# Surgery User Manual



### Department of Veterans Affairs Office of Information and Technology (OIT)

**Product Development**

### Version 3.0

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**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** |
| 11/15 | i-viii, 9, 30, 32-33, 37,  38, 40-41, 42, 43, 44,  46, 47-48, 50-52, 65,  67-68, 72-73, 76-77,  79-80, , 95, 98-99, 101-  102a, 105, 108-110,  111-113, 117, 123, 124,  124a, 124b, 140-147,  150-152b, 212e, 219a,  219b, 432-433, 449-  451, 458,459,465, 467-  469, 470a-472, 473,,  479-479a, 481-482a,  484, 486-486c, 489,  491, 493, 495-499, 501,  502a, 502c, 502e, 502g,  507, 510, 512, 527-556 | SR\*3\*18 4 | Updated definitions, added new data fields, made changes to data entry screens, reports, surgery risk management assessment transmissions. For more details, see the Annual Surgery Updates – VASQIP 2015, Release Notes. |
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|  |  |  |  |
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|  |  |  | Added ICD-10-CM Diagnosis Code Search. |
|  |  |  | Updated Warning Message to Surgeon. |
|  |  |  | Updated MailMan Messages for ICD-9 and ICD- 10 codes. |
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|  | 525, [527](#_bookmark11), [549](#_bookmark12), 553- |  |  |
|  | 554 |  |  |

# Table of Contents

Introduction 1

Overview 1

Documentation Conventions 3

Getting Help and Exiting 3

Using Screen Server 5

Introduction 5

Navigating 5

Basics of Screen Server 6

Entering Data 7

Editing Data 8

Turning Pages 8

[Entering or Editing a Range of Data Elements 9](#_TOC_250019)

Working with Multiples 10

Word Processing 14

Chapter One: Booking Operations 15

Introduction 15

Key Vocabulary 15

Exiting an Option or the System 16

Option Overview 16

Maintain Surgery Waiting List 17

Print Surgery Waiting List 18

Enter a Patient on the Waiting List 21

Edit a Patient on the Waiting List 22

Delete a Patient from the Waiting List 23

Request Operations Menu 25

Display Availability 26

Make Operation Requests 28

Delete or Update Operation Requests 36

[Make a Request from the Waiting List 42](#_TOC_250018)

Make a Request for Concurrent Cases 45

[Review Request Information 52](#_TOC_250017)

Operation Requests for a Day 53

Requests by Ward 55

List Operation Requests 57

Schedule Operations 59

Display Availability 60

Schedule Requested Operation 61

Schedule Unrequested Concurrent Cases 69

Reschedule or Update a Scheduled Operation 74

Cancel Scheduled Operation 81

Update Cancellation Reason 83

[Abort/Cancel Operation 47](#_TOC_250016)

Schedule Anesthesia Personnel 84

Create Service Blockout 85

Delete Service Blockout 87

Schedule of Operations 88

List Scheduled Operations 91

Chapter Two: Tracking Clinical Procedures 93

Introduction 93

Key Vocabulary 93

Exiting an Option or the System 94

Option Overview 94

Operation Menu 95

Using the Operation Menu Options 96

Operation Information 103

Surgical Staff [SROMEN-STAFF] 104

[Operation Startup 108](#_TOC_250015)

[Operation 113](#_TOC_250014)

Post Operation 119

Enter PAC(U) Information 121

Operation (Short Screen) 122

[Time Out Verified Utilizing Checklist 125](#_TOC_250013)

Surgeon’s Verification of Diagnosis & Procedures 125

Anesthesia for an Operation Menu 128

Operation Report 129

Anesthesia Report 131

[Nurse Intraoperative Report 140](#_TOC_250012)

Tissue Examination Report 153

Enter Referring Physician Information 154

Enter Irrigations and Restraints 155

Medications (Enter/Edit) 157

Blood Product Verification 158

Anesthesia Menu 160

Prerequisites 160

Anesthesia Data Entry Menu 161

Anesthesia Information (Enter/Edit) 162

Anesthesia Technique (Enter/Edit) 165

Medications (Enter/Edit) 169

Anesthesia Report 170

Schedule Anesthesia Personnel 173

Perioperative Occurrences Menu 175

Key Vocabulary 175

[Intraoperative Occurrences (Enter/Edit) 176](#_TOC_250011)

Postoperative Occurrences (Enter/Edit) 178

Non-Operative Occurrence (Enter/Edit) 180

Update Status of Returns Within 30 Days 181

Morbidity & Mortality Reports 183

Non-O.R. Procedures 187

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

Edit Non-O.R. Procedure 189

Procedure Report (Non-O.R.) 193

Tissue Examination Report 196

Non-OR Procedure Information 197

Annual Report of Non-O.R. Procedures 196

Report of Non-O.R. Procedures 198

Comments Option 205

CPT/ICD Coding Menu 207

CPT/ICD Update/Verify Menu 208

Update/Verify Procedure/Diagnosis Codes 209

Operation/Procedure Report 213

Nurse Intraoperative Report 217

Non-OR Procedure Information 221

Cumulative Report of CPT Codes 220

Report of CPT Coding Accuracy 224

List Completed Cases Missing CPT Codes 230

List of Operations 232

List of Operations (by Surgical Specialty) 234

Report of Daily Operating Room Activity 236

PCE Filing Status Report 238

Report of Non-O.R. Procedures 243

Chapter Three: Generating Surgical Reports 249

Introduction 249

Exiting an Option or the System 249

Option Overview 249

Surgery Reports 251

Management Reports 252

List of Operations (by Surgical Priority) 267

Surgery Staffing Reports 283

Anesthesia Reports 296

CPT Code Reports 305

Laboratory Interim Report 319

Chapter Four: Chief of Surgery Reports 321

Introduction 321

Exiting an Option or the System 321

Option Overview 321

Chief of Surgery Menu 323

View Patient Perioperative Occurrences 324

Management Reports 325

Unlock a Case for Editing 398

Update Status of Returns Within 30 Days 399

Update Cancelled Cases 400

Update Operations as Unrelated/Related to Death 401

Update/Verify Procedure/Diagnosis Codes 402

Chapter Five: Managing the Software Package 407

Introduction 407

Exiting an Option or the System 407

Option Overview 407

Surgery Package Management Menu 409

Surgery Site Parameters (Enter/Edit) 410

Operating Room Information (Enter/Edit) 413

Surgery Utilization Menu 414

Person Field Restrictions Menu 425

Update O.R. Schedule Devices 429

Update Staff Surgeon Information 430

Flag Drugs for Use as Anesthesia Agents 431

Update Site Configurable Files 432

Surgery Interface Management Menu 434

Make Reports Viewable in CPRS 440

Chapter Six: Assessing Surgical Risk 441

Introduction 441

Exiting an Option or the System 441

Surgery Risk Assessment Menu 443

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

[Creating a New Risk Assessment 445](#_TOC_250010)

Editing an Incomplete Risk Assessment 447

Preoperative Information (Enter/Edit) 448

[Laboratory Test Results (Enter/Edit) 451](#_TOC_250009)

Operation Information (Enter/Edit) 455

Patient Demographics (Enter/Edit) 457

Intraoperative Occurrences (Enter/Edit) 459

Postoperative Occurrences (Enter/Edit) 461

Update Status of Returns Within 30 Days 463

Update Assessment Status to ‘Complete’ 464

Alert Coder Regarding Coding Issues 464

Cardiac Risk Assessment Information (Enter/Edit) 465

Creating a New Risk Assessment 465

Clinical Information (Enter/Edit) 467

Laboratory Test Results (Enter/Edit) 469

[Enter Cardiac Catheterization & Angiographic Data 469](#_TOC_250008)

[Operative Risk Summary Data (Enter/Edit) 471](#_TOC_250007)

[Cardiac Procedures Operative Data (Enter/Edit) 473](#_TOC_250006)

Intraoperative Occurrences (Enter/Edit) 475

Postoperative Occurrences (Enter/Edit) 477

[Resource Data (Enter/Edit) 479](#_TOC_250005)

Update Assessment Status to ‘COMPLETE’ 481

Alert Coder Regarding Coding Issues 481

[Print a Surgery Risk Assessment 481](#_TOC_250004)

Update Assessment Completed/Transmitted in Error 487

[List of Surgery Risk Assessments 489](#_TOC_250003)

Print 30 Day Follow-up Letters 503

[Exclusion Criteria (Enter/Edit) 507](#_TOC_250002)

Monthly Surgical Case Workload Report 509

M&M Verification Report 513

Update 1-Liner Case 519

Queue Assessment Transmissions 521

Alert Coder Regarding Coding Issues 522

Risk Model Lab Test 522

Chapter Seven: Code Set Versioning 525

[Chapter Nine: Glossary 548](#_TOC_250001)

[Index 550](#_TOC_250000)

### Entering or Editing a Range of Data Elements

Colons and semicolons are used as delineators for ranges of item numbers. This allows the user to respond to two or more data elements on the same page of a screen at one time. Typing a colon and/or semicolon between the item numbers at the prompt tells the software what elements to display for editing.

Colons are used when the user wants to respond to all numbers within a sequence (for example, 2:5 means items 2, 3, 4, and 5). Semicolons are used to separate the item numbers for non-sequential items (e.g., 2; 5; 9; 11 means items 2, 5, 9 and 11). To respond to all the data elements on the page, enter “A” for all.

**Example 1: Colon**

\*\* STARTUP \*\* CASE #24 SURPATIENT,TWO

PAGE 2 OF 3

1

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PREOP CONSCIOUS:

PREOP SKIN INTEG:

TRANS TO OR BY:

HAIR REMOVAL BY:

HAIR REMOVAL METHOD:

HAIR REMOVAL COMMENTS: (WORD PROCESSING) FOLEY CATHETER INSERTED BY:

SKIN PREPPED BY (1):

SKIN PREPPED BY (2):

SKIN PREP AGENTS:

SECOND SKIN PREP AGENT:

SURGERY POSITION: (MULTIPLE)(DATA) LATERALITY OF PROCEDURE: LEFT

RESTR & POSITION AIDS: ELECTROGROUND POSITION:

(MULTIPLE)

Enter Screen Server Function: **1:4** Preoperative Consciousness: **ALERT-ORIENTED** Preoperative Skin Integrity: **INTACT** Transported to O.R. By: **STRETCHER**

R AO

I

Preop Surgical Site Hair Removal by: **SURNURSE,ONE** OS

**Example 2: Semicolon**

|  |  |  |  |
| --- | --- | --- | --- |
|  | \*\* STARTUP \*\* | CASE #24 SURPATIENT,TWO | PAGE 1 OF 3 |
| 1 | HEIGHT: | 58 INCHES |  |
| 2 | WEIGHT: | 264 LBS. |  |
| 3 | DATE OF OPERATION: | APR 19, 2006 AT 800 |  |
| 1. PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE 2. PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 3. OTHER PREOP DIAGNOSIS: (MULTIPLE) 4. OP ROOM PROCEDURE PERFORMED: OR4 5. SURGERY SPECIALTY: ORTHOPEDICS 6. PLANNED POSTOP CARE: WARD 7. CASE SCHEDULE TYPE: ELECTIVE 8. REQ ANESTHESIA TECHNIQUE: GENERAL 9. PATIENT EDUCATION/ASSESSMENT: YES 10. DELAY CAUSE: (MULTIPLE) 11. ASA CLASS: 12. PREOP MOOD:   Enter Screen Server Function: **7;9;**  Operating Room Procedure Performed: OR4// **OR2**  Planned Postop Care: WARD//**OUTPATIENT/DISCHARGE** | | | |

|  |  |
| --- | --- |
| **At this prompt:** | **The user should do this:** |
| Select REQ BLOOD KIND | Enter the type of blood product that will be needed for the operation.  The package coordinator 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. The user can then select the preferred blood product (enter two question marks for a list of blood products).  If no blood products are needed, do not enter **NO** or **NONE**. Instead, press the **<Enter>** key to bypass this prompt.  To order more than one product for the same case, use the screen server summary that concludes the option and select item 9, REQ BLOOD KIND. This is a multiple field; as many blood products as needed may be entered. |
| Requested Preoperative X-Rays | Enter the types of preoperative x-ray films and reports required for delivery to the operating room before the operation. This field may be left blank if the user does not intend to order any x-ray products. |
| Preoperative Infection | Enter the letter code “**C**” for clean or “**D**” for contaminated or “S” for ‘SPECIAL CONSIDERATIONS’ 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. |

OPERATION REQUEST: BLOOD INFORMATION

SURPATIENT,TWENTY (000-45-4886)

DEC 1, 2004

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

Request Blood Availability ? YES// **<Enter>**

OPERATION REQUEST: OTHER INFORMATION

SURPATIENT,TWENTY (000-45-4886)

DEC 1, 2004

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

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

Prin Pre-OP ICD Diagnosis Code (ICD9): **574.01** 574.01 CHOLELITH/AC GB INF-OBST (w C/C)

...OK? Yes// **<Enter>** (YES) Palliation:

Pre-admission Testing Complete (Y/N):

Case Schedule Type: **U** URGENT First Assistant: **SURSURGEON,TWO** Second Assistant: **<Enter>** Attending Surgeon:

Planned Postop Care: **WARD** W Case Schedule Order: **1**

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

Surgery Position: SUPINE// **<Enter>**

Requested Anesthesia Technique: **GENERAL <Enter>** GENERAL Request Frozen Section Tests (Y/N): **N** NO

Requested Preoperative X-Rays: **ABDOMIN** Intraoperative X-Rays (Y/N/C): **N** Request Medical Media (Y/N): **N** Preoperative Infection: **CLEAN**

Select REFERRING PHYSICIAN: **<Enter>**

General Comments: **<Enter>**

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

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

After entering the request information, the Screen Server redisplays all fields, providing an opportunity to the user to update the information.

\*\* REQUESTS \*\* CASE #227 SURPATIENT,TWENTY

PAGE 1 OF 3

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PRINCIPAL PROCEDURE: CHOLECYSTECTOMY

OTHER PROCEDURES:

(MULTIPLE)

PLANNED PRIN PROCEDURE CODE: 47480-66

LATERALITY OF PROCEDURE: (NA/ LEFT, RIGHT, BILATERAL) PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS

PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 574.01 OTHER PREOP DIAGNOSIS: (MULTIPLE)

PALLIATION:

PLANNED ADMISSION STATUS: ADMITTED PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: URGENT

SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

PRIMARY SURGEON: FIRST ASST: SECOND ASST:

SURSURGEON,ONE SURSURGEON,TWO

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

\*\* REQUESTS \*\* CASE #227 SURPATIENT,TWENTY

PAGE 2 OF 3

1

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ATTENDING SURGEON: PLANNED POSTOP CARE: CASE SCHEDULE ORDER: SURGERY POSITION:

SURSURGEON,ONE

1 (MULTIPLE)(DATA)

REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT: REQ PREOP X-RAY:

NO ABDOMIN

INTRAOPERATIVE X-RAYS: NO REQUEST BLOOD AVAILABILITY: YES

CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH

REQ BLOOD KIND: SPECIAL EQUIPMENT: PLANNED IMPLANT: SPECIAL SUPPLIES: SPECIAL INSTRUMENTS:

(MULTIPLE)(DATA) (MULTIPLE) (MULTIPLE) (MULTIPLE) (MULTIPLE)

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

\*\* REQUESTS \*\* CASE #227 SURPATIENT,TWENTY

PAGE 3 OF 3

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PHARMACY ITEMS:

REQ PHOTO:

PREOPERATIVE INFECTION: REFERRING PHYSICIAN: GENERAL COMMENTS:

(MULTIPLE)

(MULTIPLE)

(WORD PROCESSING)

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

SPD COMMENTS:

(WORD PROCESSING)

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

A request has been made for SURPATIENT,TWENTY on 12-01-01.

Press RETURN to continue

Example 1: Delete a Request

Select Request Operations Option**: D** Delete or Update Operation Requests

Select Patient: **SURPATIENT,NINE** 12-09-51 000345555 NSC VETERAN

The following cases are requested for SURPATIENT,NINE:

1. 08-15-01 CHOLECYSTECTOMY
2. 09-15-01 Release of Hammer Toes Select Operation Request: **2**
3. Delete
4. Update Request Information
5. Change the Request Date Select Number: **1**

Are you sure that you want to delete this request ? YES// **<Enter>**

Deleting Operation ... Press RETURN to continue

**Example 2: Update Request Information**

Select Request Operations Option: **D** Delete or Update Operation Requests

Select Patient: **SURPATIENT,TWENTY**

03-27-40

000454886

The following case is requested for SURPATIENT,TWENTY:

1. 12-01-01 CHOLECYSTECTOMY

1. Delete
2. Update Request Information
3. Change the Request Date Select Number: **2**

How long is this procedure ? (HOURS:MINUTES) 2:45 // **2:30**

\*\* UPDATE REQUEST \*\* CASE #227 SURPATIENT,TWENTY PAGE 1 OF 3

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PRINCIPAL PROCEDURE: CHOLECYSTECTOMY OTHER PROCEDURES: (MULTIPLE) PLANNED PRIN PROCEDURE CODE: 47480-66

LATERALITY OF PROCEDURE: (NA/ LEFT, RIGHT, BILATERAL) PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS

PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 574.01 OTHER PREOP DIAGNOSIS: (MULTIPLE) PALLIATION:

PLANNED ADMISSION STATUS: ADMISSION PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: URGENT

SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

PRIMARY SURGEON: FIRST ASST: SECOND ASST:

SURSURGEON,ONE SURSURGEON,TWO

Enter Screen Server Function: **15**

Second Assistant: **SURSURGEON,THREE**

\*\* UPDATE REQUEST \*\* CASE #227 SURPATIENT,TWENTY PAGE 1 OF 3

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13

14

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PRINCIPAL PROCEDURE: CHOLECYSTECTOMY

OTHER PROCEDURES:

(MULTIPLE)

PLANNED PRIN PROCEDURE CODE: 47480-66

LATERALITY OF PROCEDURE: (NA/ LEFT, RIGHT, BILATERAL) PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS

PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 574.01 OTHER PREOP DIAGNOSIS: (MULTIPLE)

PALLIATION:

PLANNED ADMISSION STATUS: ADMITTED PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: URGENT

SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

PRIMARY SURGEON: FIRST ASST: SECOND ASST:

SURSURGEON,ONE SURSURGEON,TWO

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

\*\* UPDATE REQUEST \*\* CASE #227 SURPATIENT,TWENTY PAGE 2 OF 3

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2

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ATTENDING SURGEON: PLANNED POSTOP CARE: WARD CASE SCHEDULE ORDER: 1

SURSURGEON,ONE

SURGERY POSITION: (MULTIPLE)(DATA) REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT:

NO

REQ PREOP X-RAY: ABDOMIN INTRAOPERATIVE X-RAYS: NO REQUEST BLOOD AVAILABILITY: YES

CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH

REQ BLOOD KIND: SPECIAL EQUIPMENT: PLANNED IMPLANT: SPECIAL SUPPLIES:

(MULTIPLE)(DATA) (MULTIPLE) (MULTIPLE) (MULTIPLE)

15 SPECIAL INSTRUMENTS: (MULTIPLE) Enter Screen Server Function: **<Enter>**

\*\* UPDATE REQUEST \*\* CASE #227 SURPATIENT,TWENTY PAGE 3 OF 3

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PHARMACY ITEMS:

REQ PHOTO:

PREOPEARTIVE INFECTION: REFERRING PHYSICIAN: GENERAL COMMENTS:

(MULTIPLE)

(MULTIPLE)

