



# **SURGERY**

## **USER MANUAL**

Version 3.0

July 1993

(Revised April 2008)







# 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
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)
06/07	176-180, 180a, 184c-d, 327c-d, 372, 375-376, 446, 449-450, 452-453, 455-456, 458, 461, 468, 470, 472, 479-479a, 482-484, 486a, 489, 491, 493, 495, 497, 499, 501, 502a-d, 504-506, 509-512, 519	SR*3*160	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the <i>Surgery NSQIP-CICSP Enhancements 2007 Release Notes</i> .  Updated data entry screens to match software; changes are unrelated to this patch. (M. Montali, PM; S. Krakosky, Tech Writer)

Date	Revised Pages	Patch Number	Description
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. (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>. (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. (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 <i>Alert Coder Regarding Coding Issues</i> option to the Surgery Risk Assessment Menu option. (M. Montali, PM; S. Krakosky, Tech Writer)</p>
04/06	445, 464a-b, 465, 480a-b	SR*3*146	<p>Added the new <i>Alert Coder Regarding Coding Issues</i> option to the Assessing Surgical Risk chapter. (M. Montali, PM; S. Krakosky, Tech Writer)</p>

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### Example: Option displayed with discrepancies

```
Select Operation Menu Option: BLOOD PRODUCT VERIFICATION

To use BAR CODE READER
    Pass reader wand over a GROUP-TYPE ( ABO/Rh) label
    =>
Enter Blood Product Identifier: KW10945

1) Unit ID: KW10945                CPDA-1 RED BLOOD CELLS
   Patient: SURPATIENT,FOURTEEN 000-45-7212      Expiration Date: NOV 27,1997

2) Unit ID: KW10945                FRESH FROZEN PLASMA, ACD-A
   Patient: SURPATIENT,FOURTEEN 000-45-7212      Expiration Date: MAY 19,1998

3) Unit ID: KW10945                PLATELETS, POOLED, IRRADIATED
   Patient: SURPATIENT,FOURTEEN 000-45-7212      Expiration Date: MAR 24,1998

Select the blood product matching the unit label: (1-3): 3

                **WARNING**

Blood Product Expiration Date is later than today's date.
```

## Anesthesia Menu [SROANES1]



The *Anesthesia Menu* is restricted to Anesthesia personnel and is locked with the SROANES key. It is designed for the convenient entry of data pertaining to the anesthesia agents and techniques used in a surgery.

The main options included in this menu are listed below. The *Anesthesia Data Entry Menu* contains sub-options. To the left of the option name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
E	<i>Anesthesia Data Entry Menu</i>
R	<i>Anesthesia Report</i>
S	<i>Schedule Anesthesia Personnel</i>

## Prerequisites

To use the *Anesthesia Data Entry Menu* or the *Anesthesia Report* option, the user must first select a patient case. The user must select an operating room to use the *Schedule Anesthesia Personnel* option.

## **Anesthesia Technique (Enter/Edit)** **[SROMEN-ANES TECH]**

The *Anesthesia Technique (Enter/Edit)* option is used to enter information concerning the anesthesia technique. More than one anesthesia technique can be entered for a case. When the user is finished entering the first technique, he or she should select this option again to start entering another anesthesia technique.

The Surgery software recognizes the following different anesthesia techniques, each with different sets of prompts.

G	<i>GENERAL</i>
M	<i>MONITORED ANESTHESIA CARE</i>
S	<i>SPINAL</i>
E	<i>EPIDURAL</i>
O	<i>OTHER</i>
L	<i>LOCAL</i>
R	<i>REGIONAL</i>

Another choice for an anesthesia technique is NO ANESTHESIA. This selection does not include any additional prompts.

### **About the prompts**

"Diagnostic/ Therapeutic (Y/N):" The user should answer **Y** or **YES** if the anesthesia procedure is itself a surgical procedure. The user will then have an opportunity to define the surgical (operative) procedure.

"Is this the Principal Technique (Y/N):" This prompt asks the user whether or not the technique being entered is the primary anesthesia technique for the case. For the technique being entered to appear on the Anesthesia AMIS Report, answer this prompt with a **Y** or **YES**.

"Select ANESTHESIA AGENTS:" The user can enter more than one anesthesia agent for a case by using the up-arrow (^) to jump to the "Select ANESTHESIA AGENTS:" prompt.

### Example 1: General Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: G (GENERAL)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): Y YES
  Trauma Resulting from Intubation Process: NONE// <Enter> NONE
  Select ANESTHESIA AGENTS: ?
```

More than one anesthesia agent may be entered for each technique.



The ANESTHESIA AGENT field uses entries from the institution's local DRUG file. Prior to using the Surgery package, drugs that will be used as anesthesia agents must be flagged (using the Chief of Surgery Menu) by the user's package coordinator. If the user experiences problems entering an agent, it is likely that the drug being chosen has not been flagged.

