY ILEOSTOMY

MUCOUS FISTULA OF COLON

04/24/05 32693 INPAT GENERAL(OR WHEN NOT DEFINED BELOW) CLOSURE OF ABDOMINAL WALL FASCIA UNRELATED

>>> SURPATIENT,TEN (000-12-3456) - DIED 05/12/05 AGE: 68

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 04/26/05 32702 | INPAT | THORACIC SURGERY (INC. CARDIAC SURG | RIGHT THORACOTOMY WITH LUNG BIOPSY | UNRELATED |
|  |  |  | DIAPHRAGM BIOPSY |  |

>>> SURPATIENT,SIXTY (000-56-7821) - DIED 04/30/05 AGE: 40

04/21/05 32567 INPAT THORACIC SURGERY (INC. CARDIAC SURG ESOPHAGECTOMY RELATED

ESOPHAGOSCOPY BRONCHOSCOPY

FEEDING TUBE JEJUNOSTOMY

TOTAL DEATHS: 3

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

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

Deaths Within 30 Days of Surgery

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

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

Print report for which section of Quarterly/Summary Report ?

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

Select number: 1// **2** Specialty Procedures

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

This report is designed to use a 132 column format.

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

###### printout follows

MAYBERRY, NC

DEATHS WITHIN 30 DAYS OF SURGERY LISTED FOR SPECIALTY PROCEDURES PAGE 1 FOR SURGERY PERFORMED FROM: APR 1,2005 TO: APR 30,2005

Report Printed: MAY 18,2005@12:38

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| OP DATE | PATIENT NAME | DATE OF DEATH | LOCAL SPECIALTY | IN/OUT | DEATH RELATED |
| CASE # | PATIENT ID# (AGE) | PROCEDURE(S) |  |  |  |

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

>>> GENERAL SURGERY <<<

04/24/05 SURPATIENT,FORTY 05/12/05 GENERAL(OR WHEN NOT DEFINED BELOW) INPAT UNRELATED

32693 000-77-7777 (70) CLOSURE OF ABDOMINAL WALL FASCIA

TOTAL DEATHS FOR GENERAL SURGERY: 1

>>> THORACIC SURGERY <<<

04/26/05 SURPATIENT,TEN 05/12/05 THORACIC SURGERY (INC. CARDIAC SURG.) INPAT UNRELATED

32702 000-12-3456 (68) RIGHT THORACOTOMY WITH LUNG BIOPSY

DIAPHRAGM BIOPSY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 04/21/05 | SURPATIENT,SIXTY | 04/30/05 | THORACIC SURGERY (INC. CARDIAC SURG.) | INPAT | RELATED |
| 32567 | 000-56-7821 (40) | ESOPHAGECTOMY |  |  |  |
|  |  | ESOPHAGOSCOPY |  |  |  |
|  |  | BRONCHOSCOPY |  |  |  |

FEEDING TUBE JEJUNOSTOMY

TOTAL DEATHS FOR THORACIC SURGERY: 2

TOTAL FOR ALL SPECIALTIES: 3

Example 3: Deaths Within 30 Days of Surgery - Index Procedures

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

Deaths Within 30 Days of Surgery

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

Start with Date: **1/1** (JAN 01, 2005) End with Date: **3/31** (MAR 31, 2005)

Print report for which section of Quarterly/Summary Report ?

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

Select number: 1// **3** Index Procedures

This report is designed to use a 132 column format.

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

###### printout follows

MAYBERRY, NC

DEATHS WITHIN 30 DAYS OF SURGERY LISTED FOR INDEX PROCEDURES PAGE 1 FOR SURGERY PERFORMED FROM: JAN 1,2005 TO: MAR 31,2005

Report Printed: APR 28,2005@13:02

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| OP DATE | PATIENT NAME | DATE OF DEATH | LOCAL SPECIALTY | IN/OUT | DEATH RELATED |
| CASE # | PATIENT ID# (AGE) | PROCEDURE(S) |  |  |  |

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

>>> Cholecystectomy <<<

03/05/05 SURPATIENT,SIXTY 03/18/05 GENERAL(OR WHEN NOT DEFINED BELOW) INPAT RELATED

32147 000-56-7821 (40) LAPAROSCOPIC CHOLECYSTECTOMY

TOTAL DEATHS FOR Cholecystectomy: 1

>>> Colon Resection (L & R) <<<

01/12/05 SURPATIENT,TEN 01/18/05 GENERAL(OR WHEN NOT DEFINED BELOW) INPAT UNRELATED

31514 000-12-3456 (60) RT. HEMICOLECTOMY

TOTAL DEATHS FOR Colon Resection (L & R): 1

>>> Hip Replacement - Elective <<<

01/15/05 SURPATIENT,SIXTEEN 01/19/05 ORTHOPEDICS INPAT RELATED

31576 000-11-1111 (93) LT. HIP ARTHROPLASTY

TOTAL DEATHS FOR Hip Replacement - Elective: 1

>>> Intraoccular Lens <<<

02/23/05 SURPATIENT,FIFTYTWO 03/15/05 OPHTHALMOLOGY OUTPAT UNRELATED

32008 000-99-8888 (90) CATARACT EXTRACTION WITH IOL OS

TOTAL DEATHS FOR Intraoccular Lens: 1

TOTAL FOR ALL INDEX PROCEDURES: 4

## Unlock a Case for Editing

### [SRO-UNLOCK]

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

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

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

Example: Unlock a Case for Editing

Select Chief of Surgery Menu Option: **U**nlock a Case for Editing

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

1. 05-15-91 CAROTID ARTERY ENDARTERECTOMY
2. 05-15-91 AORTO CORONARY BYPASS GRAFT Select Number: **1**

Press <Enter> to continue. **<Enter>**

Case #115 is now unlocked

Select Chief of Surgery Menu Option:

## Flag Drugs for Use as Anesthesia Agents

### [SROCODE]

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

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

Example: Flag Drugs Used as Anesthesia Agents

Select Surgery Package Management Menu Option: **D** Flag Drugs for use as Anesthesia Agents Enter the name of the drug you wish to flag: **HALOTHANE**

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

Enter the name of the drug you wish to flag:

## Update Site Configurable Files

### [SR UPDATE FILES]

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

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

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

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

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

Update Site Configurable Surgery Files

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

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

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

Update Information for which File ? **2**

Update Information in the Prosthesis file.

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

Select PROSTHESIS NAME: **HUMERAL**

ARE YOU ADDING 'HUMERAL' AS A NEW PROSTHESIS (THE 112TH)? **Y** (YES) NAME: HUMERAL // **HUMERAL COMPONENT**

VENDOR: **AMERICAN** MODEL: **NEER II** STERILE CODE: **MFG**

LOT/SERIAL NO: **F19705-1087** STERILE RESP: **MANUFACTURER** SIZE: **STEM 150 MM, HEAD 22 MM** QUANTITY: **<Enter>**

INACTIVE?: **<Enter>**

Select PROSTHESIS NAME:

Example 2: Re-Activate an Entry

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

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

Update Site Configurable Surgery Files

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

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

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

Update Information for which File ? **6**

Update Information in the Monitors file.

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

Select MONITORS NAME: ECG \*\* INACTIVE \*\*

NAME: ECG// **<Enter>**

INACTIVE?: YES// **@**

SURE YOU WANT TO DELETE? **Y** (YES)

Select MONITORS NAME:

## Surgery Interface Management Menu

### [SRHL INTERFACE]

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

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

|  |  |
| --- | --- |
| **Shortcut** | **Option Name** |
| I | *Flag Interface Fields* |
| F | *File Download* |
| T | *Table Download* |
| P | *Update Interface Parameter Field* |

# Chapter Six: Assessing Surgical Risk Introduction

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

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

**Exiting an Option or the System**

##### To get out of an option, the user should enter an up-arrow (**^**). The up-arrow can be entered at almost any prompt to terminate the line of questioning and return to the previous level in the routine. To completely exit the system, the user continues entering up-arrows.

