



# **SURGERY**

## **USER MANUAL**

Version 3.0

July 1993

(Revised December 2010)



# 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
12/10	i-ii, 372, 376, 449-450, 458, 467-468, 468b, 471-474, 474a-474b, 479, 479a, 482, 486, 486a, 522c-522d	SR*3*174	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the <i>Annual Surgery Updates – VASQIP 2010 Release Notes</i> . (T. Leggett, PM; B. Thomas, Tech Writer)
11/08	vii-viii, 527-556	SR*3*167	New chapter added for transplant assessments. Changed Glossary to Chapter 10, and renumbered the Index. (M. Montali, PM; G. O’Connor, Tech Writer)
04/08	iii-iv, vi, 160, 165, 168, 171-172, 296-298, 443, 447, 449-450, 459, 471-473, 479-479a, 482, 486-486a, 489, 491, 493-495, 497, 499, 501-502a, 502c, 502d-502h, 513-517, 522c-522d, 529, 534	SR*3*166	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the <i>Surgery NSQIP-CICSP Enhancements 2008 Release Notes</i> . (M. Montali, PM; G. O’Connor, Tech Writer)
11/07	479-479a, 486a	SR*3*164	Updated the <i>Resource Data Enter/Edit</i> and the <i>Print a Surgery Risk Assessment</i> options to reflect the new cardiac field for CT Surgery Consult Date. (M. Montali, PM; S. Krakosky, Tech Writer)
09/07	125, 371, 375, 382	SR*3*163	Updated the Service Classification section regarding environmental indicators, unrelated to this patch. Updated the Quarterly Report to reflect updates to the numbers and names of specific specialties in the NATIONAL SURGICAL SPECIALTY file. (M. Montali, PM; S. Krakosky, Tech Writer)
06/07	35, 210, 212b	SR*3*159	Updated screens to reflect change of the environmental indicator “Environmental Contaminant” to “SWAC” (e.g., SouthWest Asia). (M. Montali, PM; S. Krakosky, Tech Writer)

Date	Revised Pages	Patch Number	Description
06/07	176-180, 180a, 184c-d, 327c-d, 372, 375-376, 446, 449-450, 452-453, 455-456, 458, 461, 468, 470, 472, 479-479a, 482-484, 486a, 489, 491, 493, 495, 497, 499, 501, 502a-d, 504-506, 509-512, 519	SR*3*160	<p>Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the <i>Surgery NSQIP-CICSP Enhancements 2007 Release Notes</i>.</p> <p>Updated data entry screens to match software; changes are unrelated to this patch.</p> <p>(M. Montali, PM; S. Krakosky, Tech Writer)</p>
11/06	10-12, 14, 21-22, 139-141, 145-150, 152, 219, 438	SR*3*157	<p>Updated data entry options to display new fields for collecting sterility information for the Prosthesis Installed field; updated the Nurse Intraoperative Report section with these required new fields. For more details, see the <i>Surgery-Tracking Prosthesis Items Release Notes</i>.</p> <p>Updated data entry screens to match software; changes are unrelated to this patch.</p> <p>(M. Montali, PM; S. Krakosky, Tech Writer)</p>
08/06	6-9, 14, 109-112, 122-124, 141-149, 151-152, 176, 178-180, 180a-b, 181-184, 184a-d, 185-186, 218-219, 326-327, 327a-d, 328-329, 373, 377, 449-450, 452-456, 459, 461-462, 467-468, 468b, 469-470, 470a, 473-474, 474a-474b, 475, 477, 481-486, 486a-b, 489-502, 502a-b, 503-504, 509-512	SR*3*153	<p>Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software.</p> <p>Updated data entry options to incorporate renamed/new Hair Removal documentation fields.</p> <p>Updated the Nurse Intraoperative Report and Quarterly Report to include these fields.</p> <p>For more details, see the <i>Surgery NSQIP/CICSP Enhancements 2006 Release Notes</i>.</p> <p>(M. Montali, PM; S. Krakosky, Tech Writer)</p>
06/06	28-32, 40-50, 64-80, 101-102	SR*3*144	<p>Updated options to reflect new required fields (Attending Surgeon and Principal Preoperative Diagnosis) for creating a surgery case.</p> <p>(M. Montali, PM; S. Krakosky, Tech Writer)</p>
06/06	vi, 34-35, 125, 210, 212b, 522a-b	SR*3*152	<p>Updated Service Classification screen example to display new PROJ 112/SHAD prompt.</p> <p>This patch will prevent the PRIN PRE-OP ICD DIAGNOSIS CODE field of the Surgery file from being sent to the Patient Care Encounter (PCE) package.</p> <p>Added the new Alert Coder Regarding Coding Issues option to the Surgery Risk Assessment Menu option.</p> <p>(M. Montali, PM; S. Krakosky, Tech Writer)</p>