(WORD PROCESSING)

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

SPD COMMENTS:

(WORD PROCESSING)

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

**Example 3: Change the Request Date**

Select Request Operations Option: **D** Delete or Update Operation Requests Select Patient: **SURPATIENT,TWENTY** 03-27-40 000454886

The following case is requested for SURPATIENT,TWENTY:

1. 12-01-01 CHOLECYSTECTOMY

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: **3**

Change to which Date ? **11/30** (NOV 30, 2001)

The request for SURPATIENT,TWENTY has been changed to NOV 30, 2001. Press RETURN to continue

\*\* UPDATE REQUEST \*\* CASE #178 SURPATIENT,TWELVE

PAGE 1 OF 3

1

2

3

4

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14

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PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY

OTHER PROCEDURES:

(MULTIPLE)

PLANNED PRIN PROCEDURE CODE: 35301-59

LATERALITY OF PROCEDURE: (NA, LEFT, RIGHT, BILATERAL PRINCIPAL PRE-OP DIAGNOSIS:

PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): OTHER PREOP DIAGNOSIS: (MULTIPLE) PALLIATION:

PLANNED ADMISSION STATUS:

PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: STANDBY

SURGERY SPECIALTY: PERIPHERAL VASCULAR

PRIMARY SURGEON: FIRST ASST: SECOND ASST:

SURSURGEON,ONE

Enter Screen Server Function: **5;6;10**

Principal Preoperative Diagnosis: **CAROTID ARTERY STENOSIS**

Prin Pre-OP ICD Diagnosis Code: **433.1**

COMPLICATION/COMORBIDITY

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

'C'

CAROTID ARTERY OCCLUSION

Pre-admission Testing Complete (Y/N): **YES** YES

Do you want to store this information in the concurrent case ? YES// **N**

\*\* UPDATE REQUEST \*\* CASE #178 SURPATIENT,TWELVE

PAGE 1 OF 3

1

2

3

4

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12

13

14

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PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY

OTHER PROCEDURES:

(MULTIPLE)

PLANNED PRIN PROCEDURE CODE: 35301-59

LATERALITY OF PROCEDURE: (NA, LEFT, RIGHT, BILATERAL) PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 433.10

OTHER PREOP DIAGNOSIS: (MULTIPLE) PALLIATION:

PLANNED ADMISSION STATUS: ADMITTED PRE-ADMISSION TESTING: YES

CASE SCHEDULE TYPE: STANDBY

SURGERY SPECIALTY: PERIPHERAL VASCULAR

PRIMARY SURGEON: FIRST ASST: SECOND ASST:

SURSURGEON,ONE

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

\*\* UPDATE REQUEST \*\* CASE #178 SURPATIENT,TWELVE

PAGE 2 OF 3

1

2

3

4

5

6

7

8

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ATTENDING SURGEON: PLANNED POSTOP CARE: SICU

SURSURGEON,ONE

CASE SCHEDULE ORDER: 1 SURGERY POSITION: (MULTIPLE)

REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT:

NO

REQ PREOP X-RAY: DOPPLER STUDIES INTRAOPERATIVE X-RAYS: NO

REQUEST BLOOD AVAILABILITY: CROSSMATCH, SCREEN, AUTOLOGOUS: REQ BLOOD KIND: (MULTIPLE) SPECIAL EQUIPMENT: (MULTIPLE) PLANNED IMPLANT: (MULTIPLE) SPECIAL SUPPLIES: (MULTIPLE) SPECIAL INSTRUMENTS: (MULTIPLE)

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

\*\* UPDATE REQUEST \*\* CASE #229 SURPATIENT,TWELVE

PAGE 3 OF 3

1

2

3

4

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8

PHARMACY ITEMS:

REQ PHOTO:

PREOPERATIVE INFECTION: REFERRING PHYSICIAN: GENERAL COMMENTS:

(MULTIPLE)

(MULTIPLE)

(WORD PROCESSING)

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

SPD COMMENTS:

(WORD PROCESSING)

Enter Screen Server Function:

**Example 6: Change the Request Date of Concurrent Cases**

Select Request Operations Option: **D** Delete or Update Operation Requests Select Patient: **SURPATIENT,FOUR** 01-16-35 000170555 NSC VETERAN

The following cases are requested for SURPATIENT,FOUR:

1. 04-04-05

2. 04-04-05

3. 06-01-05

4. 06-01-05

ARTHROSCOPY, RIGHT KNEE REMOVE MOLE

CAROTID ARTERY ENDARTERECTOMY AORTO CORONARY BYPASS GRAFT

Select Operation Request: **3**

1. Delete
2. Update Request Information
3. Change the Request Date Select Number: **3**

Change to which Date ? **6/2** (JUN 02, 2005)

There is a concurrent case associated with this operation. Do you want to change the date of it also ? YES// **?**

Enter <Enter> if these cases will remain concurrent, or 'NO' if they will no longer be associated together.

There is a concurrent case associated with this operation. Do you want to change the date of it also ? YES// **<Enter>**

The request for SURPATIENT,FOUR has been changed to JUN 2, 2005. Press RETURN to continue

**Make a Request from the Waiting List**

#### [SRSWREQ]

The *Make a Request from the Waiting List* option uses data from the Waiting List to make an operation request. It can save time by moving data from the Waiting List to the request (simultaneously removing it from the waiting list). As with any request, a date for the surgery is required.

After the user enters the patient name, the software will list any operations on the Waiting List for that patient. The user then selects the operative procedure wanted. The software will advise if the patient selected has any outstanding requests.

Each institution might have a daily cutoff time for entering requests. After the cutoff time for a particular day, the users are prohibited from booking a request for an operation to take place through midnight of that day.

When a request is made, the user is asked to provide preoperative information about the case. It is best to enter as much information as available.

**Example: Making A Request From the Waiting List**

Select Request Operations Option: **W** Make a Request from the Waiting List

Make a request from the waiting list for which patient ? **SURPATIENT,FOURTEEN**

08-16-51 000457212

Procedures Entered on the Waiting List for SURPATIENT,FOURTEEN:

1. GENERAL(OR WHEN NOT DEFINED BELOW) Date Entered on List: NOV 17, 2005 REPAIR DIAPHRAGMATIC HERNIA

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

Make a request for which Date ? **12/1** (DEC 01, 2005)

OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)

DEC 1, 2005

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

Primary Surgeon: **SURSURGEON,TWO**

Attending Surgeon: **SURSURGEON,TWO**

Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW) Principal Operative Procedure: REPAIR DIAPHRAGMATIC HERNIA Principal Preoperative Diagnosis: **ACUTE DIAPHRAGMATIC HERNIA**

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>**

Laterality Of Procedure: **NA**

Planned Admission Status: **1** SAME DAY Planned Principal Procedure Code: **39540**

REPAIR OF DIAPHRAGM HERNIA

REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC; ACUTE

Modifier:

Sending a Notification of Appointment Booking for case #229

OPERATION REQUEST: PROCEDURE INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)

DEC 1, 2005

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

Principal Procedure: REPAIR DIAPHRAGMATIC HERNIA

Planned Principal Procedure Code (CPT): 39540 REPAIR OF DIAPHRAGM HERNIA REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC; ACUTE // **<Enter>**

Select OTHER PROCEDURE: **<Enter>**

Estimated Case Length (HOURS:MINUTES): **2:00**

BRIEF CLIN HISTORY:

1>**Patient was reporting indigestion and a burning** 2>**sensation in esophagus. Upper GI indicated hernia.** 3>**<Enter>**

EDIT Option: **<Enter>**

OPERATION REQUEST: BLOOD INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)

DEC 1, 2005

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

Request Blood Availability (Y/N): NO// **<Enter>**

OPERATION REQUEST: OTHER INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)

DEC 1, 2005

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

Principal Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA// **<Enter>**

Prin Pre-OP ICD Diagnosis Code (ICD9): **551.3**

One match found

551.3 DIAPHRAGM HERNIA W GANGR (Major CC)

OK? Yes// **<Enter>** (YES) 551.3 DIAPHRAGM HERNIA W GANGR

DIAPHRAGM HERNIA W GANGR(Major CC) 551.3 ICD-9

Palliation: **<Enter>**

Pre-admission Testing Complete (Y/N): **Y** YES Case Schedule Type: **S** STANDBY

First Assistant: **SURSURGEON,ONE**

Second Assistant: **<Enter>**

Attending Surgeon: ln,fn// **<Enter>** Planned Postop Care: **WARD** W 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: **ABDOMEN** Intraoperative X-Rays (Y/N/C): **N** NO Request Medical Media (Y/N): **N** NO Preoperative Infection: **C** CLEAN

Select REFERRING PHYSICIAN: **<Enter>**

General Comments: **<Enter>**

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

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

\*\* REQUEST \*\* CASE #229 SURPATIENT,FOURTEEN

PAGE 1 OF 3

1

2

3

4

5

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15

PRINCIPAL PROCEDURE: REPAIR DIAPHRAGMATIC HERNIA OTHER PROCEDURES: (MULTIPLE)

PLANNED PRIN PROCEDURE CODE: 39540

LATERALITY OF PROCEDURE: (NA, RIGHT, LEFT, BILATERAL) PRINCIPAL PRE-OP DIAGNOSIS: ACUTE DIAPHRAGMATIC HERNIA PRIN PRE-OP ICD DIAGNOSIS CODE: 551.3

OTHER PREOP DIAGNOSIS: (MULTIPLE) PALLIATION:

PLANNED ADMISSION STATUS: ADMITTED PRE-ADMISSION TESTING: YES

CASE SCHEDULE TYPE: SURGERY SPECIALTY: PRIMARY SURGEON: FIRST ASST:

SECOND ASST:

STANDBY

GENERAL(OR WHEN NOT DEFINED BELOW) SURSURGEON,TWO

SURSURGEON,ONE

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

\*\* REQUEST \*\* CASE #229 SURPATIENT,FOURTEEN

PAGE 2 OF 3

1

2

3

4

5

6

7

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14

15

ATTENDING SURGEON: PLANNED POSTOP CARE: CASE SCHEDULE ORDER: SURGERY POSITION:

SURSURGEON,TWO WARD

(MULTIPLE)(DATA)

REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT:

REQ PREOP X-RAY: INTRAOPERATIVE X-RAYS:

NO ABDOMEN NO

REQUEST BLOOD AVAILABILITY: NO

CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH

REQ BLOOD KIND: SPECIAL EQUIPMENT: PLANNED IMPLANT: SPECIAL SUPPLIES: SPECIAL INSTRUMENTS:

(MULTIPLE)(DATA) (MULTIPLE) (MULTIPLE) (MULTIPLE) (MULTIPLE)

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

\*\* REQUEST \*\* CASE #229 SURPATIENT,FOURTEEN

PAGE 3 OF 3

1

2

3

4

5

6

7

8

PHARMACY ITEMS:

REQ PHOTO:

PREOPERATIVE INFECTION: REFERRING PHYSICIAN:

(MULTIPLE) NO

CLEAN (MULTIPLE)

GENERAL COMMENTS:

(WORD PROCESSING)

INDICATIONS FOR OPERATIONS: (WORD PROCESSING)

BRIEF CLIN HISTORY: SPD COMMENTS:

(WORD PROCESSING)(DATA) (WORD PROCESSING)

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

A request has been made for SURPATIENT,FOURTEEN on 12/01/2005.

Press RETURN to continue

**Example 1: Make a Request for Concurrent Cases**

Select Request Operations Option: **CC** Make a Request for Concurrent Cases

Request Concurrent Cases for which Patient ? **SURPATIENT,TWELVE** 02-12-28 000418719

Make a Request for Concurrent Cases on which Date ? **12/1** (DEC 01, 1999)

FIRST CONCURRENT CASE OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,TWELVE (000-41-8719)

DEC 1, 2005

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

Primary Surgeon: **SURSURGEON,ONE** Attending Surgeon: **SURSURGEON,TWO** Surgical Specialty: **62**

62

PERIPHERAL VASCULAR PERIPHERAL VASCULAR

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>**

Laterality Of Procedure: NA Planned Admission Status: SAME DAY

Planned Principal Procedure Code: 35526 REPAIR OF ANOMALOUS CORONARY ARTERY FROM PULMONARY

ARTERY ORIGIN; BY LIGATION

Modifier:

Sending a Notification of Appointment Booking for case #230

SECOND CONCURRENT CASE OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,TWELVE (000-41-8719)

DEC 1, 2005

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

Primary 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: **CORONARY ARTERY DISEASE**

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>**

Laterality Of Procedure: NA Planned Admission Status: SAME DAY

Planned Principal Procedure Code: 35526

ARTERY BYPASS GRAFT

BYPASS GRAFT, WITH VIEN; AORTOSUBCLAVIAN, AORTOINNOMINATE, OR AORTOCAROTID

Modifier:

SECOND CONCURRENT CASE OPERATION REQUEST: PROCEDURE INFORMATION

SURPATIENT,TWELVE (000-41-8719)

DEC 1, 2005

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

Principal Procedure: AORTO CORONARY BYPASS GRAFT

Planned Principal Procedure Code (CPT): **35526** ARTERY BYPASS GRAFT Modifier: -66 SURGICAL TEAM

Select OTHER PROCEDURE: **<Enter>**

Estimated Case Length (HOURS:MINUTES): **3:30**

BRIEF CLIN HISTORY:

1>**CARDIAC CATH SHOWS 80% OCCLUSION OF THE LAD, 75% OCCLUSION OF**

2>**RIGHT CORONARY. ALSO, ANTERIOR INFERIOR HYPOKINESIS WITH**

3>**POOR LEFT VENTRICULAR FUNCTION, 27%.**

4>**<Enter>**

EDIT Option: **<Enter>**

SECOND CONCURRENT CASE OPERATION REQUEST: BLOOD INFORMATION

SURPATIENT,TWELVE (000-41-8719)

DEC 1, 2005

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

Request Blood Availability ? N// **YES**

Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH// <Enter> TYPE & CROSSMATCH Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// @

SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y (YES)

Select REQ BLOOD KIND: 04061 CPDA-1 RED BLOOD CELLS, DIVIDED UNIT 04061

Units Required: **4**

SECOND CONCURRENT CASE OPERATION REQUEST: OTHER INFORMATION

SURPATIENT,TWELVE (000-41-8719)

DEC 1, 2005

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

Principal Preoperative Diagnosis: CORONARY ARTERY DISEASE Replace <ENTER>

Prin Pre-OP ICD Diagnosis Code (ICD9): **996.03**

One match found

996.03 MALFUNC CORON BYPASS GRF(CC)

...OK? YES// **<Enter>** (YES) 996.03 MALFUNC CORON BYPASS GRF(CC) 996.03 ICD-9 MAL FUNC CORON BYPASS GRF

Palliation: **NO**

Pre-admission Testing Complete (Y/N): Y YES

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Case Schedule Type: **S** STANDBY

Do you want to store this information in the concurrent case ? YES// **<Enter>**

First Assistant: **SURSURGEON,SIX**

Second Assistant: **<Enter>**

Attending Surgeon: SURSURGEON,ONE// **<Enter>**

Planned Postop Care: ICU I Case Schedule Order: **2**

Do you want to store this information in the concurrent case ? YES// **N**

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

Surgery Position: SUPINE// **<Enter>**

Requested Anesthesia Technique: **GENERAL**

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Request Frozen Section Tests (Y/N): **N** NO

Do you want to store this information in the concurrent case ? Requested Preoperative X-Rays: **DOPPLER STUDIES**

Do you want to store this information in the concurrent case ? Intraoperative X-Rays (Y/N): **N** NO

Do you want to store this information in the concurrent case ? Request Medical Media (Y/N): **N** NO

Do you want to store this information in the concurrent case ? Preoperative Infection: **C** CLEAN

Select REFERRING PHYSICIAN: **<Enter>**

General Comments: **<Enter>**

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

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

YES// <**Enter**>

YES// **N**

YES// **<Enter>**

YES// **<Enter>**

The information to be duplicated in the concurrent case will now be entered....

Sending a Notification of Appointment Modification for case #231 Press RETURN to continue **<Enter>**

\*\* REQUESTS \*\* CASE #231 SURPATIENT,TWELVE

PAGE 1 OF 3

1

2

3

4

5

6

7

8

9

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14

15

PRINCIPAL PROCEDURE: OTHER PROCEDURES:

AORTO CORONARY BYPASS GRAFT (MULTIPLE)

PLANNED PRIN PROCEDURE CODE: 35526-66

LATERALITY OF PROCEDURE:

PRINCIPAL PRE-OP DIAGNOSIS: CORONARY ARTERY DISEASE PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 996.03

OTHER PREOP DIAGNOSIS: (MULTIPLE)

PALLIATION:

NO

PLANNED ADMISSION STATUS: ADMITTED PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: STANDBY

SURGERY SPECIALTY: THORACIC SURGERY (INC. CARDIAC SURG.)

PRIMARY SURGEON: FIRST ASST: SECOND ASST:

SURSURGEON,TWO SURSURGEON,SIX

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

\*\* REQUESTS \*\*

ATTENDING SURGEON: PLANNED POSTOP CARE: CASE SCHEDULE ORDER: SURGERY POSITION:

CASE #231 SURPATIENT,TWELVE

SURSURGEON,TWO ICU

2 (MULTIPLE)(DATA)

PAGE 2 OF 3

1

2

3

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REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT:

REQ PREOP X-RAY: INTRAOPERATIVE X-RAYS:

NO

DOPPLER STUDIES NO

REQUEST BLOOD AVAILABILITY: YES

CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH

REQ BLOOD KIND: SPECIAL EQUIPMENT: PLANNED IMPLANT: SPECIAL SUPPLIES: SPECIAL INSTRUMENTS:

(MULTIPLE)(DATA) (MULTIPLE) (MULTIPLE) (MULTIPLE) (MULTIPLE)

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

**Example 2: Update Request Information for a Concurrent Case**

Select Request Operations Option: **D** Delete or Update Operation Requests Select Patient: **SURPATIENT,TWELVE** 02-12-28 000418719

The following cases are requested for SURPATIENT,TWELVE:

1. 03-09-05 REMOVE FACIAL LESIONS
2. 12-01-05 CAROTID ARTERY ENDARTERECTOMY
3. 12-01-05 AORTO CORONARY BYPASS GRAFT Select Operation Request: **2**
4. Delete
5. Update Request Information
6. Change the Request Date Select Number: **2**

How long is this procedure ? (HOURS:MINUTES) // **1:30**

\*\* UPDATE REQUEST \*\* CASE #230 SURPATIENT,TWELVE

PAGE 1 OF 3

1

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16

PRINCIPAL PROCEDURE: OTHER PROCEDURES:

CAROTID ARTERY ENDARTERECTOMY (MULTIPLE)

PLANNED PRIN PROCEDURE CODE: 35301-59 LATERALITY OF PROCEDURE:

PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9):

OTHER PREOP DIAGNOSIS: PALLIATION:

(MULTIPLE) NO

PLANNED ADMISSION STATUS: ADMITTED PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: SURGERY SPECIALTY: PRIMARY SURGEON: FIRST ASST:

SECOND ASST: ATTENDING SURGEON:

STANDBY

PERIPHERAL VASCULAR SURSURGEON,ONE

SURSURGEON,TWO

Enter Screen Server Function: **6**

Prin Pre-OP ICD Diagnosis Code (ICD9): **433.1**

One match found

433.1

CAROTID ARTERY OCCLUSION

COMPLICATION/COMORBIDITY

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

\*\* UPDATE REQUEST \*\* CASE #230 SURPATIENT,TWELVE

PAGE 1 OF 3

1

2

3

4

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PRINCIPAL PROCEDURE: OTHER PROCEDURES:

CAROTID ARTERY ENDARTERECTOMY (MULTIPLE)

PLANNED PRIN PROCEDURE CODE: 35301-59 LATERALITY OF PROCEDURE:

PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS PRIN PRE-OP ICD DIAGNOSIS CODE (ICD): 433.1

OTHER PREOP DIAGNOSIS: PALLIATION:

(MULTIPLE)

PLANNED ADMISSION STATUS: ADMITTED PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: SURGERY SPECIALTY: PRIMARY SURGEON: FIRST ASST:

SECOND ASST:

STANDBY

PERIPHERAL VASCULAR SURSURGEON,ONE

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

\*\* UPDATE REQUEST \*\* CASE #230 SURPATIENT,TWELVE

PAGE 2 OF 3

1

2

3

4

5

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ATTENDING SURG: PLANNED POSTOP CARE: CASE SCHEDULE ORDER: SURGERY POSITION:

SURSURGEON,TWO

(MULTIPLE)

REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT: REQ PREOP X-RAY:

NO

INTRAOPERATIVE X-RAYS: NO REQUEST BLOOD AVAILABILITY: CROSSMATCH, SCREEN, AUTOLOGOUS:

REQ BLOOD KIND: SPECIAL EQUIPMENT: PLANNED IMPLANT: SPECIAL SUPPLIES: SPECIAL INSTRUMENTS:

(MULTIPLE) (MULTIPLE) (MULTIPLE) (MULTIPLE) (MULTIPLE)

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

\*\* UPDATE REQUEST \*\* CASE #230 SURPATIENT,TWELVE

PAGE 3 OF 3

1

2

3

4

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8

PHARMACY ITEMS:

REQ PHOTO:

PREOPERATIVE INFECTION: REFERRING PHYSICIAN: GENERAL COMMENTS:

(MULTIPLE) NO

(MULTIPLE)

(WORD PROCESSING)

INDICATIONS FOR OPERATIONS: (WORD PROCESSING) (DATA)

BRIEF CLIN HISTORY: SPD COMMENTS:

(WORD PROCESSING) (WORD PROCESSING)

Enter Screen Server Function:

### Review Request Information

#### [SROREQV]

Surgeons and nurses use the *Review Request Information* option to edit or review the preoperative information that was entered when the case was requested. This option can be accessed after the case has been scheduled.

