Surgery
User Manual

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

Product Development

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Revision History

Each time this manual is updated, the Title Page lists the new revised date and this page describes the changes. If the Revised Pages column lists "All," replace the existing manual with the reissued manual. If the Revised Pages column lists individual entries (e.g., 25, 32), either update the existing manual with the Change Pages Document or print the entire new manual.

Date	Revised Pages	Patch Number	Description
11/15	i-viii, 9, 30, 32-33, 37, 38, 40-41, 42, 43, 44, 46, 47-48, 50-52, 65, 67-68, 72-73, 76-77, 79-80, , 95, 98-99, 101-102a, 105, 108-110, 111-113, 117, 123, 124, 124a, 124b, 140-147, 150-152b, 212e, 219a, 219b, 432-433, 449-451, 458,459,465, 467-469, 470a-472, 473,, 479-479a, 481-482a, 484, 486-486c, 489, 491, 493, 495-499, 501, 502a, 502c, 502e, 502g, 507, 510, 512, 527-556	SR*3*184	Updated definitions, added new data fields, made changes to data entry screens, reports, surgery risk management assessment transmissions. For more details, see the Annual Surgery Updates – VASQIP 2015, Release Notes.
09/14	i, ia, iii-vii, 6-9, 11, 13, 14, 28, 31-33, 37, 38, 40-44, 46-48, 50-52, 59, 64, 66-68, 72-73, 76, 77, 79-83, 99-105, 107-111, 114, 116, 117, 119-120a, 122-124a, 131, 140, 140a, 142-147, 149, 151-152a, 165, 180, 180a, 189-191, 218-219a, 285, 346, 349, 358, 360, 394a, 394b, 426-428, 449, 449a, 455-458, 467, 468, 474-474b, 482-484, 507, 510, 512, 519,	SR*3*182	Updated definitions, added new data fields, made changes to data entry screens, reports, surgery risk management assessment transmissions. For more details, see the Annual Surgery Updates – VASQIP 2014, Release Notes. (Daniel Reed, PM; Starleigh Vetzel, Technical Writer)

Date	Revised Pages	Patch Number	Description
	549, 549a, 551-556		
07/14	i-iib, 212a, 212d-212g, 238, 273, 405, 437, 480, 525, 526	SR*3*177	Updated examples to reflect ICD-10 Diagnosis Codes. Changed File Download Option 2 from "ICD9" to "ICD." Made ICD-9 references generic to ICD. Added ICD-10-CM Diagnosis Code Search. Updated Warning Message to Surgeon. Updated MailMan Messages for ICD-9 and ICD-10 codes. (K. Krause, VA)
03/12	i-iid, v, vii, 6-11, 81-83, 120, 120a-120b, 140, 144-145, 145a-145b, 146, 151-152, 152a, 178, 207-209, 212c, 212f, 213, 215, 217-219, 219a-219b, 220, 222, 224, 226, 228, 230, 232, 234, 236, 239, 241, 243, 245, 247, 276, 327c, 394c, 395-396, 397a, 397c-397d, 411, 432, 449-450, 461, 464, 467-468, 474b, 482, 484, 486, 486a, 523, 525, 527, 549, 553-554	SR*3*176	Updated definitions, added new data fields, made changes to existing fields, data entry screens, reports, surgery risk assessment transmissions and transplant components of the VistA Surgery application. For more details, see the *Annual Surgery Updates – VASQIP 2011, Increment 2, Release Notes.* Chapter Seven: "CoreFLS/Surgery Interface" has been removed. (T. Leggett, PM; B. Thomas, Tech Writer)

Table of Contents

Entering or Editing a Range of Data Elements

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

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

Example 1: Colon

```
            ** STARTUP **   CASE #24  SURPATIENT,TWO            PAGE 2 OF 3

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

Enter Screen Server Function:  1:4                   R
Preoperative Consciousness: ALERT-ORIENTED          AO
Preoperative Skin Integrity: INTACT          I
Transported to O.R. By: STRETCHER
Preop Surgical Site Hair Removal by: SURNURSE,ONE          OS
```

Example 2: Semicolon

```
         ** STARTUP **   CASE #24  SURPATIENT,TWO            PAGE 1 OF 3

1    HEIGHT:                  58 INCHES

2    WEIGHT:                  264 LBS.
3    DATE OF OPERATION:      APR 19, 2006 AT 800
4    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE
5    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9):
6    OTHER PREOP DIAGNOSIS:   (MULTIPLE)
7    OP ROOM PROCEDURE PERFORMED:    OR4
8    SURGERY SPECIALTY:       ORTHOPEDICS
9    PLANNED POSTOP CARE:     WARD
10    CASE SCHEDULE TYPE:     ELECTIVE
11    REQ ANESTHESIA TECHNIQUE: GENERAL
12   PATIENT EDUCATION/ASSESSMENT: YES
13    DELAY CAUSE:             (MULTIPLE)
14    ASA CLASS:
15    PREOP MOOD:


Enter Screen Server Function:  7;9;
Operating Room Procedure Performed:  OR4// OR2
Planned Postop Care: WARD//OUTPATIENT/DISCHARGE
```

At this prompt:	The user should do this:
Select REQ BLOOD KIND	Enter the type of blood product that will be needed for the operation. The package coordinator can select a default response to this prompt when installing the package. If the default product is not what is wanted for a case, it can be deleted by entering the at-sign (@) at this prompt. The user can then select the preferred blood product (enter two question marks for a list of blood products). If no blood products are needed, do not enter **NO** or **NONE**. Instead, press the **<Enter>** key to bypass this prompt. To order more than one product for the same case, use the screen server summary that concludes the option and select item 9, REQ BLOOD KIND. This is a multiple field; as many blood products as needed may be entered.
Requested Preoperative X-Rays	Enter the types of preoperative x-ray films and reports required for delivery to the operating room before the operation. This field may be left blank if the user does not intend to order any x-ray products.
Preoperative Infection	Enter the letter code "**C**" for clean or "**D**" for contaminated or "S" for 'SPECIAL CONSIDERATIONS' or type in the first few letters of either word. This information allows the scheduling manager to determine how much time is needed between operations for sanitizing a room.

```
                OPERATION REQUEST: BLOOD INFORMATION

SURPATIENT,TWENTY (000-45-4886)                                 DEC  1, 2004
================================================================================


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

```
                   OPERATION REQUEST: OTHER INFORMATION

SURPATIENT,TWENTY (000-45-4886)                                 DEC  1, 2004
================================================================================

Principal Preoperative Diagnosis: CHOLELITHIASIS//  <Enter>
Prin Pre-OP ICD Diagnosis Code (ICD9): 574.01   574.01   CHOLELITH/AC GB INF-OBST (w C/C)
...OK? Yes//  <Enter> (YES)
Palliation:
Pre-admission Testing Complete (Y/N):
Case Schedule Type: U  URGENT
First Assistant: SURSURGEON,TWO
Second Assistant: <Enter>
Attending Surgeon:
Planned Postop Care: WARD       W
Case Schedule Order: 1
Select SURGERY POSITION: SUPINE// <Enter>
  Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: GENERAL <Enter>  GENERAL
Request Frozen Section Tests (Y/N): N  NO
Requested Preoperative X-Rays: ABDOMIN
Intraoperative X-Rays (Y/N/C): N
Request Medical Media (Y/N): N
Preoperative Infection: CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
SPD Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
```

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

```
          ** REQUESTS **   CASE #227  SURPATIENT,TWENTY         PAGE 1 OF 3

1    PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 47480-66
4    LATERALITY OF PROCEDURE: (NA/ LEFT, RIGHT, BILATERAL)
5    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 574.01
7    OTHER PREOP DIAGNOSIS: (MULTIPLE)
8    PALLIATION:
9    PLANNED ADMISSION STATUS: ADMITTED
10   PRE-ADMISSION TESTING:
11   CASE SCHEDULE TYPE: URGENT
12   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
13   PRIMARY SURGEON:            SURSURGEON,ONE
14   FIRST ASST:         SURSURGEON,TWO
15   SECOND ASST:

Enter Screen Server Function:  <Enter>
```

```
          ** REQUESTS **   CASE #227  SURPATIENT,TWENTY         PAGE 2 OF 3

1    ATTENDING SURGEON:        SURSURGEON,ONE
2    PLANNED POSTOP CARE:
3    CASE SCHEDULE ORDER:      1
4    SURGERY POSITION:         (MULTIPLE)(DATA)
5    REQ ANESTHESIA TECHNIQUE: GENERAL
6    REQ FROZ SECT:      NO
7    REQ PREOP X-RAY:    ABDOMIN
8    INTRAOPERATIVE X-RAYS: NO
9    REQUEST BLOOD AVAILABILITY: YES
10   CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
11   REQ BLOOD KIND:           (MULTIPLE)(DATA)
12   SPECIAL EQUIPMENT:        (MULTIPLE)
13   PLANNED IMPLANT:          (MULTIPLE)
14   SPECIAL SUPPLIES:         (MULTIPLE)
15   SPECIAL INSTRUMENTS:      (MULTIPLE)

Enter Screen Server Function: <Enter>
```

```
          ** REQUESTS **   CASE #227  SURPATIENT,TWENTY         PAGE 3 OF 3

1    PHARMACY ITEMS:          (MULTIPLE)
2    REQ PHOTO:
3    PREOPERATIVE INFECTION:
4    REFERRING PHYSICIAN:      (MULTIPLE)
5    GENERAL COMMENTS:         (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7    BRIEF CLIN HISTORY:     (WORD PROCESSING)
8    SPD COMMENTS:           (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

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

  Press RETURN to continue
```

Example 1: Delete a Request

```
Select Request Operations Option: D  Delete or Update Operation Requests
Select Patient:    SURPATIENT,NINE       12-09-51     000345555     NSC VETERAN

The following cases are requested for SURPATIENT,NINE:

1. 08-15-01   CHOLECYSTECTOMY
2. 09-15-01   Release of Hammer Toes

Select Operation Request: 2

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

Select Number: 1

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

Deleting Operation ...

Press RETURN to continue
```

Example 2: Update Request Information

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

Select Patient: SURPATIENT,TWENTY         03-27-40     000454886

The following case is requested for SURPATIENT,TWENTY:

1. 12-01-01   CHOLECYSTECTOMY

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

Select Number: 2

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

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

1    PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 47480-66
4    LATERALITY OF PROCEDURE: (NA/ LEFT, RIGHT, BILATERAL)
5    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 574.01
7    OTHER PREOP DIAGNOSIS: (MULTIPLE)
8    PALLIATION:
8    PLANNED ADMISSION STATUS: ADMISSION
10    PRE-ADMISSION TESTING:
11   CASE SCHEDULE TYPE: URGENT
12   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
13   PRIMARY SURGEON:            SURSURGEON,ONE
14   FIRST ASST:         SURSURGEON,TWO
15   SECOND ASST:

Enter Screen Server Function:  15
```

```
Second Assistant: SURSURGEON,THREE
```

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

1    PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 47480-66
4    LATERALITY OF PROCEDURE: (NA/ LEFT, RIGHT, BILATERAL)
5    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 574.01
7    OTHER PREOP DIAGNOSIS: (MULTIPLE)
8    PALLIATION:
9    PLANNED ADMISSION STATUS: ADMITTED
10    PRE-ADMISSION TESTING:
11   CASE SCHEDULE TYPE: URGENT
12   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
13   PRIMARY SURGEON:            SURSURGEON,ONE
14   FIRST ASST:         SURSURGEON,TWO
15   SECOND ASST:

Enter Screen Server Function:  <Enter>
```

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

1    ATTENDING SURGEON:        SURSURGEON,ONE
2    PLANNED POSTOP CARE: WARD
3    CASE SCHEDULE ORDER: 1
4    SURGERY POSITION:   (MULTIPLE)(DATA)
5    REQ ANESTHESIA TECHNIQUE: GENERAL
6    REQ FROZ SECT:      NO
7    REQ PREOP X-RAY:    ABDOMIN
8    INTRAOPERATIVE X-RAYS: NO
9    REQUEST BLOOD AVAILABILITY: YES
10   CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
11   REQ BLOOD KIND:      (MULTIPLE)(DATA)
12   SPECIAL EQUIPMENT:   (MULTIPLE)
13   PLANNED IMPLANT:     (MULTIPLE)
14   SPECIAL SUPPLIES:    (MULTIPLE)
15   SPECIAL INSTRUMENTS: (MULTIPLE)
Enter Screen Server Function:  <Enter>
```

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

1    PHARMACY ITEMS:          (MULTIPLE)
2    REQ PHOTO:
3    PREOPEARTIVE INFECTION:
4    REFERRING PHYSICIAN:     (MULTIPLE)
5    GENERAL COMMENTS:        (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7    BRIEF CLIN HISTORY:     (WORD PROCESSING)
8    SPD COMMENTS:           (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

Example 3: Change the Request Date

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

```
The following case is requested for SURPATIENT,TWENTY:

1. 12-01-01   CHOLECYSTECTOMY

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

Select Number: 3
Change to which Date ? 11/30  (NOV 30, 2001)

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

Press RETURN to continue
```

```
  ** UPDATE REQUEST **   CASE #178  SURPATIENT,TWELVE     PAGE 1 OF 3

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    LATERALITY OF PROCEDURE: (NA, LEFT, RIGHT, BILATERAL
5    PRINCIPAL PRE-OP DIAGNOSIS:
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9):
7    OTHER PREOP DIAGNOSIS: (MULTIPLE)
8    PALLIATION:
9    PLANNED ADMISSION STATUS:
10   PRE-ADMISSION TESTING:
11   CASE SCHEDULE TYPE: STANDBY
12   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
13   PRIMARY SURGEON:            SURSURGEON,ONE
14   FIRST ASST:
15   SECOND ASST:

Enter Screen Server Function:  5;6;10
Principal Preoperative Diagnosis: CAROTID ARTERY STENOSIS
Prin Pre-OP ICD Diagnosis Code: 433.1        'C'       CAROTID ARTERY OCCLUSION
      COMPLICATION/COMORBIDITY
         ...OK? YES//  <Enter> (YES)

Pre-admission Testing Complete (Y/N): YES    YES
Do you want to store this information in the concurrent case ?  YES//  N
```

```
          ** UPDATE REQUEST **   CASE #178  SURPATIENT,TWELVE     PAGE 1 OF 3

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    LATERALITY OF PROCEDURE: (NA, LEFT, RIGHT, BILATERAL)
5    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 433.10
7    OTHER PREOP DIAGNOSIS: (MULTIPLE)
8    PALLIATION:
9    PLANNED ADMISSION STATUS: ADMITTED
10   PRE-ADMISSION TESTING: YES
11   CASE SCHEDULE TYPE: STANDBY
12   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
13   PRIMARY SURGEON:            SURSURGEON,ONE
14   FIRST ASST:
15   SECOND ASST:

Enter Screen Server Function: <Enter>
```

```
          ** UPDATE REQUEST **   CASE #178  SURPATIENT,TWELVE     PAGE 2 OF 3

1    ATTENDING SURGEON:        SURSURGEON,ONE
2    PLANNED POSTOP CARE: SICU
3    CASE SCHEDULE ORDER: 1
4    SURGERY POSITION:   (MULTIPLE)
5    REQ ANESTHESIA TECHNIQUE: GENERAL
6    REQ FROZ SECT:      NO
7    REQ PREOP X-RAY:    DOPPLER STUDIES
8    INTRAOPERATIVE X-RAYS: NO
9    REQUEST BLOOD AVAILABILITY:
10   CROSSMATCH, SCREEN, AUTOLOGOUS:
11   REQ BLOOD KIND:     (MULTIPLE)
12   SPECIAL EQUIPMENT:  (MULTIPLE)
13   PLANNED IMPLANT:    (MULTIPLE)
14   SPECIAL SUPPLIES:    (MULTIPLE)
15   SPECIAL INSTRUMENTS: (MULTIPLE)


Enter Screen Server Function: <Enter>
```

```
          ** UPDATE REQUEST **   CASE #229  SURPATIENT,TWELVE      PAGE 3 OF 3

1    PHARMACY ITEMS:          (MULTIPLE)
2    REQ PHOTO:
3    PREOPERATIVE INFECTION:
4    REFERRING PHYSICIAN:     (MULTIPLE)
5    GENERAL COMMENTS:        (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7    BRIEF CLIN HISTORY:     (WORD PROCESSING)
8    SPD COMMENTS:           (WORD PROCESSING)

Enter Screen Server Function:
```