Date	Revised Pages	Patch Number	Description
04/06	445, 464a-b, 465, 480a-b	SR*3*146	Added the new <i>Alert Coder Regarding Coding Issues</i> option to the Assessing Surgical Risk chapter. (M. Montali, PM; S. Krakosky, Tech Writer)
04/06	6-8, 29, 31-32, 37-38, 40, 43-44, 46-48, 50, 52, 65-67, 71-73, 75-77, 79, 100, 102, 109-112, 117-120, 122-123, 125-127, 189-191, 195b, 209-212, 212a-h, 219a, 224-231, 238-242, 273-277, 311-313, 315-317, 369, 379- 392, 410, 449-464, 467-468, 468a-b, 469-470, 470a, 471-474, 474a-b, 475-479, 479a-b, 480, 483-484, 489-502, 507, 519	SR*3*142	Updated the data entry screens to reflect renaming of the Planned Principal CPT Code field and the Principal Pre-op ICD Diagnosis Code field. Updated the <i>Update/Verify Procedure/Diagnosis Coding</i> option to reflect new functionality. Updated Risk Assessment options to remove CPT codes from headers of cases displayed. Updated reports related to the coding option to reflect final CPT codes.  For more specific information on changes, see the <i>Patient Financial Services System (PFSS) – Surgery Release Notes</i> for this patch. (M. Montali, PM; S. Krakosky, Tech Writer)
10/05	9, 109-110, 144, 151, 218	SR*3*147	Updated data entry screens to reflect renaming of the Preop Shave By field to Preop Hair Clipping By field. (M. Montali, PM; S. Krakosky, Tech Writer)
08/05	10, 14, 99-100, 114, 119-120, 124, 153-154, 162-164, 164a-b, 190, 192, 209-212f, 238-242	SR*3*119	Updated the Anesthesia Data Entry Menu section (and other data entry options) to reflect new functionality for entering multiple start and end times for anesthesia. Updated examples for Referring Physician updates (e.g., capability to automatically look up physician by name). Updated the PCE Filing Status Report section. (J. Podolec, PM; B. Manies, Tech Writer)
08/04	iv-vi, 187-189, 195, 195a-195b, 196, 207-208, 219a-b, 527-528	SR*3*132	Updated the Table of Contents and Index to reflect added options. Added the new <i>Non-OR Procedure Information</i> option and the <i>Tissue Examination Report</i> option (unrelated to this patch) to the Non-OR Procedures section.
08/04	31, 43, 46, 66, 71-72, 75-76, 311	SR*3*127	Updated screen captures to display new text for ICD-9 and CPT codes.

Date	Revised Pages	Patch Number	Description
08/04	vi, 441, 443, 445-456, 458-459, 461 463, 465, 467-468, 468a-b, 469-470, 470a-b, 471, 473-474, 474a-b, 474-479, 479a-b, 480-486, 486a-b, 519, 531-534	SR*3*125	Updated the Table of Contents and Index. Clarified the location of the national centers for NSQIP and CICSIP. Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software and new options have been added. For an overview of the data entry changes, see the <i>Surgery NSQIP/CICSIP Enhancements 2004 Release Notes</i> . Added the <i>Laboratory Test Result (Enter/Edit)</i> option and the <i>Outcome Information (Enter/Edit)</i> option to the <i>Cardiac Risk Assessment Information (Enter/Edit)</i> menu section. Changed the name of the <i>Cardiac Procedures Requiring CPB (Enter/Edit)</i> option to <i>Cardiac Procedures Operative Data (Enter/Edit)</i> option. Removed the <i>Update Operations as Unrelated/Related to Death</i> option from the <i>Surgery Risk Assessment Menu</i> .
08/04	6-10, 14, 103, 105-107, 109-112, 114-120, 122-124, 141-152, 218-219, 284-287, 324, 370-377	SR*3*129	Updated examples to include the new levels for the Attending Code (or Resident Supervision). Also updated examples to include the new fields for ensuring Correct Surgery. For specific options affected by each of these updates, please see the <i>Resident Supervision/Ensuring Correct Surgery Phase II Release Notes</i> .
04/04	All	SR*3*100	All pages were updated to reflect the most recent Clinical Ancillary Local Documentation Standards and the changes resulting from the Surgery Electronic Signature for Operative Reports project, SR*3*100. For more information about the specific changes, see the patch description or the <i>Surgery Electronic Signature for Operative Reports Release Notes</i> .