**Example: Review Request Information**

Select Request Operations Option: **V** Review Request Information Select Patient: **SURPATIENT,ONE** 02-23-53 000447629

SURPATIENT,ONE

1. 03-09-99 REVISE MEDIAN NERVE (REQUESTED) Select Operation: **1**

\*\* REVIEW REQUEST \*\* CASE #35 SURPATIENT,ONE

PAGE 1 OF 2

1

2

3

4

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11

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13

14

15

PRINCIPAL PROCEDURE:

REVISE MEDIAN NERVE

OTHER PROCEDURES:

(MULTIPLE)

PLANNED PRIN PROCEDURE CODE: 64721 LATERALITY OF PROCEDURE: NA

PRINCIPAL PRE-OP DIAGNOSIS: CARPAL TUNNEL SYNDROME PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 354.0

OTHER PREOP DIAGNOSIS: (MULTIPLE) PLANNED ADMISSION STATUS: ADMITTED

CASE SCHEDULE TYPE: SURGERY SPECIALTY: PRIMARY SURGEON: FIRST ASST:

SECOND ASST: ATTENDING SURGEON: PLANNED POSTOP CARE:

ELECTIVE ORTHOPEDICS SURSURGEON,ONE SURSURGEON,THREE SURSURGEON,TWO SURSURGEON,ONE ICU

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

\*\* REVIEW REQUEST \*\* CASE #35 SURPATIENT,ONE

PAGE 2 OF 2

1

2

3

4

5

6

7

8

9

10

11

12

13

14

CASE SCHEDULE ORDER: SURGERY POSITION:

(MULTIPLE)(DATA)

REQ ANESTHESIA TECHNIQUE: GENERAL REQ FROZ SECT:

REQ PREOP X-RAY:

CARPAL TUNNEL, R WRIST

INTRAOPERATIVE X-RAYS:

REQUEST BLOOD AVAILABILITY: NO CROSSMATCH, SCREEN, AUTOLOGOUS:

REQ BLOOD KIND: (MULTIPLE) REQ PHOTO:

PREOPERATIVE INFECTION: CLEAN REFERRING PHYSICIAN: (MULTIPLE)

GENERAL COMMENTS: (WORD PROCESSING) INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function:

##### 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. | |
| Preoperative Infection | Enter the letter code “**C**” for clean or “**D**” for contaminated or “S” for ‘SPECIAL CONSIDERATIONS’ 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. | |
|  | |  |

SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

SURPATIENT,THREE (000-21-2453)

JUL 18, 2005

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

Request Blood Availability (Y/N): Y// **<Enter>** YES

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

SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? **Y** (YES) Select REQ BLOOD KIND: **FA1** FRESH FROZEN PLASMA, CPDA-1 18201

Units Required: **4**

SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

SURPATIENT,THREE (000-21-2453)

JUL 18, 2005

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

Prin Pre-OP ICD Diagnosis Code: **715.11** 715.11

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

Hospital Admission Status: **2** ADMISSION Case Schedule Type: **S** STANDBY

First Assistant: **TS** SURSURGEON,THREE Second Assistant: **SURSURGEON,FOUR** Requested Postoperative Care: **W** WARD Case Schedule Order: **1**

Requested Anesthesia Technique: **G** GENERAL Request Frozen Section Tests (Y/N): **N** NO Requested Preoperative X-Rays: **LEFT SHOULDER** Intraoperative X-Rays (Y/N/C): **Y** YES Request Medical Media (Y/N): **N** NO Preoperative Infection: **C** CLEAN

GENERAL COMMENTS:

1>**<Enter>** SPD Comments:

1>**<Enter>**

LOC PRIM OSTEOART-SHLDER

\*\* SCHEDULING \*\* CASE #264 SURPATIENT,THREE

PAGE 1 OF 2

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

PRINCIPAL PROCEDURE: SHOULDER ARTHROPLASTY-PROSTHESIS PLANNED PRIN PROCEDURE CODE: 23470

OTHER PROCEDURES:

(MULTIPLE)

PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER PRIN PRE-OP ICD DIAGNOSIS CODE: 715.11

OTHER PREOP DIAGNOSIS: (MULTIPLE) HOSPITAL ADMISSION STAUTS: ADMISSION PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: STANDBY

SURGERY SPECIALTY: PRIMARY SURGEON: FIRST ASST:

SECOND ASST: ATTENDING SURGEON:

ORTHOPEDICS

SURSURGEON,ONE SURSURGEON,THREE SURSURGEON,FOUR

SURSURGEON,TWO

PLANNED POSTOP CARE:

WARD

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

\*\* SCHEDULING \*\* CASE #264 SURPATIENT,THREE

PAGE 2 OF 2

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

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CASE SCHEDULE ORDER: 1

REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT:

NO

REQ PREOP X-RAY: LEFT SHOULDER INTRAOPERATIVE X-RAYS: YES REQUEST BLOOD AVAILABILITY: YES

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

SPECIAL EQUIPMENT: (MULTIPLE) PHARMACY ITEMS: (MULTIPLE)

REQ PHOTO:

NO

PREOPERATIVE INFECTION: CLEAN

PRINC ANESTHETIST: SURANESTHETIST,ONE ANESTHESIOLOGIST SUPVR: SURSURGEON,TWO BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)

GENERAL COMMENTS:

(WORD PROCESSING)

SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:

FIRST CONCURRENT CASE

SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

SURPATIENT,EIGHT (000-37-0555)

JUL 25, 1999

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

Prin Pre-OP ICD Diagnosis Code: **433.11** OCCL&STEN/CAR ART W/CRB INF COMPLICATION/COMORBIDITY ACTIVE

Hospital Admission Status: **2** ADMISSION

Do you want to store this information in the concurrent case ? YES// **N**

Case Schedule Type: **S** STANDBY

Do you want to store this information in the concurrent case ? YES// **<Enter>**

First Assistant: **SURSURGEON,FOUR** Second Assistant: **TS** SURSURGEON,THREE Requested Postoperative Care: **SICU**

Do you want to store this information in the concurrent case ? YES// **N**

Case Schedule Order: **2**

Do you want to store this information in the concurrent case ? YES// **N**

Requested Anesthesia Technique: **G** GENERAL

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Request Frozen Section Tests (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Requested Preoperative X-Rays: **DOPPLER STUDIES**

Do you want to store this information in the concurrent case ? YES// **N**

Intraoperative X-Rays (Y/N/C): **N** NO

Do you want to store this information in the concurrent case ? YES// **N**

Request Medical Media (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES// **Y**

Preoperative infection: **C** CLEAN

Do you want to store this information in the concurrent case ? YES// **<Enter>**

GENERAL COMMENTS:

1>**<Enter>** SPD Comments: 1>**<Enter>**

The information to be duplicated in the concurrent case will now be entered....

Press RETURN to continue **<Enter>**

\*\* SCHEDULING \*\* CASE #265 SURPATIENT,EIGHT

PAGE 1 OF 2

1

2

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PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY PLANNED PRIN PROCEDURE CODE: 35301

OTHER PROCEDURES: (MULTIPLE)

PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS PRIN PRE-OP ICD DIAGNOSIS CODE: 433.1

OTHER PREOP DIAGNOSIS: (MULTIPLE) HOSPITAL ADMISSION STATUS: ADMISSION PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: STANDBY

SURGERY SPECIALTY: PRIMARY SURGEON: FIRST ASST:

SECOND ASST:

PERIPHERAL VASCULAR

SURSURGEON,ONE SURSURGEON,FOUR SURSURGEON,THREE

ATTENDING SURG:

SURSURGEON,ONE

PLANNED POSTOP CARE: SICU

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

\*\* SCHEDULING \*\* CASE #265 SURPATIENT,EIGHT

PAGE 2 OF 2

1

2

3

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CASE SCHEDULE ORDER: 2

REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT: REQ PREOP X-RAY:

NO

DOPPLER STUDIES

INTRAOPERATIVE X-RAYS: NO REQUEST BLOOD AVAILABILITY: YES

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

PHARMACY ITEMS: REQ PHOTO:

(MULTIPLE) NO

PREOPERATIVE INFECTION: CLEAN

PRINC ANESTHETIST: SURANESTHETIST,ONE ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO BRIEF CLIN HISTORY: (WORD PROCESSING)

GENERAL COMMENTS:

(WORD PROCESSING)

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

SECOND CONCURRENT CASE

SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

SURPATIENT,SIX (000-09-8797)

SEP 16, 2005

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

Prin Pre-OP ICD Diagnosis Code: **715.90** 715.90 ACTIVE

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

(Hospital Admission Status: **2** ADMISSION

OSTEOARTHROS NOS-UNSPEC

Do you want to store this information in the concurrent case ? YES// **N**

Case Schedule Type: **S** STANDBY

Do you want to store this information in the concurrent case ? YES// **N**

First Assistant: **TS** SURSURGEON,THREE Second Assistant: **<Enter>**

Requested Postoperative Care: **WARD**

Do you want to store this information in the concurrent case ? YES// **N**

Case Schedule Order: **1**

Do you want to store this information in the concurrent case ? YES// **N**

Requested Anesthesia Technique: **GENERAL**

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Request Frozen Section Tests (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Requested Preoperative X-Rays: **<Enter>**

Intraoperative X-Rays (Y/N): **Y** YES

Do you want to store this information in the concurrent case ? YES// **N**

Request Medical Media (Y/N): **N** NO

Do you want to store this information in the concurrent case ? YES// **<Enter>**

Preoperative Infection: **C** CLEAN

Do you want to store this information in the concurrent case ? YES// **<Enter>**

GENERAL COMMENTS:

1> **<Enter>**

SPD Comments: 1>**<Enter>**

The information to be duplicated in the concurrent case will now be entered....

\*\* SCHEDULING \*\* CASE #245 SURPATIENT,SIX

PAGE 1 OF 2

1

2

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PRINCIPAL PROCEDURE: ARTHROSCOPY, R SHOULDER PLANNED PRIN PROCEDURE CODE: 23470

OTHER PROCEDURES: (MULTIPLE)

PRINCIPAL PRE-OP DIAGNOSIS: DEGERATIVE OSTEOARTHRITIS PRIN PRE-OP ICD DIAGNOSIS CODE: 715.90

OTHER PREOP DIAGNOSIS: (MULTIPLE) HOSPITAL ADMISSION STAUTS: ADMISSION PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: STANDBY

SURGERY SPECIALTY: PRIMARY SURGEON: FIRST ASST:

SECOND ASST: ATTENDING SURGEON: PLANNED POSTOP CARE:

ORTHOPEDICS

SURSURGEON,TWO SURSURGEON,THREE

SURSURGEON,TWO WARD

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

\*\* SCHEDULING \*\* CASE #245 SURPATIENT,SIX

PAGE 2 OF 2

1

2

3

4

5

6

7

8

9

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13

14

15

CASE SCHEDULE ORDER: 1

REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT: REQ PREOP X-RAY:

NO

INTRAOPERATIVE X-RAYS: YES REQUEST BLOOD AVAILABILITY: YES

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

PHARMACY ITEMS: REQ PHOTO:

(MULTIPLE) NO

PREOPERATIVE INFECTION: CLEAN

PRINC ANESTHETIST: SURANESTHETIST,ONE ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)

GENERAL COMMENTS:

(WORD PROCESSING)

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

The following cases have been entered.

1. Case # 224 SEP 16, 2005

Surgeon: SURSURGEON,ONE NEUROSURGERY Procedure: CARPAL TUNNEL RELEASE

2. Case # 245 SEP 16, 2005 Surgeon: SURSURGEON,TWO ORTHOPEDICS Procedure: ARTHROSCOPY, R SHOULDER

1. Enter Information for Case #224
2. Enter Information for Case #245

**Example 3: How to Update a Scheduled Operation**

Select Schedule Operations Option: **R** Reschedule or Update a Scheduled Operation

Select Patient: **SURPATIENT,THREE**

12-19-53

000212453

SURPATIENT,THREE (000-21-2453)

1. 09/15/05 SHOULDER ARTHROPLASTY-PROTHESIS (SCHEDULED) Select Number: **1**

Do you want to add a concurrent case ? NO// **<Enter>**

Do you want to change the date/time or operating room for which this case is scheduled ? NO// **<Enter>**

\*\* SCHEDULING \*\* CASE #218 SURPATIENT,THREE

PAGE 1 OF 2

1

2

3

4

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8

9

10

11

12

13

4

15

PRINCIPAL PROCEDURE: SHOULDER ARTHOPLASTY-PROSTHESIS PLANNED PRIN PROCEDURE CODE: 23470

OTHER PROCEDURES: (MULTIPLE)

PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER PRIN PRE-OP ICD DIAGNOSIS CODE: 715.11

OTHER PREOP DIAGNOSIS: (MULTIPLE) HOSPITAL ADMISSION STAUTS: ADMISSION PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: STANDBY

SURGERY SPECIALTY: PRIMARY SURGEON: FIRST ASST:

SECOND ASST: ATTENDING SURGEON:

PLANNED POSTOP CARE:

ORTHOPEDICS

SURSURGEON,ONE SURSURGEON,TWO SURSURGEON,FOUR

SURSURGEON,ONE WARD

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

\*\* SCHEDULING \*\* CASE #218 SURPATIENT,THREE

PAGE 2 OF 2

1

2

3

4

5

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14

15

CASE SCHEDULE ORDER: 1

REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT:

NO

REQ PREOP X-RAY: LEFT SHOULDER INTRAOPERATIVE X-RAYS: YES REQUEST BLOOD AVAILABILITY: YES

CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH

REQ BLOOD KIND: PHARMACY ITEMS: REQ PHOTO:

(MULTIPLE)(DATA) (MULTIPLE)

NO

PREOPERATIVE INFECTION: CLEAN

PRINC ANESTHETIST: SURANESTHETIST,ONE ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO BRIEF CLIN HISTORY: (WORD PROCESSING) GENERAL COMMENTS: (WORD PROCESSING)

Enter Screen Server Function: **8**

\*\* SCHEDULING \*\* CASE #218 SURPATIENT,THREE

PAGE 1 OF 1

REQ BLOOD KIND

1

2

REQ BLOOD KIND: NEW ENTRY

FRESH FROZEN PLASMA, CPDA-1

Enter Screen Server Function: **2**

Select REQ BLOOD KIND: **CPDA-1 WHOLE BLOOD** 00160

REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// **<Enter>**

\*\* SCHEDULING \*\* CASE #218 SURPATIENT,THREE

PAGE 1 OF 1

REQ BLOOD KIND (CPDA-1 WHOLE BLOOD)

1

2

REQ BLOOD KIND: UNITS REQ:

CPDA-1 WHOLE BLOOD

Enter Screen Server Function: **2**

Units Required: **2**

\*\* SCHEDULING \*\* CASE #218 SURPATIENT,THREE

PAGE 1 OF 1

REQ BLOOD KIND (CPDA-1 WHOLE BLOOD)

1. REQ BLOOD KIND:
2. UNITS REQ:

CPDA-1 WHOLE BLOOD 2

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

\*\* SCHEDULING \*\* CASE #218 SURPATIENT,THREE

PAGE 1 OF 1

REQ BLOOD KIND

1

2

3

REQ BLOOD KIND: REQ BLOOD KIND: NEW ENTRY

FRESH FROZEN PLASMA, CPDA-1 CPDA-1 WHOLE BLOOD

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

\*\* SCHEDULING \*\* CASE #218 SURPATIENT,THREE

PAGE 2 OF 2

1

2

3

4

5

6

7

8

9

19

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11

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13

14

15

CASE SCHEDULE ORDER: 1

REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT: REQ PREOP X-RAY:

NO

LEFT SHOULDER

INTRAOPERATIVE X-RAYS: YES REQUEST BLOOD AVAILABILITY: YES

CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH

REQ BLOOD KIND:

(MULTIPLE)(DATA)

SPECIAL EQUIPMENT: (MULTIPLE)

PHARMACY ITEMS: REQ PHOTO:

(MULTIPLE) NO

PREOPERATIVE INFECTION: CLEAN

PRINC ANESTHETIST: SURANESTHETIST,ONE ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO BRIEF CLIN HISTORY: (WORD PROCESSING)

GENERAL COMMENTS:

(WORD PROCESSING)

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

# Operation Menu

#### [SROPER]

The *Operation Menu* provides operating room personnel with on-line access to medical administration and laboratory information and generates post-operative reports, including the Nurse Intraoperative Report and the Operation Report. The menu options provide the opportunity to delete, edit, or review a patient’s operation history or to enter information concerning a new surgery. The *Operation Menu* allows the user to select an area on which to concentrate data entry or review, such as post operation or anesthesia information. It is designed for operating room nurses, surgeons, and anesthetists to use before, during, and after surgery. The Screen Server utility is used extensively to provide quick access to relevant information.

 This option is locked with the SROPER key.

