SURGERY

USER MANUAL

Version 3.0
July 1993

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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*.

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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                           On SURPATIENT,EIGHTEEN
Case # 262
STANDBY
  * Concurrent Case # 263 AORTO CORONARY BYPASS GRAFT

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

```
Display of Available Operating Room Time

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

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

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

Schedule a Case for which Operating Room ? OR2

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

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


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

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


Select Patient:
```

Schedule Unrequested Operations
[SROSRES]

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

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

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

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

Entering Preoperative Information

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

Schedule a case for which operating Room ?  OR1

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

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

              SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

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

Desired Procedure Date: 7 18 05 (JUL 18, 2005)
Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,TWO
Surgical Specialty: 54          ORTHOPEDICS  ORTHOPEDICS        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>
```

Schedule Unrequested Concurrent Cases
[SRSCHDC]

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

Required Prompts

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

Storing the Request Information

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

Updating the Preoperative Information Later

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

Example: Schedule Unrequested Concurrent Cases

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

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

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


Display of Available Operating Room Time

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

Select Number: 2//  4

Schedule a case for which operating Room ?  OR2

Reserve 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>
```

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

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

SURPATIENT,SIX 000-09-8797

1. 01-25-92   ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)

2. 01-05-92   CORONARY BYPASS (REQUESTED)

3. ENTER NEW SURGICAL CASE


Select Operation: <Enter>
```

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

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

```
SURPATIENT,SIX 000-09-8797

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

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

Select Number:  1//
```

Entering Information

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

Example: Enter Information

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

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

```
 SURPATIENT,THREE   000-21-2453

1. 08-15-99   SHOULDER ARTHROPLASTY (NOT COMPLETE)

2. 03-12-92   SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)

3. ENTER NEW SURGICAL CASE

Select Operation: 2
```

```
SURPATIENT,THREE  000-21-2453

 08-15-88     SHOULDER ARTHROPLASTY (NOT COMPLETE)


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

Select Number: 1//  2
```

```
   ** REVIEW **   CASE #14  SURPATIENT,THREE              PAGE 1 OF 3

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

Enter Screen Server Function:  <Enter>
```

```
   ** REVIEW **   CASE #14  SURPATIENT,THREE              PAGE 2 OF 3

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N):
4    SPONGE, SHARPS, & INST COUNTER: YES
5    COUNT VERIFIER:
6    SEQUENTIAL COMPRESSION DEVICE:
7    LASER UNIT:              (MULTIPLE)
8    CELL SAVER:              (MULTIPLE)
9    NURSING CARE COMMENTS:   (WORD PROCESSING) (DATA)
10   PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE L SHOULDER
11   PRIN PRE-OP ICD DIAGNOSIS CODE:
```

```
12   PRINCIPAL PROCEDURE:   SHOULDER ARTHROPLASTY
13   PLANNED PRIN PROCEDURE CODE :
14   OTHER PROCEDURES:        (MULTIPLE)
15   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: Operation Menu
Select Patient: SURPATIENT,NINE         12-09-51     000345555     NSC VETERAN
```

```
SURPATIENT,NINE   000-34-5555

1. 04-26-05   CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)

2. 12-20-05   REMOVE FACIAL LESIONS (NOT COMPLETE)

3. ENTER NEW SURGICAL CASE

Select Operation: 2
```

```
 SURPATIENT,NINE  000-34-5555

 12-20-05     REMOVE FACIAL LESIONS (NOT COMPLETE)

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

Select Number: 1//  3

Are you sure that you want to delete this case ? NO//  Y
  Deleting Operation...
```

Entering a New Surgical Case

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

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

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

Prompts that require a response include:

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

Example: Entering a New Surgical Case

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

Enter Screen Server Function:  <Enter>
```

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

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

Enter Screen Server Function:   <Enter>
```

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

1    SPD COMMENTS
Enter Screen Server Function:
```

Example: Operation Startup

```
Select Operation Menu Option: OS Operation Startup
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE            PAGE 1 OF 3

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

Enter Screen Server Function: 7;11
Major or Minor: J  MAJOR
Preoperative Patient Education: Y  YES
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE            PAGE 1 OF 3

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

Enter Screen Server Function: <Enter>
```

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

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

Enter Screen Server Function:  A
```

```
ASA Class: 2  2     2-MILD DISTURB.
Preoperative Mood: ?
        Enter the code corresponding to the preoperative assessment of the
        patient's emotional status upon arrival to the operating room.
        Screen prevents selection of inactive entries.
    Answer with PATIENT MOOD NAME, or CODE
   Choose from:
   AGITATED        AG
   ANGRY         ANG
   ANXIOUS         ANX
   APATHETIC         AP
   DEPRESSED         D
   RELAXED         R
   TESTY AND IRRATE, SLEEPY        BUF