September 2011 Surgery V. 3.0 User Manual 441

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

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

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

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

Preoperative Sleep Apnea: **NONE** NONE - LEVEL 1 DNR Status (Y/N): **N** NO

Functional Health Status at Evaluation for Surgery: **1** INDEPENDENT PULMONARY: **NO**

HEPATOBILIARY: **NO**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 1 OF 2** | | | | | | |
| JUN | 23,1998 | CHOLEDOCHOTOMY |  |  | |  |
|  | | | | | |
| 1. **GENERAL: NO**    1. **Height: 62 INCHES**    2. **Weight: 175 LBS.**    3. **Diabetes Mellitus: INSULIN**    4. **Current Smoker W/I 1 Year: YES**    5. **ETOH > 2 Drinks/Day: NO**    6. **Dyspnea: NO**    7. **Preop Sleep Apnea: LEVEL 1**    8. **DNR Status: NO**    9. **Preop Funct Status: INDEPENDENT** 2. **PULMONARY: NO**    1. **Ventilator Dependent: NO**    2. **History of Severe COPD: NO**    3. **Current Pneumonia: NO** | | | 1. **HEPATOBILIARY:**    1. **Ascites:** 2. **GASTROINTESTINAL:**    1. **Esophageal Varices:** 3. **CARDIAC:**    1. **CHF Within 1 Month:**    2. **MI Within 6 Months:**    3. **Previous PCI:**    4. **Previous Cardiac Surgery:**    5. **Angina Within 1 Month:**    6. **Hypertension Requiring Meds:** 4. **VASCULAR:**    1. **Revascularization/Amputation:**    2. **Rest Pain/Gangrene:** | **NO NO** | |  |
|  | | | | | |
| Select Preoperative Information to Edit: **<Enter>** | | | | | | |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 2 OF 2  JUN 23,1998 CHOLEDOCHOTOMY | | | | | |  |
|  | | | | | |
| 1. **RENAL:**    1. **Acute Renal Failure:**    2. **Currently on Dialysis:** | | | 1. **NUTRITIONAL/IMMUNE/OTHER:**    1. **Disseminated Cancer:**    2. **Open Wound:**    3. **Steroid Use for Chronic Cond.:**    4. **Weight Loss > 10%:**    5. **Bleeding Disorders:**    6. **Transfusion > 4 RBC Units:**    7. **Chemotherapy W/I 30 Days:**    8. **Radiotherapy W/I 90 Days:**    9. **Preoperative Sepsis:**    10. **Pregnancy: NOT APPLICABLE** | | |  |
| 1. **CENTRAL NERVOUS SYSTEM:**    1. **Impaired Sensorium:**    2. **Coma:**    3. **Hemiplegia:**    4. **History of TIAs:**    5. **CVA/Stroke w. Neuro Deficit:**    6. **CVA/Stroke w/o Neuro Deficit:**    7. **Tumor Involving CNS:** | | |
|  | | | | | |
| Select Preoperative Information to Edit: **3E** | | | | | | |
| SURPATIENT,SIXTY (000-56-7821) Case #63592  JUN 23,1998 CHOLEDOCHOTOMY | | | | |  | |
| History of Bleeding Disorders (Y/N): **Y** | | | YES | |

|  |  |
| --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 2 OF 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: NOT APPLICABLE    7. Tumor Involving CNS: |
| Select Preoperative Information to Edit: |

## Patient Demographics (Enter/Edit)

### [SROA DEMOGRAPHICS]

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

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

Example: Entering Patient Demographics

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

|  |  |  |  |
| --- | --- | --- | --- |
| 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 06, 2005@14:15 |  |  |
| 6. Hospital Discharge Date/Time: JUN 21, 2005@11:32 |  |  |
| 7. Admit/Transfer to Surgical Svc.: JUN 06, 2005@08:30 |  |  |
| 8. Discharge/Transfer to Chronic Care: JUN 21, 2005@11:32 |  |  |
| 9. Length of Postop Hospital Stay: 15 Days |  |  |
| 10. In/Out-Patient Status: INPATIENT |  |  |
| 11. Patient's Ethnicity: NOT HISPANIC OR LATINO |  |  |
| 12. Patient's Race: AMERICAN INDIAN OR ALASKA | NATIVE, | ASIAN |
| 13. Date of Death: NA |  |  |
| 14. 30-Day Death: NO |  |  |
| Select number of item to edit: | | |

## Intraoperative Occurrences (Enter/Edit)

### [SRO INTRAOP COMP]

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

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

Example: Enter an Intraoperative Occurrence

Select Non-Cardiac Assessment Information (Enter/Edit) Option: **IO** Intraoperative Occurrences (Enter/Edit)

SURPATIENT,EIGHT (000-37-0555)

Case #264

JUN 7,2005 ARTHROSCOPY, LEFT KNEE

There are no Intraoperative Occurrences entered for this case.

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

Definition Revised (2011): Indicate if there was any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) occurring in the operating room, ICU, ward, or out-of-hospital after the chest had been completely closed and within 30 days of surgery. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

If patient had cardiac arrest requiring CPR, indicate whether the arrest occurred intraoperatively or postoperatively. Indicate the one appropriate response:

* intraoperatively: occurring while patient was in the operating room
* postoperatively: occurring after patient left the operating room.

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

|  |  |
| --- | --- |
| SURPATIENT,EIGHT (000-37-0555) Case #264 JUN 7,2005 ARTHROSCOPY, LEFT KNEE |  |
| 1. Occurrence: CARDIAC ARREST REQUIRING CPR 2. Occurrence Category: CARDIAC ARREST REQUIRING CPR 3. ICD Diagnosis Code: 4. Treatment Instituted: 5. Outcome to Date: 6. Occurrence Comments: |
| Select Occurrence Information: **4:5** |

SURPATIENT,EIGHT (000-37-0555) Case #264 JUN 7,2005 ARTHROSCOPY, LEFT KNEE

Type of Treatment Instituted: **CPR**

Outcome to Date: **I** IMPROVED

|  |  |
| --- | --- |
| SURPATIENT,EIGHT (000-37-0555) Case #264 JUN 7,2005 ARTHROSCOPY, LEFT KNEE |  |
| 1. Occurrence: CARDIAC ARREST REQUIRING CPR 2. Occurrence Category: CARDIAC ARREST REQUIRING CPR 3. ICD Diagnosis Code: 4. Treatment Instituted: CPR 5. Outcome to Date: IMPROVED 6. Occurrence Comments: |
| Select Occurrence Information: **<Enter>** |

SURPATIENT,EIGHT (000-37-0555)

Case #264

JUN 7,2005 ARTHROSCOPY, LEFT KNEE

Enter/Edit Intraoperative Occurrences

1. CARDIAC ARREST REQUIRING CPR

Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:

## Postoperative Occurrences (Enter/Edit)

### [SRO POSTOP COMP]

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

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

Example: Enter a Postoperative Occurrence

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

SURPATIENT,EIGHT (000-37-0555) Case #264 JUN 7,2005 ARTHROSCOPY, LEFT KNEE

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

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

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

Press RETURN to continue: <Enter>

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

September 2011 Surgery V. 3.0 User Manual 461

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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:

## Alert Coder Regarding Coding Issues

### [SROA CODE ISSUE]

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

Example : Alert Coder Regarding Coding Issues

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

Select Patient: **SURPATIENT,TWO**

SC VETERAN

4-3-23 000451982

YES

SURPATIENT,THREE 000-45-1982

1. 05-10-05 CHOLECYSTECOMY (COMPLETED)
2. 01-27-06 BRONCHOSCOPY (COMPLETED) Select Operation: **1**

SURPATIENT,TWO (000-45-1982)

Case #10102

MAY 10,2005 CHOLECYSTECTOMY

The following "final" codes have been entered for the case. Principal CPT Code: 47563 LAPARO CHOLECYSTECTOMY/GRAPH

Other CPT Codes: NOT ENTERED

Postop Diagnosis Code (ICD9): 540.9 ACUTE APPENDICITIS NOS

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

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

==[ WRAP ]==[ INSERT ]=====< Coding Discrepancy Comments >===[ <PF1>H=Help ]====

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

<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======

1. Transmit Message
2. Edit Text

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

Transmitting message...

September 2011 Surgery V. 3.0 User Manual 464a

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

## Operative Risk Summary Data (Enter/Edit)

### [SROA CARDIAC OPERATIVE RISK]

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

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

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

**Example: Operative Risk Summary Data**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case JUN 18,2005 CORONARY ARTERY BYPASS  >> Coding Complete << | #60183 | PAGE: | 1 |  |
| 1. Physician's Preoperative Estimate of Operative Mortality: 78%   A. Date/Time Collected: JUN 17,2005@18:15   1. ASA Classification: 1-NO DISTURB. 2. Surgical Priority: 3. Preoperative Risk Factors: NONE   This information   1. CPT Codes (view only): 33510 cannot be edited. 2. Wound Classification: CLEAN | | | |
| Select Operative Risk Summary Information to Edit: **1:3** | | | |

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

Case #60183

Physician's Preoperative Estimate of Operative Mortality: 78

// **32**

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

// **<Enter>**

ASA Class: 1-NO DISTURB.// **3** 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 18,2005@13:29** (JUN 18, 2005@13:29)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case | | #60183 | PAGE: | 1 |  |
| JUN 18,2005 CORONARY ARTERY BYPASS | |  |  |  |
| >> Coding Complete << | |  |  |  |
| 1. Physician's Preoperative Estimate of Operative Mortality: 32% | | | | |
| A. Date/Time Collected: JUN 18,2005 18:15 | | | | |
| 2. ASA Classification: 3-SEVERE DISTURB. | | | | |
| 3. Surgical Priority: EMERGENT (ONGOING ISCHEMIA) | | | | |
| A. Date/Time Collected: JUN 18,2005 13:29 | | | | |
| 4. Preoperative Risk Factors: NONE | | | | |
| 5. CPT Codes (view only): | 33510 |  |  |  |
| 6. Wound Classification: | CLEAN |
| \*\*\* NOTE: D/Time of Surgical Priority should be < the D/Time Patient 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.

