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Chapter One: Booking Operations

Introduction

The options described in this chapter facilitate the scheduling of surgical procedures. Automated scheduling provides better operating room use and greater ease in distributing the operating room schedule. These options help accomplish the following tasks:

- Track patients on a waiting list
- Track operation requests
- Chart operating room availability
- Designate operating rooms for a surgical service
- Schedule operations by assigning operating rooms and time slots
- Generate operating room schedules on any designated printer in the medical center
- Reschedule or cancel any operative procedures

Whether you are booking a case from the *Waiting List*, *Request* Menu, or *Scheduling* Menu, you will be asked to provide preoperative information about the case. Some of the preoperative information is mandatory and must be entered immediately in order to proceed with the option, while others can be entered later. It is advisable to enter as much information as you can and update or correct it later. If you cannot answer a prompt, press the Return key to move to the next item.

Key Vocabulary

Concurrent Case	The patient undergoes two operations, by two different specialties, at the same time in the same operating room.
Cutoff Time	Your institution might have a daily cutoff time for entering requests. After the cutoff time, you are prohibited from booking a request for an operation to take place through midnight of the following day. You may still book requests two or more days in advance.
Outstanding Requests	Requests that have been entered but not scheduled. When the patient name is entered, the computer will list the outstanding requests for this patient.

Screen Server After you have entered data concerning the operation, your terminal display device will clear and then present a two-page Screen Server summary. The Screen Server summary organizes the information you have entered and gives you another opportunity to enter or edit data. Refer to "How to Use Screen Server" in the appendix for more information on how to enter and edit data from the Screen Server prompt.

Getting Out

To stop what you are doing, enter an up-arrow (^). You can use the up-arrow at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continue entering up-arrows to completely exit from the system.

Overview

The main options included in this menu are listed below. Each of these options, except the *List Operation Requests* option and *List Scheduled Operations* option, contain submenus. To the left of the option name is the shortcut synonym you can enter to select the option.

W	*Maintain Surgery Waiting List*
R	*Request Operations*
LR	*List Operation Requests*
S	*Schedule Operations*
LS	*List Scheduled Operations*

1.0 Maintain Surgery Waiting List

This submenu allows surgeons to develop waiting lists for selected surgery specialties. The patient can remain on the waiting list until sufficient information is available to book the operation for a specific date (see *Make a Request from the Waiting List* option).

The *Maintain Surgery Waiting List* submenu contains the following options. To the left is the shortcut synonym you can enter to select the option:

W	*Print Surgery Waiting List*
E	*Enter a Patient on the Waiting List*
U	*Edit a Patient on the Waiting List*
D	*Delete a Patient from the Waiting List*

1.1 Print Surgery Waiting List

Resident physicians use this option to print the waiting list for one or more surgical specialties. The waiting list includes the names of patients waiting to have an operation and the type of operation. Cases entered on the waiting list are not assigned an operation room or a date of operation.

You can sort the report several different ways. First, you can sort the report by one or more surgical specialties. Then, you can choose to sort the report either alphabetically by patient name, by the tentative date of the operation, or by the date the case was entered on the waiting list. You can request a brief form, as in Example 1, or a long form report, as in Example 2. The long form report includes the procedure name, comments, referring physician, tentative admission date, patient address, and phone numbers.

This report has an 80-column format and can be viewed on your computer terminal or copied to a printer. When the terminal screen is full you will be prompted to press the Return key to continue viewing the list.

Example 1: Print the brief form, Sort by T

```
Select Maintain Surgery Waiting List Option: W  Print Surgery Waiting List
```

```
                          Surgery Waiting List Reports

Print Report By:

         A    Alphabetical Order by Patient
         T    Tentative Date of Operation
         D    Date Entered on the Waiting List

Enter Selection (A,T, or D): T
```

```
Do you want to print the waiting list for all specialties ?  YES//  N

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

Do you want to print the brief form ?  YES//  <RET>

Print the Waiting List on which Device: [Select Print Device]
```

..... *printout follows* .....

```
Surgery Waiting List for GENERAL (OR WHEN NOT DEFINED BELOW)
Printed JUN 28, 1993 at 14:10

Date Entered   Patient                  Operative Procedure
==============================================================================
JAN 19, 1993   MUCK,G.G.                Bunionectomy
Tentative Admission: JAN 23, 1993
Tentative Date of Operation: JAN 23, 1993
------------------------------------------------------------------------------
JAN 21, 1993   SPRAGUE,HOWARD           REPAIR INGUINAL HERNIA
Tentative Admission: JAN 28, 1993
Tentative Date of Operation: JAN 29, 1993
------------------------------------------------------------------------------
NOV 29, 1989   WALTERS,JACK             ARTHROSCOPY, RIGHT SHOULDER
Tentative Admission: DEC 29, 1989
Tentative Date of Operation: None Specified
------------------------------------------------------------------------------
```

Example 2: Print the long form, Sort by D

```
Select Maintain Surgery Waiting List Option: W  Print Surgery Waiting List

                          Surgery Waiting List Reports

Print Report By:

         A    Alphabetical Order by Patient
         T    Tentative Date of Operation
         D    Date Entered on the Waiting List

Enter Selection (A,T, or D): D

Do you want to print the waiting list for all specialties ?  YES//  N

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

Do you want to print the brief form ?  YES//  N

Print the Waiting List on which Device: [Select Print Device]
```

..... *printout follows* .....

```
Surgery Waiting List for GENERAL (OR WHEN NOT DEFINED BELOW)
Printed JUN 28, 1993 at 14:11
==============================================================================
Patient:      WALTERS,JACK (382-84-0987)
Date Entered: NOV 29, 1989 09:08
Procedure:    ARTHROSCOPY, RIGHT SHOULDER

Tentative Admission Date:    DEC 29, 1989

  Home Phone: (205)663-5877             Work Phone: NOT ENTERED
  Address:

  Referring Physician/Institution:
     DR. FINE                           Phone: 888-098-0987
     122 1ST AVE.
     B'HAM, ALABAMA  35205
------------------------------------------------------------------------------
Patient:      MUCK,G.G. (412-58-7963)
Date Entered: JAN 19, 1993 15:17
Procedure:    Bunionectomy

Tentative Admission Date:    JAN 23, 1993
Tentative Date of Operation: JAN 23, 1993

  Home Phone: NOT ENTERED               Work Phone: NOT ENTERED
  Address:

  Referring Physician/Institution:
     Steve Musgrove                     Phone:
     Sylacauga OPC
------------------------------------------------------------------------------
Patient:      SPRAGUE,HOWARD (118-09-8797)
Date Entered: JAN 21, 1993 13:48
Procedure:    REPAIR INGUINAL HERNIA

Tentative Admission Date:    JAN 28, 1993
Tentative Date of Operation: JAN 29, 1993

Comments:
   Bland Diet

  Home Phone: 3225678                   Work Phone: NOT ENTERED
  Address:    117TH SO 40TH ST
              BIRMINGHAM, ALABAMA 35217

  Referring Physician/Institution:
     MOODY                            Phone: 234-567-8900
     Jefferson OPC
------------------------------------------------------------------------------
```

1.2 Enter a Patient on the Waiting List

Resident physicians use this option to enter a patient on the waiting list for a selected surgical specialty. First, identify the surgical specialty to which the patient will be assigned.

To add a new case to the waiting list, you must enter the patient name and the procedure name. You can also add comments, referring physician name and address, tentative admission date, and tentative operation date. This information will appear on the Waiting List Report. Patient names stay on the waiting list until the data is used to make a request or until it is deleted.

Example: Enter Patient on Waiting List

```
Select Maintain Surgery Waiting List Option: E  Enter a Patient on the Waiting
List
```

```
Select Surgical Specialty: 62     PERIPHERAL VASCULAR  PERIPHERAL VASCULAR 62
         ...OK? YES//  <RET> (YES)
        PERIPHERAL VASCULAR

  Select Patient: CLAMPETT,J.D.       06-04-35     665370555

  Select Operative Procedure: HAVEST SAPHENOUS VEIN

  General Comments/Special Instructions:
  1>Patient is an insulin dependent diabetic.
  2><RET>
EDIT Option: <RET>

  Tentative Admission Date: T+14  (AUG 25, 1992)
  Tentative Date of Operation: T+15  (AUG 26, 1992)

  Select REFERRING PHYSICIAN: DR. ROBERT N. MOLINA
    Street Address: VAMC HOUSTON
    City: HOUSTON
    State: TEXAS
    Zip Code: 77005
    Telephone Number: 713 561-2873
```

```
CLAMPETT,J.D. has been entered on the waiting list for PERIPHERAL VASCULAR

Press RETURN to continue  <RET>
```

1.3 Edit a Patient on the Waiting List

Resident physicians use this option to edit information collected for a patient who is already on the waiting list. First, enter the patient's name. Make sure you entered the correct patient and that you have the right case (there can be more than one). You can then update the information by simply typing in the new data at each prompt. If there is no change for a response, press the Return key and the cursor will go to the next prompt.

This option allows changes to the procedure name, the referring physician information, comments, tentative admission date, and/or the tentative operation date. A patient's name cannot be edited. A patient's name will stay on the waiting list until the data is used to make a request or until it is deleted.

Example: Edit Waiting List

```
Select Maintain Surgery Waiting List Option: U  Edit a Patient on the Waiting
List

Edit which Patient ?  CLAMPETT, J.D.         06-04-35     665370555

Procedures entered on the Waiting List for CLAMPETT,J.D.


1. PERIPHERAL VASCULAR                  Date Entered on List:     AUG 11,1992
   HAVEST SAPHENOUS VEIN                Tentative Operation Date: AUG 26,1992

Principal Operative Procedure: HAVEST SAPHENOUS VEIN
           Replace HA With HAR  Replace <RET>
   HARVEST SAPHENOUS VEIN
General Comments/Special Instructions:
  1>Patient is an insulin dependent diabetic.
EDIT Option: <RET>
Tentative Admission Date: AUG 25,1992// 8/26  (AUG 26, 1992)
Tentative Date of Operation: AUG 26,1992// 8/27  (AUG 27, 1992)

Select REFERRING PHYSICIAN: DR. ROBERT N. MOLINA// <RET>
  Referring Physician/Medical Center: DR. ROBERT N. MOLINA
           Replace <RET>
  Street Address: VAMC HOUSON// <RET>
  City: HOUSTON// <RET>
  State: TEXAS// <RET>
  Zip Code: 77005// <RET>
  Telephone Number: 713 561-2873// <RET>

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

1.4 Delete a Patient from the Waiting List

This option is used to delete a patient's procedure from the surgery waiting list. Enter the patient's name and select the procedure from the list of procedures and his or her entry will be deleted. The computer will give you a message that the procedure has been deleted.

Example: Delete Patient from Waiting List

```
Select Maintain Surgery Waiting List Option: D  Delete a Patient from the
Waiting List

Delete which Patient ? CLAMPETT,J.D.       06-04-35     665370555

Procedures entered on the Waiting List for CLAMPETT,J.D.


1. PERIPHERAL VASCULAR                  Date Entered on List:     AUG 11,1992
   HARVEST SAPHENOUS VEIN               Tentative Operation Date: AUG 26,1992


Are you sure that you want to delete this entry ?  YES// <RET>

CLAMPETT,J.D. has been removed from the Waiting List.

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

2.0 Request Operations

The *Request Operations* submenu contains several functions that the surgeons and resident physicians use to book an operation. The *Request Operations* options are used to book an operation for a certain day. The physician can request, via the computer, the operation(s) for a patient on a specific day and then enter additional information concerning the upcoming operation.

To request an operation, you must have a patient name, an operative procedure to perform, and a date to book it. Lacking a date, you can enter the patient on the Waiting List. If you have enough information to book the operation for a specific time and operating room, you can use the *Schedule Operation* menu to schedule the operation and skip the *Request Operations* menu.

The information gathered is collated by the computer and used to produce reports. The person in charge of scheduling (scheduling manager) arranges the operation requests according to the hospital's Surgical Service protocols and schedules the operation by assigning the case an operating room and a time slot.

The options included in this menu are listed below. To the left of the option name is the shortcut character(s) you can enter to select the option.

A	*Display Availability*
R	*Make Operation Requests*
D	*Delete or Update Operation Requests*
W	*Make a Request from the Waiting List*
CC	*Make a Request for Concurrent Cases*
V	*Review Request Information*
OR	*Operation Requests for a Day*
WR	*Requests by Ward*

2.1 Display Availability

Resident physicians use this option to check on the availability of an operating room before booking an operation. This option allows you to view the availability of operating rooms on a blockout graph. This is a read-only screen with no editing capabilities.

Scheduled operations show up on the graph as an equal sign (=) followed by the letter X. The equal sign before the X indicates the beginning of a scheduled operation. Surgical specialty blockouts are indicated by an abbreviation for the service (for more information on service blockouts, a function of the scheduling menu, see the *Create Service Blockouts* option).

After entering this option, you have a choice of viewing the room availability on the blockout graph in two ways. You can either view all rooms for a particular date (as in Example 1) or view a particular operating room for a range of dates (Example 2). Notice, in the first example, that you can also list requests, if any have been made.

Condensed Characters

If your display terminal can print condensed characters, a 24-hour graph will appear on the screen. If not, you will be prompted to select one of three graphs representing different chunks of that day.

Example 1: All O.R.s for one day

```
Select Request Operations Option:  A Display Availability
```

```
Do you want to view all Operating Rooms on one day ?  YES //  <RET>

Do you want to list requests also ?  NO//  <RET>

Display Operating Room Availability for which Date ?  T  (DEC 10, 1991)
```

```
Display of Available Operating Room Time

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

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

```
ROOM   6AM   7    8    9    10   11   12   13   14   15   16   17   18   19   20
OR1     |=XXX|XXXX|XXXX|gen.|gen.|gen.|____|____|____|____|____|____|____|____|
OR2     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR3     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR4     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR5     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR6     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|

Press RETURN to continue <RET>
```

Example 2: One O.R. for a date range

```
Select Request Operations Option:  Display Availability
```

```
Do you want to view all Operating Rooms on one day ?  YES //  N

Begin Display on which Date ?  T  (DEC 10, 1991)

Select OPERATING ROOM NAME: OR1
```

```
Display of Available Operating Room Time

1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availibility (12:00 PM - 12:00 AM)

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

```
Operating Room: OR1           (6:00 AM - 8:00 PM)

DATE     6    7    8    9   10   11   12   13   14   15   16   17   18   19   20
04-14-99 |____|____|____|____|____|eye.|eye.|____|____|____|____|____|____|____|
04-15-99 |____|eye.|eye.|eye.|eye.|eye.|____|____|____|____|____|____|____|____|
04-16-99 |____|gen.|gen.|gen.|gen.|gen.|____|____|____|____|____|____|____|____|
04-17-99 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-18-99 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-19-99 |____|____|____|____|____|eye.|eye.|eye.|eye.|____|____|____|____|____|
04-20-99 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-21-99 |____|____|____|____|____|eye.|eye.|____|____|____|____|____|____|____|
04-22-99 |____|eye.|eye.|eye.|eye.|eye.|____|____|____|____|____|____|____|____|
04-23-99 |=XXX|XXXX|XXXX|gen.|gen.|gen.|____|____|____|____|____|____|____|____|
04-24-99 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-25-99 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-26-99 |____|____|____|____|____|eye.|eye.|eye.|eye.|____|____|____|____|____|
04-27-99 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-28-99 |____|____|____|____|____|eye.|eye.|____|____|____|____|____|____|____|

Press RETURN to continue  <RET>
```

2.2 Make Operation Requests

This option allows the resident physician or scheduling manager to request an operation for a patient on a specific day. To request an operation you must know the patient name, the operative procedure to be performed, and the date on which to book it.

This option also asks for detailed information concerning the upcoming operation and will present four pages of prompts. First you will be prompted to enter required information, such as the operative procedure. Then, you will be prompted to enter procedure information, such as the estimated case length. The third page concerns blood product information, and the fourth page asks other miscellaneous questions about the operation.

Enter as much information as you can when you make the request. Later, you can add more information or make corrections by using the *Delete or Update Operation Request* option.

About Outstanding Requests

When the patient name is entered, the computer will list any requests that have been made but not scheduled. These requests are called outstanding requests. If you discover that the request you are entering has already been made, respond Yes to the prompt "Do you want to update the outstanding request?". Answering Yes allows you to view the information and make changes (see below).

If you are entering a new, separate request for the same patient, respond No to this prompt.

```
Select Request Operations Option:  R  Make Operation Requests
Select Patient:    OAT,WILLIE       12-09-51     449345555     NSC VETERAN

The following requests are outstanding for OAT,WILLIE:

1.   09-15-92
     Release of Hammer Toes
2.   11-20-92
     CHOLECYSTECTOMY

Do you want to update the outstanding request ?  YES// <RET>

Select Operation Request: 1
```

Prompts that require a response before you can continue with the option:

Make a Request for which Date?
Surgeon
Surgical Specialty
Principal Operative Procedure
Indications for Operations

Entering Preoperative Information

At this prompt	Do this . . .
Principal Procedure Code (CPT)	Type in the Current Procedural Terminology (CPT) identifying code for each procedure. If you do not know the code number, you can enter the type of operation (i.e., appendectomy) or a body organ and select from a list of codes.
Indications for Operations	Type in the reason this procedure is being performed. You must answer this prompt before you can continue with the option. The notation 1> indicates this is row 1 of an open-text word-processing field. You can enter as many lines (rows) as needed.
Estimated Case Length (HOURS:MINUTES)	Either accept the default answer by pressing the Return key, or enter a number for the length of time needed for this procedure. The computer will average the length of time it usually takes to perform the surgical specialty (based on CPT codes) and default to this figure.
BRIEF CLIN History	This information will show up on the Tissue Examination Report. It should contain any information relevant to the specimens being sent to the laboratory. This is also an open-text word-processing field.

At this prompt	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. Then, you can 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"— rather, press the Return key to bypass this prompt. Hint: 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 8 REQ BLOOD KIND. This is a multiple field; you can enter as many blood products as needed.
Requested Preoperative X-Rays	Enter the types of preop x-ray films and reports required for delivery to the operating room before the operation. Leave this field blank if you do not intend to order any x-ray products.
Request Clean or Contaminated	Enter the letter code C for clean or D for contaminated, or type in the first few letters of either word. This information allows the scheduling manager to determine how much time is needed between operations for sanitizing a room.

Example: Make Operation Requests

```
   A      Display Availability
   R      Make Operation Requests
   D      Delete or Update Operation Requests
   W      Make a Request from the Waiting List
   CC     Make a Request for Concurrent Cases
   V      Review Request Information
   OR     Operation Requests for a Day
   WR     Requests by Ward

Select Request Operations Option: R  Make Operation Requests
```

```
Select Patient: PETRIE,ROBERT         03-27-40     123454886

The following request is outstanding for PETRIE,ROBERT A.:

1.     03-09-92
       CARPAL TUNNEL RELEASE

Do you want to update the outstanding request ?  YES// N

Do you want to make a new request for PETRIE,ROBERT A. ? NO// Y

Make a Request for which Date ?  12/1  (DEC 01, 1992)
```

```
                     OPERATION REQUEST: REQUIRED INFORMATION

PETRIE,ROBERT (123-45-4886)                                      DEC  1, 1992
==============================================================================

Surgeon: HOWARD,MOE
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BE  LOW)        50
Principal Operative Procedure: CHOLECYSTECTOMY
Indications for Operations:
  1>ACUTE OBSTRUCTIVE GALLBLADDER DISEASE.
  2><RET>
EDIT Option: <RET>
```

```
                    OPERATION REQUEST: PROCEDURE INFORMATION

PETRIE,ROBERT (123-45-4886)                                      DEC  1, 1992
==============================================================================
Principal Procedure:      CHOLECYSTECTOMY
Principal Procedure Code (CPT): 47480          INCISION OF GALLBLADDER
           CHOLECYSTOTOMY OR CHOLECYSTOSTOMY WITH EXPLORATION, DRAINAGE,
           OR REMOVAL OF CALCULUS (SEPARATE PROCEDURE)
 Modifier: 66          SURGICAL TEAM
 Modifier: <RET>
Select OTHER PROCEDURE: <RET>
Estimated Case Length (HOURS:MINUTES): 2:45
BRIEF CLIN HISTORY:
  1>SUBSCAPULAR PAIN FOR 3 DAYS.  NAUSEA AND VOMITING. ACHOLIC
  2>STOOLS.  CHOLANGIOGRAM SHOWS COMMON DUCT OBSTRUCTION.
  3><RET>
EDIT Option: <RET>
```

```
                    OPERATION REQUEST: BLOOD INFORMATION

PETRIE,ROBERT (123-45-4886)                                      DEC  1, 1992
==============================================================================


Request Blood Availability ? YES//  <RET>
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH// <RET>  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: 2
```

```
                    OPERATION REQUEST: OTHER INFORMATION

PETRIE,ROBERT (123-45-4886)                                      DEC  1, 1992
==============================================================================

Principal Preoperative Diagnosis: CHOLELITHIASIS
Principal Diagnosis Code (ICD9): 574.01  574.01      'C'       CHOLELITH/AC GB INF-
OBST      COMPLICATION/COMORBIDITY
         ...OK? YES//  <RET> (YES)
Hospital Admission Status: I//  <RET> INPATIENT
Case Schedule Type: U  URGENT
First Assistant: FINE,LARRY
Second Assistant: <RET>
Attending Surgeon: HOWARD,MOE
Requested Postoperative Care: WARD
Case Schedule Order: 1
Select SURGERY POSITION: SUPINE// <RET>
  Surgery Position: SUPINE// <RET>
Requested Anesthesia Technique: GENERAL
Request Frozen Section Tests (Y/N): N  NO
Requested Preoperative X-Rays: ABDOMIN
Intraoperative X-Rays (Y/N): N  NO
Request Medical Media (Y/N): N  NO
Request Clean or Contaminated: CLEAN
Select REFERRING PHYSICIAN: <RET>
General Comments: <RET>
  1><RET>
```

```
** REQUESTS **   CASE #227  PETRIE,ROBERT         PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2    PRINCIPAL PROCEDURE CODE: 47480-66
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
5    PRIN DIAGNOSIS CODE: 574.01
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: URGENT
10   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
11   SURGEON:            HOWARD,MOE
12   FIRST ASST:         FINE,LARRY
13   SECOND ASST:
14   ATTEND SURG:        HOWARD,MOE
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:  <RET>
```

```
  ** REQUESTS **   CASE #227  PETRIE,ROBERT         PAGE 2 OF 2

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

Enter Screen Server Function:  <RET>
```

```
A request has been made for PETRIE,ROBERT on 12-01-92.

  Press RETURN to continue. <RET>
```

2.3 Delete or Update Operation Requests

This option is used to delete a request, to update information, or to change the date of a requested operation. When you enter this option and select a patient's name and case, you can choose one of the three functions. The three functions are explained below and the next few pages contain examples of how to use them.

The prompts differ for concurrent cases (operations performed by two different specialties at the same time on the same patient), as illustrated in Examples 4 – 6. Whenever you make a change or update information for one of the concurrent cases, the computer wants to know if the other case is affected.

The three functions available in this option are also available in the *Request Operations* option when you select an outstanding request.

With this function . . .	**You can . . .**
Delete	Permanently remove an operation request from the computer files (Examples 1 and 4). Example 4 shows the deletion of one operation in a set of concurrent cases.
Update Request Information	Change the length of the operation and edit other data fields that were entered earlier (Example 2). The computer can automatically update each case in a set of two concurrent cases (Example 5).
Change the Request Date	Alter the operation date of the request (Examples 3 and 6). For a set of concurrent cases to remain concurrent, you must change the request date for both operations (Example 6).

Example 1: Delete a Request

```
Select Request Operations Option: D  Delete or Update Operation Requests
Select Patient:    OAT,WILLIE       12-09-51     449345555     NSC VETERAN
```

```
The following cases are requested for OAT,WILLIE:

1.  08-15-92   CHOLECYSTECTOMY
2.  09-15-92   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// <RET>

  Deleting Operation ...

Press RETURN to continue  <RET>
```

Example 2: Update Request Information

```
Select Request Operations Option: D  Delete or Update Operation Requests
Select Patient: PETRIE,ROBERT         03-27-40     123454886
```

```
The following case is requested for PETRIE,ROBERT:

1.  12-01-92   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  PETRIE,ROBERT   PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2    PRINCIPAL PROCEDURE CODE: 47480-66
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
5    PRIN DIAGNOSIS CODE: 574.01
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: URGENT
10   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
11   SURGEON:            HOWARD,MOE
12   FIRST ASST:         FINE,LARRY
13   SECOND ASST:
14   ATTEND SURG:        HOWARD,MOE
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:  13
```

```
Second Assistant: JOE,CURLY
```

```
  ** UPDATE REQUEST **   CASE #227  PETRIE,ROBERT   PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2    PRINCIPAL PROCEDURE CODE: 47480-66
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
5    PRIN DIAGNOSIS CODE: 574.01
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: URGENT
10   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
11   SURGEON:            HOWARD,MOE
12   FIRST ASST:         FINE,LARRY
13   SECOND ASST:        JOE,CURLY
14   ATTEND SURG:        HOWARD,MOE
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:  <RET>
```

```
  ** UPDATE REQUEST **   CASE #227  PETRIE,ROBERT   PAGE 2 OF 2

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

Enter Screen Server Function:  <RET>
```

Example 3: Change the Request Date

```
Select Request Operations Option: D  Delete or Update Operation Requests
Select Patient:    PETRIE,ROBERT       03-27-40     123454886
```

```
The following case is requested for PETRIE,ROBERT:

1.  12-01-92   CHOLECYSTECTOMY

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

Select Number: 3


Change to which Date ? 11/30  (NOV 30, 1992)

The request for PETRIE,ROBERT has been changed to NOV 30, 1992.

Press RETURN to continue  <RET>
```

For Concurrent Cases

Any changes made to one concurrent case can affect the other case. When you delete one of the concurrent cases, a prompt will ask if you wish to delete the other case also. If you respond with No, the remaining operation will stay in the records as a single case. When you change the date of one operation of a concurrent case, you must simultaneously change the date for the other operation, otherwise the operations will no longer be considered concurrent.

When updating a response to a prompt or group of related prompts, the computer will ask if you want to store (meaning duplicate) the information in the other case. This saves time by "packing" the information into the other case so that you do not have to type it in again. If you do not want the prompt response duplicated for the other case, enter "N" or No.

Example 4: Delete a Request for Concurrent Cases

```
Select Request Operations Option: D  Delete or Update Operation Requests
Select Patient: CLEAVER,THEODORE    01-16-35     448170555     NSC VETERAN
```

```
The following cases are requested for CLEAVER,THEODORE:

1.  03-15-91       APPENDECTOMY
2.  08-15-91       CAROTID ARTERY ENDARTERECTOMY
3.  08-15-91       AORTO CORONARY BYPASS

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// <RET>

A concurrent case has been requested for this operation.  Do you want to
delete the request for it also ?  YES// <RET>
```

[Responding "Yes" here will delete both operation requests. "No" leaves the single remaining case, no longer concurrent.]

```
  Deleting Operation ...

  Deleting Concurrent Operation ...

Press <RET> to continue
```

Example 5: Update Request Information for a Concurrent Case

```
Select Request Operations Option:  Delete or Update Operation Requests
Select Patient:    DRUCKER,SAM       02-12-28     233418719
```

```
The following cases are requested for DRUCKER,SAM:

1.  03-16-92   CAROTID ARTERY ENDARTERECTOMY
2.  03-16-92   AORTO CORONARY BYPASS GRAFT

Select Operation Request: 1

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

Select Number: 2

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

```
  ** UPDATE REQUEST **   CASE #178  DRUCKER,SAM     PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    PRINCIPAL PROCEDURE CODE: 35301-59
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS:
5    PRIN DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS:
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
11   SURGEON:            HOWARD,MOE
12   FIRST ASST:
13   SECOND ASST:
14   ATTEND SURG:
15   REQ POSTOP CARE:    SICU

Enter Screen Server Function:  4;5;7;14
Principal Preoperative Diagnosis: CAROTID ARTERY STENOSIS
Principal Diagnosis Code (ICD9): 433.1        'C'       CAROTID ARTERY OCCLUSION
      COMPLICATION/COMORBIDITY
         ...OK? YES//  <RET> (YES)
Hospital Admission Status: I//  <RET> INPATIENT

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

Attending Surgeon: HOWARD,MOE
```

```
  ** UPDATE REQUEST **   CASE #178  DRUCKER,SAM     PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    PRINCIPAL PROCEDURE CODE: 35301-59
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5    PRIN DIAGNOSIS CODE: 433.10
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
11   SURGEON:            HOWARD,MOE
12   FIRST ASST:
13   SECOND ASST:
14   ATTEND SURG:        HOWARD,MOE
15   REQ POSTOP CARE:    SICU

Enter Screen Server Function: <RET>
```

```
  ** UPDATE REQUEST **   CASE #178  DRUCKER,SAM     PAGE 2 OF 2

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

Enter Screen Server Function: <RET>
```

Example 6: Change the Request Date of Concurrent Cases

```
Select Request Operations Option: D  Delete or Update Operation Requests
Select Patient: CLEAVER,THEODORE     01-16-35     448170555     NSC VETERAN


The following cases are requested for CLEAVER,THEODORE:

1.  04-04-91       ARTHROSCOPY, RIGHT KNEE
2.  04-04-91       REMOVE MOLE
3.  06-01-91       CAROTID ARTERY ENDARTERECTOMY
4.  06-01-91       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, 1991)

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

Enter <RET> 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//  <RET>

The request for CLEAVER,THEODORE has been changed to JUN  2, 1991.

Press RETURN to continue  <RET>
```

2.4 Make a Request from the Waiting List

This 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 you enter the patient name, the computer will list any operations on the waiting list for that patient. Select the operative procedure you want. The computer will advise you if the patient you have selected has any outstanding requests.

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

Whenever you make a request you are asked to provide preoperative information about the case. It is best to enter as much information as available and update it later if necessary.

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 ?  BODEAN,JETHRO
08-16-51     123457212
```

```
Procedures Entered on the Waiting List for BODEAN,JETHRO:

1. GENERAL(OR WHEN NOT DEFINED BELOW)   Date Entered on List:  NOV 17, 1992
   REPAIR DIAPHRAGMATIC HERNIA


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

The following requests are outstanding for BODEAN,JETHRO:

1.   03-17-92
     REPAIR DIAPHRAGMATIC HERNIA
2.   09-16-92
     CHOLECYSTECTOMY

Do you want to update the outstanding request ?  YES// N

Do you want to make a new request for BODEAN,JETHRO ? NO//  Y

Make a request for which Date ?  12/1  (DEC 01, 1992)
```

```
                    OPERATION REQUEST: REQUIRED INFORMATION

BODEAN,JETHRO (123-45-7212)                                    DEC  1, 1992
==============================================================================

Surgeon: FINE,LARRY
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)
Principal Operative Procedure: REPAIR DIAPHRAGMATIC HERNIA
Principal Procedure Code (CPT): 39540          REPAIR OF DIAPHRAGM HERNIA
        REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC;
        ACUTE
 Modifier: <RET>
Indications for Operations:
  1>REFLEX ESOPHAGITIS.
  2><RET>
EDIT Option: <RET>
```

```
                    OPERATION REQUEST: PROCEDURE INFORMATION

BODEAN,JETHRO (123-45-7212)                                    DEC  1, 1992
==============================================================================
Principal Procedure:      REPAIR DIAPHRAGMATIC HERNIA
Principal Procedure Code (CPT): 39540  REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN
NEONATAL), TRAUMATIC; ACUTE
         // <RET>
Select OTHER PROCEDURE: <RET>
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><RET>
EDIT Option: <RET>
```

```
                    OPERATION REQUEST: BLOOD INFORMATION

BODEAN,JETHRO (123-45-7212)                                    DEC  1, 1992
==============================================================================


Request Blood Availability ? YES//  <RET>
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH// <RET>  TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// <RET>
  Required Blood Product: CPDA-1 WHOLE BLOOD// <RET>
  Units Required: 2
```

```
                    OPERATION REQUEST: OTHER INFORMATION

BODEAN,JETHRO (123-45-7212)                                    DEC  1, 1992
==============================================================================

Principal Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA
Principal Diagnosis Code (ICD9): 551.3  551.3      'C'       DIAPHRAGM HERNIA W
GANGR      COMPLICATION/COMORBIDITY
         ...OK? YES//   <RET> (YES)
Hospital Admission Status: I//  <RET> INPATIENT
Case Schedule Type: S  STANDBY
First Assistant: HOWARD,MOE
Second Assistant: <RET>
Attending Surgeon: FINE,LARRY
```

```
Requested Postoperative Care: WARD
Case Schedule Order: 2
Select SURGERY POSITION: SUPINE// <RET>
  Surgery Position: SUPINE// <RET>
Requested Anesthesia Technique: GENERAL
Request Frozen Section Tests (Y/N): N  NO
Requested Preoperative X-Rays: ABDOMEN
Intraoperative X-Rays (Y/N): N  NO
Request Medical Media (Y/N): N  NO
Request Clean or Contaminated: C  CLEAN
Select REFERRING PHYSICIAN: <RET>
General Comments:<RET>
  1><RET>
```

```
   ** SCHEDULING **   CASE #229  BODEAN,JETHRO          PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: REPAIR DIAPHRAGMATIC HERNIA
2    PRINCIPAL PROCEDURE CODE: 39540
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: ACUTE DIAPHRAGMATIC HERNIA
5    PRIN DIAGNOSIS CODE: 551.3
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
11   SURGEON:            FINE,LARRY
12   FIRST ASST:         HOWARD,MOE
13   SECOND ASST:
14   ATTEND SURG:        FINE,LARRY
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:   <RET>
```

```
   ** SCHEDULING **   CASE #229  BODEAN,JETHRO          PAGE 2 OF 2

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

Enter Screen Server Function:   <RET>
```

```
A request has been made for BODEAN,JETHRO on 12/01/92.

  Press RETURN to continue.  <RET>
```

2.5 Make a Request for Concurrent Cases

This option is used to book concurrent operations. A concurrent case is when a patient undergoes two operations by different surgical specialties at the same time (or back-to-back in the same room). You can enter a request for each case at one time with this option. As usual, whenever you enter a request, you are asked to provide preoperative information about the case. It is best to enter as much information as you can and update it later if necessary.

Mandatory Prompts
After you enter the patient name, you will be prompted to enter some required information about the first case (the mandatory prompts include the date, procedure, surgeon, indications for operation, and time needed). If you do not answer a mandatory prompt, the computer will not book the operation and will return the cursor to the *Request Operations* menu. After answering the prompts for the first case, you will be prompted to answer the same questions about the second case. Then, the computer will give you a message that the two requests have been entered and simultaneously prompt you to select one of the cases for entering detailed information. If you do not want to enter detailed preoperative information at this time, press the Return key and the cursor will go to the *Request Operations* menu. In Example 1, detailed information is entered for the first case only.

Storing the Request Information
After most prompts, the computer will ask if you want to store (meaning duplicate) this information in the concurrent, or other, case. This saves time by "packing" the information into the other case so that you do not have to type it in again. If you do not want the prompt response duplicated for the other case, enter "N" or NO. Finally, the computer will display the Screen Server summary and pack any duplicated information into the other case. At this point, the computer will give you another message that the two requests have been entered and again prompt you to select either case for entering detailed information. You can repeat this whole process with the other case by selecting the number for it, or press the Return key to get back to the *Request Operations* menu.

Updating the Preoperative Information Later
Use the *Delete or Update Operation Requests* option to change or update any of the information entered for the either or both concurrent cases (Example 2).

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 ?  DRUCKER,SAM   02-12-28 233418719

The following request is outstanding for DRUCKER,SAM:

1.   03-09-92
     REMOVE FACIAL LESIONS

Do you want to update the outstanding request ?  YES// N

Do you want to make a new request for DRUCKER,SAM ? NO//  Y

Make a Request for Concurrent Cases on which Date ?  12/1  (DEC 01, 1992)
```

```
                              FIRST CONCURRENT CASE
                     OPERATION REQUEST: REQUIRED INFORMATION

DRUCKER,SAM (233-41-8719)                                        DEC  1, 1992
==============================================================================

Surgeon: HOWARD,MOE
Surgical Specialty: 62          PERIPHERAL VASCULAR  PERIPHERAL VASCULAR
62
Principal Operative Procedure: CAROTID ARTERY ENDARTERECTOMY
Principal Procedure Code (CPT): 35301          RECHANNELING OF ARTERY
        THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT;
        CAROTID, VERTEBRAL, SUBCLAVIAN, BY NECK INCISION
 Modifier: 59          DISTINCT PROCEDURAL SERVICE
 Modifier: <RET>
Indications for Operations:
  1>Unstable angina and impending stroke.
  2><RET>
EDIT Option: <RET>
```

```
                              SECOND CONCURRENT CASE
                     OPERATION REQUEST: REQUIRED INFORMATION

DRUCKER,SAM (233-41-8719)                                        DEC  1, 1992
==============================================================================

Surgeon: FINE,LARRY
Surgical Specialty: 58          THORACIC SURGERY (INC. CARDIAC SURG.)  THORACIC
SURGERY (INC. CARDIAC SURG.)        58
Principal Operative Procedure: AORTO CORONARY BYPASS GRAFT
Principal Procedure Code (CPT): 35526          ARTERY BYPASS GRAFT
        BYPASS GRAFT, WITH VEIN;
        AORTOSUBCLAVIAN OR CAROTID
 Modifier: 66          SURGICAL TEAM
 Modifier: <RET>
Indications for Operations:
  1>UNSTABLE ANGINA.
  2><RET>
EDIT Option: <RET>
```

```
The following requests have been entered.

1.  Case # 230                          DEC  1, 1992
    Surgeon: HOWARD,MOE                 PERIPHERAL VASCULAR
    Procedure:  CAROTID ARTERY ENDARTERECTOMY

2.  Case # 231                          DEC  1, 1992
    Surgeon: FINE,LARRY                 THORACIC SURGERY (INC. CARDIAC SURG.)
    Procedure:  AORTO CORONARY BYPASS GRAFT



1. Enter Request Information for Case #230
2. Enter Request Information for Case #231

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

```
                              SECOND CONCURRENT CASE
                     OPERATION REQUEST: PROCEDURE INFORMATION

DRUCKER,SAM (233-41-8719)                                        DEC  1, 1992
==============================================================================
Principal Procedure:      AORTO CORONARY BYPASS GRAFT
      Principal CPT Code: 35526  ARTERY BYPASS GRAFT
       Modifiers: -66 SURGICAL TEAM
Principal Procedure Code (CPT): 35526  BYPASS GRAFT, WITH VEIN; AORTOSUBCLAVIAN
OR CAROTID
         // <RET>
Select OTHER PROCEDURE: <RET>
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><RET>
EDIT Option: <RET>
```

```
                              SECOND CONCURRENT CASE
                     OPERATION REQUEST: BLOOD INFORMATION

DRUCKER,SAM (233-41-8719)                                        DEC  1, 1992
==============================================================================


Request Blood Availability ? N// YES
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH//  <RET> 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

DRUCKER,SAM (233-41-8719)                                        DEC  1, 1992
==============================================================================

Principal Preoperative Diagnosis: CORONARY ARTERY DISEASE
```

```
Principal Diagnosis Code (ICD9): 996.03  996.03      'C'       MALFUNC CORON BYPASS
GRF      COMPLICATION/COMORBIDITY
         ...OK? YES//  <RET> (YES)
Hospital Admission Status: I//  <RET> INPATIENT

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

Case Schedule Type: S  STANDBY

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

First Assistant: KILDARE,JAMES K.
Second Assistant: <RET>
Attending Surgeon: FINE,LARRY
Requested Postoperative Care: SICU

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

Case Schedule Order: 2

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

Select SURGERY POSITION: SUPINE// <RET>
  Surgery Position: SUPINE// <RET>
Requested Anesthesia Technique: GENERAL

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

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

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

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// <RET>

Request Medical Media (Y/N): N  NO

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

Request Clean or Contaminated: C  CLEAN

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

Select REFERRING PHYSICIAN: <RET>
General Comments:
  1><RET>
```

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

```
   ** REQUESTS **   CASE #231  DRUCKER,SAM              PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: AORTO CORONARY BYPASS GRAFT
2    PRINCIPAL PROCEDURE CODE: 35526-66
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: CORONARY ARTERY DISEASE
5    PRIN DIAGNOSIS CODE: 996.03
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
```

```
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  THORACIC SURGERY (INC. CARDIAC SURG.)
11   SURGEON:            FINE,LARRY
12   FIRST ASST:         KILDARE,JAMES K.
13   SECOND ASST:
14   ATTEND SURG:        FINE,LARRY
15   REQ POSTOP CARE:    SICU

Enter Screen Server Function:   <RET>
```

```
   ** REQUESTS **   CASE #231  DRUCKER,SAM              PAGE 2 OF 2

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

Enter Screen Server Function:   <RET>
```

```
The following requests have been entered.

1.  Case # 230                          DEC  1, 1992
    Surgeon: HOWARD,MOE                 PERIPHERAL VASCULAR
    Procedure:  CAROTID ARTERY ENDARTERECTOMY

2.  Case # 231                          DEC  1, 1992
    Surgeon: FINE,LARRY                 THORACIC SURGERY (INC. CARDIAC SURG.)
    Procedure:  AORTO CORONARY BYPASS GRAFT



1. Enter Request Information for Case #230
2. Enter Request Information for Case #231

Select Number:  (1-2): <RET>
```

Example 2: Update Request Information for a Concurrent Case

```
Select Request Operations Option: D  Delete or Update Operation Requests
Select Patient:    DRUCKER,SAM       02-12-28     233418719
```

```
The following cases are requested for DRUCKER,SAM:

1.  03-09-92   REMOVE FACIAL LESIONS
2.  12-01-92   CAROTID ARTERY ENDARTERECTOMY
3.  12-01-92   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  DRUCKER,SAM        PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    PRINCIPAL PROCEDURE CODE: 35301-59
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS:
5    PRIN DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
11   SURGEON:            HOWARD,MOE
12   FIRST ASST:
13   SECOND ASST:
14   ATTEND SURG:
15   REQ POSTOP CARE:    SICU

Enter Screen Server Function:  4;5;14
Principal Preoperative Diagnosis: CAROTID ARTERY STENOSIS
```

```
Principal Diagnosis Code (ICD9): 433.1  433.1      'C'       CAROTID ARTERY OCCLUSION
COMPLICATION/COMORBIDITY
         ...OK? YES// <RET>  (YES)
Attending Surgeon: DOOLITTLE,JAMES A.
```

```
   ** UPDATE REQUEST **   CASE #230  DRUCKER,SAM        PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    PRINCIPAL PROCEDURE CODE: 35301-59
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5    PRIN DIAGNOSIS CODE: 433.10
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
11   SURGEON:            HOWARD,MOE
12   FIRST ASST:
13   SECOND ASST:
14   ATTEND SURG:        DOOLITTLE,JAMES A.
15   REQ POSTOP CARE:    SICU

Enter Screen Server Function:   <RET>
```

```
   ** UPDATE REQUEST **   CASE #230  DRUCKER,SAM        PAGE 2 OF 2

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

Enter Screen Server Function:  <RET>
```

2.6 Review Request Information

Surgeons and nurses use this 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:  ZOOM,BILLY        02-23-53      231447629
```

```
 ZOOM,BILLY

1. 03-09-91   REVISE MEDIAN NERVE (REQUESTED)

Select Operation:  1
```

```
  ** REVIEW REQUEST **   CASE #35  ZOOM,BILLY       PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: REVISE MEDIAN NERVE
2    PRINCIPAL PROCEDURE CODE: 64721
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: CARPAL TUNNEL SYNDROME
5    PRIN DIAGNOSIS CODE: 354.0
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: ELECTIVE
10   SURGERY SPECIALTY:  ORTHOPEDICS
11   SURGEON:            HOWARD,MOE
12   FIRST ASST:         WELBY,MARCUS
13   SECOND ASST:        TRAPPER,JOHN
14   ATTEND SURG:        HOWARD,MOE
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:  <RET>
```

```
 ** REVIEW REQUEST **   CASE #35  ZOOM,BILLY       PAGE 2 OF 2

1    CASE SCHEDULE ORDER: 2ND
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   REQ CLEAN OR CONTAMINATED: CLEAN
12   REFERRING PHYSICIAN: (MULTIPLE)
13   GENERAL COMMENTS:   (WORD PROCESSING)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function:  <RET>
```

2.7 Operation Requests for a Day

This option allows the scheduling manager to display or print a list of operation requests. The information from all surgical requests is collected by the computer and made available by date. There are no editing capabilities for this feature. You have a choice of printing a cursory short form or a long form encompassing all the request fields.

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

Example 1: Short Form

```
Select Request Operations Option: OR  Operation Requests for a Day

Print Requests for which date ? 3/15  (MAR 15, 1992)

Would you like the long or short form ?  SHORT// <RET>

Do you want the requests for all surgical specialties ?  YES//  N

Print Requests for which Surgical Specialty ?  GENERAL(OR WHEN NOT DEFINED BELOW)

Print to Device:  [Select Print Device]
```

..... *printout follows* .....

```
OPERATION REQUESTS FOR GENERAL(OR WHEN NOT DEFINED BELOW)             03/15/92
-------------------------------------------------------------------------------

1.   Case Number: 173                   Operation Date: 03/15/92
     Patient:   PETRIE,ROBERT           Ward:
     ID#:       123-45-4886             Surgeon: HOWARD,MOE
     Procedure: CHOLECYSTECTOMY (URGENT ADD TODAY)
     Estimated Case Length: 2:30
     Requested Anesthesia:  GENERAL

2.   Case Number: 180                   Operation Date: 03/15/92
     Patient:   BODEAN,JETHRO           Ward: 1 SOUTH
     ID#:       123-45-7212             Surgeon: FINE,LARRY
     Procedure: REPAIR DIAPHRAGMATIC HERNIA (STANDBY)
     Estimated Case Length: 2:00
     Requested Anesthesia:  GENERAL


Press RETURN to continue  <RET>
```

Example 2: Long Form

```
Select Request Operations Option:  OR Operation Requests for a Day

Print Requests for which date ? 3/15  (MAR 15, 1992)

Would you like the long or short form ?  SHORT// L

Do you want the requests for all surgical specialties ?  YES//  N

Print Request for which Surgical Specialty ?  GENERAL(OR WHEN NOT DEFINED BELOW)

Print to Device: [Select Print Device]
```

..... *printout follows* .....

```
==============================================================================
OPERATION REQUESTS FOR GENERAL(OR WHEN NOT DEFINED BELOW)
ON MAR 15, 1992
------------------------------------------------------------------------------

Patient: PETRIE,ROBERT                  ID #: 123-45-4886
Age: 51                                 Ward: NOT ENTERED

Surgeon: HOWARD,MOE                     Attending: HOWARD,MOE
Preoperative Diagnosis: CHOLELITHIASIS

Principal Procedure:  CHOLECYSTECTOMY
Other Procedures:     INTRAOPERATIVE CHOLANGIOGRAM
Estimated Case Length: 2:30

Req. Anesthesia Technique: GENERAL
Blood Requested:      CPDA-1 WHOLE BLOOD   UNITS
                      FRESH FROZEN PLASMA, CPDA-1  2 UNITS
Restraints:           SAFETY STRAP
Requested by: MOODY,MARGARET on JAN  7, 1992 13:45


Press <RET> to continue, or '^' to quit:  <RET>
```

```
==============================================================================
OPERATION REQUESTS FOR GENERAL(OR WHEN NOT DEFINED BELOW)
ON MAR 15, 1992
------------------------------------------------------------------------------

Patient: BODEAN,JETHRO                  ID #: 123-45-7212
Age: 40                                 Ward: 1 SOUTH

Surgeon: FINE,LARRY                     Attending: FINE,LARRY
Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA

Principal Procedure:  REPAIR DIAPHRAGMATIC HERNIA
Estimated Case Length: 2:00

Req. Anesthesia Technique: GENERAL
Blood Requested:      CPDA-1 WHOLE BLOOD  2 UNITS
Restraints:           SAFETY STRAP
Requested by: MOODY,MARGARET on JAN 13, 1992 14:39


Press RETURN to continue  <RET>
```

2.8 Requests by Ward

Use this option to print request information for patients in all wards or a specific ward. The first prompt asks if you want to print the requests for all wards. If not, accept the No default and the next prompt will ask "Print schedule for which ward?". If you enter a question mark (?), the help screen will list the ward names from which to choose. Patients not assigned to a ward are listed under the category "Outpatient."

This report is 80-columns wide and can be viewed on your terminal screen.

Example: Requests by Ward

```
Select Request Operations Option:  WR  Requests by Ward

Do you wish to print the requests for all wards ?  NO// Y
Print the Requests on which Device: [Select Print Device]
```

..... *printout follows* .....

```
                            Requests for Operations
==============================================================================
                                 Ward: 1 SOUTH
==============================================================================
 Patient: BODEAN,JETHRO (123-45-7212)                     Case Number: 180
 Date of Operation:    03/15/92         Case Order:
 Requested Anesthesia: GENERAL
 Operation(s): REPAIR DIAPHRAGMATIC HERNIA

 Comments:
------------------------------------------------------------------------------

Press RETURN to continue or '^' to quit.  <RET>
```

```
                            Requests for Operations
==============================================================================
                                 Ward: 2 WEST
==============================================================================
 Patient: DRUCKER,SAM (233-41-8719)                       Case Number: 178
 Date of Operation:    03/15/92         Case Order:  1
 Requested Anesthesia: GENERAL
 Operation(s): CAROTID ARTERY ENDARTERECTOMY

 Comments:

    Concurrent Case Number: 179
    Procedure: AORTO CORONARY BYPASS GRAFT

Comments:
------------------------------------------------------------------------------
 Patient: DRUCKER,SAM (233-41-8719)                       Case Number: 179
 Date of Operation:    03/15/92         Case Order:  1
 Requested Anesthesia: GENERAL
 Operation(s): AORTO CORONARY BYPASS GRAFT

 Comments:

    Concurrent Case Number: 178
```

```
    Procedure: CAROTID ARTERY ENDARTERECTOMY

Comments:
-----------------------------------------------------------------------------

Press RETURN to continue or '^' to quit.  <RET>
```

```
                            Requests for Operations
==============================================================================
                                 Ward: OUTPATIENT
==============================================================================
 Patient: VEE,OLLIE (332-00-1234)                          Case Number: 172
 Date of Operation:    03/25/92         Case Order:
 Requested Anesthesia:
 Operation(s): HEMMORHOIDECTOMY

 Comments:
------------------------------------------------------------------------------
 Patient: PETRIE,ROBERT (123-45-4886)                      Case Number: 173
 Date of Operation:    03/15/92         Case Order:
 Requested Anesthesia: GENERAL
 Operation(s): CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM

 Comments:
------------------------------------------------------------------------------
 Patient: FLINTSTONE,FRED (111-11-1111)                    Case Number: 175
 Date of Operation:    03/14/92         Case Order:
 Requested Anesthesia: LOCAL
 Operation(s): REMOVE BUNION

 Comments:
------------------------------------------------------------------------------
```

3.0 List Operation Requests

Use this option to produce a list of requested cases, including cases on the waiting list. This report sorts by ward or surgical specialty.

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

Example 1: List Requests by Specialty

```
Select Surgery Menu Option:  LR  List Operation Requests

List requests by SERVICE or WARD ?  SERVICE// <RET>

Do you want requests for all surgical specialties ? YES// N


List Request for which Specialty ? GENERAL(OR WHEN NOT DEFINED BE  50
GENERAL(OR WHEN NOT DEFINED BELOW)
Print to Device: [Select Print Device]
```

..... *printout follows* .....

```
     Operative Requests for GENERAL(OR WHEN NOT DEFINED BELOW)

Date          Patient                        Ward Location
Case Number   Operative Procedure
=====================================================================
APR  4, 1991  CLEAVER,THEODORE               1 SOUTH
180           212-65-0036
              REMOVE MOLE
---------------------------------------------------------------------
JUN  1, 1991  HASKELL,EDDIE                  1 SOUTH
178           122-32-4569
              REPAIR DIAPHRAGMATIC HERNIA
---------------------------------------------------------------------
AUG 15, 1991  OAT,WILLIE                     1 NORTH
145           449-34-5555
              CHOLECYSTECTOMY
---------------------------------------------------------------------
Press <RET> to continue
```

Example 2: List Requests by Ward

```
Select Surgery Menu Option:  LR List Operation Requests

List requests by SERVICE or WARD ?  SERVICE// WARD

Do you want requests for all wards ? YES// N


Select Requests for which Ward ?  2  1 SOUTH
Print to Device:  [Select Print Device]
```

..... *printout follows* .....

```
     Operative Requests for 1 SOUTH

Date          Patient                        Surgical Specialty
Case Number   Operative Procedure
=========================================================================
APR  4, 1991  CLEAVER,THEODORE               ORTHOPEDICS
179           212-65-0036
              ARTHROSCOPY, RIGHT KNEE
-------------------------------------------------------------------------
APR  4, 1991  CLEAVER,THEODORE               GENERAL
180           212-65-0036
              REMOVE MOLE
-------------------------------------------------------------------------
JUN  1, 1991  HASKELL,EDDIE                  GENERAL
178           122-32-4569
              REPAIR DIAPHRAGMATIC HERNIA
-------------------------------------------------------------------------
JUN  1, 1991  CLEAVER,THEODORE               PERIPHERAL VASCULAR
181           212-65-0036
              CAROTID ARTERY ENDARTERECTOMY
-------------------------------------------------------------------------
JUN  1, 1991  CLEAVER,THEODORE               THORACIC SURGERY
182           212-65-0036
              AORTO CORONARY BYPASS GRAFT
-------------------------------------------------------------------------
Press <RET> to continue
```

4.0 Schedule Operations

The Schedule Operations menu is designed to be used by physicians or the Scheduling Manager to book an operation when the **date**, **time**, and **operating room** are determined. The scheduling manager may schedule an already requested operation using the *Schedule Requested Operation* option. On the other hand, the scheduling manager may book an operation that has not been previously requested if the date, time and operating room are known. In this case, the Request Menu can be skipped and the operation can be scheduled using the *Schedule Unrequested Operation* option.

Whether you are booking a case from the *Waiting List*, *Request Menu*, *Scheduling Menu*, or as a *New Surgery*, you will be asked to provide preoperative information about the case. It is advisable to enter as much information as you can. Later, you can update it or make corrections.

The information gathered by the *Request Operations* submenu is collated by the computer and used to produce reports. The person in charge of scheduling (scheduling manager) arranges the requests according to the hospital's Surgical Service protocols and schedules the operation by assigning the case an operating room and a time slot. The information gathered by the *Schedule Operations* submenu is collated by the computer and is used to produce reports for the scheduling manager.

Note: Local restrictions can be applied to the scheduling of procedures. For example, your facility can require CPT codes be entered before a surgical case is scheduled. The option *Surgery Site Parameters (Enter/Edit)* is used to select required fields.

The options included in this menu are listed below. To the left of the option name is the option's keystroke equivalent that can be used as a short cut.

A	*Display Availability*
SR	*Schedule Requested Operations*
SU	*Schedule Unrequested Operations*
CON	*Schedule Unrequested Concurrent Cases*
R	*Reschedule or Update Scheduled Operations*
C	*Cancel Scheduled Operation*
UC	*Update Cancellation Reason*
AN	*Schedule Anesthesia Personnel*
B	*Create Service Blockout*
DB	*Delete Service Blockout*
S	*Schedule of Operations*

4.1 Display Availability

View the availability of operating rooms on a blockout graph before booking an operation with this option. You might also use this option to check your booking or service blockout. This feature is the same as the *Display Availability* option from the *Request Operations* menu.

Scheduled operations show up on the graph as an equal sign (=) followed by the letter X. The equal sign before the X indicates the beginning of a scheduled operation. Surgical specialty blockouts are indicated by an abbreviation for the service. For more information on service blockouts, a function of the scheduling menu, see the *Create Service Blockouts* option.

If your display terminal can print condensed characters, a 24-hour graph will appear on the screen. If not, you will be prompted to select one of three graphs representing different chunks of that day.

Example: Display all O.R.s for One Day

```
Select Schedule Operations Option: A  Display Availability
```

```
Do you want to view all Operating Rooms on one day ?  YES //  <RET>

Do you want to list requests also ?  NO//  <RET>

Display Operating Room Availability for which Date ?  T  (JUL 01, 1993)
```

```
Display of Available Operating Room Time

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

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

```
ROOM   6AM   7    8    9    10   11   12   13   14   15   16   17   18   19   20
OR1     |____|uro.|uro.|uro.|uro.|uro.|uro.|uro.|uro.|____|____|____|____|____|
OR2     |____|card|card|card|card|card|card|card|card|card|____|____|____|____|
OR3     |____|thor|thor|thor|thor|thor|thor|thor|thor|____|____|____|____|____|
OR4     |____|gen.|gen.|gen.|gen.|gen.|gen.|gen.|gen.|____|____|____|____|____|
OR5     |____|=XXX|XXXX|=XXX|XXXX|____|____|____|____|____|____|____|____|____|

Press RETURN to continue  <RET>
```

4.2 Schedule Requested Operation

Use this option to schedule a previously requested operation when you have enough information to assign an operating room and time slot. You will also be prompted to provide anesthesia personnel information. The information entered here is reflected in the *Schedule of Operations* report. This option is designed for the scheduling manager to expeditiously schedule any or all requests on a specific date.

First, enter the patient you want to schedule. The computer will automatically display all requests for that patient. Then, pick the request you wish to schedule and assign the operating room, beginning and end times, and anesthesia personnel for the case. You can then choose another patient to schedule, or press the Return key to leave the option.

Prompts that require a response before you can continue with this option

Schedule a Case for which Operating Room?
Reserve from what time?
Reserve to what time?

Scheduling a Concurrent Case

A concurrent case is when a patient undergoes two operations by different surgical specialties at the same time, or back to back, in the same operating room. Example 2 demonstrates scheduling a requested concurrent case. When you schedule a concurrent case, you must answer the prompt "There is a concurrent case associated with this operation. Do you want to schedule it for the same time? (Y/N)". If you answer No, the two cases will not longer be considered concurrent. You can enter anesthesia personnel information for each case.

Hint: Allow enough time for **both** surgeries when you answer the prompts "Reserve from what time" and "Reserve to what time."

Example 1: Schedule a Requested Operation

```
Select Schedule Operations Option: SR  Schedule Requested Operations

Select Patient: FIFE,BARNEY         04-04-30     222001234
```

```
The following case is requested for FIFE,BARNEY:

1.  04-24-92   EXCISE RECTAL LESION


Case Information:
EXCISE RECTAL LESION
By FINE,LARRY                           On FIFE,BARNEY
Case # 210                              For 1:00 Hours
```

```
Comments:

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

```
Display of Available Operating Room Time

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

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

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

Schedule a Case for which Operating Room ?  OR1

Reserve from what time ? (24HR:NEAREST 15 MIN):  7:00

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


Principal Anesthetist: WATSON,CHERYL
Anesthesiologist Supervisor: JENNINGS,GEORGE A
```

```
Select Patient:
```

Example 2: Schedule Operation for a Concurrent Case

```
Select Schedule Operations Option: SR  Schedule Requested Operations

Select Patient: TAYLOR,OPIE         09-14-54     112223334
```

```
The following cases are requested for TAYLOR,OPIE:

1.  07-06-93   CAROTID ARTERY ENDARTERECTOMY
2.  07-06-93   AORTO CORONARY BYPASS GRAFT

Select Operation Request: 1
```

```
Case Information:
CAROTID ARTERY ENDARTERECTOMY
By HOWARD,MOE                           On TAYLOR,OPIE
Case # 262
STANDBY
  * Concurrent Case # 263  AORTO CORONARY BYPASS GRAFT

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

```
Display of Available Operating Room Time

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

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

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

Schedule a Case for which Operating Room ?  OR2

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

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


Principal Anesthetist: WATSON,CHERYL
Anesthesiologist Supervisor: JENNINGS,GEORGE A

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

```
Select Patient:
```

4.3 Schedule Unrequested Operations

Use this option to schedule an operation that has not been requested. To schedule an operation, you must determine the date, time, and operating room. The information entered in this option is reflected in the Schedule of Operations report.

Whenever you book a new case, you are asked to provide preoperative information about the case. Enter as much information as you can. Later, you can update it or make corrections.

Prompts that require a response before you can continue with this option

Schedule Procedure for which Date?
Select Patient
Schedule a Case for which operating Room?
Reserve from what time?
Reserve to what time?
Surgeon
Surgical Specialty
Principal Operative Procedure
Indications for Operations

Entering Preoperative Information

At this prompt	Do this …
Principal Procedure Code (CPT)	Type in the Current Procedural Terminology (CPT) identifying code for each procedure. If you do not know the code number, you can enter the type of operation (i.e., appendectomy) or a body organ and select from a list of codes.
Indications for Operations	Type in the reason this procedure is being performed. You must answer this prompt before you can continue with the option. The notation 1> indicates this is row 1 of an open-text word-processing field. You can enter as many lines (rows) as needed.

At this prompt	Do this…
Brief Clinical History	This information will show up on the Tissue Examination Report. Enter any information relevant to the specimens being sent to the laboratory. This is an open-text word-processing field.
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 Return key to bypass this prompt. The package coordinator at your 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, you can select the preferred blood product. (Enter two question marks for a list of blood products). *Hint*: 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 preop x-ray films and reports required for delivery to the operating room before the operation. Leave this field blank if you do not intend to order any x-ray products.
Request Clean or Contaminated	Enter the letter code **C** for clean or **D** for contaminated, or type in the first few letters of either word. This information allows the scheduling manager to determine how much time is needed between operations for sanitizing a room.

Example: Schedule an Unrequested Operation

```
Select Schedule Operations Option: SU  Schedule Unrequested Operations
```

```
Schedule a Procedure for which Date ?  T+5  (JUL 18, 1993)

Select Patient: NASIUM,JIM         12-19-53     121212453
```

```
Display of Available Operating Room Time

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

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

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

Schedule a case for which operating Room ?  OR1

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

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

```
              SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

NASIUM,JIM (121-21-2453)                                        JUL 18, 1993
==============================================================================

Surgeon: GEORGE,SUSAN
Surgical Specialty: 54          ORTHOPEDICS  ORTHOPEDICS        54
Principal Operative Procedure: SHOULDER ARTHROPLASTY-PROSTHESIS
Principal Procedure Code (CPT): 23470       RECONSTRUCT SHOULDER JOINT
        ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIARTHROPLASTY
 Modifier: <RET>
Indications for Operations:
  1>PROGRESSIVE PAIN AND INABILITY TO MOVE THE JOINT.
  2><RET>
EDIT Option: <RET>
```

```
              SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

NASIUM,JIM (121-21-2453)                                        JUL 18, 1993
==============================================================================
Principal Anesthetist: WATSON,CHERYL
Anesthesiologist Supervisor: JENNINGS,GEORGE A
```

```
              SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION

NASIUM,JIM (121-21-2453)                                        JUL 18, 1993
==============================================================================
Principal Procedure:      SHOULDER ARTHROPLASTY-PROSTHESIS
Principal Procedure Code (CPT): 23470  ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIART
HROPLASTY
         // <RET>
```

```
Select OTHER PROCEDURE: <RET>
Brief Clinical History:
  1>CHRONIC DEBILITATING PAIN.  X-RAY SHOWS SEVERE
  2>DEGENERATIVE OSTEOARTHRITIS.
  3><RET>
EDIT Option: <RET>
```

```
                    SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

NASIUM,JIM (121-21-2453)                                        JUL 18, 1993
==============================================================================


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

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

NASIUM,JIM (121-21-2453)                                        JUL 18, 1993
==============================================================================

Principal Preoperative Diagnosis: DEGENERATIVE JOINT DISEASE, L SHOULDER
Principal Diagnosis Code (ICD9): 715.11  715.11         LOC PRIM OSTEOART-SHLDER
         ...OK? YES// <RET>  (YES)
Hospital Admission Status: I//  <RET> INPATIENT
Case Schedule Type: S  STANDBY
First Assistant: PTD  DAVIS,PAUL
Second Assistant: REED,JAMES
Attending Surgeon: FINE,LARRY
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
Request Clean or Contaminated: C  CLEAN
GENERAL COMMENTS:
  1><RET>
```

```
  ** SCHEDULING **   CASE #264  NASIUM,JIM          PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: SHOULDER ARTHROPLASTY-PROSTHESIS
2    PRINCIPAL PROCEDURE CODE: 23470
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
5    PRIN DIAGNOSIS CODE: 715.11
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  ORTHOPEDICS
11   SURGEON:            GEORGE,SUSAN
12   FIRST ASST:         DAVIS,PAUL
13   SECOND ASST:        REED,JAMES
14   ATTEND SURG:        FINE,LARRY
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:  <RET>
```

```
  ** SCHEDULING **   CASE #264  NASIUM,JIM          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    REQ PHOTO:          NO
10   REQ CLEAN OR CONTAMINATED: CLEAN
11   PRINC ANESTHETIST:  WATSON,CHERYL
12   ANESTHESIOLOGIST SUPVR: JENNINGS,GEORGE A
13   BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)
14   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  <RET>
```

4.4 Schedule Unrequested Concurrent Cases

This option is used to schedule concurrent cases that have not been requested. A concurrent case is when a patient undergoes two operations by different surgical specialties at the same time (or back to back) in the same room. You can schedule both cases with this one option. As usual, whenever you enter a request, you are asked to provide preoperative information about the case. It is best to enter as much information as you can and update it later if necessary.

Mandatory Prompts
After you enter the patient name, you will be prompted to enter some required information about the first case. The mandatory prompts include the date, procedures, surgeon, indications for operation, and time needed. If you do not answer a mandatory prompt, the computer will not book the operation and will return the cursor to the Schedule Operations menu. After answering the prompts for the first case, you will be asked to answer the same prompts for the second case. The computer will then give you a message that the two requests have been entered. You can now select a case for entering detailed preoperative information. If you do not want to enter details at this time, press the Return key and the cursor will return to the Schedule Operations menu. In the example, we entered detailed information for the first case.

Storing the Request Information
After every prompt or group of related prompts, the computer will ask if you want to store (meaning duplicate) the answers in the concurrent case. This saves time by "packing" the information into the other case so that you do not have to type it again. The computer will then display the screen server summary and pack any duplicated information into the other case. Finally, the computer will tell you that the two requests have been entered and prompt you to select either case for entering detailed information. You can select a case or press the Return key to get back to the *Schedule Operations* menu.

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

Example: Schedule Unrequested Concurrent Cases

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

```
Schedule Concurrent Cases for which Patient ?  CLAMPETT,J.D.         06-04-20
  665370555

Schedule Concurrent Procedures for which Date ?  T+12  (JUL 25, 1993)
```

```
Display of Available Operating Room Time

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

Select Number: 2//  4

Schedule a case for which operating Room ?  OR2

Reserve from what time ? (24HR:NEAREST 15 MIN):  11:15

Reserve to what time ? (24HR:NEAREST 15 MIN):  16:00
```

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

CLAMPETT,J.D. (665-37-0555)                                      JUL 25, 1993
==============================================================================

Surgeon: HOWARD,MOE
Surgical Specialty: 62          PERIPHERAL VASCULAR  PERIPHERAL VASCULAR
62
Principal Operative Procedure: CAROTID ARTERY ENDARTERECTOMY
Indications for Operations:
  1>UNSTABLE ANGINA AND IMPENDING STROKE
  2><RET>
EDIT Option:<RET>
```

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

CLAMPETT,J.D. (665-37-0555)                                      JUL 25, 1993
==============================================================================

Surgeon: FINE,LARRY
Surgical Specialty: 58          THORACIC SURGERY (INC. CARDIAC SURG.)  THORACIC
SURGERY (INC. CARDIAC SURG.)        58
Principal Operative Procedure: AORTO CORONARY BYPASS GRAFT
Indications for Operations:
  1>UNSTABLE ANGINA.
  2><RET>
EDIT Option: <RET>
```

```
The following cases have been entered.

1.  Case # 265                          JUL 25, 1993
    Surgeon: HOWARD,MOE                 PERIPHERAL VASCULAR
    Procedure:  CAROTID ARTERY ENDARTERECTOMY

2.  Case # 266                          JUL 25, 1993
    Surgeon: FINE,LARRY                 THORACIC SURGERY (INC. CARDIAC SURG.)
    Procedure:  AORTO CORONARY BYPASS GRAFT



1. Enter Information for Case #265
2. Enter Information for Case #266

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

```
                              FIRST CONCURRENT CASE
              SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

CLAMPETT,J.D. (665-37-0555)                                   JUL 25, 1993
================================================================================
Principal Anesthetist: WATSON,CHERYL
Anesthesiologist Supervisor: JENNINGS,GEORGE A

                              FIRST CONCURRENT CASE
              SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION

CLAMPETT,J.D. (665-37-0555)                                   JUL 25, 1993
================================================================================
Principal Procedure:      CAROTID ARTERY ENDARTERECTOMY
Principal Procedure Code (CPT): 35301  THROMBOENDARTERECTOMY, WITH OR WITHOUT PA
TCH GRAFT; CAROTID, VERTEBRAL, SUBCLAVIAN, BY NECK INCISION
         // <RET>
Select OTHER PROCEDURE: <RET>
Brief Clinical History:
  1>Patient with 3 episodes of amaurisis fugax in the last
  2>3 months.  6 mo history of increasing angina with little
  3>control from nitrates.  Carotid arteriogram shows 95%
  4>occlusion on right, 80% on left.  Angiogram shows 80%
  5>occlusion of left main artery.
  6><RET>
EDIT Option: <RET>
```

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

CLAMPETT,J.D. (665-37-0555)                                   JUL 25, 1993
================================================================================


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

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH//<RET> TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// <RET>
  Required Blood Product: CPDA-1 WHOLE BLOOD// <RET>
  Units Required: 2
```

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

CLAMPETT,J.D. (665-37-0555)                                      JUL 25, 1993
==============================================================================

Principal Preoperative Diagnosis: CAROTID ARTERY STENOSIS
Principal Diagnosis Code (ICD9): 433.1  433.1      'C'       CAROTID ARTERY OCCL
USION      COMPLICATION/COMORBIDITY
         ...OK? YES//  <RET> (YES)
Hospital Admission Status: I// <RET>  INPATIENT

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//  <RET>

First Assistant: REED,JAMES
Second Assistant: PTD  DAVIS,PAUL
Attending Surgeon: HOWARD,MOE
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//  <RET>

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

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

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

Request Clean or Contaminated: C  CLEAN

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

GENERAL COMMENTS:
  1><RET>

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


Press RETURN to continue  <RET>
```

```
  ** SCHEDULING **   CASE #265  CLAMPETT,J.D.       PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    PRINCIPAL PROCEDURE CODE: 35301
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5    PRIN DIAGNOSIS CODE: 433.1
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
11   SURGEON:            HOWARD,MOE
12   FIRST ASST:         REED,JAMES
13   SECOND ASST:        DAVIS,PAUL
14   ATTEND SURG:        HOWARD,MOE
15   REQ POSTOP CARE:    SICU

Enter Screen Server Function:  <RET>
```

```
  ** SCHEDULING **   CASE #265  CLAMPETT,J.D.       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    REQ PHOTO:          NO
10   REQ CLEAN OR CONTAMINATED: CLEAN
11   PRINC ANESTHETIST:  WATSON,CHERYL
12   ANESTHESIOLOGIST SUPVR: JENNINGS,GEORGE A
13   BRIEF CLIN HISTORY: (WORD PROCESSING)
14   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  <RET>
```

4.5 Reschedule or Update a Scheduled Operation

This option has three uses: 1) to add a concurrent case, 2) to reschedule an operation for another date, time, and/or operating room, 3) to update the preoperative information that was entered earlier.

How to add a Concurrent Case (See Example 1*)*

After you select the case, the computer will ask if you want to add a concurrent case. If you respond Yes, the computer will prompt you for information on the second case. To add the case, you must enter a principal operative procedure, a surgical specialty, and the indications for operations. The computer will then tell you that the case has been added. You can now select another case or the same case for entering detailed preoperative information or you can press the Return key to return to the Schedule Operations menu.

How to Change the Date, Time, or Operating Room (See Example 2)

If you don't want to add a concurrent case, the computer will ask if you want to change the date, time or operating room. If you enter Yes, the computer will erase the old date, time, and operating room and ask you to re-enter this information. You will be prompted to select a new date, but if you press the Return key, the computer will default to the original date and allow you to change the room and time. The computer supplies a blockout graph to help you reschedule.

Note: If you attempt to reschedule a case after the schedule close time for the date of operation, only the time, and not the date, can be changed.

How to Update the Preoperative Info (See Example 3)

To update the preoperative information that was entered earlier, respond No to the prompt asking if you wish to change the date, time or operating room. The terminal display screen will clear and present a two-page Screen Server summary. You may change any of the data fields, as in Example 2.

Note: Example 3 also shows you how to order more than one blood product for a case.

Example 1: How to Add a Concurrent Case to a Scheduled Operation

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

Select Patient: FIFE,BARNEY         04-04-30     222001234
FIFE,BARNEY (222-00-1234)


1.  09/16/92   CARPAL TUNNEL RELEASE (SCHEDULED)
2.  02/02/93   BUNIONECTOMY (SCHEDULED)

Select Number: 1

Do you want to add a concurrent case ?  NO// Y
```

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

FIFE,BARNEY (222-00-1234)                                        SEP 16, 1992
==============================================================================

Surgeon: FINE,LARRY
Surgical Specialty: 54          ORTHOPEDICS  ORTHOPEDICS        54
Principal Operative Procedure: ARTHROSCOPY, R SHOULDER
Principal Procedure Code (CPT): 23470       RECONSTRUCT SHOULDER JOINT
        ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIARTHROPLASTY
 Modifier: <RET>
Indications for Operations:
  1>PROGRESSIVE PAIN AND INABILITY TO MOVE THE JOINTS.
  2>X-RAYS ARE CONCLUSIVE.
  3> <RET>
EDIT Option:  <RET>
```

```
                              SECOND CONCURRENT CASE
              SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

FIFE,BARNEY (222-00-1234)                                        SEP 16, 1992
==============================================================================
Principal Anesthetist: WATSON,CHERYL
Anesthesiologist Supervisor: JENNINGS,GEORGE A
```

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

FIFE,BARNEY (222-00-1234)                                        SEP 16, 1992
==============================================================================
Principal Procedure:      ARTHROSCOPY, R SHOULDER
Principal Procedure Code (CPT): 23470  ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIART
HROPLASTY
         // <RET>
Select OTHER PROCEDURE:  <RET>
Brief Clinical History:
  1>CHRONIC DEBILITATING PAIN.  X-RAY SHOWS SEVERE
  2>DEGENERATIVE OSTEOARTHRITIS.
  3>
EDIT Option:  <RET>
```

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

FIFE,BARNEY (222-00-1234)                                        SEP 16, 1992
===============================================================================


Request Blood Availability ? YES//   <RET>
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH//   <RET> TYPE &
CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// FA1  FRESH FROZEN PLASMA, CPDA-1
  18201
  Units Required: 2
```

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

FIFE,BARNEY (222-00-1234)                                        SEP 16, 1992
===============================================================================

Principal Preoperative Diagnosis: DEGENERATIVE OSTEOARTHRITIS
Principal Diagnosis Code (ICD9): 715.90 (OSTEOARTHROS NOS-UNSPEC)
OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING
UNSPECIFIED SITE

Hospital Admission Status: I//  <RET>  INPATIENT

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: PTD  DAVIS,PAULETTE
Second Assistant:  <RET>
Attending Surgeon: FINE,LARRY
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//  <RET>

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

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

Requested Preoperative X-Rays:  <RET>
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//   <RET>

Request Clean or Contaminated: C  CLEAN
```

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

GENERAL COMMENTS:
  1>  <RET>

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

```
  ** SCHEDULING **   CASE #245  FIFE,BARNEY         PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: ARTHROSCOPY, R SHOULDER
2    PRINCIPAL PROCEDURE CODE: 23470
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: DEGERATIVE OSTEOARTHRITIS
5    PRIN DIAGNOSIS CODE: 715.90
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9     CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  ORTHOPEDICS
11   SURGEON:            FINE,LARRY
12   FIRST ASST:         DAVIS,PAULETTE
13   SECOND ASST:
14   ATTEND SURG:        FINE,LARRY
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:   <RET>
```

```
  ** SCHEDULING **   CASE #245  FIFE,BARNEY         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    REQ PHOTO:          NO
10   REQ CLEAN OR CONTAMINATED: CLEAN
11   PRINC ANESTHETIST:  WATSON,CHERYL
12   ANESTHESIOLOGIST SUPVR: JENNINGS,GEORGE A
13   BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)
14   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:   <RET>
```

```
The following cases have been entered.

1.  Case # 224                          SEP 16, 1992
    Surgeon: HOWARD,MOE                 NEUROSURGERY
    Procedure:  CARPAL TUNNEL RELEASE

2.  Case # 245                          SEP 16, 1992
    Surgeon: FINE,LARRY                 ORTHOPEDICS
    Procedure:  ARTHROSCOPY, R SHOULDER



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

Select Number:  (1-2):  <RET>
```

Example 2: How to Reschedule an Operation

Change the Date, Time, or Operating Room

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

Select Patient: NASIUM,JIM         12-19-53     121212453
```

```
NASIUM,JIM (121-21-2453)


1.  09/15/92   SHOULDER ARTHROPLASTY-PROTHESIS (SCHEDULED)

Select Number: 1

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

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

```
Operating Room Reservations:

Surgeon: HOWARD,MOE
Patient: NASIUM,JIM
Procedure(s): SHOULDER ARTHROPLASTY-PROTHESIS

Operating Room:  OR3
Scheduled Start: SEP 15, 1992 08:00
Scheduled End:   SEP 15, 1992 13:00


Reschedule this Procedure for which Date ?  <RET>

Since no date has been entered, I must assume that you want to re-schedule
this case for the same date.  If you have made a mistake and want to
leave this case scheduled for the same operating room at the same times,
enter RETURN when prompted to select an operating room.

Press RETURN to continue  <RET>
```

```
Display of Available Operating Room Time

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

Select Number: 2//  4

Schedule this case for which Operating Room: OR3

Reserve from what time ? (24HR:NEAREST 15 MIN):  7:30

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


Principal Anesthetist: WATSON,CHERYL// <RET>
Anesthesiologist Supervisor: JENNINGS,GEORGE A// <RET>
```

Example 3: How to Update a Scheduled Operation

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

Select Patient: NASIUM,JIM         12-19-53     121212453
```

```
NASIUM,JIM (121-21-2453)


1.  09/15/92   SHOULDER ARTHROPLASTY-PROTHESIS (SCHEDULED)

Select Number: 1

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

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

```
 ** SCHEDULING **   CASE #218  NASIUM,JIM          PAGE 1 OF 2

1    PRINCIPAL PROCEDURE: SHOULDER ARTHOPLASTY-PROSTHESIS
2    PRINCIPAL PROCEDURE CODE: 23470
3    OTHER PROCEDURES:   (MULTIPLE)
4    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
5    PRIN DIAGNOSIS CODE: 715.11
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  ORTHOPEDICS
11   SURGEON:            HOWARD,MOE
12   FIRST ASST:         FINE,LARRY
13   SECOND ASST:        REED,JAMES
14   ATTEND SURG:        HOWARD,MOE
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:  <RET>
```

```
  ** SCHEDULING **   CASE #218  NASIUM,JIM          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    REQ PHOTO:          NO
10   REQ CLEAN OR CONTAMINATED: CLEAN
11   PRINC ANESTHETIST:  WATSON,CHERYL
12   ANESTHESIOLOGIST SUPVR: JENNINGS,GEORGE A
13   BRIEF CLIN HISTORY: (WORD PROCESSING)
14   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  8
```

```
  ** SCHEDULING **   CASE #218  NASIUM,JIM          PAGE 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// <RET>
```

```
 ** SCHEDULING **   CASE #218  NASIUM,JIM          PAGE 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  NASIUM,JIM          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:  <RET>
```

```
  ** SCHEDULING **   CASE #218  NASIUM,JIM          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:  <RET>
```

```
  ** SCHEDULING **   CASE #218  NASIUM,JIM          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    REQ PHOTO:          NO
10   REQ CLEAN OR CONTAMINATED: CLEAN
11   PRINC ANESTHETIST:  WATSON,CHERYL
12   ANESTHESIOLOGIST SUPVR: JENNINGS,GEORGE A
13   BRIEF CLIN HISTORY: (WORD PROCESSING)
14   GENERAL COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function:  <RET>
```

4.6 Cancel Scheduled Operation

When a scheduled operation is cancelled, this option will remove that case from the list of scheduled operations. If cancellation occurs *before* the schedule close time and is not rescheduled, it will be changed to a Request and will eventually be removed from the system. If cancellation occurs *after* the schedule close time, the case will remain in the system as a cancelled case and will be used in computing your site's cancellation rate.