```
Select ANESTHESIA AGENTS: ENFLURANE
  Dose (mg): <Enter>
Approach Technique: D DIRECT VISION LARYNGOSCOPY
Endotracheal Tube Route: O ORAL
Type of Laryngoscope: M MACINTOSH
Laryngoscope Size: 3
Was a Stylet Used ? (Y/N): Y YES
Was Topical Lidocaine Used ? (Y/N): Y YES
Was Intravenous Lidocaine Administered ? (Y/N): N NO
Type of Endotracheal Tube: P PVC LOW PRESSURE
Endotracheal Tube Size: 3
Location where the Endotracheal Tube was Removed: O OR
Who Removed the Endotracheal Tube ? : SURANESTHETIST,SIX
Was Reintubation Required within 8 Hours ? (Y/N): N NO
Was a Heat and Moisture Exchanger Used ? (Y/N): N NO
Was a Bacterial Filter Used ? (Y/N): N NO
Oral-Pharyngeal (OP) Score: 1 CLASS 1
Mandibular Space (length in mm): 65
Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// No (No Editing)
GENERAL COMMENTS:
  1> <Enter>
```

### Example 2: Monitored Anesthesia Care Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: M (MONITORED ANESTHESIA CARE)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: VALIUM
  Dose (mg): 5
Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
Mandibular Space (length in mm): 65// <Enter>
Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0//NO (No Editing)
GENERAL COMMENTS:
  1> <Enter>
```

### Example 3: Spinal Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: S (SPINAL)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: PONTOCAINE
  Dose (mg): 5
  Was the Catheter placed for Continuous Administration ? (Y/N): NO
  // <Enter> NO
  Baricity: 1// <Enter> HYPERBARIC
  Puncture Site: 2 L3-4
  Needle Size: 25G 25G
  Neurodermatone Anesthesia Sensory Level: T6 T6
  Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
  Mandibular Space (length in mm): 65// <Enter>
  Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
  GENERAL COMMENTS:
  1><Enter>
```

### Example 4: Epidural Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: E (EPIDURAL)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: LIDOCAINE
  Dose (mg): 5
  Was the Catheter placed for Continuous Administration ? (Y/N): YES
  // <Enter> YES
  Puncture Site: 2 L3-4
  Dural Puncture ? (Y/N): NO// Y YES
  Who Removed the Catheter ? : 213 SURANESTHETIST,SIX
  Date/Time that the Catheter was Removed: 5/4@2:30 (MAY 04, 1999@14:30)
  Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
  Mandibular Space (length in mm): 65// <Enter>
  Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
  GENERAL COMMENTS:
  1>LOSS OF RESISTANCE TECHNIQUE
  2><Enter>
  EDIT Option: <Enter>
```

### Example 5: Other Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: O (OTHER)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: LIDOCAINE
  Dose (mg): 5
  Select BLOCK SITE: ABDOMINAL WALL Y4300
  ARE YOU ADDING 'ABDOMINAL WALL' AS A NEW BLOCK SITE (THE 1ST FOR THIS ANESTHESIA TECHNIQUE)? Y
  (YES)
  Length of Needle (cm): 3
  Gauge Size of the Needle: 22
  Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
  Mandibular Space (length in mm): 65// <Enter>
  Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
  GENERAL COMMENTS:
  1> <Enter>
```

### Example 6: Local Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <Enter>
Select ANESTHESIA TECHNIQUE: L (LOCAL)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: LIDOCAINE
    Dose (mg): 5
  Select BLOCK SITE: OROPHARYNX 60200
  ARE YOU ADDING 'OROPHARYNX' AS A NEW BLOCK SITE (THE 1ST FOR THIS ANESTHESIA TECHNIQUE)? Y
  (YES)
    Length of Needle (cm): <Enter>
    Gauge Size of the Needle: <Enter>
  Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
  Mandibular Space (length in mm): 65// <Enter>
  Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
  GENERAL COMMENTS:
  1>
```