## Cardiac Procedures Operative Data (Enter/Edit)

### [SROA CARDIAC PROCEDURES]

The *Cardiac Procedures Operative Data (Enter/Edit)* option is used to enter or edit information related to cardiac procedures requiring cardiopulmonary bypass (CPB). The software will present two pages. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance the user to another option.

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

##### At this prompt, the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items. You can also use number-letter combinations, such as **11B**, to update a field within a group, such as VSD Repair.

Each prompt at the category level allows for an entry of **YES** or **NO**. If **NO** is entered, each item under that category will automatically be answered **NO**. On the other hand, responding **YES** at the category level allows the user to respond individually to each item under the main category.

##### Entry of **N** shall allow the user to **Set All to No** for the Cardiac Procedures fields. A verification prompt will follow to ensure that user understands the entry.

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

##### Items #1-#5 are numeric and their values will be set to 0.

* Valve Procedures will be set to NONE

##### #13 Maze Procedure will be set to NO MAZE PERFORMED

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

**Example: Enter Cardiac Procedures Operative Data**

Select Cardiac Risk Assessment Information (Enter/Edit) Option: **CARD** Cardiac Pr ocedures Operative Data (Enter/Edit)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case JUN 18,2005 CORONARY ARTERY BYPASS | #60183 | PAGE: | 1 | OF | 2 |  |
| Cardiac surgical procedures with or without cardiopulmonary bypass CABG distal anastomoses: 13. Maze procedure:   1. Number with vein: 14. ASD repair: 2. Number with IMA: 15. VSD repair: 3. Number with Radial Artery: 16. Myectomy: 4. Number with Other Artery: 17. Myxoma resection: 5. Number with Other Conduit: 18. Other tumor resection:   19. Cardiac transplant:   1. LV Aneurysmectomy: 20. Great Vessel Repair: 2. Bridge to transplant/Device: 21. Endovascular Repair: 3. TMR: 22. Other cardiac procedures: 4. Aortic Valve Procedure: 5. Mitral Valve Procedure: 6. Tricuspid Valve Procedure: 7. Pulmonary Valve Procedure: | | | | | |
| Select Cardiac Procedures Operative Information to Edit: **A** | | | | | |

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

CABG Distal Anastomoses with Vein: **1** CABG Distal Anastomoses with IMA: **1** Number with Radial Artery: **0**

Number with Other Artery: **1**

CABG Distal Anastomoses with Other Conduit: **1**

LV Aneurysmectomy (Y/N): **N** NO

Device for bridge to cardiac transplant / Destination therapy: **??**

Definition Revised (2006):

Indicate if patient received a mechanical support device (excluding IABP) as a bridge to cardiac transplant during the same

admission as the transplant procedure; or patient received the device as destination therapy (does not intend to have a cardiac transplant), either with or without placing the patient on cardiopulmonary bypass.

Choose from:

N NONE

B BRIDGE TO TRANSPLANT

D DESTINATION THERAPY

Device for bridge to cardiac transplant / Destination therapy: **N** NONE Transmyocardial Laser Revascularization: **N** NO

Aortic Valve Procedure: **??**

VASQIP Definition (2010):

Indicate if the patient had an aortic valve replacement (either the native or a prosthetic valve) or a repair (on the native valve to relieve stenosis and/or correct regurgitation -annuloplasty, commissurotomy, etc.); performed with or without additional procedure(s); either with or without placing the patient on cardiopulmonary bypass. (If a repair was attempted, but a replacement occurred, indicate the details of the replacement valve.) Indicate the one most appropriate procedure:

* None
* Mechanical Valve
* Stented Bioprosthetic Valve
* Stentless Bioprosthetic Valve
* Homograft
* Primary Valve Repair
* Primary Valve Repair and Annuloplasty Device
* Annuloplasty Device alone
* Autograft Procedure (Ross Procedure)
* Other

Choose from:

N NONE

M MECHANICAL

S STENTED BIOPROSTHETIC

B STENTLESS BIOPROSTHETIC

H HOMOGRAFT

PR PRIMARY REPAIR

PA PRIMARY REPAIR & ANNULOPLASTY DEVICE AN ANNULOPLASTY DEVICE ALONE

AU AUTOGRAFT (ROSS)

O OTHER

Aortic Valve Procedure: **PR** PRIMARY REPAIR Mitral Valve Procedure: **N** NONE

Tricuspid Valve Procedure: **N** NONE Pulmonary Valve Procedure: **N** NONE Maze Procedure: **N** NO MAZE PERFORMED ASD Repair (Y/N): **N** NO

VSD Repair (Y/N): **N** NO Myectomy (Y/N): **N** NO

Myxoma Resection (Y/N): **N** NO Other Tumor Resection (Y/N): **N** NO Cardiac Transplant (Y/N): **N** NO Great Vessel Repair (Y/N): **N** NO

Endovascular Repair of Aorta: **N** NO

Other Cardiac Procedures (Y/N): **N** NO

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) JUN 18,2005 CORONARY ARTERY BYPASS | Case | #60183 | PAGE: | 1 | of | 2 |  |
| Cardiac surgical procedures with or without cardiopulmonary bypass  CABG distal anastomoses: 13. Maze procedure: NO MAZE PERFORMED   1. Number with vein: 1 14. ASD repair: NO 2. Number with IMA: 1 15. VSD repair: NO 3. Number with Radial Artery: 0 16. Myectomy: NO 4. Number with Other Artery: 1 17. Myxoma resection: NO 5. Number with Other Conduit: 1 18. Other tumor resection: NO   19. Cardiac transplant: NO   1. LV Aneurysmectomy: NO 20. Great Vessel Repair: NO 2. Bridge to transplant/Device: NONE 21. Endovascular Repair: NO 3. TMR: NO 22. Other cardiac procedures: NO | | | | | | |
| 1. Aortic Valve Procedure: PRIMARY REPAIR 2. Mitral Valve Procedure: NONE 3. Tricuspid Valve Procedure: NONE 4. Pulmonary Valve Procedure: NONE | | | | | | |
| Select Operative Information to Edit: **<Enter>** | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) JUN 18,2005 CORONARY ARTERY BYPASS | | Case | #60183 | PAGE: | 2 | of | 2 |  |
| Indicate other cardiac procedures only if done with cardiopulmonary bypass | | | | | | | |
| 1. Foreign Body Removal: 2. Pericardiectomy: | N/A (began on-pump/ stayed on-pump) | | | | | | |
| Other Operative Data details: |
| 1. Total CPB Time: 2. Total Ischemic Time: 3. Incision Type: 4. Convert Off Pump to CPB: |
| Select Operative Information to Edit: | | | | | | | |

## Outcome Information (Enter/Edit)

### [SROA CARDIAC-OUTCOMES]

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

Example: Enter Outcome Information

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

|  |  |  |  |
| --- | --- | --- | --- |
| SURPATIENT,TWENTY (000-45-4886) OUTCOMES INFORMATION  FEB 10,2004 CABG | Case #238 | PAGE: 1 |  |
| 0. Operative Death: NO | | |
| Perioperative (30 day) Occurrences: | | |
| 1. Perioperative MI: NO 8. Repeat cardiac surg procedure: YES 2. Endocarditis: NO 9. Tracheostomy: YES 3. Renal failure require dialysis: NO 10. Repeat ventilator w/in 30 days: YES 4. Mediastinitis: YES 11. Stroke: NO 5. Cardiac arrest requiring CPR: YES 12. Coma >= 24 hr: NO 6. Reoperation for bleeding: NO 13. New Mech Circ Support: YES 7. On ventilator >= 48 hr: NO 14. Postop Atrial Fibrillation: NO   15. Wound Disruption: YES | | |
| Select Outcomes Information to Edit: **8**  Repeat Cardiac Surgical Procedure (Y/N): NO// **Y** YES Cardiopulmonary Bypass Status: **?** | | |
| Enter NONE, ON BYPASS, or OFF BYPASS.   1. None 2. On-bypass 3. Off-bypass | | |
| Cardiopulmonary Bypass Status: **1** On-bypass | | |

|  |  |
| --- | --- |
| SURPATIENT,TWENTY (000-45-4886) Case #238 PAGE: 1 OUTCOMES INFORMATION  FEB 10,2004 CABG |  |
| 1. Operative Death: NO Perioperative (30 day) Occurrences: 2. Perioperative MI: NO 8. Repeat cardiac surg procedure: YES 3. Endocarditis: NO 9. Tracheostomy: YES 4. Renal failure require dialysis: NO 10. Repeat ventilator w/in 30 days: YES 5. Mediastinitis: YES 11. Stroke: NO 6. Cardiac arrest requiring CPR: YES 12. Coma >= 24 hr: NO 7. Reoperation for bleeding: NO 13. New Mech Circ Support: YES 8. On ventilator >= 48 hr: NO 14. Postop Atrial Fibrillation: NO   15. Wound Disruption: YES |
| Select Outcomes Information to Edit: |