The *Operation Menu* contains the following options. To the left is the keyboard shortcut the user can enter to select the option. A restricted option, such as the *Anesthesia Menu*, will not display if the user does not have security clearance for that option.

|  |  |
| --- | --- |
| **Shortcut** | **Option Name** |
| I | *Operation Information* |
| SS | *Surgical Staff* |
| OS | *Operation Startup* |
| O | *Operation* |
| PO | *Post Operation* |
| PAC | *Enter PAC(U) Information* |
| OSS | *Operation (Short Screen)* |
| V | *Surgeon's Verification of Diagnosis & Procedures* |
| A | *Anesthesia 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)* |
| AB | *Abort/Cancel Operation* |
| B | *Blood Product Verification* |

**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) AB Abort/Cancel Operation

B Blood Product Verification

Select Operation Menu Option:

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

##### Reviewing Information

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

**Example: Review Information**

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

12-19-53

000212453

SURPATIENT,THREE 000-21-2453

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

SURPATIENT,THREE 000-21-2453

08-15-88

SHOULDER ARTHROPLASTY (NOT COMPLETE)

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

Select Number: 1// **2**

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

PAGE 1 OF 3

1

2

3

4

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

TIME PAT IN OR:

AUG 15, 1999 AT 08:00

ANES CARE TIME BLOCK: (MULTIPLE)

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

SPECIMENS: CULTURES: THERMAL UNIT:

ELECTROCAUTERY UNIT: ESU COAG RANGE:

(WORD PROCESSING) (WORD PROCESSING) (MULTIPLE)

ESU CUTTING RANGE:

TIME TOURNIQUET APPLIED: (MULTIPLE)

PROSTHESIS INSTALLED: REPLACEMENT FLUID TYPE: IRRIGATION: MEDICATIONS:

(MULTIPLE) (MULTIPLE) (MULTIPLE) (MULTIPLE)

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

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

PAGE 2 OF 3

1

2

3

4

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13

POSSIBLE ITEM RETENTION: SPONGE FINAL COUNT CORRECT: SHARPS FINAL COUNT CORRECT: INSTRUMENT FINAL COUNT CORRECT: WOUND SWEEP: No

WOUND SWEEP COMMENTS:

(WORD PROCESSING)

INTRA-OPERATIVE X-RAYS: No

INTRA-OPERATIVE X-RAYS COMMENTS: (WORD PROCESSING) SPONGE, SHARPS, & INST COUNTER:

COUNT VERIFIER:

SEQUENTIAL COMPRESSION DEVICE:

LASER PERFORMED: CELL SAVER:

(MULTIPLE) (MULTIPLE)

### Abort/Cancel Operation

#### [SROABRT]

The *Abort/Cancel Operation* option is used to Abort or Cancel a previously entered surgical case.

This menu option should only be used if the patient has been taken to the operating room and no incision has been made. If an incision is made, the case should be completed and the discontinued procedure indicated in the record. Cancellation of future surgical cases should not use this option

**Example: Abort Operation**

Select Schedule Operations Option: **AB** Abort/Cancel Operation

SURPATIENT,ELEVEN (666-00-0785) Case #21814 – JUN 22, 2015

Case Aborted?: N// **Y**

1. YES-PRE ANESTHESIA
2. YES-POST ANESTHESIA Choose 1-2: **1** YES-PRE ANESTHESIA

Time Patient In the O.R.: **JUN 22,2015@0730** (JUN 22, 2015@07:30)

Time Patient Out of the O.R.: **JUN 22,2015@0800** (JUN 22, 2015@08:00) Primary Cancellation Reason: **1** PATIENT RELATED ISSUE 1

Cancellation Date/Time: **JUN 22,2015@0810** (JUN 22, 2015@08:10) Cancellation Avoidable: **N** NO

Aborting Surgery case #21814

Enter RETURN to continue or ‘^’ to exit: **<Enter>**

**Example: Cancel Operation**

Time Patient In the

O.R. and Time Patient Out of the O.R. will only be asked if they weren’t previously

Select Schedule Operations Option: **AB** Abort/Cancel Operation SURPATIENT,ELEVEN (666-00-0785) Case #21815 – JUN 22, 2015

Case Aborted?: N// **<Enter>** NO

Primary Cancellation Reason: **6** SCHED ISSUES NON EMERGENT CASE Cancellation Date/Time: **JUN 22,2015@0700** (JUN 22, 2015@07:00) Cancellation Avoidable: **N** NO

Cancelling Surgery case #21815

Enter RETURN to continue or ‘^’ to exit: **<Enter**

##### 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 Primary Surgeon:"

"Attending Surgeon:" "Select Surgical Specialty:"

“Planned Principal Procedure Code:”

**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.

Select Primary Surgeon: **SURSURGEON,ONE**

Attending Surgeon: **SURSURGEON,TWO**

Select Surgical Specialty: **GENERAL SURGERY** GENERAL SURGERY 50 (OR WHEN NOT DEFINED BELOW)

Planned Principal Procedure Code: **44960** APPENDECTOMY

APPENDECTOMY; FOR RUPTURED APPENDIX WITH ABSCESS OR GENERALIZED PERITONITIS

Modifier:

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: AS-1 RED BLOOD CELLS// **<Enter**

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

Units Required: **2**

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

Prin Pre-OP ICD Diagnosis Code (ICD9): **540.9**

One match found

540.9

ACUTE APPENDICITIS NOS (CC)

OK? Yes// **<Enter>** YES 540.9 ACUTE APPENDICITIS NOS (CC) 540.9 ICD-9 ACUTE

Hospital Admission Status: 2 **<Enter>** ADMISSION Case Schedule Type: **EM** EMERGENCY

First Assistant: **SURSURGEON,ONE** Second Assistant: **SURSURGEON,FOUR** Attending Surgeon:

Planned Postop Care: **W** WARD

\*\* NEW SURGERY \*\*

PRINCIPAL PROCEDURE: OTHER PROCEDURES:

CASE #185 SURPATIENT,SIX

APPENDECTOMY (MULTIPLE)

PAGE 1 OF 3

1

2

3

4

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PLANNED PRIN PROCEDURE CODE: LATERALITY OF PROCEDURE: LEFT

PRINCIPAL PRE-OP DIAGNOSIS: APPENDICITIS PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 540.9

OTHER PREOP DIAGNOSIS: PALLIATION:

(MULTIPLE) NO

PLANNED ADMISSION STAUTS: ADMITTED PRE-ADMISSION TESTING:

CASE SCHEDULE TYPE: EMERGENCY

SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

PRIMARY SURGEON: FIRST ASST: SECOND ASST:

ATTENDING SURGEON:

SURSURGEON,ONE SURSURGEON,ONE SURSURGEON,FOUR

SURSURGEON,TWO

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

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\*\* NEW SURGERY \*\*

ATTENDING SURGEON: PLANNED POSTOP CARE:

CASE #185 SURPATIENT,SIX

SURSURGEON,TWO WARD

PAGE 2 OF 3

CASE SCHEDULE ORDER:

SURGERY POSITION: (MULTIPLE)(DATA) REQ ANESTHESIA TECHNIQUE: GENERAL

REQ FROZ SECT:

NO

REQ PREOP X-RAY:

INTRAOPERATIVE X-RAYS: NO REQUEST BLOOD AVAILABILITY: YES

CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH11

REQ BLOOD KIND:

(MULTIPLE)(DATA)

1. SPECIAL EQUIPMENT: (MULTIPLE)
2. PLANNED IMPLANT: (MULTIPLE)
3. SPECIAL SUPPLIES: (MULTIPLE)
4. SPECIAL INSTRUMENTS: (MULTIPLE)

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

\*\* NEW SURGERY \*\*

PHARMACY ITEMS:

REQ PHOTO:

PREOPERATIVE INFECTION: REFERRING PHYSICIAN:

CASE #185 SURPATIENT,SIX

(MULTIPLE) NO

CLEAN (MULTIPLE)

PAGE 3 OF 3

1

2

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GENERAL COMMENTS:

(WORD PROCESSING)

INDICATIONS FOR OPERATIONS: (WORD PROCESSING)

BRIEF CLIN HISTORY: SPD COMMENTS:

(WORD PROCESSING)(DATA) (WORD PROCESSING)

Enter Screen Server Function:

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/C): **N** NO Request Medical Media (Y/N): **N** NO Preoperative infection: **C** CLEAN

Select REFERRING PHYSICIAN: **<Enter>**

General Comments:

1> **<Enter>**

SPD Comments:

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

**Example: Entering Surgical Staff**

Select Operation Menu Option: **SS** Surgical Staff

\*\* SURGICAL STAFF \*\* CASE #193 SURPATIENT,THREE

PAGE 1 OF 1

1

2

3

4

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13

14

15

PRIMARY SURGEON

PGY OF PRIMARY SURGEON: FIRST ASST:

SECOND ASST: ATTENDING SURGEON:

ATTENDING/RES SUP CODE:

SURSURGEON,ONE

SURSURGEON,TWELVE SURSURGEON,TWO

SURSURGEON,ONE

PRINC ANESTHETIST: ASST ANESTHETIST:

SURANESTHETIST,FOUR

ANESTHESIOLOGIST SUPVR: SURSURGEON,TWO PERFUSIONIST:

ASST PERFUSIONIST:

OR CIRC SUPPORT:

(MULTIPLE)

OR SCRUB SUPPORT:

(MULTIPLE)

OTHER SCRUBBED ASSISTANTS: (MULTIPLE)

OTHER PERSONS IN OR:

(MULTIPLE)

Enter Screen Server Function: **6;13;15**

Attending/Res Sup Code: **C** LEVEL C: ATTENDING IN O.R., NOT SCRUBBED C

The supervising practitioner is physically present in the operative or procedural room. The supervising practitioner observes and provides direction. The resident performs the procedure.

\*\* SURGICAL STAFF \*\* CASE #193 SURPATIENT,THREE

PAGE 1

OR SCRUB SUPPORT

1 NEW ENTRY

Enter Screen Server Function: **1**

Select OR SCRUB SUPPORT: **SURNURSE,ONE**

OR SCRUB SUPPORT: SURNURSE,ONE// **<Enter>**

\*\* SURGICAL STAFF \*\* CASE #193 SURPATIENT,THREE

PAGE 1

OR SCRUB SUPPORT (SURNURSE,ONE)

1

2

3

OR SCRUB SUPPORT: TIME ON:

STATUS:

SURNURSE,ONE (MULTIPLE)

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

Educational Status: **?**

CHOOSE FROM:

O ORIENTEE

F FULLY TRAINED

Educational Status: **F** FULLY TRAINED

\*\* SURGICAL STAFF \*\* CASE #193 SURPATIENT,THREE

PAGE 1

OR SCRUB SUPPORT (SURNURSE,ONE) TIME ON

1 NEW ENTRY

Enter Screen Server Function: **1**

Select TIME ON: **8:00** (JUN 06, 1999@08:00) TIME ON: JUN 06, 1999@08:00// **<Enter>**

**Operation Startup**

#### [SROMEN-START]

The nurse or other operating room staff uses the *Operation Startup* option to enter data concerning the patient’s preparation for the surgery (for example, diagnosis, delays, skin prep, and position aids). Some data fields may be automatically filled in based on previous responses.

Some 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 restraint/position aid. When a multiple field is selected, a new screen is generated so that the user can enter data related to that multiple. At the "Enter Screen Server Function:" prompt, the user can choose the field(s) to be edited, or press the **<Enter>** key to go to the next item or page.

##### Field Information

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

|  |  |
| --- | --- |
| **Field Name** | **Definition** |
| : |  |
| DELAY CAUSE: | If the actual start time of the surgery is significantly delayed (15 minutes or more, depending on the institution's policy) it is necessary to select a reason at the "Delay Cause:" prompt. Type  in a question mark **(?)** at this prompt to select from a list of delay causes. |
| RESTR & POSITION AIDS: | A safety strap is automatically included as a restraint. |

**Example: Operation Startup**

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

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

PAGE 1 OF 3

1

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HEIGHT: WEIGHT:

DATE OF OPERATION:

58 INCHES

264 LBS.

DEC 06, 2004 AT 08:00

PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9):

OTHER PREOP DIAGNOSIS: (MULTIPLE)

OP ROOM PROCEDURE PERFORMED: SURGERY SPECIALTY: ORTHOPEDICS

OR2

PLANNED POSTOP CARE: CASE SCHEDULE TYPE:

WARD ELECTIVE

REQ ANESTHESIA TECHNIQUE: GENERAL PATIENT EDUCATION/ASSESSMENT:

DELAY CAUSE: ASA CLASS:

(MULTIPLE)

15 PREOP MOOD:

Enter Screen Server Function: **9;12** Planned Postop Care: WARD W Preoperative Patient Education: **Y** YES

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

PAGE 1 OF 3

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HEIGHT: WEIGHT:

DATE OF OPERATION:

58 INCHES

264 LBS.

DEC 06, 2004 AT 08:00

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

OTHER PREOP DIAGNOSIS: (MULTIPLE)

OP ROOM PROCEDURE PERFORMED:

OR2

SURGERY SPECIALTY: PLANNED POSTOP CARE:

ORTHOPEDICS WARD

CASE SCHEDULE TYPE:

ELECTIVE

REQ ANESTHESIA TECHNIQUE: GENERAL PATIENT EDUCATION/ASSESSMENT: YES

DELAY CAUSE: ASA CLASS: PREOP MOOD:

(MULTIPLE)

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

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

PAGE 2 OF 3

1. PREOP CONSCIOUS:
2. PREOP SKIN INTEG:
3. TRANS TO OR BY:
4. HAIR REMOVAL BY:
5. HAIR REMOVAL METHOD:
6. HAIR REMOVAL COMMENTS: (WORD PROCESSING)
7. FOLEY CATHETER INSERTED BY:
8. SKIN PREPPED BY (1):
9. SKIN PREPPED BY (2):
10. SKIN PREP AGENTS:
11. SECOND SKIN PREP AGENT:
12. SURGERY POSITION:
13. LATERALITY OF PROCEDURE:

(MULTIPLE)(DATA)

1. RESTR & POSITION AIDS: (MULTIPLE)(DATA)
2. ELECTROGROUND POSITION:

Enter Screen Server Function: **A**

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

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

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

Foley Catheter Inserted By:

Skin Prepped By: **<Enter>**

Skin Prepped By (2):

Skin Preparation Agent: **HIB**ICLENS HI Second Skin Preparation Agent: **<Enter>** Laterality Of Procedure: **NA**

Electroground Placement:

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

PAGE 1

SURGERY POSITION

1

2

SURGERY POSITION: NEW ENTRY

SUPINE

Enter Screen Server Function: **2**

Select SURGERY POSITION: **SEMISUPINE**

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

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

PAGE 1

SURGERY POSITION (SEMISUPINE)

1

2

SURGERY POSITION: TIME PLACED:

SEMISUPINE

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

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

PAGE 1 OF 1

SURGERY POSITION

1

2

3

SURGERY POSITION: SURGERY POSITION: NEW ENTRY

SUPINE SEMISUPINE

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

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

PAGE 1 OF 1

RESTR & POSITION AIDS

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

Enter Screen Server Function: **2**

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

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

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

PAGE 1 OF 1

RESTR & POSITION AIDS (FOAM PADS)

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

Enter Screen Server Function: **2**

Applied By: **SURNURSE,TWO**

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

PAGE 2 OF 3

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PREOP CONSCIOUS: PREOP SKIN INTEG: TRANS TO OR BY: HAIR REMOVAL BY:

HAIR REMOVAL METHOD: HAIR REMOVAL COMMENTS:

(WORD PROCESSING)

FOLEY CATHETER INSERTED BY: SKIN PREPPED BY (1):

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

SURGERY POSITION:

(MULTIPLE)(DATA)

LATERALITY OF PROCEDURE:

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

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.

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

PAGE 2 OF 3

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POSSIBLE ITEM RETENTION: SPONGE FINAL COUNT CORRECT: SHARPS FINAL COUNT CORRECT: INSTRUMENT FINAL COUNT CORRECT: WOUND SWEEP:

WOUND SWEEP COMMENT:

(WORD PROCESSING)

INTRA-OPERATIVE X-RAYS: No

INTRA-OPERATIVE X-RAYS COMMENT: (WORD PROCESSING) SPONGE, SHARPS, & INST COUNTER:

COUNT VERIFIER:

SEQUENTIAL COMPRESSION DEVICE:

LASER PERFORMED: CELL SAVER:

(MULTIPLE) (MULTIPLE)

NURSING CARE COMMENTS:

(WORD PROCESSING)

PRINCIPAL PRE-OP DIAGNOSIS: SDSFD DSFFDS

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

Possible Item Retention: **Y** YES Sponge Final Count Correct: **Y** YES Sharps Final Count Correct: **Y** YES

Instrument Final Count Correct: **Y** Yes

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

PAGE 2 OF 3

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POSSIBLE ITEM RETENTION: YES SPONGE FINAL COUNT CORRECT: YES SHARPS FINAL COUNT CORRECT: YES INSTRUMENT FINAL COUNT CORRECT: YES WOUND SWEEP:

WOUND SWEEP COMMENT:

(WORD PROCESSING)

INTRA-OPERATIVE X-RAYS: No

INTRA-OPERATIVE X-RAYS COMMENT: (WORD PROCESSING) SPONGE, SHARPS, & INST COUNTER:

COUNT VERIFIER:

SEQUENTIAL COMPRESSION DEVICE:

LASER PERFORMED: CELL SAVER:

(MULTIPLE) (MULTIPLE)

NURSING CARE COMMENTS:

(WORD PROCESSING)

PRINCIPAL PRE-OP DIAGNOSIS: SDSFD DSFFDS

Enter Screen Server Function: **14**

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>**

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

PAGE 1 OF 3

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DATE OF OPERATION:

MAR 09, 2005

HOSPITAL ADMISSION STATUS: SAME DAY PRIMARY SURGEON:

SURSURGEON,FOUR

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

OTHER PREOP DIAGNOSIS: (MULTIPLE)

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

OTHER PROCEDURES: HAIR REMOVAL BY: HAIR REMOVAL METHOD:

HAIR REMOVAL COMMENTS: TIME PAT IN OR:

(MULTIPLE)

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

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

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

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

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

PAGE 2 OF 3

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

OR SCRUB SUPPORT:

(MULTIPLE) (MULTIPLE)

OP ROOM PROCEDURE PERFORMED: FIRST ASST:

POSSIBLE ITEM RETENTION: SPONGE FINAL COUNT CORRECT: SHARPS FINAL COUNT CORRECT:

INSTRUMENT FINAL COUNT CORRECT: WOUND SWEEP: No

WOUND SWEEP COMMENT:

INTRA-OPERATIVE X-RAYS: No INTRA-OPERATIVE X-RAYS COMMENT: SPONGE, SHARPS, & INST COUNTER:

OR1

Enter Screen Server Function: 1;5

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

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

PAGE 2 OF 3

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

OR SCRUB SUPPORT:

MAR 12, 2006 AT 13:40

(MULTIPLE) (MULTIPLE)

OP ROOM PROCEDURE PERFORMED: FIRST ASST:

POSSIBLE ITEM RETENTION: SPONGE FINAL COUNT CORRECT: SHARPS FINAL COUNT CORRECT:

INSTRUMENT FINAL COUNT CORRECT: WOUND SWEEP: No

WOUND SWEEP COMMENT:

INTRA-OPERATIVE X-RAYS: No INTRA-OPERATIVE X-RAYS COMMENT: SPONGE,SHARPS, & INST COUNTER:

OR1

Enter Screen Server Function:

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

PAGE 3 OF 3

1. COUNT VERIFIER:
2. SURGERY SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)
3. WOUND CLASSIFICATION:
4. ATTENDING SURGEON: MO,CHAUNCEY G
5. ATTENDING/RES SUP CODE:
6. SPECIMENS: (WORD PROCESSING)
7. CULTURES: (WORD PROCESSING)
8. NURSING CARE COMMENTS: (WORD PROCESSING)
9. ASA CLASS:
10. PRINC ANESTHETIST:
11. ANESTHESIA TECHNIQUE: (MANDATORY)
12. ANES CARE TIME BLOCK: (MULTIPLE)
13. DELAY CAUSE: (MULTIPLE)

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

### Time Out Verified Utilizing Checklist

#### [SROMEN-VERF]

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

**Example: Time Out Verified Utilizing Checklist**

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

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

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

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

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

CHECKLIST COMMENT:

(WORD PROCESSING)

TIME-OUT DOCUMENT COMPLETED BY: TIME-OUT COMPLETED:

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: **1** YES, i-MED

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>**

TIME-OUT DOCUMENT COMPLETED BY: **SURNURSE,FIVE**

TIME-OUT COMPLETED:

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. CONFIRM VALID CONSENT: YES, i-MED
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

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APPROPRIATE DVT PROPHYLAXIS: YES BLOOD AVAILABILITY: YES

CHECKLIST COMMENT:

(WORD PROCESSING)

TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE TIME-OUT COMPLETED:

Enter Screen Server Function:

If the PLANNED PRIN PROCEDURE CODE field for the case is one of the following CPT codes Time Out Checklist-2 will be displayed: 32851, 32852,3 2853, 32854, 33935, 33945, 44135, 44136, 47135,

47136, 48160, 48554, 50360, 50365.