### Example 7: Regional Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO//
Select ANESTHESIA TECHNIQUE: LOCAL// R (R REGIONAL)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N NO
  Select ANESTHESIA AGENTS: LIDOCAINE
    Dose (mg): 5
  Select BLOCK SITE: OROPHARYNX 60200
  ARE YOU ADDING 'OROPHARYNX' AS A NEW BLOCK SITE (THE 1ST FOR THIS ANESTHESIA TECHNIQUE)? Y
  (YES)
    Length of Needle (cm): <Enter>
    Gauge Size of the Needle: <Enter>
  Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
  Mandibular Space (length in mm): 65// <Enter>
  Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
  GENERAL COMMENTS:
  1>
```



Page 171 has been deleted. The *Anesthesia AMIS* option has been removed.

Page 172 has been deleted. The Anesthesia AMIS option has been removed.

MAYBERRY, NC  
 SURGICAL SERVICE  
 CIRCULATING NURSE STAFFING REPORT  
 FROM: MAR 2,2001 TO: MAR 31,2001

PAGE: 1  
 REVIEWED BY:  
 DATE REVIEWED:  
 DATE PRINTED: APR 21,2001

DATE CASE #	PATIENT ID#	OPERATION(S)	SCRUB NURSE	CIRC. NURSE	TIME IN TIME OUT ELAPSED (MINS)
*****					
** SURNURSE, SEVEN **					
03/10/01 189	SURPATIENT, FIFTYONE 000-23-3221	DRAINAGE OF OVARIAN CYST	SURNURSE, THREE	SURNURSE, SEVEN	07:00 08:54 114
** SURNURSE, ONE **					
03/09/01 187	SURPATIENT, NINE 000-34-5555	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	SURNURSE, THREE	SURNURSE, ONE	09:15 12:40 205
03/10/01 200	SURPATIENT, FIFTY 000-45-9999	HEMORRHOIDECTOMY	SURNURSE, THREE	SURNURSE, ONE	14:00 14:55 55
03/17/01 203	SURPATIENT, FOURTEEN 000-45-7212	CHOLECYSTECTOMY	SURNURSE, THREE	SURNURSE, ONE	12:55 14:30 95
03/18/01 202	SURPATIENT, SEVENTEEN 000-45-5119	REPAIR INCARCERATED INGUINAL HERNIA	SURNURSE, THREE SURNURSE, SEVEN	SURNURSE, ONE	07:30 09:03 93
** SURNURSE, TWO **					
03/03/01 205	SURPATIENT, SIXTY 000-56-7821	REMOVE CATARACTS, RETRO BULBAR BLOCK	SURNURSE, THREE	SURNURSE, TWO	09:00 09:20

## Anesthesia Reports

### [SR ANESTH REPORTS]

The *Anesthesia Reports* menu provides options for printing various anesthesia reports.

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

Shortcut	Option Name
P	<i>List of Anesthetic Procedures</i>
D	<i>Anesthesia Provider Report</i>

Page 297 has been deleted. The *Anesthesia AMIS* option has been removed.

Page 298 has been deleted. The *Anesthesia AMIS* option has been removed.

# Surgery Risk Assessment Menu

## [SROA RISK ASSESSMENT]

The *Surgery Risk Assessment Menu* option provides the designated Surgical Clinical Nurse Reviewer with on-line access to medical information. The menu options provide the opportunity to edit, list, print, and update an existing assessment for a patient or to enter information concerning a new risk assessment.



This option is locked with the SR RISK ASSESSMENT key.

This chapter follows the main menu of the Risk Assessment module and contains descriptions of the options and sub-options needed to maintain a Risk Assessment, transmit data, and create reports. The options are organized to follow a logical workflow sequence. Each option description is divided into two main parts: an overview and a detailed example.

The top-level options included in this menu are listed in the following table. To the left is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
N	<i>Non-Cardiac Assessment Information (Enter/Edit) ...</i>
C	<i>Cardiac Risk Assessment Information (Enter/Edit) ...</i>
P	<i>Print a Surgery Risk Assessment</i>
U	<i>Update Assessment Completed/Transmitted in Error</i>
L	<i>List of Surgery Risk Assessments</i>
F	<i>Print 30 Day Follow-up Letters</i>
R	<i>Exclusion Criteria (Enter/Edit)</i>
M	<i>Monthly Surgical Case Workload Report</i>
V	<i>M&amp;M Verification Report</i>
O	<i>Update 1-Liner Case</i>
T	<i>Queue Assessment Transmissions</i>
CODE	<i>Alert Coder Regarding Coding Issues</i>
ERM	<i>Risk Model Lab Test (Enter/Edit)</i>

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



## Editing an Incomplete Risk Assessment

To edit an incomplete risk assessment, the user can either select the assessment by patient or by surgery case number.

### Example: Using the Select by Case Number Function to Edit an Incomplete Assessment

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

```
Select Patient: #210
```

```
SURPATIENT,TEN 000-12-3456
```

```
03-22-02      HIP REPLACEMENT (INCOMPLETE)
```

1. Enter Risk Assessment Information
2. Delete Risk Assessment Entry
3. Update Assessment Status to 'COMPLETE'

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

```
Division: ALBANY (500)
```

```
SURPATIENT,TEN 000-12-3456 Case #210 - MAR 22,2002
```

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

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: PRE
```

These options are described in the following sections.

## Preoperative Information (Enter/Edit) [SROA PREOP DATA]

The *Preoperative Information (Enter/Edit)* option is used to enter or edit preoperative assessment information. The software will present two pages. At the bottom of each page is a prompt to select one or more preoperative items to edit. If the user does not want to edit any items on the page, pressing the <Enter> key will advance to the next page or, if the user is already on page two, will exit the option.

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

At this prompt the user enters the item number he or she wishes 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 (:). Number-letter combinations can also be used, such as **2C**, to update a field within a group, such as CURRENT PNEUMONIA.

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.

For instance, if number **2** is chosen, and the "PULMONARY:" prompt is answered **YES**, the user will be asked if the patient is ventilator dependent, has a history of COPD, and has pneumonia. If the "PULMONARY:" prompt is answered **NO**, the software will place a **NO** response in all the fields of the Pulmonary group. The majority of the prompts in this option are designed to accept the letters **Y**, **N**, or **NS** for **YES**, **NO**, and **NO STUDY**.

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.

This functionality allows the nurse reviewer to duplicate preoperative information from an earlier operation within 60 days of the date of operation on the same patient.