Enter the patient name and select the operation to be deleted from the choices listed. The "Cancellation Reason" prompt is a mandatory prompt. Enter a question mark for a list of cancellation reasons from which to select. If you make a mistake, or find out later that the cancellation reason was not correct, the *Update Cancellation Reason* option allows you to change it.

If there is a concurrent case associated with the operation being cancelled, the computer will ask if you want to cancel it also.

Example 1: Cancel a Single Scheduled Operation

```
Select Schedule Operations Option: C  Cancel Scheduled Operation

Cancel a Scheduled Procedure for which Patient: HAMILTON,ALEXANDER           01-01-40
176287354     YES     SC VETERAN
```

```
HAMILTON,ALEXANDER (176-28-7354)

1.  09/12/98   FRONTAL CRANIOTOMY TO RULE OUT TUMOR (SCHEDULED)

Select Number: 1

Reservation for OR3
Scheduled Start Time: 09-12-98 11:00
Scheduled End Time:   09-12-98 13:00
Patient: HAMILTON,ALEXANDER
Physician: FINE,LAWRENCE
Procedure: FRONTAL CRANIOTOMY TO RULE OUT TUMOR

Is this the correct operation ?  YES// <RET>

Cancellation Reason:   L LAB TEST          L
Cancellation Avoidable: NO// <RET>

Do you want to create a new request for this cancelled case ??  YES// <RET>

Make the new request for which Date ?  MAR 12, 1999// 9/16

Creating the new request...
```

Example 2: Cancel a Scheduled Concurrent Case

```
Select Schedule Operations Option: C  Cancel Scheduled Operation

Cancel a Scheduled Procedure for which Patient:    FIFE,BARNEY       04-04-30
  222001234
```

```
FIFE,BARNEY (222-00-1234)


1.  09/16/98   ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)
2.  09/16/98   CARPAL TUNNEL RELEASE (SCHEDULED)

Select Number: 1

Reservation for OR2
Scheduled Start Time: 09-16-98 08:00
Scheduled End Time:   09-16-98 13:00
Patient:   FIFE,BARNEY
Physician: FINE,LARRY
Procedure: ARTHROSCOPY, RIGHT SHOULDER

Is this the correct operation ?  YES//  <RET>

Cancellation Reason: IC
     1   ICU BED          I
     2   IC  INTRAOP CHANGE/MEDICAL STATUS        IC
CHOOSE 1-2: 2  INTRAOP CHANGE/MEDICAL STATUS
Cancellation Avoidable: YES// <RET>

Do you want to create a new request for this cancelled case ??  YES// N

There is a concurrent case associated with this operation.  Do you want to
cancel it also ? YES// N
```

4.7 Update Cancellation Reason

This option is used to update the cancellation date and reason previously entered for a selected surgical case.

Example: Update Cancellation Reason

```
Select Schedule Operations Option:  UC Update Cancellation Reason
```

```
Update Cancellation Information for which Patient: HAMILTON,ALEXANDER         01-01-40
176287354     NSC VETERAN

1. 06-01-98   FRONTAL CRANIOTOMY TO RULE OUT TUMOR (CANCELLED)


Select Operation:  1
```

```
HAMILTON,ALEXANDER              176-28-7354       Case # 21199

06-01-98      FRONTAL CRANIOTOMY TO RULE OUT TUMOR (CANCELLED)


Cancellation Date: JUN 01,1998@10:53// <RET>

Cancellation Reason: LAB TEST// EM  EMERGENCY CASE SUPERSEDES     EM
Cancellation Avoidable: NO// <RET>

Press RETURN to continue
```

4.8 Schedule Anesthesia Personnel

This option allows anesthesia staff to assign, or change, anesthesia personnel for surgery cases. The scheduling manager might have already assigned some personnel to a case using other menu selections. For your convenience, the computer will default to any previously entered data.

Use this option to enter the names of the principal anesthetists, the supervisors, and anesthesia techniques for cases scheduled on a specific date. First, enter the date, and then select an operating room. The computer will display all cases scheduled in that room. After scheduling personnel for any or all cases in one operating room, you can do the same for other operating rooms without leaving this option.

Note: This option also appears on the Anesthesia Menu. It is locked with the SROANES key and will not appear on your menu if you do not have this key.

Example: Schedule Anesthesia Personnel

```
Select Schedule Operations Option: AN  Schedule Anesthesia Personnel

Schedule Anesthesia Personnel for which Date ?  8/16  (AUG 16, 1991)

Schedule Anesthesia Personnel for which Operating Room ?  OR2
```

```
Scheduled Operations for OR2
----------------------------------------------------------------------
Case # 5   Patient: PETRIE,ROBERT A.
From: 07:00  To: 09:00
HARVEST SAPHENOUS VEIN

Requested Anesthesia Technique: GENERAL//  <RET>
Principal Anesthetist: WATSON, CHERYL          CW      112G
Anesthesiologist Supervisor: JENNINGS,GEORGE A          GAJ

Press RETURN to continue, or '^' to quit   <RET>
```

```
Scheduled Operations for OR2
----------------------------------------------------------------------
Case # 14   Patient: NASIUM,JIM
From: 13:00  To: 18:00
SHOULDER ARTHROPLASTY

Requested Anesthesia Technique: GENERAL//  <RET>
Principal Anesthetist: WATSON, CHERYL//     <RET>      CW      112G
Anesthesiologist Supervisor: JENNINGS,GEORGE A       GAJ

Press RETURN to continue, or '^' to quit   <RET>
```

```
Would you like to continue with another operating room ?  YES//  <RET>

Schedule Anesthesia Personnel for which Operating Room ?  OR1

There are no cases scheduled for this operating room.

Press RETURN to continue   <RET>

Would you like to continue with another operating room ?  YES// N
```

4.9 Create Service Blockout

At times, the surgical staff may need to set aside an operating room for a particular service on a recurring basis. This option is used by the scheduling manager to blockout the operating room(s) on a graph.

The resulting service blockout is automatically charted on a graph that can be viewed from the *Display Availability* option. This service blockout does not restrict the operating room to the service, but can assist the scheduling manager when assigning operating rooms.

The scheduling manager can create the service blockouts by following the example provided on the following page. The required data fields are as follows:

At this prompt . . .	**Do this . . .**
For what service?	Enter a three or four letter abbreviation for the surgical service the room is being reserved (e.g., card for cardiology, gen for general surgery). ***Note***: Do not use the letter X or an equal sign (=).
Select Operating Room	Enter the operating room name or code. The operating room must already exist in the HOSPITAL LOCATION file and the OPERATING ROOM file. Enter a question mark to get a list of operating rooms already included in these files. See your supervisor or package coordinator to add an operating room to these files.
Select Starting Date	Enter the date you want the blockout to begin.
Reserve from what time?	Enter the times for which this room will be blocked-out for a particular service. A room may be reserved at any time during the 24-hour cycle to the nearest 15 minutes.
Reserve to what time?	Enter the end time for the service blockout.

Example: Create a Service Blockout

```
Select Schedule Operations Option: B  Create Service Blockout

For what service ? (3-4 characters, do not use 'X' or '=')  CARD
Select Operating Room: OR1

Select Starting Date: T   (NOV 18, 1998)

Reserve from what time ? (24HR:NEAREST 15 MIN):  7  (NOV 18, 1998  07:00)

Reserve to what time ? (24HR:NEAREST 15 MIN):  12  (NOV 18, 1998  12:00)

1. Every week, same time
2. Every other week
3. Every month, same day of week & week of month

Select Number:  1

Updating Schedules...
```

4.10 Delete Service Blockout

The following example shows how to remove a service blockout from the blockout graph. You can delete a service blockout for just one date or for all the reserved dates.

After starting this option, if you decide not to delete a service blockout, enter an up-arrow (^) to exit.

Example: Delete Service Blockout

```
Select Schedule Operations Option: DB  Delete Service Blockout

Select service you wish to delete. (3-4 characters)  CARD


The service 'card' has the following time(s) scheduled:
  1.  OR1 on Tuesday from 07.00 to 12.00


Which number would you like to delete ? 1

Delete the Blockout starting with which date ?  3/29  (MAR 29, 1991)

Do you want to delete the blockout for this service on this
date only ?  NO//  <RET>

Updating Schedules...



Press RETURN to continue
```

4.11 Schedule of Operations

This option generates the Operating Room Schedule used by the OR nurses, surgeons, anesthetists and other hospital services. The report lists operations and patients scheduled for a particular date. It sorts by operating room and includes the procedure(s), blood products requested, and any preoperative x-rays requested. The schedule also provides anesthesia information and surgeon names.

This report has a 132-column format and is designed to be copied to a printer.

Note: By setting up default printers in the SURGERY SITE PARAMETERS file, this report can be queued to print in various locations simultaneously. Please refer to the Package Management chapter for more details.

Example: Print Schedule of Operations

```
Select Schedule Operations Option:  S  Schedule of Operations

Print Schedule of Operations for which date ?   9/8  (SEP O8, 1999)

This report is designed to use a 132 column format.

DEVICE: [Select Print Device]
```

..... *printout follows* .....

```
                                                    MAYBERRY, NC                                                          PAGE 1
                                                  SURGICAL SERVICE
                                               SCHEDULE OF OPERATIONS            SIGNATURE OF CHIEF: DR. MOE HOWARD
PRINTED: SEP 07, 1999 11:12                       FOR: SEP 08, 1999                                  ___________________

PATIENT                DISPOSITION      PREOPERATIVE DIAGNOSIS                          REQ ANESTHESIA          SURGEON
ID#            AGE     START TIME       OPERATION(S)                                    ANESTHESIOLOGIST        FIRST ASST.
WARD                    END TIME                                                         PRIN. ANESTHETIST       ATT SURGEON
=================================================================================================================================

OPERATING ROOM: OR1

ZOOM,BILLY              WARD             CARPAL TUNNEL SYNDROME                          GENERAL                 HOWARD, M
231-44-7629     46      07:30            REVISE MEDIAN NERVE                             REED, D                 WELBY, M
TO BE ADMITTED          09:30                                                            MUSGROVE, S             HOWARD, M
Case # 143
                        PREOPERATIVE XRAYS: CARPAL TUNNEL, R WRIST


OPERATING ROOM: OR2

ZIFFEL,ARNOLD           WARD             CHOLELITHIASIS                                  GENERAL                 HOWARD, M
122-32-4569     36      06:30            CHOLECYSTECTOMY                                 JENNINGS, G             FINE, L
HICU  212-B             08:00                                                            WATSON, C               HOWARD, M
Case # 141              REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH
                        CPDA-1 RED BLOOD CELLS - 2 UNITS

DRUCKER,SAMUEL HORATIO  WARD             ACUTE DIAPHRAGMATIC HERNIA                      GENERAL                 FINE, L
233-41-8719     71      08:00            REPAIR DIAPHRAGMATIC HERNIA                     JENNINGS, G             HOWARD, M
TO BE ADMITTED          09:30                                                            WATSON, C               FINE, L
Case # 142              REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH
                        CPDA-1 RED BLOOD CELLS - 2 UNITS
                        PREOPERATIVE XRAYS: ABDOMEN

ZINN,RICHARD            WARD             CAROTID ARTERY STENOSIS                         GENERAL                 HOWARD, M
743-82-9472     48      11:15            CAROTID ARTERY ENDARTERECTOMY                   JENNINGS, G             REED, J
TO BE ADMITTED          16:00                                                            WATSON, C               HOWARD, M
                          ** Concurrent Case #157    AORTO CORONARY BYPASS GRAFT
Case # 150              REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH
                        CPDA-1 RED BLOOD CELLS - UNITS NOT ENTERED
                        CPDA-1 WHOLE BLOOD - 2 UNITS
                        PREOPERATIVE XRAYS: DOPPLER STUDIES

ZINN,RICHARD            WARD             CORONARY ARTERY DISEASE                         GENERAL                 FINE, L
743-82-9472     48      11:15            AORTO CORONARY BYPASS GRAFT                     JENNINGS, G             ADAMS, D
TO BE ADMITTED          16:00                                                            WATSON, C               FINE, L
                          ** Concurrent Case #150    CAROTID ARTERY ENDARTERECTOMY
Case # 157

TOTAL CASES SCHEDULED: 5
```

5.0 List Scheduled Operations

This option provides a short form listing of scheduled cases for a given date. It will sort by surgical specialty, operating room, or ward location.

This report is in 80-column format and can be viewed on your terminal screen.

Example: List Scheduled Operations

```
Select Surgery Menu Option:  LS  List Scheduled Operations
```

```
List of Scheduled Operations:

List Scheduled Operations for which date ?  3/12  (MAR 12, 1992)

Do you want to sort by OPERATING ROOM, SPECIALTY or WARD LOCATION ? SER

Do you want a list of scheduled operations for a specific specialty ?  YES//  N

Print to Device:  [Select Print Device]
```

..... *printout follows* .....

```
                    * Scheduled Operations for GENERAL *
                              MAR 12, 1992

Start Time   Patient                      Operating Room          Ward Location
             ID #
==============================================================================
08:00       PETRIE,ROBERT                    OR2                  OUTPATIENT
            123-45-4886
            CHOLECYSTECTOMY
------------------------------------------------------------------------------

Press RETURN to continue or '^' to quit.
```

```
                    * Scheduled Operations for ORTHOPEDICS *
                              MAR 12, 1992

Start Time   Patient                      Operating Room          Ward Location
             ID #
==============================================================================
07:15       NASIUM,JIM                       OR4                   1 WEST
            121-21-2453
            SHOULDER ARTHROPLASTY-PROTHESIS
------------------------------------------------------------------------------

Press RETURN to continue or '^' to quit.
```

```
                    * Scheduled Operations for PERIPHERAL VASCULAR *
                              MAR 12, 1992

Start Time   Patient                        Operating Room          Ward Location
             ID #
==============================================================================
11:15       CLAMPETT,J.D.                      OR2                  1 NORTH
            665-37-0555
            CAROTID ARTERY ENDARTERECTOMY
------------------------------------------------------------------------------

Press RETURN to continue or '^' to quit.
```

```
                    * Scheduled Operations for THORACIC SURGERY  *
                              MAR 12, 1992

Start Time   Patient                       Operating Room          Ward Location
             ID #
==============================================================================
11:15       CLAMPETT,J.D.                      OR2                   1 NORTH
            665-37-0555
            AORTO CORONARY BYPASS GRAFT
------------------------------------------------------------------------------

Press RETURN to continue  <RET>
```

Chapter Two: Tracking Clinical Procedures

Introduction

The options described in this chapter provide online access to medical administration and laboratory information and provide tracking of operative procedures. They allow the following:

- Entry of information specific to an individual surgical case (e.g., staff, times, diagnoses, complications, anesthesia).
- Online entry of data inside the operating room during the actual operative procedure.
- Generation of patient records and nurse reports.

Key Vocabulary

Concurrent Case	One of two simultaneous or back-to-back operations on a single patient performed in the same operating room.
Screen Server	After you have entered data concerning the operation, your terminal display device will clear and then present a two-page Screen Server summary. The Screen Server summary organizes the information you have entered and gives you another opportunity to enter or edit data. Refer to *How to Use Screen Server* in the Appendix for more information on how to enter and edit data from the Screen Server prompt.

Getting Out of an Option

To stop what you are doing, enter an up-arrow (^). You can use the up-arrow at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continue entering up-arrows to completely exit the system.

Overview

The main options included in this chapter are listed below. The *Operation Menu*, *Anesthesia Menu* and *Non-O.R. Procedures* options contain submenus. To the left of the option name is the shortcut synonym you can enter to select the option:

O	*Operation Menu*
A	*Anesthesia Menu*
PO	*Perioperative Occurrences Menu*
NON	*Non-O.R. Procedures*
C	*Comments*

1.0 Operation Menu

The *Operation Menu* option provides operating room personnel with online 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 you to select an area on which to concentrate your 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. Refer to the *How to Use Screen Server* chapter in the Appendix if you are unfamiliar with Screen Server.

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

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)*
B	*Blood Product Verification*

How to Access the Operation Menu

To use one of the *Operation Menu* options, you must first identify the patient and case on which you are working. When you select O for *Operation Menu* from the main surgery menu, you will be prompted to enter a patient name. The computer 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. Each case will have one of the following:

REQUESTED: The procedure is booked for a particular day but the time of surgery and the operating room are not yet confirmed.

SCHEDULED: The procedure is booked for both an operating room and a day, and the starting time of the surgery is scheduled.

NOT COMPLETE: The start time of the operation is recorded and the patient is still in the operating room.

COMPLETE: The operation is completed and the patient has left the operating room.

ABORTED: The patient entered the operating room, but the operation had to be cancelled.

Here is an example of how the computer lists existing cases on record for a patient:

```
Select Surgery Menu Option: O  Operation Menu
Select Patient: FIFE,BARNEY.   04-04-30     222001234      NSC VETERAN
```

```
FIFE,BARNEY.  222-00-1234

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

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

3. ENTER NEW SURGICAL CASE


Select Operation:
```

You can select from the case(s) listed or, as in an emergency situation, enter a new surgical case. When you select an existing case, the computer will ask whether you want to **1**) enter information for the case, **2**) review the information already entered, or **3**) delete the case.

```
FIFE,BARNEY.  222-00-1234

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

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

Select Number:  1//
```

1. Enter Information

Press the Return key or enter the number 1 for this feature. This feature allows you to enter or edit information contained in one of the options under the *Operation Menu*.

Example: Enter Information

```
Select Surgery Menu Option: O  Operation Menu
Select Patient: NASIUM,JIM         12-19-53     121212453
```

```
 NASIUM,JIM   121-21-2453

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

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

3. ENTER NEW SURGICAL CASE


Select Operation: 2
```

```
 NASIUM,JIM  121-21-2453

 08-15-88     SHOULDER ARTHROPLASTY (NOT COMPLETE)


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

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

```
 NASIUM,JIM (121-21-2453)   Case #14 - MAR 12,1992


   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 for an Operation Menu ...
   OR     Operation Report
   AR     Anesthesia Report
   NR     Nurse Intraoperative Report
   TR     Tissue Examination Report
   R      Enter Referring Physician Information
   RP     Enter Irrigations and Restraints
   M      Medications (Enter/Edit)
   B      Blood Product Verification

Select Operation Menu Option:
```

[Now you can select any of the *Operation Menu* options]

2. Review Information

Enter the number 2 for this feature. This feature displays a two-page summary of the case on your terminal screen. You cannot edit from this feature. Press the Return 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:    NASIUM,JIM       12-19-53     121212453
```

```
 NASIUM,JIM   121-21-2453

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

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

3. ENTER NEW SURGICAL CASE


Select Operation: 2
```

```
 NASIUM,JIM  121-21-2453

 08-15-88     SHOULDER ARTHROPLASTY (NOT COMPLETE)


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

Select Number:  1//  2
```

```
   ** REVIEW **   CASE #14  NASIUM,JIM               PAGE 1 OF 2

1    TIME PAT IN HOLD AREA: AUG 15, 1988 AT 07:40
2    TIME PAT IN OR:        AUG 15, 1988 AT 08:00
3    ANES CARE START TIME:  AUG 15, 1988 AT 08:00
4    TIME OPERATION BEGAN:  AUG 15, 1988 AT 09:00
5    SPECIMENS:             (WORD PROCESSING)
6    CULTURES:              (WORD PROCESSING)
7    THERMAL UNIT:          (MULTIPLE)
8    ELECTROCAUTERY UNIT:   7571
9    ESU COAG RANGE:
10   ESU CUTTING RANGE:
11   TIME TOURNIQUET APPLIED: (MULTIPLE)
12   PROSTHESIS INSTALLED:  (MULTIPLE)(DATA)
13   REPLACEMENT FLUID TYPE: (MULTIPLE)(DATA)
14   IRRIGATION:            (MULTIPLE)(DATA)
15   MEDICATIONS:           (MULTIPLE)

Enter Screen Server Function:  <RET>
```

```
   ** REVIEW **   CASE #14  NASIUM,JIM               PAGE 2 OF 2

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): YES
4    SPONGE, SHARPS, & INST COUNTER:
5    COUNT VERIFIER:
6    SEQUENTIAL COMPRESSION DEVICE:
7    LASER TYPE:
8    NURSING CARE COMMENTS: (WORD PROCESSING)(DATA)
9    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE L SHOULDER
10   PRIN DIAGNOSIS CODE:
11   PRINCIPAL PROCEDURE:   SHOULDER ARTHROPLASTY
12   PRINCIPAL PROCEDURE CODE:
13   OTHER PROCEDURES:      (MULTIPLE)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
15   BRIEF CLIN HISTORY:    (WORD PROCESSING)

Enter Screen Server Function:  <RET>
```

3. Delete Surgery Case

Enter 3 for this feature. The *Delete Surgery Case* feature will permanently remove all information on the operative procedure from the records.

Example: How to Delete A Case

```
Select Surgery Menu Option:  Operation Menu
Select Patient: OAT,WILLIE         12-09-51     449345555     NSC VETERAN
```

```
 OAT,WILLIE   449-34-5555

1. 04-26-92   CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)

2. 12-20-90   REMOVE FACIAL LESIONS (NOT COMPLETE)

3. ENTER NEW SURGICAL CASE


Select Operation: 2
```

```
 OAT,WILLIE  449-34-5555

 12-20-90     REMOVE FACIAL LESIONS (NOT COMPLETE)


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

Select Number:  1//  3

Are you sure that you want to delete this case ?  NO//  Y

  Deleting Operation...
```

How to Enter 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 enter the number corresponding to the ENTER NEW SURGICAL CASE field. You will be prompted to supply preoperative information concerning the case.

After you have entered data concerning the operation, your terminal screen will clear and present a two-page Screen Server summary and give you another opportunity to enter or edit data.

Prompts that require a response are:
Select the Date of Operation
Enter the Principal Operative Procedure
Select Surgical Specialty
Indications for Operations

Example: Entering a New Surgical Case

```
Select Surgery Menu Option:  O Operation Menu
Select Patient: FIFE,BARNEY         04-04-30     222001234
```

```
 FIFE,BARNEY   222-00-1234

1. ENTER NEW SURGICAL CASE


Select Operation: 1

Select the Date of Operation: T  (FEB 14, 1992)

Enter the Principal Operative Procedure: APPENDECTOMY

Select Surgeon: HOWARD,MOE

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

INDICATIONS FOR OPERATIONS:
  1>ABDOMINAL PAIN IN RIGHT LOWER QUADRANT.
  2>ELEVATED WHITE BLOOD COUNT.
  3><RET>
EDIT Option: <RET>

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><RET>
EDIT Option: <RET>
```

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

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH// <RET>
Select REQ BLOOD KIND: CPDA-1 RED BLOOD CELLS// <RET>
  Required Blood Product: CPDA-1 RED BLOOD CELLS// <RET>
  Units Required: 2

Principal Preoperative Diagnosis: APPENDICITIS
Principal Diagnosis Code (ICD9): 540.9        'C'     ACUTE APPENDICITIS NOS
      COMPLICATION/COMORBIDITY
         ...OK? YES// <RET>  (YES)
Hospital Admission Status: I//  <RET> INPATIENT
Case Schedule Type: EM  EMERGENCY
First Assistant: HOWARD,MOE
Second Assistant: REED,JAMES
Attending Surgeon: FINE,LARRY
Requested Postoperative Care: W  WARD
Case Schedule Order: <RET>
Select SURGERY POSITION: SUPINE// <RET>
  Surgery Position: SUPINE//<RET>
Requested Anesthesia Technique: G  GENERAL
Request Frozen Section Tests (Y/N): N  NO
Requested Preoperative X-Rays: <RET>
Intraoperative X-Rays (Y/N): N  NO
Request Medical Media: N  NO
Request Clean or Contaminated: C  CLEAN
Select REFERRING PHYSICIAN: <RET>
General Comments:
  1><RET>
```

```
** NEW SURGERY **   CASE #185  FIFE,BARNEY                      PAGE 1 OF 2

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

Enter Screen Server Function:  <RET>
```

```
   **  **   CASE #185  FIFE,BARNEY                      PAGE 2 OF 2

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

Enter Screen Server Function:   <RET>
```

1.1 Operation Information

Surgeons and other members of the surgical staff use this option for a quick reference on a case. It produces a report that touches on the more important areas of interest recorded for the case. The report can be viewed on your screen but cannot be edited from this option.

An asterisk indicates the principal diagnosis for the case, since some cases have more than one diagnosis. Notice that the fields for INTRAOP OCCURRENCES and POSTOP OCCURRENCES indicate if there are occurrences; however, the occurrences will not be defined as access to this information is restricted. If there is a "YES" in one of these fields, a surgeon can refer to the *Operation* or *Post Operation* option to view the occurrences.

Example: Operation Information

```
Select Operation Menu Option:  I  Operation Information
```

```
--------------------------------------------------------------------------------
  Patient: FIFE,BARNEY (222-00-1234)           Operation Date: MAR  9, 1992
  Surgeon: BRONSTEIN,SOLOMON ABRAM             Major/Minor:
  Attending Surgeon: REED,JAMES                Operation Time: 45 Minutes
  Attending Code: 3. ATTENDING NOT PRESENT, BUT AVAILABLE
  Operation(s):
  APPENDECTOMY
--------------------------------------------------------------------------------
  Postop Diagnosis:                            Intraop Occurrences: YES
  * APPENDICITIS                               Postop Occurrences:  YES
--------------------------------------------------------------------------------
  Anesthesia Technique:                        Anesthetist: DOOLITTLE,JAMES A.
    INHALATION
      ENFLURANE 125ML
--------------------------------------------------------------------------------
  Wound Classification:
  Intraoperative Blood Loss: 100 CC'S
--------------------------------------------------------------------------------


Press RETURN to continue  <RET>
```

1.2 Surgical Staff

This option allows the operating room nurse or scheduling manager to enter or edit the names of the surgical team prior to the operation. Some data fields may be automatically filled in based on previous responses. The names entered will be reflected in the Nurse Intraoperative Report and other staffing reports.

At the Screen Server prompt, choose the field(s) to be edited or press the Return key to continue. Some of the data fields are "multiple" and may contain more than one value. When a field labeled "multiple" is selected, a new screen is generated so that you can enter data related to that multiple. For instance, the CIRC SUPPORT, SCRUB SUPPORT, and SCRUBBED ASSISTANT fields generate new screens that allow you to add the TIME ON, TIME OFF, REASON FOR RELIEF, and STATUS. The TIME ON and TIME OFF fields also generate additional screens so that you may enter more than one TIME ON/OFF for the same operation as some assistants must enter and exit more than once.

Note: If entering times on other than the day of surgery, enter both the date *and* the time.

Field Information

ATTENDING CODE: This corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure. Enter a question mark (?) to get the list of codes.

OTHER SCRUBBED ASSISTANTS: If there are more than two assistants scrubbed for this case, they may be entered here.

OTHER PERSONS IN O.R.: Includes any observers, such as equipment vendors, in the operating room.

Example: Entering Surgical Staff

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

```
  ** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1 OF 1

1    SURGEON:                HOWARD,C.
2    PGY OF PRIMARY SURGEON:
3    FIRST ASST:             FINE,LAWRENCE
4    SECOND ASST:            HOWARD,M.
5    ATTEND SURG:            HOWARD,C.
6    ATTEND CODE:
7    PRINC ANESTHETIST:      SOLES,BETTE
8    ASST ANESTHETIST:
9    ANESTHESIOLOGIST SUPVR: TRAPPER,JOHN
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 Code: 2. ATTENDING IN O.R. SUITE
```

```
** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1
         OR SCRUB SUPPORT

1    NEW ENTRY

Enter Screen Server Function:  1
Select OR SCRUB SUPPORT: MCGILICUTTY,JANE
    OR SCRUB SUPPORT: MCGILICUTTY,JANE// <RET>
```

```
** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1
         OR SCRUB SUPPORT  (MCGILICUTTY,JANE)

1    OR SCRUB SUPPORT:      MCGILICUTTY,JANE
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  NASIUM,JIM      PAGE 1
         OR SCRUB SUPPORT  (MCGILICUTTY,JANE)
           TIME ON

1    NEW ENTRY

Enter Screen Server Function:  1
Select TIME ON: 8:00  (JUN 06, 1992@08:00)
    TIME ON: JUN 06, 1992@08:00// <RET>
```

```
** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1
         OR SCRUB SUPPORT  (MCGILICUTTY,JANE)
           TIME ON  (2920606.08)

1    TIME ON:               JUN 06, 1992 AT 08:00
2    TIME OFF:
3    REASON FOR RELIEF:

Enter Screen Server Function: 2:3
Time Off: 13:00  (JUN 06, 1992@13:00)
Reason for Relief: ?
     Enter the code corresponding to the reason for relief.
     CHOOSE FROM:
       P        PERSONAL
       S        SHIFT CHANGE
       A        ADMINISTRATIVE
Reason for Relief: S  SHIFT CHANGE
```

```
** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1 OF 1
         OR SCRUB SUPPORT  (MCGILICUTTY,JANE)
           TIME ON  (2920606.08)

1    TIME ON:               JUN 06, 1992 AT 08:00
2    TIME OFF:              JUN 06, 1992 AT 13:00
3    REASON FOR RELIEF:     SHIFT CHANGE

Enter Screen Server Function: <RET>
```

```
** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1 OF 1
         OR SCRUB SUPPORT  (MCGILICUTTY,JANE)
           TIME ON

1    TIME ON:               JUN 06, 1992 AT 08:00
2    NEW ENTRY

Enter Screen Server Function:  <RET>
```

```
** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1 OF 1
         OR SCRUB SUPPORT  (MCGILICUTTY,JANE)

1    OR SCRUB SUPPORT:      MCGILICUTTY,JANE
TIPLE)(DATA)
3    STATUS:                FULLY TRAINED

Enter Screen Server Function:   <RET>
```

```
 ** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1 OF 1
         OR SCRUB SUPPORT

1    OR SCRUB SUPPORT:      MCGILICUTTY,JANE
2    NEW ENTRY

Enter Screen Server Function:  <RET>
```

```
** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1 OF 1
         OTHER PERSONS IN OR

1    NEW ENTRY

Enter Screen Server Function:  1
Select OTHER PERSONS IN OR:  ROBERTO MOLINA
    OTHER PERSONS IN OR: ROBERTO MOLINA//  <RET>
```

```
  ** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1 OF 1
         OTHER PERSONS IN OR  (0)

1    OTHER PERSONS IN OR:   ROBERTO MOLINA
2    TITLE/ORGANIZATION:

Enter Screen Server Function:  2
Title and Organization: TECHNICIAN, KIRSCHNER SURGICAL EQUIP
```

```
  ** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1 OF 1
         OTHER PERSONS IN OR  (0)

1    OTHER PERSONS IN OR:   ROBERTO MOLINA
2    TITLE/ORGANIZATION:    TECHNICIAN, KIRSCHNER SURGICAL EQUIP

Enter Screen Server Function:   <RET>
```

```
 ** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1 OF 1
         OTHER PERSONS IN OR

1    OTHER PERSONS IN OR:   ROBERTO MOLINA
2    NEW ENTRY

Enter Screen Server Function:   <RET>
```

```
 ** SURGICAL STAFF **   CASE #193  NASIUM,JIM      PAGE 1 OF 1

1    SURGEON:               HOWARD,C.
2    PGY OF PRIMARY SURGEON:
3    FIRST ASST:            FINE,LAWRENCE
4    SECOND ASST:           HOWARD,M.
5    ATTEND SURG:           HOWARD,C.
6    ATTEND CODE:           2.  ATTENDING IN O.R. SUITE
7    PRINC ANESTHETIST:     SOLES,BETTE
8    ASST ANESTHETIST:
9    ANESTHESIOLOGIST SUPVR: TRAPPER,JOHN
10   PERFUSIONIST:
11   ASST PERFUSIONIST:
12   OR CIRC SUPPORT:       (MULTIPLE)
13   OR SCRUB SUPPORT:      (MULTIPLE)(DATA)
14   OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15   OTHER PERSONS IN OR:   (MULTIPLE)(DATA)

Enter Screen Server Function:   <RET>
```

1.3 Operation Startup

The nurse or other operating room staff uses this option to enter data concerning the patient's preparation for the surgery (e.g., diagnosis, delays, skin prep, 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 you can enter data related to that multiple. At the Screen Server prompt, you can choose the field(s) to be edited, or press the Return key to go to the next item or page.

Field Information

MAJOR/MINOR: Major surgery is any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered. Minor surgery is any operation not designated as Major.

CANCEL REASON: You must respond to this prompt if you have information in the CANCEL DATE field. Type in a question mark (?) at the "Cancel Reason" prompt to select from a list of cancellation reasons. The "Cancel Reason" prompt should only be answered if the case has been aborted. Use the option *Cancel Scheduled Case* if the patient has not yet entered the operating room.

DELAY CAUSE: If the actual start time of the surgery is significantly delayed (15 minutes or more, depending on your 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  NASIUM,JIM             PAGE 1 OF 2

1    DATE OF OPERATION:     DEC 06, 1990 AT 08:00
2    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
3    OTHER PREOP DIAGNOSIS: (MULTIPLE)
4    OPERATING ROOM:        OR2
5    SURGERY SPECIALTY:     ORTHOPEDICS
6    MAJOR/MINOR:
7    REQ POSTOP CARE:       WARD
8    CASE SCHEDULE TYPE:    ELECTIVE
9    REQ ANESTHESIA TECHNIQUE: GENERAL
10   PATIENT EDUCATION/ASSESSMENT:
11   CANCEL DATE:
12   CANCEL REASON:
13   CANCELLATION AVOIDABLE:
14   DELAY CAUSE:           (MULTIPLE)
15   VALID ID/CONSENT CONFIRMED BY:

Enter Screen Server Function: 6;10
Major or Minor: J  MAJOR
Preoperative Patient Education: Y  YES
```

```
  ** STARTUP **   CASE #159  NASIUM,JIM             PAGE 1 OF 2

1    DATE OF OPERATION:     DEC 06, 1990 AT 08:00
2    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
3    OTHER PREOP DIAGNOSIS: (MULTIPLE)
4    OPERATING ROOM:        OR2
5    SURGERY SPECIALTY:     ORTHOPEDICS
6    MAJOR/MINOR:           MAJOR
7    REQ POSTOP CARE:       WARD
8    CASE SCHEDULE TYPE:    ELECTIVE
9    REQ ANESTHESIA TECHNIQUE: GENERAL
10   PATIENT EDUCATION/ASSESSMENT:  YES
11   CANCEL DATE:
12   CANCEL REASON:
13   CANCELLATION AVOIDABLE:
14   DELAY CAUSE:           (MULTIPLE)
15   VALID ID/CONSENT CONFIRMED BY:

Enter Screen Server Function: <RET>
```

```
  ** STARTUP **   CASE #159  NASIUM,JIM             PAGE 2 OF 2

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

Enter Screen Server Function:  A
```

```
ASA Class: 2  2-MILD DISTURB.
Preoperative Mood: ?
     Enter the code corresponding to the preoperative assessment of the
     patient's emotional status upon arrival to the operating room.
 ANSWER WITH PATIENT MOOD  NAME, OR CODE
CHOOSE FROM:
   AGITATED        AG
   ANGRY           ANG
   ANXIOUS         ANX
   APATHETIC       AP
   DEPRESSED       D
   RELAXED         R

Preoperative Mood: ANXIOUS          ANX
Preoperative Consciousness: AO  ALERT-ORIENTED          AO
Preoperative Skin Integrity: INTACT          I
Transported to O.R. By: PACU
Preoperative Shave By: LAMBERTH,MARGARET
Skin Prepped By: <RET>
Skin Prepped By (2): <RET>
Skin Preparation Agent: HIBICLENS          HI
Second Skin Preparation Agent: <RET>
Electroground Placement:  RAT  RIGHT ANT THIGH
Electroground Position (2):<RET>
```

```
  ** STARTUP **   CASE #159  NASIUM,JIM             PAGE 1
         SURGERY POSITION

1    SURGERY POSITION:      SUPINE
2    NEW ENTRY

Enter Screen Server Function:  2
Select SURGERY POSITION: SEMISUPINE
   ARE YOU ADDING 'SEMISUPINE' AS A NEW SURGERY POSITION (THE 2ND FOR THIS SURGERY)? Y
(YES)
    SURGERY POSITION: SEMISUPINE// <RET>
```

```
  ** STARTUP **   CASE #159  NASIUM,JIM             PAGE 1
         SURGERY POSITION  (SEMISUPINE)

1    SURGERY POSITION:      SEMISUPINE
2    TIME PLACED:

Enter Screen Server Function:  <RET>
```

```
  ** STARTUP **   CASE #159  NASIUM,JIM             PAGE 1 OF 1
         SURGERY POSITION

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

Enter Screen Server Function:  <RET>
```

```
  ** STARTUP **   CASE #159  NASIUM,JIM             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// <RET>
```

```
  ** STARTUP **   CASE #159  NASIUM,JIM             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: LAMBERTH,MARGARET
```

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

1    RESTR & POSITION AIDS: FOAM PADS
2    APPLIED BY:            LAMBERTH,MARGARET

Enter Screen Server Function:  <RET>
```

```
  ** STARTUP **   CASE #159  NASIUM,JIM             PAGE 1 OF 1
         RESTR & POSITION AIDS

1    RESTR & POSITION AIDS: SAFETY STRAP
2    RESTR & POSITION AIDS: FOAM PADS
3    NEW ENTRY

Enter Screen Server Function:  <RET>
```

```
  ** STARTUP **    CASE #159  NASIUM,JIM             PAGE 2 OF 2

1    ASA CLASS:             2-MILD DISTURB.
2    PREOP MOOD:            ANXIOUS
3    PREOP CONSCIOUS:       ALERT-ORIENTED
4    PREOP SKIN INTEG:      INTACT
5    TRANS TO OR BY:        PACU
6    PREOP SHAVE BY:        LAMBERTH,MARGARET
7    SKIN PREPPED BY (1):
8    SKIN PREPPED BY (2):
9    SKIN PREP AGENTS:      HIBICLENS
10   SECOND SKIN PREP AGENT:
11   SURGERY POSITION:      (MULTIPLE)(DATA)
12   RESTR & POSITION AIDS: (MULTIPLE)(DATA)
13   ELECTROGROUND POSITION: RIGHT ANT THIGH
14   ELECTROGROUND POSITION (2):

Enter Screen Server Function:  <RET>
```

1.4 Operation

Physicians and nurses use this 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 you can enter data related to that multiple. Remember, you can use the up-arrow (^) to exit from any multiple field. Enter a question mark (?) for computer- assisted instruction.

Field Information

TIME OPERATION BEGAN: Check your institution's policy concerning an operation's start time. In some institutions, this may be the time of first incision.

Note: If entering times on other than the day of surgery, enter both the date *and* the time

Example: Operation Option

```
Select Operation Menu Option: O  Operation
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1 OF 2

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

Enter Screen Server Function:  1:5;7;13:14
Time Patient Arrived in Holding Area: 8:50  (MAR 12, 1992@08:50)
Time Patient In the O.R.: 9:00  (MAR 12, 1992@09:00)
Anesthesia Care Start Time: 9:10  (MAR 12, 1992@09:10)  (MAR 12, 1992@09:10)
Time the Operation Began: 9:20  (MAR 12, 1992@09:20)
Specimens:
  1>Gallbladder and duodenum
  2><RET>
EDIT Option: <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1
         THERMAL UNIT

1    NEW ENTRY

Enter Screen Server Function:  1
Select THERMAL UNIT: 2695
    THERMAL UNIT: 2695// <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1
         THERMAL UNIT  (2695)

1    THERMAL UNIT:          2695
2    TIME ON:
3    TEMPERATURE:
4    TIME OFF:

Enter Screen Server Function:  2:4
Date/Time Turned On: 9:05  (MAR 12, 1992@09:05)
Temperature Setting: 90
Date/Time Turned Off: 12:35  (MAR 12, 1992@12:35)
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1 OF 1
         THERMAL UNIT  (2695)

1    THERMAL UNIT:          2695
2    TIME ON:               MAR 12, 1992 AT 09:05
3    TEMPERATURE:           90
4    TIME OFF:              MAR 12, 1992 AT 12:35

Enter Screen Server Function:  <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1 OF 1
         THERMAL UNIT

1    THERMAL UNIT:          2695
2    NEW ENTRY

Enter Screen Server Function:  <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1 OF 1
         REPLACEMENT FLUID TYPE

1    NEW ENTRY

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

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

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

Enter Screen Server Function:  2;3
Quantity of Fluid (ml): 1000
Source Identification Number: TRAVENOL
```

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

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

Enter Screen Server Function:  <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1 OF 1
         REPLACEMENT FLUID TYPE

1    REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2    NEW ENTRY

Enter Screen Server Function:  <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1 OF 1
         IRRIGATION

1    NEW ENTRY

Enter Screen Server Function:  1
Select IRRIGATION: NORMAL SALINE
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1 OF 1
         IRRIGATION  (NORMAL SALINE)

1    IRRIGATION:            NORMAL SALINE
2    TIME:                  (MULTIPLE)

Enter Screen Server Function:  2
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1
         IRRIGATION  (NORMAL SALINE)
           TIME

1    NEW ENTRY

Enter Screen Server Function:  1
Select TIME: 9:40   MAR 12, 1992@09:40
    TIME: MAR 12, 1992@09:40// <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1
         IRRIGATION  (NORMAL SALINE)
           TIME  (2930601.094)

1    TIME:                  MAR 12, 1993 AT 09:40
2    AMOUNT USED:
3    PROVIDER:

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

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

1    TIME:                  MAR 12, 1993 AT 09:40
2    AMOUNT USED:           1000
3    PROVIDER:              NURSE,NANCY

Enter Screen Server Function:  <RET>
```

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

1    TIME:                  MAR 12, 1993 AT 09:40
2    NEW ENTRY

Enter Screen Server Function:  <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1 OF 1
         IRRIGATION  (NORMAL SALINE)

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

Enter Screen Server Function:  <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1 OF 1
         IRRIGATION

1    IRRIGATION:            NORMAL SALINE
2    NEW ENTRY

Enter Screen Server Function:  <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 1 OF 2

1    TIME PAT IN HOLD AREA: MAR 12, 1992 AT 08:50
2    TIME PAT IN OR:        MAR 12, 1992 AT 09:00
3    ANES CARE START TIME:  MAR 12, 1992 AT 09:10
4    TIME OPERATION BEGAN:  MAR 12, 1992 AT 09:20
5    SPECIMENS:             (WORD PROCESSING)(DATA)
6    CULTURES:              (WORD PROCESSING)
7    THERMAL UNIT:          (MULTIPLE)(DATA)
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)(DATA)
14   IRRIGATION:            (MULTIPLE)(DATA)
15   MEDICATIONS:           (MULTIPLE)

Enter Screen Server Function:  <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 2 OF 2

1    SPONGE COUNT CORRECT (Y/N):
2    SHARPS COUNT CORRECT (Y/N):
3    INSTRUMENT COUNT CORRECT (Y/N):
4    SPONGE, SHARPS, & INST COUNTER:
5    COUNT VERIFIER:
6    SEQUENTIAL COMPRESSION DEVICE:
7    LASER TYPE:
8    NURSING CARE COMMENTS: (WORD PROCESSING)
9    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
10   PRIN DIAGNOSIS CODE:   574.01
11   PRINCIPAL PROCEDURE:   CHOLECYSTECTOMY
12   PRINCIPAL PROCEDURE CODE:
13   OTHER PROCEDURES:      (MULTIPLE)(DATA)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15   BRIEF CLIN HISTORY:    (WORD PROCESSING)(DATA)

Enter Screen Server Function:  1:5;8
Final Sponge Count Correct (Y/N): Y  YES
Final Sharps Count Correct (Y/N): Y  YES
Final Instrument Count Correct (Y/N): Y  YES
Person Responsible for Final Counts: NURSE,NANCY
Count Verifier: JTM  MOODY,JUDY TRUDY
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><RET>
EDIT Option: <RET>
```

```
  ** OPERATION **   CASE #173  PETRIE,ROBERT        PAGE 2 OF 3

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): YES
4    SPONGE, SHARPS, & INST COUNTER: NURSE,NANCY
5    COUNT VERIFIER:        DAVIS,PAULETTE
6    SEQUENTIAL COMPRESSION DEVICE:
7    LASER TYPE:
8    NURSING CARE COMMENTS: (WORD PROCESSING)(DATA)
9    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
10   PRIN DIAGNOSIS CODE:   574.01
11   PRINCIPAL PROCEDURE:   CHOLECYSTECTOMY
12   PRINCIPAL PROCEDURE CODE:
13   OTHER PROCEDURES:      (MULTIPLE)(DATA)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15   BRIEF CLIN HISTORY:    (WORD PROCESSING)(DATA)

Enter Screen Server Function:  <RET>
```

1.5 Post Operation

This option concerns the close of the operation, discharge, and post anesthesia recovery. It is important to enter the operation and anesthesia end times, as well as the time the patient leaves the operation room, as these affect many reports.

Field Information

PRINCIPAL POST-OP DIAGNOSIS: The computer will automatically default to the diagnosis that was entered at the preoperative stage.

Example: Post Operation

```
Select Operation Menu Option: PO Post Operation
```

```
 ** POST OPERATION **   CASE #145  OAT,WILLIE      PAGE 1 OF 2

1    DRESSING:
2    PACKING:
3    TUBES AND DRAINS:
4    BLOOD LOSS (ML):
5    TOTAL URINE OUTPUT (ML):
6    GASTRIC OUTPUT:
7    WOUND CLASSIFICATION:
8    POSTOP MOOD:
9    POSTOP CONSCIOUS:
10   POSTOP SKIN INTEG:
11   TIME OPERATION ENDS:
12   ANES CARE END TIME:
13   TIME PAT OUT OR:
14   OP DISPOSITION:
15   DISCHARGED VIA:

Enter Screen Server Function:  A
Dressing(s): TELFA
Packing Type: <RET>
Tubes and Drains: PENROSE
Blood Loss (ml): 200
Total Urine Output (ml): 600
Gastric Output (cc's): 150
Wound Classification: CC  CLEAN/CONTAMINATED
Postoperative Mood: RELAXED          R
Postoperative Consciousness: RESTING          R
Postoperative Skin Integrity: INTACT          I
Time the Operation Ends: 12:30  (APR 26, 1992@12:30)
Anesthesia Care End Time: 12:50  (APR 26, 1992@12:50)
Time Patient Out of the O.R.: 12:40  (APR 26, 1992@12:40)
Postoperative Disposition: PACU (RECOVERY ROOM)
Patient Discharged Via: PACU BED
```

```
 ** POST OPERATION **   CASE #145  OAT,WILLIE      PAGE 1 OF 2

1    DRESSING:              TELFA
2    PACKING:
3    TUBES AND DRAINS:      PENROSE
4    BLOOD LOSS (ML):       200
5    TOTAL URINE OUTPUT (ML): 600
6    GASTRIC OUTPUT:        150
7    WOUND CLASSIFICATION:  CLEAN/CONTAMINATED
8    POSTOP MOOD:           RELAXED
9    POSTOP CONSCIOUS:      RESTING
10   POSTOP SKIN INTEG:     INTACT
11   TIME OPERATION ENDS:   APR 26, 1992 AT 12:30
12   ANES CARE END TIME:    APR 26, 1992 AT 12:50
13   TIME PAT OUT OR:       APR 26, 1992 AT 12:40
14   OP DISPOSITION:        PACU (RECOVERY ROOM)
15   DISCHARGED VIA:        PACU BED

Enter Screen Server Function: <RET>
```

```
 ** POST OPERATION **   CASE #145  OAT,WILLIE      PAGE 2 OF 2

1    PRINCIPAL POST-OP DIAG: CHOLELITHIASIS
2    PRIN DIAGNOSIS CODE:
3    OTHER POSTOP DIAG'S:   (MULTIPLE)
4    PRINCIPAL PROCEDURE:   CHOLECYSTECTOMY
5    PRINCIPAL PROCEDURE CODE:     47480
6    OTHER PROCEDURES:      (MULTIPLE)(DATA)
7    ATTENDING CODE:        2. ATTENDING IN O.R. SUITE

Enter Screen Server Function:  <RET>
```

1.6 Enter PAC(U) Information

Personnel in the Post Anesthesia Care Unit (PACU) use this option to enter the admission and discharge times and scores.

Example: Entering PAC(U) Information

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

```
 ** PACU **   CASE #145  OAT,WILLIE                PAGE 1 OF 1

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

Enter Screen Server Function: 1:4
PAC(U) Admission Time: 13:00  (APR 26, 1992@13:00)
PAC(U) Admission Score: 10
PAC(U) Discharge Date/Time: 14:00  (APR 26, 1992@14:00)
PAC(U) Discharge Score: 10
```

```
 ** PACU **   CASE #145  OAT,WILLIE                PAGE 1 OF 1

1    ADMIT PAC(U) TIME:     APR 26, 1992 AT 13:00
2    PAC(U) ADMIT SCORE:    10
3    PAC(U) DISCH TIME:     APR 26, 1992 AT 14:00
4    PAC(U) DISCH SCORE:    10

Enter Screen Server Function:  <RET>
```

1.7 Operation (Short Screen)

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

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

Example: Operation Short Screen

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

```
  ** SHORT SCREEN **   CASE #186  DRUCKER,SAM          PAGE 1 OF 3

1    DATE OF OPERATION:     MAR 09, 1992
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               REED,JAMES
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE:   REMOVE FACIAL LESIONS
8    PRINCIPAL PROCEDURE CODE: 17000
9    OTHER PROCEDURES:      (MULTIPLE)
10   TIME PAT IN OR:
11   TIME OPERATION BEGAN:
12   TIME OPERATION ENDS:
13   TIME PAT OUT OR:
14   IV STARTED BY:
15   OR CIRC SUPPORT:       (MULTIPLE)

Enter Screen Server Function: 10:13
Time Patient In the O.R.: 13:00  (MAR 09, 1992@13:00)
Time the Operation Began: 13:10  (MAR 09, 1992@13:10)
Time the Operation Ends: 13:36  (MAR 09, 1992@13:36)
Time Patient Out of the O.R.: 13:40  (MAR 09, 1992@13:40)
```

```
  ** SHORT SCREEN **   CASE #186  DRUCKER,SAM       PAGE 1 OF 3

1    DATE OF OPERATION:     MAR 09, 1992 AT 13:00
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               REED,JAMES
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE:   REMOVE FACIAL LESIONS
8    PRINCIPAL PROCEDURE CODE: 17000
9    OTHER PROCEDURES:      (MULTIPLE)
10   TIME PAT IN OR:        MAR 09, 1992 AT 13:00
11   TIME OPERATION BEGAN:  MAR 09, 1992 AT 13:10
12   TIME OPERATION ENDS:   MAR 09, 1992 AT 13:36
13   TIME PAT OUT OR:       MAR 09, 1992 AT 13:40
14   IV STARTED BY:
15   OR CIRC SUPPORT:       (MULTIPLE)

Enter Screen Server Function:  <RET>
```

```
  ** SHORT SCREEN **   CASE #186  DRUCKER,SAM       PAGE 2 OF 3

1    OR SCRUB SUPPORT:      (MULTIPLE)
2    OPERATING ROOM:        OR3
3    FIRST ASST:            NURSE,NANCY
4    SPONGE COUNT CORRECT (Y/N):
5    SHARPS COUNT CORRECT (Y/N):
6    INSTRUMENT COUNT CORRECT (Y/N):
7    SPONGE, SHARPS, & INST COUNTER:
8    COUNT VERIFIER:
9    SURGERY SPECIALTY:     PLASTIC SURGERY (INCLUDES HEAD AND NECK)
10   WOUND CLASSIFICATION:
11   ATTEND SURG:           FINE,LARRY
12   ATTEND CODE:
13   SPECIMENS:             (WORD PROCESSING)
14   CULTURES:              (WORD PROCESSING)
15   NURSING CARE COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  15
Nursing Care Comments:
  1>PATIENT ARRIVED AMBULATORY FROM AMBULATORY
  2>SURGERY UNIT.  DISCHARGED VIA WHEELCHAIR, AWAKE,
  3>ALERT, ORIENTED.
  4><RET>
EDIT Option: <RET>
```

```
  ** SHORT SCREEN **   CASE #186  DRUCKER,SAM       PAGE 2 OF 3

1    OR SCRUB SUPPORT:       (MULTIPLE)
2    OPERATING ROOM:         OR3
3    FIRST ASST:             NURSE,NANCY
4    SPONGE COUNT CORRECT (Y/N):
5    SHARPS COUNT CORRECT (Y/N):
6    INSTRUMENT COUNT CORRECT (Y/N):
7    SPONGE, SHARPS, & INST COUNTER:
8    COUNT VERIFIER:
9    SURGERY SPECIALTY:      PLASTIC SURGERY (INCLUDES HEAD AND NECK)
10   WOUND CLASSIFICATION:
11   ATTEND SURG:            FINE,LARRY
12   ATTEND CODE:
13   SPECIMENS:              (WORD PROCESSING)
14   CULTURES:               (WORD PROCESSING)
15   NURSING CARE COMMENTS: (WORD PROCESSING)(DATA)

Enter Screen Server Function:  <RET>
```

```
  ** SHORT SCREEN **   CASE #186  DRUCKER,SAM       PAGE 3 OF 3

1    ASA CLASS:
2    PRINC ANESTHETIST:      REED,JAMES
3    ANESTHESIA TECHNIQUE:   (MULTIPLE)
4    ANES CARE START TIME:
5    ANES CARE END TIME:
6    DELAY CAUSE:            (MULTIPLE)
7    CANCEL DATE:
8    CANCEL REASON:

Enter Screen Server Function:  <RET>
```

1.8 Surgeon's Verification of Diagnosis & Procedures

Surgeons use this option to verify that the stated procedure(s), diagnosis and occurrences are correct for a case. With this option, the surgeon can update the Operation Name, CPT Code, Diagnosis, and Intraoperative Occurrences before verifying the case. If the case has already been verified, you will be asked if you want to re-verify it.

The computer will provide a summary for editing if you respond Yes to the prompt "Do you need to update the information above?"

> **Note:** If there are no occurrences, the INTRAOP OCCURRENCES field should be left blank. Do not enter "No" or "None."

Example: Surgeon's Verification

```
Select Operation Menu Option: V  Surgeon's Verification of Diagnosis & Procedures
```

```
ZOOM,BILLY  (231-44-7629)
Operation Date: OCT  5, 1994
-------------------------------------------------------------------------------
1. Indications for Operation:
   Swelling in the inguinal region.

2. Principal CPT Code:  00830
3. Principal Procedure: REMOVE HERNIA

4. Other Procedures:

5. Postoperative Diagnosis:   INGUINAL HERNIA

6. Intraoperative Occurrences: NO OCCURRENCES HAVE BEEN ENTERED
-------------------------------------------------------------------------------

Do you need to update the information above ?  NO//  Y

Select Information to Edit: 2:3
```

```
  CPT Code: 00830  ANESTH, REPAIR OF HERNIA
      Description:
        ANESTHESIA FOR HERNIA REPAIRS IN LOWER ABDOMEN;
        NOT OTHERWISE SPECIFIED
-------------------------------------------------------------------------------


Principal Procedure Code (CPT): 00830  ANESTHESIA FOR HERNIA REPAIRS IN LOWER ABDOMEN;
NOT OTHERWISE SPECIFIED
         // 49521       REPAIR INGUINAL HERNIA, REC
        REPAIR RECURRENT INGUINAL HERNIA, ANY AGE;
        INCARCERATED OR STRANGULATED

 Modifier: 59       DISTINCT PROCEDURAL SERVICE
 Modifier: <RET>
```

```
Principal Procedure: REMOVE HERNIA// REPAIR INGUINAL HERNIA
```

```
ZOOM,BILLY  (231-44-7629)
Operation Date: OCT  5, 1994
-------------------------------------------------------------------------------
1. Indications for Operation:
   Swelling in the inguinal region.

2. Principal CPT Code:  49521
          Modifiers:  -59
3. Principal Procedure: REPAIR INGUINAL HERNIA

4. Other Procedures:

5. Postoperative Diagnosis:   INGUINAL HERNIA

6. Intraoperative Occurrences: NO OCCURRENCES HAVE BEEN ENTERED
-------------------------------------------------------------------------------

Do you need to update the information above ?  NO// <RET>
Will you verify that the information on your screen is correct ? YES// <RET>

Press RETURN to continue
```

1.9 Anesthesia for an Operation Menu

The *Anesthesia for an Operation Menu* is restricted to anesthesia personnel and is locked with the SROANES key. It is designed for convenient entry of data pertaining to the anesthesia agents, personnel and techniques. When you select this option from the *Operation Menu*, you are given a submenu of five options.

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

I	*Anesthesia Information (Enter/Edit)*
T	*Anesthesia Technique (Enter/Edit)*
M	*Medications (Enter/Edit)*
R	*Anesthesia Report*
S	*Schedule Anesthesia Personnel*

Prerequisites

To use any of these options except *Schedule Anesthesia Personnel* you must first select a patient case. For the *Schedule Anesthesia Personnel* option you must first select a date and then an operating room.

These options can also be accessed from the main surgery menu.

1.10 Operation Report

This report details operation information for the patient case selected. Included is the surgeon's dictation and, on hard copies, a space for the surgeon's signature. The Operation Report replaces VA Form 516.

With the *Surgery Site Parameters* option, you can select one of two different formats for the report. One format includes all field names, regardless of whether the information was previously entered (Example 1). The other format only includes fields that have actual data (Example 2).

This report prints in an 80-column format and can be viewed on your terminal screen or copied to a printer.

Example 1: Operation Report (Including all Fields)

```
Select Operation Menu Option: OR  Operation Report

DEVICE: [Select Print Device]
```

.....report follows.....

```
MEDICAL RECORD                          OPERATION REPORT     PAGE 1
CASE # 172
Preoperative Diagnosis:
  Primary: CHOLECYSTITIS
Surgeon:        FINE,LARRY          Surgical Priority: ELECTIVE
Attend Surgeon: HOWARD,MOE          Attend Code: 1. ATTENDING IN O.R.
1st Assistant:  REED,DANNY          2nd Assistant: N/A

Other Scrubbed Assistants: TATUM,WILLIAM
Anesthetist: DAVIS,DOUG                 Asst Anesthetist: MOSES,DAISY
Attending Anesthesiologist: HOWARD,C.
Anesthesia Supervisor Code: N/A
Perfusionist:   N/A                     Asst. Perfusionist: N/A
OR Support Personnel:
  Scrubbed                              Circulating
  BARNETT,PATSY (FULLY TRAINED)         DOTY,NADINE (FULLY TRAINED)
Anesthesia Technique(s):
  GENERAL  (PRINCIPAL)
     Agent:  ENFLURANE
             HALOTHANE
Anesthesia Begin: MAR 09, 1999  09:15   Anesthesia End: MAR 09, 1999  12:50
Operation Begin:  MAR 09, 1999  09:45   Operation End:  MAR 09, 1999  12:30
Tubes and Drains:
  PENROSE; CYSTIC DUCT STUMP EXTERIORIZED TO LATERAL ABDOMINAL WALL
Tourniquet: N/A
Material Sent to Laboratory for Analysis:
Specimens: N/A
Cultures:  N/A
Postoperative Diagnosis:
  Primary: CHOLECYSTITIS                                ICD9 Code: 574.01
Major Operations Performed:
Primary: CHOLECYSTECTOMY
    CPT Code: 47605  REMOVAL OF GALLBLADDER
     Modifiers: -59 DISTINCT PROCEDURAL SERVICE



SURGEON'S SIG:                                      MAR 15, 1999 11:36
OAT,WILLIE                                          AGE: 49   ID#: 449-34-5555
WARD:                                               ROOM-BED:
VAMC: MAYBERRY, NC                                  REPLACEMENT FORM 516
```

Concurrent Procedure(s): N/A

Date/Time of Dictation: MAR 09, 1999 14:50
Date/Time Transcribed: MAR 09, 1999 15:49

Indications for Operation:
Repeated attacks of abdominal pain correlated with alcohol ingestion. Gallstones noted by sonar. Increased serum amylase. It is felt that cholecystectomy is indicated with cholangiography.

Surgeon's Dictation:
Patient was brought to the operating room and placed in supine position on the operating table. After endotracheal anesthesis and intravenous fluids, the patient's abdomen was prepped and draped in a sterile field. A right subcostal incision was made under the abdomen. The gallbladder was identified, dissection was taken down to the base of the gallbladder and the cystocardia was identified and ligated with 3-0 silk sutures. Further dissection at the base of the gallbladder isolated the cystic duct. Cystic duct was narrow being only 2-3 mm in size. At this point the gallbladder was dissected down free from the gallbladder bed. The cystic duct was then tied proximally and the gallbladder amputated. Next, a cholangiogram needle was inserted into the cystic duct and the cholangiogram was performed. The cholangiogram revealed a normal size common bile duct with normal intrahepatic biliary tree and free flow into the duodenum. The wound was then irrigated, hemostatis was obtained, a #10 Flat Jackson-Pratt drain was placed into the bed of the gallbladder and brought out through a separate stab incision. The wound was then closed in layers using 0-loop nylon suture, 3-0 nylon vertical mattress was used to close the skin. The patient tolerated the procedure well, estimated blood loss was 200 ccs. Sponge and needle counts reported as correct. The patient was taken to the recovery room in satisfactory condition.

SURGEON'S SIG: MAR 15, 1999 11:36

OAT,WILLIE AGE: 49 ID#: 449-34-5555
WARD: ROOM-BED:

VAMC: MAYBERRY, NC REPLACEMENT FORM 516

Example 2: Operation Report (with Only Valid Data Fields)

```
MEDICAL RECORD                          OPERATION REPORT     PAGE 1
CASE # 172

Preoperative Diagnosis:
  Primary: CHOLECYSTITIS

Surgeon:        FINE,LARRY          Surgical Priority: ELECTIVE
Attend Surgeon: HOWARD,MOE          Attend Code: 1. ATTENDING IN O.R.
1st Assistant:  REED,DANNY          2nd Assistant: N/A

Other Scrubbed Assistants: TATUM,WILLIAM

Anesthetist: DAVIS,DOUG                 Asst. Anesthetist: MOSES,DAISY
Attending Anesthesiologist: HOWARD,C.

OR Support Personnel:
  Scrubbed                              Circulating
  BARNETT,PATSY (FULLY TRAINED)         DOTY,NADINE (FULLY TRAINED)

Anesthesia Technique(s):
  GENERAL  (PRINCIPAL)
     Agent:  ETHER INH
             PHENOBARBITAL 30MG/7.5ML ELIXIR

Anesthesia Begin: MAR 09, 1999  09:15   Anesthesia End: MAR 09, 1999  12:50
Operation Begin:  MAR 09, 1999  09:45   Operation End:  MAR 09, 1999  12:30

Tubes and Drains:
  PENROSE; CYSTIC DUCT STUMP EXTERIORIZED TO LATERAL ABDOMINAL WALL

Material Sent to Laboratory for Analysis: N/A

Postoperative Diagnosis:
  Primary: CHOLECYSTITIS  ICD9 Code: 574.01

Major Operations Performed:
  Primary: CHOLECYSTECTOMY
    CPT Code: 47605  REMOVAL OF GALLBLADDER
     Modifiers: -59 DISTINCT PROCEDURAL SERVICE

Date/Time of Dictation: MAR 09, 1999  14:50
Date/Time Transcribed:  MAR 09, 1999  15:49

Indications for Operation:
  Repeated attacks of abdominal pain correlated with alcohol ingestion.
  Gallstones noted by sonar.  Increased serum amylase.  It is felt that
  cholecystectomy is indicated with cholangiography.


SURGEON'S SIG:                                  MAR 15, 1999 11:58

OAT,WILLIE                                      AGE: 49   ID#: 449-34-5555
WARD:                                           ROOM-BED:

VAMC: MAYBERRY, NC                              REPLACEMENT FORM 516
```

Surgeon's Dictation:
Patient was brought to the operating room and placed in supine position on the operating table. After endotracheal anesthesia and intravenous fluids, the patient's abdomen was prepped and draped in a sterile field. A right subcostal incision was made under the abdomen. The gallbladder was identified, dissection was taken down to the base of the gallbladder and the cystocardia was identified and ligated with 3-0 silk sutures. Further dissection at the base of the gallbladder isolated the cystic duct. Cystic duct was narrow being only 2-3 mm in size. At this point the gallbladder was dissected down free from the gallbladder bed. The cystic duct was then tied proximally and the gallbladder amputated. Next, a cholangiogram needle was inserted into the cystic duct and the cholangiogram was performed. The cholangiogram revealed a normal size common bile duct with normal intrahepatic biliary tree and free flow into the duodenum. The wound was then irrigated, hemostatis was obtained, a #10 Flat Jackson-Pratt drain was placed into the bed of the gallbladder and brought out through a separate stab incision. The wound was then closed in layers using 0-loop nylon suture, 3-0 nylon vertical mattress was used to close the skin. The patient tolerated the procedure well, estimated blood loss was 200 ccs. Sponge and needle counts reported as correct. The patient was taken to the recovery room in satisfactory condition.

SURGEON'S SIG: MAR 15, 1999 11:58

OAT,WILLIE AGE: 49 ID#: 449-34-5555
WARD: ROOM-BED:

VAMC: MAYBERRY, NC REPLACEMENT FORM 516

1.11 Anesthesia Report

Anesthesia staff uses this option to print all the anesthesia information entered for a case. When a hard copy of this report is made, space is provided for the anesthetist's signature. This option can also be accessed from the *Anesthesia Menu* located on the main surgery menu.

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

Example: Anesthesia Report

```
Select Operation Menu Option:  AR  Anesthesia Report
DEVICE: [Select Print Device]
```

.....*report follows*.....

```
     MEDICAL RECORD                  |            ANESTHESIA REPORT

Preop Status: 2-MILD DISTURB.           Operating Room: OR2
Principal Operation:  CHOLECYSTECTOMY
    CPT Code: 47605  REMOVAL OF GALLBLADDER
     Modifiers: -59 DISTINCT PROCEDURAL SERVICE
Anesthesia Technique(s):
     GENERAL  (PRINCIPAL)
        Agents: ENFLURANE
                HALOTHANE

Intubated: YES
Approach: DIRECT VISION LARYNGOSCOPY    Route: ORAL
Laryngoscope Type: MACINTOSH
Laryngoscope Size: 3
Stylet Used: YES
Lidocaine IV: NO
Tube Type: PVC LOW PRESSURE             Tube Size: 3
Extubated In: OR                        Extubated By: DAVIS,DOUG
Bacteria Filter in Circuit: YES

OAT,WILLIE                                          449-34-5555
WARD:NORTH                                          ROOM-BED: 5C
VAMC: MAYBERRY, NC

Press RETURN to continue  <RET>
```

```
     MEDICAL RECORD                  |            ANESTHESIA REPORT

Medications:
     DIAZEPAM 5MG/ML INJ 2ML
     MAR 09, 1999 09:55                INTRAVENOUS  (10MG)
          Ordered By: FINE,LARRY       Admin By: BARNETT,PATSY
Anesthesia Start: MAR 09, 1999 09:15   Anesthesia Stop: MAR 09, 1999 12:50
Anesthetist:      DAVIS,DOUG           Relief Anesth:
Anesthesiologist: HOWARD,C.
Assistant Anesth: MOSES,DAISY          Min Intraoperative Temp:
Blood Replacement Fluids:
     RINGERS LACTATED SOLUTION         Quantity: 1000 cc's
     Source ID: TRAVENOL
     VA ID:     VA 99-5463
Intraoperative Blood Loss: 200 cc's    Urine Output: 1000 cc's

OAT,WILLIE                                       449-34-5555
WARD:NORTH                                       ROOM-BED: 5C
VAMC: MAYBERRY, NC

Press RETURN to continue  <RET>
```

```
     MEDICAL RECORD                  |            ANESTHESIA REPORT

Operation Disposition: PACU (RECOVERY ROOM)
PAC(U) Admit Score: 10                 PAC(U) Discharge Score: 10
Postop Anesthesia Note:
Intraoperative Complications:
  CARDIAC ARREST REQUIRING CPR
Postoperative Complications:
  DEEP WOUND INFECTION

ANESTHETIST'S SIG:                               MAR 12, 1999@13:20:31
OAT,WILLIE                                       449-34-5555
WARD:NORTH                                       ROOM-BED: 5C
VAMC: MAYBERRY, NC

Press RETURN to continue  <RET>
```

1.12 Nurse Intraoperative Report

This option generates the Nurse Intraoperative Report. This report details case information for the patient case selected. When a hard copy of this report is made, space is provided for the nurse's signature. This form is considered an SF 509 Progress Note and will replace the current Nurse Intraoperative Progress Report.

With the *Surgery Site Parameters* option, you can select one of two different formats for this report. One format includes all field names regardless of whether or not information was previously entered (Example 1). The other format only includes fields that have actual data (Example 2).

This report prints in an 80-column format and can be viewed on your terminal screen or copied to a printer.

Example 1: Nurse Intraoperative Report (Including all Fields)

```
Select Operation Menu Option:  NR  Nurse Intraoperative Report
DEVICE: [Select Print Device]
```

.....*report follows*.....