SUMMARY REPORT - SURGICAL SERVICE  
VERSION 3.0

PAGE  
1

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

```

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

```

SPECIALTY PROCEDURES

```

-----
PATIENTS  CASES  MAJOR  MINOR  ---DEATHS---
-----  -----  -----  -----  -----
TOTAL    %
-----  -----
48 CARDIAC SURGERY      0      0      0      0      0  0.0
49 TRANSPLANTATION     0      0      0      0      0  0.0
50 GENERAL SURGERY     63     64     54     10     1  1.6
51 OB/GYN               7      7      7      0      0  0.0
52 NEUROSURGERY       12     14     13      1      0  0.0
53 OPHTHALMOLOGY      57     59      0     59      0  0.0
54 ORTHOPEDICS        53     56     46     10      0  0.0
55 EAR, NOSE, THROAT (ENT) 35     35     32      3      0  0.0
56 PLASTIC SURGERY     8      8      4      4      0  0.0
57 PROCTOLOGY         0      0      0      0      0  0.0
58 THORACIC SURGERY    3      3      3      0      0  0.0
59 UROLOGY            19     20     20      0      0  0.0
60 ORAL SURGERY        1      1      1      0      0  0.0
61 PODIATRY           25     25      3     22      0  0.0
62 PERIPHERAL VASCULAR 21     23     20      3      1  4.3
78 ANESTHESIOLOGY     0      0      0      0      0  0.0

```

LEVEL OF RESIDENT SUPERVISION (%)

```

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

```

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

INDEX PROCEDURES

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

PERIOPERATIVE OCCURRENCE CATEGORIES

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

Clean Wound Infection Rate: 2.1



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

=====

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

SPECIALTY PROCEDURES

	PATIENTS	CASES	MAJOR	MINOR	---DEATHS---	
	-----	-----	-----	-----	TOTAL	%
	-----	-----	-----	-----	-----	-----
48 CARDIAC SURGERY	40	40	40	0	0	0.0
49 TRANSPLANTATION	0	0	0	0	0	0.0
50 GENERAL SURGERY	140	147	147	0	4	2.7
51 OB/GYN	9	9	9	0	0	0.0
52 NEUROSURGERY	53	56	56	0	1	1.8
53 OPHTHALMOLOGY	186	208	204	4	0	0.0
54 ORTHOPEDICS	156	162	159	3	1	0.6
55 EAR, NOSE, THROAT (ENT)	90	95	93	2	0	0.0
56 PLASTIC SURGERY	40	44	44	0	0	0.0
57 PROCTOLOGY	0	0	0	0	0	0.0
58 THORACIC SURGERY	19	22	22	0	0	0.0
59 UROLOGY	279	321	102	219	3	0.9
60 ORAL SURGERY	14	14	14	0	0	0.0
61 PODIATRY	36	42	42	0	0	0.0
62 PERIPHERAL VASCULAR	39	41	41	0	1	2.4
78 ANESTHESIOLOGY	99	114	0	114	0	0.0

LEVEL OF RESIDENT SUPERVISION (%)

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

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

INDEX PROCEDURES

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

PERIOPERATIVE OCCURRENCE CATEGORIES

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

SURPATIENT,SIXTY (000-56-7821)  
JUN 23,1998 CHOLEDOCHOTOMY

Case #63592

PAGE: 1 OF 2

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

Select Preoperative Information to Edit: 1:3

SURPATIENT,SIXTY (000-56-7821)  
JUN 23,1998 CHOLEDOCHOTOMY

Case #63592

-----

GENERAL: **YES**

Patient's Height 65 INCHES//: 62  
Patient's Weight 140 POUNDS//: 175  
Diabetes Mellitus Requiring Therapy With Oral Agents or Insulin: I INSULIN  
Current Smoker: Y YES  
ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: N NO  
Dyspnea: N  
  1 NO  
  2 NO STUDY  
Choose 1-2: 1 NO  
Preoperative Sleep Apnea: LEVEL 1 LEVEL 1 - NONE  
DNR Status (Y/N): N NO  
Functional Health Status at Evaluation for Surgery: 1 INDEPENDENT

PULMONARY: NO

HEPATOBILIARY: NO

SURPATIENT,SIXTY (000-56-7821) Case #63592 PAGE: 1 OF 2  
 JUN 23,1998 CHOLEDOCHOTOMY

---

1. GENERAL: NO 3. HEPATOBILIARY: NO  
 A. Height: 62 INCHES A. Ascites: NO  
 B. Weight: 175 LBS.  
 C. Diabetes Mellitus: INSULIN 4. GASTROINTESTINAL:  
 D. Current Smoker W/I 1 Year: YES A. Esophageal Varices:  
 E. ETOH > 2 Drinks/Day: NO  
 F. Dyspnea: NO 5. CARDIAC:  
 G. Preop Sleep Apnea: LEVEL 1 A. CHF Within 1 Month:  
 H. DNR Status: NO B. MI Within 6 Months:  
 I. Preop Funct Status: INDEPENDENT C. Previous PCI:  
 D. Previous Cardiac Surgery:  
 E. Angina Within 1 Month:  
 F. Hypertension Requiring Meds:

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

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

---

Select Preoperative Information to Edit: <Enter>

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

---

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

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

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

---

Select Preoperative Information to Edit: 3E

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

---

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

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

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

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

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

---

Select Preoperative Information to Edit:

## Patient Demographics (Enter/Edit) [SROA DEMOGRAPHICS]

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



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

### Example: Entering Patient Demographics

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

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

```
-----  
Enter/Edit Patient Demographic Information
```