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

```
 ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1
         SURGERY POSITION

1    SURGERY POSITION:      SUPINE
2    NEW ENTRY

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

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1
         SURGERY POSITION  (SEMISUPINE)

1    SURGERY POSITION:      SEMISUPINE
2    TIME PLACED:

Enter Screen Server Function:  <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1 OF 1
         SURGERY POSITION

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

Enter Screen Server Function:  <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1 OF 1
         RESTR & POSITION AIDS

1    RESTR & POSITION AIDS: SAFETY STRAP
2    NEW ENTRY

Enter Screen Server Function:  2
Select RESTR & POSITION AIDS: FOAM PADS
    RESTR & POSITION AIDS: FOAM PADS// <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1 OF 1
         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    TIME PAT IN HOLD AREA:
2    TIME PAT IN OR:
3    ANES CARE TIME BLOCK:    (MULTIPLE)
4    TIME OPERATION BEGAN:
5    SPECIMENS:               (WORD PROCESSING)
6    CULTURES:                (WORD PROCESSING)
7    THERMAL UNIT:            (MULTIPLE)
8    ELECTROCAUTERY UNIT:
9    ESU COAG RANGE:
10   ESU CUTTING RANGE:
11   TIME TOURNIQUET APPLIED: (MULTIPLE)
12   PROSTHESIS   INSTALLED:  (MULTIPLE)
13   REPLACEMENT FLUID TYPE:  (MULTIPLE)
14   IRRIGATION:              (MULTIPLE)
15   MEDICATIONS:             (MULTIPLE)

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

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

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

1    NEW ENTRY

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

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
         REPLACEMENT FLUID TYPE (RINGERS LACTATED SOLUTION)

1    REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2    QTY OF FLUID (ml):
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    REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2    QTY OF FLUID (ml):     1000
3    SOURCE ID:             TRAVENOL
4    VA IDENT:
5    REPLACEMENT FLUID COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

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

1    REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
    ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
         IRRIGATION

1    NEW ENTRY

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

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

1    IRRIGATION:            NORMAL SALINE
2    TIME:                  (MULTIPLE)

Enter Screen Server Function:  2
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1
         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    TIME:                  MAR 12, 1999 AT 09:40
2    AMOUNT USED:
3    PROVIDER:

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

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
         IRRIGATION (NORMAL SALINE)
           TIME  (2930601.094)

1    TIME:                  MAR 12, 1999 AT 09:40
2    AMOUNT USED:           1000
3    PROVIDER:              SURNURSE,THREE

Enter Screen Server Function:  <Enter>
```

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

1    TIME:                  MAR 12, 1999 AT 09:40
2    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

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

1    IRRIGATION:            NORMAL SALINE
2    TIME:                  (MULTIPLE)(DATA)

Enter Screen Server Function:  <Enter>
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
        IRRIGATION

1    IRRIGATION:            NORMAL SALINE
2    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 3

1    TIME PAT IN HOLD AREA:   MAR 12, 1999 AT 08:50
2    TIME PAT IN OR:          MAR 12, 1999 AT 09:00
3    ANES CARE TIME BLOCK:    (MULTIPLE)
4    TIME OPERATION BEGAN:
5    SPECIMENS:               (WORD PROCESSING)
6    CULTURES:                (WORD PROCESSING)
7    THERMAL UNIT:            (MULTIPLE)
8    ELECTROCAUTERY UNIT:
9    ESU COAG RANGE:
10   ESU CUTTING RANGE:
11   TIME TOURNIQUET APPLIED: (MULTIPLE)
12   PROSTHESIS   INSTALLED:  (MULTIPLE)
13   REPLACEMENT FLUID TYPE:  (MULTIPLE)
14   IRRIGATION:              (MULTIPLE)
15   MEDICATIONS:             (MULTIPLE)

Enter Screen Server Function: <Enter>
```

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

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

Enter Screen Server Function: 1:4
```

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

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

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

Enter Screen Server Function: 9
```

```
NURSING CARE COMMENTS:
  1>Admitted with prosthesis in place, left eye is artificial eye.
  2>Foam pads applied to elbows and knees. Pillow placed
  3>under knees.
  4><Enter>
EDIT Option: <Enter>
```

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

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

Enter Screen Server Function: <Enter>
```

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

1    BRIEF CLIN HISTORY:      (WORD PROCESSING)

Enter Screen Server Function:
```

Enter PAC(U) Information
[SROMEN-PACU]

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

Example: Entering PAC(U) Information

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

```
 ** PACU **   CASE #145  SURPATIENT,NINE               PAGE 1 OF 1

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

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

```
 ** PACU **   CASE #145  SURPATIENT,NINE               PAGE 1 OF 1

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

Enter Screen Server Function:
```

Operation (Short Screen)
[SROMEN-OUT]

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

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

Example: Operation Short Screen

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

  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 1 OF 3

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

Enter Screen Server Function: 13:15
Time Patient In the O.R.: 13:00 (MAR 09, 2005@13:00)
Time the Operation Began: 13:10 (MAR 09, 2005@13:10)
Time the Operation Ends: 13:36 (MAR 09, 2005@13:36)
```

```
  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 1 OF 3

1    DATE OF OPERATION:     MAR 09, 2005
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,FOUR
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE:   REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE: 17000
9    OTHER PROCEDURES:      (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:        MAR 09, 2005 AT 13:00
14   TIME OPERATION BEGAN:  MAR 09, 2005 at 13:10
15   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    TIME PAT OUT OR:
2    IV STARTED BY:
3    OR CIRC SUPPORT:         (MULTIPLE)
4    OR SCRUB SUPPORT:        (MULTIPLE)
5    OPERATING ROOM:
6    FIRST ASST:
7    SPONGE COUNT CORRECT (Y/N):
8    SHARPS COUNT CORRECT (Y/N):
9    INSTRUMENT COUNT CORRECT (Y/N):
10   SPONGE, SHARPS, & INST COUNTER:
11   COUNT VERIFIER:
12   SURGERY SPECIALTY:       GENERAL(OR WHEN NOT DEFINED BELOW)
13   WOUND CLASSIFICATION:
14   ATTEND SURG:             SURSURGEON,TWO
15   ATTENDING CODE:

Enter Screen Server Function:  1;5;15

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

```
  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 2 OF 3

1    TIME PAT OUT OR:         MAR 12, 2006 AT 13:40
2    IV STARTED BY:
3    OR CIRC SUPPORT:         (MULTIPLE)
4    OR SCRUB SUPPORT:        (MULTIPLE)
5    OPERATING ROOM:          OR1
6    FIRST ASST:
7    SPONGE COUNT CORRECT (Y/N):
8    SHARPS COUNT CORRECT (Y/N):
9    INSTRUMENT COUNT CORRECT (Y/N):
10   SPONGE, SHARPS, & INST COUNTER:
11   COUNT VERIFIER:
12   SURGERY SPECIALTY:       GENERAL(OR WHEN NOT DEFINED BELOW)
13   WOUND CLASSIFICATION:
14   ATTEND SURG:             SURSURGEON,TWO
15   ATTENDING CODE:          LEVEL A: ATTENDING DOING THE OPERATION

Enter Screen Server Function:  <Enter>
```

```
  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 3 OF 3

1    SPECIMENS:               (WORD PROCESSING)
2    CULTURES:                (WORD PROCESSING)
3    NURSING CARE COMMENTS:   (WORD PROCESSING) (DATA)
4    ASA CLASS:
5    PRINC ANESTHETIST:     SURANESTHETIST,FOUR
6    ANESTHESIA TECHNIQUE:    (MULTIPLE)
7    ANES CARE TIME BLOCK:    (MULTIPLE)
8    DELAY CAUSE:             (MULTIPLE)
9    CANCEL DATE:
10   CANCEL REASON:
11   CANCELLATION COMMENTS:

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    SPECIMENS:               (WORD PROCESSING)
2    CULTURES:                (WORD PROCESSING)
3    NURSING CARE COMMENTS:   (WORD PROCESSING) (DATA)
4    ASA CLASS:               3-SEVERE DISTURB.
5    PRINC ANESTHETIST:     SURANESTHETIST,FOUR
6    ANESTHESIA TECHNIQUE:    (MULTIPLE)
7    ANES CARE TIME BLOCK:    (MULTIPLE)
8    DELAY CAUSE:             (MULTIPLE)
9    CANCEL DATE:
10   CANCEL REASON:
11   CANCELLATION COMMENTS:

Enter Screen Server Function:  <Enter>
```

Time Out Verified Utilizing Checklist
[SROMEN-VERF]

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

Example: Time Out Verified Utilizing Checklist

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

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

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

Enter Screen Server Function:  A
Confirm Correct Patient Identity: Y YES
Confirm Procedure To Be Performed: Y  YES
Confirm Site of Procedure, Including Laterality: Y YES
Confirm Valid Consent Form: Y  YES
Confirm Patient Position: N   NO
Confirm Proc. Site has been Marked Appropriately and the Site of the Mark is 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    CONFIRM PATIENT IDENTITY: YES
2    PROCEDURE TO BE PERFORMED: YES
3    SITE OF PROCEDURE:       YES
4    VALID CONSENT FORM:      YES
5    CONFIRM PATIENT POSITION: YES
6    MARKED SITE CONFIRMED:   YES
7    PREOPERATIVE IMAGES CONFIRMED: YES
8    CORRECT MEDICAL IMPLANTS: YES
9    AVAILABILITY OF SPECIAL EQUIP: YES
10   ANTIBIOTIC PROPHYLAXIS: YES
11   APPROPRIATE DVT PROPHYLAXIS: YES
12   BLOOD AVAILABILITY:      YES
```

```
13   CHECKLIST COMMENT:       (WORD PROCESSING)
14   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

                          SURPATIENT,TEN (000-12-3456)
   MEDICAL RECORD       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               First Assist: SURSURGEON,FOUR
Attend Surg: SURSURGEON,THREE           Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN       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    CONFIRM PATIENT IDENTITY: YES
2    PROCEDURE TO BE PERFORMED: YES
3    SITE OF PROCEDURE:       YES
4    VALID CONSENT FORM:      YES
5    CONFIRM PATIENT POSITION: YES
6    MARKED SITE CONFIRMED:
7    PREOPERATIVE IMAGING CONFIRMED:
8    CORRECT MEDICAL IMPLANTS: YES
9    AVAILABILITY OF SPECIAL EQUIP: YES
10   ANTIBIOTIC PROPHYLAXIS: YES
11   APPROPRIATE DVT PROPHYLAXIS: YES
12   BLOOD AVAILABILITY:      YES
13   CHECKLIST COMMENT:       (WORD PROCESSING)
14   CHECKLIST CONFIRMED BY:  SURNURSE,FIVE

Enter Screen Server Function: <Enter>
```

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

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

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

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

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

```
11   TIME PAT OUT OR:
12   PRINCIPAL PROCEDURE:     CHOLECYSTECTOMY
13   OTHER PROCEDURES:        (MULTIPLE)
14   WOUND CLASSIFICATION:    CONTAMINATED
15   OP DISPOSITION:

Enter Screen Server Function:  <Enter>
```

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

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

Enter Screen Server Function:  <Enter>
```

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

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

Enter Screen Server Function:  ^
```

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.

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


Enter Screen Server Function:  10
Appropriate Antibiotic Prophylaxis: Y  YES
```

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

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

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

Example: Printing the Nurse Intraoperative Report

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

 * * The Nurse Intraoperative Report has been electronically signed. * *

 Nurse Intraoperative Report Functions:

  1. Edit report information
  2. Print/View report from beginning

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

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

DEVICE: HOME// [Select Print Device]
```

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

```
---------------------------------------------------------------------------------------------------------
SURPATIENT,TEN  000-12-3456                          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)        Case #213
JUN 30,2006   CHOLECYSTECTOMY
-------------------------------------------------------------------------------------------------------


There are no Intraoperative Occurrences entered for this case.