### **Example 1: Enter/Edit Preoperative Information**

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: PRE Preoperative  
Information (Enter/Edit)
```

```
This patient had a previous non-cardiac operation on APR 28,1998@09:00
```

```
Case #63592 CHOLEDOCHOTOMY
```

```
Do you want to duplicate the preoperative information from the earlier assessment in this  
assessment? YES// NO
```

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

Case #63592

PAGE: 1 OF 2

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

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  
DNR Status (Y/N): **N** NO  
Functional Health Status at Evaluation for Surgery: **1** INDEPENDENT

PULMONARY: **NO**

HEPATOBILIARY: **NO**

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

Case #63592

PAGE: 1 OF 2

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

Select Preoperative Information to Edit: <Enter>

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

Case #63592

PAGE: 2 OF 2

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

Select Preoperative Information to Edit: 3E

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

Case #63592

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

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

Case #63592

PAGE: 2 OF 2

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

Select Preoperative Information to Edit:

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:
14. Date Surgery Consult Requested:
15. Surgery Consult Date: JAN 12, 2005

---

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**

NSQIP Definition (2006):

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

CICSP Definition (2004):

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

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

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

-----

1. Occurrence: CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Occurrence Comments:

-----

Select Occurrence Information: **4:5**

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

-----

Type of Treatment Instituted: **CPR**  
Outcome to Date: **I IMPROVED**

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

The *Operative Risk Summary Data* option is used to enter or edit operative risk summary data for the cardiac surgery risk assessments. 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 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
-----

1. Physician's Preoperative Estimate of Operative Mortality: 78
   A. Date/Time Collected
2. ASA Classification: 1-NO DISTURB.
3. Surgical Priority:
4. Date/Time Operation Began: JUN 18,2005 07:00
5. Date/Time Operation Ended: JUN 18,2005 09:00
6. Preoperative Risk Factors: NONE
7. CPT Codes (view only): 33510

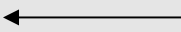
-----

Select Operative Risk Summary Information to Edit: 1:3

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

Physician's Preoperative Estimate of Operative Mortality: 32
Date/Time of Estimate of Operative Mortality: JUN 17,2005@18:15
// <Enter>
ASA Class: 3 3-SEVERE DISTURB.
Cardiac Surgical Priority: ?
Enter the surgical priority that most accurately reflects the acuity of
patient's cardiovascular condition at the time of transport to the
operating room.
CHOOSE FROM:
1 ELECTIVE
2 URGENT
3 EMERGENT (ONGOING ISCHEMIA)
4 EMERGENT (HEMODYNAMIC COMPROMISE)
5 EMERGENT (ARREST WITH CPR)
Cardiac Surgical Priority: 3 EMERGENT (ONGOING ISCHEMIA)
Date/Time of Cardiac Surgical Priority: JUN 17,2005@13:29
// <Enter>
```

This information cannot be edited.



-----  
1. Physician's Preoperative Estimate of Operative Mortality: 32%  
A. Date/Time Collected: JUN 17,2005 18:15  
2. ASA Classification: 3-SEVERE DISTURB.  
3. Surgical Priority: EMERGENT (ONGOING ISCHEMIA)  
A. Date/Time Collected: JUN 17,2005 09:46  
4. Date/Time Operation Began: JUN 18,2005 08:45  
5. Date/Time Operation Ended: JUN 18,2005 14:25  
6. Preoperative Risk Factors: NONE  
  
7. CPT Codes (view only): 33510

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

\*\*\* NOTE: D/Time of Estimate of Mortality should be < the D/Time PT in OR. \*\*\*

-----  
Select Operative Risk Summary Information to Edit:

---

The Surgery software performs data checks on the following fields:



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

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

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

---



## 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.

The user can also enter of **N** shall allow the user to **Set All to No** for the 22 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.
- #9 Valve Repair 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: 11. Bridge to transplant/Device:
 1. Number with vein: 12. TMR:
 2. Number with IMA: 13. Maze procedure:
 3. Number with Radial Artery: 14. ASD repair:
 4. Number with Other Artery: 15. VSD repair:
 5. Number with Other Conduit: 16. Myectomy for IHSS:
 17. Myxoma resection:
 6. Aortic Valve Replacement: 18. Other tumor resection:
 7. Mitral Valve Replacement: 19. Cardiac transplant:
 8. Tricuspid Valve Replacement: 20. Great Vessel Repair:
 9. Valve Repair: 21. Endovascular Repair:
10. LV Aneurysmectomy: 22. Other cardiac procedures:
-----
Select Cardiac Procedures Operative Information to Edit: A
```

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**  
Aortic Valve Replacement (Y/N): **Y** YES  
Mitral Valve Replacement (Y/N): **N** NO  
Tricuspid Valve Replacement (Y/N): **N** NO  
Valve Repair: **??**

CICSP Definition (2006):

Indicate if the patient has had any reparative procedure to a native valve, either with or without placing the patient on cardiopulmonary bypass. Valve repair is defined as a procedure performed on the native valve to relieve stenosis and/or correct regurgitation (annuloplasty, commissurotomy, etc.); the native valve remains in place. Indicate the one appropriate response.

Choose from:

- 1 AORTIC
- 2 MITRAL
- 3 TRICUSPID
- 4 OTHER/COMBINATION
- 5 NONE

Valve Repair: **1** AORTIC

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

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 Descending Thoracic Aorta: **N** NO

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

## 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. Time Patient Out OR: FEB 12, 2007@08:40
6. Date/Time Patient Extubated:
7. Date/Time Discharged from ICU: FEB 16, 2007@13:44
8. Homeless: NO
9. Surg Performed at Non-VA Facility: NO
10. Resource Data Comments:
11. Employment Status Preoperatively: EMPLOYED PART TIME
12. CT Surgery Consult Date:
13. Cause for Delay for Surgery:

```
-----  
Select number of item to edit: 11
```



```
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. Time Patient Out OR:          FEB 12, 2007@08:40
6. Date/Time Patient Extubated:
7. Date/Time Discharged from ICU: FEB 16, 2007@13:44
8. Homeless:                     NO
9. Surg Performed at Non-VA Facility: NO
10. Resource Data Comments:
11. Employment Status Preoperatively: EMPLOYED PART TIME
12. CT Surgery Consult Date:
13. Cause for Delay for Surgery:
```

```
-----
Select number of item to edit:
```

---

The Surgery software performs data checks on the following fields:

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



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

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

---



# 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	PCI:	>72 hrs - 7 days
Age:	55	Prior MI:	> 7 DAYS OF SURG
Height:	72 in	# of prior heart surgeries:	NONE
Weight:	120 kg	Prior heart surgeries:	
Diabetes:	DIET	Peripheral Vascular Disease:	NO
COPD:	NO	Cerebral Vascular Disease:	NO
FEV1:	NS	Angina (use CCS Class):	III
Cardiomegaly (X-ray):	YES	CHF (use NYHA Class):	I
Pulmonary Rates:	NO	Current Diuretic Use:	NO
Current Smoker: >3 MONTHS	PRIOR TO SUR	Current Digoxin Use:	NO
Active Endocarditis:	NO	IV NTG 48 Hours Preceding Surgery:	NO
Resting ST Depression:	YES	Preop circulatory Device:	VAD
Functional Status:	PARTIAL DEPENDENT	Hypertension:	NO

III. DETAILED LABORATORY INFO - PREOPERATIVE VALUES

Creatinine:	1.1 mg/dl	06/28/06	T. Bilirubin:	.9 mg/dl	06/28/06
Hemoglobin:	15.6 mg/dl	06/28/06	T. Cholesterol:	230 mg/dl	06/28/06
Albumin:	4.4 g/dl	06/28/06	HDL:	90 mg/dl	06/28/06
Triglyceride:	77 mg/dl	06/28/06	LDL:	125 mg/dl	06/28/06
Potassium:	4.6 mg/L	06/28/06	Hemoglobin Alc:	205 mg/dl	06/28/06

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

	(Operation Began: 07/01/06 10:10)
Physician's Preoperative	(Operation Ended: 07/01/06 12:20)
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:		Bridge to transplant/Device:	NO
Number with Vein:	2	TMR:	NO
Number with IMA:	2	Maze procedure:	NO MAZE PERFORMED
Number with Radial Artery:	0	ASD repair:	NO
Number with Other Artery:	0	VSD repair:	NO
Number with Other Conduit:	0	Myectomy for IHSS:	NO
Aortic Valve Replacement:	NO	Myxoma resection:	NO
Mitral Valve Replacement:	NO	Other tumor resection:	NO
Tricuspid Valve Replacement:	NO	Cardiac transplant:	NO
Valve Repair:	NONE	Great Vessel Repair:	NO
LV Aneurysmectomy:	NO	Endovascular Repair:	NO
		Other Cardiac procedure(s):	YES

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

Indicate other cardiac procedures only if done with cardiopulmonary bypass

Foreign body removal: YES  
Pericardiectomy: YES

Other Operative Data details

Total CPB Time: 85 min Total Ischemic Time: 60 min  
Incision Type: FULL STERNOTOMY  
Conversion Off Pump to CPB: N/A (began on-pump/ stayed on-pump)

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		

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  
Time Patient Out OR: 07/10/06 12:30  
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  
CT Surgery Consult Date: 06/29/06  
Cause for Delay for Surgery: NONE  
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.)*

# 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
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
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
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
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-----
```

INCOMPLETE RISK ASSESSMENTS  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: JAN 1,2006 TO: JUN 30,2006

DATE REVIEWED:  
REVIEWED BY:

ASSESSMENT # OPERATION DATE	PATIENT	SURGEON	OPERATIVE PROCEDURE(S)	ANESTHESIA TECHNIQUE
=====				
** SURGICAL SPECIALTY: CARDIAC SURGERY **				
28519 JAN 05, 2006	SURPATIENT,NINE	000-34-5555 SURSURGEON,ONE	* CABG X3 (2V,1A)  CPT Codes: 33736	GENERAL
-----				
** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **				
63063 JUN 09, 2006	SURPATIENT,ONE	000-44-7629 SURSURGEON,TWO	INGUINAL HERNIA  CPT Codes: 49521	SPINAL
-----				
** SURGICAL SPECIALTY: NEUROSURGERY **				
63154 JUN 24, 2006	SURPATIENT,EIGHT	000-37-0555 SURSURGEON,FOUR	CRANIOTOMY  CPT Codes: NOT ENTERED	NOT ENTERED
-----				