```
MEDICAL RECORD          |   NURSE INTRAOPERATIVE REPORT        PAGE 1

Operating Room:  OR2                    Surgical Priority: ELECTIVE

Patient in Hold: MAR 09, 1999  09:00    Patient in OR:     MAR 09, 1999  09:30
Operation Begin: MAR 09, 1999  09:45    Operation End:     MAR 09, 1999  12:30
                                        Patient Out OR:    MAR 09, 1999  12:40

Surgeon:         FINE,LARRY             First Assistant:   REED,DANNY
Attending Surg:  HOWARD,MOE             Second Assistant:  N/A
Anesthetist:     DAVIS,DOUG             Assistant Anesth:  MOSES,DAISY

Other Scrubbed Assistants:
  TATUM,WILLIAM

OR Support Personnel:
  Scrubbed                              Circulating
  BARNETT,PATSY (FULLY TRAINED)         DOTY,NADINE (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood:       N/A                   Preop Consc:    N/A
Preop Skin Integ: N/A                   Preop Converse: N/A

Valid Consent/ID Band Confirmed By:  N/A
Skin Prep By:     N/A                   Skin Prep Agent:     N/A
Skin Prep By (2): N/A                   2nd Skin Prep Agent: N/A
Preop Shave By:   N/A

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

Restraints and Position Aids:
    SAFETY STRAP                    Applied By: N/A

Electrocautery Unit:       7299
ESU Coagulation Range: N/A
ESU Cutting Range: N/A
Electroground Position(s): N/A

Major Operations Performed:
Primary: CHOLECYSTECTOMY
    CPT Code: 47605  REMOVAL OF GALLBLADDER
     Modifiers: -59 DISTINCT PROCEDURAL SERVICE

Material Sent to Laboratory for Analysis:
Specimens: N/A



NURSE'S SIG:                                        MAR 25, 1999@13:35

OAT,WILLIE                                          449-34-5555
WARD:                                               ROOM-BED:

VAMC: MAYBERRY, NC                                  SF 509 PROGRESS NOTES
```

```
MEDICAL RECORD          |   NURSE INTRAOPERATIVE REPORT        PAGE 2

Cultures:  N/A

Anesthesia Technique(s):
  GENERAL  (PRINCIPAL)
     Agent:  ENFLURANE
             HALOTHANE

Tubes and Drains:
  PENROSE; CYSTIC DUCT STUMP EXTERIORIZED TO LATERAL ABDOMINAL WALL

Tourniquet: N/A

Thermal Unit: 2695                              Temperature: 90
              Time On: MAR 09, 1999  09:50      Time Off: MAR 09, 1999  12:25

Prosthesis Installed: N/A

Medications:
  DIAZEPAM 5MG/ML INJ 2ML
    Time Administered: MAR 09, 1999  09:55
      Route: INTRAVENOUS                    Dosage: 10MG
      Ordered By: FINE,LARRY
      Administered By: BARNETT,PATSY
      Comments: N/A

Irrigation Solution(s):
  NORMAL SALINE
     Time Used: MAR 09, 1999  10:05
     Amount: 1000                       Provider: BARNETT,PATSY

Blood Replacement Fluids:
  RINGERS LACTATED SOLUTION             Quantity: 1000 ml
    Source Identification: TRAVENOL
    VA Identification: VA 99-5463

Sponge Count:       YES
Sharps Count:       YES
Instrument Count:   YES
Counter:            ALLEN,KELLY
Counts Verified By: KIMBALL,HANK

Dressing: TELFA, OP SITE
Packing:  N/A

Blood Loss: 200 cc's                    Urine Output: 1000 cc's



NURSE'S SIG:                                        MAR 25, 1999@13:35

OAT,WILLIE                                          449-34-5555
WARD:                                               ROOM-BED:

VAMC: MAYBERRY, NC                                  SF 509 PROGRESS NOTES
```

Postoperative Mood: RELAXED
Postoperative Consciousness: RESTING
Postoperative Skin Integrity: INTACT
Postoperative Skin Color: N/A

Type of Laser: N/A
Sequential Compression Device: NO

Wound Classification: CLEAN
Operation Disposition: PACU (RECOVERY ROOM)
Discharged Via: N/A

Nursing Care Comments:
Admitted with prosthesis in place; left eye an artificial eye. Foam pads applied to elbows and knees. Pillow placed under knees.

NURSE'S SIG: MAR 25, 1999@13:35

OAT,WILLIE 449-34-5555
WARD: ROOM-BED:

VAMC: MAYBERRY, NC SF 509 PROGRESS NOTES

Example 2: Nurse Intraoperative Report (with Only Valid Data Fields)

```
MEDICAL RECORD          |   NURSE INTRAOPERATIVE REPORT        PAGE 1

Operating Room:  OR2                     Surgical Priority: ELECTIVE

Patient in Hold: MAR 09, 1999  09:00     Patient in OR:     MAR 09, 1999  09:30
Operation Begin: MAR 09, 1999  09:45     Operation End:     MAR 09, 1999  12:30
                                         Patient Out OR:    MAR 09, 1999  12:40

Surgeon:         FINE,LARRY              First Assistant:   REED,DANNY
Attending Surg:  HOWARD,MOE              Second Assistant:  N/A
Anesthetist:     DAVIS,DOUG              Assistant Anesth:  MOSES,DAISY

Other Scrubbed Assistants:
  TATUM,WILLIAM

OR Support Personnel:
  Scrubbed                               Circulating
  BARNETT,PATSY (FULLY TRAINED)          DOTY,NADINE (FULLY TRAINED)

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

Restraints and Position Aids:
    SAFETY STRAP                    Applied By: N/A

Electrocautery Unit:       7299
ESU Coagulation Range: N/A
ESU Cutting Range: N/A
Electroground Position(s): N/A

Major Operations Performed:
Primary: CHOLECYSTECTOMY
    CPT Code: 47605  REMOVAL OF GALLBLADDER
     Modifiers: -59 DISTINCT PROCEDURAL SERVICE

Anesthesia Technique(s):
  GENERAL  (PRINCIPAL)
     Agent:  ETHER INH
             PHENOBARBITAL 30MG/7.5ML ELIXIR

Tubes and Drains:
  PENROSE; CYSTIC DUCT STUMP EXTERIORIZED TO LATERAL ABDOMINAL WALL

Thermal Unit: 2695                                Temperature: 90
              Time On: MAR 09, 1999  09:50        Time Off: MAR 09, 1999  12:25

NURSE'S SIG:                                        MAR 25, 1999@13:35

OAT,WILLIE                                          449-34-5555
WARD:                                               ROOM-BED:

VAMC: MAYBERRY, NC                                  SF 509 PROGRESS NOTES
```

Medications:
DIAZEPAM 5MG/ML INJ 2ML
Time Administered: MAR 09, 1999 09:55
Route: INTRAVENOUS Dosage: 10MG
Ordered By: FINE,LARRY
Administered By: BARNETT,PATSY
Comments: N/A

Irrigation Solution(s):
NORMAL SALINE
Time Used: MAR 09, 1999 10:05
Amount: 1000 Provider: BARNETT,PATSY

Blood Replacement Fluids:
RINGERS LACTATED SOLUTION Quantity: 1000 ml
Source Identification: TRAVENOL
VA Identification: VA 99-5463

Sponge Count: YES
Sharps Count: YES
Instrument Count: YES
Counter: ALLEN,KELLY
Counts Verified By: KIMBALL,HANK

Dressing: TELFA, OP SITE
Packing: N/A

Blood Loss: 200 cc's Urine Output: 1000 cc's

Postoperative Mood: RELAXED
Postoperative Consciousness: RESTING
Postoperative Skin Integrity: INTACT

Wound Classification: CLEAN
Operation Disposition: PACU (RECOVERY ROOM)

Nursing Care Comments:
Admitted with prosthesis in place; left eye an artificial eye. Foam pads applied to elbows and knees. Pillow placed under knees.

NURSE'S SIG: MAR 25, 1999@13:35

OAT,WILLIE 449-34-5555
WARD: ROOM-BED:

VAMC: MAYBERRY, NC SF 509 PROGRESS NOTES

1.13 Tissue Examination Report

This option is used to generate the Tissue Examination Report that contains information about cultures and specimens sent to the laboratory.

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

Example: Tissue Examination Report

```
Select Operation Menu Option: T Tissue Examination Report
DEVICE: [Select Print Device]
```

.....report follows.....

```
--------------------------------------------------------------------------------
     MEDICAL RECORD   |                    TISSUE EXAMINATION
--------------------------------------------------------------------------------
Specimen Submitted By:                            Obtained: MAR 09, 1992
   OR1,  SURGERY CASE # 187
--------------------------------------------------------------------------------
Specimen(s):
--------------------------------------------------------------------------------
Brief Clinical History:
  Subscapular pain for 3 days.  Nausea and vomiting.
  Increased serum amylase.
--------------------------------------------------------------------------------
Operative Procedure(s):
   CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM
--------------------------------------------------------------------------------
Preoperative Diagnosis:
   CHOLECYSTITIS
--------------------------------------------------------------------------------
Operative Findings:
  THE GALLBLADDER HAD A FEW ADHESIONS EASILY REMOVED
  AND WAS FOUND TO BE FIRMLY DISTENDED WTIH STONES.
--------------------------------------------------------------------------------
Postoperative Diagnosis:                          Signature and Title
   CHOLECYSTITIS                                  FINE,LARRY
--------------------------------------------------------------------------------
Attending Surgeon: HOWARD,MOE
--------------------------------------------------------------------------------
                             PATHOLOGY REPORT
--------------------------------------------------------------------------------
Name of Laboratory                                Accession Number(s)

--------------------------------------------------------------------------------
Gross Description, Histologic Examination and Diagnosis



                             (Continue on reverse side)
--------------------------------------------------------------------------------
PATHOLOGIST'S SIGNATURE                                   DATE:
--------------------------------------------------------------------------------
OAT,WILLIE                   AGE: 49   SEX: MALE          ID # 449-34-5555
RACE: WHITE, NOT OF HISPANIC ORIGIN                       REGISTER NO.
WARD:                        ROOM-BED:
--------------------------------------------------------------------------------
VAMC: MAYBERRY, NC                                        REPLACEMENT FORM 515
```

1.14 Enter Referring Physician Information

This option allows the surgical staff to enter the name, address and phone number of the individual or institution that referred the patient. Referring physician information is usually entered by the scheduling manager when the operation is booked. This information shows up on many reports.

Example: Enter Referring Physician Information

```
Select Operation Menu Option: R  Enter Referring Physician Information
```

```
Select REFERRING PHYSICIAN: DR. ROBERTO MOLINA
   Street Address: 1600 STRAND AVE.
   City: GALVESTON
   State: TX    TEXAS
   Zip Code:  <RET>
   Phone Number: 561-2873
```

1.15 Enter Irrigations and Restraints

This option is designed to allow the nurse to quickly document the irrigation solutions or the restraint and positioning devices used in a case. The list of solutions or devices can be different at each site.

At the select prompt, choose the number corresponding to the solution or device. For more than one choice, separate the numbers with a comma. If an item has been selected before, a default prompt will appear. You can enter an at-sign (@) to delete the selection, as in Example 3.

Example 1: Entering Irrigations

```
Select Operation Menu Option: RP  Enter Irrigations or Restraints
```

```
Enter/Edit Irrigations or Restraints and Positioning Aids:

1. Irrigations
2. Restraints and Positioning Aids
Select Number: 1
```

```
                        IRRIGATION SOLUTIONS
================================================================

  1.   AEROSP/PXYN                        2.  BACITRACIN SOLUTION
  3.   BETADINE SOLUTION                  4.  HEPARIN
  5.   HEPARINIZED SALINE                 6.  ICED SALINE
  7.   KANTREX SOLUTION                   8.  KEFLEX SOLUTION
  9.   NEOMYCIN                          10.  NEOMYCIN SOLUTION
 11.   NORMAL SALINE                     12.  POVODINE
 13.   SORBITAL                          14.  STERILE WATER
 15.   VEIN GRAFT SOLUTION              16.THROMBIN


Select the number(s) corresponding to your choice: 2,15

Entering BACITRACIN SOLUTION ...
Entering VEIN GRAFT SOLUTION ...

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

Example 2:

```
Select Operation Menu Option: RP  Enter Irrigations or Restraints
```

```
Enter/Edit Irrigations or Restraints and Positioning Aids:
1. Irrigations
2. Restraints and Positioning Aids

Select Number: 2
```

```
                    Restraints and Positioning Aids
=========================================================================
  1.   ARMSHEET                           2.  SAFETY STRAP
  3.   ARMBOARD                           4.  VAC PAC
  5.   FOAM PADS                          6.  PILLOW
  7.   AXILLARY ROLL                      8.  ADHESIVE TAPE
  9.   SURGERY ARMBOARD                  10.  KIDNEY REST
 11.   SANDBAG                           12.  OVERHEAD ARMREST
 13.   ROLLED SHEET                      14.  LEG HOLDER
 15.   FOOT EXTENSION                    16.  STIRRUPS
 17.   FRACTURE TABLE                    18.  OTHER

Select the number(s) corresponding to your choice: 3,6,9
Entering ARMBOARD ...

Entering PILLOW ...

Entering SURGERY ARMBOARD ...

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

Example 3:

```
Select Operation Menu Option: RP  Enter Irrigations or Restraints
```

```
Enter/Edit Irrigations or Restraints and Positioning Aids:
1. Irrigations
2. Restraints and Positioning Aids

Select Number: 2
```

```
                     Restraints and Positioning Aids
=========================================================================
  1.   ARMSHEET                          2.  SAFETY STRAP
  3.   ARMBOARD                          4.  VAC PAC
  5.   FOAM PADS                         6.  PILLOW
  7.   AXILLARY ROLL                     8.  ADHESIVE TAPE
  9.   SURGERY ARMBOARD                 10.  KIDNEY REST
 11.   SANDBAG                          12.  OVERHEAD ARMREST
 13.   ROLLED SHEET                     14.  LEG HOLDER
 15.   FOOT EXTENSION                   16.  STIRRUPS
 17.   FRACTURE TABLE                   18.  OTHER

Select the number(s) corresponding to your choice: 3
Entering ARMBOARD ...
  RESTR & POSITION AIDS: ARMBOARD// @
   SURE YOU WANT TO DELETE THE ENTIRE RESTR & POSITION AIDS? Y  (YES)

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

1.16 Medications (Enter/Edit)

This option lets you enter all the medications administered on a case. It is designed to help you quickly enter many different medications for a case.

In one entry, you can enter the medication, dosage, route, and time given with the use of slashes between these categories. After you have finished entering one medication, the computer will return the cursor to the beginning prompt so that you can enter another medication for the case. When you are finished entering medications for the case, press the Return key to return to the menu.

About the prompts

> ENTER MEDICATION/DOSE(MG)/ROUTE/TIME: Respond to this prompt with the medication, dosage, route, and time given separated by slashes. If the computer needs more specific information about the medication, you will be prompted. In the example, the computer reads "Valium" and then asks the user to select from the Valiums on file.
>
> A question mark can be entered in place of one of the categories in order to get help or more information. In the example, a question mark was entered in place of the route. Then, in response to the question mark, the computer offered a list of acceptable routes.

Example: Entering Medication

```
Select Operation Menu Option: Medications (Enter/Edit)
```

```
ENTER MEDICATION/DOSE(MG)/ROUTE/TIME: DIAZEPAM/5MG/?/8:00


     1   DIAZEPAM 10MG S.R. CAP                  N/F     ***NOT MANUFACTURED***
     2   DIAZEPAM 10MG S.T.                    NOTE RESTRICTIONS (ON OPTS ONLY)
     3   DIAZEPAM 15 MG S.R. CAP                 N/F     NOTE RESTRICTIONS
     4   DIAZEPAM 2MG S.T.                  N/F
     5   DIAZEPAM 5MG S.T.                    NOTE RESTRICTIONS (ON OPTS ONLY)

Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 5

Route entered is not one of the available choices.
Please enter medication route again.

Choose from:
IV        INTRAVENOUS
T        TOPICAL
IR        IRRIGATION
IM        INTRAMUSCULAR
R        RECTAL
S        SUBLINGUAL
SC        SUBCUTANEOUS
IN        INFILTRATE
O        OTHER
P        PREPUMP
OR        ORAL
```

```
Enter ROUTE: IV  INTRAVENOUS

MEDICATION ENTERED ....



ENTER MEDICATION/DOSE(MG)/ROUTE/TIME: <RET>
```

1.17 Blood Product Verification

The *Blood Product Verification* option is used for transfusion error risk management. This option is used in conjunction with a bar code reader to confirm that the blood product is assigned to the patient. The functionality provided by this option is meant as an additional check for proper patient identification and should never be relied upon as the primary check.

This option prompts the user to scan the blood product unit ID, after which the software checks the Blood Bank files for an association with the patient identified. If there are multiple entries with the unit ID scanned, these entries will be listed along with the Blood Component, Patient Associated, and Expiration Date. The user will then be prompted to select the one that matches the blood product about to be administered. If the selected product is not associated with the patient identified, a warning message will be displayed.

There are certain valid scenarios that are internal to the Blood Bank which may result in a blood component not being readable using the scanner and therefore may give an unexpected response. There will be some rare instances in which this option may not produce an expected result. After verifying proper patient identification, the option may be attempted again; however, it is recommended that the unit ID be typed in manually rather than be scanned in these cases.

Blood product manufacturers are required to label all units of blood in a consistent manner. The barcode that is to be scanned at the “Enter Blood Product Identifier” prompt will always be the barcode in the upper-left portion of the blood product label. Since this label can be in close proximity to the ABO/Rh label, care should be taken not to read both labels during a scan. One way to accomplish this would be to use a finger or some other convenient object to cover the label you do not wish to have read during the scanning process. The light emitted from the scanner itself will cause no harm to skin, latex, or any other object with which it comes in contact.

Example: **Option displayed with no discrepancies**

```
Select Operation Menu Option: BLOOD PRODUCT VERIFICATION
To use BAR CODE READER
               Pass reader wand over a GROUP-TYPE ( ABO/Rh) label
                         =>
Enter Blood Product Identifier: KW10945


 1) Unit ID: KW10945                          CPDA-1 RED BLOOD CELLS
    Patient: ZIFFEL,ARNOLD 122-32-4569        Expiration Date: NOV 27,1997

 2) Unit ID: KW10945                          FRESH FROZEN PLASMA, ACD-A
    Patient: ZIFFEL,ARNOLD 122-32-4569        Expiration Date: MAY 19,1998

 3) Unit ID: KW10945                          PLATELETS, POOLED, IRRADIATED
    Patient: ZIFFEL,ARNOLD 122-32-4569        Expiration Date: MAR 24,1998


Select the blood product matching the unit label: (1-3): 2

No Discrepancies Found
```

Example: Option displayed with discrepancies

```
Select Operation Menu Option: BLOOD PRODUCT VERIFICATION

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

 1) Unit ID: KW10945                        CPDA-1 RED BLOOD CELLS
    Patient: ZIFFEL,ARNOLD 122-32-4569      Expiration Date: NOV 27,1997

 2) Unit ID: KW10945                        FRESH FROZEN PLASMA, ACD-A
    Patient: ZIFFEL,ARNOLD 122-32-4569      Expiration Date: MAY 19,1998

 3) Unit ID: KW10945                        PLATELETS, POOLED, IRRADIATED
    Patient: ZIFFEL,ARNOLD 122-32-4569      Expiration Date: MAR 24,1998

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

                       **WARNING**

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

2.0 Anesthesia Menu

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

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

E	*Anesthesia Data Entry Menu*
R	*Anesthesia Report*
A	*Anesthesia AMIS*
S	*Schedule Anesthesia Personnel*

Prerequisites

To use the *Anesthesia Data Entry Menu* or *Anesthesia Report* options, you must first select a patient case. You do not need to select a case to use the *Anesthesia AMIS* option, as it generates a report that is a compilation of statistics for all cases. However, you must select an operating room to use the *Schedule Anesthesia Personnel* option.

2.1 Anesthesia Data Entry Menu

The *Anesthesia Data Entry Menu* option allows you to enter anesthesia data pertinent to a selected patient case. The information entered in these sub-options is reflected on the Anesthesia Report.

To use any option on the *Anesthesia Data Entry Menu*, you must first enter a patient name and choose a patient case, as shown below. The example begins with the main Surgery menu.

Example: How to Select a Case for the Data Entry Menu

```
Select Surgery Menu Option:  A  Anesthesia Menu

   E      Anesthesia Data Entry Menu
   R      Anesthesia Report
   A      Anesthesia AMIS
   S      Schedule Anesthesia Personnel

Select Anesthesia Menu Option: E  Anesthesia Data Entry Menu
Select Patient: OAT,WILLIE         12-09-51     449345555     NSC VETERAN
```

```
 OAT,WILLIE   449-34-5555

1. 04-26-92   CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)

2. 11-20-90   Release of Hammer Toes (REQUESTED)

3. ENTER NEW SURGICAL CASE


Select Operation: 1
```

```
  OAT,WILLIE (449-34-5555)   Case #145 - APR 26,1992


   I      Anesthesia Information  (Enter/Edit)
   T      Anesthesia Technique (Enter/Edit)
   M      Medications (Enter/Edit)

Select Anesthesia Data Entry Menu Option: <RET>
```

2.1.1 Anesthesia Information (Enter/Edit)

Anesthesia staff uses this option to enter anesthesia related information for a given case. The first group of prompts affects the Anesthesia AMIS report. Some of the data fields may be automatically filled in from previous responses.

At the Screen Server prompt, you can choose the field(s) to be edited, or press the Return key to continue. Some of the data fields are "multiple" and may contain more than one value. When a multiple field is selected, a new screen is generated so that you can enter data related to that multiple. For instance, the MONITORS field generates a new screen for adding the device, time installed, and time removed. The TIME INSTALLED and TIME REMOVED generate additional screens so that you may enter more than one time installed/removed for the same operation.

About some prompts

"Is this the Principal Technique (Y/N)?" This prompt asks whether or not the technique being entered is the *primary* anesthesia technique for the case. It is advisable to establish the principal technique as this information affects many reports.

"Would you like to enter additional anesthesia related information?"
If you want to enter more detailed information concerning the case, answer Yes to this prompt. You will be given two Screen Server-formatted pages for entering more anesthesia information for the case.

"Select ANESTHESIA AGENTS" You can enter more than one anesthesia agent for a case by using the up-arrow (^) to jump to the "Select ANESTHESIA AGENTS" prompt. This use of the up-arrow is covered in the *DHCP Users Guide to Computing*.

Example: Entering Anesthesia Information

```
Select Anesthesia Data Entry Menu Option: I  Anesthesia Information (Enter/Edit)
```

```
The following information is required for the Anesthesia AMIS.

Principal Anesthetist: LITTLE,DOO// <RET>
Select ANESTHESIA TECHNIQUE: G  (G   GENERAL)
  Is this the Principal Technique (Y/N): YES// <RET>
  Was the Patient Intubated ?  (Y/N): Y  YES
  Trauma Resulting from Intubation Process: NONE// <RET>
  Select ANESTHESIA AGENTS: ENFLURANE                N/F
    Dose (mg): 125
Diagnostic/Therapeutic (Y/N): NO// <RET>

ASA Class: 2  2-MILD DISTURB.

Would you like to enter additional anesthesia related information ? NO//Y
```

```
 ** ANESTHESIA INFO **   CASE #145  OAT,WILLIE     PAGE 1 OF 2

1    ANESTHESIOLOGIST SUPVR:
2    ANES SUPERVISE CODE:
3    PRINC ANESTHETIST:     LITTLE,DOO
4    RELIEF ANESTHETIST:
5    ASST ANESTHETIST:
6    ANES CARE START TIME:  APR 26, 1992 AT 09:10
7    INDUCTION COMPLETE:
8    ANES CARE END TIME:    APR 26, 1992 AT 12:50
9    ASA CLASS:             2-MILD DISTURB.
10   BLOOD LOSS (ML):       200
11   MIN INTRAOP TEMPERATURE (C):
12   FINAL ANESTHESIA TEMP (C):
13   TOTAL URINE OUTPUT (ML): 1
14   OP DISPOSITION:        PACU (RECOVERY ROOM)
15   POSTOP ANES NOTE:

Enter Screen Server Function: 10:13
Intraoperative Blood Loss (ml): 200// 500
Lowest Intraoperative Temperature (C): 28
Final Anesthesia Temperature (C): 37
Total Urine Output (ml): 1// 1800
```

```
  ** ANESTHESIA INFO **   CASE #145  OAT,WILLIE     PAGE 1 OF 2

1    ANESTHESIOLOGIST SUPVR:
2    ANES SUPERVISE CODE:
3    PRINC ANESTHETIST:     LITTLE,DOO
4    RELIEF ANESTHETIST:
5    ASST ANESTHETIST:
6    ANES CARE START TIME:  APR 26, 1992 AT 09:10
7    INDUCTION COMPLETE:
8    ANES CARE END TIME:    APR 26, 1992 AT 12:50
9    ASA CLASS:             2-MILD DISTURB.
10   BLOOD LOSS (ML):       500
11   MIN INTRAOP TEMPERATURE (C): 28
12   FINAL ANESTHESIA TEMP (C): 37
13   TOTAL URINE OUTPUT (ML): 1800
14   OP DISPOSITION:        PACU (RECOVERY ROOM)
15   POSTOP ANES NOTE:

Enter Screen Server Function:  <RET>
```

```
  ** ANESTHESIA INFO **   CASE #145  OAT,WILLIE     PAGE 2 OF 2

1    ORAL-PHARYNGEAL SCORE: CLASS 2
2    MANDIBULAR SPACE:     80
3    REPLACEMENT FLUID TYPE: (MULTIPLE)(DATA)
4    MEDICATIONS:          (MULTIPLE)(DATA)
5    MONITORS:             (MULTIPLE)
6    GENERAL COMMENTS:     (WORD PROCESSING)
7    THERMAL UNIT:         (MULTIPLE)(DATA)
8    ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)

Enter Screen Server Function:  5
```

```
  ** ANESTHESIA INFO **   CASE #145  OAT,WILLIE     PAGE 1
         MONITORS

1    NEW ENTRY

Enter Screen Server Function:  1
Select MONITORS: ECG
    MONITORS: ECG// <RET>
```

```
  ** ANESTHESIA INFO **   CASE #145  OAT,WILLIE     PAGE 1
         MONITORS  (ECG)

2    TIME INSTALLED:
3    TIME REMOVED:
4    APPLIED BY:

Enter Screen Server Function:  2:4
Time Applied: 4/26@9:20  (APR 26, 1992@09:20)
Time Removed: 4/26@12:45  (APR 26, 1992@12:45)
Person Applying the Monitor: MCGILLICUTTY,LUCY
```

```
  ** ANESTHESIA INFO **   CASE #145  OAT,WILLIE     PAGE 1 OF 1
         MONITORS  (ECG)

1    MONITORS:              ECG
2    TIME INSTALLED:        APR 26, 1992 AT 09:20
3    TIME REMOVED:          APR 26, 1992 AT 12:45
4    APPLIED BY:            MCGILLICUTTY,LUCY

Enter Screen Server Function:  <RET>
```

```
** ANESTHESIA INFO **   CASE #145  OAT,WILLIE     PAGE 1 OF 1
         MONITORS

1    MONITORS:              ECG
2    NEW ENTRY

Enter Screen Server Function:  <RET>
```

```
  ** ANESTHESIA INFO **   CASE #145  OAT,WILLIE     PAGE 2 OF 2

1    ORAL-PHARYNGEAL SCORE: CLASS 2
2    MANDIBULAR SPACE:     80
3    REPLACEMENT FLUID TYPE: (MULTIPLE)(DATA)
4    MEDICATIONS:          (MULTIPLE)(DATA)
5    MONITORS:             (MULTIPLE)(DATA)
6    GENERAL COMMENTS:     (WORD PROCESSING)
7    THERMAL UNIT:         (MULTIPLE)(DATA)
8    ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)

Enter Screen Server Function: <RET>
```

2.1.2 Anesthesia Technique (Enter/Edit)

This option is used to enter information concerning the anesthesia technique. More than one anesthesia technique can be entered for a case. When you are finished entering the first technique, select this option again to start entering another anesthesia technique.

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

G	GENERAL
M	MONITORED ANESTHESIA CARE
S	SPINAL
E	EPIDURAL
O	OTHER
L	LOCAL

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

About some prompts

Diagnostic/ Therapeutic (Y/N) Answer “Y” or “Yes” if the anesthesia procedure is itself a surgical procedure. You will then have an opportunity to define the surgical (operative) procedure.

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

Select ANESTHESIA AGENTS You can enter more than one anesthesia agent for a case by using the up-arrow (^) to jump to the "Select ANESTHESIA AGENTS" prompt. The use of the up-arrow is covered in the *DHCP Users Guide to Computing.*

Example 1: General Technique

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

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

Note: The ANESTHESIA AGENT field uses entries from your local DRUG file. Prior to using the Surgery package, drugs that will be used as anesthesia agents must be flagged (using the Chief's Menu) by your package coordinator. If you are having problems entering an agent, it is likely that the drug you are choosing has not been flagged.

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

Example 2: Monitored Anesthesia Care Technique

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

Example 3: Spinal Technique

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

Example 4: Epidural Technique

```
Select Anesthesia Data Entry Menu Option: T  Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO// <RET>
Select ANESTHESIA TECHNIQUE: E  (EPIDURAL)
  Is this the Principal Technique (Y/N): YES//  <RET>  YES
  Was the Patient Intubated ?  (Y/N): N  NO
  Select ANESTHESIA AGENTS: LIDOCAINE
    Dose (mg): 5
  Was the Catheter placed for Continuous Administration ? (Y/N): YES
         //  <RET>  YES
  Puncture Site: 2  L3-4
  Dural Puncture ?  (Y/N): NO// Y  YES
  Who Removed the Catheter ?:   213  MCGILLICUTY,LUCY
  Date/Time that the Catheter was Removed: 5/4@2:30  (MAY 04, 1995@14:30)
Oral-Pharyngeal (OP) Score: CLASS 1// <RET>
Mandibular Space (length in mm): 65// <RET>
Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0//   (No Editing)
GENERAL COMMENTS:
  1>LOSS OF RESISTANCE TECHNIQUE
  2><RET>
EDIT Option: <RET>
```

1

Example 5: Other Technique

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

Example 6: Local Technique

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

2.1.3 Medications (Enter/Edit)

Anesthesia staff members use this option to enter medications administered on a case. This is the last sub-option of the *Anesthesia Data Entry Menu*.

This option is designed to help you quickly enter many different medications for a case. In one entry, you can enter the medication, dosage, route, and time given with the use of slashes between these categories. (This is a different type of prompt response from what has been used elsewhere.) After you have finished entering one medication, the computer will return the cursor to the beginning prompt so that you can enter another medication for the case. When you are finished entering medications for the case, press the Return key to return to the *Anesthesia Data Entry Menu*.

About the prompts

ENTER MEDICATION/DOSE(MG)/ROUTE/TIME: Respond to this prompt with the medication, dosage, route, and time given separated by slashes. If the computer needs more specific information about the medication, you will be prompted. In the example, the computer reads "Valium" and then asks the user to select from the Valiums on file.

A question mark can be entered in place of one of the categories in order to get help or more information. In the following example, a question mark was entered in place of the route. Then, in response to the question mark, the computer offered a list of acceptable routes.

Example: Entering a Medication

```
Select Anesthesia Data Entry Menu Option: M  Medications (Enter/Edit)
```

```
ENTER MEDICATION/DOSE(MG)/ROUTE/TIME: VALIUM/5MG/?/7:50

     1   VALIUM 5MG          N/F
     2   VALIUM  DIAZEPAM 10MG S.T.        N/F      RESTRICTED TO
ENT/ANESTHESIA/PSYCHIATRY/PARAPLEGICS
     3   VALIUM  DIAZEPAM 2MG S.T.        N/F      RESTRICTED TO
ENT/ANESTHESIA/PSYCHIATRY/PARAPLEGICS
TYPE '^' TO STOP, OR
CHOOSE 1-3: 1    (JAN 13, 1993  07:50)

Route entered is not one of the available choices.
Please enter medication route again.

Choose from:
IV        INTRAVENOUS
T        TOPICAL
IR        IRRIGATION
IM        INTRAMUSCULAR
R        RECTAL
S        SUBLINGUAL
SC        SUBCUTANEOUS
IN        INFILTRATE
O        OTHER
P        PREPUMP
OR        ORAL

ENTER ROUTE: IV

MEDICATION ENTERED ....
```

```
ENTER MEDICATION/DOSE(MG)/ROUTE/TIME: <RET>
```

2.2 Anesthesia Report

Anesthesia staff uses this option to print all the anesthesia information entered for a case. When a hard copy of this report is made, space is provided for the Anesthetist's signature. This option is located on the *Anesthesia Menu*. It can also be accessed from the *Operation Menu*.

This report prints in an 80-column format and can be viewed on your terminal screen or copied to a printer.

Example: Printing the Anesthesia Report

```
Select Anesthesia Menu Option: R  Anesthesia Report

Select PATIENT NAME:  OAT, WILLIE       12-09-51     449345555
```

```
OAT,WILLIE   449-34-5555

1. 03-09-99   CHOLECYSTECTOMY (COMPLETED)



Select Operation: 1
DEVICE: [Select Print Device]
```

.....*report follows*.....

```
MEDICAL RECORD                    |            ANESTHESIA REPORT

Preop Status: 2-MILD DISTURB.           Operating Room: OR2

Principal Operation:  CHOLECYSTECTOMY
    CPT Code: 47605  REMOVAL OF GALLBLADDER
     Modifiers: -59 DISTINCT PROCEDURAL SERVICE

Anesthesia Technique(s):
     GENERAL  (PRINCIPAL)
        Agents: ETHER INH
                PHENOBARBITAL 30MG/7.5ML ELIXIR

Intubated: YES
Approach: DIRECT VISION LARYNGOSCOPY    Route: ORAL
Laryngoscope Type: MACINTOSH
Laryngoscope Size: 3
Stylet Used: YES
Lidocaine IV: NO
Tube Type: PVC LOW PRESSURE             Tube Size: 3
Trauma: NONE
Extubated In: OR                        Extubated By: DAVIS,DOUG
Bacteria Filter in Circuit: YES

Medications:
     DIAZEPAM 5MG/ML INJ 2ML
     MAR 09, 1999 09:55                 INTRAVENOUS  (10MG)
          Ordered By: FINE,LARRY        Admin By: BARNETT,PATSY

Anesthesia Start: MAR 09, 1999 09:15    Anesthesia Stop: MAR 09, 1999 12:50

Anesthetist:      DAVIS,DOUG            Relief Anesth:

Anesthesiologist: HOWARD,C.

Assistant Anesth: MOSES,DAISY           Min Intraoperative Temp:

Blood Replacement Fluids:
     RINGERS LACTATED SOLUTION          Quantity: 1000 cc's
     Source ID: TRAVENOL
     VA ID:     VA 99-5463

Intraoperative Blood Loss: 200 cc's     Urine Output: 1000 cc's

Operation Disposition: PACU (RECOVERY ROOM)

PAC(U) Admit Score: 10                  PAC(U) Discharge Score: 10

Postop Anesthesia Note:


OAT,WILLIE                                          449-34-5555
WARD:                                               ROOM-BED:

VAMC: MAYBERRY, NC
```

```
MEDICAL RECORD                    |            ANESTHESIA REPORT

Intraoperative Complications:
  CARDIAC ARREST REQUIRING CPR
Postoperative Complications:
  DEEP WOUND INFECTION


ANESTHETIST'S SIG:                                MAR 13, 1999@10:27:03
OAT,WILLIE                                        449-34-5555
WARD:                                             ROOM-BED:
VAMC: MAYBERRY, NC
```

2.3 Anesthesia AMIS

This option compiles statistics for all surgical cases and non-O.R. procedures within the date range selected and generates a report. This report, the Anesthesia AMIS report, is required by the Surgical Service in VA central office. This option is locked with the SROAAMIS key.

The Anesthesia AMIS Report prints in a 132-column format and must be copied to a printer.

Example: Printing the Anesthesia AMIS Report

```
Select Anesthesia Menu Option: A  Anesthesia AMIS
```

```
Anesthesia AMIS


Start with Date: 1 1 95  (JAN 01, 1995)
End with Date: 1 31 95  (JAN 31, 1995)

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


This report is designed to use a 132 column format, and must be run
on a printer.

DEVICE: [Select Print Device]
```

.....*report follows*.....

MAYBERRY, NC - ALL DIVISIONS
ANESTHESIA SERVICE
ANESTHESIA AMIS
FROM: JAN 1,1995 TO: JAN 31,1995

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: FEB 7,1995

ANESTHETICS ADMINISTERED BY PRINCIPAL TECHNIQUE USED

TOTAL NO OF ANES-THETICS ADMINISTERED	GENERAL	MAC	SPINAL	EPIDURAL	OTHER	LOCAL
54	8	1	3	1	0	41

ANESTHETICS FOR PROCEDURES ADMINISTERED BY:						**	ANESTHETICS FOR DIAG. & THERA. PROCEDURES ADMINISTERED BY:					
ANESTHESIOLOGIST		NURSE ANESTHETIST		OTHER		**	ANESTHESIOLOGIST		NURSE ANESTHETIST		OTHER	
NUMBER OF ANESTHETICS	NO. OF DEATHS	NUMBER OF ANESTHETICS	NO. OF DEATHS	NUMBER OF ANESTHETICS	NO. OF DEATHS	**	NUMBER OF ANESTHETICS	NO. OF DEATHS	NUMBER OF ANESTHETICS	NO. OF DEATHS	NUMBER OF ANESTHETICS	NO. OF DEATHS
9	0	3	0	40	1	**	1	0	0	0	1	0

DEATHS WITHIN 24 HOURS OF INDUCTION OF ANESTHETIC

TOTAL NUMBER OF DEATHS	GENERAL	MAC	SPINAL	EPIDURAL	OTHER	LOCAL
1	0	0	0	0	0	1

2.4 Schedule Anesthesia Personnel

Anesthesia staff uses this option to assign or change anesthesia personnel for surgery cases. Using other menu options, the Scheduling Manager might have already assigned personnel to the selected case. This option is locked with the SROANES key and will not appear on the menu if you do not have this key.

With this option you can enter an anesthesia technique and the names of the principal anesthetist and supervisor. When you select an operating room, the computer will present all cases scheduled for that room. After scheduling personnel for cases in one operating room, you can do the same for other operating rooms without leaving this option. For your convenience, the computer will default to the anesthetist and anesthesiologist supervisor previously scheduled for that room.

Example: Scheduling Anesthesia Personnel

```
Select Anesthesia Menu Option: S  Schedule Anesthesia Personnel
Schedule Anesthesia Personnel for which Date ?  4/26  (APR 26,1992)

Schedule Anesthesia Personnel for which Operating Room ?  OR2
```

```
Scheduled Operations for OR2
-------------------------------------------------------------------------------

Case # 145   Patient: OAT,WILLIE
From: 09:00  To: 12:00
CHOLECYSTECTOMY


Requested Anesthesia Technique: GENERAL// <RET>
Principal Anesthetist: LITTLE,DOO    DL
Anesthesiologist Supervisor: TRAPPER,JOHN// <RET>


Press <RET> to continue, or '^' to quit   <RET>
```

```
Scheduled Operations for OR2
-------------------------------------------------------------------------------

Case # 148   Patient: NASIUM,JIM
From: 13:00  To: 18:00
SHOULDER ARTHROPLASTY

Requested Anesthesia Technique: GENERAL//  <RET>
Principal Anesthetist: LITTLE,DOO//     <RET>      DL
Anesthesiologist Supervisor: TRAPPER,JOHN//  <RET>       JT

Press <RET> to continue, or '^' to quit  <RET>
```

```
Would you like to continue with another operating room ?  YES//  <RET>

Schedule Anesthesia Personnel for which Operating Room ?  OR3
```

```
Scheduled Operations for OR3
-----------------------------------------------------------------------------

Case # 136   Patient: BOB,BILLY
From: 07:00  To: 10:30
CHOLECYSECTOMY

Requested Anesthesia Technique: GENERAL//  <RET>
Principal Anesthetist: HOWARD,C          CH
Anesthesiologist Supervisor: TRAPPER,JOHN//   <RET>

Press <RET> to continue, or '^' to quit   <RET>
```

```
Would you like to continue with another operating room ?  YES// Y

Schedule Anesthesia Personnel for which Operating Room ?  OR1

There are no cases scheduled for this operating room.

Press RETURN to continue
```

```
Would you like to continue with another operating room ?  YES// N
```

3.0 Perioperative Occurrences Menu

Surgeons use this menu to enter or edit occurrences that occur before, during, and/or after a surgical procedure. It is also possible to enter occurrences for a patient who did not have a surgical procedure performed. You can enter more than one occurrence per patient.

Occurrences will be included on the Chief of Surgery's Morbidity & Mortality Reports.

Note: Please review your institution's policy to determine what is considered an occurrence for any category.

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

I	*Intraoperative Occurrences (Enter/Edit)*
P	*Postoperative Occurrences (Enter/Edit)*
N	*Non-Operative Occurrences (Enter/Edit)*
U	*Update Status of Returns Within 30 Days*
M	*Morbidity & Mortality Reports*

Key Vocabulary

Intraoperative Occurrence	Occurrence that occurs during the procedure.
Postoperative Occurrence	Occurrence that occurs after the procedure.
Non-Operative Occurrence	Occurrence that develops before a surgical procedure is performed.

3.1 Intraoperative Occurrences (Enter/Edit)

Use this option to add information about an occurrence that occurs during the procedure. You can also use this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, select an operation. The computer will then list any occurrences already entered for that operation. You can choose to edit an already-entered occurrence or, you can type the word NEW and press the Return key to enter a new occurrence.

At the prompt "Enter a New Intraoperative Occurrence:" enter two question marks (??) to get a list of categories. Be sure to enter a category for all occurrences in order to satisfy Surgery Central Office reporting needs.

Example: Entering Intraoperative Occurrences

```
Select Perioperative Occurrences Menu Option: I  Intraoperative Occurrences
(Enter/Edit)
```

```
Select Patient: RUBBLE,BETTY         10-28-45     123459999

 RUBBLE,BETTY   123-45-9999

1. 06-30-92   CHOLECYSTECTOMY (COMPLETED)

2. 03-10-92   HEMORRHOIDECTOMY (COMPLETED)


Select Operation: 1
```

```
RUBBLE,BETTY (123-45-9999)        Case #213
JUN 30,1992   CHOLECYSTECTOMY (CPT MISSING)
-------------------------------------------------------------------------------


There are no Intraoperative Occurrences entered for this case.


Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
Any cardiac arrest requiring external or open cardiopulmonary
resuscitation (CPR) of any duration occurring in the operating room, ICU,
ward, or out-of-hospital after the chest has been completely closed and
within 30 days following surgery.  Exclude intentional arrests during
cardiac surgery.


Press RETURN to continue: <RET>
```

```
RUBBLE,BETTY (123-45-9999)        Case #213
JUN 30,1992   CHOLECYSTECTOMY (CPT MISSING)
-------------------------------------------------------------------------------


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
```

```
RUBBLE,BETTY  (123-45-9999)
-------------------------------------------------------------------------------
Type of Treatment Instituted: CPR
Outcome to Date: ?
     CHOOSE FROM:
       U        UNRESOLVED
       I        IMPROVED
       D        DEATH
       W        WORSE
Outcome to Date: I  IMPROVED
```

```
RUBBLE,BETTY (123-45-9999)        Case #213
JUN 30,1992   CHOLECYSTECTOMY (CPT MISSING)
-------------------------------------------------------------------------------


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

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

Select Occurrence Information: <RET>
```

3.2 Postoperative Occurrences (Enter/Edit)

Use this option to add information about an occurrence that occurs after the procedure. You can also use this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, select an operation. The computer will then list any occurrences already entered for that operation. You can choose to edit an already-entered occurrence or you can type the word NEW and press the Return key to enter a new occurrence.

At the prompt "Enter a New Postoperative Complication:" enter two question marks (??) to get a list of categories. Be sure to enter a category for all occurrences in order to satisfy Surgery Central Office reporting needs.

Example: Entering a Postoperative Occurrence

```
Select Perioperative Occurrences Menu Option: P  Postoperative Occurrence (Enter/Edit)
```

```
Select Patient: BASS,EARNEST T.         09-13-28     123455119

 BASS,EARNEST T.   123-45-5119

1. 04-18-92   CRANIOTOMY (COMPLETED)

2. 03-18-92   REPAIR INCARCERATED INGUINAL HERNIA (COMPLETED)



Select Operation: 2
```

```
BASS,EARNEST T. (123-45-5119)        Case #202
MAR 18,1992   REPAIR INCARCERATED INGUINAL HERNIA (49505)
-------------------------------------------------------------------------------

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: URINARY TRACT INFECTION
[CDC Definition]  Symptomatic urinary tract infection must meet one of the
following TWO criteria:
 1. One of the following:  fever (>38 degrees C), urgency, frequency,
    dysuria, or suprapubic tenderness AND a urine culture of  >100,000
    colonies/ml urine with no more than two species of organisms.
 2. Two of the following:  fever (>38 degrees C), urgency, frequency,
    dysuria, or suprapubic tenderness AND any of the following:
    a. Dipstick test positive for leukocyte esterase and/or nitrate.
    b. Pyuria (>10 WBCs/cc or >3 WBC/hpf of unspun urine).
    c. Organisms seen on Gram stain of unspun urine.
    d. Two urine cultures with repeated isolation of the same uropathogen
       with >100 colonies/ml urine in non-voided specimen.
    e. Urine culture with <100,000 colonies/ml urine of single uropathogen
       in patient being treated with appropriate antimicrobial therapy.
    f. Physician's diagnosis.
    g. Physician institutes appropriate antimicrobial therapy.

Press RETURN to continue: <RET>
```

```
BASS,EARNEST T. (123-45-5119)        Case #202
MAR 18,1992   REPAIR INCARCERATED INGUINAL HERNIA (49505)
-------------------------------------------------------------------------------


1. Occurrence:            URINARY TRACT INFECTION
2. Occurrence Category:   URINARY TRACT INFECTION
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

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

Select Occurrence Information: 4:6
```

```
BASS,EARNEST T. (123-45-5119)        Case #202
MAR 18,1992   REPAIR INCARCERATED INGUINAL HERNIA (49505)
-------------------------------------------------------------------------------


Treatment Instituted: ANTIBIOTICS
Outcome to Date: I  IMPROVED
Date/Time the Complication was Noted: 3/20  (MAR 20, 1992)
```

```
BASS,EARNEST T. (123-45-5119)        Case #202
MAR 18,1992   REPAIR INCARCERATED INGUINAL HERNIA (49505)
-------------------------------------------------------------------------------


1. Occurrence:            URINARY TRACT INFECTION
2. Occurrence Category:   URINARY TRACT INFECTION
3. ICD Diagnosis Code:
4. Treatment Instituted:  ANTIBIOTICS
5. Outcome to Date:       IMPROVED
6. Date Noted:            03/20/92
7. Occurrence Comments:

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

Select Occurrence Information: <RET>
```

3.3 Non-Operative Occurrence (Enter/Edit)

Use this option to enter or edit occurrences that are not related to surgical procedures. A non-operative occurrence is an occurrence that develops before a surgical procedure is performed.

At the prompt "Occurrence Category," enter two question marks (??) to get a list of categories. Be sure to enter a category for each occurrence in order to satisfy Surgery Central Office reporting needs.

Example: Entering a Non-Operative Occurrence

```
Select Perioperative Occurrences Menu Option: N  Non-Operative Occurrences
(Enter/Edit)
```

```
NOTE:  You are about to enter an occurrence for a patient that has not had an
operation during this admission.  If this patient has a surgical procedure
during the current admission, use the option to enter or edit intraoperative
and postoperative occurrences.


Select PATIENT NAME: BASS,EARNEST T.         09-13-28     123455119
```

```
   BASS,EARNEST T.


1.            ENTER A NEW NON-OPERATIVE OCCURRENCE



Select Number:  1
```

```
Select the Date of Occurrence: T-2  (JUN 30, 1997)
Name of the Surgeon Treating the Complication: HOWARD,MOE
Name of the Attending Surgeon: FINE,LARRY
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)
Select NON-OPERATIVE OCCURRENCES: SYSTEMIC SEPSIS
  Occurrence Category: SYSTEMIC SEPSIS
This is defined as a patient noted to be acutely ill, usually febrile,
resulting from the presence of microorganisms or their poisonous
products in the blood stream.

  Treatment Instituted: ANTIBIOTICS
  Outcome to Date: U  UNRESOLVED
  Occurrence Comments:
  1>Cancel scheduled surgery for this week. Reschedule later.
  2><RET>
EDIT Option: <RET>

Press RETURN to continue  <RET>
```

3.4 Update Status of Returns Within 30 Days

This option will define a case as related or unrelated to another case. When a new surgical case is entered into the computer, you are asked whether it is related to any previous cases within the past 30 days. This option is designed to update that information.

First, enter the patient name and select a case. The computer will list any cases that occurred within 30 days prior to the selected case and will indicate if the listed cases have been flagged as related or unrelated. At this point you may update the status of the cases listed.

Example: Updating Status of Returns Within 30 days

```
Select Perioperative Occurrences Menu Option:  Update Status of Returns Within 3
0 Days

Select Patient: WILLIAMS,ROSEMARY           03-03-59     334567821     NO     NO
N-VETERAN (OTHER)
```

```
WILLIAMS,ROSEMARY   334-56-7821

1. 07-06-98   REPAIR INGUINAL HERNIA (COMPLETED)

2. 06-25-98   CHOLECYSTECTOMY, APPENDECTOMY (COMPLETED)

3. 06-23-98   CHOLEDOCHOTOMY (COMPLETED)

4. 04-10-97   CRANIOTOMY (COMPLETED)



Select Operation: 3
```

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------

1. 07/06/98    REPAIR INGUINAL HERNIA (49521-59) - UNRELATED

2. 06/25/98    CHOLECYSTECTOMY (47610-59,20,66,78) - UNRELATED

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


Select Number: 2
```

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------


2. 06/25/98    CHOLECYSTECTOMY (47610-59,20,66,78) - UNRELATED

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


This return to surgery is currently defined as UNRELATED to the case selected.
Do you want to change this status ? NO// Y
```

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------

1. 07/06/98    REPAIR INGUINAL HERNIA (49521-59) - UNRELATED

2. 06/25/98    CHOLECYSTECTOMY (47610-59,20,66,78) - RELATED

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


Select Number: <RET>
```

3.5 Morbidity & Mortality Reports

This option generates two reports: the Perioperative Occurrences Report and the Mortality Report. The Perioperative Occurrences Report includes all cases that have occurrences, both intraoperatively and postoperatively. The Mortality Report includes all cases performed within the selected date range that had a death within 30 days after surgery. These reports sort by specialty within a date range. Each surgical specialty will begin on a separate page.

After you enter the date range, the computer will ask if you want to generate both reports. If you answer "No", the computer will ask you to select from 1) the Perioperative Occurrences Report or 2) the Mortality Report.

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

Example 1: Printing the Perioperative Occurrences Report

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports
```

```
The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report.  Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N
```

```
1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 1

Start with Date: 8/1  (AUG 01, 1999)
End with Date: 8/31  (AUG 31, 1999)
```

```
Do you want to print this report for all Surgical Specialties ?  YES// N


Print the report for which Specialty ?  GENERAL(OR WHEN NOT DEFINED BE  LOW)
Select an Additional Specialty  <RET>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

.....*report follows*.....

MAYBERRY, NC
SURGICAL SERVICE
PERIOPERATIVE OCCURRENCES
FROM: AUG 1,1999 TO: AUG 31,1999

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: SEP 22,1999

GENERAL(OR WHEN NOT DEFINED BELOW)

PATIENT ID# OPERATION DATE	PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) TREATMENT	OUTCOME
DRUCKER,SAMUEL HORATIO 233-41-8719 AUG 07, 1999@07:15	REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (08/09/99) IV ANTBIOTICS	I
UPRIGHT,WILLIAM BOLT 212-65-0036 AUG 31, 1999@09:00	CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (09/02/99) ANTIBIOTICS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Example 2: Printing the Mortality Report

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports
```

```
The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report.  Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N
```

```
1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 2

Start with Date: 1/1/98  (JAN 01, 1998)
End with Date: 12/31/98  (DEC 31, 1998)

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

.....*report follows*.....

MAYBERRY, NC
SURGICAL SERVICE
MORTALITY REPORT
FROM: JAN 1,1998 TO: DEC 31,1998

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: SEP 22,1999

OPERATION DATE	PATIENT ID#	PRINCIPAL OPERATIVE PROCEDURE	DATE OF DEATH AUTOPSY (Y/N)
		OTORHINOLARYNGOLOGY (ENT)	
JAN 22, 1998	CROCKETT,DAVID 211-32-2433	LARYNGOSCOPY, BRONCHOSCOPY, ESOPHAGOGASTROSCOPY	FEB 09, 1998 NO
JAN 27, 1998	WAYNE,BRUCE 819-72-6354	BRONCHOSCOPY	FEB 26, 1998 NOT AVAILABLE
JAN 29, 1998	CROCKETT,DAVID 211-32-2433	BILATERAL NECK DISECTION, LARYNGECTOMY	FEB 09, 1998 NO
FEB 08, 1998	CROCKETT,DAVID 211-32-2433	LIGATION LT INTERNAL JUGLAR , EXPLORATORY LAPARATOMY	FEB 09, 1998 NO
FEB 19, 1998	GOLIATH,DAVID M. 676-76-7676	TRACH	FEB 21, 1998 NO
OCT 20, 1998	BROWN,JAMES 777-88-9999	LARYNGOSCOPY W/ BX, ESOPHAGOSCOPY	NOV 01, 1998 NOT AVAILABLE

4.0 Non-O.R. Procedures

The *Non-O.R. Procedures* option, locked with the SROPER key, is designed for operating room staff that enters operation or procedure information. This option is located in the main *Surgery* menu and provides access to a submenu that allows you to enter and edit procedures and generate reports. The editing feature branches to another submenu for entering and editing anesthesia information.

A non-O.R. procedure is any procedure not performed in an operating room but which still involves surgical or anesthesia providers. Any procedures involving anesthesia providers will show up on the Anesthesia AMIS report.

The main options included in this menu are listed below. The first option, *Non-O.R. Procedures Menu*, contains a submenu. To the left of the option name is the shortcut synonym you can enter to select the option:

E	*Non-O.R. Procedures (Enter/Edit)*
A	*Annual Report of Non-O.R. Procedures*
R	*Report of Non-O.R. Procedures*

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

This menu allows you to enter, edit, or delete information related to a non-O.R. procedure. The editing feature branches to another submenu that allows you to enter or edit anesthesia information for a procedure. To use one of the *Non-O.R. Procedures Menu* options, you must first identify the patient on which you are working.

How to Access the Non-O.R. Procedures Menu

When you select "E" for *Non-O.R. Procedures (Enter/Edit)*, you will be prompted to enter a patient name. The computer will then list all non-O.R. procedures on record for the patient:

```
Non-O.R. Procedures for ZIFFEL,DORIS (353-23-3221)


1.  MAR  9, 1992         STELLATE NERVE BLOCK

2.  NEW PROCEDURE


Select Procedure:
```

You can select from the procedure(s) listed or enter a new procedure. When you select an existing procedure, the computer will ask whether you want to 1) edit information for the case, or 2) delete the procedure, as follows:

```
Do you want to edit or delete this procedure ?

1. Edit
2. Delete

Select Number:  1//
```

If you enter "2" for delete, the computer will permanently remove the procedure from the records. On the other hand, if you accept the default answer "1" to edit the existing procedure, the computer will display the Non-O.R. Procedures Menu. You will see:

```
   E      Edit Non-O.R. Procedure
   AI     Anesthesia Information  (Enter/Edit)
   AM     Medications (Enter/Edit)
   AT     Anesthesia Technique (Enter/Edit)
   PR     Procedure Report (Non-OR)
   TR     Tissue Examination Report

Select Non-O.R. Procedures (Enter/Edit) Menu Option:
```

Three of these sub-options, *Anesthesia Information*, *Medications*, and *Anesthesia Technique*, are the same as the sub-options of the same name on the Anesthesia Menu.

4.1.1 Edit Non-O.R. Procedure

This option allows you to edit or delete a previously entered procedure or enter a new procedure for a selected patient.

The examples begin with the “Select Non-O.R. Procedures Option” prompt. This prompt occurs after you have selected Non-O.R. Procedures from the main Surgery menu. Select the patient and case and the computer will then ask if you want to work on an existing case, if one exists, or if you would like to enter a new procedure.

How to Edit a Previously Entered Procedure

Example 1 shows how to edit an existing case. The computer asks if you want to edit or delete the case. If you choose to edit the case, the computer presents a menu with the *Edit Non-O.R. Procedure* option on it. You must enter "E" for *Edit Non-O.R. Procedure.* The computer screen will then clear and display a two-page Screen Server summary. At the Screen Server prompt, you can choose the field(s) to be edited, or press the Return key to continue.

How to Enter a New Procedure

In Example 2 demonstrates how to enter a new procedure for a patient with no record of previous non-O.R. procedures. After entering the patient name, there are three mandatory prompts before you can get to the Screen Server prompts.

Prompts that require a response are:

Select PATIENT NAME
Enter the Procedure
Select the Date of the Procedure
Provider
Medical Specialty

At the Screen Server prompt, you can choose the field(s) to be edited, or press the Return key to continue. Some of the data fields are "multiple" and may contain more than one value. When a field labeled "multiple" is selected, the screen will branch into a new screen so that you can enter data related to that multiple. For instance, ANESTHESIA TECHNIQUE field branches into a sub screen for adding the technique, agents, and dosages. The AGENTS sub screen branches again so that you can enter more than one drug agent for the same operation.

Example 1: Edit a Previously Entered Procedure

```
Select Non-O.R. Procedures Option: E  Enter/Edit Non-O.R. Procedures Menu


Select PATIENT NAME:  ZIFFEL,DORIS       12-19-31     353233221
```

```
 ZIFFEL,DORIS   353-23-3221

1. MAR  9, 1992     STELLATE NERVE BLOCK

2.  NEW PROCEDURE

Select Procedure: 1
```

```
 ZIFFEL,DORIS   353-23-3221

 MAR  9, 1992       STELLATE NERVE BLOCK


Do you want to edit or delete this procedure ?

1. Edit
2. Delete

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

```
 ZIFFEL,DORIS  (353-23-3221)   Case #193 - MAR 09, 1992


   E      Edit Non-O.R. Procedure
   AI     Anesthesia Information  (Enter/Edit)
   AM     Medications (Enter/Edit)
   AT     Anesthesia Technique (Enter/Edit)
   PR     Procedure Report (Non-O.R.)
   TR     Tissue Examination Report

Select Non-O.R. Procedures (Enter/Edit) Option: E  Edit Non-O.R. Procedure
```

```
 ** NON-O.R. PROCEDURE **  CASE #193  ZIFFEL,DORIS   PAGE 1 OF 3

1    DATE OF PROCEDURE:       MAR 09, 1992
2    PRINCIPAL PROCEDURE:     STELLATE NERVE BLOCK
3    PRINCIPAL PROCEDURE CODE: 64510
4    MEDICAL SPECIALTY:       GENERAL(ACUTE MEDICINE)
5    IN/OUT-PATIENT STATUS:
6    TIME PROCEDURE BEGAN:    MAR 09, 1992 AT 09:45
7    TIME PROCEDURE ENDED:    MAR 09, 1992 AT 10:21
8    PROVIDER:                WATSON,CHERYL
9    NON-OR LOCATION:
10   ASSOCIATED CLINIC:
11   PRINCIPAL DIAGNOSIS:     REFLEX SYMPATHETIC DYSTROPHY
12   PRIN DIAGNOSIS CODE:
13   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
14   BRIEF CLIN HISTORY:      (WORD PROCESSING)
15   OPERATIVE FINDINGS:      (WORD PROCESSING)

Enter Screen Server Function:  9
Non-O.R. Location: AMBULATORY SURGERY
```

```
 ** NON-O.R. PROCEDURE **  CASE #193  ZIFFEL,DORIS   PAGE 1 OF 3

1    DATE OF PROCEDURE:       MAR 09, 1992
2    PRINCIPAL PROCEDURE:     STELLATE NERVE BLOCK
3    PRINCIPAL PROCEDURE CODE: 64510
4    MEDICAL SPECIALTY:       GENERAL(ACUTE MEDICINE)
5    IN/OUT-PATIENT STATUS:
6    TIME PROCEDURE BEGAN:    MAR 09, 1992 AT 09:45
7    TIME PROCEDURE ENDED:    MAR 09, 1992 AT 10:21
8    PROVIDER:                WATSON,CHERYL
9    NON-OR LOCATION:         AMBULATORY SURGERY
10   ASSOCIATED CLINIC:
11   PRINCIPAL DIAGNOSIS:     REFLEX SYMPATHETIC DYSTROPHY
12   PRIN DIAGNOSIS CODE:
13   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
14   BRIEF CLIN HISTORY:      (WORD PROCESSING)
15   OPERATIVE FINDINGS:      (WORD PROCESSING)

Enter Screen Server Function:  <RET>
```

```
          ** NON-O.R. PROCEDURE **   CASE #193  ZIFFEL,DORIS     PAGE 2 OF 3

1    ATTEND PROVIDER:
2    ATTENDING CODE:
3    PRINC ANESTHETIST:       WATSON,CHERYL
4    ANESTHESIOLOGIST SUPVR:  JENNINGS,GEORGE A
5    ANES CARE START TIME:    MAR 09, 1992 AT 09:45
6    ANES CARE END TIME:      MAR 09, 1992 AT 10:21
7    ANESTHESIA TECHNIQUE:    (MULTIPLE)(DATA)
8    ANES SUPERVISE CODE:     1. STAFF CASE
9    DIAGNOSTIC/THERAPEUTIC (Y/N): YES
10   ASA CLASS:               2-MILD DISTURB.
11   OTHER PROCEDURES:        (MULTIPLE)
12   PROCEDURE OCCURRENCE:    (MULTIPLE)
13   SPECIMENS:               (WORD PROCESSING)
14   GENERAL COMMENTS:        (WORD PROCESSING)(DATA)
15   CANCEL DATE:

Enter Screen Server Function: <RET>
```

```
          ** NON-O.R. PROCEDURE **   CASE #193  ZIFFEL,DORIS     PAGE 3 OF 3

1    CANCEL REASON:

Enter Screen Server Function:  <RET>
```

Example 2: Enter a New Non-O.R. Procedure

```
Select Non-O.R. Procedures Option: E  Enter/Edit Non-O.R. Procedures Menu

Select PATIENT NAME: HATHAWAY,JANE         01-21-40     333333333
```

```
 HATHAWAY,JANE   333-33-3333

1.  NEW PROCEDURE

Select Procedure: 1
```

```
Entering a new non-or procedure for HATHAWAY,JANE.


Enter the Procedure: CARDIOVERSION

Select the Date of the Procedure: 3/13  (MAR 13, 1992)

Provider: FINE,LARRY

Medical Specialty:  CARDIOLOGY
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 1 OF 3

1    DATE OF PROCEDURE:       MAR 13, 1999
2    PRINCIPAL PROCEDURE:     CARDIOVERSION
3    PRINCIPAL PROCEDURE CODE:
4    MEDICAL SPECIALTY:       CARDIOLOGY
5    IN/OUT-PATIENT STATUS:
6    TIME PROCEDURE BEGAN:
7    TIME PROCEDURE ENDED:
8    PROVIDER:                FINE,LARRY
9    NON-OR LOCATION:
10   ASSOCIATED CLINIC:
11   PRINCIPAL DIAGNOSIS:
12   PRIN DIAGNOSIS CODE:
13   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
14   BRIEF CLIN HISTORY:      (WORD PROCESSING)
15   OPERATIVE FINDINGS:      (WORD PROCESSING)

Enter Screen Server Function:  3:13
Principal Procedure Code (CPT): 92960          HEART ELECTROCONVERSION
        CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF
        ARRHYTHMIA, EXTERNAL
 Modifier: <RET>
Medical Specialty: CARDIOLOGY// <RET>
Hospital Admission Status: I  INPATIENT
Time Procedure Began: 3/13@14:00  (MAR 13, 1999@14:00)
Time Procedure Ended: 3/13@14:25  (MAR 13, 1999@14:25)
Provider: FINE,LARRY// <RET>
Non-OR Location: ICU
Associated Clinic: <RET>
Principal Diagnosis: ATRIAL FIBRILLATION
Principal Diagnosis Code (ICD9): 427.31  427.31        ATRIAL FIBRILLATION
COMPLICATION/COMORBIDITY
         ...OK? Yes// <RET>
Indications for Operations:
  1>ATRIAL FIBRILLATION NOT RESPONSIVE TO MEDICATIONS
  2><RET>
EDIT Option:
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 1 OF 3

1    DATE OF PROCEDURE:       MAR 13, 1999
2    PRINCIPAL PROCEDURE:     CARDIOVERSION
3    PRINCIPAL PROCEDURE CODE: 92960
4    MEDICAL SPECIALTY:       CARDIOLOGY
5    IN/OUT-PATIENT STATUS:   INPATIENT
6    TIME PROCEDURE BEGAN:    MAR 13, 1999 AT 14:00
7    TIME PROCEDURE ENDED:    MAR 13, 1999 AT 14:25
8    PROVIDER:                FINE,LARRY
9    NON-OR LOCATION:         ICU
10   ASSOCIATED CLINIC:
11   PRINCIPAL DIAGNOSIS:     ATRIAL FIBRILLATION
12   PRIN DIAGNOSIS CODE:     427.31
13   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
14   BRIEF CLIN HISTORY:      (WORD PROCESSING)
15   OPERATIVE FINDINGS:      (WORD PROCESSING)

Enter Screen Server Function: <RET>
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 2 OF 3

1    ATTEND PROVIDER:
2    ATTENDING CODE:
3    PRINC ANESTHETIST:
4    ANESTHESIOLOGIST SUPVR:
5    ANES CARE START TIME:
6    ANES CARE END TIME:
7    ANESTHESIA TECHNIQUE:    (MULTIPLE)
8    ANES SUPERVISE CODE:
9    DIAGNOSTIC/THERAPEUTIC (Y/N):
10   ASA CLASS:
11   OTHER PROCEDURES:        (MULTIPLE)
12   PROCEDURE OCCURRENCE:    (MULTIPLE)
13   SPECIMENS:               (WORD PROCESSING)
14   GENERAL COMMENTS:        (WORD PROCESSING)
15   CANCEL DATE:

Enter Screen Server Function:  3:10
Principal Anesthetist: REED,DANNY
Anesthesiologist Supervisor: MUSGROVE,STEVE
Anesthesia Care Start Time: 3/13@14:00  (MAR 13, 1999@14:00)
Anesthesia Care End Time: 3/13@14:20  (MAR 13, 1999@14:20)
Anesthesiologist's Supervisor Code: 1. STAFF CASE
Diagnostic/Therapeutic (Y/N): N  NO
ASA Class: 3  3-SEVERE DISTURB.
Anesthesiologist's Supervisor Code: 1 STAFF CASE
Diagnostic/Therapeutic (Y/N): N  NO
ASA Class: 3  3-SEVERE DISTURB.
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 1 OF 1
            ANESTHESIA TECHNIQUE

1    NEW ENTRY

Enter Screen Server Function:  1
Select ANESTHESIA TECHNIQUE: G  (GENERAL)
    ANESTHESIA TECHNIQUE: GENERAL// <RET>
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 1 OF 1
            ANESTHESIA TECHNIQUE  (0)

1    ANESTHESIA TECHNIQUE:    GENERAL
2    PRINCIPAL TECH:
3    ANESTHESIA AGENTS:       (MULTIPLE)

Enter Screen Server Function:  2:3
Is this the Principal Technique (Y/N): YES// <RET>
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 1
            ANESTHESIA TECHNIQUE  (0)
              ANESTHESIA AGENTS

1    NEW ENTRY

Enter Screen Server Function: 1
Select ANESTHESIA AGENTS: VERSED MIDAZOLAM 5MG/ML 2ML AMP         6 MO EVAL
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 1
            ANESTHESIA TECHNIQUE  (0)
              ANESTHESIA AGENTS  (MIDAZOLAM 5MG/ML 2ML AMP)

1    ANESTHESIA AGENTS:     MIDAZOLAM 5MG/ML 2ML AMP
2    DOSE (mg):

Enter Screen Server Function: <RET>
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 1 OF 1
            ANESTHESIA TECHNIQUE  (0)
              ANESTHESIA AGENTS

1    ANESTHESIA AGENTS:     MIDAZOLAM 5MG/ML 2ML AMP
2    NEW ENTRY

Enter Screen Server Function: <RET>
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 1 OF 1
            ANESTHESIA TECHNIQUE  (0)

1    ANESTHESIA TECHNIQUE:    GENERAL
2    PRINCIPAL TECH:          YES
3    ANESTHESIA AGENTS:       (MULTIPLE)(DATA)

Enter Screen Server Function: <RET>
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 1 OF 1
            ANESTHESIA TECHNIQUE

1    ANESTHESIA TECHNIQUE:    GENERAL
2    NEW ENTRY

Enter Screen Server Function: <RET>
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 2 OF 3

1    ATTEND PROVIDER:
2    ATTENDING CODE:
3    PRINC ANESTHETIST:       REED,DANNY
4    ANESTHESIOLOGIST SUPVR:  MUSGROVE,STEVE
5    ANES CARE START TIME:    MAR 13, 1999 AT 14:00
6    ANES CARE END TIME:      MAR 13, 1999 AT 14:20
7    ANESTHESIA TECHNIQUE:    (MULTIPLE)(DATA)
8    ANES SUPERVISE CODE:     1. STAFF CASE
9    DIAGNOSTIC/THERAPEUTIC (Y/N): NO
10   ASA CLASS:               3-SEVERE DISTURB.
11   OTHER PROCEDURES:        (MULTIPLE)
12   PROCEDURE OCCURRENCE:    (MULTIPLE)
13   SPECIMENS:               (WORD PROCESSING)
14   GENERAL COMMENTS:        (WORD PROCESSING)
15   CANCEL DATE:

Enter Screen Server Function: <RET>
```

```
          ** NON-O.R. PROCEDURE **  CASE #173  HATHAWAY,JANE     PAGE 3 OF 3

1    CANCEL REASON:

Enter Screen Server Function: <RET>
```

4.1.2 Procedure Report (Non-O.R.)

This option produces a report with information about the selected case. This report prints in an 80-column format and can be viewed on your terminal screen or copied to a printer.

Example: Print the Procedure Report

```
Select Non-O.R. Procedures (Enter/Edit) Option: PR  Procedure Report (Non-O.R.)
DEVICE: [Select Print Device]
```

.....report follows.....

```
MEDICAL RECORD            |  NON-O.R. PROCEDURE REPORT   PAGE 1

                              Case #:193

Med. Specialty: GENERAL(ACUTE MEDICINE)     Location: AMBULATORY SURGERY

Principal Diagnosis:
   REFLEX SYMPATHETIC DYSTROPHY                    ICD9 CODE:

Provider: WATSON,CHERYL

Attending:                                Att Code:

Attend Anesth: JENNINGS,GEORGE A
Anesthesia Supervisor Code: 1. STAFF CASE

Anesthetist: WATSON,CHERYL

Anesthesia Technique:
     LOCAL  (PRINCIPAL)
        Agents: LIDOCAINE 1% 5ML SYRINGE


Diagnostic/Therapeutic (Y/N): YES

Anes Begin:  MAR 9,1992@09:45           Anes End:  MAR 9,1992@10:21

Proc Begin:  MAR 9,1992@09:45           Proc End:  MAR 9,1992@10:21

Procedure(s) Performed:
   Principal: STELLATE NERVE BLOCK  CPT Code: 64510

Indications for Procedure:
  CHRONIC PAIN IN RIGHT UPPER EXTREMITY.


General Comments:
  Patient at high risk due to hypertension.




PROVIDER'S SIG:                                     SEP 13, 1992  10:59

ZIFFEL,DORIS                                        AGE: 60   ID#: 353-23-3221
WARD:                                               ROOM-BED:

VAMC: MAYBERRY, NC
```

4.2 Annual Report of Non-O.R. Procedures

This option is used to generate the Annual Report of Non-OR Procedures. It will display the total number of non-OR procedures within the selected date range based on CPT code.

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

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

```
Select Non-O.R. Procedures Option:  A  Annual Report of Non-O.R. Procedures
```

```
Annual Report of Non-O.R. Procedures


Starting with Date: 3/2  (MAR 02, 1992)
Ending with Date: 3/30  (MAR 30, 1992)

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

.....report follows.....

```
                       ANNUAL REPORT OF NON-O.R. PROCEDURES
                        FROM: MAR 2,1992  TO: MAR 30,1992
==============================================================================

                                    CARDIOLOGY

92960   HEART ELECTROCONVERSION                                    2

Press RETURN to continue, or '^' to quit:  <RET>
```

```
                       ANNUAL REPORT OF NON-O.R. PROCEDURES
                        FROM: MAR 2,1992  TO: MAR 30,1992
==============================================================================

                                 GENERAL SURGERY

11404   REMOVAL OF SKIN LESION                                     1

Press RETURN to continue, or '^' to quit:  <RET>
```

```
                       ANNUAL REPORT OF NON-O.R. PROCEDURES
                        FROM: MAR 2,1992  TO: MAR 30,1992
==============================================================================

                            GENERAL(ACUTE MEDICINE)

11423   REMOVAL OF SKIN LESION                                     1
64510   INJECTION FOR NERVE BLOCK                                  1

Press RETURN to continue, or '^' to quit:  <RET>
```

```
                       ANNUAL REPORT OF NON-O.R. PROCEDURES
                        FROM: MAR 2,1992  TO: MAR 30,1992
==============================================================================

                                   PSYCHIATRY

90870   ELECTROCONVULSIVE THERAPY                                  3

Press RETURN to continue, or '^' to quit:  <RET>
```

```
                       ANNUAL REPORT OF NON-O.R. PROCEDURES
                            SUMMARY OF ALL SPECIALTIES
                        FROM: MAR 2,1992  TO: MAR 30,1992
==============================================================================
CARDIOLOGY                                 TOTAL NON-O.R. PROCEDURES: 2
GENERAL SURGERY                            TOTAL NON-O.R. PROCEDURES: 1
GENERAL(ACUTE MEDICINE)                    TOTAL NON-O.R. PROCEDURES: 2
PSYCHIATRY                                 TOTAL NON-O.R. PROCEDURES: 3

         TOTAL NON-O.R. PROCEDURES FOR THIS MEDICAL CENTER: 8


Press RETURN to continue
```

4.3 Report of Non-O.R. Procedures

This report will chronologically list non-O.R. procedures sorted by surgical specialty or surgeon. This report can be sorted by specialty, provider, or location.

This report prints in a 132-column format and must be copied to a printer.

Example 1: Report of Non-O.R. Procedures by Specialty

```
Select Non-O.R. Procedures Option:  Report of Non-O.R. Procedures
```

```
Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1992)
End with Date: 3/31  (MAR 31, 1992)
```

```
How do you want the report sorted ?

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

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

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


Print the Report for which Specialty ?  Cardiology


This report is designed to use a 132 column format.

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

.....*report follows*.....

```
                                   MAYBERRY, NC
                                SURGICAL SERVICE                          REVIEWED BY:
                           REPORT OF NON-O.R. PROCEDURES                  DATE REVIEWED:
                         FROM: MAR 1,1992  TO: MAR 31,1992

DATE          PATIENT (ID#)                          PROVIDER                                   START TIME
CASE #        LOCATION (IN/OUT-PAT STATUS)           PROCEDURE(S)                               FINISH TIME
==================================================================================================================
                                   *** SPECIALTY: CARDIOLOGY ***

03/02/92      DRUCKER,SAM (233-41-8719)              DOOLITTLE,JAMES A.                         03/02/92 13:05
501           AMBULATORY SURGERY (OUTPATIENT)        CARDIOVERSION                              03/02/92 14:10

03/13/92      HATHAWAY,JANE (333-33-3333)            FINE,LARRY                                 03/13/92 14:00
500           ICU (INPATIENT)                        CARDIOVERSION                              03/13/92 14:25
```

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

```
Select Non-O.R. Procedures Option:  Report of Non-O.R. Procedures
```

```
Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1992)
End with Date: 3/31  (MAR 31, 1992)
```

```
How do you want the report sorted ?

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

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

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


Print the Report for which Provider ?  Bronstein,SOLOMON ABRAM       SAB


This report is designed to use a 132 column format.

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

.....report follows.....

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1992 TO: MAR 31,1992

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	SPECIALTY PROCEDURE(S)	START TIME FINISH TIME
	*** PROVIDER BRONSTEIN,SOLOMON ABRAM ***		
03/12/92	MUSHNICK,GRAVIS (451-23-6987)	PSYCHIATRY	03/12/92 08:00
195	PAC(U) - ANESTHESIA (INPATIENT)	ELECTROCONVULSIVE THERAPY	03/12/92 09:00
03/23/92	MUSHNICK,GRAVIS (451-23-6987)	PSYCHIATRY	03/23/92 08:10
240	PAC(U) - ANESTHESIA (INPATIENT)	ELECTROCONVULSIVE THERAPY	03/23/92 08:40
03/25/92	MUSHNICK,GRAVIS (451-23-6987)	PSYCHIATRY	03/12/92 09:30
266	PAC(U) - ANESTHESIA (INPATIENT)	ELECTROCONVULSIVE THERAPY	03/12/92 10:15

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

```
Select Non-O.R. Procedures Option:  Report of Non-O.R. Procedures
```

```
Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1992)
End with Date: 3/31  (MAR 31, 1992)
```

```
How do you want the report sorted ?

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

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

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


Print the Report for which location ?  AMBULATORY SURGERY


This report is designed to use a 132 column format.

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

.....report follows.....

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1992 TO: MAR 31,1992

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) SPECIALTY (IN/OUT-PAT STATUS)	PROVIDER PROCEDURE(S)	START TIME FINISH TIME
	*** LOCATION: AMBULATORY SURGERY ***		
03/02/92 201	DRUCKER,SAM (233-41-8719) CARDIOLOGY (OUTPATIENT)	DOOLITTLE,JAMES A. CARDIOVERSION	03/02/92 13:05 03/02/92 14:10
03/06/92 198	PETRIE,ROBERT (123-45-4886) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	REED,JAMES EXCISION OF SKIN LESION	03/07/92 16:30 03/07/92 17:08
03/09/92 193	ZIFFEL,DORIS (353-23-3221) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	WATSON,CHERYL STELLATE NERVE BLOCK	03/09/92 09:45 03/09/92 10:21
03/13/92 200	HATHAWAY,JANE (333-33-3333) CARDIOLOGY (INPATIENT)	FINE,LARRY CARDIOVERSION	03/13/92 14:00 03/13/92 14:25
03/17/92 194	TAYLOR,OPIE (112-22-3334) GENERAL SURGERY (OUTPATIENT)	REED,JAMES EXCISION OF SKIN LESION	03/17/92 13:30 03/17/92 14:42

5.0 Comments Option

Surgeons use this option to respond to the GENERAL COMMENTS field for a surgical case or non-O.R. procedure. This option is designed to give Surgeons an opportunity to directly add general comments after a case has been booked. The GENERAL COMMENTS field might already contain information added by the person booking the operation.

After selecting the patient case, you can add the general comments using the VA FileMan word-processing device, demonstrated below. You must press the Return key at the end of each line with this type of word processing; press the Return key again when you are through with your comments.

Example: Enter General Comments

```
Select Surgery Menu Option:  C  Comments
```

```
Select Patient: ANGEL,JOHNNY        08-15-42      099055066

1.  11/20/90   CAROTID ARTERY ENDARTERECTOMY  (COMPLETED)
2.  11/20/90   AORTO CORONARY BYPASS GRAFT  (CANCELLED)

Select Number: 1

General Comments:
  1>Patient at high risk due to severe hypertension.  Pre-operative
  2>evaluation recommended treatment by other than surgical means.
  3>This treatment, however, was unsuccessful necessitating
  4>surgery.  Patient should be monitored closely & anesthesia time
  5>kept to a minimum.
  6> <RET>
EDIT Option: <RET>

Select Surgery Menu Option:
```

6.0 CPT/ICD9 Coding Menu

The Surgery CPT/ICD9 Coding menu was developed to help assure access to the most accurate source documentation and to provide a means for efficient coding entry and validation. It provides coders special, limited access to the ***VISTA*** Surgery package.

From the menu, coders have ready access to the Operation Report, which is dictated by the surgeon postoperatively and contains the most comprehensive and accurate description of the procedure(s) actually performed. Coders can also view the Nurse Intraoperative Report, which is often an important supplementary source of data.

Using the same menu, coders can add and edit procedures, CPT codes, diagnoses, and ICD9 codes, without having to rely on a paper-based system. Options are available to assist surgery staff and others who perform coding validation, as are several commonly used reports.

The Surgery CPT/ICD9 Coding Menu contains the following options. To the left is the shortcut synonym you can enter to select the option:

EDIT CPT/ICD9 *Update/Verify Menu ...*
C *Cumulative Report of CPT Codes*
A *Report of CPT Coding Accuracy*
M *List Completed Cases Missing CPT Codes*
L *List of Operations*
LS *List of Operations (by Surgical Specialty)*
U *List of Undictated Operations*
D *Report of Daily Operating Room Activity*
PS *PCE Filing Status Report*
R *Report of Non-O.R. Procedures*

6.1 CPT/ICD9 Update/Verify Menu

The *CPT/ICD9 Update/Verify Menu* option is locked with the SR CODER security key. This menu option provides coding personnel with access to review and edit procedure and diagnosis information. It also provides access to the Operation Report and Nurse Intraoperative Report for operations and to the Non-OR Procedure Report for non-OR procedures.

The *CPT/ICD9 Update/Verify Menu* submenu contains the following options. To the left is the shortcut synonym you can enter to select the option.

UV	*Update/Verify Procedure/Diagnosis Codes*
OR	*Operation/Procedure Report*
NR	*Nurse Intraoperative Report*

To access the CPT/ICD9 Update/Verify Menu, you must first identify the patient and case on which you are working. When you select **EDIT** for the CPT/ICD9 Update/Verify Menu from the CPT/ICD9 Coding Menu, you will be prompted to enter a patient name. The computer will then list all the cases on record for the patient, including any operations that are completed or are in progress and any non-OR procedures.