## Intraoperative Occurrences (Enter/Edit)

### [SRO INTRAOP COMP]

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

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

Example: Enter an Intraoperative Occurrence

Select Cardiac Risk Assessment Information (Enter/Edit) Option: **IO** Intraoperative Occurrences (Enter/Edit)

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

JUN 18,2005 CORONARY ARTERY BYPASS

There are no Intraoperative Occurrences entered for this case. Enter a New Intraoperative Occurrence: **CARDIAC ARREST REQUIRING CPR**

Definition Revised (2011): Indicate if there was any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) occurring in the operating room, ICU, ward, or out-of-hospital after the chest had been completely closed and within 30 days of surgery. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

If patient had cardiac arrest requiring CPR, indicate whether the arrest occurred intraoperatively or postoperatively. Indicate the one appropriate response:

* intraoperatively: occurring while patient was in the operating room
* postoperatively: occurring after patient left the operating room

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

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

|  |  |  |
| --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) | Case #60183 |  |
| JUN 18,2005 CORONARY ARTERY BYPASS |  |
| Occurrence Category: CARDIAC ARREST REQUIRING CPR | |
| // **<Enter>** | |
| ICD Diagnosis Code: **102.8** 102.8 LATENT YAWS | |
| ...OK? YES// <Enter> (YES) | |
| Type of Treatment Instituted: **CPR** | |
| Outcome to Date: **I** IMPROVED | |

|  |  |
| --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 JUN 18,2005 CORONARY ARTERY BYPASS |  |
| 1. Occurrence: CARDIAC ARREST REQUIRING CPR 2. Occurrence Category: CARDIAC ARREST REQUIRING CPR 3. ICD Diagnosis Code: 102.8 4. Treatment Instituted: CPR 5. Outcome to Date: IMPROVED 6. Occurrence Comments: |
| Select Occurrence Information: **<Enter>** |

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

JUN 18,2005 CORONARY ARTERY BYPASS

Enter/Edit Intraoperative Occurrences

1. CARDIAC ARREST REQUIRING CPR

Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:

## Postoperative Occurrences (Enter/Edit)

### [SRO POSTOP COMP]

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

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

Example: Enter a Postoperative Occurrence

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

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

JUN 18,2005 CORONARY ARTERY BYPASS

There are no Postoperative Occurrences entered for this case. Enter a New Postoperative Occurrence: **CARDIAC ARREST REQUIRING CPR**

Definition Revised (2011): Indicate if there was any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) occurring in the operating room, ICU, ward, or out-of-hospital after the chest had been completely closed and within 30 days of surgery.

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

If patient had cardiac arrest requiring CPR, indicate whether the arrest occurred intraoperatively or postoperatively. Indicate the one appropriate response:

* intraoperatively: occurring while patient was in the operating room
* postoperatively: occurring after patient left the operating room

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

|  |  |
| --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 JUN 18,2005 CORONARY ARTERY BYPASS |  |
| 1. Occurrence: CARDIAC ARREST REQUIRING CPR 2. Occurrence Category: CARDIAC ARREST REQUIRING CPR 3. ICD Diagnosis Code: 4. Treatment Instituted: 5. Outcome to Date: 6. Date Noted: 7. Occurrence Comments: |
| Select Occurrence Information: **4:6** |

September 2011 Surgery V. 3.0 User Manual 477

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

JUN 18,2005 CORONARY ARTERY BYPASS

Treatment Instituted: **CPR**

Outcome to Date: **I** IMPROVED

Date/Time the Occurrence was Noted: **6/19/05** (JUN 19, 2005)

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

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

JUN 18,2005 CORONARY ARTERY BYPASS

Enter/Edit Intraoperative Occurrences

1. CARDIAC ARREST REQUIRING CPR

Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:

## Alert Coder Regarding Coding Issues

### [SROA CODE ISSUE]

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

Example : Alert Coder Regarding Coding Issues

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

Select Patient: **SURPATIENT,NINETEEN**

SC VETERAN

000287354

YES

SURPATIENT,NINETEEN 000-28-7354

1. 05-10-05 CHOLECYSTECOMY (COMPLETED)
2. 06-18-05 \* CORONARY ARTERY BYPASS (COMPLETED) Select Operation: **2**

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

JUN 18,2005 CORONARY ARTERY BYPASS

The following "final" codes have been entered for the case. Principal CPT Code: 33510

Other CPT Codes: NOT ENTERED

Postop Diagnosis Code (ICD9): 402.10 HYP HEART DIS BENING W/0 FAIL

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

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

==[ WRAP ]==[ INSERT ]=====< Coding Discrepancy Comments >===[ <PF1>H=Help ]====

I have reviewed this case for VASQIP. The final Principal CPT Code entered is 33510. I would like to talk to you regarding the code. I think the code should be 33502. Please call me at X2545.

<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======

1. Transmit Message
2. Edit Text

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

September 2011 Surgery V. 3.0 User Manual 480a

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

# Print a Surgery Risk Assessment

### [SROA PRINT ASSESSMENT]

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

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

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

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

Select Patient: **SURPATIENT,FORTY**

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*

|  |  |
| --- | --- |
| 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, 2006  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 In/Out-Patient Status: INPATIENT  Assessment Completed by: SURNURSE,SEVEN |
| PREOPERATIVE INFORMATION |
| GENERAL: NO HEPATOBILIARY: NO  Height: 70 INCHES Ascites: NO  Weight: 180 LBS.  Diabetes Mellitus: NO GASTROINTESTINAL: NO Current Smoker W/I 1 Year: NO Esophageal Varices: NO ETOH > 2 Drinks/Day: NO  Dyspnea: NO CARDIAC: NO Preop Sleep Apnea: LEVEL 1 CHF Within 1 Month: NO DNR Status: NO MI Within 6 Months: NO Preop Funct Status: INDEPENDENT Previous PCI: NO  Previous Cardiac Surgery: NO  PULMONARY: NO Angina Within 1 Month: NO Ventilator Dependent: NO Hypertension Requiring Meds: NO History of Severe COPD: NO  Current Pneumonia: NO VASCULAR: NO  Revascularization/Amputation: NO Rest Pain/Gangrene: NO |
| RENAL: YES NUTRITIONAL/IMMUNE/OTHER: YES  Acute Renal Failure: NO Disseminated Cancer: NO Currently on Dialysis: NO Open Wound: NO  Steroid Use for Chronic Cond.: NO CENTRAL NERVOUS SYSTEM: YES Weight Loss > 10%: NO  Impaired Sensorium: NO Bleeding Disorders: NO Coma: NO Transfusion > 4 RBC Units: NO  Hemiplegia: NO Chemotherapy W/I 30 Days: NO  History of TIAs: NO Radiotherapy W/I 90 Days: NO CVA/Stroke w. Neuro Deficit: YES Preoperative Sepsis: NONE CVA/Stroke w/o Neuro Deficit: NO Pregnancy: NOT APPLICABLE Tumor Involving CNS: NO |
| OPERATION DATE/TIMES INFORMATION |
| Patient in Room (PIR): JAN 9,2006 07:25 Procedure/Surgery Start Time (PST): JAN 9,2006 07:25 Procedure/Surgery Finish (PF): JAN 9,2006 08:00 Patient Out of Room (POR): JAN 9,2006 08:10 Anesthesia Start (AS): JAN 9,2006 07:15  Anesthesia Finish (AF): JAN 9,2006 08:08  Discharge from PACU (DPACU): JAN 9,2006 09:15 |