Example 6: Change the Request Date of Concurrent Cases

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

```
The following cases are requested for SURPATIENT,FOUR:

1. 04-04-05       ARTHROSCOPY, RIGHT KNEE
2. 04-04-05       REMOVE MOLE
3. 06-01-05       CAROTID ARTERY ENDARTERECTOMY
4. 06-01-05       AORTO CORONARY BYPASS GRAFT

Select Operation Request: 3

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

Select Number: 3

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

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

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

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

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

Press RETURN to continue
```

Make a Request from the Waiting List

[SRSWREQ]

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

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

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

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

Example: Making A Request From the Waiting List

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

Make a request from the waiting list for which patient ?  SURPATIENT,FOURTEEN
08-16-51     000457212

Procedures Entered on the Waiting List for SURPATIENT,FOURTEEN:

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

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

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

```
                    OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)                                  DEC  1, 2005
==========================================================================

Primary Surgeon: SURSURGEON,TWO
Attending Surgeon: SURSURGEON,TWO
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)
Principal Operative Procedure: REPAIR DIAPHRAGMATIC HERNIA
Principal Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA


The information entered into the Principal Preoperative Diagnosis field
has been transferred into the Indications for Operation field.
The Indications for Operation field can be updated later if necessary.


Press RETURN to continue  <Enter>

Laterality Of Procedure: NA
Planned Admission Status: 1  SAME DAY
Planned Principal Procedure Code: 39540     REPAIR OF DIAPHRAGM HERNIA
 REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC; ACUTE
 Modifier:
Sending a Notification of Appointment Booking for case #229
```

```
                    OPERATION REQUEST: PROCEDURE INFORMATION
```

```
SURPATIENT,FOURTEEN (000-45-7212)                                DEC  1, 2005
================================================================================
Principal Procedure:      REPAIR DIAPHRAGMATIC HERNIA
Planned Principal Procedure Code (CPT): 39540       REPAIR OF DIAPHRAGM HERNIA
 REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC; ACUTE  // <Enter>
Select OTHER PROCEDURE: <Enter>
Estimated Case Length (HOURS:MINUTES): 2:00
BRIEF CLIN HISTORY:
  1>Patient was reporting indigestion and a burning
  2>sensation in esophagus. Upper GI indicated hernia.
  3><Enter>
EDIT Option: <Enter>
```

```
                    OPERATION REQUEST: BLOOD INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)                                DEC  1, 2005
================================================================================

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

```
                    OPERATION REQUEST: OTHER INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)                                DEC  1, 2005
================================================================================
Principal Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA// <Enter>
Prin Pre-OP ICD Diagnosis Code (ICD9): 551.3

 One match found

      551.3     DIAPHRAGM HERNIA W GANGR (Major CC)

     OK? Yes//  <Enter> (YES) 551.3     DIAPHRAGM HERNIA W GANGR(Major CC) 551.3  ICD-9
    DIAPHRAGM HERNIA W GANGR
Palliation: <Enter>
Pre-admission Testing Complete (Y/N): Y  YES
Case Schedule Type: S  STANDBY
First Assistant: SURSURGEON,ONE
Second Assistant: <Enter>
Attending Surgeon:  ln,fn// <Enter>
Planned Postop Care: WARD       W
Case Schedule Order: <Enter>
Select SURGERY POSITION: SUPINE// <Enter>
  Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: G  GENERAL
Request Frozen Section Tests (Y/N): N  NO
Requested Preoperative X-Rays: ABDOMEN
Intraoperative X-Rays (Y/N/C): N  NO
Request Medical Media (Y/N): N  NO
Preoperative Infection: C  CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
SPD Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
```

```
** REQUEST **   CASE #229  SURPATIENT,FOURTEEN          PAGE 1 OF 3

1    PRINCIPAL PROCEDURE: REPAIR DIAPHRAGMATIC HERNIA
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 39540
4    LATERALITY OF PROCEDURE: (NA, RIGHT, LEFT, BILATERAL)
5    PRINCIPAL PRE-OP DIAGNOSIS: ACUTE DIAPHRAGMATIC HERNIA
6    PRIN PRE-OP ICD DIAGNOSIS CODE: 551.3
7    OTHER PREOP DIAGNOSIS: (MULTIPLE)
8    PALLIATION:
9    PLANNED ADMISSION STATUS: ADMITTED
10   PRE-ADMISSION TESTING: YES
11   CASE SCHEDULE TYPE:     STANDBY
12   SURGERY SPECIALTY:      GENERAL(OR WHEN NOT DEFINED BELOW)
13   PRIMARY SURGEON:        SURSURGEON,TWO
14   FIRST ASST:             SURSURGEON,ONE
15   SECOND ASST:

Enter Screen Server Function:   <Enter>
```

```
          ** REQUEST **   CASE #229  SURPATIENT,FOURTEEN          PAGE 2 OF 3

1    ATTENDING SURGEON:        SURSURGEON,TWO
2    PLANNED POSTOP CARE:     WARD
3    CASE SCHEDULE ORDER:
4    SURGERY POSITION:         (MULTIPLE)(DATA)
5    REQ ANESTHESIA TECHNIQUE: GENERAL
6    REQ FROZ SECT:            NO
7    REQ PREOP X-RAY:          ABDOMEN
8    INTRAOPERATIVE X-RAYS:    NO
9    REQUEST BLOOD AVAILABILITY: NO
10   CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
11   REQ BLOOD KIND:           (MULTIPLE)(DATA)
12   SPECIAL EQUIPMENT:        (MULTIPLE)
13   PLANNED IMPLANT:          (MULTIPLE)
14   SPECIAL SUPPLIES:         (MULTIPLE)
15   SPECIAL INSTRUMENTS:      (MULTIPLE)


Enter Screen Server Function:   <Enter>
```

```
           ** REQUEST **   CASE #229  SURPATIENT,FOURTEEN         PAGE 3 OF 3

1    PHARMACY ITEMS:            (MULTIPLE)
2    REQ PHOTO:                 NO
3    PREOPERATIVE INFECTION:    CLEAN
4    REFERRING PHYSICIAN:       (MULTIPLE)
5    GENERAL COMMENTS:          (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7    BRIEF CLIN HISTORY:        (WORD PROCESSING)(DATA)
8    SPD COMMENTS:              (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

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

  Press RETURN to continue
```

Example 1: Make a Request for Concurrent Cases

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


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

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


                            FIRST CONCURRENT CASE
                     OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,TWELVE (000-41-8719)                                    DEC  1, 2005
================================================================================

Primary Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,TWO
Surgical Specialty: 62          PERIPHERAL VASCULAR  PERIPHERAL VASCULAR
62
Principal Operative Procedure: CAROTID ARTERY ENDARTERECTOMY
Principal Preoperative Diagnosis: CAROTID ARTERY STENOSIS


The information entered into the Principal Preoperative Diagnosis field
has been transferred into the Indications for Operation field.
The Indications for Operation field can be updated later if necessary.


Press RETURN to continue <Enter>

Laterality Of Procedure: NA
Planned Admission Status: SAME DAY
Planned Principal Procedure Code: 35526    REPAIR OF ANOMALOUS CORONARY ARTERY FROM PULMONARY
ARTERY ORIGIN; BY LIGATION
Modifier:
Sending a Notification of Appointment Booking for case #230


                            SECOND CONCURRENT CASE
                     OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,TWELVE (000-41-8719)                                    DEC  1, 2005
================================================================================

Primary Surgeon: SURSURGEON,TWO
Attending Surgeon: SURSURGEON,ONE
Surgical Specialty: 58          THORACIC SURGERY (INC. CARDIAC SURG.)  THORACIC
SURGERY (INC. CARDIAC SURG.)        58
Principal Operative Procedure: AORTO CORONARY BYPASS GRAFT
Principal Preoperative Diagnosis: CORONARY ARTERY DISEASE


The information entered into the Principal Preoperative Diagnosis field
has been transferred into the Indications for Operation field.
The Indications for Operation field can be updated later if necessary.

Press RETURN to continue <Enter>

Laterality Of Procedure: NA
Planned Admission Status: SAME DAY
Planned Principal Procedure Code:  35526         ARTERY BYPASS GRAFT
 BYPASS GRAFT, WITH VIEN; AORTOSUBCLAVIAN, AORTOINNOMINATE, OR AORTOCAROTID

Modifier:
```

```
                                SECOND CONCURRENT CASE
                          OPERATION REQUEST: PROCEDURE INFORMATION

SURPATIENT,TWELVE (000-41-8719)                                  DEC  1, 2005
================================================================================
Principal Procedure:      AORTO CORONARY BYPASS GRAFT
Planned Principal Procedure Code (CPT): 35526  ARTERY BYPASS GRAFT
 Modifier: -66 SURGICAL TEAM
Select OTHER PROCEDURE: <Enter>
Estimated Case Length (HOURS:MINUTES): 3:30
BRIEF CLIN HISTORY:
  1>CARDIAC CATH SHOWS 80% OCCLUSION OF THE LAD, 75% OCCLUSION OF
  2>RIGHT CORONARY. ALSO, ANTERIOR INFERIOR HYPOKINESIS WITH
  3>POOR LEFT VENTRICULAR FUNCTION, 27%.
  4><Enter>
EDIT Option: <Enter>
```

```
                           SECOND CONCURRENT CASE
                     OPERATION REQUEST: BLOOD INFORMATION

SURPATIENT,TWELVE (000-41-8719)                                  DEC  1, 2005
================================================================================


Request Blood Availability ? N// YES
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH// <Enter> TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// @
SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y (YES)
Select REQ BLOOD KIND: 04061 CPDA-1 RED BLOOD CELLS, DIVIDED UNIT 04061
Units Required: 4
```

```
                           SECOND CONCURRENT CASE
                     OPERATION REQUEST: OTHER INFORMATION

SURPATIENT,TWELVE (000-41-8719)                                  DEC  1, 2005
================================================================================

Principal Preoperative Diagnosis: CORONARY ARTERY DISEASE
           Replace <ENTER>
Prin Pre-OP ICD Diagnosis Code (ICD9): 996.03

 One match found

     996.03   MALFUNC CORON BYPASS GRF(CC)
         ...OK? YES//  <Enter> (YES) 996.03  MALFUNC CORON BYPASS GRF(CC)  996.03 ICD-9 MAL
FUNC CORON BYPASS GRF
Palliation: NO
Pre-admission Testing Complete (Y/N): Y  YES

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

Case Schedule Type: S  STANDBY

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

First Assistant: SURSURGEON,SIX
Second Assistant: <Enter>
Attending Surgeon: SURSURGEON,ONE// <Enter>
Planned Postop Care: ICU     I
Case Schedule Order: 2

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

Select SURGERY POSITION: SUPINE// <Enter>
  Surgery Position: SUPINE// <Enter>
```

```
Requested Anesthesia Technique: GENERAL

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

Request Frozen Section Tests (Y/N): N  NO
Do you want to store this information in the concurrent case ?  YES// <Enter>
Requested Preoperative X-Rays: DOPPLER STUDIES
Do you want to store this information in the concurrent case ?  YES//  N
Intraoperative X-Rays (Y/N): N  NO
Do you want to store this information in the concurrent case ?  YES// <Enter>
Request Medical Media (Y/N): N  NO
Do you want to store this information in the concurrent case ?  YES//  <Enter>
Preoperative Infection: C  CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
SPD Comments: <Enter>
  No existing text
  Edit? NO// <Enter>

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

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

```
          ** REQUESTS **   CASE #231  SURPATIENT,TWELVE              PAGE 1 OF 3

1    PRINCIPAL PROCEDURE:     AORTO CORONARY BYPASS GRAFT
2    OTHER PROCEDURES:        (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35526-66
4    LATERALITY OF PROCEDURE:
5    PRINCIPAL PRE-OP DIAGNOSIS: CORONARY ARTERY DISEASE
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 996.03
7    OTHER PREOP DIAGNOSIS: (MULTIPLE)
8    PALLIATION:              NO
9    PLANNED ADMISSION STATUS: ADMITTED
10   PRE-ADMISSION TESTING:
11   CASE SCHEDULE TYPE:    STANDBY
12   SURGERY SPECIALTY:     THORACIC SURGERY (INC. CARDIAC SURG.)
13   PRIMARY SURGEON:       SURSURGEON,TWO
14   FIRST ASST:            SURSURGEON,SIX
15   SECOND ASST:

Enter Screen Server Function:   <Enter>
```

```
          ** REQUESTS **   CASE #231  SURPATIENT,TWELVE              PAGE 2 OF 3

1    ATTENDING SURGEON:        SURSURGEON,TWO
2    PLANNED POSTOP CARE:      ICU
3    CASE SCHEDULE ORDER:      2
4    SURGERY POSITION:         (MULTIPLE)(DATA)
5    REQ ANESTHESIA TECHNIQUE: GENERAL
6    REQ FROZ SECT:            NO
7    REQ PREOP X-RAY:          DOPPLER STUDIES
8    INTRAOPERATIVE X-RAYS:    NO
9    REQUEST BLOOD AVAILABILITY: YES
10   CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
11   REQ BLOOD KIND:           (MULTIPLE)(DATA)
12   SPECIAL EQUIPMENT:        (MULTIPLE)
13   PLANNED IMPLANT:          (MULTIPLE)
14   SPECIAL SUPPLIES:         (MULTIPLE)
15   SPECIAL INSTRUMENTS:      (MULTIPLE)
```

```
Enter Screen Server Function:  <Enter>
```

Example 2: Update Request Information for a Concurrent Case

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


The following cases are requested for SURPATIENT,TWELVE:

1. 03-09-05   REMOVE FACIAL LESIONS
2. 12-01-05   CAROTID ARTERY ENDARTERECTOMY
3. 12-01-05   AORTO CORONARY BYPASS GRAFT

Select Operation Request: 2

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

Select Number: 2

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

```
          ** UPDATE REQUEST **   CASE #230  SURPATIENT,TWELVE        PAGE 1 OF 3

1    PRINCIPAL PROCEDURE:     CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:        (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    LATERALITY OF PROCEDURE:
5    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9):
7    OTHER PREOP DIAGNOSIS:   (MULTIPLE)
8    PALLIATION:              NO
9    PLANNED ADMISSION STATUS: ADMITTED
10   PRE-ADMISSION TESTING:
11   CASE SCHEDULE TYPE:              STANDBY
12   SURGERY SPECIALTY:               PERIPHERAL VASCULAR
13   PRIMARY SURGEON:                 SURSURGEON,ONE
14   FIRST ASST:
15   SECOND ASST:
16   ATTENDING SURGEON:        SURSURGEON,TWO