```
Select CPT/ICD9 Coding Menu Option: EDIT  CPT/ICD9 Update/Verify Menu

Select Patient: DRUCKER,SAMUEL H.           02-12-28     233418719     YES     S
C VETERAN
```

```
 DRUCKER,SAMUEL H.   233-41-8719

1. 08-07-99   REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)

2. 02-24-99   CYSTOSCOPY (NON-OR PROCEDURE)

3. 02-18-99   TRACHEOSTOMY (COMPLETED)

4. 09-04-97   CHOLECYSTECTOMY (COMPLETED)

5. 09-28-95   INGUINAL HERNIA (COMPLETED)

6. 08-31-95   HIP REPLACEMENT (COMPLETED)


Select Case: 3
```

```
 DRUCKER,SAMUEL H. (233-41-8719)   Case #49124 - FEB 18,1999


   UV     Update/Verify Procedure/Diagnosis Codes
   OR     Operation/Procedure Report
   NR     Nurse Intraoperative Report

Select CPT/ICD9 Update/Verify Menu Option:
```

From this point you can select any of the CPT/ICD9 Update/Verify Menu options.

6.1.1 Update/Verify Procedure/Diagnosis Codes

Coders may use this option to review and update procedure and diagnosis information for a case. The option provides access to the free-text description of the procedure performed and the postoperative diagnosis, as well as the related CPT and ICD9 codes.

Example: Update/Verify Procedure/Diagnosis Codes Option

```
Select CPT/ICD9 Update/Verify Menu Option: UV  Update/Verify Procedure/Diagnosis
 Codes
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  NOT ENTERED

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: ?

Enter the number corresponding to the information you want to update.  You may
enter 'ALL' to update all the information displayed on this screen, or a
range of numbers separated by a ':' to update more than one item.

Select Information to Edit: 2
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------

Principal Procedure Code (CPT): 31600       INCISION OF WINDPIPE
        TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
 Modifier: 59       DISTINCT PROCEDURAL SERVICE
 Modifier:  <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: 3
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Procedures:

1. BRONCHOSCOPY
      CPT Code: NOT ENTERED
2. Enter NEW Other Procedure

Enter selection:  (1-2): 1

   BRONCHOSCOPY
      CPT Code: NOT ENTERED

OTHER PROCEDURE: BRONCHOSCOPY// <RET>
OTHER PROCEDURE CPT CODE: 31622       DX BRONCHOSCOPE/WASH
        BRONCHOSCOPY; DIAGNOSTIC, (FLEXIBLE OR RIGID), WITH OR WITHOUT CELL
        WASHING
 Modifier: <RET>

Press RETURN to continue  <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Procedures:

1. BRONCHOSCOPY
      CPT Code: 31622  DX BRONCHOSCOPE/WASH
2. Enter NEW Other Procedure

Enter selection:  (1-2): 2


Enter new OTHER PROCEDURE: ESOPHAGOSCOPY
OTHER PROCEDURE CPT CODE: 43200       ESOPHAGUS ENDOSCOPY
        ESOPHAGOSCOPY, RIGID OR FLEXIBLE;
        DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR
        WASHING (SEPARATE PROCEDURE)

 Modifier: <RET>

Press RETURN to continue  <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Procedures:

1. BRONCHOSCOPY
      CPT Code: 31622  DX BRONCHOSCOPE/WASH
2. ESOPHAGOSCOPY
      CPT Code: 43200  ESOPHAGUS ENDOSCOPY
3. Enter NEW Other Procedure

Enter selection:  (1-3): <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: 5
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------

Principal Diagnosis Code (ICD9): 934.0   934.0     FOREIGN BODY IN TRACHEA
         ...OK? Yes// <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: 6
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis

Enter selection:  (1-1): 1
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis

Enter selection:  (1-1): 1


Enter new OTHER POSTOP DIAGNOSIS: LARYNGEAL/TRACHEAL BURN
ICD DIAGNOSIS CODE: 947.1  947.1     BURN LARYNX/TRACHEA/LUNG
         ...OK? Yes// <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Postop Diagnosis:

1. LARYNGEAL/TRACHEAL BURN
      ICD9 Code: 947.1  BURN LARYNX/TRACHEA/LUNG
2. Enter NEW Other Postop Diagnosis

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

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: <RET>
```

6.1.2 Operation/Procedure Report

This option is used by the coders to print the operation report on an operation or the non-OR procedure report on a non-OR procedure.

This report prints in an 80-column format and can be viewed on your terminal screen or copied to a printer.

Example 1: Operation Report

```
Select CPT/ICD9 Update/Verify Menu Option: OR  Operation/Procedure Report
DEVICE: [Select Print Device]
```

..... *printout follows* .....

```
MEDICAL RECORD                          OPERATION REPORT     PAGE 1
CASE # 172

Preoperative Diagnosis:
  Primary: CHOLECYSTITIS                                ICD9 Code: 574.01

Surgeon:        FINE,LARRY          Surgical Priority: ELECTIVE
Attend Surgeon: HOWARD,MOE          Attend Code: 1. ATTENDING IN O.R.
1st Assistant:  REED,DANNY          2nd Assistant: N/A

Other Scrubbed Assistants: TATUM,WILLIAM

Anesthetist: DAVIS,DOUG                 Asst. Anesthetist: MOSES,DAISY
Attending Anesthesiologist: HOWARD,C.

OR Support Personnel:
  Scrubbed                              Circulating
  BARNETT,PATSY (FULLY TRAINED)         DOTY,NADINE (FULLY TRAINED)

Anesthesia Technique(s):
  GENERAL  (PRINCIPAL)
     Agent:  ETHER INH
             PHENOBARBITAL 30MG/7.5ML ELIXIR

Anesthesia Begin: MAR 09, 1999  09:15   Anesthesia End: MAR 09, 1999  12:50
Operation Begin:  MAR 09, 1999  09:45   Operation End:  MAR 09, 1999  12:30

Tubes and Drains:
  PENROSE; CYSTIC DUCT STUMP EXTERIORIZED TO LATERAL ABDOMINAL WALL

Material Sent to Laboratory for Analysis: N/A

Postoperative Diagnosis:
  Primary: CHOLECYSTITIS  ICD9 Code: 574.01

Major Operations Performed:
  Primary: CHOLECYSTECTOMY
    CPT Code: 47605  REMOVAL OF GALLBLADDER
     Modifiers: -59 DISTINCT PROCEDURAL SERVICE

Date/Time of Dictation: MAR 09, 1999  14:50
Date/Time Transcribed:  MAR 09, 1999  15:49

Indications for Operation:
  Repeated attacks of abdominal pain correlated with alcohol ingestion.
  Gallstones noted by sonar.  Increased serum amylase.  It is felt that
  cholecystectomy is indicated with cholangiography.


SURGEON'S SIG:                                  MAR 15, 1999 11:58

OAT,WILLIE                                      AGE: 49   ID#: 449-34-5555
WARD:                                           ROOM-BED:

VAMC: MAYBERRY, NC                              REPLACEMENT FORM 516
```

Surgeon's Dictation:
Patient was brought to the operating room and placed in supine position on the operating table. After endotracheal anesthesis and intravenous fluids, the patient's abdomen was prepped and draped in a sterile field. A right subcostal incision was made under the abdomen. The gallbladder was identified, dissection was taken down to the base of the gallbladder and the cystocardia was identified and ligated with 3-0 silk sutures. Further dissection at the base of the gallbladder isolated the cystic duct. Cystic duct was narrow being only 2-3 mm in size. At this point the gallbladder was dissected down free from the gallbladder bed. The cystic duct was then tied proximally and the gallbladder amputated. Next, a cholangiogram needle was inserted into the cystic duct and the cholangiogram was performed. The cholangiogram revealed a normal size common bile duct with normal intrahepatic biliary tree and free flow into the duodenum. The wound was then irrigated, hemostatis was obtained, a #10 Flat Jackson-Pratt drain was placed into the bed of the gallbladder and brought out through a separate stab incision. The wound was then closed in layers using 0-loop nylon suture, 3-0 nylon vertical mattress was used to close the skin. The patient tolerated the procedure well, estimated blood loss was 200 ccs. Sponge and needle counts reported as correct. The patient was taken to the recovery room in satisfactory condition.

SURGEON'S SIG: MAR 15, 1999 11:58

OAT,WILLIE AGE: 49 ID#: 449-34-5555
WARD: ROOM-BED:

VAMC: MAYBERRY, NC REPLACEMENT FORM 516

Example 2: Non-OR Procedure Report

```
Select CPT/ICD9 Update/Verify Menu Option: OR  Operation/Procedure Report
DEVICE: [Select Print Device]
```

..... *printout follows* .....

```
MEDICAL RECORD            |  NON-O.R. PROCEDURE REPORT   PAGE 1
                              Case #:193
Med. Specialty: GENERAL(ACUTE MEDICINE)     Location: AMBULATORY SURGERY
Principal Diagnosis:
   REFLEX SYMPATHETIC DYSTROPHY                   ICD9 CODE:
Provider: WATSON,CHERYL
Attending:                                Att Code:
Attend Anesth: JENNINGS,GEORGE A
Anesthesia Supervisor Code: 1. STAFF CASE
Anesthetist: WATSON,CHERYL
Anesthesia Technique:
     LOCAL  (PRINCIPAL)
        Agents: LIDOCAINE 1% 5ML SYRINGE


Diagnostic/Therapeutic (Y/N): YES
Anes Begin:  MAR 9,1992@09:45           Anes End:  MAR 9,1992@10:21
Proc Begin:  MAR 9,1992@09:45           Proc End:  MAR 9,1992@10:21
Procedure(s) Performed:
   Principal: STELLATE NERVE BLOCK  CPT Code: 64510
Indications for Procedure:
  CHRONIC PAIN IN RIGHT UPPER EXTREMITY.


General Comments:
  Patient at high risk due to hypertension.




PROVIDER'S SIG:                                   SEP 13, 1992  10:59
ZIFFEL,DORIS                                      AGE: 60   ID#: 353-23-3221
WARD:                                             ROOM-BED:
VAMC: MAYBERRY, NC
```

6.1.3 Nurse Intraoperative Report

This option is used by the coders to print the nurse intraoperative report for an operation.This report is not available for non-OR procedures.

This report prints in an 80-column format and can be viewed on your terminal screen or copied to a printer.

Example: Nurse Intraoperative Report

```
Select CPT/ICD9 Update/Verify Menu Option: NR  Nurse Intraoperative Report
DEVICE: [Select Print Device]
```

..... *printout follows* .....

```
MEDICAL RECORD          |   NURSE INTRAOPERATIVE REPORT        PAGE 1

Operating Room:  OR2                     Surgical Priority: ELECTIVE

Patient in Hold: MAR 09, 1999  09:00     Patient in OR:     MAR 09, 1999  09:30
Operation Begin: MAR 09, 1999  09:45     Operation End:     MAR 09, 1999  12:30
                                         Patient Out OR:    MAR 09, 1999  12:40

Surgeon:         FINE,LARRY              First Assistant:   REED,DANNY
Attending Surg:  HOWARD,MOE              Second Assistant:  N/A
Anesthetist:     DAVIS,DOUG              Assistant Anesth:  MOSES,DAISY

Other Scrubbed Assistants:
  TATUM,WILLIAM

OR Support Personnel:
  Scrubbed                               Circulating
  BARNETT,PATSY (FULLY TRAINED)          DOTY,NADINE (FULLY TRAINED)

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

Restraints and Position Aids:
    SAFETY STRAP                    Applied By: N/A

Electrocautery Unit:       7299
ESU Coagulation Range: N/A
ESU Cutting Range: N/A
Electroground Position(s): N/A

Major Operations Performed:
Primary: CHOLECYSTECTOMY
    CPT Code: 47605  REMOVAL OF GALLBLADDER
     Modifiers: -59 DISTINCT PROCEDURAL SERVICE

Anesthesia Technique(s):
  GENERAL  (PRINCIPAL)
     Agent:  ETHER INH
             PHENOBARBITAL 30MG/7.5ML ELIXIR

Tubes and Drains:
  PENROSE; CYSTIC DUCT STUMP EXTERIORIZED TO LATERAL ABDOMINAL WALL

Thermal Unit: 2695                               Temperature: 90
              Time On: MAR 09, 1999  09:50       Time Off: MAR 09, 1999  12:25

NURSE'S SIG:                                      MAR 25, 1999@13:35

OAT,WILLIE                                        449-34-5555
WARD:                                             ROOM-BED:

VAMC: MAYBERRY, NC                                SF 509 PROGRESS NOTES
```

Medications:
DIAZEPAM 5MG/ML INJ 2ML
Time Administered: MAR 09, 1999 09:55
Route: INTRAVENOUS Dosage: 10MG
Ordered By: FINE,LARRY
Administered By: BARNETT,PATSY
Comments: N/A

Irrigation Solution(s):
NORMAL SALINE
Time Used: MAR 09, 1999 10:05
Amount: 1000 Provider: BARNETT,PATSY

Blood Replacement Fluids:
RINGERS LACTATED SOLUTION Quantity: 1000 ml
Source Identification: TRAVENOL
VA Identification: VA 99-5463

Sponge Count: YES
Sharps Count: YES
Instrument Count: YES
Counter: ALLEN,KELLY
Counts Verified By: KIMBALL,HANK

Dressing: TELFA, OP SITE
Packing: N/A

Blood Loss: 200 cc's Urine Output: 1000 cc's

Postoperative Mood: RELAXED
Postoperative Consciousness: RESTING
Postoperative Skin Integrity: INTACT

Wound Classification: CLEAN
Operation Disposition: PACU (RECOVERY ROOM)

Nursing Care Comments:
Admitted with prosthesis in place; left eye an artificial eye. Foam pads applied to elbows and knees. Pillow placed under knees.

NURSE'S SIG: MAR 25, 1999@13:35

OAT,WILLIE 449-34-5555
WARD: ROOM-BED:

VAMC: MAYBERRY, NC SF 509 PROGRESS NOTES

6.2 Cumulative Report of CPT Codes

This option counts and reports the number of times a procedure was performed (based on CPT codes) during a specified date range. There is also a column showing how many times it was in the Other Operative Procedure category.

After you enter the date range, the computer will ask if you want the Cumulative Report of CPT Codes to include only operating room surgical procedures, non-OR procedures, or both.

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

Example 1: Print the Cumulative Report of CPT Codes for only OR Surgical Procedures

```
Select CPT/ICD9 Coding Menu Option: C  Cumulative Report of CPT Codes
```

```
Cumulative Report of CPT Codes

Start with Date: 3/28  (MAR 28, 1999)
End with Date: 4/3  (APR 03, 1999)
```

```
Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number:  1// <RET>

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
CUMULATIVE REPORT OF CPT CODES
FROM: MAR 28,1999 TO: APR 3,1999

REVIEWED BY
DATE REVIEWED:

O.R. SURGICAL PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	1	1	0
11440 REMOVAL OF SKIN LESION	1	1	0
11441 REMOVAL OF SKIN LESION	4	4	0
11641 REMOVAL OF SKIN LESION	4	2	2
24075 REMOVE ARM/ELBOW LESION	1	1	0
26989 HAND/FINGER SURGERY	1	1	0
30520 REPAIR OF NASAL SEPTUM	1	1	0
31231 NASAL ENDOSCOPY, DX	1	0	1
45315 PROCTOSIGMOIDOSCOPY	1	0	1
45330 SIGMOIDOSCOPY, DIAGNOSTIC	7	7	0
45333 SIGMOIDOSCOPY & POLYPECTOMY	1	1	0
45378 DIAGNOSTIC COLONOSCOPY	2	2	0
45385 COLONOSCOPY, LESION REMOVAL	3	3	0
47600 REMOVAL OF GALLBLADDER	1	0	1
49000 EXPLORATION OF ABDOMEN	1	1	0
49505 REPAIR INGUINAL HERNIA	2	1	1
66984 REMOVE CATARACT, INSERT LENS	4	3	1
68801 DILATE TEAR DUCT OPENING	1	1	0

Example 2: Print the Cumulative Report of CPT Codes for only Non-OR Procedures

```
Select CPT/ICD9 Coding Menu Option: C  Cumulative Report of CPT Codes
```

```
Cumulative Report of CPT Codes

Start with Date: 7 1 96  (JUL 01, 1996)
End with Date: 12 31 96  (DEC 31, 1996)
```

```
Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number:  1// 2

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
CUMULATIVE REPORT OF CPT CODES
FROM: JUL 1,1996 TO: DEC 31,1996

REVIEWED BY
DATE REVIEWED:

NON-O.R. PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	2	2	0
10061 DRAINAGE OF SKIN ABSCESS	1	1	0
11040 DEBRIDE SKIN PARTIAL	8	8	0
11042 DEBRIDE SKIN/TISSUE	1	1	0
11100 BIOPSY OF SKIN LESION	11	11	0
11402 REMOVAL OF SKIN LESION	1	1	0
11420 REMOVAL OF SKIN LESION	1	1	0
11620 REMOVAL OF SKIN LESION	1	1	0
11640 REMOVAL OF SKIN LESION	1	1	0
11730 REMOVAL OF NAIL PLATE	1	1	0
11750 REMOVAL OF NAIL BED	1	1	0
12001 REPAIR SUPERFICIAL WOUND(S)	3	3	0
12011 REPAIR SUPERFICIAL WOUND(S)	2	2	0
14060 SKIN TISSUE REARRANGEMENT	1	1	0
15782 ABRASION TREATMENT OF SKIN	1	1	0
17340 CRYOTHERAPY OF SKIN	1	1	0
20550 INJ TENDON/LIGAMENT/CYST	23	23	0
29799 CASTING/STRAPPING PROCEDURE	1	1	0
46083 INCISE EXTERNAL HEMORRHOID	2	2	0

6.3 Report of CPT Coding Accuracy

This report lists cases sorted by the CPT code used in the PRINCIPAL PROCEDURES field and OTHER OPERATIVE PROCEDURES field. This option is designed to help check the accuracy of the coding procedures.

About some prompts

"Do you want to print the Report of CPT Coding Accuracy for all CPT Codes?" Reply "No" to this prompt to produce the report for only one CPT code. You will then be prompted to enter the CPT code or category.

"Do you want to sort the Report of CPT Coding Accuracy by Surgical Specialty?" Press the Return key if you want to sort the report by specialty. Enter "No" to sort the report by date only.

"Do you want to print the Report to Check Coding Accuracy for all Surgical Specialties?" You can enter the code or name of the surgical service you want the report to be based on. Or, press the Return key to print the report for all surgical specialties.

Example 1: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Surgical Specialty

```
Select CPT/ICD9 Coding Menu Option: A  Report of CPT Coding Accuracy
```

```
Report to Check CPT Coding Accuracy

Start with Date: 10 8 96  (OCT 08, 1996)
End with Date: 10 8 96  (OCT 08, 1996)
```

```
Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// <RET>

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  <RET>
```

```
Do you want to sort the Report of CPT Coding Accuracy by
Surgical Specialty ?  YES//  <RET>


Do you want to print the Report to Check Coding Accuracy for all
Surgical Specialties ?  YES//  NO

Print the Coding Accuracy Report for which Surgical Specialty ?  50       GENERA
L(OR WHEN NOT DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)     50

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF CPT CODING ACCURACY
FOR GENERAL(OR WHEN NOT DEFINED BELOW)
FROM: OCT 8,1996 TO: OCT 8,1996

REVIEWED BY:
DATE REVIEWED:

O.R. SURGICAL PROCEDURES

PROCEDURE DATE / CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER / ATTEND SURG/PROV
		47600 REMOVAL OF GALLBLADDER PRINCIPAL PROCEDURES DESCRIPTION: CHOLECYSTECTOMY;	
10/08/96 07:00 63072	DUNCAN,ZACHARY 332-00-1234	CHOLECYSTECTOMY (47600-22)	FINE,LARRY ADAMS,DOC
		47605 REMOVAL OF GALLBLADDER OTHER PROCEDURES DESCRIPTION: CHOLECYSTECTOMY; WITH CHOLANGIOGRAPHY	
10/08/96 10:00 63077	WEINKIEBEAN,FUNKIE 232-34-2345	INGUINAL HERNIA (49521), OTHER OPERATIONS: CHOLECYSTECTOMY (47605-22)	REED,DANNY ADAMS,DOC
		49505 REPAIR INGUINAL HERNIA PRINCIPAL PROCEDURES DESCRIPTION: REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE	
10/08/96 06:00 63071	KREIS,ADAM 232-31-2123	INGUINAL HERNIA (49505)	ADAMS,DOC MONTALI,MICHAEL A.

Example 2: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Date

```
Select CPT/ICD9 Coding Menu Option: A  Report of CPT Coding Accuracy
```

```
Report to Check CPT Coding Accuracy

Start with Date: 10 1 96  (OCT 08, 1996)
End with Date: 10 7 96  (OCT 08, 1996)
```

```
Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// <RET>

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  <RET>
```

```
Do you want to sort the Report of CPT Coding Accuracy by
Surgical Specialty ?  YES//  N

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF CPT CODING ACCURACY
FROM: OCT 1,1996 TO: OCT 7,1996

REVIEWED BY:
DATE REVIEWED:

PAGE 1

O.R. SURGICAL PROCEDURES

PROCEDURE DATE CASE #	PATIENT ID# SPECIALTY	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
		31365 REMOVAL OF LARYNX PRINCIPAL PROCEDURES DESCRIPTION: LARYNGECTOMY; TOTAL, WITH RADICAL NECK DISSECTION	
10/03/96 07:00 63059	GRIFFIN,ROBERT 123-45-2968 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY (31365)	DAVIS,DOUG REED,DANNY
		32440 REMOVAL OF LUNG PRINCIPAL PROCEDURES DESCRIPTION: REMOVAL OF LUNG, TOTAL PNEUMONECTOMY;	
10/03/96 10:00 63060	OWENS,JAMES 123-45-8413 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY (32440)	ADAMS,DOC REED,DANNY
10/04/96 06:00 63069	LANE,TIMOTHY 123-45-1842 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY (32440)	TRAPPER,JOHN TRAPPER,JOHN
		32480 PARTIAL REMOVAL OF LUNG PRINCIPAL PROCEDURES DESCRIPTION: REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY; SINGLE LOBE (LOBECTOMY)	
10/03/96 06:00 63049	STEMBRIDGE,TOM 112-34-5678 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY (32480)	FINE,LARRY HOWARD,MOE
10/03/96 07:00 63050	GLASCOCK,DALE 516-52-4190 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY (32480)	FINE,LARRY FINE,LARRY

Example 3: Print the Report of CPT Coding Accuracy for Non-OR Procedures, sorted by CPT Code and Medical Specialty

```
Select CPT/ICD9 Coding Menu Option: A  Report of CPT Coding Accuracy
```

```
Report to Check CPT Coding Accuracy

Start with Date: 1 1 95  (JAN 01, 1995)
End with Date: 8 31 95  (AUG 31, 1995)
```

```
Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// 2

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  N


Print the Coding Accuracy Report for which CPT Code ?  92960
HEART ELECTROCONVERSION
        CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF
        ARRHYTHMIA, EXTERNAL
```

```
Do you want to sort the Report of CPT Coding Accuracy by
Medical Specialty ?  YES//  <RET>


Do you want to print the Report to Check Coding Accuracy for all
Medical Specialties ?  YES//  N


Print the Coding Accuracy Report for which Medical Specialty ?   MEDICINE

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF CPT CODING ACCURACY
FOR MEDICINE
FROM: JAN 1,1995 TO: AUG 31,1995

PAGE 1

REVIEWED BY:
DATE REVIEWED:

NON-O.R. PROCEDURES

92960 HEART ELECTROCONVERSION
PRINCIPAL PROCEDURES
DESCRIPTION: CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF ARRHYTHMIA, EXTERNAL

PROCEDURE DATE CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
01/24/95 15499	BASS,EARNEST T. 123-45-5119	CARDIOVERSION (92960)	FINE,LARRY FINE,LARRY
02/09/95 15701	MAYER,OSCAR L. 101-01-0101	CARDIOVERSION (92960)	HOWARD,MOE FINE,LARRY
03/29/95 15912	MERIWETHER,MALCOLM 212-34-3434	CARDIOVERSION (92960)	WELBY,MARCUS
08/04/95 16669	FIFE,BARNEY 222-00-1234	CARDIOVERSION (92960)	TRAPPER,JOHN ADAMS,DOC
08/25/95 16828	LAWSON,FLOYD 911-99-1111	CARDIOVERSION (92960)	FINE,LARRY FINE,LARRY

6.4 List Completed Cases Missing CPT Codes

This option generates a report of completed cases that are missing a CPT code for the principal or secondary operation(s) within a specified date range.

CPT codes need to be attributed to each procedure; only procedures that have CPT codes are included in the Annual Report of Surgical Procedures. You can use the *Operation Menu, Operation* option, to add a CPT code to a case.

After you enter the date range, the computer will ask if you want the Cumulative Report of CPT Codes to include 1) only operating room surgical procedures, 2) non-OR procedures, or 3) both.

This report is in an 80-column format and can be viewed on your terminal screen.

Example: List Completed Cases Missing CPT Codes

```
Select CPT/ICD9 Coding Menu Option: M  List Completed Cases Missing CPT Codes
```

```
Print list of Completed Cases Missing CPT Codes for

1. OR Surgical Procedures.
2. Non-OR Procedures.
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// 1
```

```
Do you want the list for all Surgical Specialties ?  YES//  <RET>

Start with Date: 2/1  (APR 01, 1999)
End with Date: 4/30  (APR 20, 1999)

Print the List of Cases Missing CPT codes to which Printer ?  [Select Print Device]
```

..... *printout follows* .....

```
                                MAYBERRY, NC
                       Completed Cases Missing CPT Codes
                            O.R. Surgical Procedures
                       From: FEB 1,1999  To: APR 30,1999
                  Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Operation Date    Patient (ID#)                            Surgeon/Provider
Case #
================================================================================
FEB 01, 1999      JACKSON,THOMAS J. (878-98-1828)          TRAPPER,JOHN
53708
                  * EXC LEFT PREAURICULAR LESION (CPT: MISSING)
--------------------------------------------------------------------------------
FEB 08, 1999      EDWARDS,JONATHAN (777-01-9119)           HOWARD,MOE
53747
                  * EXCISION LESIONS SCALP (CPT: 11420)
                  * N/A (CPT: MISSING)
--------------------------------------------------------------------------------
MAR 12, 1999      FUDD,ELMER (222-11-3333)                 FINE,LARRY
53973
                  * COLONOSCOPY (CPT: MISSING)
--------------------------------------------------------------------------------
MAR 23, 1999      FORD,JERALD C. (654-43-2109)             HOWARD,MOE
54030
                  * COLONOSCOPY/ATTEMPTED (CPT: MISSING)
--------------------------------------------------------------------------------
APR 27, 1999      DILLON,MATTHEW H (414-14-1414)           PORCINE,PERRY
54325
                  * EXCISION RT FOREARM LESIONS (CPT: MISSING)
                  * EXC LESION, RT EAR (CPT: MISSING)
                  * EXC LESION, RT FOREHEAD (CPT: MISSING)
                  * EXC LESION RT SCALP (CPT: MISSING)
                  * RXC LESION, NOSE (CPT: MISSING)
                  * EXC LESION, LEFT EAR (CPT: MISSING)
                  * EXC LESION, LEFT FOREARM (CPT: MISSING)
                  * EXC LESION, TOP OF HEAD (CPT: MISSING)
                  * EXC LESION, LEFT NECK (CPT: MISSING)
--------------------------------------------------------------------------------
```

6.5 List of Operations

This report contains general information for completed cases within a specified date range. It sorts the cases by date and includes the procedure(s), surgical service, length of actual operation, surgeons, and anesthesia technique. This report also includes aborted cases.

This report has a 132-column format and is designed to be copied to a printer.

Example: List of Operations

```
Select CPT/ICD9 Coding Menu Option: L  List of Operations
```

```
List of Operations

Start with Date:  10/8  (OCT 08, 1996)
End with Date:  10/8  (OCT 08, 1996)

This report is designed to use a 132 column format.

Print to device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
LIST OF OPERATIONS
FROM: OCT 8,1996 TO: OCT 8,1996

PAGE 1
REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: SEP 20,1999

DATE CASE #	PATIENT ID# PRIORITY	SERVICE OPERATION(S)	SURGEON 1ST ASSISTANT 2ND ASSISTANT	ANESTHESIA TECH
10/08/96 63071	KREIS,ADAM 232-31-2123 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA	ADAMS,DOC HOWARD,MOE FINE,LARRY	GENERAL OP TIME: 50 MIN.
10/08/96 63072	DUNCAN,ZACHARY 332-00-1234 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) CHOLECYSTECTOMY	FINE,LARRY ADAMS,DOC	GENERAL OP TIME: 50 MIN.
10/08/96 63073	KREIS,HEATHER 353-23-3221 URGENT, ADD TODAY	OPHTHALMOLOGY INTRAOCCULAR LENS, CHOLECYSTECTOMY	ADAMS,DOC ALEXANDER,DAVE REED,JAMES	SPINAL OP TIME: 50 MIN.
10/08/96 63074	MCGREGGOR,ALFONSE 334-55-6778 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) HIP REPLACEMENT	ADAMS,DOC REED,JAMES CARLISLE,HARALD U	NOT ENTERED OP TIME: 50 MIN.
10/08/96 63075	COLLINS,JEFFERY W 222-00-1234 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) PULMONARY LOBECTOMY	TRAPPER,JOHN WELBY,MARCUS FINE,LARRY	NOT ENTERED OP TIME: 45 MIN.
10/08/96 63077	WEINKIEBEAN,FUNKIE 232-34-2345 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA, CHOLECYSTECTOMY	REED,DANNY ALEXANDER,DAVE DAVIS,PAULETTE	GENERAL OP TIME: 63 MIN.
10/08/96 63076	UPRIGHT,WILLIAM BOLT 212-65-0036 ELECTIVE	UROLOGY TURP	MUSGROVE,STEPHEN REED,JAMES FINE,LARRY	GENERAL OP TIME: 45 MIN.

TOTAL CASES:

6.6 List of Operations (by Surgical Specialty)

This report contains general information for completed cases within a selected date range. It sorts the cases by surgical specialty and case number.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique. You can request a list for all specialties or a selected specialty.

This report has a 132-column format and is designed to be copied to a printer.

Example: List of Operations by Surgical Specialty

```
Select CPT/ICD9 Coding Menu Option: LS  List of Operations (by Surgical Specialty)
```

```
List of Operations sorted by Surgical Specialty

Start with Date:  10/4  (OCT 04, 1996)
End with Date:  10/8  (OCT 08, 1996)

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

Print the report for which Surgical Specialty ?  GENERAL (OR WHEN NOT DEFINED BELOW)

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
LIST OF OPERATIONS BY SERVICE
FROM: OCT 4,1996 TO: OCT 8,1996

PAGE 1
DATE REVIEWED:
REVIEWED BY:
DATE PRINTED: SEP 20,1999

DATE CASE #	PATIENT ID# PRIORITY	OPERATION(S)	SURGEON FIRST ASSISTANT SECOND ASSISTANT	ANESTHESIA TECHNIQUE
		GENERAL(OR WHEN NOT DEFINED BELOW)		
10/04/96 63066	COLLINS,JACK 123-45-5119 STANDBY	INGUINAL HERNIA	WELBY,MARCUS FINE,LARRY HOWARD,MOE	GENERAL OP TIME: 40 MIN.
10/04/96 63067	DAVIS,IRWIN 123-45-2182 ELECTIVE	INGUINAL HERNIA	ADAMS,DOC HOWARD,MOE FINE,LARRY	GENERAL OP TIME: 50 MIN.
10/04/96 63068	HELMS,MICHEAL 123-45-4886 ELECTIVE	INGUINAL HERNIA	WELBY,MARCUS HOWARD,MOE FINE,LARRY	GENERAL OP TIME: 45 MIN.
10/07/96 63070	HODGE,MARILYN 231-21-2234 ELECTIVE	INGUINAL HERNIA	TRAPPER,JOHN ADAMS,DOC	GENERAL OP TIME: 45 MIN.
10/08/96 63071	KREIS,ADAM 232-31-2123 ELECTIVE	INGUINAL HERNIA	ADAMS,DOC HOWARD,MOE FINE,LARRY	GENERAL OP TIME: 50 MIN.
10/08/96 63072	DUNCAN,ZACHARY 332-00-1234 ELECTIVE	CHOLECYSTECTOMY	FINE,LARRY ADAMS,DOC	GENERAL OP TIME: 50 MIN.
10/08/96 63077	WEINKIEBEAN,FUNKIE 232-34-2345 ELECTIVE	INGUINAL HERNIA, CHOLECYSTECTOMY	REED,DANNY ALEXANDER,DAVE DAVIS,PAULETTE	GENERAL OP TIME: 63 MIN.

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 7

6.7 List of Undictated Operations

This option provides a list of all completed cases that do not have responses in the DATE/TIME OF DICTATION field. Transcription procedures at the local institutional level can affect which cases appear on the list. This option is designed for the Chief of Surgery to check on cases that still require dictation. It is also located in the *Chief of Surgery* menu.

This list is in an 80-column format an can be viewed on your terminal display screen.

Example: Print List of Undicated Operations

```
Select CPT/ICD9 Coding Menu Option: U  List of Undictated Operations
```

```
List of Undictated Operations


How do you want this report printed ?

   (1) Print ALL undictated operations.
   (2) Print undictated operations for a selected DATE range.

Enter selection: 1// <RET>
Print the Report on which Device:  [Select Print Device]
```

..... *printout follows* .....

```
          UNDICTATED OPERATIONS FOR GENERAL
          DATE PRINTED: 03/27/93

CASE #    PATIENT                                SURGEON
          OPERATION DATE                         WARD LOCATION
==============================================================================

 13       JAMES,TERRELL (217-63-5402)            FINE,LARRY
          AUG 16, 1992@09:45                     OUTPATIENT
          CHOLECYSTECTOMY

          UNDICTATED OPERATIONS FOR NEUROSURGERY
          DATE PRINTED: 03/27/93

CASE #    PATIENT                                SURGEON
          OPERATION DATE                         WARD LOCATION
==============================================================================

 18       BELL,MARY (467-87-3456)                HOWARD,MOE
          AUG 16, 1992@11:15                     OUTPATIENT
          FRONTAL CRANIOTOMY

          UNDICTATED OPERATIONS FOR PERIPHERAL VASCULAR
          DATE PRINTED: 03/27/93

CASE #    PATIENT                                SURGEON
          OPERATION DATE                         WARD LOCATION
==============================================================================

 249      CLAMPETT,J.D. (665-37-0555)            FINE,LARRY
          FEB 11, 1993                           1 NORTH 162-1
          HARVEST SAPHENOUS VEIN

          UNDICTATED OPERATIONS FOR THORACIC SURGERY
          DATE PRINTED: 03/27/93

CASE #    PATIENT                                SURGEON
          OPERATION DATE                         WARD LOCATION
==============================================================================

 250      FRANKLIN,BENJAMIN (287-38-1876)        FINE,LARRY
          FEB 11, 1993                           OUTPATIENT
          HARVEST SAPHENOUS VEIN
```

6.8 Report of Daily Operating Room Activity

This option generates a report listing cases started between 7:30 AM on the date selected and 7:29 AM of the following day for all operating rooms.

This report has a 132-column format and is designed to be copied to a printer.

Example: Print the Report of Daily Operating Room Activity

```
Select CPT/ICD9 Coding Menu Option: D  Report of Daily Operating Room Activity


Print the Report of Daily Activity for which Date ?  3/9  (MAR 09, 1992)

This report will include all cases started between MAR  9, 1992 at 6:00 AM
and MAR 10, 1992 at 5:59 AM.

It is designed to use a 132 column format.

Print the Report to which Device ? [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
DAILY REPORT OF OPERATING ROOM ACTIVITY
FOR: MAR 09, 1992

PATIENT ID # WARD	AGE	TIME IN OR TIME OUT OR CASE NUMBER	POSTOPERATIVE DIAGNOSIS PROCEDURE(S)	ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
OPERATING ROOM: OR1					
DRUCKER,SAM		03/09 08:00	INGUINAL HERNIA	BARRON,L	ADAMS,D
233-41-8719	61	03/09 09:10	INGUINAL HERNIA	ALEXANDER,D	DOOLITTLE,J
1 NORTH 161-1		194			FINE,L
OPERATING ROOM: OR3					
OAT,WILLIE		03/09 09:15	CHOLECYSTITIS	JENNINGS,G	FINE,L
449-34-5555	49	03/09 12:40	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	WATSON,C	REED,J
OUTPATIENT		187			HOWARD,M
OPERATING ROOM: OR5					
FIFE,BARNEY		03/09 19:56	APPENDICITIS	JENNINGS,G	BRONSTEIN,S
222-00-1234	50	03/09 21:05	APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY, CRAIN	DOOLITTLE,J	REED,J
1 WEST 101-1		188			REED,D

6.9 PCE Filing Status Report

This option provides a report of the PCE filing status of completed cases performed during the selected date range in accordance with the site parameter controlling PCE updates. If this site parameter is turned off, the report will show no cases. The report may be printed for OR surgical cases, non-OR procedures or both. The report may also be printed for all specialties or for a single specialty only.

This report is intended to be used as a tool in the review of Surgery case information that is passed automatically to PCE. The report uses 5 status categories:

(1) FILED - This status indicates that case information has already been filed with PCE.
(2) QUEUED TO FILE - This status indicated the case is queued to file with PCE next time the Surgery nightly maintenance job runs.
(3) UPDATE QUEUED - This status indicates that information passed to PCE has been updated after the case was filed with PCE and PCE will be updated the next time the Surgery nightly maintenance job runs.
(4) NOT QUEUED - This status indicates the case is missing information required for filing with PCE.
(5) UNCERTAIN - If the UPDATES TO PCE site parameter is set to file outpatient cases only, this status indicates the IN/OUT-PATIENT STATUS field is null.

Two forms of the report are available, the long and the short. The long form uses a 132 column format and prints case information including the surgeon/provider, the attending, the specialty, the principal post-op diagnosis, and the principal procedure. If the PCE filing status is FILED, QUEUED TO FILE or UPDATE QUEUED the CPT codes and ICD diagnosis codes will be printed. If the filing status is NOT QUEUED or UNCERTAIN, information fields needed for PCE filing that do not contain data will be printed. At the end of the report, the number of cases in each PCE filing status will be printed, plus the number of CPT and ICD codes for cases with a status of FILED, QUEUED TO FILE, and UPDATE QUEUED.

The short form uses an 80 column format and does not include surgeon/provider, attending, principal post-op diagnosis and CPT and ICD code information. The totals printed at the end will show only the total cases for each status. This option generates a report listing cases started between 7:30 AM on the date selected and 7:29 AM of the following day for all operating rooms.

Example 1: PCE Filing Status Report (Short Form)

```
Select CPT/ICD9 Coding Menu Option: PS  PCE Filing Status Report
```

```
                          Report of PCE Filing Status

This report displays the filing status of completed cases performed during the
selected date range.


Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <RET>
```

```
Do you want the report for all Surgical Specialties ? YES// NO

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

Start with Date: 10/3/96  (OCT 03, 1996)
End with Date: 10/3/96  (OCT 03, 1996)

Print the long form or the short form ? SHORT// <RET>

Print the PCE Filing Status Report to which Printer ? [Select Print Device]
```

..... *printout follows* .....

```
                                MAYBERRY, NC
                          PCE FILING STATUS REPORT                    PAGE 1
                     For Completed O.R. Surgical Procedures
                        From: OCT 3,1996  To: OCT 3,1996
                      Report Printed: OCT 15,1996@10:29

DATE OF OPERATION     PATIENT NAME          PATIENT ID  (AGE)     FILING STATUS
CASE #                SPECIALTY                                   SCHED STATUS
                      PRINCIPAL PROCEDURE
================================================================================
OCT 3,1996@06:00      SMITH,JAMES           123-45-7684  (76)     FILED
63052                 GENERAL(OR WHEN NOT                         CHECKED OUT
                      INGUINAL HERNIA
--------------------------------------------------------------------------------
OCT 3,1996@06:00      COX,FRED              123-45-5000  (39)     FILED
63062                 GENERAL(OR WHEN NOT                         CHECKED OUT
                      CHOLECYSTECTOMY
--------------------------------------------------------------------------------
OCT 3,1996@08:00      MORRIS,THOMAS         123-45-6111  (60)     FILED
63054                 GENERAL(OR WHEN NOT                         CHECKED OUT
                      INGUINAL HERNIA
--------------------------------------------------------------------------------
OCT 3,1996@11:00      STEVENS,DOUGLAS       123-45-7924  (54)     FILED
63061                 GENERAL(OR WHEN NOT                         CHECKED OUT
                      INGUINAL HERNIA
--------------------------------------------------------------------------------
OCT 3,1996@13:00      PERKINS,DAVID         123-45-4279  (85)     UPDATE QUEUED
63064                 GENERAL(OR WHEN NOT                         CHECKED OUT
                      APPENDECTOMY
--------------------------------------------------------------------------------

             FILED:     4
    QUEUED TO FILE:     0
     UPDATE QUEUED:     1
        NOT QUEUED:     0
                      -----
       TOTAL CASES:     5
```

Example 2: PCE Filing Status Report (Long Form)

```
Select CPT/ICD9 Coding Menu Option: PS  PCE Filing Status Report
```

```
                          Report of PCE Filing Status

This report displays the filing status of completed cases performed during the
selected date range.


Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <RET>
```

```
Do you want the report for all Surgical Specialties ? YES// NO

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

Start with Date: 10/3/96  (OCT 03, 1996)
End with Date: 10/3/96  (OCT 03, 1996)

Print the long form or the short form ? SHORT// LONG

Print the PCE Filing Status Report to which Printer ? [Select Print Device]
```

..... *printout follows* .....

```
                                   MAYBERRY, NC
                              PCE FILING STATUS REPORT                                                    PAGE 1
                          For Completed O.R. Surgical Procedures
                             From: OCT 3,1996  To: OCT 3,1996
                            Report Printed: OCT 15,1996@10:33

DATE OF OPERATION     PATIENT NAME              SURGEON              SPECIALTY                                PCE FILING STATUS
CASE #                PATIENT ID  (AGE)         ATTENDING            PRINCIPAL POST-OP DIAGNOSIS              SCHED STATUS
                      PRINCIPAL PROCEDURE
==================================================================================================================================
OCT 3,1996@06:00      SMITH,JAMES               FINE,LARRY           GENERAL(OR WHEN NOT DEFINED BELOW)       UPDATE QUEUED
63052                 123-45-7684  (76)         REED,DANNY           BILATERAL INGUINAL HERNIA                CHECKED OUT
                      INGUINAL HERNIA

 CPT Code: 49505  REPAIR INGUINAL HERNIA                             ICD Diagnosis Code: 550.02  BILAT ING HERNIA W GANG
  Modifiers: -76 REPEAT PROCEDURE BY SAME PHYSICIAN
----------------------------------------------------------------------------------------------------------------------------------
OCT 3,1996@06:00      COX,FRED                  MUSGROVE,STEPHEN     GENERAL(OR WHEN NOT DEFINED BELOW)       UPDATE QUEUED
63062                 123-45-5000  (39)         MONOSKY,ALAN         GALLSTONES                               CHECKED OUT
                      CHOLECYSTECTOMY

 CPT Code: 47605  REMOVAL OF GALLBLADDER                             ICD Diagnosis Code: 575.2  OBSTRUCTION GALLBLADDER
  Modifiers: -66 SURGICAL TEAM                                       ICD Diagnosis Code: 540.1  ABSCESS OF APPENDIX
 CPT Code: 44960  APPENDECTOMY
  Modifiers: -32 MANDATED SERVICES
----------------------------------------------------------------------------------------------------------------------------------
OCT 3,1996@08:00      MORRIS,THOMAS             MUSGROVE,STEPHEN     GENERAL(OR WHEN NOT DEFINED BELOW)       FILED
63054                 123-45-6111  (60)         REED,DANNY           NOT ENTERED                              CHECKED OUT
                      INGUINAL HERNIA

 CPT Code: 49505  REPAIR INGUINAL HERNIA                             ICD Diagnosis Code: 550.02  BILAT ING HERNIA W GANG
----------------------------------------------------------------------------------------------------------------------------------
OCT 3,1996@11:00      STEVENS,DOUGLAS           REED,DANNY           GENERAL(OR WHEN NOT DEFINED BELOW)       FILED
63061                 123-45-7924  (54)         MUSGROVE,STEPHEN     NOT ENTERED                              CHECKED OUT
                      INGUINAL HERNIA

 CPT Code: 49507  REPAIR, INGUINAL HERNIA                            ICD Diagnosis Code: 550.92  BILAT INGUINAL HERNIA
----------------------------------------------------------------------------------------------------------------------------------
```

```
OCT 3,1996@13:00      PERKINS,DAVID              REED,DANNY            GENERAL(OR WHEN NOT DEFINED BELOW)        UPDATE QUEUED
63064                 123-45-4279  (85)          DAVIS,DOUG            ACUTE APPENDICITIS                        CHECKED OUT
                      APPENDECTOMY

 CPT Code: 44950  APPENDECTOMY                                         ICD Diagnosis Code: 540.9  ACUTE APPENDICITIS NOS
-------------------------------------------------------------------------------------------------------------------------------------
                            CPT     ICD
                     CASES  CODES   CODES
             FILED:      2      2       2
    QUEUED TO FILE:      0      0       0
     UPDATE QUEUED:      3      4       4
        NOT QUEUED:      0
                     -----  -----   -----
             TOTAL:      5      6       6
```

6.10 Report of Non-O.R. Procedures

This report will chronologically list non-O.R. procedures sorted by surgical specialty or surgeon. This report can be sorted by specialty, provider, or location.

This report prints in a 132-column format and must be copied to a printer.

Example 1: Report of Non-O.R. Procedures by Specialty

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

```
Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1992)
End with Date: 3/31  (MAR 31, 1992)
```

```
How do you want the report sorted ?

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

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

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

Print the Report for which Specialty ?  CARDIOLOGY


This report is designed to use a 132 column format.

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

..... *printout follows* .....

```
                                   MAYBERRY, NC
                                SURGICAL SERVICE                          REVIEWED BY:
                           REPORT OF NON-O.R. PROCEDURES                  DATE REVIEWED:
                         FROM: MAR 1,1992  TO: MAR 31,1992

DATE          PATIENT (ID#)                          PROVIDER                                   START TIME
CASE #        LOCATION (IN/OUT-PAT STATUS)           PROCEDURE(S)                               FINISH TIME
==================================================================================================================
                                   *** SPECIALTY: CARDIOLOGY ***

03/02/92      DRUCKER,SAM (233-41-8719)              DOOLITTLE,JAMES A.                         03/02/92 13:05
501           AMBULATORY SURGERY (OUTPATIENT)        CARDIOVERSION                              03/02/92 14:10

03/13/92      HATHAWAY,JANE (333-33-3333)            FINE,LARRY                                 03/13/92 14:00
500           ICU (INPATIENT)                        CARDIOVERSION                              03/13/92 14:25
```

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

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

```
Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1992)
End with Date: 3/31  (MAR 31, 1992)
```

```
How do you want the report sorted ?

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

Select Number:  1// 2
```

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

Print the Report for which Provider ?  BRONSTEIN

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1992 TO: MAR 31,1992

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	SPECIALTY PROCEDURE(S)	START TIME FINISH TIME
	*** PROVIDER BRONSTEIN,SOLOMON ABRAM ***		
03/12/92	MUSHNICK,GRAVIS (451-23-6987)	PSYCHIATRY	03/12/92 08:00
195	PAC(U) - ANESTHESIA (INPATIENT)	ELECTROCONVULSIVE THERAPY	03/12/92 09:00
03/23/92	MUSHNICK,GRAVIS (451-23-6987)	PSYCHIATRY	03/23/92 08:10
240	PAC(U) - ANESTHESIA (INPATIENT)	ELECTROCONVULSIVE THERAPY	03/23/92 08:40
03/25/92	MUSHNICK,GRAVIS (451-23-6987)	PSYCHIATRY	03/12/92 09:30
266	PAC(U) - ANESTHESIA (INPATIENT)	ELECTROCONVULSIVE THERAPY	03/12/92 10:15

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

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

```
Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1992)
End with Date: 3/31  (MAR 31, 1992)
```

```
How do you want the report sorted ?

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

Select Number:  1// 3
```

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

Print the Report for which Location ?  AMBULATORY SURGERY

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1992 TO: MAR 31,1992

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) SPECIALTY (IN/OUT-PAT STATUS)	PROVIDER PROCEDURE(S)	START TIME FINISH TIME
	*** LOCATION: AMBULATORY SURGERY ***		
03/02/92 201	DRUCKER,SAM (233-41-8719) CARDIOLOGY (OUTPATIENT)	DOOLITTLE,JAMES A. CARDIOVERSION	03/02/92 13:05 03/02/92 14:10
03/06/92 198	PETRIE,ROBERT (123-45-4886) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	REED,JAMES EXCISION OF SKIN LESION	03/07/92 16:30 03/07/92 17:08
03/09/92 193	ZIFFEL,DORIS (353-23-3221) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	WATSON,CHERYL STELLATE NERVE BLOCK	03/09/92 09:45 03/09/92 10:21
03/13/92 200	HATHAWAY,JANE (333-33-3333) CARDIOLOGY (INPATIENT)	FINE,LARRY CARDIOVERSION	03/13/92 14:00 03/13/92 14:25
03/17/92 194	TAYLOR,OPIE (112-22-3334) GENERAL SURGERY (OUTPATIENT)	REED,JAMES EXCISION OF SKIN LESION	03/17/92 13:30 03/17/92 14:42

Chapter Three: Generating Surgical Reports

Introduction

Surgery software integrates clinical and patient data to provide a variety of reports for Surgery Service management. This chapter describes reports that are generated for Surgical Service staff. Among the reports generated are the Annual Report of Surgical Procedures, Anesthesia AMIS, Attending Surgeons Report, and Nurse Staffing Report.

Getting Out of an Option

To stop what you are doing, enter an up-arrow (^). You can use the up-arrow at almost any prompt to terminate the line of questioning and return to the previous level in the option. Continue entering up-arrows to completely exit the system.

Overview

The main options included in this chapter are listed below. The Surgery Reports option contains submenus. To the left of the option name is the shortcut synonym you can enter to select the option. A restricted option (such as Surgery Reports) will not display if you do not have security clearance for that option.

SR	*Surgery Reports*
L	*Laboratory Interim Report*

1.0 Surgery Reports

The Chief of Surgery and staff members use this submenu to select various reports for the Surgical Service. Among the reports generated are the Annual Report of Surgical Procedures, Anesthesia AMIS, Attending Surgeons Report, and Nurse Staffing Report. This menu is locked with the SROREP key.

All of the menu items below contain sub-options. To the left of the menu name is the shortcut synonym you can enter to select the option:

M	*Management Reports*
S	*Surgery Staffing Reports*
A	*Anesthesia Reports*
CPT	*CPT Code Reports*

1.1 Management Reports

This option provides access to the Management Reports submenu. These sub-options generate reports on completed cases, meaning cases that have an entry for the TIME PAT OUT OR field.

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

S	*Schedule of Operations*
A	*Annual Report of Surgical Procedures*
L	*List of Operations*
LD	*List of Operations (by Postoperative Disposition)*
LS	*List of Operations (by Surgical Specialty)*
LP	*List of Operations (by Surgical Priority)*
P	*Report of Surgical Priorities*
U	*List of Undictated Operations*
D	*Report of Daily Operating Room Activity*
PS	*PCE Filing Status Report*
NOX	*Outpatient Encounters Not Transmitted to NPCD*

1.1.1 Schedule of Operations

This option generates the Operating Room Schedule used by the operating room nurses, surgeons, anesthetists and other hospital services. The report lists operations and patients scheduled for a particular date. It sorts by operating room and includes the procedure(s), blood products requested, and any preoperative x-rays requested. The schedule also provides anesthesia information and surgeon names.

This report can be printed on multiple printers simultaneously. Use the options included within the *Surgery Package Management Menu* to enter the name of all printers on which the schedule will print.

This report has a 132-column format and is designed to be copied to a printer with wide paper.

Example: Print Schedule of Operations

```
Select Management Reports Option:  S  Schedule of Operations

Print Schedule of Operations for which date ?   9/8  (SEP 08, 1999)

This report is designed to use a 132 column format.

Print the Report on which device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
SCHEDULE OF OPERATIONS
FOR: SEP 08, 1999

PRINTED: SEP 07, 1999 11:12

SIGNATURE OF CHIEF: DR. MOE HOWARD
_____

```
PATIENT                 DISPOSITION      PREOPERATIVE DIAGNOSIS                          REQ ANESTHESIA          SURGEON
ID#            AGE      START TIME       OPERATION(S)                                    ANESTHESIOLOGIST        FIRST ASST.
WARD                     END TIME                                                         PRIN. ANESTHETIST       ATT SURGEON
==================================================================================================================================

OPERATING ROOM: OR1

ZOOM,BILLY               WARD             CARPAL TUNNEL SYNDROME                          GENERAL                 HOWARD, M
231-44-7629      46      07:30            REVISE MEDIAN NERVE                             REED, D                 WELBY, M
TO BE ADMITTED           09:30                                                            MUSGROVE, S             HOWARD, M
Case # 143
                         PREOPERATIVE XRAYS: CARPAL TUNNEL, R WRIST


OPERATING ROOM: OR2

ZIFFEL,ARNOLD            WARD             CHOLELITHIASIS                                  GENERAL                 HOWARD, M
122-32-4569      36      06:30            CHOLECYSTECTOMY                                 JENNINGS, G             FINE, L
HICU  212-B              08:00                                                            WATSON, C               HOWARD, M
Case # 141               REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH
                         CPDA-1 RED BLOOD CELLS - 2 UNITS
                         PREOPERATIVE XRAYS: ABDOMIN

DRUCKER,SAMUEL HORATIO   WARD             ACUTE DIAPHRAGMATIC HERNIA                      GENERAL                 FINE, L
233-41-8719      71      08:00            REPAIR DIAPHRAGMATIC HERNIA                     JENNINGS, G             HOWARD, M
TO BE ADMITTED           09:30                                                            WATSON, C               FINE, L
Case # 142               REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH
                         CPDA-1 RED BLOOD CELLS - 2 UNITS
                         PREOPERATIVE XRAYS: ABDOMEN

ZINN,RICHARD             WARD             CAROTID ARTERY STENOSIS                         GENERAL                 HOWARD, M
743-82-9472      48      11:15            CAROTID ARTERY ENDARTERECTOMY                   JENNINGS, G             REED, J
TO BE ADMITTED           16:00                                                            WATSON, C               HOWARD, M
                           ** Concurrent Case #157    AORTO CORONARY BYPASS GRAFT
Case # 150               REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH
                         CPDA-1 RED BLOOD CELLS - UNITS NOT ENTERED
                         CPDA-1 WHOLE BLOOD - 2 UNITS
                         PREOPERATIVE XRAYS: DOPPLER STUDIES

ZINN,RICHARD             WARD             CORONARY ARTERY DISEASE                         GENERAL                 FINE, L
743-82-9472      48      11:15            AORTO CORONARY BYPASS GRAFT                     JENNINGS, G             ADAMS, D
TO BE ADMITTED           16:00                                                            WATSON, C               FINE, L
                           ** Concurrent Case #150    CAROTID ARTERY ENDARTERECTOMY
Case # 157


TOTAL CASES SCHEDULED: 5
```

1.1.2 Annual Report of Surgical Procedures

This option is used to generate the Annual Report of Surgical Procedures required by VA Central Office. This report counts the number of times a procedure was performed, based on the CPT code entry, within a surgical specialty.

The report includes only cases that have not been cancelled and that have an entry for the TIME PAT OUT OR field. Procedures without CPT codes are not included in this report.

You can generate this report for any date range, not only annually.

This report has a 132-column format and is designed to be copied to a printer.

Example: Annual Report of Surgical Procedures

```
Select Management Reports Option:  A  Annual Report of Surgical Procedures
```

```
Annual Report of Surgical Procedures

Start with Date:  9/1  (SEP 01, 1996)
End with Date:  9/30  (SEP 30, 1996)

Do you want to print the Annual Report of Surgical Procedures for all Surgical
Specialties?  YES//  <RET>

This report is designed to use a 132 column format, and must be run on a printer.

Select Printer:  [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
ANNUAL REPORT OF SURGICAL PROCEDURES
FROM: SEP 1,1996 TO: SEP 30,1996

PAGE: 1
REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: OCT 20,1996

CPT CODE - OPERATION	TOTAL	MAJOR STAFF	MAJOR RESIDENT	MAJOR TOTAL	MINOR STAFF	MINOR RESIDENT	MINOR TOTAL
NEUROSURGERY							
61304 OPEN SKULL FOR EXPLORATION	1	1	0	1	0	0	0
61680 INTRACRANIAL VESSEL SURGERY	1	0	0	0	1	0	1
TOTALS FOR NEUROSURGERY:	2	1	0	1	1	0	1
ORTHOPEDICS							
27130 TOTAL HIP REPLACEMENT	2	0	0	0	1	1	2
27236 REPAIR OF THIGH FRACTURE	1	0	0	0	0	1	1
TOTALS FOR ORTHOPEDICS:	3	0	0	0	1	2	3
OTORHINOLARYNGOLOGY (ENT)							
31365 REMOVAL OF LARYNX	2	0	0	0	2	0	2
TOTALS FOR OTORHINOLARYNGOLOGY (ENT):	2	0	0	0	2	0	2
THORACIC SURGERY (INC. CARDIAC SURG.)							
32480 PARTIAL REMOVAL OF LUNG	2	0	0	0	1	1	2
32500 PARTIAL REMOVAL OF LUNG	1	0	0	0	1	0	1
33510 CABG, VEIN, SINGLE	1	0	0	0	0	1	1
TOTALS FOR THORACIC SURGERY (INC. CARDIAC SURG.):	4	0	0	0	2	2	4
TOTAL OPERATIONS:	11	1	0	1	6	4	10

1.1.3 List of Operations

This report contains general information for completed cases within a specified date range. It sorts the cases by date and includes the procedure(s), surgical service, length of actual operation, surgeons, and anesthesia technique. This report also includes aborted cases.

This report has a 132-column format and is designed to be copied to a printer.

Example: List of Operations

```
Select Management Reports Option:  L  List of Operations
```

```
List of Operations

Start with Date:  10/8  (OCT 08, 1996)
End with Date:  10/8  (OCT 08, 1996)

This report is designed to use a 132 column format.

Print to device:    [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
LIST OF OPERATIONS
FROM: OCT 8,1996 TO: OCT 8,1996

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: SEP 20,1999

DATE CASE #	PATIENT ID# PRIORITY	SERVICE OPERATION(S)	SURGEON 1ST ASSISTANT 2ND ASSISTANT	ANESTHESIA TECH
10/08/96 63071	KREIS,ADAM 232-31-2123 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA	ADAMS,DOC HOWARD,MOE FINE,LARRY	GENERAL OP TIME: 50 MIN.
10/08/96 63072	DUNCAN,ZACHARY 332-00-1234 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) CHOLECYSTECTOMY	FINE,LARRY ADAMS,DOC	GENERAL OP TIME: 50 MIN.
10/08/96 63073	KREIS,HEATHER 353-23-3221 URGENT, ADD TODAY	OPHTHALMOLOGY INTRAOCCULAR LENS, CHOLECYSTECTOMY	ADAMS,DOC ALEXANDER,DAVE REED,JAMES	SPINAL OP TIME: 50 MIN.
10/08/96 63074	MCGREGGOR,ALFONSE 334-55-6778 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) HIP REPLACEMENT	ADAMS,DOC REED,JAMES CARLISLE,HARALD U	NOT ENTERED OP TIME: 50 MIN.
10/08/96 63075	COLLINS,JEFFERY W 222-00-1234 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) PULMONARY LOBECTOMY	TRAPPER,JOHN WELBY,MARCUS FINE,LARRY	NOT ENTERED OP TIME: 45 MIN.
10/08/96 63077	WEINKIEBEAN,FUNKIE 232-34-2345 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA, CHOLECYSTECTOMY	REED,DANNY ALEXANDER,DAVE DAVIS,PAULETTE	GENERAL OP TIME: 63 MIN.
10/08/96 63076	UPRIGHT,WILLIAM BOLT 212-65-0036 ELECTIVE	UROLOGY TURP	MUSGROVE,STEPHEN REED,JAMES FINE,LARRY	GENERAL OP TIME: 45 MIN.

TOTAL CASES: 7

1.1.4 List of Operations (by Postoperative Disposition)

This report contains general information for completed cases within a selected date range. It sorts the cases by postoperative disposition and by case number. Reports may also be sorted by specialty.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique.

This report has a 132-column format and is designed to be copied to a printer.

Example 1: List of Operations by Postoperative Disposition (All Dispositions)

```
Select Management Reports Option: LD  List of Operations (by Postoperative
Disposition)
```

```
List of Operations by Postoperative Disposition:



Start with Date: 10/8  (OCT 08, 1996)
End with Date: 10/8  (OCT 08, 1996)
```

```
Print the List of Operations for which of the following ?

          1. All Dispositions
          2. A Specific Disposition
          3. No Disposition Entered

Enter selection: 1// 1  All Dispositions

Do you want the report sorted by surgical specialty ?  Y// <RET>

Print for all surgical specialties ?  Y// N

Print the report for which Specialty ?  GENERAL(OR WHEN NOT DEFINED BELOW)

Select An Additional Specialty: <RET>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
LIST OF OPERATIONS BY POSTOP DISPOSITION
FROM: OCT 8,1996 TO: OCT 8,1996
POSTOP DISPOSITION: WARD

DATE PRINTED: OCT 20,1996
REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT ID#	OPERATION(S)	SURGEON 1ST ASST 2ND ASST	ANESTHESIA TECH IN/OUT-PAT STATUS OP TIME
>> GENERAL(OR WHEN NOT DEFINED BELOW) <<				
10/08/96 63072	DUNCAN,ZACHARY 332-00-1234	CHOLECYSTECTOMY	FINE,LARRY ADAMS,DOC	GENERAL OUTPATIENT 50 MIN.
10/08/96 63077	WEINKIEBEAN,FUNKIE 232-34-2345	INGUINAL HERNIA, CHOLECYSTECTOMY	REED,DANNY ALEXANDER,DAVE DAVIS,PAULETTE	GENERAL OUTPATIENT 63 MIN.
10/08/96 63071	KREIS,ADAM 232-31-2123	INGUINAL HERNIA	ADAMS,DOC HOWARD,MOE FINE,LARRY	GENERAL OUTPATIENT 50 MIN.

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW)

Example 2: List of Operations by Postoperative Disposition (A Specific Disposition)

```
Select Management Reports Option: LD  List of Operations (by Postoperative
Disposition)
```

```
List of Operations by Postoperative Disposition:



Start with Date: 10/4  (OCT 04, 1996)
End with Date: 10/8  (OCT 08, 1996)
```

```
Print the List of Operations for which of the following ?

          1. All Dispositions
          2. A Specific Disposition
          3. No Disposition Entered

Enter selection: 1// 2  A Specific Disposition

Print the report for which Disposition ?  OUTPATIENT       O

Do you want the report sorted by surgical specialty ?  Y// N

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
LIST OF OPERATIONS BY POSTOP DISPOSITION
FROM: OCT 4,1996 TO: OCT 8,1996
POSTOP DISPOSITION: OUTPATIENT

DATE PRINTED: OCT 20,1996
REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT ID#	OPERATION(S)	SURGEON 1ST ASST 2ND ASST	ANESTHESIA TECH IN/OUT-PAT STATUS OP TIME
10/04/96 63066	COLLINS,JACK 123-45-5119 (GENERAL)	INGUINAL HERNIA	WELBY,MARCUS FINE,LARRY HOWARD,MOE	GENERAL OUTPATIENT 40 MIN.
10/04/96 63067	DAVIS,IRWIN 123-45-2182 (GENERAL)	INGUINAL HERNIA	ADAMS,DOC HOWARD,MOE FINE,LARRY	GENERAL OUTPATIENT 50 MIN.
10/04/96 63068	HELMS,MICHEAL 123-45-4886 (GENERAL)	INGUINAL HERNIA	WELBY,MARCUS HOWARD,MOE FINE,LARRY	GENERAL OUTPATIENT 45 MIN.
10/07/96 63070	HODGE,MARILYN 231-21-2234 (GENERAL)	INGUINAL HERNIA	TRAPPER,JOHN ADAMS,DOC	GENERAL OUTPATIENT 45 MIN.
10/08/96 63071	KREIS,ADAM 232-31-2123 (GENERAL)	INGUINAL HERNIA	ADAMS,DOC HOWARD,MOE FINE,LARRY	GENERAL OUTPATIENT 50 MIN.

TOTAL OUTPATIENT: 5

Example 3: List of Operations by Postoperative Disposition (No Disposition Entered)

```
Select Management Reports Option: LD  List of Operations (by Postoperative
Disposition)
```

```
List of Operations by Postoperative Disposition:



Start with Date: 10/4  (OCT 04, 1996)
End with Date: 10/8  (OCT 08, 1996)
```

```
Print the List of Operations for which of the following ?

          1. All Dispositions
          2. A Specific Disposition
          3. No Disposition Entered

Enter selection: 1// 3  No Disposition Entered

Do you want the report sorted by surgical specialty ?  Y// N

This report is designed to use a 132 column format.
Print the Report on which Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
LIST OF OPERATIONS BY POSTOP DISPOSITION
FROM: OCT 4,1996 TO: OCT 8,1996
POSTOP DISPOSITION: DISPOSITION NOT ENTERED

PAGE 1

DATE PRINTED: SEP 20,1999
REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT ID#	OPERATION(S)	SURGEON 1ST ASST 2ND ASST	ANESTHESIA TECH IN/OUT-PAT STATUS OP TIME
10/04/96 63069	LANE,TIMOTHY 123-45-1842 (THORACIC SURGERY)	PULMONARY LOBECTOMY	TRAPPER,JOHN ZHIVAGO,DOCTOR ALLEN,JIM	GENERAL OUTPATIENT 60 MIN.
10/08/96 63073	KREIS,HEATHER 353-23-3221 (OPHTHALMOLOGY)	INTRAOCCULAR LENS, CHOLECYSTECTOMY	ADAMS,DOC ALEXANDER,DAVE REED,JAMES	SPINAL OUTPATIENT 50 MIN.
10/08/96 63076	UPRIGHT,WILLIAM BOLT 212-65-0036 (UROLOGY)	TURP	MUSGROVE,STEPHEN REED,JAMES FINE,LARRY	GENERAL OUTPATIENT 45 MIN.

TOTAL DISPOSITION NOT ENTERED: 3

1.1.5 List of Operations (by Surgical Specialty)

This report contains general information for completed cases within a selected date range. It sorts the cases by surgical specialty and case number.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique. You can request a list for all specialties or a selected specialty.

This report has a 132-column format and is designed to be copied to a printer.

Example: List of Operations by Surgical Specialty

```
Select Management Reports Option: LS  List of Operations (by Surgical Specialty)
```

```
List of Operations sorted by Surgical Specialty



Start with Date:  10/4  (OCT 04, 1996)
End with Date:  10/8  (OCT 08, 1996)

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

Print the report for which Surgical Specialty ?  GENERAL (OR WHEN NOT DEFINED BELOW)

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
LIST OF OPERATIONS BY SERVICE
FROM: OCT 4,1996 TO: OCT 8,1996

DATE REVIEWED:
REVIEWED BY:
DATE PRINTED: SEP 20,1999

DATE CASE #	PATIENT ID# PRIORITY	OPERATION(S)	SURGEON FIRST ASSISTANT SECOND ASSISTANT	ANESTHESIA TECHNIQUE
		GENERAL(OR WHEN NOT DEFINED BELOW)		
10/04/96 63066	COLLINS,JACK 123-45-5119 STANDBY	INGUINAL HERNIA	WELBY,MARCUS FINE,LARRY HOWARD,MOE	GENERAL OP TIME: 40 MIN.
10/04/96 63067	DAVIS,IRWIN 123-45-2182 ELECTIVE	INGUINAL HERNIA	ADAMS,DOC HOWARD,MOE FINE,LARRY	GENERAL OP TIME: 50 MIN.
10/04/96 63068	HELMS,MICHEAL 123-45-4886 ELECTIVE	INGUINAL HERNIA	WELBY,MARCUS HOWARD,MOE FINE,LARRY	GENERAL OP TIME: 45 MIN.
10/07/96 63070	HODGE,MARILYN 231-21-2234 ELECTIVE	INGUINAL HERNIA	TRAPPER,JOHN ADAMS,DOC	GENERAL OP TIME: 45 MIN.
10/08/96 63071	KREIS,ADAM 232-31-2123 ELECTIVE	INGUINAL HERNIA	ADAMS,DOC HOWARD,MOE FINE,LARRY	GENERAL OP TIME: 50 MIN.
10/08/96 63072	DUNCAN,ZACHARY 332-00-1234 ELECTIVE	CHOLECYSTECTOMY	FINE,LARRY ADAMS,DOC	GENERAL OP TIME: 50 MIN.
10/08/96 63077	WEINKIEBEAN,FUNKIE 232-34-2345 ELECTIVE	INGUINAL HERNIA, CHOLECYSTECTOMY	REED,DANNY ALEXANDER,DAVE DAVIS,PAULETTE	GENERAL OP TIME: 63 MIN.

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 7

1.1.6 List of Operations (by Surgical Priority)

This report contains general information for completed cases within a selected date range. It sorts the cases by surgical priority and surgical specialty.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique. You can request a list for all priorities or a selected priority. You can also specify one or more surgical specialties.

This report has a 132-column format and is designed to be copied to a printer.

Example: List of Operations by Surgical Priority

```
Select Management Reports Option:  LP  List of Operations (by Surgical Priority)
```

```
List of Operations by Surgical Priority:



Start with Date:  8/1  (AUG 01, 1996)
End with Date:  9/30  (SEP 30, 1996)

Print List of Operations for all priorities ? Y// N
```

```
Print report for which Priority ?

1. EMERGENCY
2. ELECTIVE
3. ADD ON TODAY (NONEMERGENT)
4. STANDBY
5. URGENT ADD TODAY
6. PRIORITY NOT ENTERED

Select Number:  1// 4

Do you want the report sorted by surgical specialty ? Y// <RET>

Print for all surgical specialties ? Y// <RET>

This report is designed to use a 132 column format.

Print the Report on which Device:  [Select Print Device]
```

..... *printout follows* .....

ISC-BIRMINGHAM, AL
SURGICAL SERVICE
LIST OF OPERATIONS BY SURGICAL PRIORITY
FROM: AUG 1,1996 TO: SEP 30,1996
SURGICAL PRIORITY: STANDBY

PAGE: 1

DATE PRINTED: OCT 20,1996
REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT ID#	OPERATION(S)	SURGEON 1ST ASST 2ND ASST	ANESTHESIA TECH
>> THORACIC SURGERY (INC. CARDIAC SURG.) <<				
08/21/96 62901	BALTIMORE,LORD 321-98-4352	PULMONARY LOBECTOMY	ADAMS,DOC TRAPPER,JOHN REED,DANNY	GENERAL OP TIME: 170 MIN.
09/02/96 63002	SPEKIS,RICH 173-48-0905	PULMONARY LOBECTOMY	FINE,LARRY TRAPPER,JOHN	GENERAL OP TIME: 95 MIN.
09/29/96 63042	HENDERSON,SAM 098-76-5435	PULMONARY LOBECTOMY	MUSGROVE,STEPHEN REED,DANNY	GENERAL OP TIME: 90 MIN.

TOTAL THORACIC SURGERY (INC. CARDIAC SURG.): 3

1.1.7 Report of Surgical Priorities

This report provides the total number of completed surgical cases for each surgical priority, such as elective, emergency, urgent within a date range. You can sort the report by all surgical specialties, one surgical specialty (Example 1), or by all operations within a date range (Example 2).

This report has an 80-column format and can be viewed on your terminal display screen.

Example 1: Print Report of Surgical Priorities for a specialty

```
Select Management Reports Option: P  Report of Surgical Priorities
```

```
Report of Surgical Priorities


Start with Date: 3/1  (MAR 01, 1992)
End with Date: T  (MAR 26, 1992)

Do you want to review this information sorted by Surgical Specialty ?  YES// <RET>

Do you want to print this report for all Surgical Specialties ?  YES// N

Print the report for which Surgical Specialty ? 50          GENERAL(OR WHEN NOT
DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)        50

Print the Report on which Device:  [Select Print Device]
```

..... *printout follows* .....

```
                                MAYBERRY, NC
                              SURGICAL SERVICE
                     TOTAL OPERATIONS BY SURGICAL PRIORITY
                       FROM: MAR 1,1992  TO: MAR 26,1992
_____________________________________________________________________________

                       GENERAL(OR WHEN NOT DEFINED BELOW)

                        1. ELECTIVE                    1
                        2. URGENT                      1
                        3. EMERGENCY                   2
                        4. ADD ON (NON-EMERGENT)       0
                        5. STANDBY                     1


                        TOTAL SURGICAL CASES:          5
```

Example 2: Print Report of Surgical Priorities for all Operations

```
Select Management Reports Option: P  Report of Surgical Priorities
```

```
Report of Surgical Priorities


Start with Date: 3/1  (MAR 01, 1992)
End with Date: T  (MAR 26, 1992)

Do you want to review this information sorted by Surgical Specialty ?  YES// N

Print the Report on which Device:  [Select Print Device]
```

..... *printout follows* .....

```
                                MAYBERRY, NC
                              SURGICAL SERVICE
                     TOTAL OPERATIONS BY SURGICAL PRIORITY
                       FROM: MAR 1,1992  TO: MAR 26,1992
_____________________________________________________________________________

                        1. ELECTIVE                    3
                        2. URGENT                      2
                        3. EMERGENCY                   2
                        4. ADD ON (NON-EMERGENT)       0
                        5. STANDBY                     4
                        6. PRIORITY NOT ENTERED        4


                        TOTAL SURGICAL CASES:         15
```

1.1.8 List of Undictated Operations

This option provides a list of all completed cases that do not have responses in the DATE/TIME OF DICTATION field. It is designed for the Chief of Surgery to check on cases that still require dictation. This option is also located in the Chief of Surgery menu.

This list is in an 80-column format an can be viewed on your terminal display screen.

Example: Print List of Undictated Operations

```
Select Management Reports Option: U  List of Undictated Operations
```

```
List of Undictated Operations


How do you want this report printed ?