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

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

Press RETURN to continue: <Enter>
```

```
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>
```

```
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: GENERAL(OR WHEN NOT DEFINED BELOW)
Select NON-OPERATIVE OCCURRENCES: SYSTEMIC SEPSIS
  Occurrence Category: SYSTEMIC SEPSIS
  Definition Revised (2007):
  Sepsis is a vast clinical entity that takes a variety of forms. The
  spectrum of disorders spans from relatively mild physiologic
  abnormalities to septic shock. Please report the most significant level
  using the criteria below:

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

   and one of the following:
     - positive blood culture
     - clinical documentation of purulence or positive culture from any
       site thought to be causative
```

Morbidity & Mortality Reports
[SROMM]

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

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

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

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

```
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

SURGICAL SERVICE REVIEWED BY:
PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP DATE REVIEWED:
FROM: JUL 1,2006 TO: JUL 31,2006 DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	ATTENDING SURGEON / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
GENERAL(OR WHEN NOT DEFINED BELOW)			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	SURSURGEON,THREE REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
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

PATIENT ID# / OPERATION DATE	SURGICAL SPECIALTY / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
ATTENDING: SURGEON,ONE			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	GENERAL(OR WHEN NOT DEFINED BELOW) REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
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

PATIENT ID# / OPERATION DATE	ATTENDING SURGEON / SURGICAL SPECIALTY / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
CATEGORY: ACUTE RENAL FAILURE			
SURPATIENT,SEVENTEEN 000-45-5119 JUN 18, 2007@07:15	SURGEON,TWO GENERAL REPAIR INCARCERATED INGUINAL HERNIA	ACUTE RENAL FAILURE DIALYSIS	I

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
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	PROVIDER PRINCIPAL ANESTHETIST ANESTHESIOLOGIST SUPERVISOR PROCEDURE(S)	START TIME FINISH TIME
	*** SPECIALTY: CARDIOLOGY ***		
03/02/99 501	SURPATIENT,TWELVE (000-41-8719) AMBULATORY SURGERY (OUTPATIENT)	SURSURGEON,TWO **SURANESTHETIST,TWO** **SURANESTHETIST,ONE** CARDIOVERSION	03/02/99 13:05 03/02/99 14:10
03/13/99 500	SURPATIENT,SIXTY (000-56-7821) ICU (INPATIENT)	SURSURGEON,TWO **SURANESTHETIST,FOUR** **SURANESTHETIST,ONE** CARDIOVERSION	03/13/99 14:00 03/13/99 14:25