Enter Screen Server Function:  6
Prin Pre-OP ICD Diagnosis Code (ICD9): 433.1

 One match found

     433.1      CAROTID ARTERY OCCLUSION      COMPLICATION/COMORBIDITY

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

```
          ** UPDATE REQUEST **   CASE #230  SURPATIENT,TWELVE        PAGE 1 OF 3

1    PRINCIPAL PROCEDURE:     CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:        (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    LATERALITY OF PROCEDURE:
5    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD): 433.1
7    OTHER PREOP DIAGNOSIS:   (MULTIPLE)
8    PALLIATION:
9    PLANNED ADMISSION STATUS: ADMITTED
10   PRE-ADMISSION TESTING:
11   CASE SCHEDULE TYPE:      STANDBY
12   SURGERY SPECIALTY:       PERIPHERAL VASCULAR
13   PRIMARY SURGEON:         SURSURGEON,ONE
14   FIRST ASST:
15   SECOND ASST:

Enter Screen Server Function:   <Enter>
```

```
          ** UPDATE REQUEST **   CASE #230  SURPATIENT,TWELVE        PAGE 2 OF 3

1    ATTENDING SURG:           SURSURGEON,TWO
2    PLANNED POSTOP CARE:
3    CASE SCHEDULE ORDER:
4    SURGERY POSITION:        (MULTIPLE)
5    REQ ANESTHESIA TECHNIQUE: GENERAL
6    REQ FROZ SECT:      NO
7    REQ PREOP X-RAY:
8    INTRAOPERATIVE X-RAYS: NO
9    REQUEST BLOOD AVAILABILITY:
10   CROSSMATCH, SCREEN, AUTOLOGOUS:
11   REQ BLOOD KIND:           (MULTIPLE)
12   SPECIAL EQUIPMENT:        (MULTIPLE)
13   PLANNED IMPLANT:          (MULTIPLE)
14   SPECIAL SUPPLIES:         (MULTIPLE)
15   SPECIAL INSTRUMENTS:      (MULTIPLE)

Enter Screen Server Function:  <Enter>
```

```
         ** UPDATE REQUEST **   CASE #230  SURPATIENT,TWELVE        PAGE 3 OF 3

1    PHARMACY ITEMS:         (MULTIPLE)
2    REQ PHOTO:              NO
3    PREOPERATIVE INFECTION:
4    REFERRING PHYSICIAN:     (MULTIPLE)
5    GENERAL COMMENTS:        (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING) (DATA)
7    BRIEF CLIN HISTORY:      (WORD PROCESSING)
8    SPD COMMENTS:            (WORD PROCESSING)

Enter Screen Server Function:
```

Review Request Information
[SROREQV]

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

Example: Review Request Information

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

 SURPATIENT,ONE

1. 03-09-99   REVISE MEDIAN NERVE (REQUESTED)

Select Operation:  1
```

```
          ** REVIEW REQUEST **   CASE #35  SURPATIENT,ONE       PAGE 1 OF 2

1    PRINCIPAL PROCEDURE:     REVISE MEDIAN NERVE
2    OTHER PROCEDURES:        (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 64721
4    LATERALITY OF PROCEDURE: NA
5    PRINCIPAL PRE-OP DIAGNOSIS: CARPAL TUNNEL SYNDROME
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 354.0
7    OTHER PREOP DIAGNOSIS:    (MULTIPLE)
8    PLANNED ADMISSION STATUS: ADMITTED
9    CASE SCHEDULE TYPE:       ELECTIVE
10   SURGERY SPECIALTY:        ORTHOPEDICS
11   PRIMARY SURGEON:          SURSURGEON,ONE
12   FIRST ASST:               SURSURGEON,THREE
13   SECOND ASST:              SURSURGEON,TWO
14   ATTENDING SURGEON:        SURSURGEON,ONE
15   PLANNED POSTOP CARE:      ICU

Enter Screen Server Function:  <Enter>
```

```
           ** REVIEW REQUEST **   CASE #35  SURPATIENT,ONE       PAGE 2 OF 2

1    CASE SCHEDULE ORDER:
2    SURGERY POSITION:         (MULTIPLE)(DATA)
3    REQ ANESTHESIA TECHNIQUE: GENERAL
4    REQ FROZ SECT:
5    REQ PREOP X-RAY:          CARPAL TUNNEL, R WRIST
6    INTRAOPERATIVE X-RAYS:
7    REQUEST BLOOD AVAILABILITY: NO
8    CROSSMATCH, SCREEN, AUTOLOGOUS:
9    REQ BLOOD KIND:          (MULTIPLE)
10   REQ PHOTO:
11   PREOPERATIVE INFECTION: CLEAN
12   REFERRING PHYSICIAN:   (MULTIPLE)
13   GENERAL COMMENTS:      (WORD PROCESSING)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
```

Enter Screen Server Function:

Entering Preoperative Information

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

```
SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

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


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

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH// <Enter> TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// @
   SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y  (YES)
Select REQ BLOOD KIND: FA1  FRESH FROZEN PLASMA, CPDA-1      18201
  Units Required: 4
```

```
                    SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

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

Prin Pre-OP ICD Diagnosis Code: 715.11  715.11         LOC PRIM OSTEOART-SHLDER
         ...OK? YES// <Enter>  (YES)
Hospital Admission Status:  2  ADMISSION
Case Schedule Type: S  STANDBY
First Assistant: TS  SURSURGEON,THREE
Second Assistant: SURSURGEON,FOUR
Requested Postoperative Care: W  WARD
Case Schedule Order: 1
Requested Anesthesia Technique: G  GENERAL
Request Frozen Section Tests (Y/N): N  NO
Requested Preoperative X-Rays: LEFT SHOULDER
Intraoperative X-Rays (Y/N/C): Y  YES
Request Medical Media (Y/N): N  NO
Preoperative Infection: C  CLEAN
GENERAL COMMENTS:
  1><Enter>
 SPD Comments:
  1><Enter>
```

```
  ** SCHEDULING **   CASE #264  SURPATIENT,THREE          PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: SHOULDER ARTHROPLASTY-PROSTHESIS
2    PLANNED PRIN PROCEDURE CODE: 23470
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 715.11
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    HOSPITAL ADMISSION STAUTS: ADMISSION
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  ORTHOPEDICS
11   PRIMARY SURGEON:            SURSURGEON,ONE
12   FIRST ASST:          SURSURGEON,THREE
13   SECOND ASST:         SURSURGEON,FOUR
14   ATTENDING SURGEON:         SURSURGEON,TWO
15   PLANNED POSTOP CARE:    WARD

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #264  SURPATIENT,THREE          PAGE 2 OF 2

1    CASE SCHEDULE ORDER: 1
2    REQ ANESTHESIA TECHNIQUE: GENERAL
3    REQ FROZ SECT:      NO
4    REQ PREOP X-RAY:    LEFT SHOULDER
5    INTRAOPERATIVE X-RAYS: YES
6    REQUEST BLOOD AVAILABILITY: YES
7    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8    REQ BLOOD KIND:     (MULTIPLE)(DATA)
9    SPECIAL EQUIPMENT:  (MULTIPLE)
10   PHARMACY ITEMS:     (MULTIPLE)
11   REQ PHOTO:          NO
12   PREOPERATIVE INFECTION: CLEAN
13   PRINC ANESTHETIST:  SURANESTHETIST,ONE
14   ANESTHESIOLOGIST SUPVR: SURSURGEON,TWO
15   BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)
16   GENERAL COMMENTS:   (WORD PROCESSING)
1   SPD COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:
```

```
                          FIRST CONCURRENT CASE
                  SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

SURPATIENT,EIGHT (000-37-0555)                                  JUL 25, 1999
================================================================================

Prin Pre-OP ICD Diagnosis Code: 433.11     OCCL&STEN/CAR ART W/CRB INF
 COMPLICATION/COMORBIDITY     ACTIVE
Hospital Admission Status:  2  ADMISSION

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

Case Schedule Type: S  STANDBY

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

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

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

Case Schedule Order: 2

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

Requested Anesthesia Technique: G  GENERAL

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

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

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

Requested Preoperative X-Rays: DOPPLER STUDIES

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

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

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

Request Medical Media (Y/N): N  NO

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

Preoperative infection: C  CLEAN

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

GENERAL COMMENTS:
  1><Enter>
SPD Comments:
  1><Enter>

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


Press RETURN to continue  <Enter>
```

```
  ** SCHEDULING **   CASE #265  SURPATIENT,EIGHT      PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    PLANNED PRIN PROCEDURE CODE: 35301
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 433.1
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    HOSPITAL ADMISSION STATUS: ADMISSION
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
11   PRIMARY SURGEON:            SURSURGEON,ONE
12   FIRST ASST:         SURSURGEON,FOUR
13   SECOND ASST:        SURSURGEON,THREE
14   ATTENDING SURG:        SURSURGEON,ONE
15   PLANNED POSTOP CARE:    SICU

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #265  SURPATIENT,EIGHT      PAGE 2 OF 2

1    CASE SCHEDULE ORDER: 2
2    REQ ANESTHESIA TECHNIQUE: GENERAL
3    REQ FROZ SECT:      NO
4    REQ PREOP X-RAY:    DOPPLER STUDIES
5    INTRAOPERATIVE X-RAYS: NO
6    REQUEST BLOOD AVAILABILITY: YES
7    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8    REQ BLOOD KIND:     (MULTIPLE)(DATA)
9    PHARMACY ITEMS:     (MULTIPLE)
10   REQ PHOTO:          NO
11   PREOPERATIVE INFECTION: CLEAN
12   PRINC ANESTHETIST:  SURANESTHETIST,ONE
13   ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO
14   BRIEF CLIN HISTORY: (WORD PROCESSING)
15   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

```
      SECOND CONCURRENT CASE
                  SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

SURPATIENT,SIX (000-09-8797)                                    SEP 16, 2005
================================================================================

Prin Pre-OP ICD Diagnosis Code: 715.90 715.90     OSTEOARTHROS NOS-UNSPEC
      ACTIVE
         ...OK? Yes// <Enter>  (Yes)
(Hospital Admission Status: 2  ADMISSION

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

Case Schedule Type:  S  STANDBY

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

First Assistant: TS  SURSURGEON,THREE
Second Assistant:  <Enter>
Requested Postoperative Care: WARD

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

Case Schedule Order: 1

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

Requested Anesthesia Technique: GENERAL

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

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

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

Requested Preoperative X-Rays:  <Enter>
Intraoperative X-Rays (Y/N): Y  YES

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

Request Medical Media (Y/N): N  NO

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

Preoperative Infection: C  CLEAN

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

GENERAL COMMENTS:
  1>  <Enter>
SPD Comments:
  1><Enter>

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

```
  ** SCHEDULING **   CASE #245  SURPATIENT,SIX         PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: ARTHROSCOPY, R SHOULDER
2    PLANNED PRIN PROCEDURE CODE: 23470
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: DEGERATIVE OSTEOARTHRITIS
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 715.90
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    HOSPITAL ADMISSION STAUTS: ADMISSION
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  ORTHOPEDICS
11   PRIMARY SURGEON:            SURSURGEON,TWO
12   FIRST ASST:          SURSURGEON,THREE
13   SECOND ASST:
14   ATTENDING SURGEON:        SURSURGEON,TWO
15   PLANNED POSTOP CARE:    WARD

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #245  SURPATIENT,SIX         PAGE 2 OF 2

1    CASE SCHEDULE ORDER: 1
2    REQ ANESTHESIA TECHNIQUE: GENERAL
3    REQ FROZ SECT:      NO
4    REQ PREOP X-RAY:
5    INTRAOPERATIVE X-RAYS: YES
6    REQUEST BLOOD AVAILABILITY: YES
7    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8    REQ BLOOD KIND:     (MULTIPLE)(DATA)
9    PHARMACY ITEMS:     (MULTIPLE)
10   REQ PHOTO:          NO
11   PREOPERATIVE INFECTION: CLEAN
12   PRINC ANESTHETIST:  SURANESTHETIST,ONE
13   ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO
14   BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)
15   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:   <Enter>
```

```
The following cases have been entered.

1.  Case # 224                          SEP 16, 2005
    Surgeon: SURSURGEON,ONE             NEUROSURGERY
    Procedure:  CARPAL TUNNEL RELEASE

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



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

Example 3: How to Update a Scheduled Operation

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

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

```
SURPATIENT,THREE (000-21-2453)


1. 09/15/05   SHOULDER ARTHROPLASTY-PROTHESIS (SCHEDULED)

Select Number: 1

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

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

```
 ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: SHOULDER ARTHOPLASTY-PROSTHESIS
2    PLANNED PRIN PROCEDURE CODE: 23470
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 715.11
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    HOSPITAL ADMISSION STAUTS: ADMISSION
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  ORTHOPEDICS
11   PRIMARY SURGEON:            SURSURGEON,ONE
12   FIRST ASST:          SURSURGEON,TWO
13   SECOND ASST:         SURSURGEON,FOUR
4   ATTENDING SURGEON:        SURSURGEON,ONE
15   PLANNED POSTOP CARE:    WARD

Enter Screen Server Function: <Enter>
```

```
  ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 2 OF 2

1    CASE SCHEDULE ORDER: 1
2    REQ ANESTHESIA TECHNIQUE: GENERAL
3    REQ FROZ SECT:      NO
4    REQ PREOP X-RAY:    LEFT SHOULDER
5    INTRAOPERATIVE X-RAYS: YES
6    REQUEST BLOOD AVAILABILITY: YES
7    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8    REQ BLOOD KIND:     (MULTIPLE)(DATA)
9    PHARMACY ITEMS:      (MULTIPLE)
10   REQ PHOTO:          NO
11   PREOPERATIVE INFECTION: CLEAN
12   PRINC ANESTHETIST:  SURANESTHETIST,ONE
13   ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO
14   BRIEF CLIN HISTORY: (WORD PROCESSING)
15   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  8
```

```
** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
         REQ BLOOD KIND

1    REQ BLOOD KIND:        FRESH FROZEN PLASMA, CPDA-1
2    NEW ENTRY

Enter Screen Server Function:  2
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD        00160
    REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// <Enter>
```

```
 ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
         REQ BLOOD KIND  (CPDA-1 WHOLE BLOOD)

1    REQ BLOOD KIND:        CPDA-1 WHOLE BLOOD
2    UNITS REQ:

Enter Screen Server Function:  2
Units Required: 2
```

```
 ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
         REQ BLOOD KIND  (CPDA-1 WHOLE BLOOD)

1    REQ BLOOD KIND:        CPDA-1 WHOLE BLOOD
2    UNITS REQ:             2

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
         REQ BLOOD KIND

1    REQ BLOOD KIND:        FRESH FROZEN PLASMA, CPDA-1
2    REQ BLOOD KIND:        CPDA-1 WHOLE BLOOD
3    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 2 OF 2


1    CASE SCHEDULE ORDER: 1
2    REQ ANESTHESIA TECHNIQUE: GENERAL
3    REQ FROZ SECT:      NO
4    REQ PREOP X-RAY:    LEFT SHOULDER
5    INTRAOPERATIVE X-RAYS: YES
6    REQUEST BLOOD AVAILABILITY: YES
7    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8    REQ BLOOD KIND:     (MULTIPLE)(DATA)
9    SPECIAL EQUIPMENT: (MULTIPLE)
19   PHARMACY ITEMS:     (MULTIPLE)
10   REQ PHOTO:          NO
11   PREOPERATIVE INFECTION: CLEAN
12   PRINC ANESTHETIST:  SURANESTHETIST,ONE
13   ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO
14   BRIEF CLIN HISTORY: (WORD PROCESSING)
15   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

Operation Menu

[SROPER]

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

This option is locked with the SROPER key.