   (1) Print ALL undictated operations.
   (2) Print undictated operations for a selected DATE range.

Enter selection: 1// <RET>
Print the Report on which Device:  [Select Print Device]
```

..... *printout follows* .....

```
           UNDICTATED OPERATIONS FOR GENERAL
           DATE PRINTED: 03/27/93

CASE #     PATIENT                                SURGEON
           OPERATION DATE                         WARD LOCATION
===============================================================================

 13        JAMES,TERRELL (217-63-5402)            FINE,LARRY
           AUG 16, 1992@09:45                     OUTPATIENT
           CHOLECYSTECTOMY

           UNDICTATED OPERATIONS FOR NEUROSURGERY
           DATE PRINTED: 03/27/93

CASE #     PATIENT                                SURGEON
           OPERATION DATE                         WARD LOCATION
===============================================================================

 18        BELL,MARY (467-87-3456)                HOWARD,MOE
           AUG 16, 1992@11:15                     OUTPATIENT
           FRONTAL CRANIOTOMY

Press RETURN to continue, or '^' to quit:   ^
```

```
           UNDICTATED OPERATIONS FOR PERIPHERAL VASCULAR
           DATE PRINTED: 03/27/93

CASE #     PATIENT                                SURGEON
           OPERATION DATE                         WARD LOCATION
===============================================================================

 249       CLAMPETT,J.D. (665-37-0555)            FINE,LARRY
           FEB 11, 1993                           1 NORTH 162-1
           HARVEST SAPHENOUS VEIN

Press RETURN to continue, or '^' to quit:   ^
```

```
           UNDICTATED OPERATIONS FOR THORACIC SURGERY
           DATE PRINTED: 03/27/93

CASE #     PATIENT                                SURGEON
           OPERATION DATE                         WARD LOCATION
===============================================================================

 250       FRANKLIN,BENJAMIN (287-38-1876)        FINE,LARRY
           FEB 11, 1993                           OUTPATIENT
           HARVEST SAPHENOUS VEIN

Press RETURN to continue, or '^' to quit:   ^
```

1.1.9 Report of Daily Operating Room Activity

This option generates a report listing cases started between 7:30 AM on the date selected and 7:29 AM of the following day for all operating rooms.

This report has a 132-column format and is designed to be copied to a printer.

Example: Print the Report of Daily Operating Room Activity

```
Select Management Reports Option: D  Report of Daily Operating Room Activity
```

```
Print the Report of Daily Activity for which Date ?  3/9  (MAR 09, 1992)

This report will include all cases started between MAR  9, 1992 at 6:00 AM
and MAR 10, 1992 at 5:59 AM.

It is designed to use a 132 column format.

Print the Report to which Device ?  [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
DAILY REPORT OF OPERATING ROOM ACTIVITY
FOR: MAR 09, 1992

PATIENT ID # WARD	AGE	TIME IN OR TIME OUT OR CASE NUMBER	POSTOPERATIVE DIAGNOSIS PROCEDURE(S)	ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
OPERATING ROOM: OR1					
DRUCKER,SAM		03/09 08:00	INGUINAL HERNIA	BARRON,L	ADAMS,D
233-41-8719	61	03/09 09:10	INGUINAL HERNIA	ALEXANDER,D	DOOLITTLE,J
1 NORTH 161-1		194			FINE,L
OPERATING ROOM: OR3					
OAT,WILLIE		03/09 09:15	CHOLECYSTITIS	JENNINGS,G	FINE,L
449-34-5555	49	03/09 12:40	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	WATSON,C	REED,J
OUTPATIENT		187			HOWARD,M
OPERATING ROOM: OR5					
FIFE,BARNEY		03/09 19:56	APPENDICITIS	JENNINGS,G	BRONSTEIN,S
222-00-1234	50	03/09 21:05	APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY, CRAIN	DOOLITTLE,J	REED,J
1 WEST 101-1		188			REED,D

1.1.10 PCE Filing Status Report

This option provides a report of the PCE filing status of completed cases performed during the selected date range in accordance with the site parameter controlling PCE updates. If this site parameter is turned off, the report will show no cases. The report may be printed for OR surgical cases, non-OR procedures or both. Also, the report may be printed for all specialties or for a single specialty only.

This report is intended to be used a tool in the review of Surgery case information that is passed automatically to PCE. The report uses 5 status categories:

(1) FILED - This status indicates that case information has already been filed with PCE.
(2) QUEUED TO FILE - This status indicates the case is queued to file with PCE next time the Surgery nightly maintenance job runs.
(3) UPDATE QUEUED - This status indicates that information passed to PCE has been updated after the case was filed with PCE and PCE will be updated the next time the Surgery nightly maintenance job runs.
(4) NOT QUEUED - This status indicates the case is missing information required for filing with PCE.
(5) UNCERTAIN - If the UPDATES TO PCE site parameter is set to file outpatient cases only, this status indicates the IN/OUT-PATIENT STATUS field is null.

Two forms of the report are available, the long and the short. The long form uses a 132 column format and prints case information including the surgeon/provider, the attending, the specialty, the principal post-op diagnosis, and the principal procedure. If the PCE filing status is FILED, QUEUED TO FILE or UPDATE QUEUED the CPT codes and ICD diagnosis codes will be printed. If the filing status is NOT QUEUED or UNCERTAIN, information fields needed for PCE filing that do not contain data will be printed. At the end of the report, the number of cases in each PCE filing status will be printed, plus the number of CPT and ICD codes for cases with a status of FILED, QUEUED TO FILE, and UPDATE QUEUED.

The short form uses an 80 column format and does not include surgeon/provider, attending, principal post-op diagnosis and CPT and ICD code information. The totals printed at the end will show only the total cases for each status. This option generates a report listing cases started between 7:30 AM on the date selected and 7:29 AM of the following day for all operating rooms.

Example 1: PCE Filing Status Report (Short Form)

```
Select Management Reports Option: PS  PCE Filing Status Report
```

```
                          Report of PCE Filing Status

This report displays the filing status of completed cases performed during the
selected date range.


Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <RET>
```

```
Do you want the report for all Surgical Specialties ? YES// NO

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

Start with Date: 10/3/96  (OCT 03, 1996)
End with Date: 10/3/96  (OCT 03, 1996)

Print the long form or the short form ? SHORT// <RET>

Print the PCE Filing Status Report to which Printer ? [Select Print Device]
```

..... *printout follows* .....

```
                                MAYBERRY, NC
                          PCE FILING STATUS REPORT                    PAGE 1
                     For Completed O.R. Surgical Procedures
                        From: OCT 3,1996  To: OCT 3,1996
                       Report Printed: OCT 15,1996@10:29

DATE OF OPERATION     PATIENT NAME          PATIENT ID  (AGE)     FILING STATUS
CASE #                SPECIALTY                                   SCHED STATUS
                      PRINCIPAL PROCEDURE
================================================================================
OCT 3,1996@06:00      SMITH,JAMES           123-45-7684  (76)     FILED
63052                 GENERAL(OR WHEN NOT                         CHECKED OUT
                      INGUINAL HERNIA
--------------------------------------------------------------------------------
OCT 3,1996@06:00      COX,FRED              123-45-5000  (39)     FILED
63062                 GENERAL(OR WHEN NOT                         CHECKED OUT
                      CHOLECYSTECTOMY
--------------------------------------------------------------------------------
OCT 3,1996@08:00      MORRIS,THOMAS         123-45-6111  (60)     FILED
63054                 GENERAL(OR WHEN NOT                         CHECKED OUT
                      INGUINAL HERNIA
--------------------------------------------------------------------------------
OCT 3,1996@11:00      STEVENS,DOUGLAS       123-45-7924  (54)     FILED
63061                 GENERAL(OR WHEN NOT                         CHECKED OUT
                      INGUINAL HERNIA
--------------------------------------------------------------------------------
OCT 3,1996@13:00      PERKINS,DAVID         123-45-4279  (85)     UPDATE QUEUED
63064                 GENERAL(OR WHEN NOT                         CHECKED OUT
                      APPENDECTOMY
--------------------------------------------------------------------------------

             FILED:     4
    QUEUED TO FILE:     0
     UPDATE QUEUED:     1
        NOT QUEUED:     0
                     -----
       TOTAL CASES:     5
```

Example 2: PCE Filing Status Report (Long Form)

```
Select Management Reports Option: PS  PCE Filing Status Report
```

```
                          Report of PCE Filing Status

This report displays the filing status of completed cases performed during the
selected date range.


Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <RET>
```

```
Do you want the report for all Surgical Specialties ? YES// NO

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

Start with Date: 10/3/96  (OCT 03, 1996)
End with Date: 10/3/96  (OCT 03, 1996)

Print the long form or the short form ? SHORT// LONG

Print the PCE Filing Status Report to which Printer ? [Select Print Device]
```

..... *printout follows* .....

```
                                                    MAYBERRY, NC
                                              PCE FILING STATUS REPORT                                                    PAGE 1
                                          For Completed O.R. Surgical Procedures
                                             From: OCT 3,1996  To: OCT 3,1996
                                            Report Printed: OCT 15,1996@10:33

DATE OF OPERATION     PATIENT NAME              SURGEON              SPECIALTY                                PCE FILING STATUS
CASE #                PATIENT ID  (AGE)         ATTENDING            PRINCIPAL POST-OP DIAGNOSIS              SCHED STATUS
                      PRINCIPAL PROCEDURE
==================================================================================================================================
OCT 3,1996@06:00      SMITH,JAMES               FINE,LARRY           GENERAL(OR WHEN NOT DEFINED BELOW)       UPDATE QUEUED
63052                 123-45-7684  (76)         REED,DANNY           BILATERAL INGUINAL HERNIA                CHECKED OUT
                      INGUINAL HERNIA

 CPT Code: 49505  REPAIR INGUINAL HERNIA                             ICD Diagnosis Code: 550.02  BILAT ING HERNIA W GANG
  Modifiers: -76 REPEAT PROCEDURE BY SAME PHYSICIAN
----------------------------------------------------------------------------------------------------------------------------------
OCT 3,1996@06:00      COX,FRED                  MUSGROVE,STEPHEN     GENERAL(OR WHEN NOT DEFINED BELOW)       UPDATE QUEUED
63062                 123-45-5000  (39)         MONOSKY,ALAN         GALLSTONES                               CHECKED OUT
                      CHOLECYSTECTOMY

 CPT Code: 47605  REMOVAL OF GALLBLADDER                             ICD Diagnosis Code: 575.2  OBSTRUCTION GALLBLADDER
  Modifiers: -32 MANDATED SERVICES                                   ICD Diagnosis Code: 540.1  ABSCESS OF APPENDIX
 CPT Code: 44960  APPENDECTOMY
----------------------------------------------------------------------------------------------------------------------------------
OCT 3,1996@08:00      MORRIS,THOMAS             MUSGROVE,STEPHEN     GENERAL(OR WHEN NOT DEFINED BELOW)       FILED
63054                 123-45-6111  (60)         REED,DANNY           NOT ENTERED                              CHECKED OUT
                      INGUINAL HERNIA

 CPT Code: 49505  REPAIR INGUINAL HERNIA                             ICD Diagnosis Code: 550.02  BILAT ING HERNIA W GANG
----------------------------------------------------------------------------------------------------------------------------------
OCT 3,1996@11:00      STEVENS,DOUGLAS           REED,DANNY           GENERAL(OR WHEN NOT DEFINED BELOW)       FILED
63061                 123-45-7924  (54)         MUSGROVE,STEPHEN     NOT ENTERED                              CHECKED OUT
                      INGUINAL HERNIA

 CPT Code: 49507  REPAIR, INGUINAL HERNIA                            ICD Diagnosis Code: 550.92  BILAT INGUINAL HERNIA
----------------------------------------------------------------------------------------------------------------------------------
OCT 3,1996@13:00      PERKINS,DAVID             REED,DANNY           GENERAL(OR WHEN NOT DEFINED BELOW)       UPDATE QUEUED
63064                 123-45-4279  (85)         DAVIS,DOUG           ACUTE APPENDICITIS                       CHECKED OUT
                      APPENDECTOMY

 CPT Code: 44950  APPENDECTOMY                                       ICD Diagnosis Code: 540.9  ACUTE APPENDICITIS NOS
----------------------------------------------------------------------------------------------------------------------------------
                            CPT     ICD
                   CASES  CODES   CODES
             FILED:     2      2       2
    QUEUED TO FILE:     0      0       0
     UPDATE QUEUED:     3      4       4
        NOT QUEUED:     0
                   -----  -----   -----
             TOTAL:     5      6       6
```

1.1.11 Outpatient Encounters Not Transmitted to NPCD

Outpatient surgical and non-OR procedures that are filed as encounters in the Patient Care Encounters (PCE) package without an active count clinic identified for each encounter are not transmitted to the National Patient Care Database (NPCD) as workload. This option may be used as a tool for identifying these encounters that represent uncounted workload so that corrective actions may be taken in the Surgery package to insure these procedures are associated with an active count clinic. After corrections are made, these encounters may be re-filed with PCE to be transmitted to NPCD.

This option provides functionality:

- To count and/or list surgical cases and non-OR procedures that have entries in PCE but have no matching entries in the OUTPATIENT ENCOUNTER file (#409.68) or have matching entries that are non-count encounters or encounters requiring action.

- To re-file with PCE the cases identified as having no matching entries in the OUTPATIENT ENCOUNTER file (#409.68) or having matching entries that are non-count encounters or encounters requiring action.

Both the report and the re-filing process may be run for OR surgical cases, non-OR procedures or both. The report and the re-filing process may be run for a specific specialty or for all specialties and may be run for a selected date range.

Example 1: Print List of Cases

```
Select Management Reports Option: NOX  Outpatient Encounters Not Transmitted to
NPCD
```

```
             Outpatient Surgery Encounters Not Transmitted to NPCD


Surgical cases filed with PCE that have no Scheduling appointment status
or that have an appointment status of ACTION REQUIRED or NON-COUNT indicate
surgical encounters that have not transmitted to the National Patient
Care Database.  This option is intended as a tool to identify these
encounters and, after taking appropriate corrective measures, to
reinitiate the encounter transmission process.


  1. Print list of cases.
  2. Print total number of cases only.
  3. Re-file cases in PCE.

Select Number: 1// <RET>


Print the list for the following.

  1. O.R. Surgical Procedures
  2. Non-O.R. Procedures
  3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <RET>
```

```
Do you want the report for all Surgical Specialties ? YES// NO

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

Start with Date: 5/1  (MAY 01, 1998)
End with Date: 5/15  (MAY 15, 1998)

Print report on which printer ? [Select Print Device]
```

..... *printout follows* .....

```
                                   MAYBERRY, NC
                 Outpatient Surgery Encounters Not Transmitted to NPCD                    Page 1
                         For Completed O.R. Surgical Procedures
                           From: MAY 1,1998  To: MAY 15,1998
                           Report Printed: MAY 20,1998@06:44

DATE OF OPERATION      CASE #         SPECIALTY              SCHED STATUS
PATIENT NAME           PRINCIPAL PROCEDURE
PATIENT ID  (AGE)
=================================================================================================================
MAY 1,1998@09:00       63028          GENERAL(OR WHEN NOT    <NONE>
UPRIGHT,WILLIAM BOLT   CHOLECYSTECTOMY
212-65-0036  (55)
-----------------------------------------------------------------------------------------------------------------
MAY 3,1998@05:45       63092          GENERAL(OR WHEN NOT    <NONE>
WILLIAMS,ROSEMARY      CHOLEDOCHOTOMY
334-56-7821  (39)
-----------------------------------------------------------------------------------------------------------------
MAY 7,1998@07:15       63142          GENERAL(OR WHEN NOT    <NONE>
DRUCKER,SAMUEL H.      REPAIR DIAPHRAGMATIC HERNIA
233-41-8719  (71)
-----------------------------------------------------------------------------------------------------------------
MAY 12,1998@06:00      63191          GENERAL(OR WHEN NOT    <NONE>
RIPROCK,DASH           INGUINAL HERNIA
234-18-9922  (64)
-----------------------------------------------------------------------------------------------------------------
MAY 14,1998@06:00      63208          GENERAL(OR WHEN NOT    ACTION REQUIRED
DRUCKER,SAMUEL H.      CHOLECYSTECTOMY
233-41-8719  (69)
-----------------------------------------------------------------------------------------------------------------
MAY 15,1998@06:01      63180          GENERAL(OR WHEN NOT    <NONE>
WILLIAMS,ROSEMARY      CHOLECYSTECTOMY
334-56-7821  (39)
-----------------------------------------------------------------------------------------------------------------

SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

      Total with NO status:     5
      Total with NON-COUNT:     0
Total with ACTION REQUIRED:     1
                            -----
    Total cases identified:     6
```

Example 2: Print Total Number of Cases Only

```
Select Management Reports Option: NOX  Outpatient Encounters Not Transmitted to
NPCD
```

```
             Outpatient Surgery Encounters Not Transmitted to NPCD


Surgical cases filed with PCE that have no Scheduling appointment status
or that have an appointment status of ACTION REQUIRED or NON-COUNT indicate
surgical encounters that have not transmitted to the National Patient
Care Database.  This option is intended as a tool to identify these
encounters and, after taking appropriate corrective measures, to
reinitiate the encounter transmission process.


  1. Print list of cases.
  2. Print total number of cases only.
  3. Re-file cases in PCE.

Select Number: 1// 2


Print the list for the following.

  1. O.R. Surgical Procedures
  2. Non-O.R. Procedures
  3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <RET>

Do you want the report for all Surgical Specialties ? YES// NO

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

Start with Date: 5/1  (MAY 01, 1998)
End with Date: 5/15  (MAY 15, 1998)

Print report on which printer ? [Select Print Device]
```

..... *printout follows* .....

```
                                  MAYBERRY, NC
             Outpatient Surgery Encounters Not Transmitted to NPCD       Page 1
                     For Completed O.R. Surgical Procedures
                       From: MAY 1,1998  To: MAY 15,1998
                       Report Printed: MAY 20,1998@07:25
===============================================================================

SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

      Total with NO status:     5
      Total with NON-COUNT:     0
Total with ACTION REQUIRED:     1
                            -----
    Total cases identified:     6
```

Example 3: Re-File Cases in PCE

```
Select Management Reports Option: NOX  Outpatient Encounters Not Transmitted to
NPCD
```

```
             Outpatient Surgery Encounters Not Transmitted to NPCD


Surgical cases filed with PCE that have no Scheduling appointment status
or that have an appointment status of ACTION REQUIRED or NON-COUNT indicate
surgical encounters that have not transmitted to the National Patient
Care Database.  This option is intended as a tool to identify these
encounters and, after taking appropriate corrective measures, to
reinitiate the encounter transmission process.


  1. Print list of cases.
  2. Print total number of cases only.
  3. Re-file cases in PCE.

Select Number: 1// 3


Re-file the following.

  1. O.R. Surgical Procedures
  2. Non-O.R. Procedures
  3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// 1

Do you want re-filing for all Surgical Specialties ? YES// NO

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

Start with Date: 5/1  (MAY 01, 1998)
End with Date: 5/15  (MAY 15, 1998)
Requested Start Time: NOW//  (MAY 20, 1998@07:37:32)
 (Task #652379)

Press RETURN to continue  <RET>
```

1.2 Surgery Staffing Reports

This option provides access to the Surgery Staffing Reports submenu.

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

A	*Attending Surgeon Reports*
S	*Surgeon Staffing Report*
N	*Surgical Nurse Staffing Report*
NS	*Scrub Nurse Staffing Report*
NC	*Circulating Nurse Staffing Report*

1.2.1 Attending Surgeon Reports

This option generates the Attending Surgeon Reports. The Attending Surgeon Report provides staffing information for completed cases (Example 1). The Attending Surgeon Cumulative Report is a table with cumulative totals for each attending code (Example 2). You can print these reports separately or you can print both reports at one time.

The Attending Surgeon Reports can be sorted by surgical specialty. They can also be generated for an individual surgeon, or for all attending surgeons.

The Attending Surgeon Report has a 132-column format and is designed to be copied to a printer. The Attending Surgeon Cumulative Report has an 80-column format and can be viewed on your display screen.

Example 1: Print the Attending Surgeon Report

```
Select Surgery Staffing Reports Option: A  Attending Surgeon Reports
```

```
Attending Surgeon Report


Starting with which Date ?  3/9  (MAR 09, 1992)
Ending with which Date ?  3/18  (MAR 18, 1992)
```

```
Do you want to print the report for all Attending Surgeons ?  YES// <RET>

Attending Surgeon Reports

1.  Attending Surgeon Report
2.  Attending Surgeon Cumulative Report
3.  Attending Surgeon Report and Attending Surgeon Cumulative Report


Select the number corresponding with the desired report(s):  1

Start report for each attending surgeon on a new page ? NO// <RET>
```

```
Do you want the report for all Surgical Specialties ?  YES//  N

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

The Attending Surgeon Report was designed to use a 132 column format.

Print the report on which Device ? [Select Print Device]
```

..... *printout follows* .....

```
                                                    MAYBERRY, NC                                                    PAGE: 1
                                                  SURGICAL SERVICE                          REVIEWED BY:
                                              ATTENDING SURGEON REPORT                      DATE REVIEWED:
                                         FROM: MAR 9,1992  TO: MAR 18,1992                  DATE PRINTED: MAR 20,1992

   DATE     PATIENT                              PRINCIPAL DIAGNOSIS                                        SURGEON
  CASE #      ID#                                PRINCIPAL OPERATIVE PROCEDURE                              1ST ASST
           ATTENDING CODE                                                                                   2ND ASST
==================================================================================================================================

                                         GENERAL(OR WHEN NOT DEFINED BELOW)
                                         ==================================

                                           ATTENDING SURGEON: FINE,LARRY
                                           -----------------------------

03/17/92    SMITH,JAMES                       CHOLELITHIASIS                                                  HOWARD,MOE
203         123-45-7684                       CHOLECYSTECTOMY                                                 REED,JAMES
            2. ATTENDING IN O.R. SUITE

03/18/92    BASS,EARNEST T.                   INCARCERATED INGUINAL HERNIA                                    HOWARD,MOE
202         123-45-5119                       REPAIR INCARCERATED INGUINAL HERNIA                             REED,JAMES
            2. ATTENDING IN O.R. SUITE

03/09/92    DRUCKER,SAM                       INCARCERATED INGUINAL HERNIA                                    WELBY,MARCUS
494         233-41-8719                       INGUINAL HERNIA                                                 DOOLITTLE,J
            ATTENDING CODE NOT ENTERED

                                           ATTENDING SURGEON: HOWARD,MOE
                                           -----------------------------

03/10/92    CLAMPETT,ELLIE MAE                RUPTURED TUBOOVARIAN ABSCESS                                    REED,JAMES
189         231-21-2234                       DRAINAGE OF OVARIAN CYST
            0. STAFF

03/09/92    OAT,WILLIE                        CHOLECYSTITIS                                                   FINE,LARRY
187         449-34-5555                       CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM                   REED,JAMES
            1. ATTENDING IN O.R.                                                                              WELDON,LARRY

                                           ATTENDING SURGEON: REED,JAMES
                                           -----------------------------

03/09/92    FIFE,BARNEY                       APPENDICITIS                                                    BRONSTEIN,S
188         222-00-1234                       APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY                      REED,JAMES
            2. ATTENDING IN O.R. SUITE
```

Example 2: Print the Attending Surgeon Cumulative Report

```
Select Surgery Staffing Reports Option: A  Attending Surgeon Reports
```

```
Attending Surgeon Report


Starting with which Date ?  3/9  (MAR 09, 1992)
Ending with which Date ?  3/18  (MAR 18, 1992)
```

```
Do you want to print the report for all Attending Surgeons ?  YES// <RET>

Attending Surgeon Reports

1.  Attending Surgeon Report
2.  Attending Surgeon Cumulative Report
3.  Attending Surgeon Report and Attending Surgeon Cumulative Report


Select the number corresponding with the desired report(s):  2
```

```
Do you want the report for all Surgical Specialties ?  YES//  N

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

The Attending Surgeon Cumulative Report was designed to use a 80 column format.

Print the report on which Device ? [Select Print Device]
```

..... *printout follows* .....

```
                                MAYBERRY, NC
                              SURGICAL SERVICE
                      ATTENDING SURGEON CUMULATIVE REPORT
                       FROM: MAR 9,1992  TO: MAR 18,1992
==============================================================================

                      GENERAL(OR WHEN NOT DEFINED BELOW)

        ATTENDING CODE                            TOTAL CASES
        --------------                            -----------
        0. STAFF                                        1
        1. ATTENDING IN O.R.                            1
        2. ATTENDING IN O.R. SUITE                      3
        3. ATTENDING NOT PRESENT, BUT AVAILABLE         0
        *  ATTENDING CODE NOT ENTERED                   2

        TOTAL CASES FROM 03/09/92 TO 03/18/92           7
```

1.2.2 Surgeon Staffing Report

This report lists completed cases sorted by the surgeon and his or her role (i.e., attending, first assistant) for each case. The report provides the procedure, diagnosis and operation date/time.

This report has a 132-column format and is designed to be copied to a printer.

Example: Print Surgeon Staffing Report

```
Select Surgery Staffing Reports Option: S  Surgeon Staffing Report
```

```
Surgeon Staffing Report


Start with Date: 3/2  (MAR 02, 1992)
End with Date: 3/31  (MAR 31, 1992)

Do you want to print this report for an individual surgeon ?  YES//  <RET>
Select Surgeon: HOWARD,MOE

This report is designed to use a 132 column format.

Print the report on which Device ? [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
SURGEON STAFFING REPORT
FROM: MAR 2,1992 TO: MAR 31,1992

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: APR 20,1992

DATE/TIME CASE #	PATIENT ID #	OPERATION(S)	DIAGNOSIS
** HOWARD,MOE **			
ROLE: ATTENDING SURGEON			
MAR 09, 1992@09:15 187	OAT,WILLIE 449-34-5555	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	CHOLECYSTITIS
MAR 10, 1992@07:00 189	CLAMPETT,ELLIE MAE 231-21-2234	DRAINAGE OF OVARIAN CYST	APPENDICITIS
MAR 10, 1992@14:00 200	RUBBLE,BETTY 123-45-9999	HEMORRHOIDECTOMY	EXTERNAL HEMORRHOIDS
ROLE: SURGEON			
MAR 10, 1992@08:00 199	MONROE,EARL 123-45-1982	CHOLECYSTECTOMY WITH CHOLANGIOGRAM	CHOLELITHIASIS WITH BILIARY COLIC
MAR 17, 1992@12:55 203	SMITH,JAMES 123-45-7684	CHOLECYSTECTOMY	CHOLELITHIASIS
MAR 18, 1992@07:30 202	BASS,EARNEST T. 123-45-5119	REPAIR INCARCERATED INGUINAL HERNIA	INCARCERATED INGUINAL HERNIA

1.2.3 Surgical Nurse Staffing Report

This option generates the Surgical Nurse Staffing Report that lists completed cases within a specified date range. It provides the names of the scrub nurse and circulating nurse, and operation times.

This report has a 132-column format and is designed to be copied to a printer.

Example: Print Surgical Nurse Staffing Report

```
Select Surgery Staffing Reports Option: N  Surgical Nurse Staffing Report
```

```
Surgical Nurse Staffing Report

Do you want the report for all nurses ?  YES// <RET>

Start with Date: 3/9  (MAR 09, 1992)
End with Date: 3/10  (MAR 10, 1992)

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
SURGICAL NURSE STAFFING REPORT
FROM: MAR 9,1992 TO: MAR 10,1992

PAGE: 1
REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: MAR 20,1992

DATE CASE #	PATIENT ID#	OPERATION(S)	SCRUB NURSE	CIRC. NURSE	TIME IN TIME OUT ELAPSED (MINS)
03/09/92 194	DRUCKER,SAM 233-41-8719	INGUINAL HERNIA	MAY,JENNY	DIP,CHAMBLIS	08:00 09:10 70
03/09/92 187	OAT,WILLIE 449-34-5555	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	NURSE,NANCY	HUFF,ROSE	09:15 12:40 205
03/09/92 188	FIFE,BARNEY 222-00-1234	APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY	NURSE,NANCY	LIGHT,GILDA	19:56 21:05 69
03/10/92 189	CLAMPETT,ELLIE MAE 231-21-2234	DRAINAGE OF OVARIAN CYST	NURSE,NANCY	BEND,ELMORE	07:00 08:54 114
03/10/92 199	MONROE,EARL 123-45-1982	CHOLECYSTECTOMY WITH CHOLANGIOGRAM	MAY,JENNY	JONES,JIMMY	08:00 10:08 128
03/10/92 200	RUBBLE,BETTY 123-45-9999	HEMORRHOIDECTOMY	NURSE,NANCY	HUFF,ROSE	14:00 14:55 55

1.2.4 Scrub Nurse Staffing Report

This report lists each operating room scrub nurse and the completed cases they are assigned to within a specified date range. It also provides the circulating nurses, other scrub nurses, and operation times.

This report has a 132-column format and is designed to be copied to a printer.

Example: Print Scrub Nurse Staffing Report

```
Select Surgery Staffing Reports Option: NS  Scrub Nurse Staffing Report
```

```
Scrub Nurse Staffing Report

Do you want the report for all nurses ?  YES// <RET>

Start with Date: 3/8  (MAR 08, 1992)
End with Date: 3/20  (MAR 20, 1992)

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
SCRUB NURSE STAFFING REPORT
FROM: MAR 8,1992 TO: MAR 20,1992

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: MAR 22,1992

DATE CASE #	PATIENT ID#	OPERATION(S)	SCRUB NURSE	CIRC. NURSE	TIME IN TIME OUT ELAPSED (MINS)
		** BEND,ELMORE **			
03/18/92 202	BASS,EARNEST T. 123-45-5119	REPAIR INCARCERATED INGUINAL HERNIA	NURSE,NANCY BEND,ELMORE	HUFF,ROSE	07:30 09:03 93
		** NURSE,NANCY **			
03/09/92 187	OAT,WILLIE 449-34-5555	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	NURSE,NANCY	HUFF,ROSE	09:15 12:40 205
03/09/92 188	FIFE,BARNEY 222-00-1234	APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY, CRAIN	NURSE,NANCY		19:56 21:05 69
03/10/92 189	CLAMPETT,ELLIE MAE 231-21-2234	DRAINAGE OF OVARIAN CYST	NURSE,NANCY	BEND,ELMORE	07:00 08:54 114
03/10/92 200	RUBBLE,BETTY 123-45-9999	HEMORRHOIDECTOMY	NURSE,NANCY	HUFF,ROSE	14:00 14:55 55
03/17/92 203	SMITH,JAMES 123-45-7684	CHOLECYSTECTOMY	NURSE,NANCY	HUFF,ROSE	12:55 14:30 95
03/18/92 202	BASS,EARNEST T. 123-45-5119	REPAIR INCARCERATED INGUINAL HERNIA	NURSE,NANCY BEND,ELMORE	HUFF,ROSE	07:30 09:03 93

1.2.5 Circulating Nurse Staffing Report

This report provides nurse staffing information, sorted by the circulating nurse's name. It lists the circulating nurses and the completed cases they are assigned to within a specified date range. The report includes the scrub nurse, other circulating nurses, and operation times.

This report has a 132-column format and is designed to be copied to a printer.

Example: Print Circulating Nurse Staffing Report

```
Select Surgery Staffing Reports Option: NC  Circulating Nurse Staffing Report
```

```
Circulating Nurse Staffing Report

Do you want the report for all nurses ?  YES// <RET>

Start with Date: 3/2  (MAR 02, 1992)
End with Date: 3/31  (MAR 31, 1992)

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
CIRCULATING NURSE STAFFING REPORT
FROM: MAR 2,1992 TO: MAR 31,1992

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: APR 21,1992

DATE CASE #	PATIENT ID#	OPERATION(S)	SCRUB NURSE	CIRC. NURSE	TIME IN TIME OUT ELAPSED (MINS)
		** BEND,ELMORE **			
03/10/92 189	CLAMPETT,ELLIE MAE 231-21-2234	DRAINAGE OF OVARIAN CYST	NURSE,NANCY	BEND,ELMORE	07:00 08:54 114
		** HUFF,ROSE **			
03/09/92 187	OAT,WILLIE 449-34-5555	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	NURSE,NANCY	HUFF,ROSE	09:15 12:40 205
03/10/92 200	RUBBLE,BETTY 123-45-9999	HEMORRHOIDECTOMY	NURSE,NANCY	HUFF,ROSE	14:00 14:55 55
03/17/92 203	SMITH,JAMES 123-45-7684	CHOLECYSTECTOMY	NURSE,NANCY	HUFF,ROSE	12:55 14:30 95
03/18/92 202	BASS,EARNEST T. 123-45-5119	REPAIR INCARCERATED INGUINAL HERNIA	NURSE,NANCY BEND,ELMORE	HUFF,ROSE	07:30 09:03 93
		** THRASHER,KELLY D **			
03/03/92 205	HATHAWAY,JANE 333-33-3333	REMOVE CATARACTS, RETRO BULBAR BLOCK	NURSE,NANCY	THRASHER,KELLY D	09:00 09:20

1.3 Anesthesia Reports

This option provides a submenu for printing various anesthesia reports.

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

A	*Anesthesia AMIS*
P	*List of Anesthetic Procedures*
D	*Anesthesia Provider Report*

1.3.1 Anesthesia AMIS

This option compiles statistics for all surgical cases and non-O.R. procedures within the date range selected and then generates a report. This option is locked with the SROAAMIS key.

The Anesthesia AMIS Report prints in a 132-column format and must be copied to a printer.

Example: Printing the Anesthesia AMIS Report

```
Select Anesthesia Menu Option: A  Anesthesia AMIS
```

```
Anesthesia AMIS


Start with Date: 1 1 95  (JAN 01, 1995)
End with Date: 1 31 95  (JAN 31, 1995)

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


This report is designed to use a 132 column format, and must be run
on a printer.

Select Printer:  [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
ANESTHESIA SERVICE
ANESTHESIA AMIS
FROM: JAN 1,1995 TO: JAN 31,1995

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: FEB 7,1995

ANESTHETICS ADMINISTERED BY PRINCIPAL TECHNIQUE USED

TOTAL NO OF ANES-THETICS ADMINISTERED	GENERAL	MAC	SPINAL	EPIDURAL	OTHER	LOCAL
54	8	1	3	1	0	41

ANESTHETICS FOR PROCEDURES ADMINISTERED BY:						**	ANESTHETICS FOR DIAG. & THERA. PROCEDURES ADMINISTERED BY:					
ANESTHESIOLOGIST		NURSE ANESTHETIST		OTHER		**	ANESTHESIOLOGIST		NURSE ANESTHETIST		OTHER	
NUMBER OF ANESTHETICS	NO. OF DEATHS	NUMBER OF ANESTHETICS	NO. OF DEATHS	NUMBER OF ANESTHETICS	NO. OF DEATHS	**	NUMBER OF ANESTHETICS	NO. OF DEATHS	NUMBER OF ANESTHETICS	NO. OF DEATHS	NUMBER OF ANESTHETICS	NO. OF DEATHS
9	0	3	0	40	1	**	1	0	0	0	1	0

DEATHS WITHIN 24 HOURS OF INDUCTION OF ANESTHETIC

TOTAL NUMBER OF DEATHS	GENERAL	MAC	SPINAL	EPIDURAL	OTHER	LOCAL
1	0	0	0	0	0	1

1.3.2 List of Anesthetic Procedures

This option generates a report listing each completed case within the date range selected. It sorts by date order and provides the anesthesia personnel. This report also provides the anesthesia start, end, and elapsed times for each case.

After you enter the date range, the computer will ask if you want the List of Anesthetic Procedures to include 1) only operating room surgical procedures, 2) non-OR procedures, or 3) both.

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

Example 1: Print the List of Anesthetic Procedures for only O.R. Surgical Procedures

```
Select Anesthesia Reports Option: P  List of Anesthetic Procedures
```

```
List of Anesthetic Procedures

Start with Date: 8/8  (AUG 08, 1996)
End with Date: 8/25  (AUG 25, 1996)
```

```
Print List of Anesthetic Procedures for

1. O.R. Surgical Procedures.
2. Non-O.R. Procedures.
3. Both O.R. Surgical Procedures and Non-O.R. Procedures.

Select Number:  1// <RET>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

..... *printout follows* .....

```
                                                    MAYBERRY, NC                                                    PAGE: 1
                                                  SURGICAL SERVICE                          REVIEWED BY:
                                            LIST OF ANESTHETIC PROCEDURES                   DATE REVIEWED:
O.R. SURGICAL PROCEDURES                   FROM: AUG 8,1996  TO: AUG 25,1996                DATE PRINTED: SEP 21,1996

  DATE            PATIENT                    PRINCIPAL DIAGNOSIS                            PRIN ANESTHETIST    START TIME
  CASE #            ID#                      PROCEDURE(S)                                   ANESTH TECHNIQUE     END TIME
                  ASA CLASS                                                                 ANESTH AGENT         ELAPSED
=================================================================================================================================
08/08/96 08:00  BOLD,BARRY              ABDOMINAL WOUND DEHISCENSE                         HAYES,ROBERT         08:00
63085           124-56-7953             CLOSURE ABDOMINAL DEHISCENSE                       GENERAL              10:30
                MILD DISTURB.                                                              DESFLURANE 240ML BTL 90

08/12/96 08:30  BYROM,BUZZY             CA OF LARYNX                                       DOLLAR,JOHN E        08:35
63090           111-22-1111             LARYNGECTOMY                                       GENERAL              10:35
                SEVERE DISTURB.                                                            SUFENTANIL CITRATE 5 120

08/16/96 08:00  BLOCKER,DAVID           LESION RT EAR LOBE                                 WRIGHT,WILBUR        08:05
63094           171-12-5645             EXC LESION LESIO RT EAR LOBE                       LOCAL                08:30
                NO DISTURB.                                                                LIDOCAINE 2% (20MG/M 25

08/21/96 06:00  FRANKLIN,BENJAMIN       DIAGNOSTIC COLONOSCOPY                             HAYES,ROBERT         06:00
63100           287-38-1876             COLONOSCOPY                                        GENERAL              07:05
                MILD DISTURB.                                                              PROPOFOL 20ML INJ    65

08/21/96 07:00  BALTIMORE,LORD          PARATHYROID ADENOMA                                WRIGHT,WILBUR        07:00
63104           321-98-4352             PARATHYROID EXPLORATION AND EXCISION ADENOMA       GENERAL              09:00
                SEVERE DISTURB.                                                            SUFENTANIL CITRATE 5 120

08/22/96 10:10  REARICK,DAVID JR        HX OF POLYP                                        HAYES,ROBERT         10:15
63106           000-99-8888             COLONOSCOPY, POLYPECTOMY                           GENERAL              11:15
                MILD DISTURB.                                                              PROPOFOL 20ML INJ    60

08/22/96 09:56  FOX,NINA E.             CHOLECYSTITIS                                      DOLLAR,JOHN E        10:00
63110           134-38-3894             LAP CHOLE                                          GENERAL              11:55
                MILD DISTURB.                                                              DESFLURANE 240ML BTL 115

08/24/96 14:55  UPRIGHT,WILLIAM BOLT    INGUINAL HERNIA                                    WRIGHT,WILBUR        14:55
63115           212-65-0036             INGUINAL HERNIA REPAIR                             GENERAL              16:05
                MILD DISTURB.                                                              PROPOFOL 20ML INJ    70
```

Example 2: Print the List of Anesthetic Procedures for only Non-OR Procedures

```
Select Anesthesia Reports Option: P  List of Anesthetic Procedures
```

```
List of Anesthetic Procedures

Start with Date: 1/1  (JAN 01, 1995)
End with Date: 1/7  (JAN 07, 1995)
```

```
Print List of Anesthetic Procedures for

1. O.R. Surgical Procedures.
2. Non-O.R. Procedures.
3. Both O.R. Surgical Procedures and Non-O.R. Procedures.

Select Number:  1// 2

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
LIST OF ANESTHETIC PROCEDURES
FROM: JAN 1,1995 TO: JAN 7,1995

PAGE: 1

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: JAN 15,1995

NON-O.R. PROCEDURES

DATE CASE #	PATIENT ID# ASA CLASS	PRINCIPAL DIAGNOSIS PROCEDURE(S)	PRIN ANESTHETIST ANESTH TECHNIQUE ANESTH AGENT	START TIME END TIME ELAPSED
01/02/95	JADESTONE,MICK	TB	NELSON.TONY	09:43
51051	232-32-3444	BRONCHOSCOPY	GENERAL	10:25
	MILD DISTURB.		PHENOBARBITAL SODIUM	42
01/02/95	JADESTONE,MICK	ILEITIS	EARLY,JUBAL	10:00
51053	232-32-3444	COLONSCOPY	OTHER	11:10
	MILD DISTURB.		FENTANYL 250MCG/5ML	70
01/02/95	LANE,BRONCO	ESOPHAGEAL VARICES	BUELL,GEORGE	13:10
51057	343-34-3343	ESOPHAGOSCOPY	GENERAL	13:45
	NO DISTURB.		PROPOFOL 20ML INJ	35
01/04/95	HATHAWAY,JANE	HISTOPLASMOSIS	BUELL,GEORGE	08:20
51169	333-33-3333	BRONCHOSCOPY	OTHER	09:15
	MILD DISTURB.		FENTANYL 250MCG/5ML	55
01/04/95	CASH,JOHNNY	CARDIAC ARRYTHMIA	KIMBALL,HANK	18:50
88	159-23-6547	CARDIOVERSION	GENERAL	19:25
	NO DISTURB.		PHENOBARBITAL 30MG/7	35
01/07/95	HATHAWAY,JANE	HISTOPLASMOSIS	BUELL,GEORGE	10:05
51181	333-33-3333	BRONCHOSCOPY	OTHER	11:05
	MILD DISTURB.		FENTANYL 250MCG/5ML	60
01/07/95	HORMONE,JOHNNY	CHRONIC DEPRESSION	KIMBALL,HANK	13:10
51185	217-63-5402	ELECTROCONVULSIVE THERAPY	OTHER	13:35
	MILD DISTURB.		MIDAZOLAM 1MG/1ML 2M	25

1.3.3 Anesthesia Provider Report

This report provides information concerning the anesthesia staff and techniques for completed cases within a selected date range. This report can be generated for all anesthesia providers or you can specify one. It sorts the cases by the principal anesthetist and includes information on anesthesia personnel, technique, agent, level of supervision, and elapsed anesthesia time.

This report has a 132-column format and is designed to be copied to a printer.

Example: Print the Anesthesia Provider Report

```
Select Anesthesia Reports Option: D  Anesthesia Provider Report
```

```
Anesthesia Provider Report

Start with Date: 3/2  (MAR 02, 1992)
End with Date: 3/15  (MAR 15, 1992)

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


Print the report for which Anesthesia Provider ?  WATSON,CHERYL

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
ANESTHESIA PROVIDER REPORT
FROM: MAR 23,1999 TO: MAR 24,1999

PAGE: 1
REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: MAR 29,1999

DATE CASE #	PATIENT ID#	PROCEDURE(S)	SUPERVISOR RELIEF ANESTH ASST ANESTH	ASA CLASS PRINCIPAL TECHNIQUE ANESTHESIA AGENT	LEVEL OF SUPERVISION ELAPSED ANES TIME
***** WATSON,CHERYL *****					
03/23/99 54014	W0RD, M 119-11-9119	ESS, SEPTO,WITH LEFT TURBINECTOMY SCAR REVISION	JENNINGS,G SMOOT,F	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 105 MINS.
03/23/99 54020	ZIFFEL, D 353-23-3221	COLONOSCOPY/ATTEMPTED	JENNINGS,G DOOLITTLE,J	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 55 MINS.
03/23/99 54050	CLAMPETT, E 231-21-2234	CYSTO, RETROGRADE, STENT	JENNINGS,G SMOOT,F	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 45 MINS.
03/24/99 54023	RUBBLE, B 123-45-9999	COLONOSCOPY/POLYPECTOMY	JENNINGS,G DOOLITTLE,J	SEVERE DISTURB. GENERAL PROPOFOL 20ML INJ	1 50 MINS.
03/24/99 54025	NASIUM, J 121-21-2453	COLONOSCOPY	JENNINGS,G SMOOT,F	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 65 MINS.
03/24/99 54024 NON-OR	HATHAWAY, J 333-33-3333	CARDIOVERSION	JENNINGS,G DOOLITTLE,J	SEVERE DISTURB. GENERAL MIDAZOLAM 1MG/1ML 2M	1 35 MINS.
03/24/99 54058	DRUCKER, S 233-41-8719	HEMORRHOIDECTOMY	JENNINGS,G SMOOT,F	SEVERE DISTURB. SPINAL BUPIVACAINE 0.25%	1 45 MINS.
03/24/99 54079	TAYLOR, O 112-22-3334	EXPL LAP, LYSIS OF ADHESIONS	JENNINGS,G SMOOT,F DOOLITTLE,J	SEVERE DIST.-EMERG GENERAL DESFLURANE 240ML BTL	1 120 MINS.

1.4 CPT Code Reports

This menu contains reports based on CPT codes.

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

C	*Cumulative Report of CPT Codes*
A	*Report of CPT Coding Accuracy*
M	*List Completed Cases Missing CPT Codes*

1.4.1 Cumulative Report of CPT Codes

This option counts and reports the number of times a procedure was performed (based on CPT codes) during a specified date range. There is also a column showing how many times the procedure was in the Principal Procedure category, and how many times it was in the Other Operative Procedure category.

After you enter the date range, the computer will ask if you want the Cumulative Report of CPT Codes to include 1) only operating room surgical procedures, 2) non-OR procedures, or 3) both.

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

Example 1: Print the Cumulative Report of CPT Codes for only OR Surgical Procedures

```
Select CPT Code Reports Option: C  Cumulative Report of CPT Codes
```

```
Cumulative Report of CPT Codes

Start with Date: 3/28  (MAR 28, 1999)
End with Date: 4/3  (APR 03, 1999)
```

```
Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number:  1// <RET>

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
CUMULATIVE REPORT OF CPT CODES
FROM: MAR 28,1999 TO: APR 3,1999

REVIEWED BY
DATE REVIEWED:

O.R. SURGICAL PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	1	1	0
11440 REMOVAL OF SKIN LESION	1	1	0
11441 REMOVAL OF SKIN LESION	4	4	0
11641 REMOVAL OF SKIN LESION	4	2	2
24075 REMOVE ARM/ELBOW LESION	1	1	0
26989 HAND/FINGER SURGERY	1	1	0
30520 REPAIR OF NASAL SEPTUM	1	1	0
31231 NASAL ENDOSCOPY, DX	1	0	1
45315 PROCTOSIGMOIDOSCOPY	1	0	1
45330 SIGMOIDOSCOPY, DIAGNOSTIC	7	7	0
45333 SIGMOIDOSCOPY & POLYPECTOMY	1	1	0
45378 DIAGNOSTIC COLONOSCOPY	2	2	0
45385 COLONOSCOPY, LESION REMOVAL	3	3	0
47600 REMOVAL OF GALLBLADDER	1	0	1
49000 EXPLORATION OF ABDOMEN	1	1	0
49505 REPAIR INGUINAL HERNIA	2	1	1
66984 REMOVE CATARACT, INSERT LENS	4	3	1
68801 DILATE TEAR DUCT OPENING	1	1	0

Example 2: Print the Cumulative Report of CPT Codes for only Non-OR Procedures

```
Select CPT Code Reports Option: C  Cumulative Report of CPT Codes
```

```
Cumulative Report of CPT Codes

Start with Date: 7 1 96  (JUL 01, 1996)
End with Date: 12 31 96  (DEC 31, 1996)
```

```
Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number:  1// 2

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
CUMULATIVE REPORT OF CPT CODES
FROM: JUL 1,1996 TO: DEC 31,1996

REVIEWED BY
DATE REVIEWED:

NON-O.R. PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	2	2	0
10061 DRAINAGE OF SKIN ABSCESS	1	1	0
11040 DEBRIDE SKIN PARTIAL	8	8	0
11042 DEBRIDE SKIN/TISSUE	1	1	0
11100 BIOPSY OF SKIN LESION	11	11	0
11402 REMOVAL OF SKIN LESION	1	1	0
11420 REMOVAL OF SKIN LESION	1	1	0
11620 REMOVAL OF SKIN LESION	1	1	0
11640 REMOVAL OF SKIN LESION	1	1	0
11730 REMOVAL OF NAIL PLATE	1	1	0
11750 REMOVAL OF NAIL BED	1	1	0
12001 REPAIR SUPERFICIAL WOUND(S)	3	3	0
12011 REPAIR SUPERFICIAL WOUND(S)	2	2	0
14060 SKIN TISSUE REARRANGEMENT	1	1	0
15782 ABRASION TREATMENT OF SKIN	1	1	0
17340 CRYOTHERAPY OF SKIN	1	1	0
20550 INJ TENDON/LIGAMENT/CYST	23	23	0
29799 CASTING/STRAPPING PROCEDURE	1	1	0
46083 INCISE EXTERNAL HEMORRHOID	2	2	0

1.4.2 Report of CPT Coding Accuracy

This report lists cases sorted by the CPT code used in the PRINCIPAL PROCEDURES field and OTHER OPERATIVE PROCEDURES field. This option is designed to help check the accuracy of the coding procedures.

About some prompts

"Do you want to print the Report of CPT Coding Accuracy for all CPT Codes?"
Reply "No" to this prompt to produce the report for only one CPT code. Then you will be prompted to enter the CPT code or category.

"Do you want to sort the Report of CPT Coding Accuracy by Surgical Specialty?"
Press the Return key if you want to sort the report by specialty. Enter "NO" to sort the report by date only.

"Do you want to print the Report to Check Coding Accuracy for all Surgical Specialties ?"
You can enter the code or name of the surgical service you want the report to be based on. Or, press the Return key to print the report for all surgical specialties.

Example 1: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Surgical Specialty

```
Select CPT Code Reports Option: A  Report of CPT Coding Accuracy
```

```
Report to Check CPT Coding Accuracy

Start with Date: 10 8 96  (OCT 08, 1996)
End with Date: 10 8 96  (OCT 08, 1996)
```

```
Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// <RET>

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  <RET>
```

```
Do you want to sort the Report of CPT Coding Accuracy by
Surgical Specialty ?  YES//  <RET>


Do you want to print the Report to Check Coding Accuracy for all
Surgical Specialties ?  YES//  NO

Print the Coding Accuracy Report for which Surgical Specialty ?  50       GENERA
L(OR WHEN NOT DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)     50
```

```
This report is designed to use a 132 column format.


Select Device:
```
[Select Print Device]

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF CPT CODING ACCURACY
FOR GENERAL(OR WHEN NOT DEFINED BELOW)
FROM: OCT 8,1996 TO: OCT 8,1996

REVIEWED BY:
DATE REVIEWED:

O.R. SURGICAL PROCEDURES

PROCEDURE DATE / CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER / ATTEND SURG/PROV
		47600 REMOVAL OF GALLBLADDER PRINCIPAL PROCEDURES DESCRIPTION: CHOLECYSTECTOMY;	
10/08/96 07:00 63072	DUNCAN,ZACHARY 332-00-1234	CHOLECYSTECTOMY (47600-22)	FINE,LARRY ADAMS,DOC
		47605 REMOVAL OF GALLBLADDER OTHER PROCEDURES DESCRIPTION: CHOLECYSTECTOMY; WITH CHOLANGIOGRAPHY	
10/08/96 10:00 63077	WEINKIEBEAN,FUNKIE 232-34-2345	INGUINAL HERNIA (49521), OTHER OPERATIONS: CHOLECYSTECTOMY (47605-22)	REED,DANNY ADAMS,DOC
		49505 REPAIR INGUINAL HERNIA PRINCIPAL PROCEDURES DESCRIPTION: REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE	
10/08/96 06:00 63071	KREIS,ADAM 232-31-2123	INGUINAL HERNIA (49505)	ADAMS,DOC MONTALI,MICHAEL A.

Example 2: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Date

```
Select CPT Code Reports Option: A  Report of CPT Coding Accuracy
```

```
Report to Check CPT Coding Accuracy

Start with Date: 10 1 96  (OCT 08, 1996)
End with Date: 10 7 96  (OCT 08, 1996)
```

```
Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// <RET>

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  <RET>
```

```
Do you want to sort the Report of CPT Coding Accuracy by
Surgical Specialty ?  YES//  N

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

..... *printout follows* .....

```
                                                    MAYBERRY, NC                                                          PAGE
                                                  SURGICAL SERVICE                                                          1
                                           REPORT OF CPT CODING ACCURACY                  REVIEWED BY:
                                          FROM: OCT 1,1996  TO: OCT 7,1996                DATE REVIEWED:
O.R. SURGICAL PROCEDURES

 PROCEDURE DATE     PATIENT                                PROCEDURES                                        SURGEON/PROVIDER
   CASE #             ID#                                                                                     ATTEND SURG/PROV
                    SPECIALTY
==================================================================================================================================

                                                 31365  REMOVAL OF LARYNX
                                            PRINCIPAL PROCEDURES
                                               DESCRIPTION: LARYNGECTOMY;
                                          TOTAL, WITH RADICAL NECK DISSECTION

----------------------------------------------------------------------------------------------------------------------------------
10/03/96 07:00      GRIFFIN,ROBERT                         PULMONARY LOBECTOMY (31365)                       DAVIS,DOUG
   63059            123-45-2968                                                                              REED,DANNY
                    THORACIC SURGERY (INC. CARDIAC SURG.)

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

                                                 32440  REMOVAL OF LUNG
                                            PRINCIPAL PROCEDURES
                        DESCRIPTION: REMOVAL OF LUNG, TOTAL PNEUMONECTOMY;

----------------------------------------------------------------------------------------------------------------------------------
10/03/96 10:00      OWENS,JAMES                            PULMONARY LOBECTOMY (32440)                       ADAMS,DOC
   63060            123-45-8413                                                                              REED,DANNY
                    THORACIC SURGERY (INC. CARDIAC SURG.)

10/04/96 06:00      LANE,TIMOTHY                           PULMONARY LOBECTOMY (32440)                       TRAPPER,JOHN
   63069            123-45-1842                                                                              TRAPPER,JOHN
                    THORACIC SURGERY (INC. CARDIAC SURG.)

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

                                                 32480  PARTIAL REMOVAL OF LUNG
                                            PRINCIPAL PROCEDURES
                        DESCRIPTION: REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY;
                                SINGLE LOBE (LOBECTOMY)

----------------------------------------------------------------------------------------------------------------------------------
10/03/96 06:00      STEMBRIDGE,TOM                         PULMONARY LOBECTOMY (32480)                       FINE,LARRY
   63049            112-34-5678                                                                              HOWARD,MOE
                    THORACIC SURGERY (INC. CARDIAC SURG.)

10/03/96 07:00      GLASCOCK,DALE                          PULMONARY LOBECTOMY (32480)                       FINE,LARRY
   63050            516-52-4190                                                                              FINE,LARRY
                    THORACIC SURGERY (INC. CARDIAC SURG.)
```

Example 3: Print the Report of CPT Coding Accuracy for Non-OR Procedures, sorted by CPT Code and Medical Specialty

```
Select CPT Code Reports Option: A  Report of CPT Coding Accuracy
```

```
Report to Check CPT Coding Accuracy

Start with Date: 1 1 95  (JAN 01, 1995)
End with Date: 8 31 95  (AUG 31, 1995)
```

```
Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// 2

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  N


Print the Coding Accuracy Report for which CPT Code ?  92960
HEART ELECTROCONVERSION
        CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF
        ARRHYTHMIA, EXTERNAL
```

```
Do you want to sort the Report of CPT Coding Accuracy by
Medical Specialty ?  YES//  <RET>


Do you want to print the Report to Check Coding Accuracy for all
Medical Specialties ?  YES//  N


Print the Coding Accuracy Report for which Medical Specialty ?   MEDICINE

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

..... printout follows .....

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF CPT CODING ACCURACY
FOR MEDICINE
FROM: JAN 1,1995 TO: AUG 31,1995

PAGE 1

REVIEWED BY:
DATE REVIEWED:

NON-O.R. PROCEDURES

92960 HEART ELECTROCONVERSION
PRINCIPAL PROCEDURES
DESCRIPTION: CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF ARRHYTHMIA, EXTERNAL

PROCEDURE DATE CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
01/24/95 15499	BASS,EARNEST T. 123-45-5119	CARDIOVERSION (92960)	FINE,LARRY FINE,LARRY
02/09/95 15701	MAYER,OSCAR L. 101-01-0101	CARDIOVERSION (92960)	HOWARD,MOE FINE,LARRY
03/29/95 15912	MERIWETHER,MALCOLM 212-34-3434	CARDIOVERSION (92960)	WELBY,MARCUS
08/04/95 16669	FIFE,BARNEY 222-00-1234	CARDIOVERSION (92960)	TRAPPER,JOHN ADAMS,DOC
08/25/95 16828	LAWSON,FLOYD 911-99-1111	CARDIOVERSION (92960)	FINE,LARRY FINE,LARRY

1.4.3 List Completed Cases Missing CPT Codes

This option generates a report of completed cases that are missing a CPT code for the principal or secondary operation(s) within a specified date range.

CPT codes need to be attributed to each procedure; only procedures that have CPT codes are included in the Annual Report of Surgical Procedures. You can use the *Operation Menu*, *Operation* option, to add a CPT code to a case.

After you enter the date range, the computer will ask if you want the Cumulative Report of CPT Codes to include 1) only operating room surgical procedures, 2) non-OR procedures, or 3) both.

This report is in an 80-column format and can be viewed on your terminal screen.

Example: List Completed Cases Missing CPT Codes

```
Select CPT Code Reports Option: M  List Completed Cases Missing CPT Codes
```

```
Print list of Completed Cases Missing CPT Codes for

1. OR Surgical Procedures.
2. Non-OR Procedures.
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// 1
```

```
Do you want the list for all Surgical Specialties ?  YES//  <RET>

Start with Date: 2/1  (APR 01, 1999)
End with Date: 4/30  (APR 20, 1999)

Print the List of Cases Missing CPT codes to which Printer ?  [Select Print Device]
```

..... *printout follows* .....

```
                                MAYBERRY, NC
                       Completed Cases Missing CPT Codes
                            O.R. Surgical Procedures
                       From: FEB 1,1999  To: APR 30,1999
                  Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Operation Date    Patient (ID#)                            Surgeon/Provider
Case #
================================================================================
FEB 01, 1999      JACKSON,THOMAS J. (878-98-1828)          TRAPPER,JOHN
53708
                  * EXC LEFT PREAURICULAR LESION (CPT: MISSING)
--------------------------------------------------------------------------------
FEB 08, 1999      EDWARDS,JONATHAN (777-01-9119)           HOWARD,MOE
53747
                  * EXCISION LESIONS SCALP (CPT: 11420)
                  * N/A (CPT: MISSING)
--------------------------------------------------------------------------------
MAR 12, 1999      FUDD,ELMER (222-11-3333)                 FINE,LARRY
53973
                  * COLONOSCOPY (CPT: MISSING)
--------------------------------------------------------------------------------
MAR 23, 1999      FORD,JERALD C. (654-43-2109)             HOWARD,MOE
54030
                  * COLONOSCOPY/ATTEMPTED (CPT: MISSING)
--------------------------------------------------------------------------------
APR 27, 1999      DILLON,MATTHEW H (414-14-1414)           PORCINE,PERRY
54325
                  * EXCISION RT FOREARM LESIONS (CPT: MISSING)
                  * EXC LESION, RT EAR (CPT: MISSING)
                  * EXC LESION, RT FOREHEAD (CPT: MISSING)
                  * EXC LESION RT SCALP (CPT: MISSING)
                  * RXC LESION, NOSE (CPT: MISSING)
                  * EXC LESION, LEFT EAR (CPT: MISSING)
                  * EXC LESION, LEFT FOREARM (CPT: MISSING)
                  * EXC LESION, TOP OF HEAD (CPT: MISSING)
                  * EXC LESION, LEFT NECK (CPT: MISSING)
--------------------------------------------------------------------------------
```

2.0 Laboratory Interim Report

This option will access the Laboratory Package to show what lab tests the patient has had. This option will print or display interim reports for a selected patient, within a given time period. The printout will go in inverse date order. This report will output all tests for the time period specified. This option only prints verified results and does not output the microbiology reports.

Example: Laboratory Interim Report

```
Select Surgery Menu Option: L   Laboratory Interim Report

Select Patient Name: WILLIAMS,ROSEMARY         03-03-59     334567821     NO
    NON-VETERAN (OTHER)
Date to START with: TODAY//5 15 97  (MAY 15, 1997)
Date to END  with: T-7//5 1 97  (MAY 01, 1997)
DEVICE: [Select Print Device]
```

..... *printout follows* .....

```
WILLIAMS,ROSEMARY                                  09/21/1998 1:21 pm
     SSN: 334-56-7821    SEX: F    AGE: 40    LOC: LRC

       Provider: ADAMS,DOC
       Specimen: SERUM
Accession [UID]: CH 0513 1 [3471330001]

                              05/13/1997 07:00
     Test name                Result    units      Ref.   range
     GLUCOSE                     87     mg/dL        60 -  123
     UREA NITROGEN               22     mg/dL        11 -   24
     CREATININE                 1.8     mg/dl         1 -  2.1
     POTASSIUM                  4.4     meq/L       3.5 -  4.8
     SODIUM                     143     meq/L       135 -  145
     CHLORIDE                   103     meq/L        95 -  105
     CO2                       27.0     meq/L        20 -   32
     CALCIUM                    8.7     mg/dL       8.5 -   11
==============================================================================
       KEY: "L"=Abnormal low, "H"=Abnormal high, "*"=Critical value


WILLIAMS,ROSEMARY          334-56-7821  09/21/1998 1:21 pm  PRESS '^' TO STOP
```

Chapter Four: Chief of Surgery Reporting

Introduction
This chapter describes options and reports for the exclusive use of the Surgical Service Chief, or his or her designee. The Chief has access to lists of cancellations and operations to be dictated, the Morbidity and Mortality Report, and Patient Complications.

Getting Out of an Option
To stop what you are doing, enter an up-arrow (^). You can use the up-arrow at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continue entering up-arrows to completely exit the system.

Overview
The main options included in this chapter are listed below. To the left of the option name is the shortcut synonym you can enter to select the option. The *Chief of Surgery Menu* option will not display if you do not have proper security clearance.

CH	*Chief of Surgery Menu*
D	*Surgeons' Dictation Menu*

1.0 Chief of Surgery Menu

The *Chief of Surgery Menu* is a restricted option allowing access to various management reports and functions. It is designed for the Chief of Surgery and his or her designees. The menu items under this option are as follows:

V	*View Patient Perioperative Occurrences*
M	*Management Reports ...*
U	*Unlock a Case for Editing*
RET	*Update Status of Returns Within 30 Days*
CAN	*Update Cancelled Case ...*
D	*Update Operations as Unrelated/Related to Death*
CODE	*Update/Verify Procedure/Diagnosis Codes*

1.1 View Patient Perioperative Occurrences

This option is designed to give the Chief of Surgery a quick view of any occurrences for a particular case. This report can be viewed on a terminal screen.

Example: View Patient Perioperative Occurrences

```
Select Chief of Surgery Menu Option: V  View Patient Perioperative Occurrences

Select Patient: OAT,WILLIE         09-01-50     449345555
```

```
 OAT,WILLIE   449-34-5555

1. 09-15-92   BYPASS (REQUESTED)

2. 09-15-92   CAROTID ARTERY ENDARTERECTOMY (SCHEDULED)

3. 03-09-92   CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)



Select Operation: 3
```

```
OAT,WILLIE (449-34-5555)                          OCCURRENCES
--------------------------------------------------------------------------------

Date of Operation:   MAR 09, 1992 09:15
Principal Operation: CHOLECYSTECTOMY (47480)

Surgeon:           FINE,LARRY
Attending Surgeon: HOWARD,MOE
Attending Code:    1. ATTENDING IN O.R.

Principal Postop Diagnosis:   CHOLECYSTITIS (574.01)

Intraoperative Occurrences:   PUNCTURED MESENTERIC ARTERY
                              Outcome: IMPROVED

Postoperative Occurrences:    EDEMA (03/10/92)
                              Outcome: IMPROVED

Press RETURN to continue  <RET>
```

1.2 Management Reports

This menu is designed to give the Chief of Surgery various management reports. The reports contained on this menu are listed below. To the left of the option/report name is the shortcut synonym you can enter to select the option:

MM	*Morbidity & Mortality Reports*
MV	*M&M Verification Report*
CD	*Comparison of Preop and Postop Diagnosis*
D	*Delay and Cancellation Reports ...*
V	*List of Unverified Surgery Cases*
RET	*Report of Returns to Surgery*
A	*Report of Daily Operating Room Activity*
U	*List of Undictated Operations*
NS	*Report of Cases Without Specimens*
ICU	*Report of Unscheduled Admissions to ICU*
OR	*Operating Room Utilization Report*
WC	*Wound Classification Report*
QM	*Quarterly Report Menu ...*
BA	*Print Blood Product Verification Audit Log*

1.2.1 Morbidity & Mortality Reports

This option generates two reports: the Perioperative Occurrences Report and the Mortality Report. The Perioperative Occurrences Report includes all cases that have occurrences, both intraoperatively and postoperatively. These reports sort by service within a date range. Each surgical service will begin on a separate page.

After you enter the date range, the computer will ask if you want to generate both reports. If you answer "No", the computer will ask you to select from 1) the Perioperative Occurrences Report or 2) the Mortality Report.

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

Example 1: Printing the Perioperative Occurrences Report

```
Select Management Reports Option:  MM Morbidity & Mortality Reports
```

```
The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report.  Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N
```

```
1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 1

Start with Date: 6/1  (JUN 01, 1992)

End with Date: T  (JUL 02, 1992)
```

```
Do you want to print this report for all Surgical Specialties ? YES// NO


Print the report for which Specialty ?  GENERAL(OR WHEN NOT DEFINED BELOW)  GENERAL(OR
WHEN NOT DEFINED BELOW)        50
Select an Additional Specialty:        <RET>

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
PERIOPERATIVE OCCURRENCES
FROM: AUG 1,1999 TO: AUG 31,1999

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: SEP 22,1999

PATIENT ID# / OPERATION DATE	PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
GENERAL(OR WHEN NOT DEFINED BELOW)			
DRUCKER,SAMUEL H. 233-41-8719 AUG 07, 1999@07:15	REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (08/09/99) IV ANTBIOTICS	I
UPRIGHT,WILLIAM BOLT 212-65-0036 AUG 31, 1999@09:00	CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (09/02/99) ANTIBIOTICS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Example 2: Print the Mortality Report

```
Select Management Reports Option:  MM Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report.  Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 2

Start with Date: 2/1/92  (FEB 01, 1992)

End with Date: 3/26/92  (MAR 26, 1992)


This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
MORTALITY REPORT
FROM: JAN 1,1998 TO: DEC 31,1998

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: SEP 22,1999

OPERATION DATE	PATIENT ID#	PRINCIPAL OPERATIVE PROCEDURE	DATE OF DEATH AUTOPSY (Y/N)
		OTORHINOLARYNGOLOGY (ENT)	
JAN 22, 1998	CROCKETT,DAVID 211-32-2433	LARYNGOSCOPY, BRONCHOSCOPY, ESOPHAGOGASTROSCOPY	FEB 09, 1998 NO
JAN 27, 1998	WAYNE,BRUCE 819-72-6354	BRONCHOSCOPY	FEB 26, 1998 NOT AVAILABLE
JAN 29, 1998	CROCKETT,DAVID 211-32-2433	BILATERAL NECK DISECTION, LARYNGECTOMY	FEB 09, 1998 NO
FEB 08, 1998	CROCKETT,DAVID 211-32-2433	LIGATION LT INTERNAL JUGLAR , EXPLORATORY LAPARATOMY	FEB 09, 1998 NO
FEB 19, 1998	GOLIATH,DAVID M. 676-76-7676	TRACH	FEB 21, 1998 NO
OCT 20, 1998	BROWN,JAMES 777-88-9999	LARYNGOSCOPY W/ BX, ESOPHAGOSCOPY	NOV 01, 1998 NOT AVAILABLE

1.2.2 M&M Verification Report

This option produces the M&M Verification Report that may be useful for (1) reviewing occurrences and their assignments to operations and (2) reviewing death unrelated/related assignments to operations

Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range and experienced intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk-assessed operations that are in a completed state but have not yet transmitted to the national database.

Variety #1: Report information is printed patient by patient, listing all operations for the patient that occurred during the selected date range, as well as any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that were performed prior to the selected date range, and, if printed by specialty, may include operations performed by other specialties. For every operation that is listed, the intraoperative and postoperative occurrences are also listed. The report also includes information about whether the operation was unrelated or related to death as well as the risk assessment type and status (if assessed). The report may be printed for a selected list of surgical specialties.

Variety #2: Report information is printed patient by patient in a format similar to Variety #1. This report lists all risk-assessed operations that are in a completed state but have not yet transmitted to the national database and that have intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The report includes any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some other operations that may or may not be risk assessed, and, if risk assessed, may have any risk assessment status (incomplete, complete, or transmitted). Every patient listed on this report will have at least one operation with a risk assessment status of “complete”.

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

```
Select Management Reports Option: MV  M&M Verification Report
```

```
                              M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences
and their assignments to operations and in the review of death unrelated or
related assignments to operations.  Two varieties of this report are available.
The first variety provides a report of all patients who had operations within
the selected date range who experienced intraoperative occurrences,
postoperative occurrences, or death within 90 days of surgery.  The second
variety provides a similar report for all risk assessed operations that are in
a completed state but have not yet transmitted to the national database.

Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.
```

```
Enter selection (1 or 2): 1// <RET>

Start with Date: 12 30 95  (DEC 30, 1995)
End with Date: 1 29 96  (JAN 29, 1996)


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

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
M&M Verification Report
From: DEC 30,1995 To: JAN 29,1996
Report Generated: OCT 21,1997

Reviewed By:
Date Reviewed:

Page 1

Op Date	Specialty	Procedure(s)	Death Related	Occurrence(s) - (Date)	Assessment Type/Status
>>> FLINSTONE,FRED (111-22-1850) - DIED 02/27/96					
01/06/96	GENERAL	TOTAL LARYNGECTOMY	NO		NON-CARD/T
01/29/96	THORACIC	CABG, VEIN, SIX+	NO		CARDIAC/I
11/20/95	PERIPHERAL	LT CAROTID ENDOARTERECTOMY	N/A	OTHER OCCURRENCE (11/20/95) ICD: 998.4 FB LEFT DURING PROCEDURE URINARY TRACT INFECTION * (12/08/95) ICD: 599.0 URIN TRACT INFECTION NOS OTHER RESPIRATORY OCCURRENCE * (11/25/95) ICD: 478.25 EDEMA PHARYNX/NASOPHARYX OTHER OCCURRENCE * (NO DATE) ICD: 530.1 ESOPHAGITIS	NON-CARD/T
12/02/95	PERIPHERAL	EVACUATION OF HEMATOMA LT.THIGH	YES	DVT/THROMBOPHLEBITIS * (12/06/95) ICD: 453.8 VENOUS THROMBOSIS NEC BLEEDING/TRANSFUSIONS * (12/04/95) BLEEDING/TRANSFUSIONS * (12/06/95) BLEEDING/TRANSFUSIONS * (12/06/95)	NON-CARD/I

Occurrences(s): '*' Denotes Postop Occurrence

Assessment Status - I:Incomplete, C:Complete, T:Transmitted

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

```
Select Management Reports Option: MV  M&M Verification Report
```

```
                            M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences
and their assignments to operations and in the review of death unrelated or
related assignments to operations.  Two varieties of this report are available.
The first variety provides a report of all patients who had operations within
the selected date range who experienced intraoperative occurrences,
postoperative occurrences, or death within 90 days of surgery.  The second
variety provides a similar report for all risk assessed operations that are in
a completed state but have not yet transmitted to the national database.

Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.

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


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

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
M&M Verification Report
Pre-Transmission Report for Completed Assessments
Report Generated: JAN 23,1998

Reviewed By:
Date Reviewed:

Op Date	Specialty	Procedure(s)	Death Related	Occurrence(s) - (Date)	Assessment Type/Status
>>> AUGUSTINO,GUSTAV (255-01-6867) - DIED 12/31/97@07:16					
12/24/97	UROLOGY	CYSTOSCOPY	YES		EXCLUDED/C
>>> ORANGE,WILLIAM (811-00-9990) - DIED 03/02/97@13:20					
01/31/97	GENERAL	LEFT BKA STUMP DEBRIDEMENT & REVISION	?	URINARY TRACT INFECTION * (02/09/97) ICD: 599.0 URIN TRACT INFECTION NOS PNEUMONIA * (02/15/97) ICD: 485. BRONCOPNEUMONIA ORG NOS	EXCLUDED/C
>>> PRINCE,ALBERT E. (007-13-0010) - DIED 08/13/97@19:00					
08/05/97	PERIPHERAL	LEFT LEG ABOVE KNEE AMPUTATION, RIGHT LEG ABOVE KNEE AMPUTATION	NO		EXCLUDED/C
>>> JAMES,JESSE A. (205-94-3233) - DIED 10/01/97					
08/21/97	PERIPHERAL	OMEGAPORT PLACEMENT	?		EXCLUDED/C
>>> LESTER,ENOCH W. (334-20-8888) - DIED 04/08/97					
03/14/97	GENERAL	HICKMAN CATH PLACMENT	NO		EXCLUDED/C

Occurrences(s): '*' Denotes Postop Occurrence Assessment Status - I:Incomplete, C:Complete, T:Transmitted

1.2.3 Comparison of Preop and Postop Diagnosis

This option generates a list of completed cases in which the principal preoperative and principal postoperative diagnosis are different.

Example: Print Comparison of Preop and Postop Diagnosis Report

```
Select Management Reports Option: CD  Comparison of Preop and Postop Diagnosis
```

```
Comparison of Preop and Postop Diagnosis

Start with Date: 3/2  (MAR 02, 1992)
End with Date: 3/31  (MAR 31, 1992)

This report is designed to use a 132 column format.

Print the Report on which device: [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
COMPARISON OF PREOP AND POSTOP DIAGNOSIS
FROM: OCT 3,1996 TO: OCT 8,1996

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: NOV 22,1996

DATE CASE #	PATIENT ID # SURGICAL SPECIALTY	PREOPERATIVE DIAGNOSIS	POSTOPERATIVE DIAGNOSIS	WOUND CLASS
10/03/96 63064	PERKINS,DAVID 123-45-4279 GENERAL	APPENDICITIS	ACUTE APPENDICITIS	D
10/04/96 63066	COLLINS,JACK 123-45-5119 GENERAL	BILATERAL INGUINAL HERNIA	BILATERAL INGUINAL HERNIA, WITH GANGRENE	C
10/04/96 63068	HELMS,MICHEAL 123-45-4886 GENERAL	BILATERAL INGUINAL HERNIA	BILAT INGUINAL HERNIA	C
10/08/96 63072	DUNCAN,ZACHARY 332-00-1234 GENERAL	CHOLECYSTITIS	CHOLECYSTITIS WITH OBSTRUCTION	C

WOUND CLASSIFICATION CODES:
C: CLEAN, CC: CLEAN/CONTAMINATED, D: CONTAMINATED, I: INFECTED

1.2.4 Delay and Cancellation Reports

The *Delay and Cancellation Reports* option provides a submenu for generating various reports used to track delays and cancellations. The reports on this menu are listed below. To the left of the option/report name is the shortcut synonym you can enter to select the option:

D	*Report of Delayed Operations*
R	*Report of Delay Reasons*
T	*Report of Delay Time*
C	*Report of Cancellations*
A	*Report of Cancellation Rates*

1.2.4.1 Report of Delayed Operations

This report will list all cases that have been delayed within a specified date range. The report sorts by surgical service and includes both the delay cause and delay time.

This report is in a 132-column format and should be copied to a printer with wide paper.

Example: Report of Delayed Operations

```
Select Delay and Cancellation Reports Option: D  Report of Delayed Operations
```

```
Report of Delayed Operations

Start with which Date ?  7/1  (JUL 01, 1999)
End with which Date ?  7/31  (JUL 31, 1999)


Do you want to print the Report of Delayed Operations for all Surgical
Specialties ?  YES//  <RET>

This report is designed to use a 132 column format.