**Example: Time Out Verified Utilizing Checklist-2**

\*\* TIME OUT CHECKLIST-2 \*\* CASE #811 SURPATIENT,FOUR PAGE 1 OF 2

1. ORGAN TO BE TRANSPLANTED: (MULTIPLE)
2. UNOS NUMBER:
3. DONOR SEROLOGY HCV:
4. DONOR SEROLOGY HBV:
5. DONOR SEROLOGY CMV:
6. DONOR SEROLOGY HIV:
7. DONOR ABO TYPE:
8. RECIPIENT ABO TYPE:
9. BLOOD BANK ABO VERIFICATION:
10. BLOOD BANK ABO VER COMMENTS:
11. D/T BLOOD BANK ABO VERIF:
12. OR ABO VERIFICATION (Y/N):
13. OR ABO VER COMMENTS:
14. D/T OR ABO VERIF:
15. SURGEON VERIFYING UNET: Enter Screen Server Function:

\*\* TIME OUT CHECKLIST-2 \*\* CASE #811 SURPATIENT,FOUR PAGE 2 OF 2

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UNET VERIF BY SURGEON (Y/N): ORGAN VER PRE-ANESTHESIA: SURGEON VER ORGAN PRE-ANES: SURGEON VER DONOR ORG PRE-ANES: DONOR ORG VER PRE-ANES:

ORGAN VER PRE-TRANSPLANT: SURGEON VER ORG PRE-TRANSPLANT: ORGAN VER PRE-TRANSPLANT:

DONOR VESSEL UNOS ID: DONOR VESSEL USAGE:

DONOR VESSEL DISPOSITION:

(MULTIPLE)

Enter Screen Server Function:

## Nurse Intraoperative Report

#### [SRONRPT]

The Nurse Intraoperative Report details case information relating to nursing care provided for the patient during the operative case selected. This option provides the capability to view and print the report, edit information contained in the report, and electronically sign the report.

With the *Surgery Site Parameters* option located on the *Surgery Package Management Menu*, the user can select one of two different formats for this report. One format includes all field names whether or not information has been entered. The other format only includes fields that have actual data.

Electronically signed reports may be viewed through CPRS for completed operations.

##### Nurse Intraoperative Report - Before Electronic Signature

Upon selecting the *Nurse Intraoperative Report* option, if the Nurse Intraoperative Report is not signed, the report will begin displaying on the screen. The Nurse Intraoperative Report displays key fields on the first page. Several of these fields are required before the software will allow the user to electronically sign the report. If any required fields are left blank, a warning will appear prompting the user to provide the missing information.

The following fields are required before electronic signature of the Nurse Intraoperative Report:

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

The WOUND SWEEP and INTRAOPERATIVE-XRAY will be required to sign the NIR if any of the cout fields (SPONGE FINAL COUNT CORRECT, SHARPS FINAL COUNT CORRECT, and INSTRUMENT FINAL COUNT CORRECT) is answered with “NO”.

If the COUNT VERIFIER field has been entered, the following fields are required:

|  |  |
| --- | --- |
| * SPONGE FINAL COUNT CORRECT | * SHARPS FINAL COUNT CORRECT |
| * INSTRUMENT FINAL COUNT   CORRECT | * SPONGE, SHARPS, & INST COUNTER * POSSIBLE ITEM RETENTION |

***NOTE:*** *The ANESTHESIA TECHNIQUE field is made mandatory in order for the NIR report to be signed.*

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

|  |  |
| --- | --- |
| * IMPLANT STERILITY CHECKED | * STERILITY EXPIRATION DATE |
| * RN VERIFIER * SERIAL NUMBER | * LOT NUMBER * PROVIDER READ BACK PERFORMED |

If the PLANNED PRIN PROCEDURE CODE field for the case is matches one of these CPT codes 32851, 32852,3 2853, 32854, 33935, 33945, 44135, 44136, 47135, 47136, 48160, 48554, 50360, 50365;

the following fields are required:

* + ORGAN TO BE TRANSPLANTED
  + UNOS NUMBER
  + DONOR SEROLOGY HCV
  + DONOR SEROLOGY HBV
  + DONOR SEROLOGY CMV
  + DONOR SEROLOGY HIV
  + DONOR ABO TYPE
  + RECEIPIENT ABO TYPE
  + BLOOD BANK ABO VERIFICATION
  + BLOOD BANK ABO VER COMMENTS
  + D/T BLOOK BANK ABO VERIF
  + OR ABO VERIFICATION
  + D/T OR ABO VERIF
  + SURGEON VERIFYING UNET
  + UNET VERIF BY SURGEON
  + ORGAN VER PRE-ANESTHESIA
  + SURGEON VER ORGAN PRE-ANES
  + SURGEON VER DONOR ORG PRE-ANES
  + DONOR ORG VER PRE-ANES
  + ORGAN VER PRE-TRANSPLANT
  + SURGEON VER ORG PRE-TRANSPLANT
  + DONOR VESSEL UNOS ID
  + DONOR VESSEL USAGE
  + DONOR VESSEL DISPOSITION



***NOTE:*** *Entering the TIME PAT OUT OR field triggers an alert that is sent to the nurse responsible for signing the report. By acting on the alert, the nurse accesses the Nurse Intraoperative Report option to electronically sign the report.*

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

**Example: First page of the Nurse Intraoperative Report**

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

MEDICAL RECORD

SURPATIENT,TEN (000-12-3456)

NURSE INTRAOPERATIVE REPORT - CASE #267226

PAGE 1

Operating Room: BO OR1

Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004

Operation Begin: JUL 12, 2004

Surgeon in OR: JUL 12, 2004

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

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

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

Primary Surgeon: SURSURGEON,THREE Attending Surgeon: SURSURGEON,THREE Anesthetist: SURANESTHETIST,SEVEN

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

Assistant Anesth: N/A

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

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

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

**Example: Editing the Nurse Intraoperative Report**

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

Nurse Intraoperative Report Functions:

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

Select number: 2// **1**

\*\* NURSE INTRAOP \*\* CASE #267226 SURPATIENT,TEN PAGE 1 OF 7

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

CONFIRM VALID CONSENT: YES, i-MED CONFIRM PATIENT POSITION: YES MARKED SITE CONFIRMED: YES PREOPERATIVE IMAGES CONFIRMED: YES CORRECT MEDICAL IMPLANTS: YES AVAILABILITY OF SPECIAL EQUIP: YES ANTIBIOTIC PROPHYLAXIS: YES APPROPRIATE DVT PROPHYLAXIS: YES BLOOD AVAILABILITY: YES

CHECKLIST COMMENT:

(WORD PROCESSING)

TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE TIME-OUT COMPLETED: 07/12/2004@0800

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

\*\* NURSE INTRAOP \*\* CASE #267226 SURPATIENT,TEN PAGE 2 OF 7

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POSSIBLE ITEM RENTENTION: YES SPONGE FINAL COUNT CORRECT: YES SHARPS FINAL COUNT CORRECT: YES INSTRUMENT FINAL COUNT CORRECT: WOUND SWEEP:

WOUND SWEEP COMMENTS: (WORD PROCESSING) INTRA-OPERATIVE X-RAY:

INTRA-OPERATIVE X-RAY COMMENTS: SPONE, SHARPS, & INST COUNTER:

(WORD PROCESSING)

COUNT VERIFIED:

TIME PAT IN HOLD AREA: TIME PAT IN OR:

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

JUL 12, 2004 AT 07:30

JUL 12, 2004 AT 08:00

JUL 12, 2004 at 08:58)

JUL 12, 2004 AT 12:30

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

\*\* NURSE INTRAOP \*\* CASE #267226 SURPATIENT,TEN PAGE 3 OF 7

1

2

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TIME PAT OUT OR: PRINCIPAL PROCEDURE:

OTHER PROCEDURES:

WOUND CLASSIFICATION:

OP DISPOSITION:

OP ROOM PROCEDURE PERFORMED: OR1

CASE SCHEDULE TYPE: PRIMARY SURGEON: ATTENDING SURGEON: FIRST ASST:

SECOND ASST:

ELECTIVE SURSURGEON,THREE SURSURGEON,THREE SURSURGEON,FOUR

12

13

14

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PRINC ANESTHETIST:

SURANESTHETIST,SEVEN

ASST ANESTHETIST:

OTHER SCRUBBED ASSISTANTS: (MULTIPLE) OR SCRUB SUPPORT: (MULTIPLE)

Enter Screen Server Function: <Enter>

\*\* NURSE INTRAOP \*\* CASE #267226 SURPATIENT,TEN PAGE 4 OF 7

1. OR CIRC SUPPORT: (MULTIPLE)
2. OTHER PERSONS IN OR: (MULTIPLE)
3. PREOP MOOD:
4. PREOP CONSCIOUS:
5. PREOP SKIN INTEG: INTACT
6. PREOP CONVERSE: NOT ANSWER QUESTIONS
7. HAIR REMOVAL BY: SURNURSE,FIVE
8. HAIR REMOVAL METHOD: OTHER
9. HAIR REMOVAL COMMENTS: (WORD PROCESSING)(DATA)
10. SKIN PREPPED BY (1): SURNURSE,FIVE
11. SKIN PREPPED BY (2):
12. SKIN PREP AGENTS: BETADINE
13. SECOND SKIN PREP AGENT: POVIDONE IODINE
14. SURGERY POSITION: (MULTIPLE)(DATA)
15. RESTR & POSITION AIDS: (MULTIPLE)(DATA)

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

Primary Surgeon: SURSURGEON,THREE First Assist: SURSURGEON,FOUR Attending Surgeon: 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

--- Time Out Checklist ---

Confirm Correct Patient Identity: YES Confirm Procedure to be Performed: YES

Confirm Site of the Procedure, including laterality: YES Confirm Valid Consent: YES, i-MED

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

Time-Out Document Completed By: SURNURSE,FIVE Time-Out Completed: 07/12/2004@0800

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

Immediate Use Steam Sterilization Episodes: Contamination: 0

SPS Processing/OR Management Issues: 0 Emergency Case: 0

No Better Option: 0

Loaner or Short Notice Instrument: 0

Decontamination of Instruments Contaminated During the Case: 0

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 Number: T87-12321 Serial Number: 945673WRU Sterile Resp: SPD

Size: LG Quantity: 2

Medications: N/A Irrigation Solution(s):

HEPARINIZED SALINE NORMAL SALINE

COLD SALINE

Blood Replacement Fluids: N/A

Possible Item Retention: YES Sponge Final Count Correct:

Sharps Final Count Correct: YES

Instrument Final Count Correct: NOT APPLICABLE Wound Sweep: \* NOT ENTERED \* Wound Sweep Comment: NO COMMENTS ENTERED

Intra-Operative X-Ray: \* NOT ENTERED \*

Intra-Operative X-Ray Comment: NO COMMENTS ENTERED 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 Performed: N/A

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

Devices: N/A

This section will only appear for Transplant cases that have a PLANNED PRIN PROCEDURE

CODE that is one of the following: 32851,32852,32853,32854,33935,33

945,44135,44136,47135,47136,4816

0,48554,50360,50365

Transplant Information:

Organ to be Transplanted: \* NOT ENTERED \* UNOS Identification Number of Donor:

Donor Serology Hepatitis C virus (HCV): \* NOT ENTERED \* Donor Serology Hepatitis B Virus (HBV): \* NOT ENTERED \* Donor Serology Cytomegalovirus (CMV): \* NOT ENTERED \* Donor Serology HIV: \* NOT ENTERED \*

Donor ABO Type: \* NOT ENTERED \* Recipient ABO Type: \* NOT ENTERED \*

Blood Bank Verification of ABO Type: \* NOT ENTERED \* Blood Bank ABO Verification Comments:

Date/Time of Blood Bank ABO Verification: \* NOT ENTERED \* OR Verification of ABO Type: \* NOT ENTERED \*

OR ABO Verification Comments:

Date/Time OR ABO Verification: \* NOT ENTERED \* Surgeon Performing UNET Verification: \* NOT ENTERED \* UNET Verification by Surgeon: \* NOT ENTERED \*

Organ Verification Prior to Anesthesia: \* NOT ENTERED \* Surgeon Verifying Organ Prior to Anesthesia: \* NOT ENTERED \*

Surgeon Verifying Organ Prior to Donor Anesthesia: \* NOT ENTERED \* Donor Organ Verification Prior to Anesthesia: \* NOT ENTERED \* Organ Verification Prior to Transplant: \* NOT ENTERED \*

Surgeon Verifying the Organ Prior to Transplant: \* NOT ENTERED \* Donor Vessel Usage: \* NOT ENTERED \*

Donor Vessel Disposition if not used:

Donor Vessel UNOS ID:

Immediate Use Steam Sterilization Episodes: Contamination: 0

SPS Processing/OR Management Issues: 0 Emergency Case: 0

No Better Option: 0

Loaner or Short Notice Instrument: 0

Decontamination of Instruments Contaminated During the Case: 0

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.

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

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 CONFIRM VALID CONSENT CONFIRM PATIENT POSITION CORRECT MEDICAL IMPLANTS ANTIBIOTIC PROPHYLAXIS APPROPRIATE DVT PROPHYLAXIS BLOOD AVAILABILITY AVAILABILITY OF SPECIAL EQUIP CHECKLIST COMMENT

TIME-OUT COMPLETED

The WOUND SWEEP na d INTRAOPERATIVE X-XRAY fields will be required to sign the NIR if any of the count fields (SPONGE FINAL COUNT CORRECT, SHARPS FINAL COUNT CORRECT, and INSTRUMENT FINAL COUNT CORRECT) is answered with “NO”

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

SPONGE FINAL COUNT CORRECT SHARPS FINAL COUNT CORRECT INSTRUMENT FINAL COUNT CORRECT SPONGE, SHARPS, & INST COUNTER POSSIBLE ITEM RETENTION

The ANESTHESIA TECHNIQUE field is made mandatory in order for the NIR report to be signed.

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 LOT NUMBER

SERIAL NUMBER PROVIDER READ BACK PERFORMED

If the PLANNED PRIN PROCEDURE CODE field is one of the following codes 32851,32852,32853,32854,33935,33945,44135,44136,47135,47136,48160,48554,50360,50365

the following fields are required:

ORGAN TOBE TRANSPLANED SURGEON VERIFYING UNET UNOS NUMBER UNET VERIF BY SURGEON

DONOR SEROLOGY HCV ORGAN VER PRE-ANESTHESIA

DONOR SEROLOGY HBV SURGEON VER ORGAN PRE-ANES

DONOR SEROLOGY CMV SURGEON VER DONOR PRE-ANES

DONOR SEROLOGY HIV DONOR ORG VER PRE-ANES

DONOR ABO TYPE ORGAN VER PRE-TRANSPLANT

RECIPIENT ABO TYPE SURGEON VER ORG PRE-TRANSPLANT BLOOD BANK ABO VERIFICATION DONOR VESSEL UNOS ID

BLOOD BANK ABO VER COMMENTS DONOR VESSEL USAGE

D/T BLOOD BANK ABO VERIF DONOR VESSEL DISPOSITION OR ABO VERIFICATION

OR ABO VER COMMENTS D/T OR ABO VERIF

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 7

1

2

3

4

5

6

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8

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10

11

12

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15

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

CONFIRM VALID CONSENT: YES, i-MED CONFIRM PATIENT POSITION: YES MARKED SITE CONFIRMED: YES PREOPERATIVE IMAGES CONFIRMED: YES CORRECT MEDICAL IMPLANTS: YES AVAILABILITY OF SPECIAL EQUIP: YES ANTIBIOTIC PROPHYLAXIS: YES APPROPRIATE DVT PROPHYLAXIS:

BLOOD AVAILABILITY: YES

CHECKLIST COMMENT:

(WORD PROCESSING)

TIME-OUT DOCUMENT COMPLETED BY: **SURNURSE, FIVE**

TIME-OUT COMPLETED: 07/12/2004@0800

Enter Screen Server Function: **10**

Appropriate Antibiotic Prophylaxis: **Y** YES

**\*\* NURSE INTRAOP \*\* CASE #267226 SURPATIENT,TEN**

PAGE 1 OF 7

1

2

3

4

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

CONFIRM VALID CONSENT: YES, i-MED CONFIRM PATIENT POSITION: YES MARKED SITE CONFIRMED: YES PREOPERATIVE IMAGES CONFIRMED: YES CORRECT MEDICAL IMPLANTS: YES AVAILABILITY OF SPECIAL EQUIP: YES ANTIBIOTIC PROPHYLAXIS: YES APPROPRIATE DVT PROPHYLAXIS: YES BLOOD AVAILABILITY: YES

CHECKLIST COMMENT:

(WORD PROCESSING)

TIME-OUT DOCUMENT COMPLETED BY: **SURNURSE, FIVE**

TIME-OUT COMPLETED: 07/12/2004@0800

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.

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 Time-Out Document Completed By field was changed from SURNURSE,FOUR

to SURNURSE,FIVE

Addendum Comment: OPERATION END TIME WAS CORRECTED.