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

Shortcut	Option Name
I	*Operation Information*
SS	*Surgical Staff*
OS	*Operation Startup*
O	*Operation*
PO	*Post Operation*
PAC	*Enter PAC(U) Information*
OSS	*Operation (Short Screen)*
V	*Surgeon's Verification of Diagnosis & Procedures*
A	*Anesthesia Menu*
OR	*Operation Report*
AR	*Anesthesia Report*
NR	*Nurse Intraoperative Report*
TR	*Tissue Examination Report*
R	*Enter Referring Physician Information*
RP	*Enter Irrigations and Restraints*
M	*Medications (Enter/Edit)*
AB	*Abort/Cancel Operation*
B	*Blood Product Verification*

Entering Information

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

Example: Enter Information

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

```
 SURPATIENT,THREE   000-21-2453

1. 03-12-92   SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)

2. 08-15-88   SHOULDER ARTHROPLASTY (NOT COMPLETE)

3. ENTER NEW SURGICAL CASE


Select Operation: 2
```

```
 SURPATIENT,THREE  000-21-2453

 08-15-88     SHOULDER ARTHROPLASTY (NOT COMPLETE)


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

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

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

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


   I      Operation Information
   SS     Surgical Staff
   OS     Operation Startup
   O      Operation
   PO     Post Operation
   PAC    Enter PAC(U) Information
   OSS    Operation (Short Screen)
   TO     Time Out Verified Utilizing Checklist
   V      Surgeon's Verification of Diagnosis & Procedures
   A      Anesthesia for an Operation Menu ...
   OR     Operation Report
   AR     Anesthesia Report
   NR     Nurse Intraoperative Report
   TR     Tissue Examination Report
   R      Enter Referring Physician Information
   RP     Enter Irrigations and Restraints
   M      Medications (Enter/Edit)
   AB     Abort/Cancel Operation
   B      Blood Product Verification

Select Operation Menu Option:
```

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

Reviewing Information

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

Example: Review Information

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

```
 SURPATIENT,THREE   000-21-2453

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

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

3. ENTER NEW SURGICAL CASE

Select Operation: 2
```

```
SURPATIENT,THREE  000-21-2453

 08-15-88     SHOULDER ARTHROPLASTY (NOT COMPLETE)


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

Select Number:  1//  2
```

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

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

Enter Screen Server Function:  <Enter>
```

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

1    POSSIBLE ITEM RETENTION:
2    SPONGE FINAL COUNT CORRECT:
3    SHARPS FINAL COUNT CORRECT:
4    INSTRUMENT FINAL COUNT CORRECT:
5    WOUND SWEEP: No
6    WOUND SWEEP COMMENTS:    (WORD PROCESSING)
7    INTRA-OPERATIVE X-RAYS: No
8    INTRA-OPERATIVE X-RAYS COMMENTS:  (WORD PROCESSING)
9    SPONGE, SHARPS, & INST COUNTER:
10   COUNT VERIFIER:
11   SEQUENTIAL COMPRESSION DEVICE:
12   LASER PERFORMED:         (MULTIPLE)
13   CELL SAVER:              (MULTIPLE)
```

Abort/Cancel Operation
[SROABRT]

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

Example: Abort Operation

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

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

Case Aborted?: N// Y
     1   YES-PRE ANESTHESIA
     2   YES-POST ANESTHESIA
Choose 1-2: 1  YES-PRE ANESTHESIA
Time Patient In the O.R.: JUN 22,2015@0730  (JUN 22, 2015@07:30)
Time Patient Out of the O.R.: JUN 22,2015@0800  (JUN 22, 2015@08:00)
Primary Cancellation Reason: 1  PATIENT RELATED ISSUE    1
Cancellation Date/Time: JUN 22,2015@0810  (JUN 22, 2015@08:10)
Cancellation Avoidable: N  NO

Aborting Surgery case #21814

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

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

Example: Cancel Operation

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

 SURPATIENT,ELEVEN (666-00-0785)   Case #21815 - JUN 22, 2015
-------------------------------------------------------------------------------------------------

Case Aborted?: N// <Enter> NO
Primary Cancellation Reason: 6  SCHED ISSUES NON EMERGENT CASE
Cancellation Date/Time: JUN 22,2015@0700  (JUN 22, 2015@07:00)
Cancellation Avoidable: N  NO

Cancelling Surgery case #21815

Enter RETURN to continue or '^' to exit: <Enter
```

Entering a New Surgical Case

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

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

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

Prompts that require a response include:

"Select the Date of Operation:"

“Desired Procedure Date:”
"Enter the Principal Operative Procedure:"
"Principal Preoperative Diagnosis:"
"Select Primary Surgeon:"
"Attending Surgeon:"
"Select Surgical Specialty:"
“Planned Principal Procedure Code:”

Example: Entering a New Surgical Case

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

 SURPATIENT,SIX   000-09-8797

1. ENTER NEW SURGICAL CASE

Select Operation: 1

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

Enter the Principal Operative Procedure: APPENDECTOMY
Principal Preoperative Diagnosis: APPENDICITIS

The information entered into the Principal Preoperative Diagnosis field
has been transferred into the Indications for Operation field.
The Indications for Operation field can be updated later if necessary.

Select Primary Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,TWO
Select Surgical Specialty: GENERAL SURGERY     GENERAL SURGERY 50  (OR WHEN NOT DEFINED BELOW)
Planned Principal Procedure Code: 44960    APPENDECTOMY
 APPENDECTOMY; FOR RUPTURED APPENDIX WITH ABSCESS OR GENERALIZED PERITONITIS
 Modifier:

Brief Clinical History:
  1>PATIENT WITH 5-DAY HISTORY OF INCREASING ABDOMINAL
  2>PAIN, ONSET OF FEVER IN LAST 24 HOURS. REBOUND
  3>TENDERNESS IN RIGHT LOWER QUAD. NAUSEA AND
  4>VOMITING FOR 3 DAYS.
  5><Enter>
EDIT Option: <Enter>

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

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH// <Enter> TYPE & CROSSMATCH

Select REQ BLOOD KIND: AS-1 RED BLOOD CELLS// <Enter
  Required Blood Product: CPDA-1 RED BLOOD CELLS// <Enter>
  Units Required: 2
```

```
Principal Preoperative Diagnosis: APPENDICITIS// <Enter>
Prin Pre-OP ICD Diagnosis Code (ICD9): 540.9

 One match found

     540.9     ACUTE APPENDICITIS NOS (CC)

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

Hospital Admission Status: 2 <Enter> ADMISSION
Case Schedule Type: EM  EMERGENCY
First Assistant: SURSURGEON,ONE
Second Assistant: SURSURGEON,FOUR
Attending Surgeon:
Planned Postop Care: W  WARD
```

```
Case Schedule Order: <Enter>
Select SURGERY POSITION: SUPINE// <Enter>
  Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: G  GENERAL
Request Frozen Section Tests (Y/N): N  NO
Requested Preoperative X-Rays: <Enter>
Intraoperative X-Rays (Y/N/C): N  NO
Request Medical Media (Y/N): N  NO
Preoperative infection: C  CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments:
  1> <Enter>
SPD Comments:
  No existing text
  Edit? NO// <Enter>
```

```
          ** NEW SURGERY **   CASE #185  SURPATIENT,SIX                    PAGE 1 OF 3

1    PRINCIPAL PROCEDURE:     APPENDECTOMY
2    OTHER PROCEDURES:        (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE:
4    LATERALITY OF PROCEDURE: LEFT
5    PRINCIPAL PRE-OP DIAGNOSIS: APPENDICITIS
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 540.9
7    OTHER PREOP DIAGNOSIS:    (MULTIPLE)
8    PALLIATION:                NO
9    PLANNED ADMISSION STAUTS: ADMITTED
10    PRE-ADMISSION TESTING:
11   CASE SCHEDULE TYPE: EMERGENCY
12   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
13   PRIMARY SURGEON:            SURSURGEON,ONE
14   FIRST ASST:          SURSURGEON,ONE
15   SECOND ASST:         SURSURGEON,FOUR
15   ATTENDING SURGEON:         SURSURGEON,TWO

Enter Screen Server Function:  <Enter>
```

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

1    ATTENDING SURGEON:         SURSURGEON,TWO
2    PLANNED POSTOP CARE:    WARD
3    CASE SCHEDULE ORDER:
4    SURGERY POSITION:   (MULTIPLE)(DATA)
5    REQ ANESTHESIA TECHNIQUE: GENERAL
6    REQ FROZ SECT:      NO
7    REQ PREOP X-RAY:
8    INTRAOPERATIVE X-RAYS: NO
9    REQUEST BLOOD AVAILABILITY: YES
10    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH11   REQ BLOOD KIND:
(MULTIPLE)(DATA)

12   SPECIAL EQUIPMENT:          (MULTIPLE)
13    PLANNED IMPLANT:           (MULTIPLE)
14    SPECIAL SUPPLIES:          (MULTIPLE)
15    SPECIAL INSTRUMENTS:       (MULTIPLE)

Enter Screen Server Function:   <Enter>
```

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

1    PHARMACY ITEMS:            (MULTIPLE)
2    REQ PHOTO:                 NO
3    PREOPERATIVE INFECTION:    CLEAN
4    REFERRING PHYSICIAN:       (MULTIPLE)
5    GENERAL COMMENTS:          (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7   BRIEF CLIN HISTORY:        (WORD PROCESSING)(DATA)
8   SPD COMMENTS:              (WORD PROCESSING)

Enter Screen Server Function:
```

Example: Entering Surgical Staff

```
Select Operation Menu Option: SS Surgical Staff

          ** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1 OF 1

1    PRIMARY SURGEON             SURSURGEON,ONE
2    PGY OF PRIMARY SURGEON:
3    FIRST ASST:            SURSURGEON,TWELVE
4    SECOND ASST:           SURSURGEON,TWO
5    ATTENDING SURGEON:           SURSURGEON,ONE
6    ATTENDING/RES SUP CODE:
7    PRINC ANESTHETIST:     SURANESTHETIST,FOUR
8    ASST ANESTHETIST:
9    ANESTHESIOLOGIST SUPVR: SURSURGEON,TWO
10   PERFUSIONIST:
11   ASST PERFUSIONIST:
12   OR CIRC SUPPORT:       (MULTIPLE)
13   OR SCRUB SUPPORT:      (MULTIPLE)
14   OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15   OTHER PERSONS IN OR:   (MULTIPLE)

Enter Screen Server Function: 6;13;15
Attending/Res Sup Code: C  LEVEL C: ATTENDING IN O.R., NOT SCRUBBED  C
  The supervising practitioner is physically present in the operative or
  procedural room. The supervising practitioner observes and provides
  direction. The resident performs the procedure.
```

```
** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1
         OR SCRUB SUPPORT

1    NEW ENTRY

Enter Screen Server Function:  1
Select OR SCRUB SUPPORT: SURNURSE,ONE
    OR SCRUB SUPPORT: SURNURSE,ONE// <Enter>
```

```
** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1
         OR SCRUB SUPPORT  (SURNURSE,ONE)

1    OR SCRUB SUPPORT:      SURNURSE,ONE
2    TIME ON:               (MULTIPLE)
3    STATUS:

Enter Screen Server Function: 2:3
Educational Status:  ?
     CHOOSE FROM:
       O        ORIENTEE
       F        FULLY TRAINED
Educational Status: F  FULLY TRAINED
```

```
** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1
         OR SCRUB SUPPORT  (SURNURSE,ONE)
           TIME ON

1    NEW ENTRY

Enter Screen Server Function:  1
Select TIME ON: 8:00  (JUN 06, 1999@08:00)
    TIME ON: JUN 06, 1999@08:00// <Enter>
```

Operation Startup

[SROMEN-START]

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

Some of the data fields are "multiple fields" and can have more than one value. For example, a patient can have more than one diagnosis or restraint/position aid. When a multiple field is selected, a new screen is generated so that the user can enter data related to that multiple. At the "Enter Screen Server Function:" prompt, the user can choose the field(s) to be edited, or press the **<Enter>** key to go to the next item or page.

Field Information

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

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

Example: Operation Startup

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

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

1    HEIGHT:                  58 INCHES
2    WEIGHT:                  264 LBS.
3    DATE OF OPERATION:       DEC 06, 2004 AT 08:00
4    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
5    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9):
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    OP ROOM PROCEDURE PERFORMED:        OR2
8    SURGERY SPECIALTY:     ORTHOPEDICS
9    PLANNED POSTOP CARE:       WARD
10    CASE SCHEDULE TYPE:    ELECTIVE
11   REQ ANESTHESIA TECHNIQUE: GENERAL
12   PATIENT EDUCATION/ASSESSMENT:
13   DELAY CAUSE:           (MULTIPLE)
14   ASA CLASS:
15   PREOP MOOD:
Enter Screen Server Function: 9;12
Planned Postop Care: WARD       W
Preoperative Patient Education: Y  YES
```

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

1    HEIGHT:                  58 INCHES
2    WEIGHT:                  264 LBS.
3    DATE OF OPERATION:     DEC 06, 2004 AT 08:00
4    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    OP ROOM PROCEDURE PERFORMED:        OR2
8    SURGERY SPECIALTY:     ORTHOPEDICS
9    PLANNED POSTOP CARE:       WARD
10    CASE SCHEDULE TYPE:    ELECTIVE
11    REQ ANESTHESIA TECHNIQUE: GENERAL
12   PATIENT EDUCATION/ASSESSMENT: YES
13   DELAY CAUSE:           (MULTIPLE)
14   ASA CLASS:
15   PREOP MOOD:

Enter Screen Server Function: <Enter>
```

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

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

Enter Screen Server Function:  A
```

```
Preoperative Consciousness: AO  ALERT-ORIENTED     AO
Preoperative Skin Integrity: INTACT       I
Transported to O.R. By: PACU BED
Preop Surgical Site Hair Removal by: SURNURSE,TWO
Surgical Site Hair Removal Method: N  NO HAIR REMOVED
Hair Removal Comments:
  No existing text
  Edit? NO//  <Enter>
Foley Catheter Inserted By:
Skin Prepped By: <Enter>
Skin Prepped By (2):
Skin Preparation Agent: HIBICLENS       HI
Second Skin Preparation Agent: <Enter>
Laterality Of Procedure: NA
Electroground Placement:
```

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

1    SURGERY POSITION:      SUPINE
2    NEW ENTRY

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

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

1    SURGERY POSITION:      SEMISUPINE
2    TIME PLACED:

Enter Screen Server Function:  <Enter>
```

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

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

Enter Screen Server Function:  <Enter>
```

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

1    RESTR & POSITION AIDS: SAFETY STRAP
2    NEW ENTRY

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

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

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

Enter Screen Server Function:  2
Applied By: SURNURSE,TWO
```

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

1    PREOP CONSCIOUS:
2    PREOP SKIN INTEG:
3    TRANS TO OR BY:
4    HAIR REMOVAL BY:
5    HAIR REMOVAL METHOD:
6    HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
7    FOLEY CATHETER INSERTED BY:
80   SKIN PREPPED BY (1):
91   SKIN PREPPED BY (2):
10   SKIN PREP AGENTS:
11   SECOND SKIN PREP AGENT:
12   SURGERY POSITION:        (MULTIPLE)(DATA)
13   LATERALITY OF PROCEDURE:
14   RESTR & POSITION AIDS:   (MULTIPLE)(DATA)
15   ELECTROGROUND POSITION:

Enter Screen Server Function:  <Enter>
```

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

1   ELECTROGROUND POSITION (2):

Enter Screen Server Function:  1
Electroground Position (2): LF  LEFT FLANK
```

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

1   ELECTROGROUND POSITION (2):

Enter Screen Server Function:
```

(This page included for two-sided copying.)

Operation
[SROMEN-OP]

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

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

Field Information

The following are fields that correspond to the Operation entries.

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

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

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

1    POSSIBLE ITEM RETENTION:
2    SPONGE FINAL COUNT CORRECT:
3    SHARPS FINAL COUNT CORRECT:
4    INSTRUMENT FINAL COUNT CORRECT:
5    WOUND SWEEP:
6    WOUND SWEEP COMMENT:    (WORD PROCESSING)
7    INTRA-OPERATIVE X-RAYS: No
8    INTRA-OPERATIVE X-RAYS COMMENT: (WORD PROCESSING)
9    SPONGE, SHARPS, & INST COUNTER:
10   COUNT VERIFIER:
11   SEQUENTIAL COMPRESSION DEVICE:
12   LASER PERFORMED:          (MULTIPLE)
13   CELL SAVER:               (MULTIPLE)
14   NURSING CARE COMMENTS:    (WORD PROCESSING)
15   PRINCIPAL PRE-OP DIAGNOSIS: SDSFD DSFFDS

Enter Screen Server Function: 1:4
```

```
Possible Item Retention: Y  YES
Sponge Final Count Correct: Y  YES
Sharps Final Count Correct: Y  YES
Instrument Final Count Correct: Y  Yes
```

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

1    POSSIBLE ITEM RETENTION:  YES
2    SPONGE FINAL COUNT CORRECT: YES
3    SHARPS FINAL COUNT CORRECT: YES
4    INSTRUMENT FINAL COUNT CORRECT: YES
5    WOUND SWEEP:
6    WOUND SWEEP COMMENT:    (WORD PROCESSING)
7    INTRA-OPERATIVE X-RAYS: No
8    INTRA-OPERATIVE X-RAYS COMMENT: (WORD PROCESSING)
9    SPONGE, SHARPS, & INST COUNTER:
10   COUNT VERIFIER:
11   SEQUENTIAL COMPRESSION DEVICE:
12   LASER PERFORMED:          (MULTIPLE)
13   CELL SAVER:               (MULTIPLE)
14   NURSING CARE COMMENTS:    (WORD PROCESSING)
15   PRINCIPAL PRE-OP DIAGNOSIS: SDSFD DSFFDS