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

```
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
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	SPECIALTY PRINCIPAL ANESTHETIST ANESTHESIOLOGIST SUPERVISOR PROCEDURE(S)	START TIME FINISH TIME
*** PROVIDER SURSURGEON,SIXTEEN ***			
03/12/99 195	SURPATIENT,TWO (000-45-1982) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY SURANESTHETIST,TWO SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY	03/12/99 08:00 03/12/99 09:00
03/23/99 240	SURPATIENT,NINE (000-34-5555) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY SURANESTHETIST,SIX SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY	03/23/99 08:10 03/23/99 08:40
03/25/99 266	SURPATIENT,FOURTEEN (000-45-7212) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY SURANESTHETIST,TWO SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY	03/12/99 09:30 03/12/99 10:15

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

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

Report of Non-OR Procedures


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

How do you want the report sorted ?

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

Select Number: 1// 3

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

Print the Report for which Location ? AMBULATORY SURGERY

This report is designed to use a 132 column format.

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

printout follows

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) SPECIALTY (IN/OUT-PAT STATUS)	PROVIDER PRINCIPAL ANESTHETIST ANESTHESIOLOGIST SUPERVISOR PROCEDURE(S)	START TIME FINISH TIME
	*** LOCATION: AMBULATORY SURGERY ***		
03/02/99 201	SURPATIENT,TWELVE (000-41-8719) CARDIOLOGY (OUTPATIENT)	SURSURGEON,TWO SURANESTHETIST,FOUR SURANESTHETIST,ONE CARDIOVERSION	03/02/99 13:05 03/02/99 14:10
03/06/99 198	SURPATIENT,TWENTY (000-45-4886) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	SURSURGEON,FOUR SURANESTHETIST,FIVE SURANESTHETIST,ONE EXCISION OF SKIN LESION	03/07/99 16:30 03/07/99 17:08
03/09/99 193	SURPATIENT,FIFTY (000-45-9999) GENERAL (ACUTE MEDICINE) (OUTPATIENT)	SURANESTHETIST,ONE SURANESTHETIST,FIVE SURANESTHETIST,SEVEN STELLATE NERVE BLOCK	03/09/99 09:45 03/09/99 10:21
03/13/99 200	SURPATIENT,SIXTY (000-56-7821) CARDIOLOGY (INPATIENT)	SURSURGEON,TWO SURANESTHETIST,TWO SURANESTHETIST,ONE CARDIOVERSION	03/13/99 14:00 03/13/99 14:25
03/17/99 194	SURPATIENT,EIGHTEEN (000-22-3334) GENERAL SURGERY (OUTPATIENT)	SURSURGEON,FOUR SURANESTHETIST,SIX SURANESTHETIST,SEVEN EXCISION OF SKIN LESION	03/17/99 13:30 03/17/99 14:42

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.)

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	ATTENDING SURGEON / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
GENERAL(OR WHEN NOT DEFINED BELOW)			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	SURSURGEON,THREE REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
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

PATIENT ID# / OPERATION DATE	SURGICAL SPECIALTY / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
ATTENDING: SURGEON,ONE			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	GENERAL(OR WHEN NOT DEFINED BELOW) REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
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

SURGICAL SERVICE REVIEWED BY:
PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP DATE REVIEWED:
FROM: JUN 1,2007 TO: JUN 30,2007 DATE PRINTED: AUG 22,2007

PATIENT ID# / OPERATION DATE	ATTENDING SURGEON / SURGICAL SPECIALTY / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
CATEGORY: ACUTE RENAL FAILURE			
SURPATIENT,SEVENTEEN 000-45-5119 JUN 18, 2007@07:15	SURGEON,TWO GENERAL REPAIR INCARCERATED INGUINAL HERNIA	ACUTE RENAL FAILURE DIALYSIS	I

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 CASE #	PATIENT NAME PATIENT ID (AGE)	SURGICAL SPECIALTY PRINCIPAL PROCEDURE	MISSING ITEMS
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 CASE # *OCCURRENCE - (DATE)	PATIENT NAME PATIENT ID (AGE)	SURGICAL SPECIALTY PROCEDURE(S) PERFORMED	ANESTHESIA TECHNIQUE	DATE OF ADMISSION
SEP 24,2004@12:30 30395 *OTHER OCCURRENCE - (10/03/04)	SURPATIENT,FORTY 000-77-7777 (72)	THORACIC SURGERY (INC. CARDIAC MEDIASTINOSCOPY WITH NODE BIOPSY	GENERAL	OCT 3,2004@14:11
SEP 25,2004@14:30 30544 *OTHER OCCURRENCE - (09/28/04)	SURPATIENT,EIGHTEEN 000-22-3334 (71)	GENERAL(OR WHEN NOT DEFINED BE LEFT INGUINAL HERNIORRAPHY HYDROCELECTOMY	GENERAL	SEP 28, 2004@10:06
NOV 18,2004@09:45 31034 *SUPERFICIAL WOUND INFECTION - (11/28/04)	SURPATIENT,FIFTEEN 000-98-1234 (55)	PLASTIC SURGERY (INCLUDES HEAD GANGLION CYST LT. WRIST INCLUSION OF CYST INDEX FINGER LT. EXCISION OF LIPOMA OF LT. FOOT APPLICATION SHORT ARM SPLINT	GENERAL	NOV 28, 2004@12:51
DEC 9,2004@13:35 31242 *SUPERFICIAL WOUND INFECTION - (12/29/04)	SURPATIENT,EIGHT 000-37-0555 (64)	ORTHOPEDICS ORIF RT ULNA REPAIR RT. DISTALRADIOULNAR FX (	GENERAL	DEC 9, 2004@17:55
DEC 31,2004@07:30 31277 *OTHER CNS OCCURRENCE - (01/05/03)	SURPATIENT,FIFTYONE 000-23-3221 (31)	OTORHINOLARYNGOLOGY (ENT) NASAL SINUS SURGERY WITH BIL SPENOETHMOID POLYPECTOMY (CPT Code: 31205) BILATERAL ANTROSTOMY BILATERAL TURBINECTOMY	GENERAL	DEC 31, 2004@18:02

TOTAL CASES: 5

Deaths Within 30 Days of Surgery [SROQD]

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

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

   A. All Cases

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

   B. Outpatient Cases Only

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

   C. Inpatient Cases Only

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

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

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

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

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

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

                         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// All Cases

This report is designed to use a 132 column format.

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

printout follows

MAYBERRY, NC

DEATHS WITHIN 30 DAYS OF SURGERY PAGE 1
FOR SURGERY PERFORMED FROM: APR 1,2005 TO: APR 30,2005
Report Printed: MAY 18,2005@12:09

OP DATE	CASE #	IN/OUT	SURGICAL SPECIALTY	PROCEDURE(S)	DEATH 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 RIGHT HEMICOLECTOMY ILEOSTOMY MUCOUS FISTULA OF COLON	UNRELATED
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 DIAPHRAGM BIOPSY	UNRELATED
>>> SURPATIENT,SIXTY (000-56-7821) - DIED 04/30/05 AGE: 40					
04/21/05	32567	INPAT	THORACIC SURGERY (INC. CARDIAC SURG	ESOPHAGECTOMY ESOPHAGOSCOPY BRONCHOSCOPY FEEDING TUBE JEJUNOSTOMY	RELATED

TOTAL DEATHS: 3

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

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

                         Deaths Within 30 Days of Surgery

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

Start with Date: 4/1 (APR 01, 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 / CASE #	PATIENT NAME / PATIENT ID# (AGE)	DATE OF DEATH / PROCEDURE(S)	LOCAL SPECIALTY	IN/OUT	DEATH RELATED
>>> GENERAL SURGERY <<<					
04/24/05 32693	SURPATIENT,FORTY 000-77-7777 (70)	05/12/05 CLOSURE OF ABDOMINAL WALL FASCIA	GENERAL(OR WHEN NOT DEFINED BELOW)	INPAT	UNRELATED
TOTAL DEATHS FOR GENERAL SURGERY: 1					
>>> THORACIC SURGERY <<<					
04/26/05 32702	SURPATIENT,TEN 000-12-3456 (68)	05/12/05 RIGHT THORACOTOMY WITH LUNG BIOPSY DIAPHRAGM BIOPSY	THORACIC SURGERY (INC. CARDIAC SURG.)	INPAT	UNRELATED
04/21/05 32567	SURPATIENT,SIXTY 000-56-7821 (40)	04/30/05 ESOPHAGECTOMY ESOPHAGOSCOPY BRONCHOSCOPY FEEDING TUBE JEJUNOSTOMY	THORACIC SURGERY (INC. CARDIAC SURG.)	INPAT	RELATED
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 / CASE #	PATIENT NAME / PATIENT ID# (AGE)	DATE OF DEATH / PROCEDURE(S)	LOCAL SPECIALTY	IN/OUT	DEATH RELATED
>>> Cholecystectomy <<<					
03/05/05 32147	SURPATIENT,SIXTY 000-56-7821 (40)	03/18/05 LAPAROSCOPIC CHOLECYSTECTOMY	GENERAL(OR WHEN NOT DEFINED BELOW)	INPAT	RELATED
TOTAL DEATHS FOR Cholecystectomy: 1					
>>> Colon Resection (L & R) <<<					
01/12/05 31514	SURPATIENT,TEN 000-12-3456 (60)	01/18/05 RT. HEMICOLECTOMY	GENERAL(OR WHEN NOT DEFINED BELOW)	INPAT	UNRELATED
TOTAL DEATHS FOR Colon Resection (L & R): 1					
>>> Hip Replacement - Elective <<<					
01/15/05 31576	SURPATIENT,SIXTEEN 000-11-1111 (93)	01/19/05 LT. HIP ARTHROPLASTY	ORTHOPEDICS	INPAT	RELATED
TOTAL DEATHS FOR Hip Replacement - Elective: 1					
>>> Intraoccular Lens <<<					
02/23/05 32008	SURPATIENT,FIFTYTWO 000-99-8888 (90)	03/15/05 CATARACT EXTRACTION WITH IOL OS	OPHTHALMOLOGY	OUTPAT	UNRELATED
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:  Unlock a Case for Editing

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

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

Select Number:  1

Press <Enter> to continue. <Enter>

Case #115 is now unlocked

Select Chief of Surgery Menu Option:
```