Enter RETURN to continue or '^' to exit:

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

**Example: Printing the Nurse Intraoperative Report**

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

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

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

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

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

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

SURPATIENT,TEN 000-12-3456 NURSE INTRAOPERATIVE REPORT

NOTE DATED: 07/12/2004 08:00 NURSE INTRAOPERATIVE REPORT SUBJECT: Case #: 267226

Operating Room: BO OR1 Surgical Priority: ELECTIVE

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

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

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

Major Operations Performed:

Primary: MVR

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

Primary Surgeon: SURSURGEON,THREE First Assist: SURSURGEON,FOUR Attending Surgeon: 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

--- Time Out Checklist ---

Confirm Correct Patient Identity: YES Confirm Procedure to be Performed: YES

Confirm Site of the Procedure, including laterality: YES Confirm Valid Consent: YES, i-MED

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

Time-Out Document Completed By: SURNURSE,FOUR Time-Out Completed:07/12/2004@0800

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

Immediate Use Steam Sterilization Episodes:

Contamination: 0

SPS Processing/OR Management Issues: 0 Emergency Case: 0

No Better Option: 0

Loaner or Short Notice Instrument: 0

Decontamination of Instruments Contaminated During the Case: 0

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 Number: T87-12321 Serial Number: 945673WRU Sterile Resp: SPD

Size: LG

Provider Read Back Performed: YES Quantity: 2 Medications: N/A

Irrigation Solution(s): HEPARINIZED SALINE NORMAL SALINE

COLD SALINE

Blood Replacement Fluids: N/A Possible Item Retention: YES Sponge Count: YES

Sharps Count: YES

Instrument Count: NOT APPLICABLE

Wound Sweep: \* NOT ENTERED \* Wound Sweep Comment: NO COMMENTS ENTERED Intra-Operative X-Ray: \* NOT ENTERED \*

Intra-Operative X-Ray Comment: NO COMMENTS ENTERED 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 Performed: (Multiple) Sequential Compression Device: NO

Cell Saver(s): N/A Devices: N/A

This section will only appear for Transplant cases that have a PLANNED PRIN PROCEDURE

CODE that is one of the following: 32851,32852,32853,32854,33935,33

945,44135,44136,47135,47136,4816

0,48554,50360,50365

Transplant Information:

Organ to be Transplanted: \* NOT ENTERED \* UNOS Identification Number of Donor:

Donor Serology Hepatitis C virus (HCV): \* NOT ENTERED \* Donor Serology Hepatitis B Virus (HBV): \* NOT ENTERED \* Donor Serology Cytomegalovirus (CMV): \* NOT ENTERED \* Donor Serology HIV: \* NOT ENTERED \*

Donor ABO Type: \* NOT ENTERED \* Recipient ABO Type: \* NOT ENTERED \*

Blood Bank Verification of ABO Type: \* NOT ENTERED \* Blood Bank ABO Verification Comments:

Date/Time of Blood Bank ABO Verification: \* NOT ENTERED \* OR Verification of ABO Type: \* NOT ENTERED \*

OR ABO Verification Comments:

Date/Time OR ABO Verification: \* NOT ENTERED \* Surgeon Performing UNET Verification: \* NOT ENTERED \* UNET Verification by Surgeon: \* NOT ENTERED \*

Organ Verification Prior to Anesthesia: \* NOT ENTERED \* Surgeon Verifying Organ Prior to Anesthesia: \* NOT ENTERED \*

Surgeon Verifying Organ Prior to Donor Anesthesia: \* NOT ENTERED \* Donor Organ Verification Prior to Anesthesia: \* NOT ENTERED \* Organ Verification Prior to Transplant: \* NOT ENTERED \*

Surgeon Verifying the Organ Prior to Transplant: \* NOT ENTERED \* Donor Vessel Usage: \* NOT ENTERED \*

Donor Vessel Disposition if not used:

Donor Vessel UNOS ID:

Immediate Use Steam Sterilization Episodes: Contamination: 0

SPS Processing/OR Management Issues: 0 Emergency Case: 0

No Better Option: 0

Loaner or Short Notice Instrument: 0

Decontamination of Instruments Contaminated During the Case: 0 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 Time-Out Document Completed 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.)*

**Example: ICD-10 Code**

|  |
| --- |
| SRPATIENTA, ONE (000-12-3456) Case #45731  FEB 27, 2014 HEART TRANSPLANT |
| Other Postop Diagnosis:   1. ICD10 Code:E83.41 Hypermagnesemia 2. ICD10 Code: V72. 1XXD Passenger on bus injured in clsn w 2/3-whl mv momtraf, Subs 3. Enter NEW Other Postop Diagnosis Code Enter selection: (1-3): 1   SRPATIENTA, ONE (xxx-xx-xxxx) Case #45731 FEB 27, 2014 HEART TRANSPLANT |
| Other Postop Diagnosis:  1. ICD10 Code: E83.41 Hypermagnesemia Select on of the following   1. Update Other Postop Diagnosis Code 2. Update Service Connected/Environmental Indicators only Enter selection (1 or 2): 1// |

When additional diagnoses and procedure codes are entered, the user should review the procedure to diagnosis associations to ensure that the associations are correct. In this example, additional associations will be assigned.

|  |  |  |  |
| --- | --- | --- | --- |
| SURPATIENT,SEVENTEEN JUL 15, 2005 CABG | (000-45-5119) | Case #314 |  |
| Other Procedures: | | |
| 1. CPT Code: 33510 CABG, VEIN, SINGLE Modifiers: NOT ENTERED  Assoc. DX: NOT ENTERED | | |
| Only the following ICD Diagnosis Codes can be associated: | | |
| 1. 402.01-HYP HEART DIS MALIGN WITH FAIL 2. 599.0-URIN TRACT INFECTION NOS | | |
| Select the number(s) of the Diagnosis Code to associate to the procedure selected: 1// **1,2** | | |

|  |  |
| --- | --- |
| SURPATIENT,SEVENTEEN (000-45-5119) Case #314 |  |
| JUL 15, 2005 CABG |
| Other Procedures: |
| 1. CPT Code: 33510 CABG, VEIN, SINGLE |
| Assoc. DX: 402.01-HYP HEART DIS MALIGN 599.0-URIN TRACT INFECTION N |
| 2. Enter NEW Other Procedure Code |
| Enter selection: (1-2): **<Enter>** |

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

Devices: N/A

Signed by: /es/ FIVE SURNURSE

03/04/2004 10:41

**Non-OR Procedure Information**

#### [SR NON-OR INFO]

The *Non-OR Procedure Information* option displays information on the selected non-OR procedure, with the exception of the provider's dictated summary.

This report prints in an 80-column format and can be viewed on the screen.

**Example: Non-OR Procedure Information**

SURPATIENT,FIFTEEN (000-98-1234) Case #267260 - APR 22,2002

UV OR NR PI

Update/Verify Procedure/Diagnosis Codes Operation/Procedure Report

Nurse Intraoperative Report Non-OR Procedure Information

Select CPT/ICD Update/Verify Menu Option: **I** Non-O.R. Procedure Information

DEVICE: HOME// [Select Print Device]

*printout follows*

SURPATIENT,FIFTEEN (000-98-1234) Age: 60 PAGE 1 NON-O.R. PROCEDURE - CASE #267260 Printed: AUG 04, 2004@14:40

Med. Specialty: GENERAL Location: NON OR Principal Diagnosis: LARYNGEAL/TRACHEAL BURN

Provider: SURSURGEON,FIFTEEN Patient Status: NOT ENTERED Attending:

Attending Code:

Attend Anesth: N/A

Anesthesia Supervisor Code: N/A Anesthetist: N/A

Anesthesia Technique(s): N/A

Proc Begin: JAN 14, 2004 08:00 Proc End: JAN 14, 2004 09:00

Procedure(s) Performed:

Principal: BRONCHOSCOPY

Dictated Summary Expected: YES

Enter RETURN to continue or '^' to exit:

### 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. Special Equipment
16. Planned Implant
17. Pharmacy Items
18. Special Instruments
19. Special Supplies

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

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 RESP: **MANUFACTURER** SIZE: **STEM 150 MM, HEAD 22 MM** QUANTITY: **<Enter>**

LOT NUMBER: **F19705-1087** SERIAL NUMBER: **<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. Special Equipment
16. Planned Implant
17. Pharmacy Items
18. Special Instruments
19. Special Supplies

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

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:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,EIGHT (666-00-0787) Case | #10146 | PAGE: | 1 | OF | 2 |  |
| APR 6,2007 APPENDECTOMY |  |  |  |  |  |
| 1. GENERAL: C. Current Pneumonia: | | | | | |
| A. Height: 58 INCHES 3. HEPATOBILIARY: | | | | | |
| B. Weight: A. Ascites: | | | | | |
| C. Diabetes - Long Term: | | | | | |
| D. Diabetes - 2 Wks Preop: 4. GASTROINTESTINAL: | | | | | |
| E. Tobacco Use: A. Esophageal Varices: | | | | | |
| F. Tobacco Use Timeframe: NOT APPLICABLE | | | | | |
| G. ETOH > 2 Drinks/Day: 5. CARDIAC: | | | | | |
| H. Positive Drug Screening: A. Congestive Heart Failure: 1 | | | | | |
| I. Dyspnea: B. Prior MI: | | | | | |
| J. Preop Sleep Apnea: LEVEL 3 C. PCI: | | | | | |
| K. Sleep Apnea-Compliance: > OR EQUAL D. Prior Heart Surgery: | | | | | |
| L. DNR Status: E. Angina Severity: | | | | | |
| M. Functional Status: PARTIAL DEPENDENT F. Angina Timeframe: | | | | | |
| N. Current Residence: LONG TERM CARE G. Hypertension: | | | | | |
| O. Ambulation Device: AMB W/CANE | | | | | |
| 2. PULMONARY: 6. VASCULAR: | | | | | |
| A. Ventilator Dependent: A. PAD: | | | | | |
| B. History of Severe COPD: B. Rest Pain/Gangrene: | | | | | |
| Select Preoperative Information to Edit: | **A** |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| SURPATIENT,SIXTY (000-56-7821)  JUN 23,1998 CHOLEDOCHOTOMY | Case #63592 |  |
| GENERAL: **YES**  Patient's Height 65 INCHES//: **62**  Patient's Weight 140 POUNDS//: **175**  Diabetes Mellitus: Chronic, Long-Term Management: **I** INSULIN Diabetes Mellitus: Management Prior to Surgery: **I** INSULIN Tobacco Use: **2** NO USE IN LAST 12 MOS  Tobacco Use Timeframe: NOT APPLICABLE// **<enter>**  ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: **N** NO Positive Drug Screening:  Dyspnea: **N**   1. NO 2. NO STUDY Choose 1-2: 1 **NO**   Preoperative Sleep Apnea: LEVEL 1// 3 SLEEP APNEA CONFIRMED – LEVEL 3 Sleep Apnea-Compliance: ?  Enter the level of the patient's reported compliance with sleep apnea Treatment.  Choose from:   * 1. NIGHTLY   2. > OR EQUAL 4 TIMES A WEEK   3. < 4 TIMES A WEEK   4. NOT DOCUMENTED   Sleep Apnea-Compliance: **4** NOT DOCUMENTED DNR Status (Y/N): **N** NO | |
| Functional Status at Evaluation for Surgery: **1** INDEPENDENT  Current Residence (w/in 30 days prior to surgery): LONG TERM CARE// **<Enter>**  Ambulation Device: AMBULATES W/OUT ASSISTIVE DEVICE// **<Enter>** | |
| PULMONARY: **NO** | |
| HEPATOBILIARY: **NO** | |
| GASTRONINTESTINAL: **NO** | |
| CARDIAC: **NO** | |
| VASCULAR: **NO** | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 | PAGE: | 1 | OF | 2 |  |  |
| JUN 23,1998 CHOLEDOCHOTOMY |  |  |  |  |  |
| 1. GENERAL: C. Current Pneumonia: | | | | |  |
| A. Height: 58 INCHES 3. HEPATOBILIARY: | | | | |
| B. Weight: A. Ascites: | | | | |
| C. Diabetes - Long Term: | | | | |
| D. Diabetes - 2 Wks Preop: 4. GASTROINTESTINAL: | | | | |
| E. Tobacco Use: A. Esophageal Varices: | | | | |
| F. Tobacco Use Timeframe:NOT APPLICABLE | | | | |
| G. ETOH > 2 Drinks/Day: 5. CARDIAC: | | | | |
| H. Positive Drug Screening: A. Congestive Heart Failure: 1 | | | | |
| I. Dyspnea: B. Prior MI: | | | | |
| J. Preop Sleep Apnea: LEVEL 3 C. PCI: | | | | |
| K. Sleep Apnea-Compliance: > OR EQUAL D. Previous Heart Surgeries: | | | | |
| L. DNR Status: E. Angina Severity: | | | | |
| M. Functional Status:PARTIAL INDEPENDENT F. Angina Timeframe: | | | | |
| N. Current Residence: LONG TERM CARE G. Hypertension: | | | | |
| O. Ambulation Device: | | | | |
| 2. PULMONARY: 6. VASCULAR: | | | | |
| A. Ventilator Dependent: A. Peripheral Arterial Disease: | | | | |
| B. History of Severe COPD: B. Rest Pain/Gangrene: | | | | |
| Select Preoperative Information to Edit: **<Enter>** | | | | |

|  |  |
| --- | --- |
| SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 2 OF 2  JUN 23,1998 CHOLEDOCHOTOMY |  |
| 1. RENAL: 3. NUTRITIONAL/IMMUNE/OTHER:    1. Acute Renal Failure: A. Disseminated Cancer:    2. Currently on Dialysis: B. Open Wound:    3. Steroid Use for Chronic Cond.: 2. CENTRAL NERVOUS SYSTEM: D. Weight Loss > 10%:    1. Impaired Sensorium: E. Bleeding Disorders: YES    2. Coma: F. Bleeding Risk Due to Medication    3. Hemiplegia: G. Transfusion >4 RBC Units:    4. CVD Repair/Obstruct: H. Chemo for Malig Last 90 Days:    5. History of CVD: I. Radiotherapy W/I 90 Days:    6. Tumor Involving CNS: J. Preoperative Sepsis:    7. Impaired Cognitive Function K. Pregnancy       1. History of Cancer:       2. History of Radiation Therapy:       3. Num of Prior Surg in Same Op: |
| Select Preoperative Information to Edit: 3E |

SURPATIENT,SIXTY (000-56-7821)

JUN 23,1998 CHOLEDOCHOTOMY

Case #63592

Bleeding (Coagulation) Disorders (Y/N): **Y** YES

### Laboratory Test Results (Enter/Edit)

#### [SROA LAB]

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

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

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

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

**Example 1: Capture Preoperative Laboratory Information**

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

SURPATIENT,FORTY (000-77-7777)

SEP 19, 2003 CHOLEDOCHOTOMY

Case #68112

Enter/Edit Laboratory Test Results

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

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

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

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

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

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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. Admit/Transfer to Surgical Svc.: JUN 06, 2005@08:30 | | | |
| 7. Discharge/Transfer to Chronic Care: JUN 21, 2005@11:32 | | | |
| 8. DC/REL Destination: | | | |
| 9. Length of Postop Hospital Stay: 15 Days | | | |
| 10. Hospital Admission Status:: ADMISSION | | | |
| 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** IMPROVE

# Cardiac Risk Assessment Information (Enter/Edit)

#### [SROA CARDIAC ENTER/EDIT]

The Surgical Clinical Nurse Reviewer uses the options within the *Cardiac Risk Assessment Information (Enter/Edit)* menu to create a new risk assessment for a cardiac patient. Cardiac cases are evaluated differently from non-cardiac cases, and the prompts are different. This option is also used to make changes to an assessment that has already been entered.

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

|  |  |
| --- | --- |
| **Shortcut** | **Option Name** |
| CLIN | *Clinical Information (Enter/Edit)* |
| LAB | *Laboratory Test Results (Enter/Edit)* |
| CATH | *Enter Cardiac Catheterization & Angiographic Data* |
| OP | *Operative Risk Summary Data (Enter/Edit)* |
| CARD | *Cardiac Procedures Operative Data (Enter/Edit)* |
| IO | *Intraoperative Occurrences (Enter/Edit)* |
| PO | *Postoperative Occurrences (Enter/Edit)* |
| R | *Resource Data* |
| U | *Update Assessment Status to ‘COMPLETE’* |
| CODE | *Alert Coder Regarding Coding Issues* |

These sub-options are used for entering more in-depth data for a case, and are described in this chapter.

**Creating a New Risk Assessment**

1. Enter either the patient’s name/patient ID (for example, SURPATIENT,NINETEEN) or the surgical case assessment number preceded by # (for example, #47063). If the patient has any previous assessments, they will be displayed. An asterisk (\*) indicates a cardiac case. The user can now choose to create a new assessment or edit one of the previously entered assessments.
2. After choosing an operation on which to report, the user should respond **YES** to the prompt "Are you sure that you want to create a Risk Assessment for this surgical case ?" The user must answer **YES** (or press the **<Enter>** key to accept the **YES** default) to get to any of the sub-options. If the answer given is **NO**, the case created in step 1 will not be considered an assessment, although it can appear on some lists, and the software will return the user to the "Select Patient:" prompt.
3. The screen will clear and present the sub-options menu. The user can select a sub-option now to enter more in-depth information for the case, or press the **<Enter>** key to return to the main menu.

### Clinical Information (Enter/Edit)

#### [SROA CLINICAL INFORMATION]

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

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

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

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

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

**Example: Enter Clinical Information**

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

|  |  |
| --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 JUN 18,2005 CORONARY ARTERY BYPASS | |
| 1. Height: 70 in 17. PAD: NO 2. Weight: 185 lb 18. CVD Repair/Obstruct: NO CVD 3. Diabetes - Long Term: NO 19. History of CVD: NO CVD 4. Diabetes - 2 Wks Preop: NO 20. Angina Severity: NONE 5. COPD: NO 21. Angina Timeframe:W/N 14 DAY OF SU 6. FEV1: 9.3 liters 22. Congestive Heart Failure: 0 7. Cardiomegaly (X-ray): YES 23. Current Diuretic Use: NO 8. Tobacco Use: NEVER USED TOBACCO 24. IV NTG within 48 Hours: NO 9. Tobacco Use Timeframe: NOT APPLICABLE 25. Preop Circulatory Device: NONE 10. Positive Drug Screening: NOT DONE 26. Hypertension: NO 11. Active Endocarditis: NO 27. Preop Atrial Fibrillation: NO 12. Functional Status: INDEPENDENT 28. Preop Sleep Apnea: LEVEL 1 13. PCI: NONE 29. Sleep Apnea-Compliance: 14. Prior MI: UNKNOWN 30. Impaired Cognitive Func: 1 15. Num Prior Heart Surgeries:NONE 16. Prior Heart Surgery: NONE |  |
| Select Clinical Information to Edit: **A** |

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

Case #60183

PAGE: 1

Prior heart surgeries:

1. NONE
2. CABG-ONLY
3. VALVE-ONLY
4. CABG/VALVE
5. OTHER
6. CABG/OTHER
7. UNKNOWN

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

2 - VALVE-ONLY Peripheral Arterial Disease : 2 YES-W/O ANGI,REVASC,or AMPUT Prior Surgical Repair/Carotid Artery Obstruction: 0 NO CVD History of CVD Events: 0 NO CVD

Angina Severity: **IV** CLASS IV Angina Timeframe: **1** NO ANGINA

Preop Congestive Heart Failure: N CARD DX, CHF, OR SX

Current Diuretic Use (Y/N): **Y** YES

IV NTG within 48 Hours Preceding Surgery (Y/N): **Y** YES Preop use of circulatory Device: **N** NONE Hypertension:**2** YES WITHOUT MED

Preoperative Atrial Fibrillation: **N** NO Preoperative Sleep Apnea: **1** NONE - LEVEL 1 Sleep Apnea-Compliance:

Impaired Cognitive Function in the 90 Days Preop: YES-DOCUMENTED HISTORY

//

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

JUN 18,2005 CORONARY ARTERY BYPASS

Patient's Height: 63 INCHES// **76**

Patient's Weight: 170 LBS// **210**

Diabetes Mellitus: Chronic, Long-Term Management: I INSULIN Diabetes Mellitus: Management Prior to Surgery: I INSULIN History of Severe COPD (Y/N): **Y** YES

FEV1 : **NS**

Cardiomegaly on Chest X-Ray (Y/N): **Y** YES Tobacco Use: 3 CIGARETTES ONLY

Tobacco Use Timeframe: 1 WITHIN 2 WEEKS Positive Drug Screening:

Active Endocarditis (Y/N): **N** NO Functional Status: **I** INDEPENDENT PCI: NONE

Prior MI: **1** YES, < OR EQUAL TO 7 DAYS PRIOR TO SURG

Number of Prior Heart Surgeries: **1** 1

|  |  |
| --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 JUN 18,2005 CORONARY ARTERY BYPASS | |
| 1. Height: 70 in 17. PAD: NO 2. Weight: 185 lb 18. CVD Repair/Obstruct: NO CVD 3. Diabetes - Long Term: NO 19. History of CVD: NO CVD 4. Diabetes - 2 Wks Preop: NO 20. Angina Severity: NONE 5. COPD: NO 21. Angina Timeframe: W/N 14 6. FEV1: 9.3 liters 22. Congestive Heart Failure: 0 7. Cardiomegaly (X-ray): YES 23. Current Diuretic Use: NO 8. Tobacco Use: NEVER USED TOBACCO 24. IV NTG within 48 Hours: NO 9. Tobacco Use Timeframe: NOT APPLICABLE 25. Preop Circulatory Device: NONE 10. Positive Drug Screening: NOT DONE 26. Hypertension: NO 11. Active Endocarditis: NO 27. Preop Atrial Fibrillation: NO 12. Functional Status: INDEPENDENT 28. Preop Sleep Apnea: LEVEL 3 13. PCI: NONE 29. Sleep Apnea-Compliance: > OR EQUAL 14. Prior MI: UNKNOWN 30. Impaired Cognitive Func: 1 15. Num Prior Heart Surgeries:NONE 16. Prior Heart Surgeries: NONE | DAY OF SU |
| Select Clinical Information to Edit: |

### Laboratory Test Results (Enter/Edit)

#### [SROA LAB-CARDIAC]

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

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

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

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

##### About the "Select Laboratory Information to Edit:" Prompt

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

After the information has been entered or edited, the 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 Laboratory Test Results**

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

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

PAGE: 1

JUN 18,2005 CORONARY ARTERY BYPASS

Enter/Edit Laboratory Test Results

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

This selection loads the most recent cardiac lab data for tests performed preoperatively.