Enter Screen Server Function: 14
```

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

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

1    DATE OF OPERATION:     MAR 09, 2005
2    HOSPITAL ADMISSION STATUS: SAME DAY
3    PRIMARY SURGEON:               SURSURGEON,FOUR
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE:   REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE: 17000
9    OTHER PROCEDURES:      (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:        MAR 09, 2005 AT 13:00
14   TIME OPERATION BEGAN:  MAR 09, 2005 at 13:10
15   TIME OPERATION ENDS:   MAR 09, 2005 AT 13:36

Enter Screen Server Function:  <Enter>
```

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

1    TIME PAT OUT OR:
2    IV STARTED BY:
3    OR CIRC SUPPORT:         (MULTIPLE)
4    OR SCRUB SUPPORT:        (MULTIPLE)
5    OP ROOM PROCEDURE PERFORMED:          OR1
6    FIRST ASST:
7    POSSIBLE ITEM RETENTION:
8    SPONGE FINAL COUNT CORRECT:
9    SHARPS FINAL COUNT CORRECT:
10   INSTRUMENT FINAL COUNT CORRECT:
11   WOUND SWEEP: No
12   WOUND SWEEP COMMENT:
13   INTRA-OPERATIVE X-RAYS: No
14   INTRA-OPERATIVE X-RAYS COMMENT:
15   SPONGE, SHARPS, & INST COUNTER:

Enter Screen Server Function:  1;5

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

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

1    TIME PAT OUT OR:         MAR 12, 2006 AT 13:40
2    IV STARTED BY:
3    OR CIRC SUPPORT:         (MULTIPLE)
4    OR SCRUB SUPPORT:        (MULTIPLE)
5    OP ROOM PROCEDURE PERFORMED:          OR1
6    FIRST ASST:
7    POSSIBLE ITEM RETENTION:
8    SPONGE FINAL COUNT CORRECT:
9    SHARPS FINAL COUNT CORRECT:
10   INSTRUMENT FINAL COUNT CORRECT:
11   WOUND SWEEP: No
12   WOUND SWEEP COMMENT:
13   INTRA-OPERATIVE X-RAYS: No
14   INTRA-OPERATIVE X-RAYS COMMENT:
15   SPONGE,SHARPS, & INST COUNTER:

Enter Screen Server Function:
```

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

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

Enter Screen Server Function:  <Enter>
```

Time Out Verified Utilizing Checklist
[SROMEN-VERF]

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

Example: Time Out Verified Utilizing Checklist

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

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

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

Enter Screen Server Function:  A
Confirm Correct Patient Identity: Y  YES
Confirm Procedure To Be Performed: Y  YES
Confirm Site of Procedure, Including Laterality: Y  YES
Confirm Valid Consent: 1  YES, i-MED
Confirm Patient Position: N   NO
Confirm Proc. Site has been Marked Appropriately and the Site of the Mark is Vis
ible After Prep: Y  YES
Pertinent Medical Images Have Been Confirmed: Y  YES
Correct Medical Implant(s) is Available: Y  YES
Availability of Special Equipment: Y  YES
Appropriate Antibiotic Prophylaxis: Y  YES
Appropriate Deep Vein Thrombosis Prophylaxis: Y  YES
Blood Availability: Y  YES
Checklist Comment:
  No existing text
  Edit? NO// <Enter>
TIME-OUT DOCUMENT COMPLETED BY: SURNURSE,FIVE
TIME-OUT COMPLETED:

Checklist Comments should be entered when a "NO" response is entered for any of
 the Time Out Verified Utilizing Checklist fields.
Do you want to enter Checklist Comment ?  YES//

Checklist Comment:
  No existing text
  Edit? NO//
```

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

1    CONFIRM PATIENT IDENTITY: YES
2    PROCEDURE TO BE PERFORMED: YES
3    SITE OF PROCEDURE: YES
4    CONFIRM VALID CONSENT: YES, i-MED
5    CONFIRM PATIENT POSITION: YES
6    MARKED SITE CONFIRMED: YES
7    PREOPERATIVE IMAGES CONFIRMED: YES
8    CORRECT MEDICAL IMPLANTS: YES
9    AVAILABILITY OF SPECIAL EQUIP: YES
10   ANTIBIOTIC PROPHYLAXIS:  YES
```

```
11   APPROPRIATE DVT PROPHYLAXIS: YES
12   BLOOD AVAILABILITY: YES
13   CHECKLIST COMMENT:       (WORD PROCESSING)
14   TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE
15   TIME-OUT COMPLETED:
Enter Screen Server Function:
```

If the PLANNED PRIN PROCEDURE CODE field for the case is one of the following CPT codes Time Out Checklist-2 will be displayed: 32851, 32852,3 2853, 32854, 33935, 33945, 44135, 44136, 47135, 47136, 48160, 48554, 50360, 50365.

Example: Time Out Verified Utilizing Checklist-2

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

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

Enter Screen Server Function:
```

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

1    UNET VERIF BY SURGEON (Y/N):
2    ORGAN VER PRE-ANESTHESIA:
3    SURGEON VER ORGAN PRE-ANES:
4    SURGEON VER DONOR ORG PRE-ANES:
5    DONOR ORG VER PRE-ANES:
6    ORGAN VER PRE-TRANSPLANT:
7    SURGEON VER ORG PRE-TRANSPLANT:
8    ORGAN VER PRE-TRANSPLANT:
9    DONOR VESSEL UNOS ID:    (MULTIPLE)
10   DONOR VESSEL USAGE:
11   DONOR VESSEL DISPOSITION:

Enter Screen Server Function:
```

Nurse Intraoperative Report

[SRONRPT]

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

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

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

Nurse Intraoperative Report - Before Electronic Signature

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

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

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

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

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

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

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

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

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

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

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

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

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

Example: First page of the Nurse Intraoperative Report

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

                          SURPATIENT,TEN (000-12-3456)
   MEDICAL RECORD       NURSE INTRAOPERATIVE REPORT - CASE #267226       PAGE 1

Operating Room:  BO OR1                 Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004  07:30    Patient in OR:  JUL 12, 2004  08:00
Operation Begin: JUL 12, 2004  08:58    Operation End:  JUL 12, 2004  12:10
Surgeon in OR:   JUL 12, 2004  07:55    Patient Out OR: JUL 12, 2004  12:45

Major Operations Performed:
Primary: MVR

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

Primary Surgeon: SURSURGEON,THREE               First Assist: SURSURGEON,FOUR
Attending Surgeon: SURSURGEON,THREE           Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN       Assistant Anesth: N/A

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

After the user enters an **A** at the prompt, the *Nurse Intraoperative Report* functions are displayed. The following examples demonstrate how these three functions are accessed and how they operate.
If the user enters a **1**, the Nurse Intraoperative Report data can be edited.

Example: Editing the Nurse Intraoperative Report

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

 Nurse Intraoperative Report Functions:

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

Select number: 2// 1
```

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

1    CONFIRM PATIENT IDENTITY: YES
2    PROCEDURE TO BE PERFORMED: YES
3    SITE OF PROCEDURE: YES
4    CONFIRM VALID CONSENT: YES, i-MED
5    CONFIRM PATIENT POSITION: YES
6    MARKED SITE CONFIRMED: YES
7    PREOPERATIVE IMAGES CONFIRMED: YES
8    CORRECT MEDICAL IMPLANTS: YES
9    AVAILABILITY OF SPECIAL EQUIP: YES
10   ANTIBIOTIC PROPHYLAXIS:  YES
11   APPROPRIATE DVT PROPHYLAXIS: YES
12   BLOOD AVAILABILITY: YES
13   CHECKLIST COMMENT:       (WORD PROCESSING)
14   TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE
15   TIME-OUT COMPLETED: 07/12/2004@0800

Enter Screen Server Function: <Enter>
```

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

1    POSSIBLE ITEM RENTENTION: YES
2    SPONGE FINAL COUNT CORRECT: YES
3    SHARPS FINAL COUNT CORRECT: YES
4    INSTRUMENT FINAL COUNT CORRECT:
5    WOUND SWEEP:
6    WOUND SWEEP COMMENTS:   (WORD PROCESSING)
7    INTRA-OPERATIVE X-RAY:
8    INTRA-OPERATIVE X-RAY COMMENTS:   (WORD PROCESSING)
9    SPONE, SHARPS, & INST COUNTER:
10   COUNT VERIFIED:
11   TIME PAT IN HOLD AREA:    JUL 12, 2004 AT 07:30
12   TIME PAT IN OR:           JUL 12, 2004 AT 08:00
13   TIME OPERATION BEGAN:     JUL 12, 2004 at 08:58)
14   TIME OPERATION ENDS:      JUL 12, 2004 AT 12:30
15   SURG PRESENT TIME:

Enter Screen Server Function:  <Enter>
```

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

1    TIME PAT OUT OR:
2    PRINCIPAL PROCEDURE:
3    OTHER PROCEDURES:
4    WOUND CLASSIFICATION:
5    OP DISPOSITION:
6    OP ROOM PROCEDURE PERFORMED: OR1
7    CASE SCHEDULE TYPE:          ELECTIVE
8    PRIMARY SURGEON:             SURSURGEON,THREE
9    ATTENDING SURGEON:           SURSURGEON,THREE
10   FIRST ASST:                  SURSURGEON,FOUR
11   SECOND ASST:
```

```
12   PRINC ANESTHETIST:           SURANESTHETIST,SEVEN
13   ASST ANESTHETIST:
14   OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15   OR SCRUB SUPPORT: (MULTIPLE)

Enter Screen Server Function:  <Enter>
```

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

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

Enter Screen Server Function:  ^
```

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

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

Example: Printing the Nurse Intraoperative Report

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

 Nurse Intraoperative Report Functions:

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

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

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

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

SUBJECT: Case #: 267226

Operating Room:  BO OR1                Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004  07:30    Patient in OR:  JUL 12, 2004  08:00
Operation Begin: JUL 12, 2004  08:58    Operation End:  JUL 12, 2004  12:10
Surgeon in OR:   JUL 12, 2004  07:55    Patient Out OR: JUL 12, 2004  12:45

Major Operations Performed:
Primary: MVR

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

Primary Surgeon: SURSURGEON,THREE             First Assist: SURSURGEON,FOUR
Attending Surgeon: SURSURGEON,THREE           Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN             Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:
  Scrubbed                             Circulating
 SURNURSE,ONE (FULLY TRAINED)          SURNURSE,FIVE (FULLY TRAINED)
                                       SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood:       ANXIOUS              Preop Consc:    ALERT-ORIENTED
Preop Skin Integ: INTACT               Preop Converse: N/A

--- Time Out Checklist ---
Confirm Correct Patient Identity: YES
Confirm Procedure to be Performed: YES
Confirm Site of the Procedure, including laterality: YES
Confirm Valid Consent: YES, i-MED
Confirm Patient Position: YES
Confirm Proc. Site has been Marked Appropriately and that the Site of the
 Mark is Visible After Prep and Draping: YES
Pertinent Medical Images have been Confirmed: YES
Correct Medical Implant(s) is available: YES
Availability of Special Equipment: YES
Appropriate Antibiotic Prophylaxis: YES
Appropriate Deep Vein Thrombosis Prophylaxis: YES
Blood Availability: YES
Checklist Comment: NO COMMENTS ENTERED

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

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

Preop Surgical Site Hair Removal by: SURNURSE,FIVE
Surgical Site Hair Removal Method: OTHER
  Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):
  SUPINE                               Placed: N/A

Restraints and Position Aids:
  SAFETY STRAP                     Applied By: N/A
  ARMBOARD                         Applied By: N/A
  FOAM PADS                        Applied By: N/A
  KODEL PAD                        Applied By: N/A
  STIRRUPS                         Applied By: N/A
```

```
Immediate Use Steam Sterilization Episodes:
   Contamination:                      0
```

```
   SPS Processing/OR Management Issues: 0
   Emergency Case:                      0
   No Better Option:                    0
   Loaner or Short Notice Instrument:   0
   Decontamination of Instruments Contaminated During the Case: 0

Electrocautery Unit:       8845,5512
ESU Coagulation Range:     50-35
ESU Cutting Range:         35-35
Electroground Position(s): RIGHT BUTTOCK
                           LEFT BUTTOCK


Material Sent to Laboratory for Analysis:
Specimens:
 1. MITRAL VALVE
Cultures:  N/A

Anesthesia Technique(s):
 GENERAL  (PRINCIPAL)


Tubes and Drains:
  #16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
  Item: MITRAL VALVE
    Implant Sterility Checked (Y/N): YES
    Sterility Expiration Date: DEC 15, 2004
    RN Verifier: SURNURSE,ONE
    Vendor: BAXTER EDWARDS
    Model: 6900
    Lot Number: T87-12321
    Serial Number: 945673WRU
    Sterile Resp: SPD
    Size: LG                                          Quantity: 2


Medications: N/A

Irrigation Solution(s):
  HEPARINIZED SALINE
  NORMAL SALINE
  COLD SALINE

Blood Replacement Fluids: N/A

Possible Item Retention:    YES
Sponge Final Count Correct:
Sharps Final Count Correct:       YES
Instrument Final Count Correct:   NOT APPLICABLE
Wound Sweep:                * NOT ENTERED *
Wound Sweep Comment: NO COMMENTS ENTERED
Intra-Operative X-Ray:      * NOT ENTERED *
Intra-Operative X-Ray Comment: NO COMMENTS ENTERED
Counter:            SURNURSE,FOUR
Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing:  NONE

Blood Loss: 800 ml                     Urine Output: 750 ml

Postoperative Mood:           RELAXED
Postoperative Consciousness:  ANESTHETIZED
Postoperative Skin Integrity: SUTURED INCISION
```

```
Postoperative Skin Color:     N/A

Laser Performed: N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Transplant Information:
      Organ to be Transplanted: * NOT ENTERED *
      UNOS Identification Number of Donor:
      Donor Serology Hepatitis C virus (HCV): * NOT ENTERED *
      Donor Serology Hepatitis B Virus (HBV): * NOT ENTERED *
      Donor Serology Cytomegalovirus (CMV): * NOT ENTERED *
      Donor Serology HIV: * NOT ENTERED *
      Donor ABO Type: * NOT ENTERED *
      Recipient ABO Type: * NOT ENTERED *
      Blood Bank Verification of ABO Type: * NOT ENTERED *
      Blood Bank ABO Verification Comments:
      Date/Time of Blood Bank ABO Verification: * NOT ENTERED *
      OR Verification of ABO Type: * NOT ENTERED *
      OR ABO Verification Comments:
      Date/Time OR ABO Verification: * NOT ENTERED *
      Surgeon Performing UNET Verification: * NOT ENTERED *
      UNET Verification by Surgeon: * NOT ENTERED *
      Organ Verification Prior to Anesthesia: * NOT ENTERED *
      Surgeon Verifying Organ Prior to Anesthesia: * NOT ENTERED *
      Surgeon Verifying Organ Prior to Donor Anesthesia: * NOT ENTERED *
      Donor Organ Verification Prior to Anesthesia: * NOT ENTERED *
      Organ Verification Prior to Transplant: * NOT ENTERED *
      Surgeon Verifying the Organ Prior to Transplant: * NOT ENTERED *
      Donor Vessel Usage: * NOT ENTERED *
      Donor Vessel Disposition if not used:
      Donor Vessel UNOS ID:

Immediate Use Steam Sterilization Episodes:
   Contamination:                      0
   SPS Processing/OR Management Issues: 0
   Emergency Case:                     0
   No Better Option:                   0
   Loaner or Short Notice Instrument:   0
   Decontamination of Instruments Contaminated During the Case: 0

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

This section will only appear for Transplant cases that have a PLANNED PRIN PROCEDURE CODE that is one of the following: 32851,32852,32853,32854,33935,33945,44135,44136,47135,47136,48160,48554,50360,50365

(This page included for two-sided copying.)

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

Example: Signing the Nurse Intraoperative Report

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

 Nurse Intraoperative Report Functions:

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

Select number: 2// 3
```

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

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

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

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

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

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

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

IMPLANT STERILITY CHECKED (Y/N)
RN VERIFIER
SERIAL NUMBER
STERILITY EXPIRATION DATE
LOT NUMBER
PROVIDER READ BACK PERFORMED