## Example 2: List of Completed Assessments

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

List of Surgery Risk Assessments

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

COMPLETED RISK ASSESSMENTS  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: JAN 1,2006 TO: JUN 30,2006

PAGE 1

DATE REVIEWED:  
REVIEWED BY:

ASSESSMENT #	PATIENT	DATE COMPLETED	ANESTHESIA TECHNIQUE
OPERATION DATE	OPERATIVE PROCEDURE		

=====

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

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

-----

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

1898 APR 28, 2006	SURPATIENT,FORTYONE 000-43-2109 INTRAOCULAR LENS	MAY 28, 2006  CPT Codes: NOT ENTERED	GENERAL
----------------------	---	--	---------

-----



### Example 3: List of Transmitted Assessments

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

List of Surgery Risk Assessments

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

- |   |    |                  |    |       |
|---|----|------------------|----|-------|
| 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*-----

TRANSMITTED RISK ASSESSMENTS

PAGE 1

MAYBERRY, NC

SURGERY SERVICE

OPERATION DATES FROM: JAN 1,2006 TO: JUN 30,2006

DATE REVIEWED:

REVIEWED BY:

ASSESSMENT # OPERATION DATE	PATIENT PRINCIPAL OPERATIVE PROCEDURE	TRANSMISSION DATE	ANESTHESIA TECHNIQUE
*****			
** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **			
63076 JAN 08, 2006	SURPATIENT,FOURTEEN 000-45-7212 INGUINAL HERNIA CPT Codes: 49521	FEB 12, 2006	GENERAL
63077 FEB 08, 2006	SURPATIENT,FIVE 000-58-7963 INGUINAL HERNIA, OTHER PROC1 CPT Codes: NOT ENTERED	FEB 30, 2006	GENERAL
63103 MAR 27, 2006	SURPATIENT,NINE 000-34-5555 INGUINAL HERNIA CPT Codes: 49521	APR 09, 2006	GENERAL
63171 MAY 17, 2006	SURPATIENT,FIFTYTWO 000-99-8888 CHOLECYSTECTOMY CPT Codes: 47600	JUN 05, 2006	GENERAL
*****			

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

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

List of Surgery Risk Assessments

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

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

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

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

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

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

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

NON-ASSESSED MAJOR SURGICAL CASES BY SURGICAL SPECIALTY  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: JAN 1,2006 TO: JUN 30,2006

PAGE 1

DATE REVIEWED:  
REVIEWED BY:

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

=====

SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

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

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 2

-----

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

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

#### List of Surgery Risk Assessments

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

Select the Number of the Report Desired: (1-11): **5**

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

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

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

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

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

ALL MAJOR SURGICAL CASES BY SURGICAL SPECIALTY  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: JAN 1,2006 TO: JUN 30,2006

PAGE 1

DATE REVIEWED:  
REVIEWED BY:

CASE #	PATIENT	ASSESSMENT STATUS	ANESTHESIA TECHNIQUE
OPERATION DATE	OPERATIVE PROCEDURE(S)	EXCLUSION CRITERIA	SURGEON
=====			
SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)			
63110 JAN 23, 2006	SURPATIENT,SIXTY 000-56-7821 CHOLEDOCHOTOMY CPT Codes: 47420	COMPLETED SCNR WAS ON A/L	GENERAL SURSURGEON,TWO
63131 APR 21, 2006	SURPATIENT,FIFTYTWO 000-99-8888 PERINEAL WOUND EXPLORATION CPT Codes: NOT ENTERED	NO ASSESSMENT	GENERAL SURSURGEON,NINE
63136 JUN 07, 2006	SURPATIENT,EIGHT 000-34-5555 CHOLECYSTECTOMY CPT Codes: 47600	NO ASSESSMENT	GENERAL SURSURGEON,ONE
TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 3			
-----			

## Example 6: List of All Surgical Cases

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

List of Surgery Risk Assessments

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

ALL SURGICAL CASES BY SURGICAL SPECIALTY  
MAYBERRY, NC  
SURGERY SERVICE  
FROM: JAN 1,2006 TO: JUN 30,2006

PAGE 1

DATE REVIEWED:  
REVIEWED BY:

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

=====

SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

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

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 4

-----



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

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

List of Surgery Risk Assessments

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

MAYBERRY, NC

FROM: JAN 1,2006 TO: JUN 30,2006

DATE PRINTED: JUL 13,2006

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

ASSESSMENT #	PATIENT		TYPE	STATUS
OPERATION DATE	OPERATION(S)			
63172	SURPATIENT,FIFTYTWO	000-99-8888	NON-CARDIAC	TRANSMITTED
MAY 17, 2006	REPAIR ARTERIAL BLEEDING			
	CPT Code: 33120			
	Missing information:			
	1. The final coding for Procedure and Diagnosis is not complete.			
	2. Anesthesia Technique			
63185	SURPATIENT,SIXTEEN	000-11-1111	NON-CARDIAC	TRANSMITTED
APR 17, 2006	INGUINAL HERNIA, CHOLECYSTECTOMY			
	Missing information:			
	1. The final coding for Procedure and Diagnosis is not complete.			
	2. Concurrent Case			
	3. History of COPD (Y/N)			
	4. Ventilator Dependent Greater than 48 Hrs (Y/N)			
	5. Weight Loss > 10% of Usual Body Weight (Y/N)			
	6. Transfusion Greater than 4 RBC Units this Admission (Y/N)			
63080	SURPATIENT,THIRTY	000-82-9472	EXCLUDED	COMPLETE
JAN 03, 2006	TURP			
	Missing information:			
	1. The final coding for Procedure and Diagnosis is not complete.			