Flag Drugs for Use as Anesthesia Agents
[SROCODE]

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

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

Example: Flag Drugs Used as Anesthesia Agents

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

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


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

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

Update Site Configurable Files
[SR UPDATE FILES]

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

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

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

```
Select Surgery Package Management Menu Option:  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.

(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:
  A. Height:                                 A. Ascites:
  B. Weight:
  C. Diabetes Mellitus:                    4. GASTROINTESTINAL:
  D. Current Smoker W/I 1 Year:              A. Esophageal Varices:
  E. ETOH > 2 Drinks/Day:
  F. Dyspnea:                              5. CARDIAC:
  G. Preop Sleep Apnea:                      A. CHF Within 1 Month:
  H. DNR Status:                             B. MI Within 6 Months:
  I. Preop Funct Status:                     C. Previous PCI:
                                             D. Previous Cardiac Surgery:
2. PULMONARY:                                E. Angina Within 1 Month:
  A. Ventilator Dependent:                   F. Hypertension Requiring Meds:
  B. History of Severe COPD:
  C. Current Pneumonia:                    6. VASCULAR:
                                             A. Revascularization/Amputation:
                                             B. Rest Pain/Gangrene:
-------------------------------------------------------------------------------------------------------------------------
Select Preoperative Information to Edit: 1:3
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------------------------------------


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       3. HEPATOBILIARY:                  NO
  A. Height:                      62 INCHES      A. Ascites:                      NO
  B. Weight:                       175 LBS.
  C. Diabetes Mellitus:             INSULIN   4. GASTROINTESTINAL:
  D. Current Smoker W/I 1 Year: YES             A. Esophageal Varices:
  E. ETOH > 2 Drinks/Day:          NO
  F. Dyspnea:                      NO         5. CARDIAC:
  G. Preop Sleep Apnea:           LEVEL 1       A. CHF Within 1 Month:
  H. DNR Status:                   NO           B. MI Within 6 Months:
  I. Preop Funct Status:    INDEPENDENT         C. Previous PCI:
                                                D. Previous Cardiac Surgery:
2. PULMONARY:                        NO         E. Angina Within 1 Month:
  A. Ventilator Dependent:           NO         F. Hypertension Requiring Meds:
  B. History of Severe COPD:         NO
  C. Current Pneumonia:              NO       6. VASCULAR:
                                                A. Revascularization/Amputation:
                                                B. Rest Pain/Gangrene:
-------------------------------------------------------------------------------------------------------------------------
Select Preoperative Information to Edit: <Enter>
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                 PAGE: 2 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------------------------------------------------

1. RENAL:                                3. NUTRITIONAL/IMMUNE/OTHER:
  A. Acute Renal Failure:                  A. Disseminated Cancer:
  B. Currently on Dialysis:                B. Open Wound:
                                           C. Steroid Use for Chronic Cond.:
2. CENTRAL NERVOUS SYSTEM:                 D. Weight Loss > 10%:
  A. Impaired Sensorium:                   E. Bleeding Disorders:
  B. Coma:                                 F. Transfusion > 4 RBC Units:
  C. Hemiplegia:                           G. Chemotherapy W/I 30 Days:
  D. History of TIAs:                      H. Radiotherapy W/I 90 Days:
  E. CVA/Stroke w. Neuro Deficit:          I. Preoperative Sepsis:
  F. CVA/Stroke w/o Neuro Deficit:         J. Pregnancy:          NOT APPLICABLE
  G. 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:
  A. Acute Renal Failure:                  A. Disseminated Cancer:
  B. Currently on Dialysis:                B. Open Wound:
                                           C. Steroid Use for Chronic Cond.:
2. CENTRAL NERVOUS SYSTEM:                 D. Weight Loss > 10%:
  A. Impaired Sensorium:                   E. Bleeding Disorders:            YES
  B. Coma:                                 F. Transfusion > 4 RBC Units:
  C. Hemiplegia:                           G. Chemotherapy W/I 30 Days:
  D. History of TIAs:                      H. Radiotherapy W/I 90 Days:
  E. CVA/Stroke w. Neuro Deficit:          I. Preoperative Sepsis:
  F. CVA/Stroke w/o Neuro Deficit:         J. Pregnancy:          NOT APPLICABLE
  G. 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
```

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


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         4-3-23    000451982       YES
  SC VETERAN
```

```
 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...
```

(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 #60183                        PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
>> Coding Complete <<
-------------------------------------------------------------------------------------------------------------

 1. Physician's Preoperative Estimate of Operative Mortality: 78%
    A. Date/Time Collected: JUN 17,2005@18:15
 2. ASA Classification:        1-NO DISTURB.
 3. Surgical Priority:
 4. Preoperative Risk Factors: NONE

 5. CPT Codes (view only):     33510
 6. Wound Classification:      CLEAN


-------------------------------------------------------------------------------------------------------------
Select Operative Risk Summary Information to Edit: 1:3
```

This information cannot be edited.