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

ORGAN TOBE TRANSPLANED	SURGEON VERIFYING UNET
UNOS NUMBER	UNET VERIF BY SURGEON
DONOR SEROLOGY HCV	ORGAN VER PRE-ANESTHESIA
DONOR SEROLOGY HBV	SURGEON VER ORGAN PRE-ANES
DONOR SEROLOGY CMV	SURGEON VER DONOR PRE-ANES
DONOR SEROLOGY HIV	DONOR ORG VER PRE-ANES
DONOR ABO TYPE	ORGAN VER PRE-TRANSPLANT
RECIPIENT ABO TYPE	SURGEON VER ORG PRE-TRANSPLANT
BLOOD BANK ABO VERIFICATION	DONOR VESSEL UNOS ID
BLOOD BANK ABO VER COMMENTS	DONOR VESSEL USAGE
D/T BLOOD BANK ABO VERIF	DONOR VESSEL DISPOSITION
OR ABO VERIFICATION	
OR ABO VER COMMENTS	
D/T OR ABO VERIF	

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

Example: Missing Field Warning

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

     ANTIBIOTIC PROPHYLAXIS
     CHECKLIST COMMENT

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

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

1    CONFIRM PATIENT IDENTITY: YES
2    PROCEDURE TO BE PERFORMED: YES
3    SITE OF PROCEDURE: YES
4    CONFIRM VALID CONSENT: YES, i-MED
5    CONFIRM PATIENT POSITION: YES
6    MARKED SITE CONFIRMED: YES
7    PREOPERATIVE IMAGES CONFIRMED: YES
8    CORRECT MEDICAL IMPLANTS: YES
9    AVAILABILITY OF SPECIAL EQUIP: YES
10   ANTIBIOTIC PROPHYLAXIS:  YES
11   APPROPRIATE DVT PROPHYLAXIS:
12   BLOOD AVAILABILITY: YES
13   CHECKLIST COMMENT:       (WORD PROCESSING)
14   TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE
15   TIME-OUT COMPLETED:  07/12/2004@0800

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

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


1    CONFIRM PATIENT IDENTITY: YES
2    PROCEDURE TO BE PERFORMED: YES
3    SITE OF PROCEDURE: YES
4    CONFIRM VALID CONSENT: YES, i-MED
5    CONFIRM PATIENT POSITION: YES
6    MARKED SITE CONFIRMED: YES
7    PREOPERATIVE IMAGES CONFIRMED: YES
8    CORRECT MEDICAL IMPLANTS: YES
9    AVAILABILITY OF SPECIAL EQUIP: YES
10   ANTIBIOTIC PROPHYLAXIS:  YES
11   APPROPRIATE DVT PROPHYLAXIS: YES
12   BLOOD AVAILABILITY: YES
13   CHECKLIST COMMENT:       (WORD PROCESSING)
14   TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE
15   TIME-OUT COMPLETED:  07/12/2004@0800

Enter Screen Server Function: ^
```

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

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

 Nurse Intraoperative Report Functions:

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

Select number: 2// 3  Sign the report electronically

Enter your Current Signature Code: XXXXXX   SIGNATURE VERIFIED

Press RETURN to continue... <Enter>
```

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

Before the addendum is signed, comments may be added.

Example: Signing the Addendum

```
Comment: OPERATION END TIME WAS CORRECTED.

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

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

Addendum Comment: OPERATION END TIME WAS CORRECTED.

Enter RETURN to continue or '^' to exit:

Enter your Current Signature Code: XXXXXX   SIGNATURE VERIFIED..

Press RETURN to continue... <Enter>
```

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

Example: Printing the Nurse Intraoperative Report

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

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

 Nurse Intraoperative Report Functions:

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

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

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

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

----------printout follows----------

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

SUBJECT: Case #: 267226

Operating Room:  BO OR1                 Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004  07:30    Patient in OR:  JUL 12, 2004  08:00
Operation Begin: JUL 12, 2004  08:58    Operation End:  JUL 12, 2004  12:30
Surgeon in OR:   JUL 12, 2004  07:55    Patient Out OR: JUL 12, 2004  12:45

Major Operations Performed:
Primary: MVR

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

Primary Surgeon: SURSURGEON,THREE               First Assist: SURSURGEON,FOUR
Attending Surgeon: SURSURGEON,THREE           Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN             Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:
  Scrubbed                              Circulating
 SURNURSE,ONE (FULLY TRAINED)           SURNURSE,FIVE (FULLY TRAINED)
                                        SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood:       ANXIOUS               Preop Consc:    ALERT-ORIENTED
Preop Skin Integ: INTACT                Preop Converse: N/A

--- Time Out Checklist ---
Confirm Correct Patient Identity: YES
Confirm Procedure to be Performed: YES
Confirm Site of the Procedure, including laterality: YES
Confirm Valid Consent: YES, i-MED
Confirm Patient Position: YES
Confirm Proc. Site has been Marked Appropriately and that the Site of the
 Mark is Visible After Prep and Draping: YES
Pertinent Medical Images have been Confirmed: YES
Correct Medical Implant(s) Is Available: YES
Availability of Special Equipment: YES
Appropriate Antibiotic Prophylaxis: YES
Appropriate Deep Vein Thrombosis Prophylaxis: YES
Blood Availability: YES
Checklist Comment: NO COMMENTS ENTERED

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

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

Preop Surgical Site Hair Removal by: SURNURSE,FIVE
Surgical Site Hair Removal Method: OTHER
  Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):
  SUPINE                                Placed: N/A

Restraints and Position Aids:
  SAFETY STRAP                      Applied By: N/A
  ARMBOARD                          Applied By: N/A
  FOAM PADS                         Applied By: N/A
  KODEL PAD                         Applied By: N/A
  STIRRUPS                          Applied By: N/A

Immediate Use Steam Sterilization Episodes:
```

```
   Contamination:                        0
   SPS Processing/OR Management Issues: 0
   Emergency Case:                       0
   No Better Option:                     0
   Loaner or Short Notice Instrument:    0
   Decontamination of Instruments Contaminated During the Case: 0

Electrocautery Unit:       8845,5512
ESU Coagulation Range:     50-35
ESU Cutting Range:         35-35
Electroground Position(s): RIGHT BUTTOCK
                           LEFT BUTTOCK

Material Sent to Laboratory for Analysis:
Specimens:
 1. MITRAL VALVE
Cultures:  N/A
Anesthesia Technique(s):
 GENERAL  (PRINCIPAL)

Tubes and Drains:
  #16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
  Item: MITRAL VALVE
    Implant Sterility Checked (Y/N): YES
    Sterility Expiration Date: DEC 15, 2004
    RN Verifier: SURNURSE,ONE
    Vendor: BAXTER EDWARDS
    Model: 6900
    Lot Number: T87-12321
    Serial Number: 945673WRU
    Sterile Resp: SPD
    Size: LG
    Provider Read Back Performed: YES                                    Quantity: 2

Medications: N/A

Irrigation Solution(s):
  HEPARINIZED SALINE
  NORMAL SALINE
  COLD SALINE

Blood Replacement Fluids: N/A
Possible Item Retention:    YES
Sponge Count:       YES
Sharps Count:       YES
Instrument Count:   NOT APPLICABLE
Wound Sweep:                * NOT ENTERED *
Wound Sweep Comment: NO COMMENTS ENTERED
Intra-Operative X-Ray:      * NOT ENTERED *
Intra-Operative X-Ray Comment: NO COMMENTS ENTERED
Counter:            SURNURSE,FOUR
Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing:  NONE

Blood Loss: 800 ml                      Urine Output: 750 ml

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

Laser Performed: (Multiple)

Sequential Compression Device: NO
```

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

Devices: N/A

Transplant Information:
      Organ to be Transplanted: * NOT ENTERED *
      UNOS Identification Number of Donor:
      Donor Serology Hepatitis C virus (HCV): * NOT ENTERED *
      Donor Serology Hepatitis B Virus (HBV): * NOT ENTERED *
      Donor Serology Cytomegalovirus (CMV): * NOT ENTERED *
      Donor Serology HIV: * NOT ENTERED *
      Donor ABO Type: * NOT ENTERED *
      Recipient ABO Type: * NOT ENTERED *
      Blood Bank Verification of ABO Type: * NOT ENTERED *
      Blood Bank ABO Verification Comments:
      Date/Time of Blood Bank ABO Verification: * NOT ENTERED *
      OR Verification of ABO Type: * NOT ENTERED *
      OR ABO Verification Comments:
      Date/Time OR ABO Verification: * NOT ENTERED *
      Surgeon Performing UNET Verification: * NOT ENTERED *
      UNET Verification by Surgeon: * NOT ENTERED *
      Organ Verification Prior to Anesthesia: * NOT ENTERED *
      Surgeon Verifying Organ Prior to Anesthesia: * NOT ENTERED *
      Surgeon Verifying Organ Prior to Donor Anesthesia: * NOT ENTERED *
      Donor Organ Verification Prior to Anesthesia: * NOT ENTERED *
      Organ Verification Prior to Transplant: * NOT ENTERED *
      Surgeon Verifying the Organ Prior to Transplant: * NOT ENTERED *
      Donor Vessel Usage: * NOT ENTERED *
      Donor Vessel Disposition if not used:
      Donor Vessel UNOS ID:

Immediate Use Steam Sterilization Episodes:
   Contamination:                       0
   SPS Processing/OR Management Issues: 0
   Emergency Case:                      0
   No Better Option:                    0
   Loaner or Short Notice Instrument:   0
   Decontamination of Instruments Contaminated During the Case: 0

Nursing Care Comments:

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

                  Signed by: /es/ FIVE SURNURSE
                                  07/13/2004 10:41
07/17/2004 16:42     ADDENDUM

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

Addendum Comment: OPERATION END TIME WAS CORRECTED.
                  Signed by: /es/ FIVE SURNURSE
                                  07/17/2004 16:42
```

This section will only appear for Transplant cases that have a PLANNED PRIN PROCEDURE CODE that is one of the following: 32851,32852,32853,32854,33935,33945,44135,44136,47135,47136,48160,48554,50360,50365

(This page included for two-sided copying.)

Example: ICD-10 Code

```
SRPATIENTA, ONE (000-12-3456) Case #45731
FEB 27, 2014 HEART TRANSPLANT

-------------------------------------------------------------------------------------------------
Other Postop Diagnosis:
1. ICD10 Code:E83.41 Hypermagnesemia

2. ICD10 Code: V72. 1XXD Passenger on bus injured in clsn w 2/3-whl mv momtraf,
Subs

3. Enter NEW Other Postop Diagnosis Code
Enter selection: (1-3): 1

SRPATIENTA, ONE (xxx-xx-xxxx) Case #45731
FEB 27, 2014 HEART TRANSPLANT

-------------------------------------------------------------------------------------------------

Other Postop Diagnosis:

1. ICD10 Code: E83.41 Hypermagnesemia

       Select on of the following

1.  Update Other Postop Diagnosis Code
2.  Update Service Connected/Environmental Indicators only

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

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

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #314
JUL 15, 2005   CABG
-------------------------------------------------------------------------------
Other Procedures:

1. CPT Code: 33510  CABG, VEIN, SINGLE
     Modifiers: NOT ENTERED
     Assoc. DX: NOT ENTERED

-------------------------------------------------------------------------------
Only the following ICD Diagnosis Codes can be associated:

1. 402.01-HYP HEART DIS MALIGN WITH FAIL
2. 599.0-URIN TRACT INFECTION NOS

   Select the number(s) of the Diagnosis Code to associate to
   the procedure selected:  1// 1,2
```

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #314
JUL 15, 2005   CABG
-------------------------------------------------------------------------------
Other Procedures:

1. CPT Code: 33510  CABG, VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN     599.0-URIN TRACT INFECTION N
2. Enter NEW Other Procedure Code

Enter selection:  (1-2): <Enter>
```

Laser Performed: (Multiple)

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Signed by: /es/ FIVE SURNURSE

03/04/2004 10:41

Non-OR Procedure Information
[SR NON-OR INFO]

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

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

Example: Non-OR Procedure Information

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


   UV     Update/Verify Procedure/Diagnosis Codes
   OR     Operation/Procedure Report
   NR     Nurse Intraoperative Report
   PI     Non-OR Procedure Information

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

DEVICE: HOME// [Select Print Device]

-------------------------------------printout follows---------------------------------

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

Med. Specialty: GENERAL                       Location: NON OR

Principal Diagnosis: LARYNGEAL/TRACHEAL BURN

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

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

Anesthesia Technique(s): N/A

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

Procedure(s) Performed:
  Principal: BRONCHOSCOPY


Dictated Summary Expected: YES

Enter RETURN to continue or '^' to exit:
```

Update Site Configurable Files
[SR UPDATE FILES]

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

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

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

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

================================================================================
                    Update Site Configurable Surgery Files
================================================================================
1.  Surgery Transportation Devices
2.  Prosthesis
3.  Surgery Positions
4.  Restraints and Positional Aids
5.  Surgical Delay
6.  Monitors
7.  Irrigations
8.  Surgery Replacement Fluids
9.  Skin Prep Agents
10. Skin Integrity
11. Patient Mood
12. Patient Consciousness
13. Local Surgical Specialty
14. Electroground Positions
15. Special Equipment
16. Planned Implant
17. Pharmacy Items
18. Special Instruments
19. Special Supplies

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

Update Information for which File ?  2
```

```
Update Information in the Prosthesis file.
================================================================================


Select PROSTHESIS NAME: HUMERAL
   ARE YOU ADDING 'HUMERAL' AS A NEW PROSTHESIS (THE 112TH)?  Y (YES)
NAME: HUMERAL // HUMERAL COMPONENT
VENDOR: AMERICAN
MODEL: NEER II
STERILE RESP: MANUFACTURER
SIZE: STEM 150 MM, HEAD 22 MM
QUANTITY: <Enter>
LOT NUMBER: F19705-1087
SERIAL NUMBER: <Enter>
INACTIVE?: <Enter>


Select PROSTHESIS NAME:
```

Example 2: Re-Activate an Entry

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

================================================================================
                    Update Site Configurable Surgery Files
================================================================================
1.  Surgery Transportation Devices
2.  Prosthesis
3.  Surgery Positions
4.  Restraints and Positional Aids
5.  Surgical Delay
6.  Monitors
7.  Irrigations
8.  Surgery Replacement Fluids
9.  Skin Prep Agents
10. Skin Integrity
11. Patient Mood
12. Patient Consciousness
13. Local Surgical Specialty
14. Electroground Positions
15. Special Equipment
16. Planned Implant
17. Pharmacy Items
18. Special Instruments
19. Special Supplies
================================================================================

Update Information for which File ?  6
```

```
Update Information in the Monitors file.
================================================================================


Select MONITORS NAME: ECG             ** INACTIVE **
NAME: ECG// <Enter>
INACTIVE?: YES// @
   SURE YOU WANT TO DELETE? Y  (YES)


Select MONITORS NAME:
```

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

-------------------------------------------------------------------------------
Select Preoperative Information to Edit: A
```

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

GENERAL: YES
Patient's Height 65 INCHES//: 62
Patient's Weight 140 POUNDS//: 175
Diabetes Mellitus: Chronic, Long-Term Management: I  INSULIN
Diabetes Mellitus: Management Prior to Surgery: I  INSULIN
Tobacco Use: 2  NO USE IN LAST 12 MOS
Tobacco Use Timeframe: NOT APPLICABLE// <enter>
ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: N  NO
Positive Drug Screening:
Dyspnea: N
     1   NO
     2   NO STUDY
Choose 1-2: 1  NO
Preoperative Sleep Apnea: LEVEL 1// 3  SLEEP APNEA CONFIRMED - LEVEL 3
Sleep Apnea-Compliance: ?
     Enter the level of the patient's reported compliance with sleep apnea
     Treatment.
     Choose from:
      1        NIGHTLY
      2        > OR EQUAL 4 TIMES A WEEK
      3        < 4 TIMES A WEEK
      4        NOT DOCUMENTED
Sleep Apnea-Compliance: 4  NOT DOCUMENTED
DNR Status (Y/N): N  NO

Functional Status at Evaluation for Surgery: 1  INDEPENDENT
Current Residence (w/in 30 days prior to surgery): LONG TERM CARE// <Enter>
Ambulation Device: AMBULATES W/OUT ASSISTIVE DEVICE// <Enter>

PULMONARY: NO

HEPATOBILIARY: NO

GASTRONINTESTINAL: NO

CARDIAC: NO

VASCULAR: NO
```