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

TOTAL FOR ALL SPECIALTIES: 3

## 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
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
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*-----

1-LINER CASES MISSING INFORMATION  
MABERRY, NC  
FROM: FEB 27,2006 TO: JUN 30,2006  
DATE PRINTED: JUN 30,2006

PAGE 1

\*\* UROLOGY

CASE #	PATIENT	TYPE	STATUS
OP DATE	OPERATION(S)		
317	SURPATIENT,FOURTEEN 000-45-7212	CARDIAC	COMPLETE
APR 10, 2006	Vasectomy CPT Codes: NOT ENTERED		

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

TOTAL FOR UROLOGY: 1

## Example 9: List of Eligible Cases

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

List of Surgery Risk Assessments

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

'\*' Denotes Eligible CPT Code

>>> CARDIAC SURGERY

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

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

10084 JUL 08, 2006	SURPATIENT,NINE CABG	000-34-5555 CARDIAC	COMPLETE
-----------------------	-------------------------	------------------------	----------

CPT Codes: \*33502, 11402

10380 FEB 06, 2007	SURPATIENT,THREE CORONARY ARTERY BYPASS	000-21-2453 NOT LOGGED	COMPLETE
-----------------------	--	---------------------------	----------

CPT Codes: NOT ENTERED

10383 FEB 08, 2007	SURPATIENT,ONE STENT	000-44-7629 NON-CARDIAC	COMPLETE
-----------------------	-------------------------	----------------------------	----------

CPT Codes: NOT ENTERED

TOTAL FOR CARDIAC SURGERY: 4

>>> GENERAL SURGERY

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

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

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

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

TOTAL FOR GENERAL SURGERY: 2

## 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
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
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*-----

CASES WITHOUT CPT CODES  
 ALBANY - ALL DIVISIONS  
 FROM: JAN 1,2007 TO: JAN 23,2008  
 DATE PRINTED: JAN 23,2008

PAGE 1

>>> CARDIAC SURGERY

CASE # OP DATE	PATIENT OPERATION(S)	TYPE	STATUS
10429 FEB 12, 2007	SURPATIENT,TEN 666-12-3456 CABG	CARDIAC	COMPLETE
10420 FEB 12, 2007	SURPATIENT,F. 666-00-0804 CABG	CARDIAC	TRANSMITTED
10423 MAR 12, 2007	SURPATIENT,TWO 666-45-1982 cabg	CARDIAC	INCOMPLETE
10430 MAR 18, 2007	SURPATIENT,EIGHT 666-37-0555 CABG X3	CARDIAC	INCOMPLETE
10374 MAY 10, 2007	SURPATIENT,NINE 666-34-5555 CABG X 3	NOT LOGGED	NO ASSESSMENT

TOTAL FOR CARDIAC SURGERY: 5

TOTAL FOR ALL SPECIALTIES: 5



## 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
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
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]**

SUMMARY LIST OF ASSESSED CASES  
 ALBANY  
 FROM: JAN 1,2008 TO: JAN 30,2008  
 DATE PRINTED: JAN 30,2008

SURGICAL SPECIALTY	INCOMPLETE	COMPLETE	TRANSMITTED	EXCLUDED
CARDIAC SURGERY	8	1	1	0
GENERAL SURGERY	17	1	1	6
NEUROSURGERY	1	0	1	0
OPHTHALMOLOGY	2	0	0	0
ORTHOPEDICS	2	0	0	0
OTORHINOLARYNGOLOGY (ENT)	1	0	0	0
PLASTIC SURGERY (INCLUDES HEAD	2	0	0	0
TWO GENERAL	1	0	0	0
UROLOGY	0	0	0	1
TOTAL FOR ALL SPECIALTIES:	34	2	3	7

# M&M Verification Report

## [SRO M&M VERIFICATION REPORT]

The *M&M Verification Report* option produces the M&M Verification Report, which may be useful for:

- reviewing occurrences and their assignment to operations
- reviewing death unrelated/related assignments to operations

The full report includes all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences or death within 90 days of surgery. The pre-transmission report is similar but includes operations with completed risk assessments that have not yet transmitted to the national database.

### Full Report:

Information is printed by patient, listing all operations for the patient that occurred during the selected date range, plus any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that were performed prior to the selected date range and, if printed by specialty, may include operations performed by other specialties. For every operation listed, the intraoperative and postoperative occurrences are listed. The report indicates if the operation was flagged as unrelated or related to death and the risk assessment type and status. The report may be printed for a selected list of surgical specialties.

### Pre-Transmission Report:

Information is printed in a format similar to the full report. This report lists all completed risk assessed operations that have not yet transmitted to the national database and that have intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The report includes any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that may or may not be risk assessed, and, if risk assessed, may have a status other than 'complete'. However, every patient listed on this report will have at least one operation with a risk assessment status of 'complete'.