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

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

Press <RET> to continue **<Enter>**

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

PAGE: 1

JUN 18,2005 CORONARY ARTERY BYPASS

Enter/Edit Laboratory Test Results

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

Select Number: **2**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) PREOPERATIVE LABORATORY RESULTS  JUN 18,2005 CORONARY ARTERY BYPASS | | | Case | #60183 | PAGE: 1 | |
| 1. HDL: | NS |  |  | | |  |
| 2. LDL: | 168 | (JAN | 2004) | | |
| 3. Total Cholesterol: | 321 | (JAN | 2004) | | |
| 1. Serum Triglyceride: 2. Serum Potassium: | >70  NS | (JAN | 2004) | | |
| 6. Serum Bilirubin: | NS |  |  | | |
| 7. Serum Creatinine: | NS |  |  | | |
| 8. Serum Albumin: | NS |  |  | | |
| 9. Hemoglobin: | NS |  |  | | |
| 10. Hemoglobin A1c: | NS |  |  | | |
| 11. BNP: | NS |  |  | | |
| Select Laboratory Information to Edit: **1** | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) PREOPERATIVE LABORATORY RESULTS  JUN 18,2005 CORONARY ARTERY BYPASS | | Case | #60183 | PAGE: 1 | |
| HDL (mg/dl): NS// **177**  HDL, Date: **JAN, 2005** | (JAN 2005) | | | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) PREOPERATIVE LABORATORY RESULTS  JUN 18,2005 CORONARY ARTERY BYPASS | | | Case | #60183 | PAGE: 1 | |
| 1. HDL: | 177 | (JAN | 2005) | | |  |
| 2. LDL: | 168 | (JAN | 2004) | | |
| 3. Total Cholesterol: | 321 | (JAN | 2004) | | |
| 4. Serum Triglyceride: | >70 | (JAN | 2004) | | |
| 5. Serum Potassium: | NS |  |  | | |
| 6. Serum Bilirubin: | NS |  |  | | |
| 7. Serum Creatinine: | NS |  |  | | |
| 8. Serum Albumin: | NS |  |  | | |
| 9. Hemoglobin: | NS |  |  | | |
| 10. Hemoglobin A1c: | NS |  |  | | |
| 11. BNP: | NS |  |  | | |
| Select Laboratory Information to Edit: | | | | | |

### Enter Cardiac Catheterization & Angiographic Data

#### [SROA CATHETERIZATION]

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

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

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

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

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

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

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

SURPATIENT,NINETEEN (000-28-7354)

Case #60183

PAGE: 1 OF 2

JUN 18,2005 CORONARY ARTERY BYPASS

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

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) JUN 18,2005 CORONARY ARTERY BYPASS | | | | Case | #60183 | PAGE: | 1 | OF 2 |
| 1. Procedure: 2. LVEDP: 3. Aortic Systolic | Pressure: | Cath  56 mm  120 mm | Hg Hg | | | | |  |
| For patients having right heart cath   1. PA Systolic Pressure: 30 mm Hg 2. PAW Mean Pressure: 15 mm Hg | | | | | | | |  |
| 6. LV Contraction Grade (from contrast  or radionuclide angiogram or 2D echo): IIIa 0.40-0.44 MODERATE DYSFUNCTION A | | | | | | | |  |
| 1. Mitral Regurgitation: MODERATE 2. Aortic Stenosis: MILD | | | | | | | |  |
| Select Cardiac Catheterization and Angiographic Information to Edit: **<Enter>** | | | | | | | |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) JUN 18,2005 CORONARY ARTERY BYPASS | |  | Case | #60183 |  | PAGE: 2 of 2 | |
| ----- Native Coronaries ----- | | | | | | |  |
| 1. Left main stenosis: | NS |  | | |  | |
| 2. LAD Stenosis: | NS |  | | |  | |
| 3. Right coronary stenosis: | NS |  | | |  | |
| 4. Circumflex Stenosis: | NS |  | | |  | |
| Select Cardiac Catheterization and Angiographic Information to Edit: | | | | | **3** | |
| Right Coronary Artery Stenosis: NS// | | **?** | | |  | |
| Enter the percent (0-100) stenosis. | | | | |  | |
| Right Coronary Artery Stenosis: NS// | | **30** | | |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SURPATIENT,NINETEEN (000-28-7354) JUN 18,2005 CORONARY ARTERY BYPASS | | Case | #60183 | PAGE: 2 of 2 | |
| ----- Native Coronaries ----- |  | | | |  |
| 1. Left main stenosis: | NS | | | |
| 2. LAD Stenosis: | NS | | | |
| 3. Right coronary stenosis: | 30 | | | |
| 4. Circumflex Stenosis: | NS | | | |
| Select Cardiac Catheterization and Angiographic Information to Edit: | | | | |

*(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. ASA Classification: 1-NO DISTURB. |  |  |  |  |
| 2. Surgical Priority: |  |  |  |  |
| 3. Preoperative Risk Factors: NONE |  |  |  |  |
|  |  | This information |  |  |
| 4. CPT Codes (view only): 33510 |  | cannot be edited. |  |  |
| 5. Wound Classification: CLEAN |  |  |  |  |
| Select Operative Risk Summary Information to Edit: | **1:3** |  |  |  |

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

Case #60183

ASA Class: 1-NO DISTURB.// **3** 3

Cardiac Surgical Priority: **?**

3-SEVERE DISTURB.

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. ASA Classification: 3-SEVERE DISTURB. | | | | |  | |
| 2. Surgical Priority: EMERGENT (ONGOING |  | ISCHEMIA) |  |  |
| A. Date/Time Collected: JUN 18,2005@18:15 | | | | |
| 3. CPT Codes (view only): 33736 | | | | |
| 4. 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.

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

**Example: Enter Cardiac Procedures Operative Data**

|  |  |  |
| --- | --- | --- |
| Select Cardiac Risk Assessment Information (Enter/Edit) Option: **CARD** Cardiac Procedures Operative Data (Enter/Edit)  SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 JUN 18,2005 CORONARY ARTERY BYPASS | | |
| Operative Data details: | N/A (began on-pump/ stayed on-pump) |  |
| 1. Bridge to Transplant: 2. Total CPB Time: 3. Total Ischemic Time: 4. Incision Type: 5. Convert Off Pump to CPB: |
| Select Operative Information to Edit: | |

### Resource Data (Enter/Edit)

#### [SROA CARDIAC RESOURCE]

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

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

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

SURPATIENT,TEN (000-12-3456)

Case #49413

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

Enter/Edit Patient Resource Data

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

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

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

SURPATIENT,TEN (000-12-3456)

Case #49413

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

Enter/Edit Patient Resource Data

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

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

|  |  |
| --- | --- |
| SURPATIENT,TEN (000-12-3456) Case #49413 PAGE: 1 OF 2 OCT 18,2007 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD |  |
| 1. Transfer Status: NON-VAMC ACUTE CARE HOSPITAL 2. Hospital Admission Date: 3. Hospital Discharge Date: 4. DC/REL Destination: ACUTE CARE FACIL TRANSFER VA/NON-VA 5. Cardiac Catheterization Date: MAY 14, 2015@12:07 6. Time Patient In OR: OCT 03, 2007@08:00 7. Date/Time Operation Began: OCT 03, 2007@09:00 8. Date/Time Operation Ended: OCT 03, 2007@10:00 9. Time Patient Out OR: OCT 03, 2007@12:30 10. Date/Time Patient Extubated: OCT 03, 2007@14:35 Postop Intubation Hrs: +2.1 11. Date/Time Discharged from ICU: 12. Homeless: NO 13. Employment Status Preoperatively: NOT EMPLOYED 14. Date of Death: NA 15. 30-Day Death: NO |

|  |  |  |
| --- | --- | --- |
| SURPATIENT,TEN (000-12-3456) Case #49413 PAGE: 2 OF 2 | |  |
| OCT 18,2007 CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD | |
| 1. Current Residence: | ACUTE CARE FACILITY |
| 2. Ambulation Device: | AMBULATES W/OUT ASSISTIVE DEVICE |
| 3. History of Cancer: | NO |
| 4. History of Radiation Therapy: | YES |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 5. Num | of | Prior | Surg | in | Same | OP: | >5 | PREVIOUS | SURGERIES |  |
| Select Resource Information to Edit: | | | | | | | | | |

The Surgery software performs data checks on the following fields:

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

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

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

# Print a Surgery Risk Assessment

#### [SROA PRINT ASSESSMENT]

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

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

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

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

Select Patient: **SURPATIENT,FORTY**

ERAN

05-07-23

000777777

NO

NSC VET

SURPATIENT,FORTY 000-77-7777

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

Select Surgical Case: **2**

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

*printout follows*

VA NON-CARDIAC RISK ASSESSMENT Assessment: 236 PAGE 1 FOR SURPATIENT,FORTY 000-77-7777 (COMPLETED)

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

Medical Center: ALBANY

Age: 81 Operation Date: JAN 09, 2006

Sex: MALE Ethnicity: NOT HISPANIC OR LATINO Race: AMERICAN INDIAN OR ALASKA

NATIVE, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, WHITE

Transfer Status: NOT ENTERED

Observation Admission Date: NA

Observation Discharge Date: NA

Observation Treating Specialty: NA

Hospital Admission Date: NOV 27,2007 13:11 Hospital Discharge Date:

Admitted/Transferred to Surgical Service: Discharged/Transferred to Chronic Care:

DC/REL Destination: NOT ENTERED Hospital Admission Status:

Assessment Completed by: SURNURSE,SEVEN PREOPERATIVE INFORMATION

GENERAL: YES HEPATOBILIARY: YES

Height: Ascites: YES Weight:

Diabetes - Long Term: GASTROINTESTINAL:

Diabetes - 2 Wks Preop: Esophageal Varices: NO Tobacco Use:

Tobacco Use Timeframe: NOT APPLICABLE

ETOH > 2 Drinks/Day: NO CARDIAC:

Positive Drug Screening: Congestive Heart Failure: N CARD DX, CHF Dyspnea: NO Prior MI:

Preop Sleep Apnea: LEVEL 3 PCI:

Sleep Apnea-Compliance: > OR EQUA

DNR Status: Prior Heart Surgery:

Functional Status: Angina Severity: Current Residence: ACUTE CARE FACILITY Angina Timeframe: Ambulation Device: Hypertension:

PULMONARY:

Ventilator Dependent: VASCULAR:

History of Severe COPD: PAD:

Current Pneumonia: Rest Pain/Gangrene: PREOPERATIVE INFORMATION

RENAL: NUTRITIONAL/IMMUNE/OTHER:

Acute Renal Failure: Disseminated Cancer:

Currently on Dialysis: Open Wound:

Steroid Use for Chronic Cond.:

CENTRAL NERVOUS SYSTEM: Weight Loss > 10%:

Impaired Sensorium: Bleeding Disorders: Bleeding Due To Med:

Coma: Transfusion > 4 RBC Units:

Hemiplegia: Chemo for Malig Last 90 Days:

CVD Repair/Obstruct: Radiotherapy W/I 90 Days:

History of CVD: Preoperative Sepsis:

Tumor Involving CNS: Pregnancy: NOT APPLICABLE Impaired Cognitive Function: History of Cancer: YES

History of Radiation Therapy: Y Prior Surg in Same Operative:

OPERATION DATE/TIMES INFORMATION

Patient in Room (PIR): JUL 20,2007 07:00 Procedure/Surgery Start Time (PST): JUL 20,2007 07:30 Procedure/Surgery Finish (PF): JUL 20,2007 08:30 Patient Out of Room (POR): JUL 20,2007 08:40

Anesthesia Start (AS): Anesthesia Finish (AF): Discharge from PACU (DPACU):

Page 482a removed

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| WOUND OCCURRENCES: | YES | | CNS OCCURRENCES: | YES |  |
| Superficial Incisional SSI: | NO | | Stroke/CVA: |  | NO |
| Deep Incisional SSI: | NO | | Coma > 24 Hours: |  | NO |
| Wound Disruption:  \* 427.31 ATRIAL FIBRILLATI | 01/10/06 Peripheral Nerve Injury: 01/10/06 | | | 01/10/06 | |
| URINARY TRACT OCCURRENCES: | YES |  | CARDIAC OCCURRENCES: | YES |  |
| Renal Insufficiency: |  | NO | Arrest Requiring CPR: |  | NO |
| Acute Renal Failure: |  | NO | Myocardial Infarction: |  | 01/09/06 |
| Urinary Tract Infection: | 01/11/06 | |  | |  |
| RESPIRATORY OCCURRENCES: | YES | | OTHER OCCURRENCES: YES | |  |
| Pneumonia: | NO | | Bleeding/Transfusions: | | NO |
| Unplanned Intubation: | NO | | Graft/Prosthesis/Flap Failure: | | NO |
| Pulmonary Embolism: | NO | | DVT/Thrombophlebitis: | | NO |
| On Ventilator > 48 Hours: | NO | | Systemic Sepsis: SEPTIC SHOCK | | 01/11/06 |
| \* 477.0 RHINITIS DUE TO P | 01/12/06 | | Organ/Space SSI:  C. difficile Colitis: | | 01/11/06  NO |
| \* indicates Other (ICD) |  | |  | |  |

VA NON-CARDIAC RISK ASSESSMENT

Assessment: 236

PAGE 3

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

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

OUTCOME INFORMATION

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

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

PERIOPERATIVE OCCURRENCE INFORMATION

VA SURGICAL QUALITY IMPROVEMENT PROGRAM - CARDIAC SPECIALTY

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

1. IDENTIFYING DATA Case #: 45730

Patient: SQWMNW,BILL 000-00-1941 Fac./Div. #: 442

Surgery Date: 01/27/14 Address:

Phone: NS/Unknown Zip Code: NS/Unknown Date of Birth: 08/11/57

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

1. CLINICAL DATA

Gender: MALE Age: 67

Height: 70 in Prior MI: UNKNOWN

Weight: 185 lb Number of prior heart surgeries: NONE Diabetes - Long Term: NO Prior heart surgery: NONE Diabetes - 2 Wks Preop: NO PAD: NO COPD: NO CVD Repair/Obstruct: NO CVD

FEV1: 9.3 liters History of CVD: NO CVD

Cardiomegaly (X-ray): YES Angina Severity: NONE Tobacco Use: NEVER USED TOBACCO Angina Timeframe: W/N 14 DAY OF SURG Tobacco Use Timeframe: NOT APPLICABLE Congestive Heart Failure: 0-N CARD DX Positive Drug Screening: NOT DONE Current Diuretic Use: NO Active Endocarditis: NO IV NTG 48 Hours Preceding Surgery: NO Functional Status: INDEPENDENT Preop Circulatory Device: NONE PCI: NONE Hypertension: NO Preop Sleep Apnea: LEVEL 1 Preoperative Atrial Fibrillation: NO Sleep Apnea-Compliance: Impaired Cognitive Function: YES-DOCUMEN

1. DETAILED LABORATORY INFO - PREOPERATIVE VALUES

Creatinine: mg/dl (NS) T. Cholesterol: mg/dl (NS) Hemoglobin: mg/dl (NS) HDL: mg/dl (NS)

Albumin: g/dl (NS) LDL: mg/dl (NS) Triglyceride: mg/dl (NS) Hemoglobin A1c: % (NS) Potassium: mg/L (NS) BNP: mg/dl (NS)

T. Bilirubin: mg/dl (NS)

1. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA Cardiac Catheterization Date:

Procedure: Native Coronaries:

LVEDP: mm Hg Left Main Stenosis: Aortic Systolic Pressure: mm Hg LAD Stenosis:

Right Coronary Stenosis: For patients having right heart cath: Circumflex Stenosis:

PA Systolic Pressure: mm Hg

PAW Mean Pressure: mm Hg If a Re-do, indicate stenosis

in graft to: LAD:

Right coronary (include PDA): Circumflex:

LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo): Grade Ejection Fraction Range Definition

Mitral Regurgitation:

Aortic stenosis:

1. OPERATIVE RISK SUMMARY DATA ASA Classification:

Surgical Priority:

Principal CPT Code: CPT Code Missing Other Procedures CPT Codes:

Wound Classification:

VI. OPERATIVE DATA Bridge to Transplant:

Operative Data details

Total CPB Time: Incision Type:

min

Total Ischemic Time: min

Conversion Off Pump to CPB:

VII. OUTCOMES

Perioperative (30 day) Occurrences: Mycardial Infarction: Endocarditis:

Superficial Incisional SSI: Mediastinitis:

Cardiac Arrest Requiring CPR: Reoperation for Bleeding:

On ventilator > or = 48 hr: Repeat cardiac Surg procedure:

YES

Tracheostomy:

NO

NO Unplanned Intub W/In 30 Days:

NO

NO Stroke/CVA:

NO Coma > or = 24 Hours:

NO SYMPTOMS

NO

NO New Mech Circulatory Support: NO

NO Postop Atrial Fibrillation: NO Wound Disruption:

NO NO

NO Renal Failure Requiring Dialysis: NO

VIII. RESOURCE DATA Transfer Status: Hospital Admission Date:

DC/REL Destination:

Time Patient In OR:

Operation Ended:

Date and Time Patient Extubated: Postop Intubation Hrs:

Date and Time Patient Discharged from ICU: Patient is Homeless:

Date of Death:

Current Residence: History of Cancer:

Prior Surg in Same Operative:

Operation Began: Time Patient Out OR:

30-Day Death: Ambulation Device:

History of Radiation Therapy:

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

1. SOCIOECONOMIC, ETHNICITY, AND RACE Employment Status Preoperatively:

Ethnicity: UNANSWERED

Race Category(ies): UNANSWERED

1. DETAILED DISCHARGE INFORMATION Discharge ICD-9 Codes:

Type of Disposition:

Place of Disposition:

Preferred VAMC identification code:

Primary care or referral VAMC identification code: Follow-up VAMC identification code:

\*\*\* End of report for SQWMNW,BILL 000-00-1941 assessment #45730 \*\*\* Enter RETURN to continue or ‘^’ to exit:

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

# List of Surgery Risk Assessments

#### [SROA ASSESSMENT LIST]

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

* 1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases (Deactivated)
  5. List of All Major Surgical Cases (Deactivated)
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases
  10. List of Cases With No CPT Codes
  11. Summary List of Assessed Cases

**Example 1: List of Incomplete Assessments**

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

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

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

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

1. MAYBERRY, NC

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

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

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

printout follows

**Example 2: List of Completed Assessments**

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

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

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

*printout follows*

**Example 3: List of Transmitted Assessments**

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

Print by Date of Operation or by Date of Transmission ?