Print the Report on which device ? [Select Print Device]
```

..... *printout follows* .....

```
                                                    MAYBERRY, NC                                                    PAGE: 1
                                                  SURGICAL SERVICE                          REVIEWED BY:
                                             REPORT OF DELAYED OPERATIONS                   DATE REVIEWED:
                                                    NEUROSURGERY
                                         FROM: JUL 1,1999  TO: JUL 31,1999                  DATE PRINTED: AUG 13,1999

DATE        PATIENT                        ATTENDING SURGEON                      DELAY COMMENTS
DELAY TIME    ID #                         OPERATION(S)
==================================================================================================================

                                                OPERATING SURGEON NOT PRESENT
                                                -----------------------------

07/13/99    BASS,EARNEST T.                WELBY,MARCUS
30 MINS.      123-45-5119                  L3-4 LUMBAR LAMINECTOMY WITH PARTIAL
                                           FACETECTOMY AND LEFT
                                           NEUROFORAMINOTOMY, ADDITIONAL L4-5


                                                 STAFF SURGEON NOT PRESENT
                                                 -------------------------

07/28/99    HATHAWAY,JANE                  FINE,LARRY                             WEDNESDAY UNIVERSITY MEETING
45 MINS.      333-33-3333                  RT. MEDIAN NERVE DECOMPRESSION AT
                                           WRIST
```

1.2.4.2 Report of Delay Reasons

This report lists reasons for delays, and the number of occurrences for delayed operations, within a specified date range.

This report is in an 80-column format and can be viewed on your terminal screen.

Example: Report of Delay Reasons

```
Select Delay and Cancellation Reports Option: R  Report of Delay Reasons
```

```
Report of Delayed Operations

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


Do you want to print the Report of Delay Reasons for all Surgical
Specialties ?  YES// <RET>

Do you want to display the totals for each Surgical Specialty ?  YES// ?

Enter RETURN to display the totals for delay reasons for each specialty.  If
you want to display the totals for all delay reasons for the entire medical
center, enter 'NO'.

Do you want to display the totals for each Surgical Specialty ?  YES// <RET>

Print the Report on which device: [Select Print Device]
```

..... *printout follows* .....

```
                            REPORT OF DELAY REASONS
                           FROM 03/01/99  TO 03/31/99

                       GENERAL(OR WHEN NOT DEFINED BELOW)
                       ----------------------------------

ANESTHETIST NOT PRESENT                                                1
SPECIAL EQUIPMENT NOT READY                                            1
OTHER                                                                  1

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


                           OTORHINOLARYNGOLOGY (ENT)
                           -------------------------

OPERATING SURGEON NOT PRESENT                                          1

   TOTAL DELAYS FOR OTORHINOLARYNGOLOGY (ENT)                          1


Press RETURN to continue, or '^' to quit:  <RET>
```

```
                            REPORT OF DELAY REASONS
                           FROM 03/01/99  TO 03/31/99

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


OPERATING SURGEON NOT PRESENT                                          1
ANESTHETIST NOT PRESENT                                                1
SPECIAL EQUIPMENT NOT READY                                            1
OTHER                                                                  1

TOTAL DELAY REASONS                                                    4

Press RETURN to continue  <RET>
```

1.2.4.3 Report of Delay Time

This report provides the total amount of delay time for each delay reason for a specified date range. The report sorts by surgical specialty.

This report is in an 80-column format and can be viewed on your terminal screen.

Example: Report of Delay Time

```
Select Delay and Cancellation Reports Option: T  Report of Delay Time
```

```
Report of Delay Time

Start with which Date ?  3/1  (MAR 01, 1999)

End with which Date ?  3/31  (MAR 31, 1999)


Do you want to print the Report of Delay Time for all delay reasons ?  YES// ?

Enter RETURN to print this report for all delay reasons, or 'NO' to select
a specific delay reason.


Do you want to print the Report of Delay Time for all delay reasons ?  YES// <RET>


Do you want to print the Report of Delayed Operations for all Surgical
Specialties ?  YES//  <RET>

Print the Report on which device: [Select Print Device]
```

..... *printout follows* .....

```
                                 MAYBERRY, NC                          PAGE 1
                            Report of Delay Times
                          From 03/01/99  To 03/31/99

                                 # OF       MINUTES
SURGICAL SPECIALTY              DELAYS      DELAYED
==============================================================================
               >> Delay Reason: OPERATING SURGEON NOT PRESENT <<

OTORHINOLARYNGOLOGY (ENT)           1           15

------------------------------------------------------------------------------
                  >> Delay Reason: ANESTHETIST NOT PRESENT <<

GENERAL(OR WHEN NOT DEFINED BE      1           30

------------------------------------------------------------------------------
                >> Delay Reason: SPECIAL EQUIPMENT NOT READY <<

GENERAL(OR WHEN NOT DEFINED BE      1           10

Press RETURN to continue, or '^' to quit.  <RET>
```

```
                                 MAYBERRY, NC                          PAGE 2
                            Report of Delay Times
                          From 03/01/99  To 03/31/99

                                 # OF       MINUTES
SURGICAL SPECIALTY              DELAYS      DELAYED
==============================================================================
                          >> Delay Reason: OTHER <<

GENERAL(OR WHEN NOT DEFINED BE      1           15

Press RETURN to continue, or '^' to quit.  <RET>
```

```
                                 MAYBERRY, NC                          PAGE 3
                            Report of Delay Times
                          From 03/01/99  To 03/31/99

                                 # OF       MINUTES
DELAY REASON                    DELAYS      DELAYED
==============================================================================
OPERATING SURGEON NOT PRESENT       1           15
ANESTHETIST NOT PRESENT             1           30
SPECIAL EQUIPMENT NOT READY         1           10
OTHER                               1           15

                        TOTAL       4           70

Press RETURN to continue  <RET>
```

1.2.4.4 Report of Cancellations

This report is designed to provide information for cases that have been scheduled and cancelled.

This report is in a 132-column format and must be copied to a printer.

Example: Print Report of Cancellations

```
Select Delay and Cancellation Reports Option: C  Report of Cancellations
```

```
Report of Cancellations

NOTE: This report contains all cancelled cases, including those that were
      cancelled after the patient had entered the operating room.  Aborted
      cases are identified by an '*' next to the procedure name.


Start with Date: 3/1  (MAR 01, 1999)
End with Date: 3/3  (MAR 03, 1999)


Do you want to print the report for all Surgical Specialties ?  YES//  <RET>

This report is designed to use a 132 column format.

Print the Report on which device: [Select Print Device]
```

..... *printout follows* .....

```
                                                    MAYBERRY, NC                                          PAGE: 1
                                                REPORT OF CANCELLATIONS                      REVIEWED BY:
PRINTED: MAR 23, 1999                          FROM 03/01/99  TO 03/03/99                    DATE REVIEWED:

DATE           PATIENT                      OPERATION(S)                                     CANCEL DATE
CASE #         ID#                                                                           REASON
==================================================================================================================
                                          >> SURGICAL SPECIALTY: OPHTHALMOLOGY <<

MAR 01, 1999   MARTIN,JOE                   * PHACEOMULSIFICATION, LENS IMPLANT OS           MAR 01, 1999  11:00
31725          030-03-3030                                                                   MEDICAL

------------------------------------------------------------------------------------------------------------------
                                            >> SURGICAL SPECIALTY: ORTHOPEDICS <<

MAR 01, 1999   WEINKIEBEAN,FUNKIE           LT. TOTAL KNEE ARTHROPLASTY                      MAR 01, 1999  08:01
32066          232-34-2345                                                                   MEDICAL

MAR 03, 1999   NASIUM,JIM                   HARDWARE REMOVAL RT. ANKLE                       MAR 03, 1999  12:49
32143          121-21-2453                                                                   ADMINISTRATIVE CANCELLATION

------------------------------------------------------------------------------------------------------------------
                                >> SURGICAL SPECIALTY: PLASTIC SURGERY (INCLUDES HEAD AND NECK) <<

MAR 01, 1999   COLLINS,THOMAS               DEBRIDMENT OF BACK, NECK WOUNDS, GOLDWEIGHT TO   MAR 01, 1999  07:36
32089          222-00-1234                  RT. EYE, RT. LATERAL CANTHOPLASTY                SURGEON

MAR 03, 1999   WILSON,DONALD                PRIMARY CLOSURE LT. CHEEK, SKIN GRAFT VS SKIN    APR 02, 1999  08:21
32141          123-98-9898                  FLAP                                             PATIENT NOT NPO

------------------------------------------------------------------------------------------------------------------
                                 >> SURGICAL SPECIALTY: THORACIC SURGERY (INC. CARDIAC SURG.) <<

MAR 01, 1999   DISNEY,WALTER Q.             LT. THORACOTOMY, LOBECTOMY, PNEUMONECTOMY        MAR 01, 1999  07:35
32013          991-77-7777                                                                   MEDICAL

------------------------------------------------------------------------------------------------------------------
                                                >> SURGICAL SPECIALTY: UROLOGY <<

MAR 03, 1999   TAYLOR,ANDY                  TRANSURETHRAL RESECTION OF BLADDER TUMOR         MAR 19, 1999  08:00
32119          123-45-4321                                                                   PATIENT/GUARDIAN REFUSES

------------------------------------------------------------------------------------------------------------------
                                                >> SURGICAL SPECIALTY: PODIATRY <<

MAR 02, 1999   OWENS,JESSE                  1ST METATARSL REMODELING RT. FOOT, REMOVAL OF    MAR 29, 1999  08:52
31865          321-54-9876                  SOFT TISSUE NODULE RT. FOOT                      MEDICAL

------------------------------------------------------------------------------------------------------------------
```

1.2.4.5 Report of Cancellation Rates

This option generates a report on the calculations of cancellation rates. This report can be printed for one or a few surgical specialties (Example 1), or for all surgical specialties (Example 2). Emergency cases are not included in this report.

This report is in an 80-column format and can be viewed on your terminal screen.

How the Cancellation Rates Are Calculated

Cancellation Rate for Scheduled Cases =
(Total Cancels / Total Scheduled) x 100

Avoidable Cancellation Rate for Scheduled Cases =
(Total Avoidable Cancels / Total Scheduled) x 100

Avoidable Cancellation rate for all Cancelled Cases =
(Total Avoidable Cancels / Total Cancels) x 100

Example 1: View for Individual Surgical Specialties

```
Select Delay and Cancellation Reports Option: A  Report of Cancellation Rates
```

```
Report of Cancellation Rates


Start with which Date ?  3/2  (MAR 02, 1999)
End with which Date ?  3/20  (MAR 20, 1999)


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


Print the report for which Specialty ?  50          GENERAL(OR WHEN NOT DEFINED BELOW)
Select An Additional Specialty:  ORTHOPEDICS  54        ORTHOPEDICS
Select An Additional Specialty:  PLASTIC SURGERY (INCLUDES HEAD AND NECK)  PROCTOLOGY
56        PLASTIC SURGERY (INCLUDES HEAD AND NECK)
Select An Additional Specialty:  <RET>

Print the Report on which device: [Select Print Device]
```

..... *printout follows* .....

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

TOTAL SCHEDULED SURGICAL CASES: 18
CANCELLATION RATE FOR SCHEDULED CASES: 17 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
PREV. CASE LENGTH                                  3                0
                                                 -----            -----
TOTAL CANCELLATIONS                                3                0


Press RETURN to continue, or '^' to quit:  <RET>
```

```
                              ** ORTHOPEDICS **

TOTAL SCHEDULED SURGICAL CASES: 23
CANCELLATION RATE FOR SCHEDULED CASES: 26 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 9 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 33 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
ADMINISTRATIVE CANCELLATION                        1                1
MEDICAL                                            4                1
SCHEDULING ERROR                                   1                0
                                                 -----            -----
TOTAL CANCELLATIONS                                6                2


Press RETURN to continue, or '^' to quit:  <RET>
```

```
                 ** PLASTIC SURGERY (INCLUDES HEAD AND NECK) **

TOTAL SCHEDULED SURGICAL CASES: 10
CANCELLATION RATE FOR SCHEDULED CASES: 30 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 20 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 67 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
PATIENT NOT NPO                                    1                1
PREV. CASE LENGTH                                  1                0
SURGEON                                            1                1
                                                 -----            -----
TOTAL CANCELLATIONS                                3                2


Press RETURN to continue, or '^' to quit:  <RET>
```

Example 2: View for All Specialties

```
Select Delay and Cancellation Reports Option: A  Report of Cancellation Rates
```

```
Report of Cancellation Rates


Start with which Date ?  3/2  (MAR 02, 1999)
End with which Date ?  3/20  (MAR 20, 1999)


Do you want to print the report for all Surgical Specialties ?  YES//  <RET>

Do you want to display the cancellation reasons for each Surgical
Specialty ?  YES//

Print the Report on which device: [Select Print Device]
```

..... *printout follows* .....

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

TOTAL SCHEDULED SURGICAL CASES: 18
CANCELLATION RATE FOR SCHEDULED CASES: 17 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
PREV. CASE LENGTH                                  3                0
                                                 -----            -----
TOTAL CANCELLATIONS                                3                0


Press RETURN to continue, or '^' to quit:  <RET>
```

```
                              ** NEUROSURGERY **

TOTAL SCHEDULED SURGICAL CASES: 8
CANCELLATION RATE FOR SCHEDULED CASES: 25 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 13 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 50 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
OPERATING ROOM                                     1                0
PATIENT NO-SHOW                                    1                1
                                                 -----            -----
TOTAL CANCELLATIONS                                2                1


Press RETURN to continue, or '^' to quit:  <RET>
```

```
                              ** ORTHOPEDICS **

TOTAL SCHEDULED SURGICAL CASES: 23
CANCELLATION RATE FOR SCHEDULED CASES: 26 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 9 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 33 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
ADMINISTRATIVE CANCELLATION                      1                1
MEDICAL                                          4                1
SCHEDULING ERROR                                 1                0
                                             -----            -----
TOTAL CANCELLATIONS                              6                2


Press RETURN to continue, or '^' to quit:  <RET>
```

```
                        ** OTORHINOLARYNGOLOGY (ENT) **

TOTAL SCHEDULED SURGICAL CASES: 18
CANCELLATION RATE FOR SCHEDULED CASES: 6 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 6 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 100 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
SCHEDULING ERROR                                 1                1
                                             -----            -----
TOTAL CANCELLATIONS                              1                1


Press RETURN to continue, or '^' to quit:  <RET>
```

```
                           ** PERIPHERAL VASCULAR **

TOTAL SCHEDULED SURGICAL CASES: 16
CANCELLATION RATE FOR SCHEDULED CASES: 25 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 6 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 25 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
MEDICAL                                          2                0
PREV. CASE LENGTH                                1                0
SCHEDULING ERROR                                 1                1
                                             -----            -----
TOTAL CANCELLATIONS                              4                1


Press RETURN to continue, or '^' to quit:  <RET>
```

```
                 ** PLASTIC SURGERY (INCLUDES HEAD AND NECK) **

TOTAL SCHEDULED SURGICAL CASES: 10
CANCELLATION RATE FOR SCHEDULED CASES: 30 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 20 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 67 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
PATIENT NOT NPO                                   1                1
PREV. CASE LENGTH                                 1                0
SURGEON                                           1                1
                                             -----            -----
TOTAL CANCELLATIONS                               3                2


Press RETURN to continue, or '^' to quit:  <RET>
```

```
                                 ** PODIATRY **

TOTAL SCHEDULED SURGICAL CASES: 14
CANCELLATION RATE FOR SCHEDULED CASES: 7 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
MEDICAL                                           1                0
                                             -----            -----
TOTAL CANCELLATIONS                               1                0


Press RETURN to continue, or '^' to quit:  <RET>
```

```
                                 ** UROLOGY **

TOTAL SCHEDULED SURGICAL CASES: 11
CANCELLATION RATE FOR SCHEDULED CASES: 18 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
MEDICAL                                           1                0
PATIENT/GUARDIAN REFUSES                          1                0
                                             -----            -----
TOTAL CANCELLATIONS                               2                0


Press RETURN to continue, or '^' to quit:  <RET>
```

```
TOTAL SURGICAL CASES SCHEDULED FOR MAYBERRY, NC: 118
CANCELLATION RATE FOR SCHEDULED CASES: 19 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 6 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 32 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
ADMINISTRATIVE CANCELLATION                       1                1
MEDICAL                                           8                1
OPERATING ROOM                                    1                0
PATIENT NO-SHOW                                   1                1
```

```
PATIENT NOT NPO                                  1                1
PATIENT/GUARDIAN REFUSES                         1                0
PREV. CASE LENGTH                                5                0
SCHEDULING ERROR                                 3                2
SURGEON                                          1                1
                                             -----            -----
TOTAL CANCELLATIONS                             22                7

Press RETURN to continue, or '^' to quit:  <RET>
```

```
                                            PERCENT AVOIDABLE CANCELLATIONS
                                           -----------------------------------
SURGICAL SPECIALTY                         SCHEDULED CASES     CANCELLED CASES
==============================================================================


GENERAL(OR WHEN NOT DEFINED BELOW)                  0 %                 0 %
NEUROSURGERY                                       13 %                50 %
ORTHOPEDICS                                         9 %                33 %
OTORHINOLARYNGOLOGY (ENT)                           6 %               100 %
PERIPHERAL VASCULAR                                 6 %                25 %
PLASTIC SURGERY (INCLUDES HEAD AND NECK)           20 %                67 %
PODIATRY                                            0 %                 0 %
UROLOGY                                             0 %                 0 %

Press RETURN to continue  <RET>
```

1.2.5 List of Unverified Surgery Cases

This option will generate a list of all completed surgery cases that have not had the procedure, diagnosis, and complications verified. You can verify a case using the *Surgeon's Verification of Diagnosis & Procedures* option in the *Operation Menu*. This list can be compiled for one or all surgical specialties.

This report is in an 80-column format and can be viewed on your terminal screen.

Example: List of Unverified Surgery Cases

```
Select Management Reports Option: V  List of Unverified Surgery Cases

Do you want the list for all Surgical Specialties ?  YES//  N

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

Start with Date: 3/9  (MAR 09, 1999)

End with Date: 3/20  (MAR 20, 1999)

Print the List of Unverified Cases to which Printer ? [Select Print Device]
```

..... printout follows .....

```
     List of Unverified Cases for GENERAL(OR WHEN NOT DEFINED BELOW)

Operation Date      Patient (Case #)                        Surgeon
                    Patient ID #                            Attending Surgeon
================================================================================
MAR  9, 1999        FIFE,BARNEY (15188)                       BRONSTEIN, S
                    222-00-1234                             REED,JAMES

                    APPENDECTOMY * CPT CODE MISSING *
--------------------------------------------------------------------------------
MAR 10, 1999        CLAMPETT,ELLIE MAE (15189)                REED,JAMES
                    231-21-2234                             HOWARD,MOE

                    DRAINAGE OF OVARIAN CYST * CPT CODE MISSING *
--------------------------------------------------------------------------------
MAR 10, 1999        MONROE,EARL (15199)                       HOWARD,MOE
                    123-45-1982                             NOT ENTERED

                    CHOLECYSTECTOMY WITH CHOLANGIOGRAM * CPT CODE MISSING *
--------------------------------------------------------------------------------
MAR 17, 1999        SMITH,JAMES (15203)                       HOWARD,MOE
                    123-45-7684                             FINE,LARRY

                    CHOLECYSTECTOMY * CPT CODE MISSING *
--------------------------------------------------------------------------------
MAR 18, 1999        BASS,EARNEST T. (15202)                   HOWARD,MOE
                    123-45-5119                             FINE,LARRY

                    REPAIR INCARCERATED INGUINAL HERNIA * CPT CODE MISSING *
--------------------------------------------------------------------------------

Press RETURN to continue, or '^' to quit:.  <RET>
```

1.2.6 Report of Returns to Surgery

This report lists cases that have had related surgical procedures performed within 30 days of the date of the operation. You must enter a date range for the computer to sort by.

This report has a 132 column format and must be copied to a printer with wide paper.

Example: Print the Report of Returns to Surgery

```
Select Management Reports Option: RET  Report of Returns to Surgery
```

```
Report of Returns to Surgery


Start with Date: 7/1  (JUL 01, 1999)
End with Date: 7/14  (JUL 14, 1999)

This report will list cases completed during the date range entered that
have had return cases associated with them.  It is designed to use a 132
column format.


Print the Report on which Device: [Select Print Device]
```

..... *printout follows* .....

```
                                   MAYBERRY, NC
                                SURGICAL SERVICE                          REVIEWED BY:
                          REPORT OF RETURNS TO SURGERY                    DATE REVIEWED:
                       FROM: JUL 1,1999  TO: JUL 14,1999                  DATE PRINTED: AUG 27,1999

OPERATION DATE   PATIENT (ID#)                                PRINCIPAL OPERATIVE PROCEDURE
==================================================================================================================

JUL 03, 1999     CLAMPETT,JED (333-44-5555)                   REPAIR GASTRIC PERFORATION

    RETURNS TO SURGERY:
                    JUL 07, 1999   EXPLORATORY LAPAROTOMY

JUL 06, 1999     MADISON,JAMES (321-98-4352)                  ATTEMPTED REVISION OF LEFT ARM A-V FISTULA WITH GRAFT

    RETURNS TO SURGERY:
                    JUL 15, 1999   CREATION OF A-V FISTULA W/VASCULAR GRAFT, RT ARM

JUL 06, 1999     MCDONALD,RONALD (678-90-1234)                EXCISION OF GRANULATION TISSUE RT. FOOT

    RETURNS TO SURGERY:
                    AUG 03, 1999   STSG FROM RT. THIGH TO  RIGHT FOOT

JUL 06, 1999     CLOWN,BOZO (232-31-2121)                     IRRIGATION AND DEBRIDEMENT OF LT. FOOT

    RETURNS TO SURGERY:
                    JUL 14, 1999   IRRIGATION AND DEBRIDEMENT OF LT. FOOT

JUL 07, 1999     FRANKLIN,BENJAMIN (287-38-1876)              EXPLORATORY LAPAROTOMY

    RETURNS TO SURGERY:
                    AUG 05, 1999   TRACHEOSTOMY

JUL 10, 1999     JOHNSTON,ALBERT S. (419-91-4419)             RIGHT LOWER QUADRANT EXPLORATION

    RETURNS TO SURGERY:
                    JUL 13, 1999   SIGMOID COLECTOMY
```

1.2.7 Report of Daily Operating Room Activity

This report provides a list of completed cases started between 6:00 AM on the date selected and 5:59 AM of the following day for all operating rooms.

Example: Print the Report of Daily Operating Room Activity

```
Select Management Reports Option: A Report of Daily Operating Room Activity
```

```
Print the Report of Daily Activity for which Date ?  7/1  (JUL 01, 1999)

This report will include all cases started between MAR 12, 1992 at 6:00 AM
and MAR 13, 1992 at 5:59 AM.

It is designed to use a 132 column format.

Print the Report to which Device ?  [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
DAILY REPORT OF OPERATING ROOM ACTIVITY
FOR: JUL 01, 1999

PATIENT ID # WARD	AGE	TIME IN OR TIME OUT OR CASE NUMBER	POSTOPERATIVE DIAGNOSIS PROCEDURE(S)	ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
OPERATING ROOM: CYSTO1					
BYROM,BUZZY		07/01 14:00	GROSS HEMATURIA	DAVIS,J	ROBINSON,W
111-22-1111	45	07/01 16:05	CYSTOURETHROSCOPY WITH BLADDER BIOPSY,	REED,D	
OUTPATIENT		33536	TRANSURETHRAL RESECTION OF BLADDER TUMOR		MASON,P
OPERATING ROOM: OR1					
WRIGHT,ORVILLE		07/01 08:00	LEFT COLD FOOT	STEPHENS,G	FINE,L
212-12-1212	56	07/01 16:30	LEFT FEMORO-TIB TO TIB PERONEAL TRUNK	HANKS,N	CLARK,M
OUTPATIENT		33512	SAPHENOUS,IN-SITU, TIBIAL-PERONEAL EMBOLECTOMY,		COX,WALLY
			EXCLUSION OF POPLITEAL ANEURYSM, COMPLETION		
			ANGIOGRAPHY, COMPLETION DUPLEX		
SMITH,JASON		07/01 09:10	RT. CAROTID STENOSIS	ANDERSON,J	WALLACE,M
443-35-5778	71	07/01 13:00	RT. CAROTID ENDARTERECTOMY		
OUTPATIENT		33521			JUSTICE,B
OPERATING ROOM: OR2					
MCARTHUR,DOUGLAS		07/01 06:00	APPENDICITIS	MATTHEWS,D	TRAPPER,J
233-11-8735	35	07/01 07:35	APPENDECTOMY	MCDUGAL,J	
OUTPATIENT		33519			JOLLEY,E
OPERATING ROOM: OR4					
JAMES,JESSE J		07/01 07:45	RT. EAR,RT. EYELID BASAL CELL CA	BONES,W	WATTS,J
666-77-8888	75	07/01 12:00	EXCISION OF RT. UPPER EYELID BASAL CELL CA,	EARLY,J	
OUTPATIENT		33409	EXCISION OF RT. EAR BASAL CELL CA		REED,W
OPERATING ROOM: OR5					
LEMONS,JACKIE		07/01 07:50	SINUSITIS ,RHNOPHYMA,NASAL OBSTRUCTION	SMITH,J	HOUSTON,S
090-99-0000	67	07/01 10:27	SEPTOPLASTY, TURBINECTOMY, INTERNAL INTRA NASAL	SCOTT,G	
OUTPATIENT		33399	SYNOIDECTOMY, LASER RESURFACE OF NOSE, NASAL		BAKER,R
			POLYECTOMY RT., NASAL POLYPECTOMY LT.		

1.2.8 List of Undictated Operations

This option provides a list of all completed cases that do not have a date/time of dictation entered. The list is for the Chief of Surgery to use in checking on cases that still require dictation. This option is also included under the *Surgery Reports* submenu.

This list is in an 80-column format and can be viewed on your terminal.

Example: List of Undictated Operations

```
Select Management Reports Option: U  List of Undictated Operations
```

```
List of Undictated Operations


How do you want this report printed ?

   (1) Print ALL undictated operations.
   (2) Print undictated operations for a selected DATE range.

Enter selection: 1// <RET>
Print the Report on which Device: [Select Print Device]
```

..... *printout follows* .....

```
          UNDICTATED OPERATIONS FOR GENERAL
          DATE PRINTED: MAR 26,1999

CASE #    PATIENT                                SURGEON
          OPERATION DATE                         WARD LOCATION
==============================================================================

 13       JAMES,TERRELL (217-63-5402)            FINE,LARRY
          MAR 16, 1999@09:45                     OUTPATIENT
          CHOLECYSTECTOMY

          UNDICTATED OPERATIONS FOR NEUROSURGERY
          DATE PRINTED: MAR 26,1999


CASE #    PATIENT                                SURGEON
          OPERATION DATE                         WARD LOCATION
==============================================================================

 18       BELL,MARY (467-87-3456)                HOWARD,MOE
          MAR 16, 1999@11:15                     OUTPATIENT
          FRONTAL CRANIOTOMY

          UNDICTATED OPERATIONS FOR PERIPHERAL VASCULAR
          DATE PRINTED: MAR 26,1999


CASE #    PATIENT                                SURGEON
          OPERATION DATE                         WARD LOCATION
==============================================================================

 249      CLAMPETT,J.D. (665-37-0555)            FINE,LARRY
          MAR 11, 1999@09:10                       1 NORTH 162-1
          HARVEST SAPHENOUS VEIN

          UNDICTATED OPERATIONS FOR THORACIC SURGERY
          DATE PRINTED: MAR 26,1999


CASE #    PATIENT                                SURGEON
          OPERATION DATE                         WARD LOCATION
==============================================================================

 250      FRANKLIN,BENJAMIN (287-38-1876)        FINE,LARRY
          FEB 11, 1999@11:20                     OUTPATIENT
          HARVEST SAPHENOUS VEIN
```

1.2.9 Report of Cases Without Specimens

This report lists all completed cases in which there were no specimens taken from the operative site. The report can be printed for an individual surgical specialty if wanted.

This report is in a 132-column format and must be copied to a printer with wide paper.

Example: Print the Report of Cases without Specimens

```
Select Management Reports Option: NS  Report of Cases Without Specimens
```

```
Report of Cases Without Specimens


Starting with which Date ?  7/12  (JUL 12, 1999)
Ending with which Date ?  7/14  (JUL 14, 1999)

Do you want the report sorted by Surgical Specialty ?  NO// <RET>

This report is designed to use a 132 column format.

Print the Report on which Device ? [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
CASES WITHOUT SPECIMENS
FROM: JUL 12,1999 TO: JUL 14,1999

PAGE 1
REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: JUL 27,1999

DATE CASE #	PATIENT PATIENT ID	SURGICAL SPECIALTY POSTOPERATIVE DIAGNOSIS OPERATIVE PROCEDURE	SURGEON ATTENDING SURGEON
07/12/99 33613	WELK,LARRY 333-21-3333	PERIPHERAL VASCULAR RENAL FAILURE PLACEMENT OF LEFT FEMORAL DIALYSIS TESSIO-CATHETER	WELBY,MARCUS HOWARD,MOE
07/12/99 33616	RUNYON,ALBERT Y. 633-33-4000	OTORHINOLARYNGOLOGY (ENT) NASAL OBSTRUCTION LEFT LATERAL RHINOTOMY WITH RECONSTRUCTION OF NASAL VESTIBULE	TRAPPER,JOHN HOWARD,MOE
07/12/99 33659	CYPRUS,TERRANCE 777-55-3322	UROLOGY SIGMOID CA CYSTOURETOROSCOPY, RETROGRADE PYELOGRAPHY, BILATERAL URETERAL STENT PLACEMENT	ADAMS,DOC ADAMS,DOC
07/12/99 33653	FRENCH,VICTOR 010-44-8899	GENERAL(OR WHEN NOT DEFINED BELOW) PROLONGED ANTIBOTIC THERAPHY PLACEMENT OF HICKMAN CATHETER	FINE,LARRY TAYLOR,LIZ
07/13/99 33554	KEY,FRANCIS S. 888-33-8383	OPHTHALMOLOGY CATARACT OS PHACEOMULSIFICATION, LENS IMPLANT OS	JONES,JOHN P HOWARD,MOE
07/14/99 33598	LEGHORN,CORNEL 471-00-3332	PLASTIC SURGERY (INCLUDES HEAD AND NECK) MOH'S DEFECT LT. UPPER LIP FLAP CLOSURE OF MOHS DEFECT LEFT UPPER LIP	JACKSON,ANDREW ADAMS,DOC
07/14/99 33645	TRUETT,WINDELL 156-15-6156	PLASTIC SURGERY (INCLUDES HEAD AND NECK) INFECTED DIABETIC FOOT DEBRIDEMENT RIGHT FOOT, SKIN GRAFT RT THIGH TO RT FOOT	DOOLITTLE,JAMES JONES,BARNABY

TOTAL CASES WITHOUT SPECIMENS: 7

1.2.10 Report of Unscheduled Admissions to ICU

This report lists all unscheduled admissions to the ICU based on the requested (expected) postoperative care and actual postoperative disposition.

This report is in a 132-column format and must be copied to a printer with wide paper.

Example: Print Report of Unscheduled Admissions to ICU

```
Select Management Reports Option: ICU  Report of Unscheduled Admissions to ICU
```

```
Report of Unscheduled Admissions to the ICU


Starting with which Date ?  7/1  (JUL 01, 1999)
Ending with which Date ?  7/31  (JUL 32, 1999)

Do you want the report for a specific Surgical Specialty ?  NO//  <RET>

This report is designed to use a 132 column format.

Print the Report on which Device ? [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC
SURGICAL SERVICE
UNSCHEDULED ADMISSIONS TO ICU
FROM 07/01/99 TO 07/31/99

REVIEWED BY:
DATE REVIEWED:

DATE	PATIENT PATIENT ID REQ DISPOSITION/POSTOP DISPOSITION	SURGICAL SPECIALTY POSTOPERATIVE DIAGNOSIS OPERATIVE PROCEDURE(S)	SURGEON ATTENDING SURGEON
07/01/99	GOODE,JOHNNY B. 130-13-0130 PACU (RECOVERY ROOM)/SICU	GENERAL(OR WHEN NOT DEFINED BELOW) APPENDICITIS APPENDECTOMY	JEFFERSON,THOMAS WELBY,MARCUS
07/06/99	KANDY,JOHN 044-44-0000 WARD/SICU	GENERAL(OR WHEN NOT DEFINED BELOW) INABILITY TO TAKE ORAL OR USE NG TUBE PLACEMENT OF G-TUBE	LOWE,AMY DRUMMOND,LEE
07/08/99	PRINCE,EDWARD I. 677-77-6666 WARD/MICU	GENERAL(OR WHEN NOT DEFINED BELOW) GANGRENE LT. FOOT LT. BELOW KNEE AMPUTATION	OGLETHORPE,JAMES WELBY,MARCUS
07/23/99	MARBLE,IVAN 744-13-1128 WARD/SICU	PERIPHERAL VASCULAR IV ACCESS PLACEMENT OF HICKMAN CATHATER, INTRODUCTION OF DOBHOFF TUBE	RUPERT,RUDY ADAMS,DOC
07/27/99	REINS,CLAUDE 886-66-8886 WARD/MICU	GENERAL(OR WHEN NOT DEFINED BELOW) RT BUTTOCK ABCESS I AND D OF RIGHT BUTTOCK ABSCESS	TELL,WILLIAM FINE,LARRY
07/29/99	WILLIAMS,JOE 933-81-0100 WARD/MICU	GENERAL(OR WHEN NOT DEFINED BELOW) INCARCERATED EPIGASTRIC HERNIA REPAIR OF INCARCERATED EPIGASTRIC HERNIA	SONNET,WILL STANDISH,MILES

1.2.11 Operating Room Utilization Report

This report prints utilization information for a selected date range for all operating rooms or for a single operating room. The report displays the percent utilization, the number of cases, the total operation time and the time worked outside normal hours for each operating room individually and all operating rooms collectively.

How the Percent Utilization is Derived

The percent utilization is derived by dividing the total operation time for all operations (including total time patients were in OR, plus the cleanup time allowed for each case) by the total functioning time, as defined in the SURGERY UTILIZATION file. The quotient is then multiplied by 100.

This report must be copied to a printer with wide paper

Example: Print the Operating Room Utilization Report

```
Select Management Reports Option: OR  Operating Room Utilization Report
```

```
Operating Room Utilization Report


Print utilization information starting with which date ?  3/8  (MAR 08, 1999)

Print utilization information through which date ?  3/9  (MAR 09, 1999)
```

```
Do you want to print the Operating Room Utilization Report for all
operating rooms ?  YES//  <RET>
Print the Operating Room Utilization Report on which Device ? [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC PAGE 1
SURGICAL SERVICE
OPERATING ROOM UTILIZATION REPORT
FOR ALL OPERATING ROOMS FROM: MAR 8,1999 TO: MAR 9,1999
DATE PRINTED: MAR 17,1999

OPERATING ROOM	PERCENT UTILIZATION	NUMBER OF CASES	TOTAL OPERATION TIME (INCLUDING OR MAINTENANCE)	TIME WORKED OUTSIDE NORMAL HRS
OR1	70%	3	17 hrs and 35 mins	6 hrs and 20 mins
OR2	39%	1	7 hrs and 25 mins	1 hr and 10 mins
OR3	133%	8	23 hrs and 42 mins	2 hrs and 30 mins
OR4	29%	3	4 hrs and 41 mins	-
OR5	84%	7	18 hrs and 50 mins	5 hrs and 25 mins
OR6	0	0	-	-
OR7	0	0	-	-
TOTAL UTILIZATION FOR ALL ROOMS	63%	22	72 hrs and 13 mins	15 hrs and 25 mins

1.2.12 Wound Classification Report

This option generates a report showing the total number of surgical cases in each of the various wound classifications for a specified date range. The report is sorted by surgical service.

After selecting a date range, you have the choice of printing one of three reports:

1. Wound Classification Report. Enter the number 1 to print this summary of wound classifications entered for surgical cases performed during the date range.
2. List of Operations by Wound Classification. Enter the number 2 to print this list of operations sorted by wound classification and by surgical specialty performed during the date range.
3. Clean Wound Infection Summary. Enter the number 3 to print this summary of clean wound infections.

These reports are in an 80-column format and can be copied to your terminal screen.

Example 1: Wound Classification Report (Summary)

```
Select Management Reports Option: WC  Wound Classification Report
```

```
Wound Classification Report


Start with Date: 7/1  (JUL 01, 1999)
End with Date: 7/15  (JUL 15, 1999)

Print which of the following ?

1.  Wound Classification Report (Summary)
2.  List of Operations by Wound Classification
3.  Clean Wound Infection Summary

Select Number:  1// <RET>


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


Print the report for which Specialty ?  GENERAL(OR WHEN NOT DEFINED BE  LOW)
    50
Select An Additional Specialty:  ORTHOPEDICS          54
Select An Additional Specialty:  <RET>

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

..... *printout follows* .....

```
                         WOUND CLASSIFICATION REPORT
                       FROM: JUL 1,1999  TO: JUL 15,1999
-----------------------------------------------------------------------------

                                CLEAN                                NO CLASS
SURGICAL SERVICE     CLEAN   CONTAMINATED   CONTAMINATED   INFECTED    ENTERED

GENERAL                 9         10             4             3           0
ORTHOPEDICS             9          0             0             0           0

SUB TOTAL:             18         10             4             3           0

TOTAL:    35

CLEAN WOUND INFECTION RATE:   0.0%

Press RETURN to continue  <RET>
```

Example 2: List of Operations by Wound Classification

```
Select Management Reports Option: WC  Wound Classification Report

Wound Classification Report


Start with Date: 7/8  (JUL 08, 1999)
End with Date: 7/8  (JUL 08, 1999)

Print which of the following ?

1.  Wound Classification Report (Summary)
2.  List of Operations by Wound Classification
3.  Clean Wound Infection Summary

Select Number:  1// 2


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

Print report for which Wound Classification ?

1.  CLEAN
2.  CLEAN/CONTAMINATED
3.  CONTAMINATED
4.  INFECTED
5.  NO CLASS ENTERED

Select Number:  1


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

Print the report for which Specialty ?  GENERAL(OR WHEN NOT DEFINED BELOW)  50
Select An Additional Specialty:  PERIPHERAL VASCULAR  62
Select An Additional Specialty:  <RET>

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

..... *printout follows* .....

```
                 List of Surgical Cases by Wound Classification          Page:
                        FROM: JUL 8,1999  TO: JUL 8,1999                   1
                          Wound Classification: CLEAN
DATE PRINTED: JUL 27,1999

Operation Date    Patient                        Surgeon/Provider
Case #            ID #
==============================================================================
                     >> GENERAL(OR WHEN NOT DEFINED BELOW) <<

JUL 08, 1999      TRUMAN,HARRY L                 DEWEY,TOM H
33280             111-22-3333
                  * RT. INGUINAL HERNIA REPAIR
------------------------------------------------------------------------------
JUL 08, 1999      KAISER,KENNETH G               BARTON,CLARENCE
33629             024-13-3456
                  * INCARCERATED UMBILICAL HERNIA REPAIR
------------------------------------------------------------------------------

Press RETURN to continue, or '^' to quit:<RET>
```

```
                 List of Surgical Cases by Wound Classification          Page:
                        FROM: JUL 8,1999  TO: JUL 8,1999                   2
                          Wound Classification: CLEAN
DATE PRINTED: JUL 27,1999

Operation Date    Patient                        Surgeon/Provider
Case #            ID #
==============================================================================
                           >> PERIPHERAL VASCULAR <<

JUL 08, 1999      MANNIX,JOE                     RUSSELL,KITTY
33478             444-55-6666
                  * LEFT CAROTID ENDARTERECTOMY
                  * REOPERATION LEFT CAROTID
------------------------------------------------------------------------------
JUL 08, 1999      CRICK,LIEF                     NORTON,EDWARD
33575             987-98-7987
                  * LT. A-V FISTULA WITH LOOP VEIN GRAFT
------------------------------------------------------------------------------

Press RETURN to continue  <RET>
```

Example 3: Clean Wound Infection Summary

```
Select Management Reports Option: WC  Wound Classification Report
```

```
Wound Classification Report


Start with Date: 6/1  (JUN 01, 1999)
End with Date: 6/30  (JUN 30, 1999)
```

```
Print which of the following ?

1.  Wound Classification Report (Summary)
2.  List of Operations by Wound Classification
3.  Clean Wound Infection Summary

Select Number:  1// 3


Do you want to print the report for all Surgical Specialties ?  YES// <RET>

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

..... printout follows .....

```
                                MAYBERRY, NC
                              SURGICAL SERVICE
                        CLEAN WOUND INFECTION SUMMARY
                     FROM: JUN 1,1999  TO: JUN 30,1999
                         DATE PRINTED: JUL 18,1999
                 REVIEWED BY:              DATE REVIEWED:
```

SURGICAL SERVICE	CLEAN WOUNDS	INFECTIONS	INFECTION RATE
GENERAL	21	1	4.8%
GYNECOLOGY	0	0	0.0%
NEUROSURGERY	11	0	0.0%
OPHTHALMOLOGY	30	0	0.0%
ORTHOPEDICS	20	1	5.0%
OTORHINOLARYNGOLOGY	6	0	0.0%
PLASTIC SURGERY	7	0	0.0%
PROCTOLOGY	0	0	0.0%
THORACIC SURGERY	2	0	0.0%
UROLOGY	2	0	0.0%
ORAL SURGERY	0	0	0.0%
PODIATRY	14	0	0.0%
PERIPHERAL VASCULAR	28	0	0.0%
CARDIAC SURGERY	0	0	0.0%
TRANSPLANTATION	0	0	0.0%
ANESTHESIOLOGY	0	0	0.0%
RHEUMATOLOGY	1	0	0.0%
PULMONARY	0	0	0.0%
GASTROENTEROLOGY	0	0	0.0%
NO SPECIALTY ENTERED	0	0	0.0%
TOTAL	142	2	1.4%

1.2.13 Quarterly Report Menu

This menu contains the option to generate the Quarterly Report and the associated options that may be helpful in validating information on the Quarterly Report. The options on this menu are listed below. To the left of the option name is the shortcut synonym you can enter to select the option:

Q	Quarterly Report - Surgical Service
D	Deaths Within 30 Days of Surgery
A	Admissions Within 14 Days of Outpatient Surgery
I	List of Invasive Diagnostic Procedures
L	List of Operations Included on Quarterly Report
M	Report of Missing Quarterly Report Data

1.2.13.1 Quarterly Report — Surgical Specialty

This option looks at all the surgical procedures performed and provides breakdowns on different characteristics of the procedures. The breakdown is in the form of either the Quarterly Report, to be submitted to the Surgical Service at VHA Headquarters, or a Summary Report for a selected date range.

The Quarterly Report for Central Office can be printed and/or automatically transmitted to the national database at Chicago. When the report is transmitted, a mail message containing the report goes to members of the SR-QUARTERLY mail group.

Prerequisites

The Quarterly/Summary Report uses information stored in the following data fields of the SURGERY file (#130). To produce an accurate report, these fields should be addressed when you enter information about an operation:

MAJOR/MINOR (#.03)
IN/OUT-PATIENT STATUS (#.011)
CASE SCHEDULE TYPE (#.035)
ASA CLASS (#1.13)
SURGERY SPECIALTY (#.04)
ATTENDING CODE (#.165)
PRINCIPAL PROCEDURE CODE (#27)
OTHER PROCEDURE CPT CODE (#3 in OTHER PROCEDURES multiple)
INTRAOPERATIVE OCCURRENCES (#1.14)
OCCURRENCE CATEGORY (#3 in INTRAOPERATIVE OCCURRENCES multiple)
POSTOP OCCURRENCE (#1.16)
OCCURRENCE CATEGORY (#5 in POSTOP OCURRENCE multiple)
WOUND CLASSIFICATION (#1.09)

These reports are formatted in an 80-column format and can be viewed on your terminal screen.

Example 1: Summary Report for Surgical Service

```
Select Management Reports Option: Q  Quarterly Report - Surgical Specialty
```

```
QUARTERLY/SUMMARY REPORT FOR SURGICAL SERVICE

NOTE:  Listed below are the CPT codes for the index procedures on these reports.

    Procedure                 CPT Code(s)
    ---------                 -----------
    Inguinal Hernia           49505,49507,49520,49521,49525
    Cholecystectomy           47600,47605,47610,56340,56341,56342
    Coronary Artery Bypass    33510,33511,33512,33513,33514,33516,33517,33518,
                              33519,33521,33522,33523,33533,33534,33535,33536
    Colon Resection (L & R)   44140,44141,44143,44144,44145,44146,44147,44160
    Fem-Pop Bypass            35656,35556
    Pulmonary Lobectomy       32480,32500,32440
    Hip Replacement
      - Elective              27125,27130,27132,27134,27137,27138
      - Acute Fracture        27236
    TURP                      52601
    Laryngectomy              31360,31365,31367,31368
    Craniotomy                61304,61305,61312,61314,61510,61512,61518,61519,
                              61700,61680
    Intraoccular Lens         66983,66984

Press RETURN to continue or '^' to quit: <RET>
```

```
Run which report ?

   1. Summary Report for Selected Date Range
   2. Quarterly Report for Central Office

Select Report Number:  1// 1
```

```
SUMMARY REPORT FOR SURGICAL SERVICE

Enter date range for data to be included on report.
Start with date:  4/1  (APR 01, 1999)

End with date:  4/30  (APR 30, 1999)

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

..... *printout follows* .....

SUMMARY REPORT - SURGICAL SERVICE PAGE
VERSION 3.0 1

Hospital: MAYBERRY, NC
Station Number: 999
For Dates: APR 01, 1999 to: APR 30, 1999

	Total Cases	% of Total
Surgical Cases	227	100.0
Major Procedures	153	67.4
ASA Class (1)	16	10.5
ASA Class (2)	52	34.0
ASA Class (3)	79	51.6
ASA Class (4)	6	3.9
ASA Class (5)	0	0.0
Postoperative Deaths	3	1.3
Ambulatory: 0		
Postoperative Occurrences	20	8.8
Ambulatory Procedures	134	59.0
Admitted Within 14 Days: 0		
Invasive Diagnostic: 0		
Inpatient Procedures	93	41.0
Emergency Procedures	15	6.6
Age>60 Years	94	41.4

SPECIALTY PROCEDURES

		PATIENTS	CASES	MAJOR	MINOR	---DEATHS--- TOTAL	%
50	GENERAL	56	59	53	6	1	1.7
51	GYNECOLOGY	2	2	2	0	0	0.0
52	NEUROSURGERY	12	13	12	1	0	0.0
53	OPHTHALMOLOGY	34	34	2	32	0	0.0
54	ORTHOPEDICS	23	23	23	0	0	0.0
55	OTORHINOLARYNGOLOGY	24	25	23	2	0	0.0
56	PLASTIC SURGERY	10	11	6	5	0	0.0
57	PROCTOLOGY	0	0	0	0	0	0.0
58	THORACIC SURGERY	3	3	3	0	2	66.7
59	UROLOGY	16	16	13	3	0	0.0
60	ORAL SURGERY	1	1	1	0	0	0.0
61	PODIATRY	18	18	4	14	0	0.0
62	PERIPHERAL VASCULAR	20	22	11	11	0	0.0
500	CARDIAC SURGERY	0	0	0	0	0	0.0
501	TRANSPLANTATION	0	0	0	0	0	0.0
502	ANESTHESIOLOGY	0	0	0	0	0	0.0

LEVEL OF RESIDENT SUPERVISION (%)

	MAJOR	MINOR
Level 0	9.2	4.1
Level 1	79.1	86.5
Level 2	2.6	0.0
Level 3	9.2	0.0
Level Not Entered	0.0	9.5

SUMMARY REPORT - SURGICAL SERVICE PAGE
VERSION 3.0 2

Hospital: MAYBERRY, NC
Station Number: 999
For Dates: APR 01, 1999 to: APR 30, 1999

INDEX PROCEDURES

	CASES	DEATHS	CASES WITH OCCURRENCES
Inguinal Hernia	12	0	0
Cholecystectomy	7	0	2
Coronary Artery Bypass	0	0	0
Colon Resection (L & R)	3	1	1
Fem-Pop Bypass	1	0	0
Pulmonary Lobectomy	0	0	0
Hip Replacement			
- Elective	2	0	0
- Acute Fracture	0	0	0
TURP	4	0	0
Laryngectomy	2	0	1
Craniotomy	1	0	0
Intraoccular Lens	29	0	0

PERIOPERATIVE OCCURRENCE CATEGORIES

Wound Occurrences	Total
A. Superficial Infection	5
B. Deep Wound Infection	1
C. Wound Disruption	2

Urinary Occurrences	Total
A. Renal Insufficiency	1
B. Acute Renal Failure	2
C. Urinary Tract Infection	3
D. Other	0

Respiratory Occurrences	Total
A. Pneumonia	2
B. Unplanned Intubation	3
C. Pulmonary Embolism	0
D. On Ventilator >48 Hours	5
E. Other	0

CNS Occurrences	Total
A. CVA/Stroke	0
B. Coma >24 Hours	0
C. Peripheral Nerve Injury	0
D. Other	0

Cardiac Occurrences	Total
A. Cardiac Arrest Req. CPR	1
B. Myocardial Infarction	0
C. Endocarditis	0
D. Low Cardiac Output >6 Hrs.	0
E. Mediastinitis	0
F. Repeat Card-Pul Bypass	0
G. Other	3

Other Occurrences	Total
A. Ileus/Bowel Obstruction	1
B. Bleeding/Transfusions	0
C. Graft/Prosthesis/Flap Failure	1
D. DVT/Thrombophlebitis	0
E. Systemic Sepsis	3
F. Reoperation for Bleeding	0
G. Other	9

Clean Wound Infection Rate: 2.2%

Example 2: Quarterly Report for Surgical Service

```
Select Management Reports Option: Q  Quarterly Report - Surgical Specialty
```

```
QUARTERLY/SUMMARY REPORT FOR SURGICAL SERVICE

NOTE:  Listed below are the CPT codes for the index procedures on these reports.

    Procedure                 CPT Code(s)
    ---------                 -----------
    Inguinal Hernia           49505,49507,49520,49521,49525
    Cholecystectomy           47600,47605,47610,56340,56341,56342
    Coronary Artery Bypass    33510,33511,33512,33513,33514,33516,33517,33518,
                              33519,33521,33522,33523,33533,33534,33535,33536
    Colon Resection (L & R)   44140,44141,44143,44144,44145,44146,44147,44160
    Fem-Pop Bypass            35656,35556
    Pulmonary Lobectomy       32480,32500,32440
    Hip Replacement
      - Elective              27125,27130,27132,27134,27137,27138
      - Acute Fracture        27236
    TURP                      52601
    Laryngectomy              31360,31365,31367,31368
    Craniotomy                61304,61305,61312,61314,61510,61512,61518,61519,
                              61700,61680
    Intraoccular Lens         66983,66984

Press RETURN to continue or '^' to quit: <RET>
```

```
Run which report ?

   1. Summary Report for Selected Date Range
   2. Quarterly Report for Central Office

Select Report Number:  1// 2
```

```
QUARTERLY REPORT FOR SURGICAL SERVICE

Run report for which quarter of the fiscal year ?

     (1) October 1 - December 31
     (2) January 1 - March 31
     (3) April 1 - June 30
     (4) July 1 - September 30

Select Quarter:  2

Select FISCAL YEAR: 1999// <RET>

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

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

..... *printout follows* .....

QUARTERLY REPORT - SURGICAL SERVICE PAGE
VERSION 3.0 1

Hospital: MAYBERRY, NC Station Number: 999
For Dates: JAN 01, 1999 to: MAR 31, 1999 Fiscal Year: 1999

	Total Cases	% of Total
Surgical Cases	657	100.0
Major Procedures	454	69.1
ASA Class (1)	27	5.9
ASA Class (2)	138	30.4
ASA Class (3)	254	55.9
ASA Class (4)	31	6.8
ASA Class (5)	4	0.9
Postoperative Deaths	20	3.0
Ambulatory: 1		
Postoperative Occurrences	49	7.5
Ambulatory Procedures	347	52.8
Admitted Within 14 Days: 0		
Invasive Diagnostic: 5		
Inpatient Procedures	310	47.2
Emergency Procedures	47	7.2
Age>60 Years	330	50.2

SPECIALTY PROCEDURES

		PATIENTS	CASES	MAJOR	MINOR	---DEATHS--- TOTAL	%
50	GENERAL	112	118	98	20	8	6.8
51	GYNECOLOGY	5	5	5	0	0	0.0
52	NEUROSURGERY	28	29	28	1	1	3.4
53	OPHTHALMOLOGY	72	74	6	68	0	0.0
54	ORTHOPEDICS	76	89	79	10	2	2.2
55	OTORHINOLARYNGOLOGY	89	94	85	9	3	3.2
56	PLASTIC SURGERY	30	34	19	15	0	0.0
57	PROCTOLOGY	0	0	0	0	0	0.0
58	THORACIC SURGERY	13	14	13	1	2	14.3
59	UROLOGY	55	58	54	4	1	1.7
60	ORAL SURGERY	2	2	2	0	0	0.0
61	PODIATRY	54	64	12	52	0	0.0
62	PERIPHERAL VASCULAR	69	76	53	23	3	3.9
500	CARDIAC SURGERY	0	0	0	0	0	0.0
501	TRANSPLANTATION	0	0	0	0	0	0.0
502	ANESTHESIOLOGY	0	0	0	0	0	0.0

LEVEL OF RESIDENT SUPERVISION (%)

	MAJOR	MINOR
Level 0	7.3	3.0
Level 1	83.0	91.6
Level 2	3.5	1.5
Level 3	5.9	2.5
Level Not Entered	0.2	1.5

QUARTERLY REPORT - SURGICAL SERVICE PAGE
VERSION 3.0 2

Hospital: MAYBERRY, NC Station Number: 999
For Dates: JAN 01, 1999 to: MAR 31, 1999 Fiscal Year: 1999

INDEX PROCEDURES

	CASES	DEATHS	CASES WITH OCCURRENCES
Inguinal Hernia	23	0	0
Cholecystectomy	15	1	5
Coronary Artery Bypass	0	0	0
Colon Resection (L & R)	2	1	1
Fem-Pop Bypass	7	0	1
Pulmonary Lobectomy	2	0	0
Hip Replacement			
- Elective	8	1	2
- Acute Fracture	0	0	0
TURP	2	0	0
Laryngectomy	0	0	0
Craniotomy	2	0	1
Intraoccular Lens	61	1	0

PERIOPERATIVE OCCURRENCE CATEGORIES

Wound Occurrences	Total
A. Superficial Infection	6
B. Deep Wound Infection	1
C. Wound Disruption	0

Urinary Occurrences	Total
A. Renal Insufficiency	9
B. Acute Renal Failure	1
C. Urinary Tract Infection	7
D. Other	1

Respiratory Occurrences	Total
A. Pneumonia	6
B. Unplanned Intubation	8
C. Pulmonary Embolism	0
D. On Ventilator >48 Hours	15
E. Other	2

CNS Occurrences	Total
A. CVA/Stroke	3
B. Coma >24 Hours	1
C. Peripheral Nerve Injury	2
D. Other	1

Cardiac Occurrences	Total
A. Cardiac Arrest Req. CPR	3
B. Myocardial Infarction	0
C. Endocarditis	0
D. Low Cardiac Output >6 Hrs.	0
E. Mediastinitis	0
F. Repeat Card-Pul Bypass	0
G. Other	5

Other Occurrences	Total
A. Ileus/Bowel Obstruction	2
B. Bleeding/Transfusions	0
C. Graft/Prosthesis/Flap Failure	5
D. DVT/Thrombophlebitis	3
E. Systemic Sepsis	5
F. Reoperation for Bleeding	0
G. Other	15

Clean Wound Infection Rate: 0.3%

1.2.13.2 Deaths Within 30 Days of Surgery

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

1. Total Cases Summary
   This report may be printed in one of three ways.
   A. All Cases
      The report will list all patients who had surgery within the selected date range and who died within 30 days of surgery, along with all of the patients' operations that were performed during the selected date range. These patients are included in the postoperative deaths totals on the Quarterly Report.
   B. Outpatient Cases Only
      The report will list only the surgical cases that are associated with deaths that are counted as outpatient (ambulatory) deaths on the Quarterly Report.
   C. Inpatient Cases Only
      The report will list only the surgical cases that are associated with deaths that are counted as inpatient deaths. Although the count of deaths associated with inpatient cases is not a part of the Quarterly Report, this report is provided to help with data validation.

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

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

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

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

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

```
                        Deaths Within 30 Days of Surgery

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

Start with Date: 4/1  (APR 01, 1999)
End with Date: 4/30  (APR 30, 1999)

Print report for which section of Quarterly/Summary Report ?

 1. Total Cases Summary
 2. Specialty Procedures
 3. Index Procedures

Select number: 1// 1  Total Cases Summary
```

```
Print Deaths within 30 Days of Surgery for

  A - All cases
  O - Outpatient cases only
  I - Inpatient cases only

Select Letter (I, O or A): A// All Cases

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
DEATHS WITHIN 30 DAYS OF SURGERY
FOR SURGERY PERFORMED FROM: APR 1,1999 TO: APR 30,1999
Report Printed: MAY 18,1999@12:09

OP DATE	CASE #	IN/OUT	SURGICAL SPECIALTY	PROCEDURE(S)	DEATH RELATED
>>> BRADY,MATTHEW (004-12-1861) - DIED 05/12/99 AGE: 70					
04/13/99	32571	INPAT	GENERAL(OR WHEN NOT DEFINED BELOW)	EXPLORATORY LAPAROTOMY (CPT Code: 49000) RIGHT HEMICOLECTOMY (CPT Code: 44140) ILEOSTOMY (CPT Code: 44144) MUCOUS FISTULA OF COLON (CPT Code: 44144)	UNRELATED
04/24/99	32693	INPAT	GENERAL(OR WHEN NOT DEFINED BELOW)	CLOSURE OF ABDOMINAL WALL FASCIA (CPT Code: 13160)	UNRELATED
>>> FLINTSTONE,TED (400-55-5500) - DIED 05/12/99 AGE: 68					
04/26/99	32702	INPAT	THORACIC SURGERY (INC. CARDIAC SURG	RIGHT THORACOTOMY WITH LUNG BIOPSY (CPT Code: 32095) DIAPHRAGM BIOPSY (CPT Code: 39599)	UNRELATED
>>> EINSTEIN,ALFRED (211-36-0000) - DIED 04/30/99 AGE: 63					
04/21/99	32567	INPAT	THORACIC SURGERY (INC. CARDIAC SURG	ESOPHAGECTOMY (CPT Code: 43112-62) ESOPHAGOSCOPY (CPT Code: 43200) BRONCHOSCOPY (CPT Code: 31622) FEEDING TUBE JEJUNOSTOMY (CPT Code: B4084)	RELATED

TOTAL DEATHS: 3

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

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

```
                        Deaths Within 30 Days of Surgery

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

Start with Date: 4/1  (APR 01, 1999)
End with Date: 4/30  (APR 30, 1999)

Print report for which section of Quarterly/Summary Report ?

 1. Total Cases Summary
 2. Specialty Procedures
 3. Index Procedures

Select number: 1// 2  Specialty Procedures
```

```
Do you want the report for all National Surgical Specialties ? YES// <RET>

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
DEATHS WITHIN 30 DAYS OF SURGERY LISTED FOR SPECIALTY PROCEDURES PAGE 1
FOR SURGERY PERFORMED FROM: APR 1,1999 TO: APR 30,1999
Report Printed: MAY 18,1999@12:38

OP DATE CASE #	PATIENT NAME PATIENT ID# (AGE)	DATE OF DEATH PROCEDURE(S)	LOCAL SPECIALTY	IN/OUT	DEATH RELATED
>>> GENERAL(OR WHEN NOT DEFINED BELOW) <<<					
04/24/99 32693	BRADY,MATTHEW 004-12-1861 (70)	05/12/99 CLOSURE OF ABDOMINAL WALL FASCIA (CPT Code: 13160)	GENERAL(OR WHEN NOT DEFINED BELOW)	INPAT	UNRELATED
TOTAL DEATHS FOR GENERAL(OR WHEN NOT DEFINED BELOW): 1					
>>> THORACIC SURGERY (INC. CARDIAC SURG.) <<<					
04/26/99 32702	FLINTSTONE,TED 400-55-5500 (68)	05/12/99 RIGHT THORACOTOMY WITH LUNG BIOPSY (CPT Code: 32095) DIAPHRAGM BIOPSY (CPT Code: 39599)	THORACIC SURGERY (INC. CARDIAC SURG.)	INPAT	UNRELATED
04/21/99 32567	EINSTEIN,ALFRED 211-36-0000 (63)	04/30/99 ESOPHAGECTOMY (CPT Code: 43112-62) ESOPHAGOSCOPY (CPT Code: 43200) BRONCHOSCOPY (CPT Code: 31622) FEEDING TUBE JEJUNOSTOMY (CPT Code: B4084)	THORACIC SURGERY (INC. CARDIAC SURG.)	INPAT	RELATED
TOTAL DEATHS FOR THORACIC SURGERY (INC. CARDIAC SURG.): 2					

TOTAL FOR ALL SPECIALTIES: 3

Example 3: Deaths Within 30 Days of Surgery - Index Procedures

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

                         Deaths Within 30 Days of Surgery

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

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

Print report for which section of Quarterly/Summary Report ?

 1. Total Cases Summary
 2. Specialty Procedures
 3. Index Procedures

Select number: 1// 3  Index Procedures

This report is designed to use a 132 column format.

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

..... *printout follows* .....

```
                                        MAYBERRY, NC
                   DEATHS WITHIN 30 DAYS OF SURGERY LISTED FOR INDEX PROCEDURES                          PAGE 1
                     FOR SURGERY PERFORMED FROM: JAN 1,1999  TO: MAR 31,1999
                                Report Printed: APR 28,1999@13:02

OP DATE     PATIENT NAME                    DATE OF DEATH   LOCAL SPECIALTY                          IN/OUT   DEATH RELATED
CASE #      PATIENT ID#  (AGE)              PROCEDURE(S)
=================================================================================================================================
>>> Cholecystectomy <<<

03/05/99    GRANT,ULYSSES E.                03/18/99        GENERAL(OR WHEN NOT DEFINED BELOW)        INPAT    RELATED
32147       662-77-2222  (52)               LAPAROSCOPIC CHOLECYSTECTOMY  (CPT Code: 56341)


TOTAL DEATHS FOR Cholecystectomy: 1
---------------------------------------------------------------------------------------------------------------------------------
>>> Colon Resection (L & R) <<<

01/12/99    STEVENSON,ROBERT                01/18/99        GENERAL(OR WHEN NOT DEFINED BELOW)        INPAT    UNRELATED
31514       890-67-1234  (76)               RT. HEMICOLECTOMY (CPT Code: 44140-59)


TOTAL DEATHS FOR Colon Resection (L & R): 1
---------------------------------------------------------------------------------------------------------------------------------
>>> Hip Replacement - Elective <<<

01/15/99    CROCKETT,DAVID                  01/19/99        ORTHOPEDICS                               INPAT    RELATED
31576       411-11-1112  (93)               LT. HIP ARTHROPLASTY (CPT Code: 27130)


TOTAL DEATHS FOR Hip Replacement - Elective: 1
---------------------------------------------------------------------------------------------------------------------------------
>>> Intraoccular Lens <<<

02/23/99    TAYLOR,ZACHORY                  03/15/99        OPHTHALMOLOGY                             OUTPAT   UNRELATED
32008       333-34-4444  (90)               CATARACT EXTRACTION WITH IOL OS (CPT Code: 66983)


TOTAL DEATHS FOR Intraoccular Lens: 1
---------------------------------------------------------------------------------------------------------------------------------

TOTAL FOR ALL INDEX PROCEDURES: 4
```

1.2.13.3 Admissions Within 14 Days of Outpatient Surgery

This option provides a list of patients with completed outpatient surgical cases that resulted in at least one postoperative occurrence AND a hospital admission within 14 days of the surgery. These patients are included in the "Admitted Within 14 Days" total on the Quarterly Report.

This report has a 132-column format and is designed to be copied to a printer.

Example: Report of Admissions Within 14 Days of Outpatient Surgery

```
Select Quarterly Report Menu Option: A  Admissions Within 14 Days of Outpatient
Surgery
```

```
                  Outpatient Cases with Postop Occurrences
                        and Admissions Within 14 Days


This report displays the completed outpatient surgical cases which resulted in
at least one postoperative occurrence and a hospital admission within 14 days.


Start with Date: 9 1 98  (SEP 01, 1998)
End with Date: 12 31 98 (DEC 31, 1998)
```

```
Do you want the report for all Surgical Specialties ? YES// <RET>

This report is designed to use a 132 column format.

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

..... *printout follows* .....

```
                                        MAYBERRY, NC
OUTPATIENT CASES WITH POSTOP OCCURRENCES AND ADMISSIONS WITHIN 14 DAYS                    PAGE 1
                                From: SEP 1,1998  To: DEC 31,1998
                                Report Printed: FEB 12,1999@13:44

DATE OF OPERATION     PATIENT NAME                  SURGICAL SPECIALTY              ANESTHESIA TECHNIQUE       DATE OF ADMISSION
CASE #                PATIENT ID  (AGE)             PROCEDURE(S) PERFORMED
*OCCURRENCE - (DATE)
==================================================================================================================================
SEP 24,1998@12:30     BROOKS,RAYFORD                THORACIC SURGERY (INC. CARDIAC   GENERAL                    OCT 3,1998@14:11
30395                 216-67-3434  (72)             MEDIASTINOSCOPY WITH NODE BIOPSY (CPT Code: 39400)
*OTHER OCCURRENCE - (10/03/98)


SEP 25,1998@14:30     JOHNSON,ANDREW P              GENERAL(OR WHEN NOT DEFINED BE   GENERAL                    SEP 28,1998@10:06
30544                 616-16-1616  (75)             LEFT INGUINAL HERNIORRAPHY (CPT Code: 49505)
*OTHER OCCURRENCE - (09/28/98)                      HYDROCELECTOMY (CPT Code: 55040)


NOV 18,1998@09:45     RABBIT,PETER H                PLASTIC SURGERY (INCLUDES HEAD   GENERAL                    NOV 28,1998@12:51
31034                 654-32-1098  (50)             GANGLION CYST LT. WRIST (CPT Code: 25111)
*SUPERFICIAL WOUND INFECTION - (11/28/98)           INCLUSION OF CYST INDEX FINGER LT. (CPT Code: 26210)
                                                    EXCISION OF LIPOMA OF LT. FOOT (CPT Code: 28043)
                                                    APPLICATION SHORT ARM SPLINT  (CPT Code: 29125)


DEC 9,1998@13:35      HESS,RUDOLF W                 ORTHOPEDICS                      GENERAL                    DEC 9,1998@17:55
31242                 222-33-4444  (49)             ORIF RT ULNA (CPT Code: 25545)
*SUPERFICIAL WOUND INFECTION - (12/29/98)           REPAIR RT. DISTALRADIOULNAR FX (CPT Code: 25676)


DEC 31,1998@07:30     MADISON,DOLLY                 OTORHINOLARYNGOLOGY (ENT)        GENERAL                    DEC 31,1998@18:02
31277                 020-88-0002  (31)             NASAL SINUS SURGERY WITH BIL SPENOETHMOID POLYPECTOMY (CPT Code: 31205)
*OTHER CNS OCCURRENCE - (01/05/99)                  BILATERAL ANTROSTOMY (CPT Code: 31256)
                                                    BILATERAL TURBINECTOMY (CPT Code: 30130)


TOTAL CASES: 5
```

1.2.13.4 List of Invasive Diagnostic Procedures

This option provides a report listing the completed surgical cases that were performed during the selected date range and have a principal CPT code on the invasive diagnostic procedures list defined by Surgical Service at VHA Headquarters.

This report has a 132-column format and is designed to be copied to a printer.

Example: List of Invasive Diagnostic Procedures Report

```
Select Quarterly Report Menu Option: I  List of Invasive Diagnostic Procedures
```

```
                    List of Invasive Diagnostic Procedures

This report displays the completed surgical cases that meet the selection
criteria and that have a principal CPT code on the list below defined by
Surgical Service at VHA Headquarters as invasive diagnostic procedures.

   Procedure Group            CPT Code(s)
   ---------------            -----------
   Urologic                   52000,52005,52007,52010,52204
   ENT                        31231
   Pulmonary (Respiratory)    31615,31622,31625,31628,31629,31656
   Upper Gastrointestinal     43200,43202,43234,43235,43239,43259,43263
   Small Bowel and Stomach    44360,44361,44376,44377,44380,44382,44385,44386,
                              44388,44389
   Colon and Rectum           45330,45331,45355,45378,45380,46600,46606


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

```
Print List of Invasive Diagnostic Procedures for

  A - All cases
  O - Outpatient cases only
  I - Inpatient cases only

Select Letter (I, O or A): O// Outpatient Cases Only

Start with Date: 5/7  (MAY 07, 1999)
End with Date: 5/7  (MAY 07, 1999)

Do you want the report for all Surgical Specialties ? YES// <RET>
```

```
This report is designed to use a 132 column format.

Print the List of Invasive Diagnostic Procedures to which Printer ? [Select Print
Device]
```

..... *printout follows* .....

MAYBERRY, NC
LIST OF INVASIVE DIAGNOSTIC PROCEDURES PAGE 1
From: MAY 7,1999 To: MAY 7,1999
Report Printed: JUN 10,1999@14:16

DATE OF OPERATION CASE #	PATIENT NAME PATIENT ID (AGE)	SURGICAL SPECIALTY PROCEDURE(S) PERFORMED	ANESTHESIA TECHNIQUE	IN/OUT-PATIENT
MAY 7,1999@08:20 34398	ROOSEVELT,FRANK M. 534-88-4444 (84)	UROLOGY CYSTO (CPT Code: 52000)	LOCAL	OUTPATIENT
MAY 7,1999@09:25 34397	FRASIER,WATSON 111-22-3333 (57)	GENERAL(OR WHEN NOT DEFINED FLEX SIG (CPT Code: 45330)	NOT ENTERED	OUTPATIENT
MAY 7,1999@09:30 34399	JAMES,JOHN T. 222-00-3001 (79)	UROLOGY CYSTO (CPT Code: 52000)	LOCAL	OUTPATIENT
MAY 7,1999@11:45 34440	SCHLITZ,WALTER 999-26-1001 (52)	UROLOGY CYSTOSCOPY (CPT Code: 52000)	LOCAL	OUTPATIENT
MAY 7,1999@12:20 34441	JOHNSTON,JOSEPH 848-22-9090 (61)	UROLOGY CYSTOSCOPY (CPT Code: 52007)	LOCAL	OUTPATIENT

TOTAL OUTPATIENT CASES: 5

1.2.13.5 List of Operations Included on Quarterly Report

This option generates a list of completed operations that are included in the totals displayed on the Quarterly Report. The report displays the data fields that are checked by the Quarterly Report.

This report has a 132-column format and is designed to be copied to a printer.

Example: List of Operations Included on Quarterly Report

```
Select Quarterly Report Menu Option: L  List of Operations Included on Quarterly
Report
```

```
                 List of Operations Included on Quarterly Report


This option generates a list of completed operations that are included on the
Quarterly Report and displays the data fields for each case that are checked
by the Quarterly Report.

Start with Date: 12/31  (DEC 31, 1998)
End with Date: 12/31  (DEC 31, 1998)
```

```
Do you want the report for all Surgical Specialties ? YES// <RET>

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
List of Operations Included on Quarterly Report PAGE 1
From: DEC 31,1998 To: DEC 31,1998
Report Printed: FEB 13,1999@14:37

```
DATE OF OPERATION     PATIENT NAME                    PATIENT ID  (AGE)          ASA CLASS                  RESIDENT SUPERVISION
CASE #  (MAJ/MIN)     SURGICAL SPECIALTY              CASE SCHEDULE TYPE         WOUND CLASS                IN/OUT-PAT STATUS
OCCURENCE(S)                                          PROCEDURE(S)
==========================================================================================================================
DEC 31,1998@07:30     JUSTICE,BUFORD                  767-68-6868  (31)          2-MILD DISTURB.            LEVEL 1
31277  (MAJOR)        OTORHINOLARYNGOLOGY (ENT)       ELECTIVE                   CLEAN/CONTAMINATED         OUTPATIENT
POSTOP - OTHER CNS OCCURRENCE                         NASAL SINUS SURGERY WITH BIL SPENOETHMOID POLYPECTOMY (CPT Code: 31205)
                                                      BILATERAL ANTROSTOMY (CPT Code: 31256)
                                                      BILATERAL TURBINECTOMY (CPT Code: 30130)
--------------------------------------------------------------------------------------------------------------------------
DEC 31,1998@07:35     ANTONIO,JUAN                    200-10-3000  (63)          2-MILD DISTURB.            LEVEL 1
31408  (MAJOR)        OTORHINOLARYNGOLOGY (ENT)       ELECTIVE                   CLEAN/CONTAMINATED         OUTPATIENT
                                                      SEPTOPLASTY, INTRANASAL ETHMOIDECTOMY (CPT Code: 30520)
--------------------------------------------------------------------------------------------------------------------------
DEC 31,1998@08:00     LINCOLN,MOSES                   656-33-7575  (75)          3-SEVERE DISTURB.          LEVEL 1
31412  (MINOR)        GENERAL(OR WHEN NOT DEFINED BE  URGENT                     CLEAN                      OUTPATIENT
                                                      A-V FISTULA LT  (CPT Code: 36825)
--------------------------------------------------------------------------------------------------------------------------
DEC 31,1998@09:50     WASHINGTON,GEORGE Q.            225-52-2552  (51)          2-MILD DISTURB.            LEVEL 1
31278  (MAJOR)        OTORHINOLARYNGOLOGY (ENT)       ELECTIVE                   CLEAN/CONTAMINATED         OUTPATIENT
                                                      INTRANASAL SINUS SURGERY WITH NASAL POLYPECTOMY (CPT Code: 31256)
--------------------------------------------------------------------------------------------------------------------------
DEC 31,1998@10:15     ALDEN,JOHN T.                   111-11-1119  (51)          3-SEVERE DISTURB.          LEVEL 1
31437  (MAJOR)        PERIPHERAL VASCULAR             URGENT                     INFECTED                   INPATIENT
                                                      LT BKA (CPT Code: 27880)
--------------------------------------------------------------------------------------------------------------------------
DEC 31,1998@11:55     COLUMBUS,CHRISTOPHER            911-91-1911  (66)          3-SEVERE DISTURB.          LEVEL 1
31362  (MAJOR)        OTORHINOLARYNGOLOGY (ENT)       ELECTIVE                   CLEAN                      OUTPATIENT
                                                      BLEPHAROPLASTY LEFT LOWER LID (CPT Code: 15820)
                                                      ADDITIONAL LEFT UPPER LID (CPT Code: 15823)
                                                      ADDITIONAL RIGHT UPPER LID (CPT Code: 15823)
                                                      ADDITIONAL RIGHT LOWER LID (CPT Code: 15820)
--------------------------------------------------------------------------------------------------------------------------

TOTAL CASES: 6
```

1.2.13.6 Report of Missing Quarterly Report Data

This option generates a list of surgical cases performed within the selected date range that are missing information used by the Quarterly Report. This report includes surgical cases with an entry in the TIME PAT IN OR field but does not include aborted cases.

This report has a 132-column format and is designed to be copied to a printer.

Example: Report of Missing Quarterly Report Data

```
Select Quarterly Report Menu Option: M  Report of Missing Quarterly Report Data
```

```
                  Report of Missing Quarterly Report Data


For surgical cases with an entry in the TIME PAT IN OR field and that are not
aborted, this option generates a report of cases missing any of the following
pieces of information used by the Quarterly Report:

          In/Out-Patient Status
          Major/Minor
          Case Schedule Type
          Attending Code
          Time Pat Out OR
          Wound Classification
          ASA Class
          CPT Code (Principal)
          CPT Code (Other)


Start with Date: 4 1  (APR 01, 1999)
End with Date: 4 30  (APR 30, 1999)
```

```
Do you want the report for all Surgical Specialties ? YES// <RET>

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
Report of Missing Data for Quarterly Report PAGE 1
From: APR 1,1999 To: APR 30,1999
Report Printed: MAY 11,1999@15:09

DATE OF OPERATION CASE #	PATIENT NAME PATIENT ID (AGE)	SURGICAL SPECIALTY PRINCIPAL PROCEDURE	MISSING ITEMS
APR 6,1999@07:40 32474	WINCHESTER,CHARLES E. 400-10-7606 (43)	OPHTHALMOLOGY PHACHOEMULSIFICATION, LENS IMPLANT OD	D
APR 12,1999@12:00 32508	POWERS,AUSTIN E 922-92-9222 (78)	OPHTHALMOLOGY PHACOEMULSIFICATION, LENS IMPLANT OS	D
APR 12,1999@13:50 32534	CHRISTIAN,FLETCHER 010-00-0010 (77)	PLASTIC SURGERY (INCLUDES HEAD AND NECK) EXCISION OF RT. WRIST MASS	D
APR 12,1999@14:00 32544	LINDBURGH,CHARLES B. 567-10-8888 (81)	OPHTHALMOLOGY PHACOEMULSIFICATION OD	D
APR 13,1999@09:20 32513	WALTON,ZEB 777-77-7777 (79)	OPHTHALMOLOGY PHACOEMULSIFICATION, LENS IMPLANT OD	D
APR 15,1999@13:05 32351	ROSS,BETSY 555-55-6666 (40)	GENERAL(OR WHEN NOT DEFINED BELOW) EXCISIONAL BIOPSY MASS RT. BREAST	D
APR 19,1999@13:00 32580	PIZARRO,PONCHO 232-34-3545 (52)	OPHTHALMOLOGY PHACOEMULSIFICATION LENS IMPLANT OD	D
APR 27,1999@13:15 32684	SULLIVAN,EDWIN 928-37-4655 (69)	OPHTHALMOLOGY TRABECULECTOMY OD	F

TOTAL CASES MISSING DATA: 8

MISSING ITEMS CODES: A-IN/OUT-PATIENT STATUS, B-MAJOR/MINOR, C-CASE SCHEDULE TYPE, D-ATTENDING CODE,
E-TIME PAT OUT OR, F-WOUND CLASSIFICATION, G-ASA CLASS, H-CPT CODE (PRINCIPAL), I-CPT CODE (OTHER)

1.2.14 Print Blood Product Verification Audit Log

The Surgery option *Blood Product Verification Audit Log* is used to print the KERNEL audit log for the *Blood Product Verification* option.