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

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

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

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

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

```
-----  
Enter/Edit Patient Demographic Information
```

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

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

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

---

1. Transfer Status:
2. Observation Admission Date/Time:
3. Observation Discharge Date/Time:
4. Observation Treating Specialty:
5. Hospital Admission Date/Time:
6. Hospital Discharge Date/Time:
7. Admit/Transfer to Surgical Svc.:
8. Discharge/Transfer to Chronic Care:
9. Length of Postop Hospital Stay:
10. In/Out-Patient Status: INPATIENT
11. Patient's Ethnicity: UNANSWERED
12. Patient's Race: UNANSWERED
13. Date of Death:

---

Select number of item to edit:

## Clinical Information (Enter/Edit) [SROA CLINICAL INFORMATION]

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

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

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

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

### **Example: Enter Clinical Information**

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

```
SURPATIENT,NINETEEN (000-28-7354)          Case #60183          PAGE: 1  
JUN 18,2005    CORONARY ARTERY BYPASS
```

```
-----  
1. Height:                63 in          14. Number prior heart surgeries:  
2. Weight:                170 lb         15. Prior heart surgeries:  
3. Diabetes:              16. Peripheral Vascular Disease:  
4. COPD:                  17. Cerebral Vascular Disease:  
5. FEV1:                  18. Angina (use CCS Class):  
6. Cardiomegaly (X-ray):  19. CHF (use NYHA Class):  
7. Pulmonary Rales:       20. Current Diuretic Use:  
8. Current Smoker:        21. Current Digoxin Use:  
9. Active Endocarditis:   22. IV NTG within 48 Hours:  
10. Resting ST Depression: 23. Preop Circulatory Device:  
11. Functional Status:    24. Hypertension (Y/N):  
12. PCI:                  25. Preop Atrial Fibrillation:  
13. Prior MI:  
-----
```

```
Select Clinical Information to Edit: A
```

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: 0 ORAL  
History of Severe COPD (Y/N): Y YES  
FEV1 : NS  
Cardiomegaly on Chest X-Ray (Y/N): Y YES  
Pulmonary Rales (Y/N): Y YES  
Current Smoker: 2 WITHIN 2 WEEKS OF SURGERY  
Active Endocarditis (Y/N): N NO  
Resting ST Depression (Y/N): N NO  
Functional Status: I INDEPENDENT  
PCI: 0 NONE  
Prior Myocardial Infarction: 1 LESS THAN OR EQUAL TO 7 DAYS PRIOR TO SURGERY  
Number of Prior Heart Surgeries: 1 1

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1  
JUN 18,2005 CORONARY ARTERY BYPASS

-----  
Prior heart surgeries:

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

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

Peripheral Vascular Disease (Y/N): Y YES  
Cerebral Vascular Disease (Y/N): N NO  
Angina (use CCS Functional Class): IV CLASS IV  
Congestive Heart Failure (use NYHA Functional Class): II SLIGHT LIMITATION  
Current Diuretic Use (Y/N): Y YES  
Current Digoxin Use (Y/N): N NO  
IV NTG within 48 Hours Preceding Surgery (Y/N): Y YES  
Preop use of circulatory Device: N NONE  
History of Hypertension (Y/N): Y YES  
Preoperative Atrial Fibrillation: N NO

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1  
JUN 18,2005 CORONARY ARTERY BYPASS

-----  
1. Height: 76 in 14. Number prior heart surgeries: 1  
2. Weight: 210 lb 15. Prior heart surgeries: VALVE-ONLY  
3. Diabetes: ORAL 16. Peripheral Vascular Disease: YES  
4. COPD: YES 17. Cerebral Vascular Disease: NO  
5. FEV1: NS 18. Angina (use CCS Class): IV  
6. Cardiomegaly (X-ray): YES 19. CHF (use NYHA Class): II  
7. Pulmonary Rales: YES 20. Current Diuretic Use: YES  
8. Current Smoker: WITHIN 2 WEEKS OF S 21. Current Digoxin Use: NO  
9. Active Endocarditis: NO 22. IV NTG within 48 Hours: YES  
10. Resting ST Depression: NO 23. Preop Circulatory Device: NONE  
11. Functional Status: INDEPENDENT 24. Hypertension (Y/N): YES  
12. PCI: NONE 25. Preop Atrial Fibrillation: NO  
13. Prior MI: < OR = 7 DAYS

-----  
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) Case #60183 PAGE: 1  
PREOPERATIVE LABORATORY RESULTS  
JUN 18,2005 CORONARY ARTERY BYPASS

-----  
1. HDL: NS  
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 Alc: NS  
11. BNP: NS  
-----

Select Laboratory Information to Edit: 1

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1  
PREOPERATIVE LABORATORY RESULTS  
JUN 18,2005 CORONARY ARTERY BYPASS

-----  
HDL (mg/dl): NS// 177  
HDL, Date: JAN, 2005 (JAN 2005)

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1  
PREOPERATIVE LABORATORY RESULTS  
JUN 18,2005 CORONARY ARTERY BYPASS

-----  
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 Alc: NS  
11. BNP: NS  
-----

Select Laboratory Information to Edit:

## Operative Risk Summary Data (Enter/Edit) [SROA CARDIAC OPERATIVE RISK]

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

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

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

### Example: Operative Risk Summary Data

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

```
SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1
JUN 18,2005 CORONARY ARTERY BYPASS
>> Coding Complete <<
```

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

This information cannot be edited.