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


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 #60183                    PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:                13. Maze procedure:
 1. Number with vein:                   14. ASD repair:
 2. Number with IMA:                    15. VSD repair:
 3. Number with Radial Artery:          16. Myectomy:
 4. Number with Other Artery:           17. Myxoma resection:
 5. Number with Other Conduit:          18. Other tumor resection:
                                        19. Cardiac transplant:
 6.  LV Aneurysmectomy:                 20. Great Vessel Repair:
 7.  Bridge to transplant/Device:       21. Endovascular Repair:
 8. TMR:                                22. Other cardiac procedures:

 9. Aortic Valve Procedure:
10. Mitral Valve Procedure:
11. Tricuspid Valve Procedure:
12. Pulmonary Valve Procedure:
-------------------------------------------------------------------------------
Select Cardiac Procedures Operative Information to Edit: A
```

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

CABG Distal Anastomoses with Vein: 1
CABG Distal Anastomoses with IMA: 1
Number with Radial Artery: 0
Number with Other Artery: 1
CABG Distal Anastomoses with Other Conduit: 1
LV Aneurysmectomy (Y/N): N  NO
Device for bridge to cardiac transplant / Destination therapy: ??
        Definition Revised (2006):
        Indicate if patient received a mechanical support device
        (excluding IABP) as a bridge to cardiac transplant during the same
        admission as the transplant procedure; or patient received the device
        as destination therapy (does not intend to have a cardiac transplant),
        either with or without placing the patient on cardiopulmonary bypass.

     Choose from:
       N        NONE
       B        BRIDGE TO
TRANSPLANT
        D       DESTINATION THERAPY
Device for bridge to cardiac transplant / Destination therapy: N NONE
Transmyocardial Laser Revascularization: N  NO
Aortic Valve Procedure: ??
        VASQIP Definition (2010):
        Indicate if the patient had an aortic valve replacement (either the
        native or a prosthetic valve) or a repair (on the native valve to
        relieve stenosis and/or correct regurgitation -annuloplasty,
        commissurotomy, etc.); performed with or without additional
        procedure(s); either with or without placing the patient on
        cardiopulmonary bypass. (If a repair was attempted, but a replacement
        occurred, indicate the details of the replacement valve.) Indicate
        the one most appropriate procedure:
          * None
          * Mechanical Valve
          * Stented Bioprosthetic Valve
          * Stentless Bioprosthetic Valve
          * Homograft
          * Primary Valve Repair
          * Primary Valve Repair and Annuloplasty Device
          * Annuloplasty Device alone
          * Autograft Procedure (Ross Procedure)
          * Other

     Choose from:
       N        NONE
       M        MECHANICAL
       S        STENTED BIOPROSTHETIC
       B        STENTLESS BIOPROSTHETIC
       H        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)       Case #60183                 PAGE: 1 of 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:                13. Maze procedure: 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
 6. LV Aneurysmectomy:           NO     20. Great Vessel Repair:      NO
 7. Bridge to transplant/Device: NONE   21. Endovascular Repair:      NO
 8. TMR:                         NO     22. Other cardiac procedures: NO

 9. Aortic Valve Procedure:      PRIMARY REPAIR
10. Mitral Valve Procedure:      NONE
11. Tricuspid Valve Procedure:   NONE
12. Pulmonary Valve Procedure:   NONE
-------------------------------------------------------------------------------
Select Operative Information to Edit: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)      Case #60183                  PAGE: 2 of 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
Indicate other cardiac procedures only if done with cardiopulmonary bypass
-------------------------------------------------------------------------------

 1. Foreign Body Removal:
 2. Pericardiectomy:

Other Operative Data details:
-------------------------------------------
 3. Total CPB Time:
 4. Total Ischemic Time:
 5. Incision Type:
 6. Convert Off Pump to CPB:  N/A (began on-pump/ stayed on-pump)
-------------------------------------------------------------------------------

Select Operative Information to Edit:
```

Outcome Information (Enter/Edit)
[SROA CARDIAC-OUTCOMES]

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

Example: Enter Outcome Information

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

SURPATIENT,TWENTY (000-45-4886)     Case #238                          PAGE: 1
OUTCOMES INFORMATION
FEB 10,2004   CABG
-------------------------------------------------------------------------------

0. Operative Death:               NO

Perioperative (30 day) Occurrences:

1. Perioperative MI:              NO    8. Repeat cardiac surg procedure:  YES
2. Endocarditis:                  NO    9. Tracheostomy:                   YES
3. Renal failure require dialysis: NO   10. Repeat ventilator w/in 30 days: YES
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.
0        None
1        On-bypass
2        Off-bypass


Cardiopulmonary Bypass Status: 1  On-bypass
```

```
SURPATIENT,TWENTY (000-45-4886)     Case #238                          PAGE: 1
OUTCOMES INFORMATION
FEB 10,2004   CABG
-------------------------------------------------------------------------------

0. Operative Death:               NO

Perioperative (30 day) Occurrences:

1. Perioperative MI:              NO    8. Repeat cardiac surg procedure:  YES
2. Endocarditis:                  NO    9. Tracheostomy:                   YES
3. Renal failure require dialysis: NO   10. Repeat ventilator w/in 30 days: YES
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:
```

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
```

```
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             000287354       YES
  SC VETERAN
```

```
 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>
```

(This page included for two-sided copying.)

Print a Surgery Risk Assessment
[SROA PRINT ASSESSMENT]

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

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

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

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


Select Patient: SURPATIENT,FORTY         05-07-23     000777777     NO     NSC VET
ERAN