482 Surgery V. 3.0 User Manual September 2011

Example 2: Print Surgery Risk Assessment for a Cardiac Case

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

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

Select Patient: **R9922** SURPATIENT,NINE VETERAN

12-19-51

000345555

NO

SC

SURPATIENT,NINE 000-34-5555

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

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

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

###### printout follows

|  |  |
| --- | --- |
| VA SURGICAL QUALITY IMPROVEMENT PROGRAM – CARDIAC SPECIALTY  ================================================================================   1. IDENTIFYING DATA   Patient: SURPATIENT,NINE 000-34-5555 Case #: 238 Fac./Div. #: 500  Surgery Date: 07/01/06 Address: Anyplace Way  Phone: NS/Unknown Zip Code: 33445-1234 Date of Birth: 12/19/51  ================================================================================   1. CLINICAL DATA   Gender: MALE Prior MI: < OR = 7 DAYS OF SURG  Age: 56 # of prior heart surgeries: 1  Height: 76 in Prior heart surgeries: Valve-only  Weight: 210 lb Peripheral Vascular Disease: YES  Diabetes: ORAL Cerebral Vascular Disease: NO  COPD: YES Angina (use CCS Class): IV  FEV1: NS CHF (use NYHA Class): II  Cardiomegaly (X-ray): YES Current Diuretic Use: YES Pulmonary Rales: YES Current Digoxin Use: NO Current Smoker: WITHIN 2 WEEKS OF SURG IV NTG 48 Hours Preceding Surgery: YES Active Endocarditis: NO Preop Circulatory Device: NONE Resting ST Depression: NO Hypertension: YES Functional Status: INDEPENDENT Preoperative Atrial Fibrillation: NO PCI: None   1. DETAILED LABORATORY INFO - PREOPERATIVE VALUES   Creatinine: mg/dl (NS) T. Cholesterol: mg/dl (NS) Hemoglobin: mg/dl (NS) HDL: mg/dl (NS)  Albumin: g/dl (NS) LDL: mg/dl (NS) Triglyceride: mg/dl (NS) Hemoglobin A1c: % (NS) Potassium: mg/L (NS) BNP: mg/dl (NS)  T. Bilirubin: mg/dl (NS)  IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA Cardiac Catheterization Date: 06/28/06  Procedure: NS Native Coronaries:  LVEDP: NS Left Main Stenosis: NS Aortic Systolic Pressure: NS LAD Stenosis: NS  Right Coronary Stenosis: NS For patients having right heart cath: Circumflex Stenosis: NS PA Systolic Pressure: NS  PAW Mean Pressure: NS If a Re-do, indicate stenosis  in graft to:  LAD: NS  Right coronary (include PDA): NS Circumflex: NS | |
| LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo): Grade Ejection Fraction Range Definition  NO LV STUDY |  |
| Mitral Regurgitation: NS Aortic stenosis: NS  V. OPERATIVE RISK SUMMARY DATA Physician's Preoperative  Estimate of Operative Mortality: NS 07/28/06 15:30) ASA Classification: 3-SEVERE DISTURB.  Surgical Priority: ELECTIVE 07/28/06 15:31) Principal CPT Code: 33517  Other Procedures CPT Codes: 33510  Preoperative Risk Factors:  Wound Classification: CLEAN |

SURPATIENT,NINE 00-34-5555

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

1. OPERATIVE DATA

Cardiac surgical procedures with or without cardiopulmonary bypass

CABG distal anastomoses: Maze procedure: NO MAZE PERFORMED Number with Vein: 1 ASD repair: NO

Number with IMA: 1 VSD repair: NO

Number with Radial Artery: 0 Myectomy: NO

Number with Other Artery: 1 Myxoma resection: NO Number with Other Conduit: 1 Other tumor resection: NO LV Aneurysmectomy: NO Cardiac transplant: NO Bridge to transplant/Device: NONE Great Vessel Repair: NO TMR: NO Endovascular Repair: NO Other Cardiac procedure(s): NO

Aortic Valve Procedure: PRIMARY REPAIR

Mitral Valve Procedure: NONE Tricuspid Valve Procedure: NONE Pulmonary Valve Procedure: NONE

\* Other Cardiac procedures (Specify):

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

Pericardiectomy: YES

Other Operative Data details

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

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

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 Postop Atrial Fibrillation: NO

Wound Disruption: YES

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 Operation Began: 07/01/06 10:10 Operation Ended: 07/10/06 12:30 Time Patient Out OR: 07/01/06 12:20 Date and Time Patient Extubated: 07/10/06 13:13

Postop Intubation Hrs: +1.9

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

Cardiac Surg Performed at Non-VA Facility: UNKNOWN Resource Data Comments:

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

1. SOCIOECONOMIC, ETHNICITY, AND RACE

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

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

1. DETAILED DISCHARGE INFORMATION

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

Type of Disposition: TRANSFER

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

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

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

# Monthly Surgical Case Workload Report

### [SROA MONTHLY WORKLOAD REPORT]

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

Example: Monthly Surgical Case Workload Report – Single Month

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

Report of Monthly Case Workload Totals Print which report?

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

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

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

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

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

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

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

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

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

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

*printout follows*

September 2011 Surgery V. 3.0 User Manual 509

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

# Update 1-Liner Case

### [SROA ONE-LINER UPDATE]

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

Example: Update 1-Liner Case

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: |

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

# Queue Assessment Transmissions

### [SROA TRANSMIT ASSESSMENTS]

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

Example: Queue Assessment Transmissions

Select Surgery Risk Assessment Menu Option: **T** Queue Assessment Transmissions Transmit Surgery Risk Assessments

Requested Start Time: NOW// **<Enter>**

Queued as task #2651700 Press RETURN to continue

September 2011 Surgery V. 3.0 User Manual 521

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

# Alert Coder Regarding Coding Issues

### [SROA CODE ISSUE]

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

Example : Alert Coder Regarding Coding Issues

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

Select Patient: **SURPATIENT,TWELVE**

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 Operation: **1**

SURPATIENT,TWELVE (000-41-8719)

Case #142

AUG 7,2004 REPAIR DIAPHRAGMATIC HERNIA

The following "final" codes have been entered for the case. Principal CPT Code: 39540 REPAIR DIAPHRAGMATIC HERNIA

Other CPT Codes: NOT ENTERED

Postop Diagnosis Code (ICD9): 551.3 DIAPHRAGM HERNIA W GANGR (w C/C)

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

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

==[ WRAP ]==[ INSERT ]=====< Coding Discrepancy Comments >===[ <PF1>H=Help ]====

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

<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======

1. Transmit Message
2. Edit Text

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

Transmitting message...

September 2011 Surgery V. 3.0 User Manual 522a

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

# Risk Model Lab Test

### [SROA LAB TEST EDIT]

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

Risk Model Lab Test (Enter/Edit)

Select Surgery Risk Assessment Menu Option: Risk Model Lab Test (Enter/Edit)

Risk Model Lab Test (Enter/Edit) Select item to edit from list below:

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

Enter number (1-25): **6**

Risk Model Lab Test (Enter/Edit)

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

Specimen: SERUM

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

Select LABORATORY DATA NAME: **CHOLESTEROL**

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

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

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

September 2011 Surgery V. 3.0 User Manual 522c

Risk Model Lab Test (Enter/Edit) Select item to edit from list below:

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

Enter number (1-26):

# Chapter Nine: Assessing Transplants

# Introduction

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

September 2011 Surgery V. 3.0 User Manual 527

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETYSIX JUN 17,2008 KIDNEY | (0288) VACO TRANSPLANT | ID: | 12121 | CASE: | 482 | PAGE: 1 OF 5 RECIPIENT INFORMATION | |  |
| 1. VACO ID: 12121   1. Date Placed on Waiting: 2. Date Started Dialysis: 3. Recipient ABO Blood Type: 4. Recipient CMV: | |  |  | | | |  |
| Diagnosis Information  ======================   1. Calcineurin Inhibitor Toxicity: 2. Glomerular Sclerosis/Nephritis: 3. Graft Failure: 4. IgA Nephropathy: 5. Lithium Toxicity: 6. Membranous Nephropathy: | |  | 1. Obstructive Uropathy from BPH: 2. Polycistic Disease: 3. Renal Cancer: 4. Rejection: | | | |
| 12. Transplant Comments: | |  |  | | | |
| Select Transplant Information to Edit: **2:5** | | | | | | |