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

Select Preoperative Information to Edit: <Enter>
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                PAGE: 2 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
1. RENAL:                                 3. NUTRITIONAL/IMMUNE/OTHER:
  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. Bleeding Risk Due to Medication
  C. Hemiplegia:                            G. Transfusion >4 RBC Units:
  D. CVD Repair/Obstruct:                   H. Chemo for Malig Last 90 Days:
  E. History of CVD:                        I. Radiotherapy W/I 90 Days:
  F. Tumor Involving CNS:                   J. Preoperative Sepsis:
  G. Impaired Cognitive Function            K. Pregnancy
                                            L. History of Cancer:
                                            M. History of Radiation Therapy:
                                            N. Num of Prior Surg in Same Op:
-------------------------------------------------------------------------------
Select Preoperative Information to Edit: 3E
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
Bleeding (Coagulation) Disorders (Y/N): Y  YES
```

Laboratory Test Results (Enter/Edit)
[SROA LAB]

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

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

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

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

Example 1: Capture Preoperative Laboratory Information

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

SURPATIENT,FORTY (000-77-7777)        Case #68112
SEP 19, 2003   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

Enter/Edit Laboratory Test Results

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

Select Number: 1

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

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

The 'Time Operation Began' must be entered before continuing.

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

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

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

..Moving preoperative lab test data to Surgery Risk Assessment file….

Press <RET> to continue  <Enter>
```

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

 1. Transfer Status:                    NOT TRANSFERRED
 2. Observation Admission Date/Time:    NA
 3. Observation Discharge Date/Time:    NA
 4. Observation Treating Specialty:     NA
 5. Hospital Admission Date/Time:       JUN 06, 2005@14:15
 6. Admit/Transfer to Surgical Svc.:    JUN 06, 2005@08:30
 7. Discharge/Transfer to Chronic Care: JUN 21, 2005@11:32
 8. DC/REL Destination:
 9. Length of Postop Hospital Stay:     15 Days
10. Hospital Admission Status::         ADMISSION
11. Patient's Ethnicity:                NOT HISPANIC OR LATINO
12. Patient's Race:                     AMERICAN INDIAN OR ALASKA NATIVE, ASIAN
13. Date of Death:                      NA
14. 30-Day Death:                       NO

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

Intraoperative Occurrences (Enter/Edit)
[SRO INTRAOP COMP]

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

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

Example: Enter an Intraoperative Occurrence

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

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

There are no Intraoperative Occurrences entered for this case.


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

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


Press RETURN to continue: <Enter>
```

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

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

------------------------------------------------------------------------------

Select Occurrence Information: 4:5
```

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

Type of Treatment Instituted: CPR
Outcome to Date: I  IMPROVE
```

Cardiac Risk Assessment Information (Enter/Edit)

[SROA CARDIAC ENTER/EDIT]

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

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

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

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

Creating a New Risk Assessment

1. Enter either the patient's name/patient ID (for example, SURPATIENT,NINETEEN) or the surgical case assessment number preceded by # (for example, #47063). If the patient has any previous assessments, they will be displayed. An asterisk (*) indicates a cardiac case. The user can now choose to create a new assessment or edit one of the previously entered assessments.

2. After choosing an operation on which to report, the user should respond **YES** to the prompt "Are you sure that you want to create a Risk Assessment for this surgical case ?" The user must answer **YES** (or press the **<Enter>** key to accept the **YES** default) to get to any of the sub-options. If the answer given is **NO**, the case created in step 1 will not be considered an assessment, although it can appear on some lists, and the software will return the user to the "Select Patient:" prompt.

3. The screen will clear and present the sub-options menu. The user can select a sub-option now to enter more in-depth information for the case, or press the **<Enter>** key to return to the main menu.

Clinical Information (Enter/Edit)

[SROA CLINICAL INFORMATION]

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

About the "Select Clinical Information to Edit:" Prompt

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

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

Example: Enter Clinical Information

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

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

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

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

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

Patient's Height: 63 INCHES// 76
Patient's Weight: 170 LBS// 210
Diabetes Mellitus: Chronic, Long-Term Management: I  INSULIN
Diabetes Mellitus: Management Prior to Surgery: I  INSULIN
History of Severe COPD (Y/N): Y  YES
FEV1 : NS
Cardiomegaly on Chest X-Ray (Y/N): Y  YES
Tobacco Use: 3  CIGARETTES ONLY
Tobacco Use Timeframe: 1  WITHIN 2 WEEKS
Positive Drug Screening:
Active Endocarditis (Y/N): N  NO
Functional Status: I  INDEPENDENT
PCI:   NONE
Prior MI: 1  YES, < OR EQUAL TO 7 DAYS PRIOR TO SURG
Number of Prior Heart Surgeries: 1  1
```

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


Prior heart surgeries:

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

Enter your choice(s) separated by commas  (0-5): // 2
                                          2 - VALVE-ONLY
Peripheral Arterial Disease : 2  YES-W/O ANGI,REVASC,or AMPUT
Prior Surgical Repair/Carotid Artery Obstruction: 0  NO CVD
History of CVD Events: 0  NO CVD
Angina Severity: IV  CLASS IV
Angina Timeframe: 1  NO ANGINA
Preop Congestive Heart Failure: N CARD DX, CHF, OR SX

Current Diuretic Use (Y/N): Y  YES
IV NTG within 48 Hours Preceding Surgery (Y/N): Y  YES
Preop use of circulatory Device: N  NONE
Hypertension:2  YES WITHOUT MED
Preoperative Atrial Fibrillation: N  NO
Preoperative Sleep Apnea: 1  NONE - LEVEL 1
Sleep Apnea-Compliance:
Impaired Cognitive Function in the 90 Days Preop: YES-DOCUMENTED HISTORY
         //
```

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

 1. Height:                   70 in       17. PAD:                        NO
 2. Weight:                   185 lb      18. CVD Repair/Obstruct:        NO CVD
 3. Diabetes - Long Term:     NO          19. History of CVD:             NO CVD
 4. Diabetes - 2 Wks Preop:   NO          20. Angina Severity:            NONE
 5. COPD:                     NO          21. Angina Timeframe:           W/N 14 DAY OF SU
 6. FEV1:                     9.3 liters  22. Congestive Heart Failure:   0
 7. Cardiomegaly (X-ray):     YES         23. Current Diuretic Use:       NO
 8. Tobacco Use:       NEVER USED TOBACCO 24. IV NTG within 48 Hours:     NO
 9. Tobacco Use Timeframe: NOT APPLICABLE 25. Preop Circulatory Device:   NONE
10. Positive Drug Screening:  NOT DONE    26. Hypertension:               NO
11. Active Endocarditis:      NO          27. Preop Atrial Fibrillation:  NO
12. Functional Status:       INDEPENDENT  28. Preop Sleep Apnea:          LEVEL 3
13. PCI:                      NONE        29. Sleep Apnea-Compliance: > OR EQUAL
14. Prior MI:                 UNKNOWN     30. Impaired Cognitive Func:    1
15. Num Prior Heart Surgeries:NONE
16. Prior Heart Surgeries:    NONE
------------------------------------------------------------------------------
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 A1c:          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 A1c:          NS
11. BNP:                     NS

-------------------------------------------------------------------------------

Select Laboratory Information to Edit:
```

Enter Cardiac Catheterization & Angiographic Data
[SROA CATHETERIZATION]

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

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

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

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

Example: Enter Cardiac Catheterization & Angiographic Data

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

SURPATIENT,NINETEEN (000-28-7354)        Case #60183                   PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
1. Procedure:
2. LVEDP:
3. Aortic Systolic Pressure:

For patients having right heart cath
4. PA Systolic Pressure:
5. PAW Mean Pressure:

6. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo):

7. Mitral Regurgitation:
8. Aortic Stenosis:

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: A

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

Procedure Type: NS  NO STUDY/UNKNOWN
Do you want to automatically enter 'NS' for NO STUDY for all other fields within
  this option ? YES// <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                    PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
1. Procedure:               Cath
2. LVEDP:                    56 mm Hg
3. Aortic Systolic Pressure: 120 mm Hg

For patients having right heart cath
4. PA Systolic Pressure:      30 mm Hg
5. PAW Mean Pressure:         15 mm Hg

6. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo): IIIa 0.40-0.44 MODERATE DYSFUNCTION A

7. Mitral Regurgitation:      MODERATE
8. Aortic Stenosis:           MILD

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: <Enter>
```

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

----- Native Coronaries -----
1. Left main stenosis:          NS
2. LAD Stenosis:                NS
3. Right coronary stenosis:     NS
4. Circumflex Stenosis:         NS


-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: 3
Right Coronary Artery Stenosis: NS// ?
     Enter the percent (0-100) stenosis.
Right Coronary Artery Stenosis: NS// 30
```

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

----- Native Coronaries -----
1. Left main stenosis:          NS
2. LAD Stenosis:                NS
3. Right coronary stenosis:     30
4. Circumflex Stenosis:         NS

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit:
```

(This page included for two-sided copying.)

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

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

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

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

Example: Operative Risk Summary Data

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

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

 1. ASA Classification:        1-NO DISTURB.
 2. Surgical Priority:
 3. Preoperative Risk Factors: NONE

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


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

This information cannot be edited.

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


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


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

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

The Surgery software performs data checks on the following fields:

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

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

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

Cardiac Procedures Operative Data (Enter/Edit)

[SROA CARDIAC PROCEDURES]

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

About the "Select Operative Information to Edit:" prompt

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

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

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

Example: Enter Cardiac Procedures Operative Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CARD  Cardiac Procedures
Operative Data (Enter/Edit)
SURPATIENT,NINETEEN (000-28-7354)      Case #60183                 PAGE:  1
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

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

Select Operative Information to Edit:
```

Resource Data (Enter/Edit)
[SROA CARDIAC RESOURCE]

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

Example: Resource Data (Enter/Edit)

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

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

Enter/Edit Patient Resource Data

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

Select Number:  (1-2): 1

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

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

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

Enter/Edit Patient Resource Data

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

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

```
SURPATIENT,TEN (000-12-3456)        Case #49413                   PAGE: 1 OF 2
OCT 18,2007   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD
------------------------------------------------------------------------------

 1. Transfer Status:                   NON-VAMC ACUTE CARE HOSPITAL
 2. Hospital Admission Date:
 3. Hospital Discharge Date:
 4. DC/REL Destination:          ACUTE CARE FACIL TRANSFER VA/NON-VA
 5. Cardiac Catheterization Date:      MAY 14, 2015@12:07
 6. Time Patient In OR:                OCT 03, 2007@08:00
 7. Date/Time Operation Began:         OCT 03, 2007@09:00
 8. Date/Time Operation Ended:         OCT 03, 2007@10:00
 9. Time Patient Out OR:               OCT 03, 2007@12:30
10. Date/Time Patient Extubated:       OCT 03, 2007@14:35
          Postop Intubation Hrs:       +2.1
11. Date/Time Discharged from ICU:
12. Homeless:                          NO
13. Employment Status Preoperatively:  NOT EMPLOYED
14. Date of Death:                     NA
15. 30-Day Death:                      NO
```

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

```
 5. Num of Prior Surg in Same OP:      >5 PREVIOUS SURGERIES

--------------------------------------------------------------------------------
 Select Resource Information to Edit:
```

The Surgery software performs data checks on the following fields:

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

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

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

Print a Surgery Risk Assessment

[SROA PRINT ASSESSMENT]

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

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

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

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


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

SURPATIENT,FORTY  000-77-7777

1. 02-10-04   * CABG (INCOMPLETE)

2. 01-09-06   APPENDECTOMY (COMPLETED)


Select Surgical Case: 2

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

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

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

Medical Center: ALBANY
Age:            81                     Operation Date:    JAN 09, 2006
Sex:            MALE                   Ethnicity: NOT HISPANIC OR LATINO
                                       Race:      AMERICAN INDIAN OR ALASKA
                                                  NATIVE, NATIVE HAWAIIAN OR
                                                  OTHER PACIFIC ISLANDER, WHITE
Transfer Status:                              NOT ENTERED
Observation Admission Date:                   NA
Observation Discharge Date:                   NA
Observation Treating Specialty:               NA
Hospital Admission Date:                      NOV 27,2007  13:11
Hospital Discharge Date:
Admitted/Transferred to Surgical Service:
Discharged/Transferred to Chronic Care:
DC/REL Destination:                    NOT ENTERED
Hospital Admission Status:
Assessment Completed by:                      SURNURSE,SEVEN
--------------------------------------------------------------------------------
                           PREOPERATIVE INFORMATION

GENERAL:                      YES      HEPATOBILIARY:                  YES
Height:                                Ascites:                        YES
Weight:
Diabetes - Long Term:                  GASTROINTESTINAL:
Diabetes - 2 Wks Preop:                Esophageal Varices:             NO
Tobacco Use:
Tobacco Use Timeframe: NOT APPLICABLE
ETOH > 2 Drinks/Day:          NO       CARDIAC:
Positive Drug Screening:               Congestive Heart Failure:       N CARD DX, CHF
Dyspnea:                      NO       Prior MI:
Preop Sleep Apnea:           LEVEL 3   PCI:
Sleep Apnea-Compliance:      > OR EQUA
DNR Status:                            Prior Heart Surgery:
Functional Status:                     Angina Severity:
Current Residence: ACUTE CARE FACILITY Angina Timeframe:
Ambulation Device:                     Hypertension:

PULMONARY:
Ventilator Dependent:                  VASCULAR:
History of Severe COPD:                PAD:
Current Pneumonia:                     Rest Pain/Gangrene:
                           PREOPERATIVE INFORMATION

RENAL:                                 NUTRITIONAL/IMMUNE/OTHER:
Acute Renal Failure:                   Disseminated Cancer:
Currently on Dialysis:                 Open Wound:
                                       Steroid Use for Chronic Cond.:
CENTRAL NERVOUS SYSTEM:                Weight Loss > 10%:
Impaired Sensorium:                    Bleeding Disorders:
                                       Bleeding Due To Med:
Coma:                                  Transfusion > 4 RBC Units:
Hemiplegia:                            Chemo for Malig Last 90 Days:
CVD Repair/Obstruct:                   Radiotherapy W/I 90 Days:
History of CVD:                        Preoperative Sepsis:
Tumor Involving CNS:                   Pregnancy:              NOT APPLICABLE
Impaired Cognitive Function:           History of Cancer:      YES
                                       History of Radiation Therapy:   Y
                                       Prior Surg in Same Operative:
                      OPERATION DATE/TIMES INFORMATION

               Patient in Room (PIR): JUL 20,2007  07:00
   Procedure/Surgery Start Time (PST): JUL 20,2007  07:30
        Procedure/Surgery Finish (PF): JUL 20,2007  08:30
            Patient Out of Room (POR): JUL 20,2007  08:40
                Anesthesia Start (AS):
               Anesthesia Finish (AF):
          Discharge from PACU (DPACU):
```

Page 482a removed

```
VA NON-CARDIAC RISK ASSESSMENT             Assessment: 236          PAGE 3
FOR SURPATIENT,FORTY  000-77-7777 (COMPLETED)
================================================================================

                           OUTCOME INFORMATION

  Postoperative Diagnosis Code (ICD9): 540.1  ABSCESS OF APPENDIX
Length of Postoperative Hospital Stay: 3 DAYS
                        Date of Death:
          Return to OR Within 30 Days: NO


                     PERIOPERATIVE OCCURRENCE INFORMATION

WOUND OCCURRENCES:            YES     CNS OCCURRENCES:              YES
Superficial Incisional SSI:     NO      Stroke/CVA:                    NO
Deep Incisional SSI:            NO      Coma > 24 Hours:               NO
Wound Disruption:            01/10/06   Peripheral Nerve Injury:    01/10/06
* 427.31 ATRIAL FIBRILLATI   01/10/06