Prior to printing entries from the KERNEL audit log for the *Blood Product Verification* option, the audit function must be turned on either through the *System Manager Menu* or by invoking the KERNEL option *Establish System Audit Parameters*, as shown below.

Example: Establish System Audit Parameters

```
Select Systems Manager Menu Option: SYStem Security

Select System Security Option: AUDIt Features

Select Audit Features Option: MAintain System Audit Options

Select Maintain System Audit Options Option: EStablish System Audit Parameters
```

```
                        Kernel Site Parameter edit
  DOMAIN: [Enter your domain here.]

OPTION AUDIT: SPECIFIC OPTIONS AUDITED    FAILED ACCESS ATTEMPTS:
   INITIATE AUDIT: [Enter date here.]        TERMINATE AUDIT: [Enter date here.]

   Option to audit                        Namespace to audit
   SR BLOOD PRODUCT VERIFICATION



   User to audit                          Device to audit




_____________________________________________________________________________


COMMAND:                                        Press <PF1>H for help    Insert
```

Example: Print Blood Product Verification Audit Log

```
Select Management Reports Option: BA  Print Blood Product Verification Audit Log

         Enter a date range to print the Blood Verification Audit Log.

* Previous selection: DATE/TIME from Feb 21,1999
START WITH DATE/TIME: FIRST// <RET>
DEVICE: [Select Print Device]
```

..... *printout follows* .....

```
MENU OPTION AUDIT LOG    APR 2,1999         3:04 PM             PAGE 1
-------------------------------------------------------------------------------
         *** OPTION:  SR BLOOD PRODUCT VERIFICATION
    USER:  WASHINGTON,MARTHA
DATE/TIME (ENTRY):  MAR  5,1999  09:24     (EXIT):  MAR  5,1999  09:24
CPU:  VAA              DEVICE:  _LTA8720:        JOB:  541070010

         *** OPTION:  SR BLOOD PRODUCT VERIFICATION
    USER:  DAVIS,VARINA
DATE/TIME (ENTRY):  MAR  5,1999  09:24     (EXIT):  MAR  5,1999  09:24
CPU:  VAA              DEVICE:  _LTA8720:        JOB:  541070010

         *** OPTION:  SR BLOOD PRODUCT VERIFICATION
    USER:  DOUGLAS,STEPHEN
DATE/TIME (ENTRY):  MAR  6,1999  13:06     (EXIT):  MAR  6,1999  13:07
CPU:  VAA              DEVICE:  _LTA1411:        JOB:  541072157

         *** OPTION:  SR BLOOD PRODUCT VERIFICATION
    USER:  DOUGLAS,STEPHEN
DATE/TIME (ENTRY):  MAR  6,1999  13:10     (EXIT):  MAR  6,1999  13:11
CPU:  VAA              DEVICE:  _LTA1411:        JOB:  541072157

         *** OPTION:  SR BLOOD PRODUCT VERIFICATION
    USER:  DOUGLAS,STEPHEN
DATE/TIME (ENTRY):  MAR  6,1999  13:20     (EXIT):  MAR  6,1999  13:20
CPU:  VAA              DEVICE:  _LTA1411:        JOB:  541072157
```

1.3 Unlock a Case for Editing

The Chief of Surgery, or a designee, uses this option to unlock a case so that it can be edited. A case that has been completed will automatically lock within a specified time after the date of operation. **When a case is locked, the data cannot be edited.**

With this option, the case selected will be unlocked so that you can use another option (such as in the *Operation Menu* or *Anesthesia Menu*) to make changes. The case will automatically re-lock in the evening. The package coordinator has the ability to set the automatic lock times.

Example: Unlock a Case

```
Select Chief of Surgery Menu Option:  Unlock a Case for Editing
```

```
Select PATIENT NAME:  ANGEL, JOHNNY  08-15-91  099055066

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

Select Number:  1

Press <RET> to continue.  <RET>

Case #115 is now unlocked

Select Chief of Surgery Menu Option:
```

1.4 Update Status of Returns Within 30 Days

This option is used to update the status of Returns to Surgery within 30 days of a surgical case.

Example: Update Status of Returns

```
Select Chief of Surgery Menu Option: RET  Update Status of Returns Within 30 Days

Select Patient: RUBBLE,BETTY         10-28-45     123459999

 RUBBLE,BETTY   123-45-9999

1. 07-13-92   SPLENECTOMY (NOT COMPLETE)

2. 06-30-92   CHOLECYSTECTOMY (COMPLETED)

3. 03-10-92   HEMORRHOIDECTOMY (COMPLETED)



Select Operation: 2

RUBBLE,BETTY (123-45-9999)        Case #213                RETURNS TO SURGERY
JUN 30,1992   CHOLECYSTECTOMY (CPT MISSING)
-------------------------------------------------------------------------------

1. 07/13/92    SPLENECTOMY (CPT MISSING) - RELATED


This return to surgery is currently defined as RELATED to the case selected.
Do you want to change this status ? NO// Y

Press RETURN to continue  <RET>
```

1.5 Update Cancelled Cases

Normally, a cancelled case cannot be accessed for editing. However, this restricted option allows the Chief of Surgery to edit a cancelled case.

When you enter this option, the computer will allow you access to the Operations Menu.

Example: Update a Cancelled Case

```
Select Chief of Surgery Menu Option: CAN  Update Cancelled Case
```

```
Update Cancelled Case


Select Patient: BODEAN,JETHRO         08-16-51     123457212
```

```
 BODEAN,JETHRO   123-45-7212

1. 09-16-92   CHOLECYSTECTOMY (CANCELLED)

2. 09-15-92   CHOLECYSTECTOMY (CANCELLED)



Select Operation: 2
```

```
BODEAN,JETHRO (123-45-7212)   Case #15644 - SEP 15,1992


   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 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

Select Update Cancelled Case Option:
```

1.6 Update Operations as Unrelated/Related to Death

This option is used to update the status of operations performed within 90 days prior to death. The status is either Unrelated or Related to death. With this option you can add comments to further document the review of death.

Example: Updating an Operation as Related to Death

```
Select Surgery Risk Assessment Menu Option: D  Update Operations as Unrelated/Related
to Death
```

```
               Update Operations as Unrelated or Related to Death


Select Patient:    FLINSTONE,FRED       01-12-01     111221850     NO     NON-VETERAN
(OTHER)
```

```
               Update Operations as Unrelated or Related to Death

FLINSTONE,FRED   111-22-1850        * DIED 02/27/96 *

Operations in 90 Days Prior to Death:

1. 01/29/96    CABG, VEIN, SIX+ (33516) - UNRELATED
                >>> Died 29 days postop. <<<

2. 01/06/96    TOTAL LARYNGECTOMY (CPT MISSING) - UNRELATED
                >>> Died 52 days postop. <<<

3. 12/02/95    EVACUATION OF HEMATOMA LT.THIGH (27301) - UNRELATED
                >>> Died 87 days postop. <<<

Select Number of Operation to be Updated:  (1-3): 1
```

```
               Update Operations as Unrelated or Related to Death

FLINSTONE,FRED   111-22-1850        * DIED 02/27/96 *

1. 01/29/96    CABG, VEIN, SIX+ (33516) - UNRELATED
                >>> Died 29 days postop. <<<

Was the Death Unrelated or Related to the Surgery?: UNRELATED
         // R  RELATED
Review of Death Comments:
  No existing text
  Edit? NO// <RET>
```

```
                Update Operations as Unrelated or Related to Death

FLINSTONE,FRED   111-22-1850        * DIED 02/27/96 *

Operations in 90 Days Prior to Death:

1. 01/29/96    CABG, VEIN, SIX+ (33516) - RELATED
                >>> Died 29 days postop. <<<

2. 01/06/96    TOTAL LARYNGECTOMY (CPT MISSING) - UNRELATED
                >>> Died 52 days postop. <<<

3. 12/02/95    EVACUATION OF HEMATOMA LT.THIGH (27301) - UNRELATED
                >>> Died 87 days postop. <<<

Select Number of Operation to be Updated:  (1-3): <RET>
```

```
                Update Operations as Unrelated or Related to Death


Select Patient: <RET>
```

1.7 Update/Verify Procedure/Diagnosis Codes

This option is used to edit and/or verify the CPT and ICD9 codes for an operation or non-OR procedure.

```
Select Chief of Surgery Menu Option: CODE  Update/Verify Procedure/Diagnosis Codes

Select Patient: D8719  DRUCKER,SAMUEL H.         02-12-28     233418719
 YES     SC VETERAN
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  NOT ENTERED

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: ?

Enter the number corresponding to the information you want to update.  You may
enter 'ALL' to update all the information displayed on this screen, or a
range of numbers separated by a ':' to update more than one item.

Select Information to Edit: 2
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------

Principal Procedure Code (CPT): 31600       INCISION OF WINDPIPE
        TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
 Modifier: 59       DISTINCT PROCEDURAL SERVICE
 Modifier:  <RET>

DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: 3
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
```

```
Other Procedures:

1. BRONCHOSCOPY
      CPT Code: NOT ENTERED
2. Enter NEW Other Procedure

Enter selection:  (1-2): 1

   BRONCHOSCOPY
      CPT Code: NOT ENTERED

OTHER PROCEDURE: BRONCHOSCOPY// <RET>
OTHER PROCEDURE CPT CODE: 31622       DX BRONCHOSCOPE/WASH
        BRONCHOSCOPY; DIAGNOSTIC, (FLEXIBLE OR RIGID), WITH OR WITHOUT CELL
        WASHING
 Modifier: <RET>

Press RETURN to continue  <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Procedures:

1. BRONCHOSCOPY
      CPT Code: 31622  DX BRONCHOSCOPE/WASH
2. Enter NEW Other Procedure

Enter selection:  (1-2): 2


Enter new OTHER PROCEDURE: ESOPHAGOSCOPY
OTHER PROCEDURE CPT CODE: 43200       ESOPHAGUS ENDOSCOPY
        ESOPHAGOSCOPY, RIGID OR FLEXIBLE;
        DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR
        WASHING (SEPARATE PROCEDURE)

 Modifier: <RET>

Press RETURN to continue  <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Procedures:

1. BRONCHOSCOPY
      CPT Code: 31622  DX BRONCHOSCOPE/WASH
2. ESOPHAGOSCOPY
      CPT Code: 43200  ESOPHAGUS ENDOSCOPY
3. Enter NEW Other Procedure

Enter selection:  (1-3): <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59
```

```
3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: 5
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------

Principal Diagnosis Code (ICD9): 934.0   934.0     FOREIGN BODY IN TRACHEA
         ...OK? Yes// <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: 6
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis

Enter selection:  (1-1): 1
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis

Enter selection:  (1-1): 1


Enter new OTHER POSTOP DIAGNOSIS: LARYNGEAL/TRACHEAL BURN
ICD DIAGNOSIS CODE: 947.1  947.1     BURN LARYNX/TRACHEA/LUNG
         ...OK? Yes// <RET>
```

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
Other Postop Diagnosis:

1. LARYNGEAL/TRACHEAL BURN
      ICD9 Code: 947.1  BURN LARYNX/TRACHEA/LUNG
2. Enter NEW Other Postop Diagnosis

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

```
DRUCKER,SAMUEL H.  (233-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: <RET>
```

2.0 Surgeons’ Dictation Menu

In the Surgery package, transcription refers to the operation notes written or dictated by a surgeon. The operation notes concern a recently performed surgical procedure. They are usually dictated by the surgeon and transcribed by a professional transcriptionist. The resulting transcript, an Operation Report, is approved and signed by the surgeon and filed with the patient's record.

Note*:* Every completed surgical case should have operation notes. The Surgery package is carefully designed with checks to ensure that the notes are dictated, transcribed and verified. If one of these steps is omitted, the case will show up on one of the special reports for the Chief of Surgery to investigate.

This menu contains options associated with the Surgeon's dictation of operation notes.

D	*Enter/Edit Date of Dictation*
T	*List of Untranscribed Surgeon's Dictation*
U	*Undictated Operations*

2.1 Enter/Edit Date of Dictation

This option allows the transcriptionist or surgeon to enter the date of dictation for a particular case. After selecting the patient and operation, you only have to enter the date and time of dictation at the appropriate prompt.

Example: Enter the Date of Dictation

```
Select Surgeons' Dictation Menu Option: D  Enter/Edit Date of Dictation

Select Patient: FIFE,BARNEY         04-04-30     222001234
```

```
 FIFE,BARNEY   222-00-1234

1. 04-24-99   REMOVE RECTAL TAGS (REQUESTED)

2. 03-09-99   APPENDECTOMY (COMPLETED)


Select Operation: 2
```

```
Patient:           FIFE,BARNEY (222-00-1234)
Case Number:       188
Operation Date:    MAR  9, 1999 10:56
Attending Surgeon: BRONSTEIN,SOLOMON ABRAM
Surgeon:           FINE,LARRY
-------------------------------------------------------------------------------

Date/Time of Dictation: 3/10@13:00  (MAR 10, 1999@13:00)

Press RETURN to continue  <RET>
```

2.2 List of Untranscribed Surgeon's Dictation

This option lists all the completed operations for which the operation notes have not been transcribed.

A surgical case might be dictated but not yet transcribed. If so, a date of dictation needs to be entered. Until the dictation is transcribed, the surgical case will appear on this list. If the case has no dictation at all, it will appear on the Undictated Operations list.

Example: List Untranscribed Dictation

```
Select Surgeons' Dictation Menu Option: T  List of Untranscribed Surgeon's Dictation
```

```
List of Untranscribed Surgeon's Dictations


Sort Cases by:

1. Surgeon
2. Service
3. Date of Operation

Enter number: 2

List Cases for which Service ?  ALL//  <RET>

Start with date: 3/8  (MAR 08, 1992)
End with Date: 3/10  (MAR 10, 1992)

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

..... *printout follows* .....

```
        UNTRANSCRIBED CASES FOR GENERAL(OR WHEN NOT DEFINED BELOW)

CASE #  PATIENT                                SURGEON
        ID #                                   DATE/TIME OF DICTATION
        DATE OF OPERATION
==============================================================================
188     FIFE,BARNEY                            BRONSTEIN,SOLOMON ABRAM
        222-00-1234                            MAR 10, 1992@13:00
        MAR  9, 1992 20:15
        APPENDECTOMY

189     CLAMPETT,ELLIE MAE                     REED,JAMES
        231-21-2234                            AUG 30, 1992
        MAR 10, 1992 07:00
        DRAINAGE OF OVARIAN CYST

199     MONROE,EARL                            HOWARD,MOE
        123-45-1982                            AUG 30, 1992
        MAR 10, 1992 08:05
        CHOLECYSTECTOMY WITH CHOLANGIOGRAM

Press RETURN to continue, '^' to quit  <RET>
```

```
        UNTRANSCRIBED CASES FOR PLASTIC SURGERY (INCLUDES HEAD AND NECK)

CASE #  PATIENT                                SURGEON
        ID #                                   DATE/TIME OF DICTATION
        DATE OF OPERATION
==============================================================================
186     DRUCKER,SAM                            REED,JAMES
        233-41-8719                            AUG 30, 1992
        MAR  9, 1992 13:10
        REMOVE FACIAL LESIONS

Press RETURN to continue, '^' to quit  <RET>
```

```
        UNTRANSCRIBED CASES FOR PROCTOLOGY

CASE #  PATIENT                                SURGEON
        ID #                                   DATE/TIME OF DICTATION
        DATE OF OPERATION
==============================================================================
200     RUBBLE,BETTY                           BRONSTEIN,SOLOMON ABRAM
        123-45-9999                            AUG 30, 1992
        MAR 10, 1992 14:10
        HEMORRHOIDECTOMY

Press RETURN to continue  <RET>
```

2.3 Undictated Operations

This option is designed to allow a surgeon to view the Operation Report for one of his or her cases and see if the case requires dictation. The surgeon can enter the date of dictation while in this option. This is a restricted option and only users such as the surgeon and the Chief of Surgery who have the SROSURG key have access.

The surgeon making the inquiry is able to view only his or her cases.

> *Note*: Any completed case without a Date of Dictation will show up on this list, even if dictation has been transcribed.

Example: View an Undictated Operation and Enter a Date of Dictation

```
Select Surgeons' Dictation Menu Option:  U  Undictated Operations
```

```
          Undictated Operations for WELBY,MARCUS
-----------------------------------------------------------------------------

1.    Case Number: 41138
          Patient: VADER,DARTH  (451-23-6987)
             Date: JUL 21, 1998  11:15
             Ward: NOT AN INPATIENT
     Procedure(s): PERINEAL WOUND EXPLORATION

2.    Case Number: 41234
          Patient: SOX,HAL  (101-01-1010)
             Date: JUL 24, 1998  06:00
             Ward: NOT AN INPATIENT
     Procedure(s): HIP REPLACEMENT

Enter the number desired, or RETURN to continue  1

Do you need to view the Operation Report ?  NO// Y
```

```
     MEDICAL RECORD                          OPERATION REPORT     PAGE 1
     CASE # 41138

Preoperative Diagnosis:
  Primary: BLEEDING OF PERINEAL WOUND

Surgeon:        WELBY,MARCUS        Surgical Priority: EMERGENCY
Attend Surgeon: FINE,LARRY          Attend Code: 1. ATTENDING IN O.R.
1st Assistant:  REED,JAMES          2nd Assistant: ARMSTRONG,JOSEPH


Press RETURN to continue, or '^' to quit: <RET>
```

```
     MEDICAL RECORD                       OPERATION REPORT        PAGE 2



Anesthetist: DAVIS,DOUG                 Asst. Anesthetist: ALLEN,JIM
Attending Anesthesiologist: REED,DANNY

OR Support Personnel:
  Scrubbed                              Circulating
  CRAIG,ALISON (ORIENTEE)               REYNOLDS,NANCY (FULLY TRAINED)
  CLERK,WARD (FULLY TRAINED)


Press RETURN to continue, or '^' to quit: <RET>
```

```
     MEDICAL RECORD                       OPERATION REPORT        PAGE 3


Anesthesia Technique(s):
  GENERAL  (PRINCIPAL)
     Agent:  ENFLURANE 125ML

Anesthesia Begin: JUL 21, 1998  11:20   Anesthesia End: JUL 21, 1998  14:00
Operation Begin:  JUL 21, 1998  12:30   Operation End:  JUL 21, 1998  13:30

Tubes and Drains:
  1/4"ROUND DRAIN W/JP X2

Material Sent to Laboratory for Analysis: N/A


Press RETURN to continue, or '^' to quit: <RET>
```

```
     MEDICAL RECORD                       OPERATION REPORT        PAGE 4


Postoperative Diagnosis:
  Primary: BLEEDING OF PERINEAL WOUND  ICD9 Code: 459.0

Major Operations Performed:
  Primary: PERINEAL WOUND EXPLORATION
    CPT Code: 49002  REOPENING OF ABDOMEN
     Modifiers: -80 ASSISTANT SURGEON


Press RETURN to continue, or '^' to quit: <RET>
```

```
     MEDICAL RECORD                       OPERATION REPORT        PAGE 5


Date/Time of Dictation: NOT ENTERED
Date/Time Transcribed:  NOT ENTERED

Indications for Operation:
  POST OP.BLEEDING

Surgeon's Dictation: N/A

Press RETURN to continue: <RET>
```

```
Date/Time of Dictation: 7/21@14:00  (JUL 21, 1998@14:00)

Do you want to select another surgery case ?  YES//  N
```

Chapter Five: Managing the Software Package

Introduction

This chapter describes options designed for the exclusive use of the Surgery package coordinator. The package coordinator can configure some of the Surgery package fields to conform to a site's needs.

Getting Out of an Option

To stop what you are doing, enter an up-arrow (^). You can use the up-arrow at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continue entering up-arrows to completely exit the system.

Overview

The main option included in this menu is listed below. To the left of the option name is the shortcut synonym you can enter to select the option. This is a restricted option and only users with the SRCOORD security key have access.

M *Surgery Package Management Menu*

1.0 Surgery Package Management Menu

This option provides access to the Surgery Package Management Menu. These sub-options are used to manage the Surgery software. Each option is discussed in the rest of this chapter.

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

S	*Surgery Site Parameters (Enter/Edit)*
OR	*Operating Room Information (Enter/Edit)*
SU	*Surgery Utilization Menu ...*
KEY	*Person Field Restrictions Menu ...*
SD	*Update O.R. Schedule Devices*
U	*Update Staff Surgeon Information*
D	*Flag Drugs for Use as Anesthesia Agents*
F	*Update Site Configurable Files*
SI	*Surgery Interface Management Menu ...*

1.1 Surgery Site Parameters (Enter/Edit)

Surgical Service managers use this option to create or update local site parameters for the Surgery package.

You can enter a question mark or two to access the help text at any prompt.

Example: Enter Surgery Site Parameters

```
Select Surgery Package Management Menu Option: S  Surgery Site Parameters (Enter/Edit)

Edit Parameters for which Surgery Site:  MAYBERRY, NC
```

```
 MAYBERRY, NC  (999)                            PAGE 1 OF 2

1    MAIL CODE FOR ANESTHESIA: 112G
2    CANCEL IVS:           CANCEL
3    DEFAULT BLOOD REQUEST: CPDA-1 RED BLOOD CELLS
4    CHIEF'S NAME:         DR. MOE HOWARD
5    LOCK AFTER HOW MANY DAYS:
6    REQUEST DEADLINE:     15:00
7    SCHEDULE CLOSE TIME:  14:00
8    NURSE INTRAOP REPORT: PRINT TITLES WITH INFO ONLY
9    OPERATION REPORT FORMAT: PRINT TITLES WITH INFO ONLY
10   RISK ASSESSMENT IN USE (Y/N): YES
11   ASK FOR RISK PREOP INFO: NO
12   UPDATES TO PCE:       OUTPATIENT ONLY
13   PCE UPDATE ACTIVATION DATE: OCT 01, 1996
14   ASK CLASSIFICATION QUESTIONS: YES
15   SURGICAL RESIDENTS (Y/N): NO

Enter Screen Server Function:  5
Lock Completed Cases after How Many Days ?: 14
```

```
 MAYBERRY, NC  (999)                            PAGE 1 OF 2

1    MAIL CODE FOR ANESTHESIA: 112G
2    CANCEL IVS:           CANCEL
3    DEFAULT BLOOD REQUEST: CPDA-1 RED BLOOD CELLS
4    CHIEF'S NAME:         DR. MOE HOWARD
5    LOCK AFTER HOW MANY DAYS: 14
6    REQUEST DEADLINE:     15:00
7    SCHEDULE CLOSE TIME:  14:00
8    NURSE INTRAOP REPORT: PRINT TITLES WITH INFO ONLY
9    OPERATION REPORT FORMAT: PRINT TITLES WITH INFO ONLY
10   RISK ASSESSMENT IN USE (Y/N): YES
11   ASK FOR RISK PREOP INFO: NO
12   UPDATES TO PCE:       OUTPATIENT ONLY
13   PCE UPDATE ACTIVATION DATE: OCT 01, 1996
14   ASK CLASSIFICATION QUESTIONS: YES
15   SURGICAL RESIDENTS (Y/N): NO

Enter Screen Server Function:  <RET>
```

```
 MAYBERRY, NC  (999)                            PAGE 2 OF 2

1    REQUIRED FIELDS FOR SCHEDULING: (MULTIPLE)(DATA)
2    REQUEST CUTOFF FOR SUNDAY: SATURDAY
3    REQUEST CUTOFF FOR MONDAY: FRIDAY
4    REQUEST CUTOFF FOR TUESDAY: MONDAY
5    REQUEST CUTOFF FOR WEDNESDAY: TUESDAY
6    REQUEST CUTOFF FOR THURSDAY: WEDNESDAY
7    REQUEST CUTOFF FOR FRIDAY: THURSDAY
8    REQUEST CUTOFF FOR SATURDAY: FRIDAY
9    HOLIDAY SCHEDULING ALLOWED: (MULTIPLE)(DATA)
10   INACTIVE?:

Enter Screen Server Function:  1
```

```
 MAYBERRY, NC  (999)                            PAGE 1 OF 1
         REQUIRED FIELDS FOR SCHEDULING

1    NEW ENTRY

Enter Screen Server Function:  1
Select REQUIRED FIELDS FOR SCHEDULING: 27  PRINCIPAL PROCEDURE CODE
   ARE YOU ADDING 'PRINCIPAL PROCEDURE CODE' AS
       A NEW REQUIRED FIELDS FOR SCHEDULING (THE 1ST FOR THIS SURGERY SITE
PARAMETERS)? Y  (YES)
    REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
         // <RET>
```

```
 MAYBERRY, NC  (999)                            PAGE 1 OF 1
         REQUIRED FIELDS FOR SCHEDULING  (PRINCIPAL PROCEDURE CODE)

1    REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
2    COMMENTS:              (WORD PROCESSING)

Enter Screen Server Function:  2
Comments:
  1>This field is required for the Quarterly Report.
  2><RET>
EDIT Option: <RET>
```

```
 MAYBERRY, NC  (999)                            PAGE 1 OF 1
         REQUIRED FIELDS FOR SCHEDULING  (PRINCIPAL PROCEDURE CODE)

1    REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
2    COMMENTS:              (WORD PROCESSING)(DATA)

Enter Screen Server Function:  <RET>
```

```
 MAYBERRY, NC  (999)                            PAGE 1 OF 1
         REQUIRED FIELDS FOR SCHEDULING

1    REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
2    NEW ENTRY

Enter Screen Server Function:  <RET>
```

```
 MAYBERRY, NC  (999)                             PAGE 2 OF 2

1    REQUIRED FIELDS FOR SCHEDULING: (MULTIPLE)(DATA)
2    REQUEST CUTOFF FOR SUNDAY: SATURDAY
3    REQUEST CUTOFF FOR MONDAY: FRIDAY
4    REQUEST CUTOFF FOR TUESDAY: MONDAY
5    REQUEST CUTOFF FOR WEDNESDAY: TUESDAY
6    REQUEST CUTOFF FOR THURSDAY: WEDNESDAY
7    REQUEST CUTOFF FOR FRIDAY: THURSDAY
8    REQUEST CUTOFF FOR SATURDAY: FRIDAY
9    HOLIDAY SCHEDULING ALLOWED: (MULTIPLE)(DATA)
10   INACTIVE?:

Enter Screen Server Function:  <RET>
```

1.2 Operating Room Information (Enter/Edit)

This option is used to enter or edit information pertinent to a selected operating room, including start and end times, and cleaning time.

At the TYPE field, you can enter two question marks (??) to get a list of operating room types from which to select. If an operating room is not in service, you can enter "YES" at the INACTIVE field to make the operating room inactive and prevent its use by other people using the Surgery software.

Example: Entering Operating Room Information

```
Select Surgery Package Management Menu Option: OR  Operating Room Information
(Enter/Edit)
```

```
Enter/Edit Information for which Operating Room ?  OR1
```

```
OR1   ** Update O.R. **                        PAGE 1 OF 1

1    LOCATION:              1 WEST
2    PERSON RESP.:          AUDUBON,AUDREY F
3    TELEPHONE:             534-1231
4    TYPE:                  GENERAL PURPOSE OPERATING ROOM
5    CLEANING TIME:         15
6    REMARKS:
7    INACTIVE?:

Enter Screen Server Function:  2
Person Responsible for this Operating Room: LEW,THELMA// NURSE,NANCY
```

```
OR1   ** Update O.R. **                        PAGE 1 OF 1

1    LOCATION:              1 WEST
2    PERSON RESP.:          NURSE,NANCY
3    TELEPHONE:             534-1231
4    TYPE:                  GENERAL PURPOSE OPERATING ROOM
5    CLEANING TIME:         15
6    REMARKS:
7    INACTIVE?:

Enter Screen Server Function: <RET>
```

1.3 Surgery Utilization Menu

This menu contains options designed to help determine operating room use. With this menu, Surgery Service managers can schedule the normal operating hours for an operating room as well as the actual hours an operating room was in use. Operating rooms can also be inactivated. A report can be generated to see what percentage of available hours an operating room was in use and to see if an O.R. was used outside normal hours.

E	*Operating Room Utilization (Enter/Edit)*
N	*Normal Daily Hours (Enter/Edit)*
R	*Operating Room Utilization Report*
H	*Report of Normal Operating Room Hours*
P	*Purge Utilization Information*

1.3.1 Operating Room Utilization (Enter/Edit)

This option is used to update the actual start and end times for operating rooms on a selected date, one operating room at a time. This information is used when generating the operating room utilization reports.

First enter the date, then the name of the operating room. The computer will default to the start and end times and allow you to edit the times. There is also a prompt for inactivating a room. If you do not want to edit, press the Return key to go to the next prompt.

When you have finished entering or editing times for an operating room, you will be prompted for the name of the next operating room. Press the Return key if you do not want to edit times for any more operating rooms on this date. The computer will then prompt you for a new date and the cycle begins again. If you are finished editing times, you can press the Return key or enter an up-arrow (^) to exit this option.

Example: Enter and Edit Operating Room Times

```
Select Surgery Utilization Menu Option: E  Operating Room Utilization (Enter/Edit)
```

```
Update Start and End Times for Operating Rooms

Update Times for which Date ?  T  (NOV 03, 1998)
```

```
Operating Room Utilization on NOV  3, 1998
-----------------------------------------------------------------------------

Update Start and End Times for which Operating Room ?  OR1

Time this Operating Room Begins Functioning: 07:00
         // <RET>
Time this Operating Room Stops Functioning: 17:00
         // 13:50  (NOV 03, 1992@13:50)
Has this Room been Inactivated on this Date ?  (Y/N): N  NO
```

```
Operating Room Utilization on NOV  3, 1998
-----------------------------------------------------------------------------

Update Start and End Times for which Operating Room ?  OR2

Time this Operating Room Begins Functioning: 07:00
         // <RET>
Time this Operating Room Stops Functioning: 17:00
         // 13:30  (NOV 03, 1992@13:30)
Has this Room been Inactivated on this Date ?  (Y/N): N  NO
```

```
Operating Room Utilization on NOV  3, 1998
-------------------------------------------------------------------------------

Update Start and End Times for which Operating Room ?  OR3

Time this Operating Room Begins Functioning: 07:00
         // <RET>
Time this Operating Room Stops Functioning: 17:00
         // <RET>
Has this Room been Inactivated on this Date ?  (Y/N): Y  YES
```

```
Operating Room Utilization on NOV  3, 1998
-------------------------------------------------------------------------------

Update Start and End Times for which Operating Room ?  <RET>
```

```
Update Start and End Times for Operating Rooms and Surgical Specialties

Update Times for which Date ?  <RET>
```

1.3.2 Normal Daily Hours (Enter/Edit)

This option is used to schedule the normal start and end times of an operating room for each day of the week, one operating room at a time. The information is used to help determine operating room use on a weekly basis.

First, enter the name of the operating room. Beginning with Sunday, the computer will provide an editing schedule for each day of the week and prompt you for normal start and end times for each day. There is also a prompt for inactivating a room. When you have completed the schedules for the week, you will be prompted for the name of the next operating room for which you want to enter times. If you are finished editing times, you can press the Return key or enter an up-arrow (^) to exit this option.

At the "Select information to edit" prompt, you can 1) enter the letter A to update all the information on the schedule, 2) enter a number to update information in the corresponding field, 3) enter a range of numbers separated by a colon (:), or 4) press the Return key to move to the next day's schedule. To edit the schedule for a particular day, enter an up-arrow followed by a day of the week. For example, to edit Friday's schedule, enter the characters ^Friday. This is demonstrated in the example below.

> ***Note:*** The start and end times must be in military time. Also, use a leading zero when the hour is a single digit (e.g., 7 AM is 07:00).

Example: Enter Normal Start and End Times for an Operating Room

```
Select Surgery Utilization Menu Option: N  Normal Daily Hours (Enter/Edit)


==============================================================================
               Normal Daily Schedules for Operating Rooms
==============================================================================

Enter the name of the operating room: OR1


          Editing the SUNDAY Schedule for the OR1 Operating Room
==============================================================================

1. Normal Start Time:   07:00
2. Normal End Time:     15:30
3. Inactive (Y/N):

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


Select information to edit: <RET>
```

```
          Editing the MONDAY Schedule for the OR1 Operating Room
==============================================================================

1. Normal Start Time:
2. Normal End Time:
3. Inactive (Y/N):

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


Select information to edit: 1:2


Normal Starting Time: 07:00
Normal Ending Time: 15:30
```

```
          Editing the MONDAY Schedule for the OR1 Operating Room
==============================================================================

1. Normal Start Time:   07:00
2. Normal End Time:     15:30
3. Inactive (Y/N):

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


Select information to edit: ^FRIDAY
```

```
          Editing the FRIDAY Schedule for the OR1 Operating Room
==============================================================================

1. Normal Start Time:
2. Normal End Time:
3. Inactive (Y/N):

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


Select information to edit: 1:2


Normal Starting Time: 07:00
Normal Ending Time: 15:30
```

```
          Editing the FRIDAY Schedule for the OR1 Operating Room
==============================================================================

1. Normal Start Time:   07:00
2. Normal End Time:     15:30
3. Inactive (Y/N):

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


Select information to edit: ^
```

```
==============================================================================
               Normal Daily Schedules for Operating Rooms
==============================================================================

Enter the name of the operating room: ^
```

1.3.3 Operating Room Utilization Report

This report prints utilization information, within a selected date range, for all operating rooms or for a single operating room. The report displays the percent utilization, the number of cases, the total operation time and the time worked outside normal hours for each operating room individually and all operating rooms collectively.

How the Percent Utilization is Derived

The percent utilization is derived by dividing the total operation time for all operations (including total time patients were in O.R., plus the cleanup time allowed for each case) by the total functioning time as defined in the SURGERY UTILIZATION file. The quotient is then multiplied by 100.

This report must be copied to a printer with wide paper

Example: Print the Operating Room Utilization Report

```
Select Management Reports Option: OR  Operating Room Utilization Report

Operating Room Utilization Report


Print utilization information starting with which date ?  3/8  (MAR 08, 1999)

Print utilization information through which date ?  3/9  (MAR 09, 1999)
```

```
Do you want to print the Operating Room Utilization Report for all
operating rooms ?  YES//  <RET>
Print the Operating Room Utilization Report on which Device ? [Select Print Device]
```

..... *printout follows* .....

MAYBERRY, NC PAGE 1
SURGICAL SERVICE
OPERATING ROOM UTILIZATION REPORT
FOR ALL OPERATING ROOMS FROM: MAR 8,1999 TO: MAR 9,1999
DATE PRINTED: MAR 17,1999

OPERATING ROOM	PERCENT UTILIZATION	NUMBER OF CASES	TOTAL OPERATION TIME (INCLUDING OR MAINTENANCE)	TIME WORKED OUTSIDE NORMAL HRS
OR1	70%	3	17 hrs and 35 mins	6 hrs and 20 mins
OR2	39%	1	7 hrs and 25 mins	1 hr and 10 mins
OR3	133%	8	23 hrs and 42 mins	2 hrs and 30 mins
OR4	29%	3	4 hrs and 41 mins	-
OR5	84%	7	18 hrs and 50 mins	5 hrs and 25 mins
OR6	0	0	-	-
OR7	0	0	-	-
TOTAL UTILIZATION FOR ALL ROOMS	63%	22	72 hrs and 13 mins	15 hrs and 25 mins

1.3.4 Report of Normal Operating Room Hours

This report provides the start time and the end time of the normal working hours for all operating rooms or for the selected operating room for each date within the specified date range. The total time of the normal working day is displayed for each operating room for each date.

Example: Print Operating Room Normal Working Hours Report

```
Select Surgery Utilization Menu Option: H  Report of Normal Operating Room Hours
```

```
Operating Room Normal Working Hours Report


Print normal working hours starting with which date ?  3/1  (MAR 01, 1992)

Print normal working hours through which date ?  3/12  (MAR 12, 1992)
```

```
Do you want to print the Operating Room Normal Working Hours Report for all
operating rooms ?  YES//  <RET>

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

..... *printout follows* .....

```
                    OPERATING ROOM NORMAL WORKING HOURS
                         FROM 03/01/92  TO 03/12/92

OPERATING ROOM      START TIME     END TIME                  TOTAL TIME
-------------------------------------------------------------------------------
                             ** MAR  1, 1992 **

OR1                   07:00          15:30                 8 hrs and 30 mins
OR2                   07:00          15:30                 8 hrs and 30 mins
OR3                            ** INACTIVE **
OR4                            ** INACTIVE **
OR5                   07:00          17:00                     10 hrs

                             ** MAR  2, 1992 **

OR1                   07:00          15:30                 8 hrs and 30 mins
OR2                   07:00          15:30                 8 hrs and 30 mins
OR3                   07:00          15:30                 8 hrs and 30 mins
OR4                            ** INACTIVE **
OR5                   07:00          17:00                     10 hrs

                             ** MAR  3, 1992 **

OR1                   07:00          15:30                 8 hrs and 30 mins
OR2                   07:00          15:30                 8 hrs and 30 mins
OR3                   07:00          15:30                 8 hrs and 30 mins
OR4                   07:00          13:30                 6 hrs and 30 mins
OR5                   07:00          17:00                     10 hrs

                             ** MAR  4, 1992 **

OR1                   07:00          15:30                 8 hrs and 30 mins
OR2                   07:00          15:30                 8 hrs and 30 mins
OR3                   07:00          15:30                 8 hrs and 30 mins
OR4                   07:00          13:30                 6 hrs and 30 mins
OR5                   07:00          17:00                     10 hrs

                             ** MAR  5, 1992 **

OR1                   07:00          15:30                 8 hrs and 30 mins
OR2                   07:00          15:30                 8 hrs and 30 mins
OR3                   07:00          15:30                 8 hrs and 30 mins
OR4                   07:00          13:30                 6 hrs and 30 mins
OR5                   07:00          17:00                     10 hrs

                             ** MAR  6, 1992 **

OR1                   07:00          15:30                 8 hrs and 30 mins
OR2                   07:00          15:30                 8 hrs and 30 mins
OR3                   07:00          15:30                 8 hrs and 30 mins
OR4                   07:00          13:30                 6 hrs and 30 mins
OR5                   07:00          17:00                     10 hrs

                             ** MAR  7, 1992 **

OR1                   07:00          15:30                 8 hrs and 30 mins
OR2                   07:00          15:30                 8 hrs and 30 mins
```

OPERATING ROOM NORMAL WORKING HOURS
FROM 03/01/92 TO 03/12/92

OPERATING ROOM	START TIME	END TIME	TOTAL TIME
		** MAR 7, 1992 **	
OR3		** INACTIVE **	
OR4		** INACTIVE **	
OR5	07:00	17:00	10 hrs
		** MAR 8, 1992 **	
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3		** INACTIVE **	
OR4		** INACTIVE **	
OR5	07:00	17:00	10 hrs
		** MAR 9, 1992 **	
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4		** INACTIVE **	
OR5	07:00	17:00	10 hrs
		** MAR 10, 1992 **	
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
		** MAR 11, 1992 **	
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
		** MAR 12, 1992 **	
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs

1.3.5 Purge Utilization Information

This option is used to purge utilization information for a selected date range. After selecting a starting date, you can purge all utilization information for dates prior to, and including, that starting date.

Example: Purge Utilization Information

```
Select Surgery Utilization Menu Option: P  Purge Utilization Information
```

```
Purge Utilization Information


Starting with Date: 2/1  (FEB 28, 1999)

This option will purge all utilization information for the dates prior to (and
including) FEB 28, 1999.

Are you sure that you want to purge for this date range ?  NO// Y

The option to purge utilization data has been queued.

Press RETURN to continue  <RET>
```

1.4 Person Field Restrictions Menu

This menu contains options used by the package coordinator to maintain restrictions applied to person-type fields (meaning a field that points to the NEW PERSON field) in files.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym you can enter to select the option. None of these options will display if you do not have proper security clearance.

E	*Enter Restrictions for 'Person' Fields*
R	*Remove Restrictions on 'Person' Fields*

1.4.1 Enter Restrictions for 'Person' Fields

This option allows IRM personnel to assign a key to a specific person-type field (meaning any field that points to the NEW PERSON field) in a file or sub-file.

A key limits the acceptable responses to a field. The Surgery software can be tailored to limit acceptable responses in the field to only those people assigned one of the keys used to restrict the field. For example, a prompt asking for the name of the attending surgeon can be modified to accept only the names of surgeons. Additionally, a field can have more than one key assigned to it; thus the ATTENDING SURGEON field can be modified to accept the names of surgeons and other surgical staff.

Example 1 below shows how to enter the surgeon key for the SURGEON field in the SURGERY file. Example 2 shows how to enter the surgeon, nurse, and anesthetist keys for a sub-field in the SURGERY file.

Keys can be removed using the *Remove Restrictions on 'Person' Fields* option.

If you need assistance while interacting with the software, enter one or two question marks to access the on-line help. You can enter a question mark at the "Select Additional Key" prompt for a list of keys from which to select.

Example 1: Enter Restrictions

```
Select Person Field Restrictions Menu Option: E  Enter Restrictions for 'Person'
Fields
```

```
Add 'PERSON' Field Restrictions:

Select File: SURGERY
     1   SURGERY
     2   SURGERY CANCELLATION REASON
     3   SURGERY DISPOSITION
     4   SURGERY EXTRACT
     5   SURGERY INTERFACE PARAMETER
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  SURGERY
Select FIELD: SURGEON
     1   SURGEON
     2   SURGEON'S DICTATION      (word-processing)
CHOOSE 1-2: 1  SURGEON

There are no keys restricting entries in this field.

Do you want to add a key ?  YES// <RET>

Select Additional Key: SR SURGEON
Select Additional Key: <RET>

Entering Keys...
```

Example 2: Enter Restrictions

```
Select Person Field Restrictions Menu Option: E  Enter Restrictions for 'Person'
Fields
```

```
Add 'PERSON' Field Restrictions:

Select File: SURGERY
     1   SURGERY
     2   SURGERY CANCELLATION REASON
     3   SURGERY DISPOSITION
     4   SURGERY EXTRACT
     5   SURGERY INTERFACE PARAMETER
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  SURGERY
Select FIELD: RESTR & POSITION AIDS      (multiple)
Select RESTR & POSITION AIDS SUB-FIELD: APPLIED BY

There are no keys restricting entries in this field.

Do you want to add a key ?  YES// <RET>

Select Additional Key: SR NURSE
Select Additional Key: SR SURGEON
Select Additional Key: SR ANESTHETIST
Select Additional Key: <RET>

Entering Keys...
```

1.4.2 Remove Restrictions on 'Person' Fields

This option allows IRM personnel to remove a key to a specific person-type field in a specific file. A key limits the acceptable responses to a field; removing a key removes a restriction on the acceptable responses.

In the example below, the key that permits the name of an anesthetist is removed from the RESTRAINTS & POSITION AIDS field, leaving the nurse and surgeon keys intact. All of the keys can be removed at one time by entering "ALL" at the "Select Number or ALL" prompt.

Example: Remove Restrictions

```
Select Person Field Restrictions Menu Option: R  Remove Restrictions on 'Person'
Fields
```

```
Remove 'PERSON' field restrictions:

Select File: SURGERY
     1   SURGERY
     2   SURGERY CANCELLATION REASON
     3   SURGERY DISPOSITION
     4   SURGERY EXTRACT
     5   SURGERY INTERFACE PARAMETER
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  SURGERY
Select FIELD: RESTR & POSITION AIDS      (multiple)
Select RESTR & POSITION AIDS SUB-FIELD: APPLIED BY
```

```
Current Restrictions for this Field:

  1. SR NURSE
  2. SR SURGEON
  3. SR ANESTHETIST

Do you want to remove one of these keys ?  YES//<RET>

Select Number or "ALL": 3
```

```
Select Person Field Restrictions Option:
```

1.5 Update O.R. Schedule Devices

This option is used to update the list of devices that will print the Schedule of Operations when printing to all pre-defined printers.

Example: Add a New Schedule Device

```
Select Surgery Package Management Menu Option: SD  Update O.R. Schedule Devices
```

```
Update O.R. Schedule Devices
----------------------------


Select OR SCHEDULE DEVICES: FIDO
   ARE YOU ADDING 'FIDO' AS A NEW OR SCHEDULE DEVICES (THE 1ST FOR THIS SURGERY
SITE PARAMETERS)? Y  (YES)
Select OR SCHEDULE DEVICES: <RET>
```

1.6 Update Staff Surgeon Information

This option allows the designation of a user as a staff surgeon by assigning a security key called SR STAFF SURGEON. The Annual Report of Surgical Procedures will count cases performed by holders of this security key as having been performed by "staff." All other cases will be counted as performed by "resident."

Example 1: Designate a Staff Surgeon

```
Select Surgery Package Management Menu Option: U  Update Staff Surgeon Information


Update Information for which Surgeon: HOWARD,MOE

Do you want to designate this person as a 'Staff Surgeon' ? YES// <RET>

HOWARD,MOE is now designated as a staff surgeon.

Press RETURN to continue  <RET>
```

Example 1: Remove Staff Surgeon Designation

```
Select Surgery Package Management Menu Option: U  Update Staff Surgeon Information


Update Information for which Surgeon: HOWARD,MOE

This person is already designated as a staff surgeon.  Do you want to remove
that designation ?  NO//  Y

Removing key designating HOWARD,MOE as a staff surgeon...

Press RETURN to continue  <RET>
```

1.7 Flag Drugs for Use as Anesthesia Agents

Surgery Service managers use this option to mark drugs for use as anesthesia agents. If the drug is not flagged, you will not be able to select it as an entry for the ANESTHESIA AGENT data field.

To flag a drug, it must already be listed in the Pharmacy DRUG file. To add a drug to this file, contact the Pharmacy Package Coordinator at your site.

Example: Flag Drugs Used as Anesthesia Agents

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

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


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


Enter the name of the drug you wish to flag:  <RET>
```

1.8 Update Site Configurable Files

This option is designed for the package coordinator to add, edit, or inactivate file entries for the site configurable files.

The computer provides a numbered list of site configurable files. Enter the number corresponding to the file that you want to update. The computer will default to any previously entered information on the entry and give you a chance to edit it. The last prompt asks if you want to inactivate the entry; answer "Yes" or "1" if you want to inactivate it.

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.  Surgery Cancellation Reasons
10. Skin Prep Agents
11. Skin Integrity
12. Patient Mood
13. Patient Consciousness
14. Local Surgical Specialty
15. Electroground Positions
16. Surgery Dispostions
==============================================================================

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: KIRSCHNER MEDICAL
MODEL: NEER II
STERILE CODE: MFG
LOT/SERIAL NO: F19705-1087
STERILE RESP: MANUFACTURER
SIZE: STEM 150 MM, HEAD 22 MM
QUANTITY: <RET>
INACTIVE?: <RET>


Select PROSTHESIS NAME: <RET>
```

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.  Surgery Cancellation Reasons
10. Skin Prep Agents
11. Skin Integrity
12. Patient Mood
13. Patient Consciousness
14. Local Surgical Specialty
15. Electroground Positions
16. Surgery Dispostions
==============================================================================

Update Information for which File ?  6
```

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


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


Select MONITORS NAME: <RET>
```

1.9 Surgery Interface Management Menu

This menu contains options that allow the user to set up certain interface parameters that control the processing of HL7 messages. The interface adheres to the Health Level 7 (HL7) protocol and forms the basis for the exchange of health care information between the Veterans Health Information Systems and Technology Architecture (**V***IST***A**) Surgery package and any ancillary system.

At this time, there are four options on the *Surgery Interface Management Menu*.

I	*Flag Interface Fields*
F	*File Download*
T	*Table Download*
P	*Update Interface Parameter Field*

1.9.1 Flag Interface Fields

This option allows the package coordinator to set the INTERFACE field (#3) in the SURGERY INTERFACE file (#133.2). The categories listed on the first screen correspond to entries in File #133.2. These categories are listed in the *Surgery Health Level 7 Interface Specifications* document as being the OBR (Observation Request) text identifiers. Each identifier corresponds to several fields in the V*IST*A Surgery package. This allows the user to control the flow of data between the V*IST*A Surgery package and the ancillary system on a field-by-field basis.

The option lists each identifier and its current setting. To receive the data coming from the ancillary system for a category, set the flag to R for receive. To ignore the data, set the flag to N for not receive. To see a second underlying layer of OBX (Observation/Result) text identifiers (SURGERY file (#130) fields) and their settings, set the OBR text identifier to R for receive. The option will allow the user to toggle the settings for a range of items or for individual items.

Example: Flagging Operation Information to be Received

```
Select Surgery Interface Management Menu Option: I  Flag Interface Fields
```

```
                        Surgery Interface Setup Menu

To change the setting in one of the following categories, enter the
corresponding number.
 (R - Receive)
 (S - Send)
 (S/R - Send and Receive)
 (I - Ignore)


  1.  OPERATION (S/R)
  2.  TOURNIQUET (I)
  3.  MONITOR (I)
  4.  MEDICATION (R)
  5.  ANESTHESIA (R)
  6.  PROCEDURE (I)
  7.  PROCEDURE OCCURRENCE (I)
  8.  INTRAOPERATIVE OCCURRENCE (I)
  9.  POSTOPERATIVE OCCURRENCE (I)
 10.  NONOPERATIVE OCCURRENCE (I)

Enter a number: ?

The categories above refer to VistA Surgery data fields.  Below are examples:
OPERATION -> File 130 fields.
TOURNIQUET -> TIME TOURNIQUET APPLIED (#.48) and File 130.02 fields.
MONITOR -> MONITORS (#.293) and File 130.41 fields.
MEDICATION -> MEDICATIONS (#.375) and File 130.33 fields.
ANESTHESIA -> ANESTHESIA TECHNIQUE (#.37) and File 130.06 fields.
Enter the corresponding number of the category you wish to edit. To edit
underlying fields, set the category to R for receive or S to send.

Enter a number: 1

Do you wish to change the current setting of OPERATION: IGNORE// RECEIVE
```

```
                                    OPERATION DATA

Toggle the current setting to (R)eceive, (S)end, or (I)gnore.

 1. TIME OPERATION BEGAN (S)            17. OR SETUP TIME (I)
 2. TIME OPERATION ENDS (S)             18. ANESTHESIA TEMP (I)
 3. NURSE PRESENT TIME (I)              19. HR (I)
 4. TIME PATIENT IN HOLDING AREA (I)    20. RR (I)
 5. ANESTHESIA AVAILABLE TIME (I)       21. BP (I)
 6. TIME PATIENT IN OR (S)              22. ASA CLASS (I)
 7. SURGEON PRESENT TIME (I)            23. CASE SCHEDULE TYPE (I)
 8. ANESTHESIA CARE START TIME (I)      24. ATTENDING CODE (I)
 9. ANESTHESIA CARE END TIME (I)        25. REPLACEMENT FLUID (R)
10. TIME PATIENT OUT OR (I)             26. INDUCTION COMPLETE (I)
11. PRIN. ANES. (I)                     27. ANES. SUPERVISE CODE (I)
12. RELIEF ANESTHETIST (I)              28. SURGEON PGY (I)
13. ASSISTANT ANESTHETIST (I)           29. OR LOCATION (I)
14. ANES. SUPER. (I)                    30. PAC(U) ADMIT TIME (I)
15. BLOOD LOSS (I)                      31. PAC(U) DISCHARGE TIME (I)
16. TOTAL URINE OUTPUT (I)
Enter a number: ?

The items above refer to VistA Surgery package fields.  Below are examples:
  HR -> End Pulse (#.84)
  BP -> End BP    (#.85)
  RR -> End Resp  (#.86)
To toggle the current setting of an item, enter its corresponding number.
```

1.9.2 File Download

This option is used to download Surgery interface files to the Automated Anesthesia Information System (AAIS). The process is currently being done by a screen capture to a file. In the future, this will be changed to a background task that can be queued to send HL7 master file updates.

Example: Downloading Interface Files

```
Select Surgery Interface Management Menu Option: F File Download
```

```
               Surgery Interface File Download Option


1.  CPT4
2.  ICD9
3.  MEDICATION
4.  MONITOR
5.  PERSONNEL
6.  REPLACEMENT FLUID
7.  ANES SUPERVISE CODE
8.  LOCATION

Enter file to Capture:  (1-8): 4
Update the MONITOR file? YES// <RET>
Queuing message
```

1.9.3 Table Download

This option downloads the SURGERY file (#130) set of codes to the Automated Anesthesia Information System (AAIS). This process is currently being done by a screen capture to a file. In the future, this will be changed to a background task that can be queued to send HL7 master file updates.

Example: Downloading Surgery Set of Codes

```
Select Surgery Interface Management Menu Option: T Table Download
```

```
                Surgery Interface Table Setup Menu

This option allows the users to populate table files on the Automated
Anesthesia Information System.


 1. ASA CLASS                           11. TUBE TYPE
 2. CASE SCHEDULE TYPE                  12. EXTUBATED IN
 3. ATTENDING CODE                      13. BARICITY
 4. SITE TOURNIQUET APPLIED             14. EPIDURAL METHOD
 5. MEDICATION ROUTE                    15. ADMINISTRATION METHOD
 6. PRINCIPAL ANES TECHNIQUE (Y/N)      16. PROCEDURE OCCURRENCE OUTCOME
 7. PATIENT STATUS                      17. INTRAOP OCCURRENCE OUTCOME
 8. ANESTHESIA ROUTE                    18. POSTOP OCCURRENCE OUTCOME
 9. ANESTHESIA APPROACH                 19. NONOP OCCURRENCE OUTCOME
10. LARYNGOSCOPE TYPE

Enter a list or range of numbers (1-19): 3
Update the ATTENDING CODE table? YES// <RET>
MAD Sending HL7 Master File addition message.....
```

1.9.4 Update Interface Parameter Field

This option may be used to edit the parameter that determines which Surgery HL7 interface will be used, the interface compatible with HL7 V. 1.6 or the older one compatible with HL7 V. 1.5.

If applications communicating with the Surgery HL7 interface must use the interface designed for use with HL7 V. 1.5, enter YES. Otherwise, enter NO or leave this field blank.

Example: Updating Interface Parameter Field

```
Select Surgery Interface Management Menu Option: P  Update Interface Parameter Field

This option may be used to edit the parameter that determines which Surgery
HL7 interface will be used, the interface compatible with HL7 v1.6 or the
older one compatible with HL7 v1.5.

If applications communicating with the Surgery HL7 interface must use the
interface designed for HL7 v1.5, enter YES.  Otherwise, enter NO or
or leave this field blank.

Use Surgery Interface Compatible with VistA HL7 v1.5 (Y/N): NO
```

Chapter Six: Assessing Surgical Risk

Introduction
Unadjusted surgical mortality and morbidity rates can vary dramatically from hospital to hospital in the VA hospital system, as well as in the private sector. This can be the result of differences in patient mix, as well as differences in quality of care. Studies are being conducted to develop surgical risk assessment models for many of the major surgical procedures done in the VA system. It is hoped that these models will correct differences in patient mix between the hospitals so that remaining differences in adjusted mortality and morbidity might be an indicator of differences in quality of care. The objective of this module is to facilitate data entry and transmission to the centers where the data is analyzed. Non-cardiac data are transmitted to the Center for Cooperative Studies in Health Services (CCSHS) located at the VA Medical Center at Hines, Illinois. Cardiac data are transmitted to the Cardiac Research section at the VA Medical Center at Denver, Colorado. The National Surgical Quality Improvement Program (NSQIP) Executive Committee oversees the overall direction of the Surgery Risk Assessment program.

This Risk Assessment part of the Surgery software provides medical centers a mechanism to track information related to surgical risk and operative mortality. It gives surgeons an on-line method of evaluating and tracking patient probability of operative mortality. For instance, a patient with a history of chronic illness may be more “at risk” than a patient with no prior illness.

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

Getting Out of an Option
To get out of an option, enter an up-arrow (^). You can use the up-arrow at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continue entering up-arrows to completely exit the system.

Overview

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

The top-level options included in this menu are listed below. To the left is the shortcut synonym you can enter to select the option.

N	*Non-Cardiac Assessment Information (Enter/Edit) ...*
C	*Cardiac Risk Assessment Information (Enter/Edit) ...*
P	*Print a Surgery Risk Assessment*
U	*Update Assessment Completed/Transmitted in Error*
L	*List of Surgery Risk Assessments*
F	*Print 30 Day Follow-up Letters*
R	*Exclusion Criteria (Enter/Edit)*
M	*Monthly Surgical Case Workload Report*
D	*Update Operations as Unrelated/Related to Death*
V	*M&M Verification Report*
O	*Update 1-Liner Case*
T	*Queue Assessment Transmissions*

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

The nurse reviewer uses this option to enter a new risk assessment for a non-cardiac patient. This option is also used to make changes to an assessment that has already been entered. Cardiac cases are evaluated differently from non-cardiac cases and are entered into the computer from different options.

In the following example, we show you how to create a new risk assessment for non-cardiac patients and how to get to the sub-option menu below:

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

These sub-options add in-depth data for a case. Sections 1.1 through 1.8 of this chapter describe these sub-options.

How to Create a New Risk Assessment

1. First enter a patient name. If the patient has any previously entered assessments, they will be displayed. An asterisk(*) indicates cardiac cases. You can now choose to create a new assessment or edit one of the previously entered assessments.

2. Choose an operation to report on, then respond Yes to the prompt, “Are you sure that you want to create a Risk Assessment for this surgical case?” You must answer Yes (or press the Return key to accept the Yes default) to get to any of the sub-options. If you say No, the case you created in step 1 will not be considered an assessment, although it can appear on some lists, and the computer will bring you back to the “Select Patient” prompt.

3. Enter preoperative, operative, postoperative, and lab information using the sub-option(s).

If you need assistance while interacting with the software, enter one or two question marks to access the on-line help.

Example: Creating a New Risk Assessment (Non-Cardiac)

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

```
Select Patient:    RICHARDS,JOHN  01-01-45  767676767     NSC VETERAN


 RICHARDS,JOHN  767-67-6767

1. 02-01-95   INTRAOCCULAR LENS (INCOMPLETE)

2. 02-01-95   HIP REPLACEMENT (INCOMPLETE)

3. 09-18-91   FEMORAL POPLITEAL BYPASS GRAFT (INCOMPLETE)

4.   ----     CREATE NEW ASSESSMENT


Select Surgical Case: 4
```

```
 RICHARDS,JOHN  767-67-6767

1. 10-03-91   ABDOMINAL AORTIC ANEURYSM RESECTION (NOT COMPLETE)



Select Operation: 1
```

```
Are you sure that you want to create a Risk Assessment for this surgical
case ?  YES// <RET>
```

1.1 Preoperative Information (Enter/Edit)

This sub-option is used to enter or edit preoperative assessment information. The computer will present two pages. At the bottom of each page is a prompt to select one or more preoperative items to edit. If you do not want to edit any items on the page, press the Return key to proceed to the next page or, if you are already on page two, to exit the option.

About the "Select Preoperative Information to Edit" prompt

At this prompt, enter the item number you want to edit. You can enter **A** for All if you want to respond to every item on the page, or you can enter a range of numbers separated by a colon (:) to respond to a range of items. You can also use number-letter combinations, such as 2C, to update a field within a group, such as Current Pneumonia.

Each prompt at the category level allows for an entry of Yes or No. If you enter No, each item under that category will automatically be answered No. On the other hand, responding Yes at the category level will allow you to respond individually to each item under the main category.

For instance, if you choose item number 2 and answer Yes at the "PULMONARY" prompt, you will be asked if the patient is ventilator dependent, has a history of COPD, and has pneumonia. If you answer No to the "PULMONARY" prompt, the computer will place a No response in all the fields of the Pulmonary group. The majority of the prompts in this option are designed to accept the letters Y, N, or NS for Yes, No, and No Study.

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

Example 1: Enter/Edit Preoperative Information

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

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

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

Case #63115  PULMONARY LOBECTOMY

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

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #63592                PAGE: 1 OF 2
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------

1. GENERAL:                                3. HEPATOBILIARY:
   A. Diabetes Mellitus:                      A. Ascites:
   B. Current Smoker W/I 1 Year:
   C. Pack/Years:
   D. ETOH > 2 Drinks/Day:                 4. CARDIAC:
   E. Dyspnea:                                A. CHF Within 1 Month:
   F. DNR Status:
   G. Functional Status:                   5. RENAL:
                                              A. Acute Renal Failure:
2. PULMONARY:                                 B. Currently on Dialysis:
   A. Ventilator Dependent:
   B. History of Severe COPD:
   C. Current Pneumonia:
-------------------------------------------------------------------------------

Select Preoperative Information to Edit: 1:3
```

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #63592
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------



GENERAL: YES

Diabetes: I  INSULIN
Current Smoker: Y  YES
Smoking History in Pack/Years:??
     If the patient has ever been a smoker, enter the total number of
     pack/years of smoking for this patient.  The number of pack/years is
     determined by multiplying the number of packs of cigarettes smoked per day
     by the number of years the patient has smoked.  If the patient has
     never been a smoker, enter "0".  If the smoking history for this
     patient cannot be determined, enter "NS".  The possible range for number
     of pack/years is 0 to 200.
Smoking History in Pack/Years: 25
ETOH Greater than 2 Drinks/Day (Y/N): N  NO
Dyspnea: NO
     1   NO
     2   NO STUDY
```

```
Choose 1-2: 1  NO
DNR Status (Y/N): N  NO
Functional Health Status: 1  INDEPENDENT

PULMONARY: NO

HEPATOBILIARY: NO
```

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #63592                PAGE: 1 OF 2
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------

1. GENERAL:                       YES       3. HEPATOBILIARY:                NO
   A. Diabetes Mellitus:          INSULIN      A. Ascites:                   NO
   B. Current Smoker W/I 1 Year:  YES
   C. Pack/Years:                 25
   D. ETOH > 2 Drinks/Day:        NO        4. CARDIAC:
   E. Dyspnea:                    NO           A. CHF Within 1 Month:
   F. DNR Status:                 NO
   G. Functional Status:   INDEPENDENT      5. RENAL:
                                               A. Acute Renal Failure:
2. PULMONARY:                     NO           B. Currently on Dialysis:
   A. Ventilator Dependent:       NO
   B. History of Severe COPD:     NO
   C. Current Pneumonia:          NO

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

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

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #63592                PAGE: 2 OF 2
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------

1. CENTRAL NERVOUS SYSTEM:             2. NUTRITIONAL/IMMUNE/OTHER:
   A. Impaired Sensorium:                 A. Disseminated Cancer:
   B. Coma:                               B. Open Wound:
   C. Hemiplegia:                         C. Steroid Use for Chronic Cond.:
   D. History of TIAs:                    D. Weight Loss > 10%:
   E. CVA/Residual Neuro Deficit:         E. Bleeding Disorders:
   F. CVA/No Neuro Deficit:               F. Transfusion > 4 RBC Units:
   G. Tumor Involving CNS:                G. Chemotherapy W/I 30 Days:
                                          H. Radiotherapy W/I 90 Days:
                                          I. Preoperative Sepsis:

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

Select Preoperative Information to Edit: 2E
```

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #63592
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------


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

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #63592                PAGE: 2 OF 2
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------

1. CENTRAL NERVOUS SYSTEM:             2. NUTRITIONAL/IMMUNE/OTHER:
   A. Impaired Sensorium:                 A. Disseminated Cancer:
   B. Coma:                               B. Open Wound:
   C. Hemiplegia:                         C. Steroid Use for Chronic Cond.:
   D. History of TIAs:                    D. Weight Loss > 10%:
   E. CVA/Residual Neuro Deficit:         E. Bleeding Disorders:         YES
   F. CVA/No Neuro Deficit:               F. Transfusion > 4 RBC Units:
   G. Tumor Involving CNS:                G. Chemotherapy W/I 30 Days:
                                          H. Radiotherapy W/I 90 Days:
                                          I. Preoperative Sepsis:

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

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

1.2 Laboratory Test Results (Enter/Edit)

Use this 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 you to merge (also called "capture" or "load") lab information into the risk assessment from the DHCP Laboratory software. The third feature provides a two-page summary of the lab profile and allows you to edit information directly.

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

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

If you need assistance while interacting with the software, enter one or two question marks to receive on-line help.

Example 1: Capture Preoperative Laboratory Information

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

```
RICHARDS,ELLEN (206-05-0464P)        Case #62113
SEP 25,1995   APPENDECTOMY (CPT MISSING)
-------------------------------------------------------------------------------

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// <RET>

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

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

Time the Operation Began:  8:00  (SEP 25, 1995@08:00)

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

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

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

Example 2: Capture Postoperative Laboratory Information

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

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


Select Number: 2

This selection loads highest or lowest lab data for tests performed within 30 days
after the operation.
```

```
Do you want to automatically load postoperative lab data ?  YES//<RET>

'Time the Operation Ends' must be entered before continuing.

Do you want to enter the time that the operation was completed at
this time ?  YES//  <RET>

Time the Operation Ends: 12:00  (SEP 25, 1995@12:00)

..Searching lab record for postoperative lab test data....

..Moving postoperative lab data to Surgery Risk Assessment file....

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

Example 3: Enter, Edit, or Review Laboratory Test Results

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

```
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: 3
```

```
DISNEY,WALT (321-32-3214)        Case #68112                      PAGE: 1 OF 2
LATEST PREOP LAB RESULTS IN 90 DAYS PRIOR TO SURGERY
SEP 19,1998   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------

 1. Serum Sodium:                      139   (SEP 18,1998)
 2. BUN:                               13    (SEP 18,1998)
 3. Serum Creatinine:                  1     (SEP 18,1998)
 4. Serum Albumin:                     4     (SEP 18,1998)
 5. Total Bilirubin:                   .8    (SEP 18,1998)
 6. SGOT:                              29    (SEP 18,1998)
 7. Alkaline Phosphatase:              120   (SEP 18,1998)
 8. WBC:                               12.8  (SEP 18,1998)
 9. Hematocrit:                        45.7  (SEP 18,1998)
10. Platelet Count:                    NS
11. PTT:                               NS
12. PT:                                NS

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

Select Preoperative Laboratory Information to Edit: 10:12
```

```
DISNEY,WALT (321-32-3214)        Case #68112
SEP 19,1998   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------

Preoperative Platelet Count (X 1000/mm3): 289
Date Preoperative Platelet Count was Performed: 9/18/98  (SEP 18, 1998)
Preoperative PTT (seconds): 33.7
Date Preoperative PTT was Performed: 9/18/98  (SEP 18, 1998)
Preoperative PT (seconds): 11.8
Date Preoperative PT was Performed: 9/18/98  (SEP 18, 1998)
```

```
DISNEY,WALT (321-32-3214)        Case #68112                      PAGE: 1 OF 2
LATEST PREOP LAB RESULTS IN 90 DAYS PRIOR TO SURGERY
SEP 19,1998   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------

 1. Serum Sodium:               139     (SEP 18,1998)
 2. BUN:                        13      (SEP 18,1998)
 3. Serum Creatinine:            1      (SEP 18,1998)
 4. Serum Albumin:               4      (SEP 18,1998)
 5. Total Bilirubin:            .8      (SEP 18,1998)
 6. SGOT:                       29      (SEP 18,1998)
 7. Alkaline Phosphatase:      120      (SEP 18,1998)
 8. WBC:                      12.8      (SEP 18,1998)
 9. Hematocrit:               45.7      (SEP 18,1998)
10. Platelet Count:            289      (SEP 18,1998)
11. PTT:                      33.7      (SEP 18,1998)
12. PT:                       11.8      (SEP 18,1998)

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

Select Preoperative Laboratory Information to Edit: <RET>
```

```
DISNEY,WALT (321-32-3214)        Case #68112                      PAGE: 2 OF 2
POSTOP LAB RESULTS WITHIN 30 DAYS AFTER SURGERY
SEP 19,1998   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------

 1. Highest Serum Sodium:          139       (SEP 20,1998)
 2. Lowest Serum Sodium:           135       (SEP 20,1998)
 3. Highest Potassium:             4.4       (SEP 20,1998)
 4. Lowest Potassium:              3.4       (SEP 20,1998)
 5. Highest Serum Creatinine:      1.2       (SEP 20,1998)
 6. Highest CPK:                   NS
 7. Highest CPK-MB Band:           NS
 8. Highest Total Bilirubin:       NS
 9. Highest WBC:                   11.8      (SEP 20,1998)
10. Lowest Hematocrit:             40.3      (SEP 20,1998)
11. Highest Troponin I:            10.18     (SEP 24,1998)
12. Highest Troponin T:            12.13     (SEP 24,1998)

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

Select Postoperative Laboratory Information to Edit: 1
```

```
DISNEY,WALT (321-32-3214)        Case #68112
SEP 19,1998   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------

Highest Postoperative Serum Sodium: 139// 144
Date Highest Serum Sodium was Recorded: 9/21/98  (SEP 21, 1998)
```

```
DISNEY,WALT (321-32-3214)        Case #68112                      PAGE: 2 OF 2
POSTOP LAB RESULTS WITHIN 30 DAYS AFTER SURGERY
SEP 19,1998   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------

 1. Highest Serum Sodium:          144       (SEP 21,1998)
 2. Lowest Serum Sodium:           135       (SEP 20,1998)
 3. Highest Potassium:             4.4       (SEP 20,1998)
 4. Lowest Potassium:              3.4       (SEP 20,1998)
 5. Highest Serum Creatinine:      1.2       (SEP 20,1998)
 6. Highest CPK:                   NS
 7. Highest CPK-MB Band:           NS
 8. Highest Total Bilirubin:       NS
 9. Highest WBC:                   11.8      (SEP 20,1995)
10. Lowest Hematocrit:             40.3      (SEP 20,1995)
11. Highest Troponin I:            10.18     (SEP 24,1998)
12. Highest Troponin T:            12.13     (SEP 24,1998)

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

Select Postoperative Laboratory Information to Edit:<RET>
```

1.3 Operation Information (Enter/Edit)

This sub-option is used to enter or edit information related to the operation. At the bottom of each page is a prompt to select one or more operative items to edit. If you do not want to edit any items on the page, press the Return key to exit the option. If they are not already there, it is important to enter the operation's beginning and ending times so that you can later enter postoperative information.

About the "Select Operative Information to Edit" prompt

At this prompt, enter the item number you wish to edit.You can enter **A** for All if you want 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 you have entered or edited information, your terminal display screen will clear and present a summary. The summary organizes the information you have entered and gives you another chance to enter or edit data. If information has been entered for the Other Procedures or Concurrent Procedures fields, the summary will say **INFORMATION ENTERED** to the right of the items.

If you need assistance while interacting with the software, enter one or two question marks to receive on-line help.

Example: Enter/Edit Operation Information

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

```
FRANKLIN,BENJAMIN (287-38-1876)        Case #61851                 PAGE: 1 OF 2
Surgeon: HOWARD,MOE
JUN 17,1998   PULMONARY LOBECTOMY (32485)
-------------------------------------------------------------------------------

 1. Surgical Specialty:           THORACIC SURGERY (INC. CARDIAC SURG.)
 2. Principal Operation:          PULMONARY LOBECTOMY
 3. Principal CPT Code:           32485
 4. Other Procedures:             ***INFORMATION ENTERED***
 5. Concurrent Procedure:         ***INFORMATION ENTERED***
 6. PGY of Primary Surgeon:       2
 7. Surgical Priority:            ELECTIVE
 8. Wound Classification:
 9. ASA Classification:
10. Anesthesia Technique:         GENERAL
11. RBC Units Transfused:         99
12. Postop Diagnosis Code (ICD9): 115.01   HISTOPLASM CAPSUL MENING
13. Major or Minor:               MAJOR

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

Select Operative Information to Edit: 8:9
```

```
FRANKLIN,BENJAMIN (287-38-1876)        Case #61851
Surgeon: HOWARD,MOE
JUN 17,1998   PULMONARY LOBECTOMY (32485)
-------------------------------------------------------------------------------

Wound Classification: C  CLEAN
ASA Class: 3  3-SEVERE DISTURB.
```

```
FRANKLIN,BENJAMIN (287-38-1876)        Case #61851                 PAGE: 1 OF 2
Surgeon: HOWARD,MOE
JUN 17,1998   PULMONARY LOBECTOMY (32485)
-------------------------------------------------------------------------------

 1. Surgical Specialty:           THORACIC SURGERY (INC. CARDIAC SURG.)
 2. Principal Operation:          PULMONARY LOBECTOMY
 3. Principal CPT Code:           32485
 4. Other Procedures:             ***INFORMATION ENTERED***
 5. Concurrent Procedure:         ***INFORMATION ENTERED***
 6. PGY of Primary Surgeon:       2
 7. Surgical Priority:            ELECTIVE
 8. Wound Classification:         CLEAN
 9. ASA Classification:           3. SEVERE DISTURBANCE
10. Anesthesia Technique:         GENERAL
11. RBC Units Transfused:         99
12. Postop Diagnosis Code (ICD9): 115.01   HISTOPLASM CAPSUL MENING
13. Major or Minor:               MAJOR

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

Select Operative Information to Edit: <RET>
```

```
FRANKLIN,BENJAMIN (287-38-1876)        Case #61851                 PAGE: 2 OF 2
Surgeon: HOWARD,MOE
JUN 17,1998   PULMONARY LOBECTOMY (32485)
-------------------------------------------------------------------------------

1. Date/Time Patient In OR:            JUN 17, 1998  05:00
2. Date/Time Operation Began:          JUN 17, 1998  05:05
3. Date/Time Operation Ended:          JUN 17, 1998  11:10
4. Date/Time Patient Out OR:           JUN 17, 1998  11:20
5. Anesthesia Care Start Date/Time:    JUN 17, 1998  05:01
6. Anesthesia Care End Date/Time:      JUN 17, 1998  11:25
7. PAC(U) Discharge Date/Time:         JUN 17, 1993  13:15

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

Select Operative Information to Edit: <RET>
```

1.4 Patient Demographics (Enter/Edit)

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

Example: Entering Patient Demographics

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

```
FRANKLIN,BENJAMIN (287-38-1876)        Case #61851
June 17, 1998   PULMONARY LOBECTOMY (32480-59,66)
-------------------------------------------------------------------------------

Enter/Edit Patient Demographic Information

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

Select Number:  (1-2): 1

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

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

```
FRANKLIN,BENJAMIN (287-38-1876)        Case #61851
June 17, 1998   PULMONARY LOBECTOMY (32480-59,66)
-------------------------------------------------------------------------------

Enter/Edit Patient Demographic Information

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

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

```
FRANKLIN,BENJAMIN (287-38-1876)        Case #61851
June 17, 1998   PULMONARY LOBECTOMY (32480-59,66)
-------------------------------------------------------------------------------

 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:            JUN 15, 1998@10:15
 6. Hospital Discharge Date:            JUN 25, 1998@15:10
 7. Admit/Transfer to Surgical Svc.:    JUN 16, 1998@14:20
 8. Discharge/Transfer to Chronic Care: JUN 19, 1998@08:00
 9. Length of Postop Hospital Stay:     1 Day
10. In/Out-Patient Status:              INPATIENT
11. Patient's Race:                     WHITE, NOT OF HISPANIC ORIGIN

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

1.5 Intraoperative Occurrences (Enter/Edit)

The nurse reviewer uses this 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 you have entered or edited an occurrence category, the terminal display screen will clear and present a summary. The summary organizes the information you have entered and gives you 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)
```

```
DISNEY,WALT (321-32-3214)        Case #58112
SEP 19,1997   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------


There are no Intraoperative Occurrences entered for this case.


Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
Any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) of
any duration occurring in the operating room, ICU, ward, or out-of-hospital after the
chest has been completely closed and within 30 days following surgery.  Exclude
intentional arrests during cardiac surgery.
```

```
DISNEY,WALT (321-32-3214)        Case #58112
SEP 19,1997   CHOLEDOCHOTOMY (47425)
--------------------------------------------------------------------------------



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
```

```
DISNEY,WALT (321-32-3214)        Case #58112
SEP 19,1997   CHOLEDOCHOTOMY (47425)
--------------------------------------------------------------------------------



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

```
DISNEY,WALT (321-32-3214)        Case #58112
SEP 19,1997   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------


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

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

Select Occurrence Information: <RET>
```

```
DISNEY,WALT (321-32-3214)        Case #58112
SEP 19,1997   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------
Enter/Edit Intraoperative Occurrences

1.   CARDIAC ARREST REQUIRING CPR
     Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence: <RET>
```

1.6 Postoperative Occurrences (Enter/Edit)

The nurse reviewer uses this option to enter or change information related to postoperative occurrences (called complications in earlier versions). Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, enter a question mark (?) at the “Enter a New Postoperative Occurrence” prompt.

After you have entered or edited an occurrence category, the terminal display screen will clear and present a summary. The summary organizes the information you have entered and gives you another chance to enter or edit data.

Example: Enter a Postoperative Occurrence

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: PO  Postoperative
Occurrences (Enter/Edit)
```

```
DISNEY,WALT (321-32-3214)        Case #58112
SEP 19,1997   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------


There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: WOUND DISRUPTION
Separation of the layers of a surgical wound, which may be partial or complete, with
disruption of the fascia.
```

```
DISNEY,WALT (321-32-3214)        Case #58112
SEP 19,1997   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------


1. Occurrence:          WOUND DISRUPTION
2. Occurrence Category: WOUND DISRUPTION
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:            SEP 21,1997
7. Occurrence Comments:

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

Select Occurrence Information: 4
```

```
DISNEY,WALT (321-32-3214)        Case #58112
SEP 19,1997   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------


Treatment Instituted: SUTURE
```

```
DISNEY,WALT (321-32-3214)        Case #58112
SEP 19,1997   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------


1. Occurrence:          WOUND DISRUPTION
2. Occurrence Category: WOUND DISRUPTION
3. ICD Diagnosis Code:
4. Treatment Instituted:SUTURE
5. Outcome to Date:
6. Date Noted:          SEP 21,1997
7. Occurrence Comments:

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

Select Occurrence Information: <RET>
```

```
DISNEY,WALT (321-32-3214)        Case #58112
SEP 19,1997   CHOLEDOCHOTOMY (47425)
-------------------------------------------------------------------------------
Enter/Edit Postoperative Occurrences

1.   WOUND DISRUPTION
     Category: WOUND DISRUPTION

Select a number (1), or type 'NEW' to enter another occurrence: <RET>
```

1.7 Update Status of Returns Within 30 Days

This option is used to update the status of Returns to Surgery within 30 days of a surgical case.