|  |  |  |
| --- | --- | --- |
| SURPATIENT,NINETYSIX (0288) VACO ID: 12121 | CASE: 482 |  |
| JUN 17,2008 KIDNEY TRANSPLANT |  |
| Date Placed on Waiting List: **05/04/2008** (MAY 04, 2008) | |
| Date Started Dialysis: **1 21 08** (JAN 21, 2008) | |
| Recipient ABO Blood Type: **O** O | |
| Recipient CMV: **+** POSITIVE | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETYSIX JUN 17,2008 KIDNEY | (0288) VACO TRANSPLANT | ID: | 12121 | CASE: | 482 | PAGE: 1 OF 5 RECIPIENT INFORMATION | |  |
| 1. VACO ID: 12121 | | | | | | |  |
| 2. Date Placed on Waiting: MAY 04, 2008 | | | | | | |
| 3. Date Started Dialysis: JAN 21, 2008 | | | | | | |
| 4. Recipient ABO Blood Type: O | | | | | | |
| 5. Recipient CMV: POSITIVE | | | | | | |
| Diagnosis Information | | | | | | |
| ====================== | | | | | | |
| 6. Calcineurin Inhibitor Toxicity: 13. Obstructive Uropathy from BPH: | | | | | | |
| 7. Glomerular Sclerosis/Nephritis: 14. Polycistic Disease: | | | | | | |
| 8. Graft Failure: 15. Renal Cancer: | | | | | | |
| 9. lgA Nephropathy: 16. Rejection: | | | | | | |
| 10. Lithium Toxicity: | | | | | | |
| 11. Membranous Nephropathy: | | | | | | |
| 12. Transplant Comments: | | | | | | |
| Select Transplant Information to Edit: **<Enter>** | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETYSIX JUN 17,2008 KIDNEY | (0288) VACO TRANSPLANT | ID: | 12121 | CASE: 482  KIDNEY | PAGE: 2 OF 5 TRANSPLANT INFORMATION | |  |
| 1. Warm Ischemia time: | | | | | |  |
| 2. Cold Ischemia time: | | | | | |
| 3. Total Ischemia time: | | | | | |
| 4. Crossmatch D/R: | | | | | |
| 5. PRA at Listing: | | | | | |
| 6. PRA at Transplant: | | | | | |
| 7. IVIG Recipient: | | | | | |
| 8. Plasmapheresis: | | | | | |
| HLA Typing (#,#,#,#) | | | | | |
| ==================== | | | | | |
| 9. Recipient HLA-A: | | | | | |
| 10. Recipient HLA-B: | | | | | |
| 11. Recipient HLA-C: | | | | | |
| 12. Recipient HLA-DR: | | | | | |
| 13. Recipient HLA-BW: | | | | | |
| 14. Recipient HLA-DQ: | | | | | |
| Select Transplant Information to Edit: **<Enter>** | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETYSIX JUN 17,2008 KIDNEY | (0288) VACO TRANSPLANT | ID: | 12121 | CASE: | 482 | PAGE: 3 OF 5 RISK ASSESSMENT | |  |
| 1. Diabetic Retinopathy: 2. Diabetic Neuropathy: 3. Cardiac Disease: 4. Liver Disease: 5. HIV + (positive): 6. Lung Disease: 7. Pre-Transplant Malignancy: 8. Active Infection Immediately Pre-TX req. Antibiotics: 9. Non-Compliance (Med and Diet): 10. Recipient Substance Abuse: 11. Post-TX Prophylaxis for CMV/Antiviral Treatment: 12. Post-TX Prophylaxis for PCP/Antibiotic Treatment: 13. Post-TX Prophylaxis for TB/Antimycobacterial Treatment: 14. Graft Failure Date: | | | | | | |  |
| Select Transplant Information to Edit: **<Enter>** | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETYSIX (0288) VACO | ID: | 12121 | CASE: 482 PAGE: 4 OF 5 | |  |
| JUN 17,2008 KIDNEY TRANSPLANT |  |  | DONOR INFORMATION | |
| 1. Donor Race: |  |  |  |  |
| 2. Donor Gender: |  |  |  |
| 3. Donor Height: |  |  | HLA Typing (#,#,#,#) |
| 4. Donor Weight: |  |  | ==================== |
| 5. Donor DOB: |  |  | 13. Donor HLA-A: |
| 6. Donor Age: |  |  | 14. Donor HLA-B: |
| 7. Donor ABO Blood Type: |  |  | 15. Donor HLA-C: |
| 8. Donor CMV: |  |  | 16. Donor HLA-DR: |
| 9. Donor Substance Abuse: |  |  | 17. Donor HLA-BW: |
| 10. Deceased Donor: |  |  | 18. Donor HLA-DQ: |
| 11. Living Donor: |  |  |  |
| 12. Donor with Malignancy: |  |  |  |
| Select Transplant Information to Edit: **<Enter>** | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETYSIX | (0288) VACO | ID: | 12121 | CASE: | 482 | PAGE: 5 OF 5 | |  |
| JUN 17,2008 KIDNEY | TRANSPLANT |  |  |  |  | PANCREAS INFORMATION | |
| 1. Pancreas (SPK/PAK): NO STUDY | | | | | | |  |
| 2. Glucose at Time of Listing: NO STUDY | | | | | | |
| 3. C-peptide at Time of Listing: NO STUDY | | | | | | |
| 4. Pancreatic Duct Anastomosis: NO STUDY | | | | | | |
| 5. Glucose Post Transplant: NO STUDY | | | | | | |
| 6. Amylase Post Transplant: NO STUDY | | | | | | |
| 7. Lipase Post Transplant: NO STUDY | | | | | | |
| 8. Insulin Req Post transplant: NO STUDY | | | | | | |
| 9. Oral Hypoglycemics Req Post-TX: NO STUDY | | | | | | |
| Select Transplant Information to Edit: **<Enter>** | | | | | | |
| Are you ready to complete and transmit this transplant assessment? NO// **<Enter>** | | | | | | |

**Edit a Transplant Assessment**

##### When selecting an existing transplant assessment, the user has the following options.

* + Enter Transplant Assessment Information

##### Delete Transplant Assessment Entry

* + Update Transplant Assessment Status to 'COMPLETE'
  + Change VA/Non-VA Transplant Indicator

**Enter Transplant Assessment Information**

Example: Editing a Transplant Assessment

Division: ALBANY (500)

E P L S

Enter/Edit Transplant Assessments Print Transplant Assessment

List of Transplant Assessments

Transplant Assessment Parameters (Enter/Edit)

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

Select Patient: **SURPATIENT,NINETYSIX** 05-05-64 666000288

NSC VETERAN

SURPATIENT,NINETYSIX 666-00-0288

1. 06-17-08 KIDNEY TRANSPLANT (INCOMPLETE)

2. ----

CREATE NEW TRANSPLANT ASSESSMENT

Select Assessment: **1**

SURPATIENT,NINETYSIX

06-17-06

KIDNEY TRANSPLANT (INCOMPLETE)

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

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETYSIX JUN 17,2008 KIDNEY | (0288) VACO TRANSPLANT | ID: | 12121 | CASE: | 482 | PAGE: 1 OF 5 RECIPIENT INFORMATION | |  |
| 1. VACO ID: 12121 | | | | | | |  |
| 2. Date Placed on Waiting: MAY 04, 2008 | | | | | | |
| 3. Date Started Dialysis: JAN 21, 2008 | | | | | | |
| 4. Recipient ABO Blood Type: O | | | | | | |
| 5. Recipient CMV: POSITIVE | | | | | | |
| Diagnosis Information | | | | | | |
| ====================== | | | | | | |
| 6. Calcineurin Inhibitor Toxicity: 13. Obstructive Uropathy from BPH: | | | | | | |
| 7. Glomerular Sclerosis/Nephritis: 14. Polycistic Disease: | | | | | | |
| 8. Graft Failure: 15. Renal Cancer: | | | | | | |
| 9. lgA Nephropathy: 16. Rejection: | | | | | | |
| 10. Lithium Toxicity: | | | | | | |
| 11. Membranous Nephropathy: | | | | | | |
| 12. Transplant Comments: | | | | | | |
| Select Transplant Information to Edit: **6** | | | | | | |

# Chapter Ten: Glossary

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

|  |  |
| --- | --- |
| **Term** | **Definition** |
| Aborted | Case status indicating the case was cancelled after the patient entered the operating room. Cases with ABORTED status must contain entries in TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232), plus  CANCEL DATE field (#17) and/or CANCEL REASON field (#18). |
| ASA Class | This is the American Society of Anesthesiologists classification relating to the  patient’s physiologic status. Numbers followed by an 'E' indicate an emergency. |
| Attending Code | Code that corresponds to the highest level of supervision provided by the  attending staff surgeon during the procedure. |
| Blockout Graph | Graph showing the availability of operating rooms. |
| Cancelled Case | Case status indicating that an entry has been made in the CANCEL DATE  field and/or the CANCEL REASON field without the patient entering the operating room. |
| CCSHS | VA Center for Cooperative Studies in Health Services located at Hines,  Illinois. |
| CICSP | Continuous Improvement in Cardiac Surgery Program. |
| Completed Case | Case status indicating that an entry has been made in the TIME PAT OUT OR  field. |
| Concurrent Case | A patient undergoing two operations by different surgical specialties at the  same time, or back to back, in the same operating room. |
| CPT Code | Also called Operation Code. CPT stands for Current Procedural Terminology. |
| CRT | Cathode ray tube display. A display device that uses a cathode ray tube. |
| Intraoperative  Occurrence | Perioperative occurrence during the procedure. |
| Major | Any operation performed under general, spinal, or epidural anesthesia plus all  inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered. |
| Minor | All operations not designated as Major. |
| New Surgical Case | A surgical case that has not been previously requested or scheduled such as an emergency case. A surgical case entered in the records without being booked through scheduling will not appear on the Schedule of Operations or as an  operative request. |
| Non-Operative  Occurrence | Occurrence that develops before a surgical procedure is performed. |
| Not Complete | Case status indicating one of the following two situations with no entry in the TIME PAT OUT OR field (#.232).   1. Case has entry in TIME PAT IN OR field (#.205). 2. Case has not been requested or scheduled. |
| NSQIP | National Surgical Quality Improvement Program. |
| Operation Code | Identifying code for reporting medical services and procedures performed by  physicians. See CPT Code. |