URINARY TRACT OCCURRENCES:    YES     CARDIAC OCCURRENCES:          YES
Renal Insufficiency:            NO      Arrest Requiring CPR:          NO
Acute Renal Failure:            NO      Myocardial Infarction:      01/09/06
Urinary Tract Infection:     01/11/06

RESPIRATORY OCCURRENCES:      YES     OTHER OCCURRENCES:            YES
Pneumonia:                      NO      Bleeding/Transfusions:         NO
Unplanned Intubation:           NO      Graft/Prosthesis/Flap Failure: NO
Pulmonary Embolism:             NO      DVT/Thrombophlebitis:          NO
On Ventilator > 48 Hours:       NO      Systemic Sepsis: SEPTIC SHOCK 01/11/06
* 477.0 RHINITIS DUE TO P    01/12/06   Organ/Space SSI:            01/11/06
                                        C. difficile Colitis:          NO


* indicates Other (ICD)
```

```
VA SURGICAL QUALITY IMPROVEMENT PROGRAM - CARDIAC SPECIALTY

================================================================================
I. IDENTIFYING DATA                                      Case #: 45730
Patient: SQWMNW,BILL  000-00-1941                        Fac./Div. #: 442
Surgery Date: 01/27/14   Address:
Phone: NS/Unknown        Zip Code: NS/Unknown        Date of Birth: 08/11/57
================================================================================

II. CLINICAL DATA
Gender:                   MALE          Age:                                67
Height:                   70 in         Prior MI:                      UNKNOWN
Weight:                   185 lb        Number of prior heart surgeries:  NONE
Diabetes - Long Term:     NO            Prior heart surgery:              NONE
Diabetes - 2 Wks Preop:   NO            PAD:                                NO
COPD:                     NO            CVD Repair/Obstruct:            NO CVD
FEV1:                     9.3 liters    History of CVD:                 NO CVD
Cardiomegaly (X-ray):     YES           Angina Severity:                  NONE
Tobacco Use:       NEVER USED TOBACCO   Angina Timeframe:    W/N 14 DAY OF SURG
Tobacco Use Timeframe: NOT APPLICABLE   Congestive Heart Failure:   0-N CARD DX
Positive Drug Screening:  NOT DONE      Current Diuretic Use:               NO
Active Endocarditis:      NO            IV NTG 48 Hours Preceding Surgery:  NO
Functional Status:        INDEPENDENT   Preop Circulatory Device:         NONE
PCI:                      NONE          Hypertension:                       NO
Preop Sleep Apnea:        LEVEL 1       Preoperative Atrial Fibrillation:   NO
Sleep Apnea-Compliance:                 Impaired Cognitive Function: YES-DOCUMEN

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

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA
Cardiac Catheterization Date:
Procedure:                              Native Coronaries:
LVEDP:                      mm Hg       Left Main Stenosis:
Aortic Systolic Pressure:   mm Hg       LAD Stenosis:
                                        Right Coronary Stenosis:
For patients having right heart cath:   Circumflex Stenosis:
PA Systolic Pressure:       mm Hg
PAW Mean Pressure:          mm Hg       If a Re-do, indicate stenosis
                                            in graft to:
                                        LAD:
                                        Right coronary (include PDA):
                                        Circumflex:
--------------------------------------------------------------------------------
LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):
       Grade     Ejection Fraction Range           Definition

--------------------------------------------------------------------------------
Mitral Regurgitation:
Aortic stenosis:

V. OPERATIVE RISK SUMMARY DATA
     ASA Classification:
     Surgical Priority:
     Principal CPT Code:           CPT Code Missing
     Other Procedures CPT Codes:
     Wound Classification:

VI. OPERATIVE DATA

Bridge to Transplant:


Operative Data details
Total CPB Time:      min                 Total Ischemic Time:  min
Incision Type:
```

```
Conversion Off Pump to CPB:

VII. OUTCOMES
Perioperative (30 day) Occurrences:
  Mycardial Infarction:                YES   Tracheostomy:                      NO
  Endocarditis:                    NO    Unplanned Intub W/In 30 Days:   NO
  Superficial Incisional SSI:      NO    Stroke/CVA:                NO SYMPTOMS
  Mediastinitis:                   NO    Coma > or = 24 Hours:             NO
  Cardiac Arrest Requiring CPR:    NO    New Mech Circulatory Support:     NO
  Reoperation for Bleeding:        NO    Postop Atrial Fibrillation:       NO
  On ventilator > or = 48 hr:      NO    Wound Disruption:                 NO
  Repeat cardiac Surg procedure:   NO    Renal Failure Requiring Dialysis: NO
```

```
VIII. RESOURCE DATA
Transfer Status:
Hospital Admission Date:

DC/REL Destination:
Time Patient In  OR:                          Operation Began:
Operation Ended:                              Time Patient Out OR:
Date and Time Patient Extubated:
     Postop Intubation Hrs:
Date and Time Patient Discharged from ICU:
Patient is Homeless:
Date of Death:                                30-Day Death:
Current Residence:                            Ambulation Device:
History of Cancer:                            History of Radiation Therapy:
Prior Surg in Same Operative:

================================================================================
IX. SOCIOECONOMIC, ETHNICITY, AND RACE
Employment Status Preoperatively:
 Ethnicity:                                UNANSWERED
Race Category(ies):                       UNANSWERED

X. DETAILED DISCHARGE INFORMATION
   Discharge ICD-9 Codes:

Type of Disposition:
Place of Disposition:
Preferred VAMC identification code:
```

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

*** End of report for SQWMNW,BILL  000-00-1941 assessment #45730 ***

Enter RETURN to continue or '^' to exit:
```

(This page included for two-sided copying.)

List of Surgery Risk Assessments
[SROA ASSESSMENT LIST]

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

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

Example 1: List of Incomplete Assessments

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

List of Surgery Risk Assessments

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

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

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

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

1. MAYBERRY, NC

Select Number:  (1-2): 1

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

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

----------printout follows----------

Example 2: List of Completed Assessments

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

List of Surgery Risk Assessments

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

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

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1

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

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

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

Example 3: List of Transmitted Assessments

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

List of Surgery Risk Assessments

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

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

Print by Date of Operation or by Date of Transmission ?

   1. Date of Operation
   2. Date of Transmission

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

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)


Print which Transmitted Cases ?

   1. Assessed Cases Only
   2. Excluded Cases Only
   3. Both Assessed and Excluded

Select Number:  (1-3): 1// <Enter>

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// N

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

Example 4: List of Non-Assessed Major Surgical Cases

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

List of Surgery Risk Assessments

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

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

This display is no longer used. Please select a different list.

Press Enter to continue
```

Page 496 has been deleted. The *List of Non-Assessed Major Surgical Cases* has been removed with patch SR*3*184.

Example 5: List of All Major Surgical Cases

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

List of Surgery Risk Assessments

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

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

This display is no longer used. Please select a different list.

Press Enter to continue
```

Page 498 has been deleted. The *List of All Major Surgical Cases* has been removed with patch SR*3*184.

Example 6: List of All Surgical Cases

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

List of Surgery Risk Assessments

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

Select the Number of the Report Desired:  (1-11): 6

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>


Print report for ALL specialties ?  YES// N

Print the Report for which Surgical Specialty: 50       GENERAL(OR WHEN NOT DEFINED BELOW)
GENERAL(OR WHEN NOT DEFINED BELOW)        50

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1


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

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

----------printout follows----------

Example 7: List of Completed/Transmitted Assessments Missing Information

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

List of Surgery Risk Assessments

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

Select the Number of the Report Desired:  (1-11): 7

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1
Print the List of Assessments to which Device: [Select Print Device]
```

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

Example 8: List of 1-Liner Cases Missing Information

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

List of Surgery Risk Assessments

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

Select the Number of the Report Desired:  (1-11): 8

Start with Date: 2 27 06  (FEB 27, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1

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

----------printout follows----------

Example 9: List of Eligible Cases

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

List of Surgery Risk Assessments

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

Select the Number of the Report Desired:  (1-11): 9

Start with Date: 6 1 06  (JUN 01, 2006)
End with Date: 6 30 07  (JUN 30, 2007)

Print which Eligible Cases ?

   1. Assessed Cases Only
   2. Excluded Cases Only
   3. Non-Assessed Cases only
   4. All Cases

Select Number:  (1-4): 1// <Enter>

Print by Surgical Specialty ?  YES// <Enter>
Print report for ALL specialties ?  YES// NO  NO

Print the Report for which Surgical Specialty: GENERAL SURGERY  50     GENERAL SURGERY

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1

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

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

Example 10: List of Cases With No CPT Codes

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

List of Surgery Risk Assessments

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

Select the Number of the Report Desired:  (1-11): 10

Start with Date: 1 1 07  (JAN 01, 2007)
End with Date: T  (JAN 23, 2008)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

Do you want to print all divisions? YES// <Enter>
Print the List of Assessments to which Device: HOME// [Select Print Device]
```

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

Example 11: Summary List of Assessed Cases

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

List of Surgery Risk Assessments

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

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

Start with Date: 01 01 08  (JAN 01, 2008)
End with Date: 01 30 08  (JAN 30, 2008)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

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

1. ALBANY
2. PHILADELPHIA, PA

Select Number:  (1-2): 1
Print the List of Assessments to which Device: HOME// [Select Print Device]
```

Exclusion Criteria (Enter/Edit)

[SR NO ASSESSMENT REASON]

The *Exclusion Criteria (Enter/Edit)* option is used to flag major cases that will not have a surgery risk assessment due to certain exclusion criteria. At the prompt "Reason an Assessment was not Created:" enter a question mark (**?**) to see a list of reasons.

Example: Enter Reason for No Assessment

```
Select Surgery Risk Assessment Menu Option: R Exclusion Criteria (Enter/Edit)

Select Patient: R9922  SURPATIENT,NINE         03-03-34     000345555     NO     SC
 VETERAN
```

```
SURPATIENT,NINE   000-34-5555

1. 11-01-04   TURP (COMPLETED)

2. 08-01-03   CABG X3 (1A,2V), ARTERIAL GRAFTING (COMPLETED)

3. 07-03-01   PULMONARY LOBECTOMY, TURP (COMPLETED)


Select Operation: 1

Reason an Assessment was not Created: 6  10% RULE
```

```
SURPATIENT,NINE (000-34-5555)        Case #63159
Transmission Status: QUEUED TO TRANSMIT
NOV 1,2004   TURP (CPT Code: 52601-59)
------------------------------------------------------------------------------

1. Exclusion Criteria:             10% RULE
2. Surgical Priority:              ELECTIVE
3. Surgical Specialty:             UROLOGY
4. Principal Anesthesia Technique: GENERAL
5. Major or Minor:                 MAJOR

------------------------------------------------------------------------------

Select Excluded Case Information to Edit:
```

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

TOTAL CASES PERFORMED	=	249
TOTAL ELIGIBLE CASES	=	227
CASES MEETING EXCLUSION CRITERIA	=	114
NON-SURGEON CASE	=	55
EXCEEDS MAX. ASSESSMENTS	=	0
EXCEEDS MAXIMUM TURPS	=	0
INCLSN CRTA NOT MET	=	59
10% RULE	=	0
CONCURRENT CASE	=	0
EXCEEDS MAXIMUM HERNIAS	=	0
ABORTED	=	0
ASSESSED CASES	=	135
NOT LOGGED ELIGIBLE CASES	=	0
CARDIAC CASES	=	16
NON-CARDIAC CASES	=	119
ASSESSED CASES PER DAY	=	6.75

NUMBER OF INCOMPLETE ASSESSMENTS REMAINING FOR PAST YEAR

	CARDIAC	NON-CARDIAC	TOTAL
MAY 2006	0	0	0
JUN 2006	0	0	0
JUL 2006	0	0	0
AUG 2006	0	0	0
SEP 2006	0	0	0
OCT 2006	0	0	0
NOV 2006	0	0	0
DEC 2006	0	0	0
JAN 2007	0	0	0
FEB 2007	0	0	0
MAR 2007	0	0	0
APR 2007	0	0	0
MAY 2007	15	82	97
	15	82	97

ALBANY - ALL DIVISIONS
REPORT OF SURGICAL CASE WORKLOAD
FOR OCT 2005 THROUGH MAY 2006

TOTAL CASES PERFORMED	=	30
TOTAL ELIGIBLE CASES	=	5
CASES MEETING EXCLUSION CRITERIA	=	1
NON-SURGEON CASE	=	0
ANESTHESIA TYPE	=	0
EXCEEDS MAX. ASSESSMENTS	=	0
EXCEEDS MAXIMUM TURPS	=	0
INCLSN CRTA NOT MET	=	0
10% RULE	=	1
CONCURRENT CASE	=	0
EXCEEDS MAXIMUM HERNIAS	=	0
ABORTED	=	0
ASSESSED CASES	=	20
NOT LOGGED ELIGIBLE CASES	=	0
CARDIAC CASES	=	4
NON-CARDIAC CASES	=	16

Pages 527-547 have been deleted. The *Transplant Assessment Menu* has been removed with patch SR*3*184.

Chapter Nine: Glossary

The following table contains terms that are used throughout the *Surgery V.3.0 User Manual*, and will aid the user in understanding the use of the Surgery package.

Term	Definition
Aborted	Case status indicating the case was cancelled after the patient entered the operating room. The Cases shall be considered "ABORTED" if the TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232) and CANCEL DATE field (#17), and the CASE ABORTED field entered with "YES".
ASA Class	This is the American Society of Anesthesiologists classification relating to the patient's physiologic status. Numbers followed by an 'E' indicate an emergency.
Attending Code	Code that corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure.
Blockout Graph	Graph showing the availability of operating rooms.
Cancelled Case	Case status indicating that an entry has been made in the CANCEL DATE field, CANCELLATION TIMEFRAME and/or the PRIMARY CANCEL REASON field without the patient entering the operating room.
CCSHS	VA Center for Cooperative Studies in Health Services located at Hines, Illinois.
CICSP	Continuous Improvement in Cardiac Surgery Program.
Completed Case	Case status indicating that an entry has been made in the TIME PAT OUT OR field.
Concurrent Case	A patient undergoing two operations by different surgical specialties at the same time, or back to back, in the same operating room.
CPT Code	Also called Operation Code. CPT stands for Current Procedural Terminology.
CRT	Cathode ray tube display. A display device that uses a cathode ray tube.
Intraoperative Occurrence	Perioperative occurrence during the procedure.
Major	Any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered.
Minor	All operations not designated as Major.
New Surgical Case	A surgical case that has not been previously requested or scheduled such as an emergency case. A surgical case entered in the records without being booked through scheduling will not appear on the Schedule of Operations or as an operative request.
Non-Operative Occurrence	Occurrence that develops before a surgical procedure is performed.
Not Complete	Case status indicating one of the following two situations with no entry in the TIME PAT OUT OR field (#.232). 1) Case has entry in TIME PAT IN OR field (#.205). 2) Case has not been requested or scheduled.
NSQIP	National Surgical Quality Improvement Program.

Operation Code	Identifying code for reporting medical services and procedures performed by physicians. See CPT Code.
PACU	Post Anesthesia Care Unit.
Postoperative Occurrence	Perioperative occurrence following the procedure.
Procedure Occurrence	Occurrence related to a non-O.R. procedure.
Requested	Operation has been slotted for a particular day but the time and operating room are not yet firm.
Risk Assessment	Part of the Surgery software that provides medical centers a mechanism to track information related to surgical risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical analysis.
Scheduled	Operation has both an operating room and a scheduled starting time, but the operation has not yet begun.
Screen Server	A format for displaying data on a cathode ray tube display. Screen Server is designed specifically for the Surgery Package.
Screen Server Function	The Screen Server prompt for data entry.
Service Blockouts	The reservation of an operating room for a particular service on a recurring basis. The reservation is charted on a blockout graph.
Transplant Assessments	Part of the Surgery software that provides medical centers a mechanism to track information related to transplant risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical analysis. The *Transplant Assessment Menu* has been removed with patch SR*3*184.
VASQIP	Veterans Affairs Surgery Quality Improvement Program.

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