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

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

```
-----
Physician's Preoperative Estimate of Operative Mortality: 78
// 32
Date/Time of Estimate of Operative Mortality: JUN 17, 2005@18:15
// <Enter>
ASA Class: 1-NO DISTURB.// 3 3 3-SEVERE DISTURB.
Cardiac Surgical Priority: ?
Enter the surgical priority that most accurately reflects the acuity of
patient's cardiovascular condition at the time of transport to the
operating room.
Choose from:
1 ELECTIVE
2 URGENT
3 EMERGENT (ONGOING ISCHEMIA)
4 EMERGENT (HEMODYNAMIC COMPROMISE)
5 EMERGENT (ARREST WITH CPR)
Cardiac Surgical Priority: 3 EMERGENT (ONGOING ISCHEMIA)
Date/Time of Cardiac Surgical Priority: JUN 18,2005@13:29 (JUN 18, 2005@13:29)
```

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1  
JUN 18,2005 CORONARY ARTERY BYPASS  
>> Coding Complete <<

-----  
1. Physician's Preoperative Estimate of Operative Mortality: 32%  
A. Date/Time Collected: JUN 18,2005 18:15  
2. ASA Classification: 3-SEVERE DISTURB.  
3. Surgical Priority: EMERGENT (ONGOING ISCHEMIA)  
A. Date/Time Collected: JUN 18,2005 13:29  
4. Preoperative Risk Factors: NONE  
5. CPT Codes (view only): 33510

\*\*\* NOTE: D/Time of Surgical Priority should be < the D/Time Patient in OR.\*\*\*  
-----

Select Operative Risk Summary Information to Edit:

---

The Surgery software performs data checks on the following fields:

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



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

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

---

## Cardiac Procedures Operative Data (Enter/Edit) [SROA CARDIAC PROCEDURES]

The *Cardiac Procedures Operative Data (Enter/Edit)* option is used to enter or edit information related to cardiac procedures requiring cardiopulmonary bypass (CPB). The software will present two pages. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the <Enter> key will advance the user to another option.

### About the "Select Operative Information to Edit:" prompt

At this prompt, the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items. You can also use number-letter combinations, such as **11B**, to update a field within a group, such as VSD Repair.

Each prompt at the category level allows for an entry of **YES** or **NO**. If **NO** is entered, each item under that category will automatically be answered **NO**. On the other hand, responding **YES** at the category level allows the user to respond individually to each item under the main category.

Entry of **N** shall allow the user to **Set All to No** for the Cardiac Procedures fields. A verification prompt will follow to ensure that user understands the entry.

Fields that do not have YES/NO responses will be updated as follows.

- Items #1-#5 are numeric and their values will be set to 0.
- Valve Procedures will be set to NONE
- #13 Maze Procedure will be set to NO MAZE PERFORMED

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

### Example: Enter Cardiac Procedures Operative Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CARD Cardiac Pr  
ocedures Operative Data (Enter/Edit)
```

```
SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 OF 2  
JUN 18,2005 CORONARY ARTERY BYPASS
```

```
-----  
Cardiac surgical procedures with or without cardiopulmonary bypass  
CABG distal anastomoses: 13. Maze procedure:  
1. Number with vein: 14. ASD repair:  
2. Number with IMA: 15. VSD repair:  
3. Number with Radial Artery: 16. Myectomy for IHSS:  
4. Number with Other Artery: 17. Myxoma resection:  
5. Number with Other Conduit: 18. Other tumor resection:  
19. Cardiac transplant:  
6. LV Aneurysmectomy: 20. Great Vessel Repair:  
7. Bridge to transplant/Device: 21. Endovascular Repair:  
8. TMR: 22. Other cardiac procedures:  
  
9. Aortic Valve Procedure:  
10. Mitral Valve Procedure:  
11. Tricuspid Valve Procedure:  
12. Pulmonary Valve Procedure:  
-----
```