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
```

Example 2: Print Surgery Risk Assessment for a Cardiac Case

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

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


Select Patient: R9922 SURPATIENT,NINE          12-19-51     000345555     NO     SC
 VETERAN

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
================================================================================
I. IDENTIFYING DATA
Patient: SURPATIENT,NINE  000-34-5555      Case #: 238         Fac./Div. #: 500
Surgery Date: 07/01/06   Address: Anyplace Way
Phone: NS/Unknown        Zip Code: 33445-1234        Date of Birth: 12/19/51
================================================================================
II. CLINICAL DATA
Gender:                   MALE          Prior MI:         < OR = 7 DAYS OF SURG
Age:                      56            # of prior heart surgeries:        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

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

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA
Cardiac Catheterization Date: 06/28/06
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
================================================================================
 VI. 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)

VII. OUTCOMES
Operative Death:  NO                      Date of Death:

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

VIII. RESOURCE DATA
Hospital Admission Date:                      06/30/06 06:05
Hospital Discharge Date:                      07/10/06 08:50
Time Patient In  OR:     07/10/06 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:
================================================================================
IX. SOCIOECONOMIC, ETHNICITY, AND RACE
 Employment Status Preoperatively:      SELF EMPLOYED
 Ethnicity:                             NOT HISPANIC OR LATINO
 Race Category(ies):                    AMERICAN INDIAN OR ALASKA NATIVE,
                                        NATIVE HAWAIIAN OR OTHER PACIFIC
                                        ISLANDER, WHITE

X. DETAILED DISCHARGE INFORMATION
   Discharge ICD-9 Codes: 414.01 V70.7 433.10 285.1 412. 307.9  427.31

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

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

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Monthly Surgical Case Workload Report
[SROA MONTHLY WORKLOAD REPORT]

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

Example: Monthly Surgical Case Workload Report – Single Month

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

Report of Monthly Case Workload Totals

Print which report?

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

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

This option provides a report of the monthly risk assessment surgical case
workload totals which include the following categories:
     1. All cases performed
     2. Eligible cases
     3. Eligible cases meeting exclusion criteria
     4. Assessed cases
     5. Not logged eligible cases
     6. Cardiac cases
     7. Non-cardiac cases
     8. Assessed cases per day (based on 20 days/month)

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

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

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

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

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

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

printout follows

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

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

NUMBER OF INCOMPLETE ASSESSMENTS REMAINING FOR PAST YEAR

	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                    02-12-28     000418719     YES
    SC VETERAN
```

```
 SURPATIENT,TWELVE            000-41-8719

1. 08-07-04   REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)

2. 02-18-99   TRACHEOSTOMY, BRONCHOSCOPY, ESOPHAGOSCOPY (COMPLETED)

3. 09-04-97   CHOLECYSTECTOMY (COMPLETED)

Select 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:
```

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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
```

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Alert Coder Regarding Coding Issues
[SROA CODE ISSUE]

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

Example : Alert Coder Regarding Coding Issues

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

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

```
 SURPATIENT,TWELVE             000-41-8719

1. 08-07-04   REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)

2. 02-18-99   TRACHEOSTOMY, BRONCHOSCOPY, ESOPHAGOSCOPY (COMPLETED)

3. 09-04-97   CHOLECYSTECTOMY (COMPLETED)

Select Operation: 1
```

```
SURPATIENT,TWELVE (000-41-8719)        Case #142
AUG 7,2004   REPAIR DIAPHRAGMATIC HERNIA
-------------------------------------------------------------------------------

The following "final" codes have been entered for the case.

Principal CPT Code: 39540 REPAIR DIAPHRAGMATIC HERNIA
Other CPT Codes:    NOT ENTERED
Postop Diagnosis Code (ICD9): 551.3 DIAPHRAGM HERNIA W GANGR (w C/C)


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

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

```
==[ 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...
```

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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>
```

```
                    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.

(This page included for two-sided copying.)

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

1.  VACO ID:                  12121
2.  Date Placed on Waiting:
3.  Date Started Dialysis:
4.  Recipient ABO Blood Type:
5.  Recipient CMV:

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

12. Transplant Comments:
-------------------------------------------------------------------------------
Select Transplant Information to Edit: 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 (0288)   VACO ID: 12121   CASE: 482          PAGE: 1 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                          RECIPIENT INFORMATION
-------------------------------------------------------------------------------
1.  VACO ID:                  12121
2.  Date Placed on Waiting:   MAY 04, 2008
3.  Date Started Dialysis:    JAN 21, 2008
4. Recipient ABO Blood Type: O
5.  Recipient CMV:            POSITIVE

Diagnosis Information
=====================
6.  Calcineurin Inhibitor Toxicity:      13. Obstructive Uropathy from BPH:
7.  Glomerular Sclerosis/Nephritis:      14. Polycistic Disease:
8.  Graft Failure:                       15. Renal Cancer:
9.  lgA Nephropathy:                     16. Rejection:
10. Lithium Toxicity:
11. Membranous Nephropathy:
12. Transplant Comments:
-------------------------------------------------------------------------------
Select Transplant Information to Edit: <Enter>
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482          PAGE: 2 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                  KIDNEY TRANSPLANT INFORMATION
------------------------------------------------------------------------------

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

HLA Typing (#,#,#,#)
====================
9. Recipient HLA-A:
10. Recipient HLA-B:
11. Recipient HLA-C:
12. Recipient HLA-DR:
13. Recipient HLA-BW:
14. Recipient HLA-DQ:

------------------------------------------------------------------------------
Select Transplant Information to Edit: <Enter>
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482          PAGE: 3 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                                RISK ASSESSMENT
------------------------------------------------------------------------------

1.  Diabetic Retinopathy:
2.  Diabetic Neuropathy:
3.  Cardiac Disease:
4.  Liver Disease:
5.  HIV + (positive):
6.  Lung Disease:
7.  Pre-Transplant Malignancy:
8.  Active Infection Immediately Pre-TX req. Antibiotics:
9.  Non-Compliance (Med and Diet):
10. Recipient Substance Abuse:
11. Post-TX Prophylaxis for CMV/Antiviral Treatment:
12. Post-TX Prophylaxis for 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      Enter/Edit Transplant Assessments
   P      Print Transplant Assessment
   L      List of Transplant Assessments
   S      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 (0288)   VACO ID: 12121   CASE: 482           PAGE: 1 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                          RECIPIENT INFORMATION
------------------------------------------------------------------------------
1.  VACO ID:                  12121
2.  Date Placed on Waiting:   MAY 04, 2008
3.  Date Started Dialysis:    JAN 21, 2008
4. Recipient ABO Blood Type: O
5.  Recipient CMV:            POSITIVE

Diagnosis Information
=====================
6.  Calcineurin Inhibitor Toxicity:      13. Obstructive Uropathy from BPH:
7.  Glomerular Sclerosis/Nephritis:      14. Polycistic Disease:
8.  Graft Failure:                       15. Renal Cancer:
9.  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.

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