1. Date of Operation
2. Date of Transmission

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

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

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

Print which Transmitted Cases ?

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

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

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

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

50

GENERAL

1. 50 GENERAL SURGERY 50
2. 50 GASTROENTEROLOGY 50 GASTR
3. 50 TWO GENERAL 50 TG

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

printout follows

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

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

This display is no longer used. Please select a different list.

Press Enter to continue

Page 496 has been deleted. The *List of Non-Assessed Major Surgical Cases* has been removed with patch SR\*3\*184.

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

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

This display is no longer used. Please select a different list.

Press Enter to continue

Page 498 has been deleted. The *List of All Major Surgical Cases* has been removed with patch SR\*3\*184.

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

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

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

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

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

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

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

GENERAL(OR WHEN NOT DEFINED BELOW)

GENERAL(OR WHEN NOT DEFINED BELOW) 50

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

printout follows

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

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

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

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

*printout follows*

**Example 8: List of 1-Liner Cases Missing Information**

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

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

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

printout follows

**Example 9: List of Eligible Cases**

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Daectivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

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

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

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

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

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

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

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

GENERAL SURGERY

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

*printout follows*

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

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

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

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

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

*printout follows*

**Example 11: Summary List of Assessed Cases**

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

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

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

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

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

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

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

1. ALBANY
2. PHILADELPHIA, PA

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

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

# Exclusion Criteria (Enter/Edit)

#### [SR NO ASSESSMENT REASON]

The *Exclusion Criteria (Enter/Edit)* option is used to flag major cases that will not have a surgery risk assessment due to certain exclusion criteria. At the prompt "Reason an Assessment was not Created:" enter a question mark (**?**) to see a list of reasons.

**Example: Enter Reason for No Assessment**

Select Surgery Risk Assessment Menu Option: **R** Exclusion Criteria (Enter/Edit)

Select Patient: **R9922** SURPATIENT,NINE VETERAN

03-03-34

000345555

NO

SC

SURPATIENT,NINE 000-34-5555

1. 11-01-04 TURP (COMPLETED)
2. 08-01-03 CABG X3 (1A,2V), ARTERIAL GRAFTING (COMPLETED)
3. 07-03-01 PULMONARY LOBECTOMY, TURP (COMPLETED)

Select Operation: **1**

Reason an Assessment was not Created: **6** 10% RULE

|  |  |
| --- | --- |
| SURPATIENT,NINE (000-34-5555) Case #63159  Transmission Status: QUEUED TO TRANSMIT NOV 1,2004 TURP (CPT Code: 52601-59) |  |
| 1. Exclusion Criteria: 10% RULE 2. Surgical Priority: ELECTIVE 3. Surgical Specialty: UROLOGY 4. Principal Anesthesia Technique: GENERAL 5. Major or Minor: MAJOR |
| Select Excluded Case Information to Edit: |

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 |
| INCLSN CRTA NOT MET | = | 59 |
| 10% RULE | = | 0 |
| CONCURRENT CASE | = | 0 |
| EXCEEDS MAXIMUM HERNIAS | = | 0 |
| ABORTED | = | 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

ALBANY - ALL DIVISIONS REPORT OF SURGICAL CASE WORKLOAD

FOR OCT 2005 THROUGH MAY 2006

|  |  |  |
| --- | --- | --- |
| TOTAL CASES PERFORMED | = | 30 |
| TOTAL ELIGIBLE CASES | = | 5 |
| CASES MEETING EXCLUSION CRITERIA | = | 1 |
| NON-SURGEON CASE | = | 0 |
| ANESTHESIA TYPE | = | 0 |
| EXCEEDS MAX. ASSESSMENTS | = | 0 |
| EXCEEDS MAXIMUM TURPS | = | 0 |
| INCLSN CRTA NOT MET | = | 0 |
| 10% RULE | = | 1 |
| CONCURRENT CASE | = | 0 |
| EXCEEDS MAXIMUM HERNIAS | = | 0 |
| ABORTED | = | 0 |
| ASSESSED CASES | = | 20 |
| NOT LOGGED ELIGIBLE CASES | = | 0 |
| CARDIAC CASES | = | 4 |
| NON-CARDIAC CASES | = | 16 |

Pages 527-547 have been deleted. The *Transplant Assessment Menu* has been removed with patch SR\*3\*184.

# Chapter Nine: 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. The Cases shall be considered “ABORTED” if the TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232) and  CANCEL DATE field (#17), and the CASE ABORTED field entered with “YES”. |
| 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, CANCELLATION TIMEFRAME and/or the PRIMARY 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. The *Transplant Assessment Menu* has been removed  with patch SR\*3\*184. |
| VASQIP | Veterans Affairs Surgery Quality Improvement Program. |

# Index

A

AAIS, 437, 438

anesthesia agents, 128, 160

entering data, 161

printing information, 170

staff, 162

techniques, 160 anesthesia agents flagging a drug, 431

anesthesia personnel, 61, 128

assigning, 173

scheduling, 84 anesthesia technique

entering information, 165, 173 assessment

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

Automated Anesthesia Information System (AAIS), 437, 438

B

bar code reader, 158

blockout an operating room, 85 blockout graph, 60

Blood Bank, 158 blood product label, 158

verification, 158 book an operation, 25

book concurrent operation, 45 C

cancellation rates calculations, 347 case

cancelled, 345

cardiac, 465

delayed, 338

designation, 96

editing cancelled, 400 list of requested, 57 scheduled, 96, 345

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

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

checking accuracy of procedures, 310 entry, 207

validation, 207 comments adding, 205

completed cases, 355, 357

PCE filing status of, 238, 273

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

reports on, 252

staffing information for, 284 surgical priority, 269

complications, 93, 459

concurrent case, 93

adding, 74

defined, 15

scheduling, 61

scheduling unrequested operations, 69 condensed characters, 26

count clinic active, 278

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

CPT modifiers, 525

cultures, 153, 196

cutoff time, 15, 42 D

deaths reviewing, 330

within 30 days of surgery, 183, 326

within 90 days of surgery, 330 delays

reasons for, 340

devices, 155 updating list of, 429

diagnosis, 113, 208, 238, 273

dosage, 157, 169

downloading Surgery set of codes, 438 E

electronically signing a report Anesthesia Report, 131, 134 Nurse Intraoperative Report, 2

F

flag a drug, 431 G

Glossary, 549 H

HL7, 434, 435, 439

master file updates, 437, 438 I

ICD-10 codes, 207, 525

interim reports, 319 intraoperative occurrence entering, 459, 475

irrigation solutions, 155 K

KERNEL audit log, 393 L

laboratory information, 95

entering, 451

Laboratory Package, 319 list of requested cases, 57

M

medical administration, 95

medications, 157, 169

mortality and morbidity rates, 183, 326

multiple fields, 108 N

new surgical case, 101 non-count encounters, 278

non-O.R. procedure, 187

deleting data, 188

editing data, 188

entering data, 188

NSQIP, 509, 519, 550

NSQIP transmission process, 521 nurse staffing information, 294 nursing care, 140

O

occurrence, 180

adding information about a postoperative, 178 editing, 176

entering, 176

intraoperative, 330, 459, 475 adding information about an, 176 M&M Verification Report, 330

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

reviewing, 330

viewing, 324 Operating Room

determining use of, 414 entering information, 413

percent utilization, 361

rescheduling, 74

reserving on a recurring basis, 85 utilization reports, 415

viewing availability of, 26 viewing availability of, 60

Operating Room Schedule, 88, 253

operation

book concurrent, 45

booking, 25, 59

canceling scheduled, 81

close of, 119

delayed, 108, 338, 340

discharge, 119

outstanding requests, 28

patient preparation, 108

post anesthesia recovery, 119 requesting, 25

rescheduling, 74

scheduled, 26

scheduled by surgical specialty, 91 scheduling requested, 59

scheduling unrequested, 64

starting time, 113 operation information entering or editing, 455 operation request deleting, 36

printing a list, 53 Options

Admissions Within 14 Days of Outpatient Surgery, 0

Anesthesia Data Entry Menu, 161 Anesthesia for an Operation Menu, 128 Anesthesia Information (Enter/Edit), 162 Anesthesia Menu, 160

Anesthesia Provider Report, 303 Anesthesia Report, 131, 170

Anesthesia Reports, 296

Anesthesia Technique (Enter/Edit), 165 Annual Report of Non-O.R. Procedures, 196 Annual Report of Surgical Procedures, 255 Attending Surgeon Reports, 284

Blood Product Verification, 158 Cancel Scheduled Operation, 81

Cardiac Procedures Requiring CPB (Enter/Edit), 473

Chief of Surgery, 323

Chief of Surgery Menu, 321 Circulating Nurse Staffing Report, 294 Clinical Information (Enter/Edit), 467 Comments Option, 205

Comparison of Preop and Postop Diagnosis, 335 CPT Code Reports, 305

CPT/ICD-10 Coding Menu, 207 CPT/ICD-10 Update/Verify Menu, 208 Create Service Blockout, 85

Cumulative Report of CPT Codes, 220, 306

Deaths Within 30 Days of Surgery, 395 Delay and Cancellation Reports, 337 Delete a Patient from the Waiting List, 23 Delete or Update Operation Requests, 36 Delete Service Blockout, 87

Display Availability, 26, 60

Edit a Patient on the Waiting List, 22 Edit Non-O.R. Procedure, 189

Enter a Patient on the Waiting List, 21

Enter Cardiac Catheterization & Angiographic Data, 469

Enter Irrigations and Restraints, 155 Enter PAC(U) Information, 121, 125

Enter Referring Physician Information, 154 Enter Restrictions for 'Person' Fields, 426 Exclusion Criteria (Enter/Edit), 507

File Download, 437

Flag Drugs for Use as Anesthesia Agents, 431 Flag Interface Fields, 435

Intraoperative Occurrences (Enter/Edit), 176, 459, 475

Laboratory Interim Report, 319

Laboratory Test Results (Enter/Edit), 451, 470 List Completed Cases Missing CPT Codes, 230,

316

List of Anesthetic Procedures, 299 List of Operations, 232, 257

List of Operations (by Postoperative Disposition), 259

List of Operations (by Surgical Priority), 267 List of Operations (by Surgical Specialty), 234,

265

List of Surgery Risk Assessments, 489 List of Unverified Surgery Cases, 352 List Operation Requests, 57

List Scheduled Operations, 91 M&M Verification Report, 330, 513

Maintain Surgery Waiting List menu, 17 Make a Request for Concurrent Cases, 45 Make a Request from the Waiting List, 42 Make Operation Requests, 28

Make Reports Viewable in CPRS, 440 Management Reports, 252, 325

Medications (Enter/Edit), 157, 169

Monthly Surgical Case Workload Report, 509 Morbidity & Mortality Reports, 183, 326 Non-Cardiac Risk Assessment Information

(Enter/Edit), 445

Non-O.R. Procedures, 187

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

Non-Operative Occurrence (Enter/Edit), 180

Normal Daily Hours (Enter/Edit), 417 Nurse Intraoperative Report, 140, 217

Operating Room Information (Enter/Edit), 413 Operating Room Utilization (Enter/Edit), 415 Operating Room Utilization Report, 361, 419

Operation, 113

Operation (Short Screen), 122 Operation Information, 103

Operation Information (Enter/Edit), 455 Operation Menu, 95

Operation Report, 129

Operation Requests for a Day, 53 Operation Startup, 108

Operation/Procedure Report, 213

Operative Risk Summary Data (Enter/Edit), 471 Outpatient Encounters Not Transmitted to

NPCD, 278

Patient Demographics (Enter/Edit), 457 PCE Filing Status Report, 238, 273 Perioperative Occurrences Menu, 175 Person Field Restrictions Menu, 425 Post Operation, 119

Postoperative Occurrences (Enter/Edit), 178, 461, 477

Print 30 Day Follow-up Letters, 503 Print a Surgery Risk Assessment, 481

Print Blood Product Verification Audit Log, 393 Print Surgery Waiting List, 18

Procedure Report (Non-O.R.), 193 Purge Utilization Information, 424 Queue Assessment Transmissions, 521

Remove Restrictions on 'Person' Fields, 428 Report of Cancellation Rates, 347

Report of Cancellations, 345

Report of Cases Without Specimens, 357 Report of CPT Coding Accuracy, 224, 310 Report of Daily Operating Room Activity, 236,

271, 355

Report of Delay Reasons, 340 Report of Delay Time, 342

Report of Delayed Operations, 338

Report of Missing Quarterly Report Data, 0 Report of Non-O.R. Procedures, 198, 243 Report of Normal Operating Room Hours, 421 Report of Returns to Surgery, 353

Report of Surgical Priorities, 269

Report of Unscheduled Admissions to ICU, 359 Request Operations menu, 25

Requests by Ward, 55

Reschedule or Update a Scheduled Operation, 74

Resource Data (Enter/Edit), 479 Review Request Information, 52 Risk Assessment, 465

Schedule Anesthesia Personnel, 84, 173

Schedule of Operations, 88, 253

Schedule Operations, 59

Schedule Requested Operation, 61

Schedule Unrequested Concurrent Cases, 69 Schedule Unrequested Operations, 64

Scrub Nurse Staffing Report, 292 Surgeon Staffing Report, 288

Surgeon’s Verification of Diagnosis & Procedures, 125

Surgery Interface Management Menu, 434 Surgery Package Management Menu, 409 Surgery Reports, 251

Surgery Site Parameters (Enter/Edit), 410 Surgery Staffing Reports, 283

Surgery Utilization Menu, 414 Surgical Nurse Staffing Report, 290 Surgical Staff, 104

Table Download, 438

Tissue Examination Report, 153 Unlock a Case for Editing, 398 Update 1-Liner Case, 519

Update Assessment Completed/Transmitted in Error, 487

Update Assessment Status to ‘Complete’, 464, 0 Update Assessment Status to ‘COMPLETE’,

481

Update Cancellation Reason, 83 Update Cancelled Cases, 400

Update Interface Parameter Field, 439 Update O.R. Schedule Devices, 429 Update Operations as Unrelated/Related to

Death, 401

Update Site Configurable Files, 432 Update Staff Surgeon Information, 430

Update Status of Returns Within 30 Days, 181, 399, 463

Update/Verify Procedure/Diagnosis Codes, 209, 402

View Patient Perioperative Occurrences, 324 Wound Classification Report, 363

Options:, 196, 197, 221 outstanding requests defined, 15

P

PACU, 121

PCE filing status, 238, 273

percent utilization, 361, 419

person-type field assigning a key, 426 removing a key, 426, 428

Pharmacy Package Coordinator, 431 positioning devices, 155

Post Anesthesia Care Unit (PACU), 121 postoperative occurrence

entering, 461, 474, 477 preoperative assessment entering information, 448

preoperative information, 15

editing, 52

entering, 29, 65

reviewing, 52

updating, 74

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

procedure deleting, 23

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

purging utilization information, 424 Q

quick reference on a case, 103 R

Referring physician information, 154 reporting

tracking cancellations, 337

tracking delays, 337 reports

Admissions Within 14 Days of Outpatient Surgery Report, 0

Anesthesia Provider Report, 303 Anesthesia Report, 131

Annual Report of Non-O.R. Procedures, 196 Annual Report of Surgical Procedures, 255 Attending Surgeon Cumulative Report, 284, 286 Attending Surgeon Report, 284

Cases Without Specimens, 357 Circulating Nurse Staffing Report, 294 Clean Wound Infection Summary, 367

Comparison of Preop and Postop Diagnosis, 335 Completed Cases Missing CPT Codes, 230, 316 Cumulative Report of CPT Codes, 220, 222,

306, 308

Daily Operating Room Activity, 236 Daily Operating Room Activity, 271

Daily Operating Room Activity, 325 Daily Operating Room Activity, 355 Daily Operating Room Activity, 355 Deaths Within 30 Days of Surgery, 396, 0 Laboratory Interim Report, 319

List of Anesthetic Procedures, 299, 301

List of Operations, 232, 257

List of Operations (by Surgical Specialty), 234 List of Operations by Postoperative Disposition,

259, 261, 263

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

List of Operations by Wound Classification, 365 List of Unverified Cases, 352

M&M Verification Report, 330, 333, 513, 516 Missing Quarterly Report Data, 0

Monthly Surgical Case Workload Report, 509, 511

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

Operating Room Normal Working Hours Report, 421

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

Operation Requests, 57 Operation Requests for a Day, 53

Outpatient Surgery Encounters Not Transmitted to NPCD, 278, 280

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

Perioperative Occurrences Report, 183, 326

Procedure Report (Non-O.R.), 195, 216 Procedure Report (Non-OR), 215

Re-Filing Cases in PCE, 282

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

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

314

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

Report of Daily Operating Room Activity, 271 Report of Delay Time, 342

Report of Delayed Operations, 338

Report of Non-O.R. Procedures, 198, 200, 202,

243, 245, 247

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

Schedule of Operations, 88 Scheduled Operations, 91

Scrub Nurse Staffing Report, 292 Surgeon Staffing Report, 288

Surgery Risk Assessment, 481, 485 Surgery Waiting List, 18

Surgical Nurse Staffing Report, 290 Tissue Examination Report, 153, 196 Unscheduled Admissions to ICU, 359 Wound Classification Report, 363 request an operation, 25

restraint, 108, 155

risk assessment, 330

changing, 445

creating, 445, 544

creating cardiac, 465

entering non-cardiac patient, 445

entering the clinical information for cardiac case, 467

Risk Assessment, 481, 550 Risk Assessment module, 443 Risk Model Lab Test, 522 route, 157, 169

S

schedule an unrequested operation, 64 scheduled, 79, 84, 98, 550

scheduling a concurrent case, 61 Screen Server, 93

data elements, 6

Defined, 5

editing data, 8

entering a range of elements, 9 entering data, 7

header, 6

multiple screen shortcut, 12 multiples, 10

Navigation, 5

prompt, 6

turning pages, 8

word processing, 14

service blockout, 60

creating, 85

removing, 87

short form listing of scheduled cases, 91 site-configurable files, 432

specimens, 153, 196 staff surgeon

designating a user as, 430 surgeon key, 426

Surgery case cancelled, 400

unlocking, 398

Surgery package coordinator, 407 Surgery Site parameters

entering, 410

Surgical Service Chief, 321 Surgical Service managers, 410 surgical specialty, 21, 57, 74, 234

Surgical staff, 104 T

time given, 157, 169 transfusion

error risk management, 158 U

utilization information, 361, 419

purging, 424 V

VA Central Office, 255

W

Waiting List

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

waiting lists, 17 workload report, 509

uncounted, 278

wound classification, 363

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