```
Select Cardiac Procedures Operative Information to Edit: A
```

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

-----  
CABG Distal Anastomoses with Vein: **1**  
CABG Distal Anastomoses with IMA: **1**  
Number with Radial Artery: **0**  
Number with Other Artery: **1**  
CABG Distal Anastomoses with Other Conduit: **1**  
LV Aneurysmectomy (Y/N): **N** NO

Device for bridge to cardiac transplant / Destination therapy: **??**

CICSP Definition (2006):

Indicate if patient received a mechanical support device (excluding IABP) as a bridge to cardiac transplant during the same admission as the transplant procedure; or patient received the device as destination therapy (does not intend to have a cardiac transplant), either with or without placing the patient on cardiopulmonary bypass.

Choose from:

Y YES  
N NO

Device for bridge to cardiac transplant / Destination therapy: **N** NO

Transmyocardial Laser Revascularization: **N** NO

Aortic Valve Procedure: **??**

VASQIP Definition (2010):

Indicate if the patient had an aortic valve replacement (either the native or a prosthetic valve) or a repair (on the native valve to relieve stenosis and/or correct regurgitation -annuloplasty, commissurotomy, etc.); performed with or without additional procedure(s); either with or without placing the patient on cardiopulmonary bypass. (If a repair was attempted, but a replacement occurred, indicate the details of the replacement valve.) Indicate the one most appropriate procedure:

- \* None
- \* Mechanical Valve
- \* Stented Bioprosthetic Valve
- \* Stentless Bioprosthetic Valve
- \* Homograft
- \* Primary Valve Repair
- \* Primary Valve Repair and Annuloplasty Device
- \* Annuloplasty Device alone
- \* Autograft Procedure (Ross Procedure)
- \* Other

Choose from:

N NONE  
M MECHANICAL  
S STENTED BIOPROSTHETIC  
B STENTLESS BIOPROSTHETIC  
H HOMOGRAFT  
PR PRIMARY REPAIR  
PA PRIMARY REPAIR & ANNULOPLASTY DEVICE  
AN ANNULOPLASTY DEVICE ALONE  
AU AUTOGRAFT (ROSS)  
O OTHER

Aortic Valve Procedure: **PR** PRIMARY REPAIR

Mitral Valve Procedure: **N** NONE

Tricuspid Valve Procedure: **N** NONE

Pulmonary Valve Procedure: **N** NONE

Maze Procedure: **N** NO MAZE PERFORMED

ASD Repair (Y/N): **N** NO

VSD Repair (Y/N): **N** NO

Myectomy for IHSS (Y/N): **N** NO

Myxoma Resection (Y/N): **N** NO

Other Tumor Resection (Y/N): **N** NO

Cardiac Transplant (Y/N): **N** NO

Great Vessel Repair (Y/N): **N** NO

Endovascular Repair of Aorta: **N** NO

Other Cardiac Procedures (Y/N): **N** NO

-----  
Cardiac surgical procedures with or without cardiopulmonary bypass  
CABG distal anastomoses:  
1. Number with vein: 1 13. Maze procedure: NO MAZE PERFORMED  
2. Number with IMA: 1 14. ASD repair: NO  
3. Number with Radial Artery: 0 15. VSD repair: NO  
4. Number with Other Artery: 1 16. Myectomy for IHSS: NO  
5. Number with Other Conduit: 1 17. Myxoma resection: NO  
18. Other tumor resection: NO  
6. LV Aneurysmectomy: NO 19. Cardiac transplant: NO  
7. Bridge to transplant/Device: NO 20. Great Vessel Repair: NO  
8. TMR: NO 21. Endovascular Repair: NO  
22. Other cardiac procedures: NO  
9. Aortic Valve Procedure: PRIMARY REPAIR  
10. Mitral Valve Procedure: NONE  
11. Tricuspid Valve Procedure: NONE  
12. Pulmonary Valve Procedure: NONE  
-----

Select Operative Information to Edit: <Enter>

-----  
Indicate other cardiac procedures only if done with cardiopulmonary bypass  
-----

1. Foreign Body Removal:
2. Pericardiectomy:

Other Operative Data details:  
-----

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

Select Operative Information to Edit:

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

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

### Example: Enter Outcome Information

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

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

-----  
0. Operative Death: NO

Perioperative (30 day) Occurrences:

1. Perioperative MI:	NO	8. Repeat cardiac surg procedure:	NO
2. Endocarditis:	NO	9. Tracheostomy:	YES
3. Renal failure require dialysis:	NO	10. Repeat ventilator w/in 30 days:	YES
4. Mediastinitis:	YES	11. Stroke:	NO
5. Cardiac arrest requiring CPR:	YES	12. Coma >= 24 hr:	NO
6. Reoperation for bleeding:	NO	13. New Mech Circ Support:	YES
7. On ventilator >= 48 hr:	NO	14. Postop Atrial Fibrillation:	NO

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

Enter NONE, ON BYPASS, or OFF BYPASS.

0 None  
1 On-bypass  
2 Off-bypass

Cardiopulmonary Bypass Status: **1** On-bypass

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

-----  
0. Operative Death: NO

Perioperative (30 day) Occurrences:

1. Perioperative MI:	NO	8. Repeat cardiac surg procedure:	YES
2. Endocarditis:	NO	9. Tracheostomy:	YES
3. Renal failure require dialysis :	NO	10. Repeat ventilator w/in 30 days:	YES
4. Mediastinitis:	YES	11. Stroke:	NO
5. Cardiac arrest requiring CPR:	YES	12. Coma >= 24 hr:	NO
6. Reoperation for bleeding:	NO	13. New Mech Circ Support:	YES
7. On ventilator >= 48 hr:	NO	14. Postop Atrial Fibrillation:	NO

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

- 
- |  |                    |
|--|--------------------|
| 1. Hospital Admission Date:            | FEB 11, 2007@15:39 |
| 2. Hospital Discharge Date:            | FEB 16, 2007@13:44 |
| 3. Cardiac Catheterization Date:       |                    |
| 4. Time Patient In OR:                 | FEB 12, 2007@06:30 |
| 5. Date/Time Operation Began:          | FEB 12, 2007@06:40 |
| 6. Date/Time Operation Ended:          | FEB 12, 2007@08:30 |
| 7. Time Patient Out OR:                | FEB 12, 2007@08:40 |
| 8. Date/Time Patient Extubated:        |                    |
| 9. Date/Time Discharged from ICU:      | FEB 16, 2007@13:44 |
| 10. Homeless:                          | NO                 |
| 11. Surg Performed at Non-VA Facility: | NO                 |
| 12. Resource Data Comments:            |                    |
| 13. Employment Status Preoperatively:  | EMPLOYED PART TIME |

-----  
Select Resource Information to Edit:

```
Employment Status Preoperatively: EMPLOYED FULL TIME// ?
Enter the patient's employment status preoperatively.
Choose from:
1      EMPLOYED FULL TIME
2      EMPLOYED PART TIME
3      NOT EMPLOYED
4      SELF EMPLOYED
5      RETIRED
6      ACTIVE MILITARY DUTY
9      UNKNOWN
Employment Status Preoperatively: 3 NOT EMPLOYED
```

```
SURPATIENT,TEN (000-12-3456)      Case #49413
OCT 18,2007  CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD
```

```
-----
1. Hospital Admission Date:      FEB 11, 2007@15:39
2. Hospital Discharge Date:     FEB 16, 2007@13:44
3. Cardiac Catheterization Date:
4. Time Patient In OR:         FEB 12, 2007@06:30
5. Date/Time Operation Began:   FEB 12, 2007@06:40
6. Date/Time Operation Ended:   FEB 12, 2007@08:30
7. Time Patient Out OR:        FEB 12, 2007@08:40
8. Date/Time Patient Extubated:
9. Date/Time Discharged from ICU: FEB 16, 2007@13:44
10. Homeless:                  NO
11. Surg Performed at Non-VA Facility: NO
12. Resource Data Comments:
13. Employment Status Preoperatively: NOT EMPLOYED
```

```
-----
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          05-07-23      000777777      NO      NSC VET
ERAN