|  |  |
| --- | --- |
| PACU | Post Anesthesia Care Unit. |
| Postoperative  Occurrence | Perioperative occurrence following the procedure. |
| Procedure Occurrence | Occurrence related to a non-O.R. procedure. |
| Requested | Operation has been slotted for a particular day but the time and operating room  are not yet firm. |
| Risk Assessment | Part of the Surgery software that provides medical centers a mechanism to track information related to surgical risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical  analysis. |
| Scheduled | Operation has both an operating room and a scheduled starting time, but the  operation has not yet begun. |
| Screen Server | A format for displaying data on a cathode ray tube display. Screen Server is  designed specifically for the Surgery Package. |
| Screen Server  Function | The Screen Server prompt for data entry. |
| Service Blockouts | The reservation of an operating room for a particular service on a recurring  basis. The reservation is charted on a blockout graph. |
| Transplant Assessments | Part of the Surgery software that provides medical centers a mechanism to track information related to transplant risk and operative mortality. Completed  assessments are transmitted to the VASQIP national database for statistical analysis. |
| VASQIP | Veterans Affairs Surgery Quality Improvement Program. |

550 Surgery V. 3.0 User Manual September 2011

# Index

## A

##### AAIS, 437, 438

anesthesia

agents, 130, 162

entering data, 163

printing information, 170

staff, 164

techniques, 162

##### anesthesia agents

flagging a drug, 431

##### anesthesia personnel, 61, 130

assigning, 173

scheduling, 84

##### anesthesia technique

entering information, 165, 173

##### assessment

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

Automated Anesthesia Information System (AAIS), 437, 438

## B

##### bar code reader, 160

blockout an operating room, 86 blockout graph, 60

##### Blood Bank, 160 blood product

label, 160

verification, 160

##### book an operation, 25

book concurrent operation, 45

## C

##### cancellation rates

calculations, 347

##### case

cancelled, 345

cardiac, 465

delayed, 338

designation, 97

editing cancelled, 400 list of requested, 57 scheduled, 97, 345

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

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

coding

checking accuracy of procedures, 311 entry, 207

validation, 207

##### comments

adding, 205

##### completed cases, 355, 357

PCE filing status of, 238, 273

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

reports on, 252

staffing information for, 285 surgical priority, 269

##### complications, 94, 460

concurrent case, 94

adding, 74

defined, 15

scheduling, 61

scheduling unrequested operations, 69

##### condensed characters, 26 count clinic

active, 278

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

CPT modifiers, 525

##### cultures, 155, 197

cutoff time, 15, 42

## D

##### death totals, 378 deaths

reviewing, 330

within 30 days of surgery, 183, 327

within 90 days of surgery, 330

##### delays

reasons for, 340

##### devices, 157

updating list of, 429

##### diagnosis, 115, 208, 238, 273

dosage, 159, 169

downloading Surgery set of codes, 438

## E

electronically signing a report Anesthesia Report, 133, 136 Nurse Intraoperative Report, 148

Enter/Edit Transplant Assessments, 531

## F

flag a drug, 431

## G

Glossary, 549

## H

##### HL7, 434, 435, 439

master file updates, 437, 438

hospital admission, 385

## I

##### ICD9 codes, 207, 525

interim reports, 320 intraoperative occurrence

entering, 460, 475

irrigation solutions, 157

## K

##### KERNEL audit log, 393

Key Missing Surgical Package Data, 394a

## L

##### laboratory information, 96

entering, 452

##### Laboratory Package, 320 list of requested cases, 57

List of Transplant Assessments, 544

## M

##### medical administration, 96

medications, 159, 169

##### mortality and morbidity rates, 183, 326

multiple fields, 110

## N

##### new surgical case, 102 non-count encounters, 278

non-O.R. procedure, 187

deleting data, 188

editing data, 188

entering data, 188

NSQIP transmission process, 521 nurse staffing information, 295 nursing care, 142

## O

##### occurrence, 180

adding information about a postoperative, 178 editing, 176

entering, 176

intraoperative, 330, 460, 475

adding information about an, 176 M&M Verification Report, 330 number of for delayed operations, 340 postoperative, 330, 462

reviewing, 330

viewing, 325

Operating Room determining use of, 414 entering information, 413

percent utilization, 361

rescheduling, 74

reserving on a recurring basis, 86 utilization reports, 415

viewing availability of, 26 viewing availability of, 60

##### Operating Room Schedule, 89, 253 operation

book concurrent, 45

booking, 25, 59

canceling scheduled, 81

close of, 121

delayed, 110, 338, 340

discharge, 121

outstanding requests, 28

patient preparation, 110

post anesthesia recovery, 121 requesting, 25

rescheduling, 74

scheduled, 26

scheduled by surgical specialty, 92 scheduling requested, 59

scheduling unrequested, 64

starting time, 115

##### operation information

entering or editing, 456

operation request deleting, 36 printing a list, 53

##### Options

Admissions Within 14 Days of Outpatient Surgery, 394c Anesthesia Data Entry Menu, 163

Anesthesia for an Operation Menu, 130 Anesthesia Information (Enter/Edit), 164 Anesthesia Menu, 162

Anesthesia Provider Report, 304 Anesthesia Report, 133, 170

Anesthesia Reports, 297

Anesthesia Technique (Enter/Edit), 165 Annual Report of Non-O.R. Procedures, 196 Annual Report of Surgical Procedures, 255 Attending Surgeon Reports, 285

Blood Product Verification, 160 Cancel Scheduled Operation, 81

Cardiac Procedures Requiring CPB (Enter/Edit), 473 Chief of Surgery, 324

Chief of Surgery Menu, 322 Circulating Nurse Staffing Report, 295 Clinical Information (Enter/Edit), 467 Comments Option, 205

552 Surgery V. 3.0 User Manual September 2011

Comparison of Preop and Postop Diagnosis, 335 CPT Code Reports, 306

CPT/ICD9 Coding Menu, 207 CPT/ICD9 Update/Verify Menu, 208 Create Service Blockout, 86

Cumulative Report of CPT Codes, 220, 307 Deaths Within 30 Days of Surgery, 395 Delay and Cancellation Reports, 337 Delete a Patient from the Waiting List, 23 Delete or Update Operation Requests, 36 Delete Service Blockout, 88

Display Availability, 26, 60

Edit a Patient on the Waiting List, 22 Edit Non-O.R. Procedure, 190

Ensuring Correct Surgery Compliance Report, 395 Enter a Patient on the Waiting List, 21

Enter Cardiac Catheterization & Angiographic Data, 469

Enter Irrigations and Restraints, 157 Enter PAC(U) Information, 123

Enter Referring Physician Information, 156 Enter Restrictions for 'Person' Fields, 426 Exclusion Criteria (Enter/Edit), 507

File Download, 437

Flag Drugs for Use as Anesthesia Agents, 431 Flag Interface Fields, 435

Intraoperative Occurrences (Enter/Edit), 176, 460, 475 Laboratory Interim Report, 320

Laboratory Test Results (Enter/Edit), 452, 469

List Completed Cases Missing CPT Codes, 230, 317 List of Anesthetic Procedures, 300

List of Invasive Diagnostic Procedures, 387 List of Operations, 232, 257

List of Operations (by Postoperative Disposition), 259 List of Operations (by Surgical Priority), 267

List of Operations (by Surgical Specialty), 234, 265 List of Operations Included on Quarterly Report, 389 List of Surgery Risk Assessments, 489

List of Unverified Surgery Cases, 352 List Operation Requests, 57

List Scheduled Operations, 92 M&M Verification Report, 330, 513

Maintain Surgery Waiting List menu, 17 Make a Request for Concurrent Cases, 45 Make a Request from the Waiting List, 42 Make Operation Requests, 28

Make Reports Viewable in CPRS, 440 Management Reports, 252, 326

Medications (Enter/Edit), 159, 169

Monthly Surgical Case Workload Report, 509 Morbidity & Mortality Reports, 183, 327

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

Non-O.R. Procedures, 187

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

Non-Operative Occurrence (Enter/Edit), 180 Normal Daily Hours (Enter/Edit), 417 Nurse Intraoperative Report, 142, 217

Operating Room Information (Enter/Edit), 413 Operating Room Utilization (Enter/Edit), 415 Operating Room Utilization Report, 361, 419