### Example 1: Generate an M&M Verification Report (Full Report)

```
Select Surgery Risk Assessment Menu Option: V M&M Verification Report
```

#### M&M Verification Report

```
The M&M Verification Report is a tool to assist in the review of occurrences and their assignment to operations and in the review of death unrelated or related assignments to operations.
```

```
The full report includes all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences or death within 90 days of surgery. The pre-transmission report is similar but includes only operations with completed risk assessments that have not yet transmitted to the national database.
```

Print which report ?

1. Full report for selected date range.
2. Pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// **<Enter>**

Start with Date: **03 01 07** (MAR 01, 2007)

End with Date: **03 30 07** (MAR 30, 2007)

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

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

This report is designed to use a 132 column format.

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

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

REVIEWED BY:  
DATE REVIEWED:

OP DATE	CASE #	SURGICAL SPECIALTY PRINCIPAL PROCEDURE	ASSESSMENT TYPE	STATUS	DEATH RELATED
=====					
>>> SURPATIENT,FIVE (666-58-7963)					
03/01/07	10401	GENERAL SURGERY APPENDECTOMY CPT Codes: 44970 Occurrences: ACUTE RENAL FAILURE ** POSTOP ** (03/02/07)	NON-CARDIAC	TRANSMITTED	N/A
-----					
>>> SURPATIENT,ONE (666-44-7629)					
03/07/07	10421	GENERAL SURGERY APPENDECTOMY, CHOLECYSTECTOMY CPT Codes: 44950, 47610 Occurrences: URINARY TRACT INFECTION ** POSTOP ** (03/09/07) ACUTE RENAL FAILURE ** POSTOP ** (03/10/07) OTHER RESPIRATORY OCCURRENCE ** POSTOP ** (03/10/07) ICD: 478.25 EDEMA PHARYNX/NASOPHARYX	NON-CARDIAC	TRANSMITTED	N/A
-----					
>>> SURPATIENT,TWO (666-45-1982)					
03/07/07	10422	NEUROSURGERY LAMINECTOMY CPT Codes: 22630 Occurrences: OTHER OCCURRENCE (03/07/07) ICD: 415.19 OTH PULM EMB & INFARC	NON-CARDIAC	TRANSMITTED	N/A
-----					
>>> SURPATIENT,ELEVEN (666-00-0748) - DIED 03/10/07@14:50					
03/10/07	10100	GENERAL SURGERY REMOVAL OF GALLBLADDER CPT Codes: 47600 Occurrences: PULMONARY EMBOLISM ** POSTOP ** (03/10/07) >>> Comments: Patient complained of chest pain and shortness of breath. Heparin was administered immediately by IV. Date of Death: 03/10/07@14:50 Review of Death Comments: Patient expired from large pulmonary embolus before anticoagulant treatment could take effect. Patient's obesity and prolonged immobilization were likely contributing factors.	NON-CARDIAC	INCOMPLETE	NO
-----					

## Example 2: Generate an M&M Verification Report (Pre-Transmission Report)

Select Surgery Risk Assessment Menu Option: **V** M&M Verification Report

### M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences and their assignment to operations and in the review of death unrelated or related assignments to operations.

The full report includes all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences or death within 90 days of surgery. The pre-transmission report is similar but includes only operations with completed risk assessments that have not yet transmitted to the national database.

Print which report ?

1. Full report for selected date range.
2. Pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// **2**

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

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

This report is designed to use a 132 column format.

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

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

ALBANY - ALL DIVISIONS  
M&M Verification Report  
PRE-TRANSMISSION REPORT FOR COMPLETED ASSESSMENTS  
Report Generated: OCT 23,2007

REVIEWED BY:  
DATE REVIEWED:

OP DATE	CASE #	SURGICAL SPECIALTY PRINCIPAL PROCEDURE	ASSESSMENT TYPE	STATUS	DEATH RELATED
=====					
>>> SURPATIENT,TWELVE (666-00-0762)					
09/21/07	45466	PLASTIC SURGERY RHINOPLASTY CPT Codes: 30410 Occurrences: DEEP INCISIONAL SSI ** POSTOP ** (09/23/07)	NON-CARDIAC	COMPLETE	N/A
-----					
>>> SURPATIENT,FIFTEEN (666-00-0194)					
09/16/07	45475	EAR, NOSE, THROAT (ENT) LARYNGECTOMY (TOTAL) CPT Codes: 31360 Occurrences: BLEEDING/TRANSFUSIONS ** POSTOP ** (09/17/07) >>> Comments: Esophageal varices were the source of bleeding.	NON-CARDIAC	COMPLETE	N/A
-----					
>>> SURPATIENT,FORTY (666-00-4174)					
09/19/07	45499	GENERAL SURGERY INGUINAL HERNIA CPT Codes: 49505 Occurrences: URINARY TRACT INFECTION ** POSTOP ** (09/21/07)	NON-CARDIAC	COMPLETE	N/A
-----					





*(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 item to edit from list below:

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

Enter number (1-25): **5**

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

Enter number (1-25):

Select Surgery Risk Assessment Menu Option:

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---

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