SURPATIENT,FORTY  000-77-7777

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

Select Surgical Case: 2

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

-----printout follows-----
```



## Example 2: Print Surgery Risk Assessment for a Cardiac Case

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

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

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

SURPATIENT,NINE 000-34-5555

1. 07-01-06 \* CABG X3 (1A,2V), ARTERIAL GRAFTING (TRANSMITTED)
2. 03-27-05 INGUINAL HERNIA (TRANSMITTED)
3. 07-03-04 PULMONARY LOBECTOMY (TRANSMITTED)

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

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

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

VA CONTINUOUS IMPROVEMENT IN CARDIAC SURGERY PROGRAM (CICSP/CICSP-X)

I. IDENTIFYING DATA

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

II. CLINICAL DATA

Gender: MALE Prior MI: < OR = 7 DAYS OF SURG  
 Age: 56 # of prior heart surgeries: 1  
 Height: 76 in Prior heart surgeries: Valve-only  
 Weight: 210 lb Peripheral Vascular Disease: YES  
 Diabetes: ORAL Cerebral Vascular Disease: NO  
 COPD: YES Angina (use CCS Class): IV  
 FEV1: NS CHF (use NYHA Class): II  
 Cardiomegaly (X-ray): YES Current Diuretic Use: YES  
 Pulmonary Rales: YES Current Digoxin Use: NO  
 Current Smoker: WITHIN 2 WEEKS OF SURG IV NTG 48 Hours Preceding Surgery: YES  
 Active Endocarditis: NO Preop Circulatory Device: NONE  
 Resting ST Depression: NO Hypertension: YES  
 Functional Status: INDEPENDENT Preoperative Atrial Fibrillation: NO  
 PCI: None

III. DETAILED LABORATORY INFO - PREOPERATIVE VALUES

Creatinine:	mg/dl (NS)	T. Cholesterol:	mg/dl (NS)
Hemoglobin:	mg/dl (NS)	HDL:	mg/dl (NS)
Albumin:	g/dl (NS)	LDL:	mg/dl (NS)
Triglyceride:	mg/dl (NS)	Hemoglobin Alc:	% (NS)
Potassium:	mg/L (NS)	BNP:	mg/dl (NS)
T. Bilirubin:	mg/dl (NS)		

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA

Cardiac Catheterization Date: 06/28/06

Procedure:	NS	Native Coronaries:	
LVEDP:	NS	Left Main Stenosis:	NS
Aortic Systolic Pressure:	NS	LAD Stenosis:	NS
		Right Coronary Stenosis:	NS
For patients having right heart cath:		Circumflex Stenosis:	NS
PA Systolic Pressure:	NS		
PAW Mean Pressure:	NS	If a Re-do, indicate stenosis in graft to:	
		LAD:	NS
		Right coronary (include PDA):	NS
		Circumflex:	NS

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

Mitral Regurgitation: NS  
 Aortic stenosis: NS

V. OPERATIVE RISK SUMMARY DATA

Physician's Preoperative  
 Estimate of Operative Mortality: NS 07/28/06 15:30)  
 ASA Classification: 3-SEVERE DISTURB.  
 Surgical Priority: ELECTIVE 07/28/06 15:31)  
 Principal CPT Code: 33517  
 Other Procedures CPT Codes: 33510  
 Preoperative Risk Factors:

SURPATIENT,NINE 000-34-5555

=====

VI. OPERATIVE DATA

Cardiac surgical procedures with or without cardiopulmonary bypass

CABG distal anastomoses:		Maze procedure:	NO MAZE PERFORMED
Number with Vein:	1	ASD repair:	NO
Number with IMA:	1	VSD repair:	NO
Number with Radial Artery:	0	Myectomy for IHSS:	NO
Number with Other Artery:	1	Myxoma resection:	NO
Number with Other Conduit:	1	Other tumor resection:	NO
LV Aneurysmectomy:	NO	Cardiac transplant:	NO
Bridge to transplant/Device:	NO	Great Vessel Repair:	NO
TMR:	NO	Endovascular Repair:	NO
		Other Cardiac procedure(s):	NO

Aortic Valve Procedure: PRIMARY REPAIR

Mitral Valve Procedure: NONE

Tricuspid Valve Procedure: NONE

Pulmonary Valve Procedure: NONE

\* Other Cardiac procedures (Specify):

Indicate other cardiac procedures only if done with cardiopulmonary bypass

Foreign body removal: YES

Pericardiectomy: YES

Other Operative Data details

Total CPB Time: 85 min Total Ischemic Time: 60 min

Incision Type: FULL STERNOTOMY

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

VII. OUTCOMES

Operative Death: NO Date of Death:

Perioperative (30 day) Occurrences:

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

VIII. RESOURCE DATA

Hospital Admission Date:	06/30/06 06:05
Hospital Discharge Date:	07/10/06 08:50
Time Patient In OR: 07/10/06 10:00	Operation Began: 07/01/06 10:10
Operation Ended: 07/10/06 12:30	Time Patient Out OR: 07/01/06 12:20
Date and Time Patient Extubated:	07/10/06 13:13
Postop Intubation Hrs: +1.9	
Date and Time Patient Discharged from ICU:	07/10/06 08:00
Patient is Homeless:	NS
Cardiac Surg Performed at Non-VA Facility:	UNKNOWN
Resource Data Comments:	

=====

IX. SOCIOECONOMIC, ETHNICITY, AND RACE

Employment Status Preoperatively:	SELF EMPLOYED
Ethnicity:	NOT HISPANIC OR LATINO
Race Category(ies):	AMERICAN INDIAN OR ALASKA NATIVE, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, WHITE

X. DETAILED DISCHARGE INFORMATION

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

Type of Disposition: TRANSFER

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

Primary care or referral VAMC identification code: 526

Follow-up VAMC identification code: 526

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

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





# Risk Model Lab Test

## [SROA LAB TEST EDIT]

In order to assist the nurse reviewer, in the *Surgery Risk Assessment Menu* is the *Risk Model Lab Test (Enter/Edit)* option, which allows the nurse to map NSQIP-CICSP data in the RISK MODEL LAB TEST file (#139.2). The option synonym is ERM.

```
Risk Model Lab Test (Enter/Edit)
Select Surgery Risk Assessment Menu Option: Risk Model Lab Test (Enter/Edit)
```

```

Risk Model Lab Test (Enter/Edit)

Select item to edit from list below:

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

Enter number (1-25): 6
```

```

Risk Model Lab Test (Enter/Edit)

Test Name: CHOLESTEROL

Laboratory Data Name(s): NONE ENTERED

Specimen: SERUM

Do you want to edit this test ? NO// YES

Select LABORATORY DATA NAME: CHOLESTEROL
1 CHOLESTEROL
2 CHOLESTEROL CRYSTALS
CHOOSE 1-2: 1 CHOLESTEROL
Select LABORATORY DATA NAME: <Enter>
Specimen: SERUM// <Enter>
```



Risk Model Lab Test (Enter/Edit)

Select item to edit from list below:

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

Enter number (1-26):