Operation, 115

Operation (Short Screen), 124 Operation Information, 105

Operation Information (Enter/Edit), 456 Operation Menu, 96

Operation Report, 131

Operation Requests for a Day, 53 Operation Startup, 110

Operation/Procedure Report, 213

Operative Risk Summary Data (Enter/Edit), 471 Outpatient Encounters Not Transmitted to NPCD, 278 Patient Demographics (Enter/Edit), 458

PCE Filing Status Report, 238, 273 Perioperative Occurrences Menu, 175 Person Field Restrictions Menu, 425 Post Operation, 121

Postoperative Occurrences (Enter/Edit), 178, 462, 477

Print 30 Day Follow-up Letters, 503 Print a Surgery Risk Assessment, 481

Print Blood Product Verification Audit Log, 393 Print Surgery Waiting List, 18

Procedure Report (Non-O.R.), 194 Purge Utilization Information, 424 Queue Assessment Transmissions, 521

Remove Restrictions on 'Person' Fields, 428 Report of Cancellation Rates, 347

Report of Cancellations, 345

Report of Cases Without Specimens, 357 Report of CPT Coding Accuracy, 224, 311

Report of Daily Operating Room Activity, 236, 271, 355 Report of Delay Reasons, 340

Report of Delay Time, 342

Report of Delayed Operations, 338 Report of Non-O.R. Procedures, 198, 243

Report of Normal Operating Room Hours, 421 Report of Returns to Surgery, 353

Report of Surgical Priorities, 269

Report of Unscheduled Admissions to ICU, 359 Request Operations menu, 25

Requests by Ward, 55

Reschedule or Update a Scheduled Operation, 74 Resource Data (Enter/Edit), 479

Review Request Information, 52 Risk Assessment, 465

Schedule Anesthesia Personnel, 84, 173

Schedule of Operations, 89, 253

Schedule Operations, 59

Schedule Requested Operation, 61

Schedule Unrequested Concurrent Cases, 69 Schedule Unrequested Operations, 64

Scrub Nurse Staffing Report, 293 Surgeon Staffing Report, 289

Surgeon’s Verification of Diagnosis & Procedures, 127 Surgery Interface Management Menu, 434

Surgery Package Management Menu, 409 Surgery Reports, 251

Surgery Site Parameters (Enter/Edit), 410 Surgery Staffing Reports, 284

Surgery Utilization Menu, 414 Surgical Nurse Staffing Report, 291 Surgical Staff, 106

Table Download, 438

Tissue Examination Report, 155

Unlock a Case for Editing, 398 Update 1-Liner Case, 519

Update Assessment Completed/Transmitted in Error, 487

Update Assessment Status to ‘Complete’, 465, 477, a Update Assessment Status to ‘COMPLETE’, 478 Update Cancellation Reason, 83

Update Cancelled Cases, 400

Update Interface Parameter Field, 439 Update O.R. Schedule Devices, 429

Update Operations as Unrelated/Related to Death, 401 Update Site Configurable Files, 432

Update Staff Surgeon Information, 430

Update Status of Returns Within 30 Days, 181, 399, 464

Update/Verify Procedure/Diagnosis Codes, 209, 402 View Patient Perioperative Occurrences, 325 Wound Classification Report, 363

##### Options:, 197, 199, 220 outstanding requests

defined, 15

## P

##### PACU, 123

PCE filing status, 238, 273

##### percent utilization, 361, 419 person-type field

assigning a key, 426 removing a key, 426, 428

##### Pharmacy Package Coordinator, 431 positioning devices, 157

Post Anesthesia Care Unit (PACU), 123 postoperative occurrence, 385

entering, 462, 468, 477

##### preoperative assessment

entering information, 449

##### preoperative information, 15

editing, 52

entering, 29, 65

reviewing, 52

updating, 74

##### Preoperative Information (Enter/Edit), 449 principal diagnosis, 105

Printing a Transplant Assessment, 541 procedure

deleting, 23

dictating a summary, 190 editing data for non-O.R., 190 entering data for non-O.R., 190 filed as encounters, 278 summary for non-O.R., 194

purging utilization information, 424

## Q

##### Quarterly Report, 368

quick reference on a case, 105

**R**

##### Referring physician information, 156 reporting

tracking cancellations, 337

tracking delays, 337

##### reports

Admissions Within 14 Days of Outpatient Surgery Report, 385

Anesthesia Provider Report, 304 Anesthesia Report, 133

Annual Report of Non-O.R. Procedures, 196 Annual Report of Surgical Procedures, 255 Attending Surgeon Cumulative Report, 285, 287 Attending Surgeon Report, 285

Cases Without Specimens, 357 Circulating Nurse Staffing Report, 295 Clean Wound Infection Summary, 367

Comparison of Preop and Postop Diagnosis, 335 Completed Cases Missing CPT Codes, 230, 317 Cumulative Report of CPT Codes, 220, 222, 307, 309 Daily Operating Room Activity, 236

Daily Operating Room Activity, 271 Daily Operating Room Activity, 326 Daily Operating Room Activity, 355 Daily Operating Room Activity, 355

Deaths Within 30 Days of Surgery, 379, 381, 383 Ensuring Correct Surgery Compliance Report, 395, 396 Laboratory Interim Report, 320

List of Anesthetic Procedures, 300, 302 List of Invasive Diagnostic Procedures, 387 List of Operations, 232, 257

List of Operations (by Surgical Specialty), 234

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

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

List of Operations by Wound Classification, 365

List of Operations Included on Quarterly Report, 389 List of Unverified Cases, 352

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

Monthly Surgical Case Workload Report, 509, 511 Mortality Report, 183, 327, 328

Nurse Intraoperative Report, 143

Operating Room Normal Working Hours Report, 421 Operating Room Utilization Report, 419

Operation Report, 132, 213

Operation Requests, 57 Operation Requests for a Day, 53

Outpatient Surgery Encounters Not Transmitted to NPCD, 278, 281

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

Perioperative Occurrences Report, 183, 327

Procedure Report (Non-O.R.), 196, 216 Procedure Report (Non-OR), 215 Quarterly Report - Surgical Service, 374 Quarterly Report - Surgical Specialty, 370 Re-Filing Cases in PCE, 283

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

Report of CPT Coding Accuracy, 224, 311, 313, 315 Report of CPT Coding Accuracy for OR Surgical

Procedures, 226, 228

Report of Daily Operating Room Activity, 271 Report of Delay Time, 342

Report of Delayed Operations, 338

Report of Non-O.R. Procedures, 198, 200, 202, 243,

245, 247

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

Schedule of Operations, 89 Scheduled Operations, 92

Scrub Nurse Staffing Report, 293 Surgeon Staffing Report, 289 Surgery Risk Assessment, 481, 485 Surgery Waiting List, 18

Surgical Nurse Staffing Report, 291 Tissue Examination Report, 155, 197 Unscheduled Admissions to ICU, 359 Wound Classification Report, 363

##### request an operation, 25 restraint, 110, 157

risk assessment, 330

changing, 445

creating, 445, 544

creating cardiac, 465

entering non-cardiac patient, 445

entering the clinical information for cardiac case, 467

Risk Assessment, 481, 550 Risk Assessment module, 443 Risk Model Lab Test, 522 route, 159, 169

## S

##### schedule an unrequested operation, 64 scheduled, 79, 84, 99, 550

scheduling a concurrent case, 61 Screen Server, 94

data elements, 6

Defined, 5

editing data, 8

entering a range of elements, 9 entering data, 7

header, 6

multiple screen shortcut, 12 multiples, 10

Navigation, 5

prompt, 6

turning pages, 8

word processing, 14

##### service blockout, 60

creating, 86

removing, 88

##### short form listing of scheduled cases, 92 site-configurable files, 432

specimens, 155, 197

##### staff surgeon

designating a user as, 430 surgeon key, 426 Surgery

major,defined, 110

minor,defined, 110

##### Surgery case

cancelled, 400

unlocking, 398

##### Surgery package coordinator, 407 Surgery Site parameters

entering, 410

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

Surgical staff, 106

## T

##### time given, 159, 169

Time Out Verified Utilizing Checklist, 124a transfusion

error risk management, 160

##### transplant assessment

change VA/Non-VA indicator, 540 changing, 531

creating, 531

deleting, 538

editing, 536

entering, 531

printing, 541

update to complete, 539

##### Transplant Assessment, 550 Transplant Assessment module, 529 transplant assessment parameters

change, 546

Transplant Assessment Parameters, 546

## U

##### utilization information, 361, 419

purging, 424

## V

##### VA Central Office, 255

VASQIP, 509, 519, 521, 522c, 527, 550

## W

##### Waiting List

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

##### waiting lists, 17 workload

report, 509

uncounted, 278

##### wound classification, 363