Example: Update Status of Returns

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: RET  Update Statu
s of Returns Within 30 Days
```

```
WILLIAMS,ROSEMARY   334-56-7821

1. 07-06-98   REPAIR INGUINAL HERNIA (COMPLETED)

2. 06-25-98   CHOLECYSTECTOMY, APPENDECTOMY (COMPLETED)

3. 06-23-98   CHOLEDOCHOTOMY (COMPLETED)

4. 04-10-97   CRANIOTOMY (COMPLETED)



Select Operation: 3
```

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------

1. 07/06/98    REPAIR INGUINAL HERNIA (49521-59) - UNRELATED

2. 06/25/98    CHOLECYSTECTOMY (47610-59,20,66,78) - UNRELATED

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


Select Number: 2
```

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------


2. 06/25/98    CHOLECYSTECTOMY (47610-59,20,66,78) - UNRELATED

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


This return to surgery is currently defined as UNRELATED to the case selected.
Do you want to change this status ? NO// Y
```

```
WILLIAMS,ROSEMARY (334-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1998   CHOLEDOCHOTOMY (47420-58,62,22,78)
-------------------------------------------------------------------------------

1. 07/06/98    REPAIR INGUINAL HERNIA (49521-59) - UNRELATED

2. 06/25/98    CHOLECYSTECTOMY (47610-59,20,66,78) - RELATED

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


Select Number: <RET>
```

1.8 Update Assessment Status to ‘Complete’

Use this option to upgrade the status of an assessment to Complete. A complete assessment has enough information for it to be transmitted to the centers where data are analyzed. Only complete assessments are transmitted. After updating the status, you can print the patient’s entire surgery risk assessment report. This report can be copied to your terminal screen or to a printer.

Example : Update Assessment Status to COMPLETE

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: U  Update Assessm
ent Status to 'COMPLETE'
```

```
This assessment is missing the following items:

      1. Major or Minor
      2. Case Schedule Type
      3. ASA Class

Do you want to enter the missing items at this time? NO// YES
MAJOR/MINOR: MA  MAJOR
CASE SCHEDULE TYPE: EL  ELECTIVE
ASA CLASS: 2  2-MILD DISTURB.

Are you sure you want to complete this assessment ? NO// YES

Updating the current status to 'COMPLETE'...

Do you want to print the completed assessment ?  YES//  NO
```

2.0 Cardiac Risk Assessment Information (Enter/Edit)

The Surgical Clinical Nurse Reviewer uses this option 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.

In the example below, we show you how to create a new risk assessment for cardiac patients and get to the sub-option menu as follows:

CLIN	*Clinical Information (Enter/Edit)*
CATH	*Enter Cardiac Catheterization & Angiographic Data*
OP	*Operative Risk Summary Data (Enter/Edit)*
CARD	*Cardiac Procedures Requiring CPB (Enter/Edit)*
IO	*Intraoperative Occurrences (Enter/Edit)*
PO	*Postoperative Occurrences (Enter/Edit)*
R	*Resource Data*
U	*Update Assessment Status to 'COMPLETE'*

These eight sub-options are used for entering more in-depth data for a case. Sections 2.1 through 2.8 of this chapter describe each of the sub-options.

How to Create a New Risk Assessment

1. First enter a patient name. If the patient has any previous assessments, they will be displayed. An asterisk (*) indicates a cardiac case. You can now choose to create a new assessment or edit one of the previously entered assessments. (For a description of editing features, see the end of this chapter).

2. Choose the operation to report on, then respond Yes to the prompt "Are you sure that you want to create a Risk Assessment for this surgical case?" You must answer Yes (or press the Return key to accept the Yes default) to get to any of the sub-options. If you say No, the case you created in step 1 will not be considered an assessment, although it can appear on some lists, and the computer will bring you back to the "Select Patient" prompt.

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

Example: Creating A New Risk Assessment (Cardiac)

```
Select Surgery Risk Assessment Menu Option: C Cardiac Risk Assessment Information
(Enter/Edit)
```

```
Select Patient: DOE,BUTCH          03-03-45     333221212       NSC VETERAN


 DOE,BUTCH  333-22-1212

1.   ----     CREATE NEW ASSESSMENT


Select Surgical Case: 1
```

```
 DOE,BUTCH   333-22-1212

1. 01-18-95   CORONARY ARTERY BYPASS (COMPLETED)

2. 06-18-93   INGUINAL HERNIA (COMPLETED)



Select Operation: 1
```

```
Are you sure that you want to create a Risk Assessment for this surgical
case ?  YES// <RET>
```

2.1 Clinical Information (Enter/Edit)

This sub-option is used to enter the clinical information required for a cardiac risk assessment. The computer will present one page; at the bottom is a prompt to select one or more items to edit. If you do not want to edit any items on the page, press the Return key to proceed to another option.

About the "Select Clinical Information to Edit" prompt
At this prompt, enter the item number you wish to edit. You can enter **A** for All if you want 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 you have entered or edited information, the terminal display screen will clear and present a summary. The summary organizes the information you have entered and gives you another chance to enter or edit data. If you need assistance while interacting with the software, 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)
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------


 1. Height:                              14. Functional Status:
 2. Weight:                              15. PTCI:
 3. Diabetes:                            16. Prior MI:
 4. COPD:                                17. Prior Heart Surgery:
 5. FEV1:                                18. Peripheral Vascular Disease:
 6. Cardiomegaly (X-ray):                19. Cerebral Vascular Disease:
 7. Pulmonary Rales:                     20. Angina (use CCS Class):
 8. Current Smoker (2 Wk):               21. CHF (use NYHA Class):
 9. Creatinine:    NS   mg/dl            22. Current Diuretic Use:
10. Hemoglobin:    NS    g/dl            23. Current Digoxin Use:
11. Serum Albumin: NS    g/dl            24. IV NTG within 48 Hours:
12. Active Endocarditis:                 25. Preop Use of IABP:
13. Resting ST Depression:

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

Select Clinical Information to Edit: A
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------



Patient's Height: 76
Patient's Weight: 210
Diabetes: O  ORAL
History of COPD (Y/N): Y  YES
FEV1 : NS
Cardiomegaly on Chest X-Ray (Y/N): Y  YES
Pulmonary Rales (Y/N): Y  YES
Current Smoker: Y  YES
Preoperative Serum Creatinine (mg/dl): NS// 1.2
Date Preoperative Serum Creatinine was Performed: 6/6/97
Preoperative Hemoglobin (g/dl): NS
Date Preoperative Hemoglobin was Performed: <RET>
Preoperative Serum Albumin (g/dl): 3.8
Date Preoperative Serum Albumin was Performed: 6/6/97
Active Endocarditis (Y/N): N  NO
Resting ST Depression (Y/N): N  NO
Functional Health Status: INDEPENDENT
PTCA: 1  NONE RECENT
Prior Myocardial Infarction: 1  LESS THAN OR EQUAL TO 7 DAYS PRIOR TO SURGERY
Prior Heart Surgery (Y/N): Y  YES
Peripheral Vascular Disease (Y/N): Y  YES
Cerebral Vascular Disease (Y/N): N  NO
Angina (use CCS Functional Class): IV  CLASS IV
Congestive Heart Failure (use NYHA Functional Class): II  SLIGHT LIMITATION
Current Diuretic Use (Y/N): Y  YES
Current Digoxin Use (Y/N): N  NO
IV NTG within 48 Hours Preceding Surgery (Y/N): Y  YES
Preoperative use of IABP (Y/N): N  NO
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------


 1. Height:                76 in        14. Functional Status:     INDEPENDENT
 2. Weight:                210 lb       15. PTCA:                  NONE RECENT
 3. Diabetes:              ORAL         16. Prior MI:            < OR = 7 DAYS
 4. COPD:                  YES          17. Prior Heart Surgery:           YES
 5. FEV1:                  NS           18. Peripheral Vascular Disease:   YES
 6. Cardiomegaly (X-ray):  YES          19. Cerebral Vascular Disease:     NO
 7. Pulmonary Rales:       YES          20. Angina (use CCS Class):        IV
 8. Current Smoker (2 Wk): YES          21. CHF (use NYHA Class):          II
 9. Creatinine:            1.2  mg/dl   22. Current Diuretic Use:          YES
10. Hemoglobin:            NS   mg/dl   23. Current Digoxin Use:           NO
11. Serum Albumin:         3.8  g/dl    24. IV NTG within 48 Hours:        YES
12. Active Endocarditis:   NO           25. Preop Use of IABP:             NO
13. Resting ST Depression: NO

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

Select Clinical Information to Edit: <RET>
```

2.2 Enter Cardiac Catheterization & Angiographic Data

This sub-option is used to enter or edit cardiac catheterization and angiographic information for a cardiac risk assessment. The computer will present one page. At the bottom of the page is a prompt to select one or more items to edit. If you do not want to edit any items on the page, press the Return key to proceed to another option.

About the "Select Cardiac Catheterization and Angiographic Information to Edit" prompt

At this prompt, enter the item number you wish to edit. You can enter **A** for All if you want 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 you have entered or edited information, your terminal display screen will clear and present a summary. The summary organizes the information you have entered and gives you 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
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

 1. LVEDP:
 2. Aortic Systolic Pressure:
 3. *PA Systolic Pressure:
 4. *PAW Mean Pressure:

 5. Left Main Stenosis:
 6. LAD Stenosis:
 7. Right Coronary Stenosis:
 8. Circumflex Stenosis:

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

10. Mitral Regurgitation:

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

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

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------


Left Ventricular End-Diastolic Pressure: 56
Aortic Systolic Pressure: 120
PA Systolic Pressure: 30
PAW Mean Pressure: 15
Left Main Stenosis: 65
Left Anterior Descending (LAD) Stenosis: 50
Right Coronary Artery Stenosis: 40
Circumflex Coronary Artery Stenosis: 30
LV Contraction Grade: III  III    0.35-0.44    MODERATE DYSFUNCTION
Mitral Regurgitation: ?
     Enter the code describing presence/severity of mitral regurgitation.
     CHOOSE FROM:
       0        NONE
       1        MILD
       2        MODERATE
       3        SEVERE
       NS       NO STUDY
Mitral Regurgitation: 2  MODERATE
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

 1. LVEDP:                      56 mm Hg
 2. Aortic Systolic Pressure: 120 mm Hg
 3. *PA Systolic Pressure:      30 mm Hg
 4. *PAW Mean Pressure:         15 mm Hg

 5. Left Main Stenosis:         65%
 6. LAD Stenosis:               50%
 7. Right Coronary Stenosis:    40%
 8. Circumflex Stenosis:        30%

 9. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo): III 0.35-0.44  MODERATE DYSFUNCTION

10. Mitral Regurgitation:     MODERATE

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

2.3 Operative Risk Summary Data (Enter/Edit)

This sub-option is used to enter or edit operative risk summary data for a cardiac risk assessment. This option records the physician's subjective estimate of operative mortality. To avoid bias, this should be completed preoperatively. The computer will present one page. At the bottom of the page is a prompt to select one or more items to edit. If you do not want to edit any of the items, press the Return key to proceed to another option.

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

At this prompt, enter the item number you wish to edit. You can enter **A** for All if you want 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.

Example: Operative Risk Summary Data

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

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

1. Physician's Preoperative Estimate of Operative Mortality:
2. ASA Classification:
3. Surgical Priority:
4. Operative Death:           NO
5. Date/Time Operation Began: JUN 18,1997 08:45
6. Date/Time Operation Ended: JUN 18,1997 14:25
7. Principle CPT Code:        33510
8. Other Procedures CPT Code:  ***INFORMATION ENTERED***
9. Preoperative Risk Factors:   [This field is used to further explain any preoperative risk factors that
cannot be answered above. The maximum length of this field is 130 characters.]

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

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

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------



Physician's Preoperative Estimate of Operative Mortality: 32
Date/Time of Estimate of Operative Mortality: JUN 17,1997@18:15
         // <RET>
ASA Class: 3  3-SEVERE DISTURB.
Cardiac Surgical Priority: ?
     Enter the surgical priority that most accurately reflects the acuity of
     patient's cardiovascular condition at the time of transport to the
     operating room.
     CHOOSE FROM:
       1        ELECTIVE
       2        URGENT
       3        EMERGENT (ONGOING ISCHEMIA)
       4        EMERGENT (HEMODYNAMIC COMPROMISE)
       5        EMERGENT (ARREST WITH CPR)
Cardiac Surgical Priority: 3  EMERGENT (ONGOING ISCHEMIA)
Date/Time of Cardiac Surgical Priority:  JUN 17,1997@13:29
         // <RET>
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

1. Physician's Preoperative Estimate of Operative Mortality: 32%
   A. Date/Time Collected:    JUN 17,1997 18:15
2. ASA Classification:        3. SEVERE DISTURBANCE
3. Surgical Priority:         EMERGENT (ONGOING ISCHEMIA)
   A. Date/Time Collected:    JUN 17,1997 09:46
4. Operative Death:           NO
5. Date/Time Operation Began: JUN 18,1997 08:45
6. Date/Time Operation Ended: JUN 18,1997 14:25
7. Principle CPT Code:        33510
8. Other Procedures CPT Code: ***INFORMATION ENTERED***
9. Preoperative Risk Factors:

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

Select Operative Risk Summary Information to Edit:<RET>
```

2.4 Cardiac Procedures Requiring CPB (Enter/Edit)

This sub-option is used to enter or edit information related to cardiac procedures requiring cardiopulmonary bypass (CPB). The computer will present one page. At the bottom of the page is a prompt to select one or more items to edit. If you do not want to edit any items on the page, press the Return key to proceed to another option.

About the "Select Operative Information to Edit" prompt

At this prompt, enter the item number you wish to edit. You can enter **A** for All if you want to respond to every item on the page or you can enter a range of numbers separated by a colon (:) 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.

Responding No at the category level will cause each item under that category to be answered No. On the other hand, responding Yes at the category level will allow you to enter Yes or No for each item under it.

After you have entered or edited information, your terminal display screen will clear and present a summary. The summary organizes the information you have entered and gives you another chance to enter or edit data.

Example: Enter Cardiac Procedures Requiring CPB

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CARD  Cardiac
Procedures Requiring CPB (Enter/Edit)
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

CABG Distal Anastomoses                  12. Cardiac Transplant:
 1. Number with Vein:                    13. Electrophysiologic Procedure:
 2. Number with IMA:                     14. Misc. Cardiac Procedures:
 3. Number with Other Conduit:               A. ASD Repair:
                                             B. VSD Repair:
 4. Aortic Valve Replacement:                C. Myxoma Resection:
 5. Mitral Valve Replacement:                D. Foreign Body Removal:
 6. Tricuspid Valve Replacement:             E. Myectomy for IHSS:
 7. Valve Repair:                            F. Pericardiectomy:
 8. LV Aneurysmectomy:                       G. Other Tumor Resection:
 9. Great Vessel Repair (Req CPB):           H. Other Procedure(s):
10. Total Ischemic Time:                 15. Minimally Invasive Procedure Used:
11. Total CPB Time:                      16. Batista Procedure:

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

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------



CABG Distal Anastomoses with Vein: 1
CABG Distal Anastomoses with IMA: 1
CABG Distal Anastomoses with Other Conduit: 0
Aortic Valve Replacement (Y/N): Y  YES
Mitral Valve Replacement (Y/N): N  NO
Tricuspid Valve Replacement (Y/N): N  NO
Valve Repair (Y/N): Y  YES
LV Aneurysmectomy (Y/N): N  NO
Great Vessel Repair, requiring CPB (Y/N): Y  YES
Total Ischemic Time (minutes): 0
Total CPB (Cardiopulmaonary ByPass Time (minutes): 50
Cardiac Transplant (Y/N): N  NO
Electrophysiologic Procedure (Y/N): N  NO
Miscellaneous Cardiac Procedures: N  NO
Baptista Procedure Used (Y/N): N  NO
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

CABG Distal Anastomoses                 12. Cardiac Transplant:                NO
 1. Number with Vein:              1    13. Electrophysiologic Procedure:      NO
 2. Number with IMA:               1    14. Misc. Cardiac Procedures:          NO
 3. Number with Other Conduit:     0         A. ASD Repair:                    NO
                                             B. VSD Repair:                    NO
 4. Aortic Valve Replacement:      YES       C. Myxoma Resection:              NO
 5. Mitral Valve Replacement:      NO        D. Foreign Body Removal:          NO
 6. Tricuspid Valve Replacement:   NO        E. Myectomy for IHSS:             NO
 7. Valve Repair:                  YES       F. Pericardiectomy:               NO
 8. LV Aneurysmectomy:             NO        G. Other Tumor Resection:         NO
 9. Great Vessel Repair (Req CPB): YES       H. Other Procedure(s):            NO
10. Total Ischemic Time:     0 minutes  15. Minimally Invasive Procedure Used: NO
11. Total CPB Time:         50 minutes  16. Batista Procedure:                 NO

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

Select Operative Information to Edit: <RET>
```

2.5 Intraoperative Occurrences (Enter/Edit)

The nurse reviewer uses this option to enter or change information related to intraoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, enter a question mark (?) at the “Enter a New Intraoperative Occurrence” prompt.

After you have entered or edited an occurrence category, the terminal display screen will clear and present a summary. The summary organizes the information you have entered and gives you another chance to enter or edit data.

Example: Enter an Intraoperative Occurrence

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

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

There are no Intraoperative Occurrences entered for this case.


Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
Any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) of
any duration occurring in the operating room, ICU, ward, or out-of-hospital after the
chest has been completely closed and within 30 days following surgery.  Exclude
intentional arrests during cardiac surgery.


Press RETURN to continue: <RET>
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

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

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

Select Occurrence Information: 2:5
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

Occurrence Category: CARDIAC ARREST REQUIRING CPR
         // <RET>
ICD Diagnosis Code: 102.8  102.8        LATENT YAWS
         ...OK? YES//<RET>   (YES)
Type of Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

1. Occurrence:          CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:    102.8
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Occurrence Comments:

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

Select Occurrence Information: <RET>
```

2.6 Postoperative Occurrences (Enter/Edit)

The nurse reviewer uses this option to enter or change information related to postoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, enter a question mark (?) at the "Enter a New Postoperative Occurrence" prompt.

After you have entered or edited an occurrence category, the terminal display screen will clear and present a summary. The summary organizes the information you have entered and gives you another chance to enter or edit data.

Example: Enter a Postoperative Occurrence

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: PO  Postoperative
Occurrences (Enter/Edit)
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: CARDIAC ARREST REQUIRING CPR
Any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) of
any duration occurring in the operating room, ICU, ward, or out-of-hospital after the
chest has been completely closed and within 30 days following surgery.  Exclude
intentional arrests during cardiac surgery.


Press RETURN to continue: <RET>
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------


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

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

Select Occurrence Information: 4:6
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
Date/Time the Occurrence was Noted: 6/19/97  (JUN 19, 1997)
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
-------------------------------------------------------------------------------

1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Date Noted:            06/19/97
7. Occurrence Comments:

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

Select Occurrence Information: <RET>
```

2.7 Resource Data (Enter/Edit)

The nurse reviewer uses this option to enter, edit or review risk assessment cardiac patient demographic information such as hospital admission, discharge dates and other information related to this surgical episode.

Example: Resource Data (Enter/Edit)

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

```
DOE,PAUL (223-33-4445)        Case #49413
JUN 18,1997   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
-------------------------------------------------------------------------------

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//<RET>

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

```
DOE,PAUL (223-33-4445)        Case #49413
JUN 18,1997   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
-------------------------------------------------------------------------------

Enter/Edit Patient Resource Data

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

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

```
DOE,PAUL (223-33-4445)        Case #49413
JUN 18,1997   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
-------------------------------------------------------------------------------

1. Hospital Admission Date:            JUN 16, 1997@08:00
2. Hospital Discharge Date:            JUN 30, 1997@08:00
3. Cardiac Catheterization Date:       JUN 21, 1997
4. Time Patient In OR:                 JUN 18, 1997@07:30
5. Time Patient Out OR:                JUN 18, 1997@14:30
6. Employment Status Preoperatively:   SELF EMPLOYED
7. Resource Data Comments:

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

Select number of item to edit: 6
Employment Status Preoperatively: EMPLOYED FULL TIME// NOT  NOT EMPLOYED
```

```
DOE,PAUL (223-33-4445)        Case #49413
JUN 18,1997   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
-------------------------------------------------------------------------------

1. Hospital Admission Date:            JUN 16, 1997@08:00
2. Hospital Discharge Date:            JUN 30, 1997@08:00
3. Cardiac Catheterization Date:       JUN 21, 1997
4. Time Patient In OR:                 JUN 18, 1997@07:30
5. Time Patient Out OR:                JUN 18, 1997@14:30
6. Employment Status Preoperatively:   NOT EMPLOYED
7. Resource Data Comments:

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

Select number of item to edit: <RET>
```

2.8 Update Assessment Status to ‘Complete’

Use this option to upgrade the status of an assessment to Complete. A complete assessment has enough information for it to be transmitted to the centers where data are analyzed. Only complete assessments are transmitted. After updating the status, you can print the patient’s entire surgery risk assessment report. This report can be copied to your terminal screen or to a printer.

Example : Update Assessment Status to COMPLETE

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: U  Update Assess
ment Status to 'COMPLETE'
```

```
This assessment is missing the following items:

      1. Batista Procedure Used
      2. Minimally Invasive Procedure Technique Used Y/N

Do you want to enter the missing items at this time? NO// YES
BATISTA PROCEDURE USED (Y/N): N  NO
MINIMALLY INVASIVE PROC (Y/N): N  NO

Are you sure you want to complete this assessment ? NO// YES

Updating the current status to 'COMPLETE'...

Do you want to print the completed assessment ?  YES//  NO
```

3.0 Print a Surgery Risk Assessment

This option prints an entire Surgery Risk Assessment report for an individual patient. This report can be displayed temporarily on your terminal screen. As the report fills the terminal screen you will prompted to press the Return 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 appears 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//  <RET>


Select Patient: DISNEY,WALT         05-07-23     321323214     NO     NSC VET
ERAN
```

```
DISNEY,WALT  321-32-3214

1. 06-23-98   CHOLEDOCHOTOMY (TRANSMITTED)

2. 01-20-95   EXPLORATORY LAP, GRAM PATCH OF DUODENAL ULCER (TRANSMITTED)



Select Surgical Case: 1

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

..... *printout follows* .....

```
VA NON-CARDIAC RISK ASSESSMENT             Assessment: 112            PAGE 1
FOR DISNEY,WALT  321-32-3214 (TRANSMITTED 08/10/98)
==============================================================================

Medical Center: ISC-BIRMINGHAM, AL
Age:            39                      Operation Date:    JUN 23, 1998
Sex:            MALE                    Race:  WHITE, NOT OF HISPANIC ORIGIN

Transfer Status: NOT TRANSFERRED
Observation Admission Date:                    JUN 23,1998  08:10
Observation Discharge Date:                    JUN 24,1998  07:00
Observation Treating Specialty:                SURGICAL OBSERVATION
Hospital Admission Date:                       JUN 24,1998  07:01
Hospital Discharge Date:                       JUN 30,1998  11:22
Admitted/Transferred to Surgical Service:      JUN 24,1998  07:01
Discharged/Transferred to Chronic Care:        JUN 30,1998  11:22
In/Out-Patient Status:                         INPATIENT
------------------------------------------------------------------------------

                            PREOPERATIVE INFORMATION


GENERAL:                      NO         HEPATOBILIARY:                  NO
Diabetes Mellitus:            NO         Ascites:                        NO
Current Smoker W/I 1 Year:    NO
Pack/Years:                   0
ETOH > 2 Drinks/Day:          NO         CARDIAC:                        NO
Dyspnea:                      NO         CHF Within 1 Month:             NO
DNR Status:                   NO
Functional Status:  INDEPENDENT          RENAL:                          NO
                                         Acute Renal Failure:            NO
PULMONARY:                    NO         Currently on Dialysis:          NO
Ventilator Dependent:         NO
History of Severe COPD:       NO
Current Pneumonia:            NO

CENTRAL NERVOUS SYSTEM:       NO         NUTRITIONAL/IMMUNE/OTHER:       NO
Impaired Sensorium:           NO         Disseminated Cancer:            NO
Coma:                         NO         Open Wound:                     NO
Hemiplegia:                   NO         Steroid Use for Chronic Cond.:  NO
History of TIAs:              NO         Weight Loss > 10%:              NO
CVA/Residual Neuro Deficit:   NO         Bleeding Disorders:             NO
CVA/No Neuro Deficit:         NO         Transfusion > 4 RBC Units:      NO
Tumor Involving CNS:          NO         Chemotherapy W/I 30 Days:       NO
                                         Radiotherapy W/I 90 Days:       NO
                                         Preoperative Sepsis:            NO


                         OPERATION DATE/TIMES INFORMATION

              Date/Time Patient in OR: JUN 23,1998  06:00
            Date/Time Operation Began: JUN 23,1998  06:15
            Date/Time Operation Ended: JUN 23,1998  07:05
          Date/Time Patient Out of OR: JUN 23,1998  07:15
      Anesthesia Care Start Date/Time: JUN 23,1998  06:02
        Anesthesia Care End Date/Time: JUN 23,1998  07:15
             PACU Discharge Date/Time: JUN 23,1998  07:30
```

OPERATIVE INFORMATION

Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Principal Operation: CHOLEDOCHOTOMY
Principal CPT Code: 47425

Concurrent Procedure:
CPT Code:
PGY of Primary Surgeon: 0
Emergency Case (Y/N): NO
Major or Minor: MAJOR
Wound Classification: CLEAN/CONTAMINATED
ASA Classification: 2. MILD DISTURBANCE
Anesthesia Technique: GENERAL
Airway Trauma: NOT ENTERED
Airway Index: NOT ENTERED
RBC Units Transfused: 0

PREOPERATIVE LABORATORY TEST RESULTS

Serum Sodium:	145	(JUN 22,1998)
Serum Creatinine:	1.1	(JUN 22,1998)
BUN:	22	(JUN 22,1998)
Serum Albumin:	3.5	(JUN 22,1998)
Total Bilirubin:	.7	(JUN 22,1998)
SGOT:	22	(JUN 22,1998)
Alkaline Phosphatase:	66	(JUN 22,1998)
White Blood Count:	9.1	(JUN 22,1998)
Hematocrit:	39.4	(JUN 22,1998)
Platelet Count:	278	(JUN 22,1998)
PTT:	27.4	(JUN 22,1998)
PT:	11.9	(JUN 22,1998)

POSTOPERATIVE LABORATORY RESULTS

* Highest Value
** Lowest Value

* Serum Sodium:	148	(JUN 28,1998)
** Serum Sodium:	139	(JUN 25,1998)
* Potassium:	4.8	(JUN 28,1998)
** Potassium:	3.7	(JUN 25,1998)
* Serum Creatinine:	1.3	(JUN 25,1998)
* CPK:	NS	
* CPK-MB Band:	NS	
* Total Bilirubin:	.9	(JUN 26,1998)
* White Blood Count:	13.8	(JUN 24,1998)
** Hematocrit:	36.2	(JUN 29,1998)
* Troponin I:	NS	
* Troponin T:	NS	

OUTCOME INFORMATION

Postoperative Diagnosis Code (ICD9): 550.92 BILAT INGUINAL HERNIA
Length of Postoperative Hospital Stay: 7 DAYS
Date of Death:
Return to OR Within 30 Days: NO

PERIOPERATIVE OCCURRENCE INFORMATION

WOUND OCCURRENCES:	YES	CNS OCCURRENCES:	NO
Superficial Infection:	06/25/98	Stroke/CVA:	NO
Deep Wound Infection:	NO	Coma > 24 Hours:	NO
Wound Disruption:	NO	Peripheral Nerve Injury:	NO
URINARY TRACT OCCURRENCES:	NO	CARDIAC OCCURRENCES:	YES
Renal Insufficiency:	NO	Arrest Requiring CPR:	NO
Acute Renal Failure:	NO	Myocardial Infarction:	NO
Urinary Tract Infection:	NO	* 427.89 CARDIAC DYSRHYTHM	06/23/98
RESPIRATORY OCCURRENCES:	NO	OTHER OCCURRENCES:	NO
Pneumonia:	NO	Ileus/Bowel Obstruction:	NO
Unplanned Intubation:	NO	Bleeding/Transfusions:	NO
Pulmonary Embolism:	NO	Graft/Prosthesis/Flap Failure:	NO
On Ventilator > 48 Hours:	NO	DVT/Thrombophlebitis:	NO
		Systemic Sepsis:	NO

* indicates Other (ICD9)

Example 2: Print Surgery Risk Assessment for a Cardiac Case

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

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


Select Patient: R9922  RIPROCK,DASH         03-03-34     234189922     NO     SC
 VETERAN
```

```
RIPROCK,DASH  234-18-9922

1. 08-01-97   * CABG X3 (1A,2V), ARTERIAL GRAFTING (TRANSMITTED)

2. 03-27-97   INGUINAL HERNIA (TRANSMITTED)

3. 07-03-95   PULMONARY LOBECTOMY (TRANSMITTED)



Select Surgical Case: Select Surgical Case: 1

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

..... *printout follows* .....

```
                    VA CARDIAC SURGERY RISK ASSESSMENT PROGRAM

Patient: RIPROCK,DASH  234-18-9922                    Surgery Date: 08/01/97
Assessment Number: 28428                              Hospital Number: 999
I. CLINICAL DATA
Gender:                   MALE          Resting ST Depression:            NO
Age:                      63            Functional Status:        INDEPENDENT
Height:                   68 in         PTCI:                     NONE RECENT
Weight:                   95 kg         Prior MI:                       NONE
Diabetes:                 NO            Prior Heart Surgery:              NO
COPD:                     YES           Peripheral Vascular Disease:      NO
FEV1:                     1.5 liters    Cerebral Vascular Disease:        NO
Cardiomegaly (X-ray):     NO            Angina (use CCS Class):           III
Pulmonary Rales:          NO            CHF (use NYHA Class):             II
Current Smoker:           NO            Current Diuretic Use:             NO
Creatinine:               1 mg/dl       Current Digoxin Use:              NO
Hemoglobin:               15.3  g/dl    IV NTG 48 Hours Preceding Surgery: NO
Serum Albumin:            3.7  g/L      Preop Use of IABP:                NO
Active Endocarditis:      NO
II. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA
    LVEDP:                      12 mm Hg     Left Main Stenosis:       40%
    Aortic Systolic Pressure: 100 mm Hg      LAD Stenosis:             80%
    *PA Systolic Pressure:      NS mm Hg     Right Coronary Stenosis:  90%
    *PAW Mean Pressure:         NS mm Hg     Circumflex Stenosis:       0%
    Mitral Regurgitation:     NONE
    LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):
       Grade     Ejection Fraction Range           Definition
         I          > or = 0.55                    NORMAL
III. OPERATIVE RISK SUMMARY DATA        (Operation Began: 08/01/97 11:05)
     Physician's Preoperative           (Operation Ended: 08/01/97 16:50)
       Estimate of Operative Mortality: 5%               (08/01/97 10:00)
     ASA Classification:           4. LIFE THREATENING
     Surgical Priority:            ELECTIVE              (07/31/97 08:37)
     Principal CPT Code: 33518
     Other Procedures CPT Codes:  33533-82
     Preoperative Risk Factors:
```

```
IV. OPERATIVE DATA
   A. Cardiac Procedures Requiring Cardiopulmonary Bypass
       CABG Distal Anastomoses                Cardiac Transplant:           NO
         Number with Vein:          2         Electrophysiologic Procedure: NO
         Number with IMA:           1         Misc. Cardiac Procedures
         Number with Other Conduit: 0           ASD Repair:                 NO
       Aortic Valve Replacement:       NO       VSD Repair:                 NO
       Mitral Valve Replacement:       NO       Myxoma Resection:           NO
       Tricuspid Valve Replacement:    NO       Foreign Body Removal:       NO
       Valve Repair:                   NO       Myectomy for IHSS:          NO
       LV Aneurysmectomy:              NO       Pericardiectomy:            NO
       Great Vessel Repair (Req CPB):  NO       Other Tumor Resection:      NO
       Total Ischemic Time (minutes):  34       Minimally Invasive Procedure: NO
       Total CPB Time (minutes):       125      Batista Procedure:            NO
                                                Other Procedure(s):         NO
   B. Operative Death:    NO                  Date of Death:
   C. Perioperative (30 day) Occurrences
      Perioperative MI:                  NO  Reoperation for Bleeding:      NO
      Endocarditis:                      NO  On Ventilator > or = 48 Hours: NO
      Renal Failure Requiring Dialysis:  NO  Repeat Cardiopulmonary Bypass: NO
      Low Cardiac Output > or = 6 Hours: NO  Coma > or = 24 Hours:          NO
      Mediastinitis:                     NO  Stroke/CVA:                    NO
      Cardiac Arrest Requiring CPR:      NO
V. RESOURCE DATA
     Time Patient In  OR:          08/01/97 10:20
     Time Patient Out OR:          08/01/97 16:58
     Hospital Admission Date:      07/31/97 09:59
     Hospital Discharge Date:      08/09/97 15:08
     Cardiac Catheterization Date: 07/24/97
     Employment Status Preoperatively: RETIRED
     Resource Data Comments:

 *** End of report for RIPROCK,DASH  234-18-9922 assessment number 28428 ***
```

4.0 Update Assessment Completed/Transmitted in Error

This option is used to change the status of a completed or transmitted assessment that contains errors or has been entered in error. The status will change from Completed or Transmitted to Incomplete so that you can edit the assessment. Transmitted assessments will be re-transmitted if they are re-completed within 14 days of the original transmission date.

Example: Update Assessment Completed/Transmitted in Error

```
Select Surgery Risk Assessment Menu Option: U  Update Assessment Completed/Transmitted
in Error


Select Patient: HONEYCUTT,B.J.        03-03-30     321984352     SC VETERAN
```

```
 HONEYCUTT,B.J.  321-98-4352

1. 02-08-95   CORONARY ARTERY BYPASS (INCOMPLETE)

2. 01-25-95   PULMONARY LOBECTOMY (TRANSMITTED)



Select Surgical Case: 2
```

```
Are you sure that you want to change the status of this assessment
from 'TRANSMITTED' to 'INCOMPLETE' ?  YES//  <RET>

The Assessment Status has been changed to 'INCOMPLETE'.

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

5.0 List of Surgery Risk Assessments

Use this option to print lists of assessments within a date range. You can print lists of assessments in different phases of completion (i.e., incomplete, completed, transmitted) or a list of all surgical cases entered in the Surgery Risk Assessment software. You can also request that the list be sorted by surgical service. The computer will prompt you to enter a beginning date and an ending date. Examples 1-7 illustrate printing assessments in each of the formats below:

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

Example 1: List of Incomplete Assessments

```
Select Surgery Risk Assessment Menu Option: LIst of Surgery Risk Assessments
```

```
List of Surgery Risk Assessments

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

Select the Number of the Report Desired: 1
```

```
Start with Date: 10 1 96  (OCT 01, 1996)
End with Date: 9 30 97  (SEP 30, 1997)

Print by Surgical Specialty ?  YES// <RET>

Print report for ALL specialties ?  YES// <RET>
```

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

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

..... printout follows .....

INCOMPLETE RISK ASSESSMENTS PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: OCT 1,1996 TO: SEP 30,1997 REVIEWED BY:

ASSESSMENT #	PATIENT	PRINCIPAL OPERATIVE PROCEDURE	ANESTHESIA TECHNIQUE	OPERATION DATE
** SURGICAL SPECIALTY: CARDIAC SURGERY **				
28519	HANKS,TOM 123-98-5432	* CABG X3 (2V,1A)	GENERAL	AUG 05, 1997
** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **				
63063	KING,LOUIS 123-45-3998	INGUINAL HERNIA	SPINAL	OCT 03, 1996
** SURGICAL SPECIALTY: NEUROSURGERY **				
63154	STEVENS,DOUGLAS 123-45-7924	CRANIOTOMY	NOT ENTERED	AUG 08, 1997

Example 2: List of Completed Assessments

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

```
List of Surgery Risk Assessments

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

Select the Number of the Report Desired: 2
```

```
Start with Date: 10 1 97  (OCT 01, 1997)
End with Date: 9 30 98  (SEP 30, 1998)

Print by Surgical Specialty ?  YES// <RET>

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


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

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

.....*printout follows*.....

COMPLETED RISK ASSESSMENTS PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: OCT 1,1997 TO: SEP 30,1998 REVIEWED BY:

ASSESSMENT # / OPERATION DATE	PATIENT / PRINCIPAL OPERATIVE PROCEDURE	DATE COMPLETED	ANESTHESIA TECHNIQUE
** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **			
92	WILLIAMS,ROSEMARY 334-56-7821	OCT 19, 1998	GENERAL
JUN 23, 1998	CHOLEDOCHOTOMY		
63045	COLNER,ANTHONY 200-50-7782	NOV 29, 1997	GENERAL
OCT 01, 1997	INGUINAL HERNIA		
** SURGICAL SPECIALTY: OPHTHALMOLOGY **			
1898	FRANKLIN,BENJAMIN 287-38-1876	JAN 28, 1998	GENERAL
DEC 28, 1997	INTRAOCCULAR LENS		

Example 3: List of Transmitted Assessments

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

```
List of Surgery Risk Assessments

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

Select the Number of the Report Desired: 3
```

```
Start with Date: 10 1 96  (OCT 01, 1996)
End with Date: 9 30 98  (SEP 30, 1998)

Print by Surgical Specialty ?  YES// <RET>

Print report for ALL specialties ?  YES// N

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


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

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

.....*printout follows*.....

TRANSMITTED RISK ASSESSMENTS PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: OCT 1,1996 TO: SEP 30,1998 REVIEWED BY:

ASSESSMENT # / OPERATION DATE	PATIENT / PRINCIPAL OPERATIVE PROCEDURE	TRANSMISSION DATE	ANESTHESIA TECHNIQUE
** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **			
63076	UPRIGHT,WILLIAM BOLT 212-65-0036	AUG 12, 1998	GENERAL
OCT 08, 1996	INGUINAL HERNIA		
63077	WEINKIEBEAN,FUNKIE 232-34-2345	JAN 30, 1997	GENERAL
OCT 08, 1996	INGUINAL HERNIA, OTHER PROC1		
63103	RIPROCK,DASH 234-18-9922	JUL 09, 1997	GENERAL
MAR 27, 1997	INGUINAL HERNIA		
63171	VADER,DARTH 451-23-6987	SEP 05, 1998	GENERAL
JUL 17, 1998	CHOLECYSTECTOMY		

Example 4: List of Non-Assessed Major Surgical Cases

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

```
List of Surgery Risk Assessments

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

Select the Number of the Report Desired: 4
```

```
Start with Date: 10 1 96  (OCT 01, 1996)
End with Date: 9 30 97  (SEP 30, 1997)

Print by Surgical Specialty ?  YES// <RET>

Print report for ALL specialties ?  YES// N

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


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

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

.....*printout follows*.....

NON-ASSESSED MAJOR SURGICAL CASES BY SURGICAL SPECIALTY PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: OCT 1,1996 TO: SEP 30,1997 REVIEWED BY:

CASE # / OPERATION DATE	PATIENT / OPERATIVE PROCEDURE(S)	ANESTHESIA TECHNIQUE / PRINCIPAL CPT CODE
SURGICAL SPECIALTY:	GENERAL(OR WHEN NOT DEFINED BELOW)	
63071	KREIS,ADAM 232-31-2123	GENERAL
OCT 08, 1996	INGUINAL HERNIA	49505
63136	STEVENS,DOUGLAS 123-45-7924	GENERAL
AUG 07, 1997	CHOLECYSTECTOMY	47605

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 2

Example 5: List of All Major Surgical Cases

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

```
List of Surgery Risk Assessments

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

Select the Number of the Report Desired: 5
```

```
Start with Date: 8/1/97  (AUG 01, 1997)
End with Date: 9/30/98  (SEP 30, 1998)

Print by Surgical Specialty ?  YES// <RET>

Print report for ALL specialties ?  YES// N

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


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

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

.....*printout follows*.....

ALL MAJOR SURGICAL CASES BY SURGICAL SPECIALTY PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: AUG 1,1997 TO: SEP 30,1998 REVIEWED BY:

CASE # / OPERATION DATE	PATIENT / OPERATIVE PROCEDURE(S)	ASSESSMENT STATUS / EXCLUSION CRITERIA	ANESTHESIA TECHNIQUE
SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)			
63110	WILLIAMS,ROSEMARY 334-56-7821	COMPLETED	GENERAL
JUN 23, 1998	CHOLEDOCHOTOMY	SCNR WAS ON A/L	
63131	VADER,DARTH 451-23-6987	NO ASSESSMENT	GENERAL
JUL 21, 1998	PERINEAL WOUND EXPLORATION		
63136	STEVENS,DOUGLAS 123-45-7924	NO ASSESSMENT	GENERAL
AUG 07, 1997	CHOLECYSTECTOMY		

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 3

Example 6: List of All Surgical Cases

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

```
List of Surgery Risk Assessments

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

Select the Number of the Report Desired: 6
```

```
Start with which Date: 10/1/97  (OCT 01, 1997)
End with which Date: 9/30/98  (SEP 30, 1998)

Print by Surgical Specialty ?  YES// <RET>

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


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

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

.....*printout follows*.....

ALL SURGICAL CASES BY SURGICAL SPECIALTY PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: OCT 1,1997 TO: SEP 30,1998 REVIEWED BY:

CASE # / OPERATION DATE	PATIENT / PRINCIPAL OPERATIVE PROCEDURE	ASSESSMENT STATUS / EXCLUSION CRITERIA	ANESTHESIA TECHNIQUE
SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)			
63079	REARICK,DAVID JR 000-99-8888	INCOMPLETE	GENERAL
APR 02, 1998	INGUINAL HERNIA		
63110	WILLIAMS,ROSEMARY 334-56-7821	COMPLETED	GENERAL
JUN 23, 1998	CHOLEDOCHOTOMY	SCNR WAS ON A/L	
63131	VADER,DARTH 451-23-6987	NO ASSESSMENT	GENERAL
JUL 21, 1998	PERINEAL WOUND EXPLORATION		
63180	WILLIAMS,ROSEMARY 334-56-7821	NO ASSESSMENT	NOT ENTERED
JUN 23, 1998	CHOLECYSTECTOMY		

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 4

Example 7: List of Completed/Transmitted Assessments Missing Information

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

```
List of Surgery Risk Assessments

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

Select the Number of the Report Desired: 7
```

```
Start with Date: 10 1 97  (OCT 01, 1997)
End with Date: 10 13 98  (OCT 13, 1998)

Print by Surgical Specialty ?  YES// <RET>

Print report for ALL specialties ?  YES// <RET>
Print the List of Assessments to which Device: [Select Print Device]
```

.....*printout follows*.....

```
             COMPLETED/TRANSMITTED ASSESSMENTS MISSING INFORMATION       PAGE 1
                                  MAYBERRY, NC
                        FROM: OCT 1,1997  TO: OCT 13,1998
                            DATE PRINTED: OCT 13,1998

** GENERAL(OR WHEN NOT DEFINED BELOW)

ASSESSMENT #      PATIENT                            TYPE           STATUS
OPERATION DATE    OPERATION(S)
==============================================================================
63172             VADER,DARTH 451-23-6987            NON-CARDIAC    TRANSMITTED
JUL 17, 1998      REPAIR ARTERIAL BLEEDING
     Missing information:
     1. Principal Procedure Code (CPT)
     2. Anesthesia Technique
------------------------------------------------------------------------------
63185             FRANKLIN,BENJAMIN 287-38-1876      NON-CARDIAC    TRANSMITTED
JUN 17, 1998      INGUINAL HERNIA, CHOLECYSTECTOMY
     Missing information:
     1. Principal Procedure Code (CPT)
     2. Concurrent Case
     3. History of COPD (Y/N)
     4. Ventilator Dependent Greater than 48 Hrs (Y/N)
     5. Weight Loss > 10% of Usual Body Weight (Y/N)
     6. Transfusion Greater than 4 RBC Units this Admission (Y/N)
------------------------------------------------------------------------------
63080             FLINSTONE,FRED 111-22-1850         EXCLUDED       COMPLETE
JAN 03, 1998      TURP
     Missing information:
     1. Major or Minor

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

TOTAL FOR ALL SPECIALTIES: 3
```

6.0 Print 30 Day Follow-up Letters

The Surgical Clinical Nurse Reviewer uses this option to automatically print a letter, or a batch of letters, addressed to a specific patient or patients.

About the "Do you want to print the letter for a specific assessment?" prompt

Respond Yes to this prompt in order to print a follow-up letter for a single assessment. The computer will ask you to select the patient and case for which the letter will be printed. See Example 1 below.

Respond No to this prompt if you wish to print a batch of follow-up letters for surgical cases within a data range. The computer will ask for the beginning and ending dates of the date range for which the letters will be printed. See Example 2 on the following pages.

Example 1: Print a Single Follow-up Letter

```
Select Surgery Risk Assessment Menu Option: F  Print 30 Day Follow-up Letters

Do you want to print the letter for a specific assessment ?  YES// <RET>

Select Patient:      HONEYCUTT,B.J.      03-03-30     321984352     SC VETERAN

 HONEYCUTT,B.J.  321-98-4352

1. 06-18-97   CORONARY ARTERY BYPASS (INCOMPLETE)

2. 01-25-97   PULMONARY LOBECTOMY (TRANSMITTED)



Select Surgical Case: 1

Print 30 Day Letters on which Device: [Select Print Device]
```

..... *printout follows* .....

HONEYCUTT,B.J. JUL 18, 1997
87 OAK STREET
MT. PILOT, NC 65216

Dear Mr. Honeycutt,

One month ago, you had an operation at the VA Medical Center. We are interested in how you feel. Have you had any health problems since your operation ? We would like to hear from you. Please take a few minutes to answer these questions and return this letter in the self-addressed stamped envelope.

Have you been to a hospital or seen a doctor for any reason since your operation ? ___ Yes ___ No

If you answered NO, you do not need to answer any more questions. Please return this sheet in the self-addressed stamped envelope.

If you have answered YES, please answer the following questions.

1) Have you been seen in an outpatient clinic or doctor's office ?
___ Yes ___ No

Why did you go to the clinic or doctor's office ? _____

Where ? (name and location) _____ Date ? _____

Who was your doctor ? _____

2) Were you admitted to a hospital ? ___ Yes ___ No

Why did you go to the hospital ? _____

Where ? (name and location) _____ Date ? _____

Who was your doctor ? _____

Please return this letter whether or not you have had any medical problems. Your health and opinion are important to us. Thank You.

Sincerely,

Surgical Clinical Nurse Reviewer

Example 2: Print Letters Within a Date Range

```
Select Surgery Risk Assessment Menu Option:  P Print 30 Day Follow-up Letters
```

```
Do you want to print the letter for a specific assessment ?  YES//  N

This option will allow you to reprint the 30 day follow up letters for the date that
they were originally printed.  When printed automatically, the letters print 25 days
after the date of operation.

Print letters for BEGINNING date: TODAY// 6/1/99  (JUN 01, 1999)
Print letters for ENDING date: TODAY// <RET> (JUN 02, 1999)

Print 30 Day Letters on which Device: [Select Print Device]
```

..... *printout follows* .....

```
    BENJAMIN FRANKLIN                                        JUN 02, 1999
    87 NORTH STREET
    PHILADELPHIA, PA 91776


    Dear Mr. Franklin,

    One month ago, you had an operation at the VA Medical Center.  We are
    interested in how you feel.  Have you had any health problems since your
    operation ?  We would like to hear from you.  Please take a few minutes
    to answer these questions and return this letter in the self-addressed
    stamped envelope.

    Have you been to a hospital or seen a doctor for any reason since your
    operation ?   ___ Yes  ___ No

    If you answered NO, you do not need to answer any more questions.  Please
    return this sheet in the self-addressed stamped envelope.

    If you have answered YES, please answer the following questions.

       1) Have you been seen in an outpatient clinic or doctor's office ?
          ___ Yes  ___ No

          Why did you go to the clinic or doctor's office ? _______________

          Where ? (name and location) _____________________  Date ? ________

          Who was your doctor ? ___________________________________________


       2) Were you admitted to a hospital ?  ___ Yes  ___ No

          Why did you go to the hospital ? ________________________________

          Where ? (name and location) _____________________  Date ? ________

          Who was your doctor ? ___________________________________________

    Please return this letter whether or not you have had any medical problems.
    Your health and opinion are important to us.  Thank You.

    Sincerely,

    Surgical Clinical Nurse Reviewer
```

7.0 Exclusion Criteria (Enter/Edit)

This 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  RIPROCK,DASH         03-03-34     234189922     NO     SC
 VETERAN
```

```
 RIPROCK,DASH   234-18-9922

1. 11-01-98   TURP (COMPLETED)

2. 08-01-97   CABG X3 (1A,2V), ARTERIAL GRAFTING (COMPLETED)

3. 07-03-90   PULMONARY LOBECTOMY, TURP (COMPLETED)


Select Operation: 1

Reason an Assessment was not Created: 6  SCNR WAS ON ANNUAL LEAVE
```

```
RIPROCK,DASH (234-18-9922)        Case #63159
Transmission Status: QUEUED TO TRANSMIT
NOV 1,1998   TURP (52601-59)
-------------------------------------------------------------------------------

1. Exclusion Criteria:             SCNR WAS ON A/L
2. Surgical Priority:              ELECTIVE
3. Surgical Specialty:             UROLOGY
4. Principal Operation (CPT):      52601-59
5. Principal Anesthesia Technique: GENERAL
6. Major or Minor:                 MAJOR

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

Select Excluded Case Information to Edit: <RET>
```

8.0 Monthly Surgical Case Workload Report

This option generates the Monthly Surgical Case Workload Report that may be printed and/or transmitted to the NSQIP national database.

Example: Monthly Surgical Case Workload Report

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

```
Report of Monthly Case Workload Totals

This option provides a report of the monthly risk assessment surgical case
workload totals which include the following categories:
     1. All cases performed
     2. Excluded cases
     3. Assessed cases
     4. Non-assessed cases
     5. Cardiac cases
     6. Non-cardiac cases
     7. Assessed cases per day (based on 20 days/month)

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

Compile workload totals for which month and year? SEP 1999// 8 99


Compile totals for AUG 1999? YES// <RET>

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

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

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

..... *printout follows* .....

MAYBERRY, NC
REPORT OF MONTHLY SURGICAL CASE WORKLOAD
FOR AUG 1999

TOTAL CASES PERFORMED	=	249
TOTAL MAJOR CASES	=	227
TOTAL MINOR CASES	=	22
CASES MEETING EXCLUSION CRITERIA	=	114
ANESTHESIA TYPE	=	55
EXCEEDS MAX. ASSESSMENTS	=	0
EXCEEDS MAXIMUM TURPS	=	0
STUDY CRITERIA	=	59
SCNR WAS ON A/L	=	0
CONCURRENT CASE	=	0
EXCEEDS MAXIMUM HERNIAS	=	0
ASSESSED CASES	=	135
NOT LOGGED MAJOR 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
AUG 1998	0	0	0
SEP 1998	0	0	0
OCT 1998	0	0	0
NOV 1998	0	0	0
DEC 1998	0	0	0
JAN 1999	0	0	0
FEB 1999	0	0	0
MAR 1999	0	0	0
APR 1999	0	0	0
MAY 1999	0	0	0
JUN 1999	0	0	0
JUL 1999	0	0	0
AUG 1999	15	82	97
	15	82	97

9.0 Update Operations as Unrelated/Related to Death

This option is used to update the status of operations performed within 90 days prior to death. The status is either Unrelated or Related to death. With this option you can add comments to further document the review of death.

Example: Updating an Operation as Related to Death

```
Select Surgery Risk Assessment Menu Option: D  Update Operations as Unrelated/Related
to Death
```

```
               Update Operations as Unrelated or Related to Death


Select Patient:    FLINSTONE,FRED       01-12-01     111221850     NO     NON-VETERAN
(OTHER)
```

```
               Update Operations as Unrelated or Related to Death

FLINSTONE,FRED   111-22-1850        * DIED 02/27/96 *

Operations in 90 Days Prior to Death:

1. 01/29/96    CABG, VEIN, SIX+ (33516) - UNRELATED
                >>> Died 29 days postop. <<<

2. 01/06/96    TOTAL LARYNGECTOMY (CPT MISSING) - UNRELATED
                >>> Died 52 days postop. <<<

3. 12/02/95    EVACUATION OF HEMATOMA LT.THIGH (27301) - UNRELATED
                >>> Died 87 days postop. <<<

Select Number of Operation to be Updated:  (1-3): 1
```

```
               Update Operations as Unrelated or Related to Death

FLINSTONE,FRED   111-22-1850        * DIED 02/27/96 *

1. 01/29/96    CABG, VEIN, SIX+ (33516) - UNRELATED
                >>> Died 29 days postop. <<<

Was the Death Unrelated or Related to the Surgery?: UNRELATED
         // R  RELATED
Review of Death Comments:
  No existing text
  Edit? NO// <RET>
```

```
               Update Operations as Unrelated or Related to Death

FLINSTONE,FRED   111-22-1850        * DIED 02/27/96 *

Operations in 90 Days Prior to Death:

1. 01/29/96    CABG, VEIN, SIX+ (33516) - RELATED
                >>> Died 29 days postop. <<<

2. 01/06/96    TOTAL LARYNGECTOMY (CPT MISSING) - UNRELATED
                >>> Died 52 days postop. <<<

3. 12/02/95    EVACUATION OF HEMATOMA LT.THIGH (27301) - UNRELATED
                >>> Died 87 days postop. <<<

Select Number of Operation to be Updated:  (1-3): <RET>
```

```
               Update Operations as Unrelated or Related to Death


Select Patient: <RET>
```

10.0 M&M Verification Report

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

(1) Reviewing occurrences and their assignments to operations and
(2) Reviewing death unrelated/related assignments to operations.

Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range and experienced intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk assessed operations that are in a completed state but have not yet transmitted to the national database.

Variety #1: Report information is sorted alphabetically by patient name, listing all operations for the patient that occurred during the selected date range, plus any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that were performed prior to the selected date range and, if printed by specialty, may include operations performed by other specialties. For every operation that is listed, the intraoperative and postoperative occurrences are also listed. Also, the report includes information about whether the operation was unrelated or related to death and the risk assessment type and status (if assessed). The report may be printed for a selected list of surgical specialties.

Variety #2: Report information is sorted alphabetically by patient name in a format like the first variety. This report lists all risk-assessed operations that are in a completed state but have not yet transmitted to the national database and that have intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The report includes any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some other operations that may or may not be risk assessed, and, if risk assessed, may have any risk assessment status (incomplete, complete, or transmitted). However, every patient listed on this report will have at least one operation with a risk assessment status of 'complete'.

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

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

```
                              M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences
and their assignments to operations and in the review of death unrelated or
related assignments to operations.  Two varieties of this report are available.
The first variety provides a report of all patients who had operations within
the selected date range who experienced intraoperative occurrences,
postoperative occurrences, or death within 90 days of surgery.  The second
variety provides a similar report for all risk assessed operations that are in
a completed state but have not yet transmitted to the national database.
```

```
Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.
```

```
Enter selection (1 or 2): 1// <RET>
```

```
Start with Date: 12 30 95  (DEC 30, 1995)
End with Date: 1 29 96  (JAN 29, 1996)


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

This report is designed to use a 132 column format.

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

..... *printout follows* .....

MAYBERRY, NC
M&M Verification Report
From: DEC 30,1995 To: JAN 29,1996
Report Generated: OCT 21,1997

Reviewed By:
Date Reviewed:

Op Date	Specialty	Procedure(s)	Death Related	Occurrence(s) - (Date)	Assessment Type/Status
>>> FLINSTONE,FRED (111-22-1850) - DIED 02/27/96					
01/06/96	GENERAL	TOTAL LARYNGECTOMY	NO		NON-CARD/T
01/29/96	THORACIC	CABG, VEIN, SIX+	NO		CARDIAC/I
11/20/95	PERIPHERAL	LT CAROTID ENDOARTERECTOMY	N/A	OTHER OCCURRENCE (11/20/95) ICD: 998.4 FB LEFT DURING PROCEDURE URINARY TRACT INFECTION * (12/08/95) ICD: 599.0 URIN TRACT INFECTION NOS OTHER RESPIRATORY OCCURRENCE * (11/25/95) ICD: 478.25 EDEMA PHARYNX/NASOPHARYX OTHER OCCURRENCE * (NO DATE) ICD: 530.1 ESOPHAGITIS	NON-CARD/T
12/02/95	PERIPHERAL	EVACUATION OF HEMATOMA LT.THIGH	YES	DVT/THROMBOPHLEBITIS * (12/06/95) ICD: 453.8 VENOUS THROMBOSIS NEC BLEEDING/TRANSFUSIONS * (12/04/95) BLEEDING/TRANSFUSIONS * (12/06/95) BLEEDING/TRANSFUSIONS * (12/06/95)	NON-CARD/I

Occurrences(s): '*' Denotes Postop Occurrence

Assessment Status - I:Incomplete, C:Complete, T:Transmitted

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

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

```
                            M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences
and their assignments to operations and in the review of death unrelated or
related assignments to operations.  Two varieties of this report are available.
The first variety provides a report of all patients who had operations within
the selected date range who experienced intraoperative occurrences,
postoperative occurrences, or death within 90 days of surgery.  The second
variety provides a similar report for all risk assessed operations that are in
a completed state but have not yet transmitted to the national database.
```

```
Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.

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

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

This report is designed to use a 132 column format.

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

..... *printout follows* .....

Op Date	Specialty	Procedure(s)	Death Related	Occurrence(s) - (Date)	Assessment Type/Status
>>> AUGUSTINO,GUSTAV (255-01-6867) - DIED 12/31/97@07:16					
12/24/97	UROLOGY	CYSTOSCOPY	YES		EXCLUDED/C
>>> ORANGE,WILLIAM (811-00-9990) - DIED 03/02/97@13:20					
01/31/97	GENERAL	LEFT BKA STUMP DEBRIDEMENT & REVISION	?	URINARY TRACT INFECTION * (02/09/97) ICD: 599.0 URIN TRACT INFECTION NOS PNEUMONIA * (02/15/97) ICD: 485. BRONCOPNEUMONIA ORG NOS	EXCLUDED/C
>>> PRINCE,ALBERT E. (007-13-0010) - DIED 08/13/97@19:00					
08/05/97	PERIPHERAL	LEFT LEG ABOVE KNEE AMPUTATION, RIGHT LEG ABOVE KNEE AMPUTATION	NO		EXCLUDED/C
>>> JAMES,JESSE A. (205-94-3233) - DIED 10/01/97					
08/21/97	PERIPHERAL	OMEGAPORT PLACEMENT	?		EXCLUDED/C
>>> LESTER,ENOCH W. (334-20-8888) - DIED 04/08/97					
03/14/97	GENERAL	HICKMAN CATH PLACMENT	NO		EXCLUDED/C

Occurrences(s): '*' Denotes Postop Occurrence Assessment Status - I:Incomplete, C:Complete, T:Transmitted

11.0 Update 1-Liner Case

This option may be used to enter missing data for the 1-liner cases (major cases marked for exclusion from assessment, minor cases and cardiac assessed cases that transmit to the NSQIP database as a single line or two of data). Cases edited with this option will be queued for transmission to the NSQIP database at Chicago.

Example: Update 1-Liner Case

```
Select Surgery Risk Assessment Menu Option: O  Update 1-Liner Case

Select Patient: DRUCKER,SAMUEL HORATIO           02-12-28     233418719     YES
    SC VETERAN
```

```
 DRUCKER,SAMUEL HORATIO   233-41-8719

1. 08-07-99   REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)

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

3. 09-04-97   CHOLECYSTECTOMY (COMPLETED)


Select Case: 1
```

```
DRUCKER,SAMUEL HORATIO (233-41-8719)        Case #142
Transmission Status: TRANSMITTED
AUG 7,1999   REPAIR DIAPHRAGMATIC HERNIA (39540-62,66,78)
-------------------------------------------------------------------------------

 1. In/Out-Patient Status:      OUTPATIENT
 2. Major or Minor:             MAJOR
 3. Surgical Specialty:         GENERAL(OR WHEN NOT DEFINED BELOW)
 4. Surgical Priority:          STANDBY
 5. Attending Code:             0. STAFF ALONE
 6. ASA Class:                  2-MILD DISTURB.
 7. Wound Classification:
 8. Anesthesia Technique:       GENERAL
 9. Principal Operation (CPT):  39540-62,66,78
10. Other Procedures:           ***NONE ENTERED***

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

Select number of item to edit: 7

Wound Classification: C  CLEAN
```

```
DRUCKER,SAMUEL HORATIO (233-41-8719)        Case #142
Transmission Status: QUEUED TO TRANSMIT
AUG 7,1999   REPAIR DIAPHRAGMATIC HERNIA (39540-62,66,78)
-------------------------------------------------------------------------------

 1. In/Out-Patient Status:      OUTPATIENT
 2. Major or Minor:             MAJOR
 3. Surgical Specialty:         GENERAL(OR WHEN NOT DEFINED BELOW)
 4. Surgical Priority:          STANDBY
 5. Attending Code:             0. STAFF ALONE
 6. ASA Class:                  2-MILD DISTURB.
 7. Wound Classification:       CLEAN
 8. Anesthesia Technique:       GENERAL
 9. Principal Operation (CPT):  39540-62,66,78
10. Other Procedures:           ***NONE ENTERED***

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

Select number of item to edit: <RET>
```

12.0 Queue Assessment Transmissions

This option may be used to manually queue the NSQIP transmission process to run at a selected time. The NSQIP transmission process is a part of the nightly maintenance and cleanup process.

Example: Queue Assessment Transmissions

```
Select Surgery Risk Assessment Menu Option: T  Queue Assessment Transmissions

Transmit Surgery Risk Assessments

Requested Start Time: NOW// <RET>

Queued as task #2651700

Press RETURN to continue <RET>
```

Editing Features

In the preceding pages, the main menu of the Surgery Risk Assessment module was followed and each of the sub-options needed to maintain the Risk Assessment system, transmit data, and create reports were described. This section focuses on the three editing features provided in the Surgery Risk Assessment module.

The first two options of the main menu, *Enter/Edit Non-Cardiac Risk Assessment Information* and *Enter/Edit Cardiac Risk Assessment Information,* permit two modes of operation ; enter mode and edit mode. The enter mode, which allows you to enter a surgical case and reach the sub-options menu to enter more in-depth data and eventually obtain a display or printout of information, has been described previously. In this section, the Edit mode, in which you can enter/modify data, delete data, or prepare the data for transmission, will be described.

An assessment that has been transmitted cannot be edited without first changing the status of the assessment back to “Incomplete”.

How to Access the Editing Features
First, select one of the two enter/edit options from the main Surgery Risk Assessment menu. Then, enter a patient name. The computer displays the patient’s previously entered assessments, if any. An asterisk (*) indicates cardiac cases. You can now enter a new surgical case or edit one of the previously entered assessments.

When you select an assessment, the computer wants to know what editing you wish to do. You have the following choices:

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

This chapter describes these three editing features and provides examples.

1. Enter Risk Assessment Information

This feature is similar to entering a new risk assessment except many data fields are already filled in. Nurse reviewers use this option to modify data.

After selecting a specific patient and case, and entering “1” to select this feature, the computer screen will clear and then present the menu of sub-options. If the case is a cardiac risk assessment the cardiac sub-options will appear. The user can now concentrate the edit on any of the sub-options.

Enter one or two question marks for on-line help if you need assistance while interacting with the software.

In the example below, we begin at the main menu and access the editing features, select an operation, and then choose to enter risk assessment information.

Example: Entering New Information for a Previously Entered Risk Assessment

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


Select Patient:    FLINSTONE,FRED         01-12-01     111111111     NON-VETERAN
(OTHER)
```

```
FLINSTONE,FRED  111-11-1111

1. 03-11-95   REPAIR (R) AFB LIMB PSEUDOANEURYSM, FEM-PT BYPASS W/(L)
              SAPHENOUS & CUBITAL, THROMBECTOMY (R) FEMORAL ARTERY, 4
              COMPARTMENT FASCIOTOMY RLE (INCOMPLETE)

2. 02-17-95   CHOLEDOCHOTOMY OR CHOLEDOCHOSTOMY WITH EXPLORATION, BILIARY
              ENDOSCOPY (TRANSMITTED)

3.   ----     CREATE NEW ASSESSMENT


Select Surgical Case: 1
```

```
 FLINSTONE,FRED  111-11-1111

03-11-95      REPAIR (R) AFB LIMB PSEUDOANEURYSM, FEM-PT BYPASS W/(L)
              SAPHENOUS & CUBITAL, THROMBECTOMY (R) FEMORAL ARTERY, 4
              COMPARTMENT FASCIOTOMY RLE (INCOMPLETE)

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

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

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

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

2. Delete Risk Assessment Entry

This editing feature allows you to delete a specific surgical case from the Surgery Risk Assessment software records.

Example 2: Delete Risk Assessment Entry

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


Select Patient: HONEYCUTT,B.J.         03-03-30     321984352     SC VETERAN
```

```
 HONEYCUTT,B.J.  321-98-4352

1. 02-07-95   * CORONARY ARTERY BYPASS (COMPLETED)

2. 01-25-94   PULMONARY LOBECTOMY (INCOMPLETE)

3.   ----     CREATE NEW ASSESSMENT


Select Surgical Case: 1
```

```
 HONEYCUTT,B.J.  321-98-4352

07-18-95      CORONARY ARTERY BYPASS (INCOMPLETE)

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

Select Number:  1//  2

This assessment has a current status of 'Incomplete'

Are you sure that you want to delete this assessment ? NO//  Y

Deleting Assessment...

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

3. Update Assessment Status to COMPLETE

Use this feature to upgrade the status of an assessment to Complete. A complete assessment has enough information for it to be transmitted to the centers where data are analyzed. Only complete assessments are transmitted. After updating the status, you can print the patient's entire surgery risk assessment report. This report can be copied to your terminal screen or to a printer.

Example 3: Update Assessment Status to COMPLETE

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

Select Patient: FLINSTONE,FRED           01-12-01     111111111     NON-VETERAN
(OTHER)
```

```
 FLINSTONE,FRED  111-11-1111

1. 03-11-95   REPAIR (R) AFB LIMB PSEUDOANEURYSM, FEM-PT BYPASS W/(L)
              SAPHENOUS & CUBITAL, THROMBECTOMY (R) FEMORAL ARTERY, 4
              COMPARTMENT FASCIOTOMY RLE (INCOMPLETE)

2. 02-17-95   CHOLEDOCHOTOMY OR CHOLEDOCHOSTOMY WITH EXPLORATION, BILIARY
              ENDOSCOPY (TRANSMITTED)

3.   ----     CREATE NEW ASSESSMENT


Select Surgical Case: 1
```

```
 FLINSTONE,FRED  111-11-1111

03-11-95      REPAIR (R) AFB LIMB PSEUDOANEURYSM, FEM-PT BYPASS W/(L)
              SAPHENOUS & CUBITAL, THROMBECTOMY (R) FEMORAL ARTERY, 4
              COMPARTMENT FASCIOTOMY RLE (INCOMPLETE)

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

Select Number:  1//  3
```

```
This assessment is missing the following items:

     Disseminated Cancer (Y/N)

Do you want to enter the missing items at this time? NO// YES
DISSEMINATED CANCER (Y/N): Y  YES

Are you sure you want to complete this assessment ? NO// YES

Updating the current status to 'COMPLETE'...

Do you want to print the completed assessment ?  YES//  NO
```

CHAPTER SEVEN: DOWNLOADING TRANSCRIPTION

Introduction
In the Surgery package, transcription refers to the operation notes written or dictated by a surgeon. The operation notes concern a recently performed surgical procedure. They are usually dictated by the surgeon and transcribed by a professional transcriptionist. The resulting transcript, an Operation Report, is approved and signed by the surgeon and filed with the patient's record.

Every completed surgical case should have operation notes. The Surgery package is carefully designed with checks to ensure that the notes are dictated, transcribed and verified. If one of these steps is omitted, the case will show up on one of the special reports for the Chief of Surgery to investigate.

Transcription may be typed on a personal computer using any word processing software the typist prefers. To produce a hard copy and incorporate the transcription into the **V***IST***A** system, it must be "downloaded" or transmitted to the Surgery package. This is an easy task after the initial preparations. Transcription can also be typed directly into the **V***IST***A** system using VA FileMan's word processing; however, most professional transcriptionists prefer to use other wordprocessing programs and download the text. Both methods are demonstrated in this chapter.

Getting Out of an Option

To get out of an option, enter an up-arrow (^). You can use the up-arrow at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continue entering up-arrows to completely exit the system.

Overview

The main options included in this menu are listed below. To the left is the shortcut synonym you can enter to select the main option.

T	*Transmit Transcribed Operation Notes*
P	*Batch Print Transcripted Operation Notes*
Q	*List Operation Notes in the 'Print' Queue*
U	*List of Unmerged Operation Notes*
TFM	*Transcribe Surgeon's Dictation (FileMan)*
DIC	*Enter/Edit Date of Dictation*

1.0 Transmit Transcribed Operation Notes

This option is designed to download a batch of dictated operation notes from a word processor or personal computer to the **V***IST***A** system. The operation notes are merged with the proper patient case in the Surgery file. This option is designed for the transcriptionist who has many cases to transmit at one time If you wish to transmit just one case's operation notes, it is simpler to use the *Transcribe Surgeon's Dictation* option.

Formatting Text

Since data is batched (processed all at once), the user must have a way of signaling the end of the data file. This is accomplished with a heading and an ending.

Heading
Each heading signals the computer to start a new case. The heading must start with an at-sign (@) followed by the case number with no space between them. After the case number, type a slash (/), the date of operation, slash, and the patient's identifier. The patient's identifier is the first letter of the patient's last name followed by the last four digits of his or her social security number (this unique identifier is used in many **V***IST***A** applications). The header will look similar to this:

```
@15546/3 9 99/M4555
```

In the above header, the case number is 15546, the operation date is March 9, 1999, and the patient's identifier is M (for Mr. Moody) 4555. Notice there must be a slash (/) separating the case number (15546), the date (3 9 99), and the patient identifier (M4555).

Many cases can be entered, but **each case must have a heading**. Double check the heading; if there is an error, it will not match up with the appropriate case in the **V***IST***A** computer files.

Ending
At the end of the **entire** batch, whether you are inputting one case or many, type the characters representing the end of the text on a separate line. These characters are:

```
@###
```

This is a signal for the end of the batch. When the computer reads a line starting with the characters @###, it is finished. There may be a day's worth of transcribing between the first heading and the end of text characters.

After you have concluded your transcription with the end of text characters, you can store the data on your PC or word processor. These operative notes must be stored in an ASCII (text) file. Various PCs and word processors have different methods of saving files, but virtually all of them can save in ASCII (text) format. If you need assistance with this, please refer to your package coordinator.

The operation notes might lose some formatting when they are transmitted, requiring you to add carriage returns, hyphens, etc.

Transmitting the Operation Notes

Whether working from a personal computer or word processor, the operation notes must be stored in an ASCII (text) file. Various PCs and word processors have different methods of transmitting (sending) files and may require different types of emulation software to link the PC with the **V***IST***A** system. The package coordinator or site manager can set this up for you.

After transcribing the operation notes on your PC, switch to the **V***IST***A** computer and select the option *Transmit Transcribed Operation Note*s from the Transcriptionist's Menu. You will be prompted to transmit the file. At this point, use whatever function exists on your PC to send this file into the **V***IST***A** system. Your terminal screen will display the operation notes as they are being transmitted.

If the transmission is unsuccessful and the computer is unable to merge the transcription, you will see a message like the following:

```
Transmission completed.  Now sorting and storing dictation.

Case # 16629 does not match.  This case cannot be processed.
Case # 16713 does not match.  This case cannot be processed.

Finished.
```

There may be data in the print queue from the last time you transmitted operation notes. If so, you will see this message when you select *Transmit Surgery Dictations* option:

```
There is old text remaining in your file.  By transmitting a new batch,
the old text will be erased.
Do you want to continue ?  YES//
```

If you accept the yes default, the print queue will empty and you can re-select the *Transmit Surgery Dictations* option from the menu.

Example: Transmitting the Transcription

```
   T          Transmit Transcribed Operation Notes
   P          Batch Print Transcripted Operation Notes
   Q          List Operation Notes in the 'Print' Queue
   U          List of Unmerged Operation Notes
   TFM        Transcribe Surgeon's Dictation (FileMan)
   DIC        Enter/Edit Date of Dictation

Select Surgery Transcription Menu Option: T  Transmit Transcribed Operation Notes
```

```
Transmit the file of operation notes to be merged:          [Send File]

@29/9 22 92/B3327
Procedure:  After placing a roll under patient's shoulders, patient was draped and
prepped in Betadine fashion.  5cc of 1% plain Xylocaine used to anesthetize the right
subclavian area.  On one stick attempt left subclavian vein was cannulated and guide
wire was placed down toward the subclavian superior vena cava.  Fluroscopy was used to
ensure catheter length would be in the superior vena cava.  4cc of Xylocaine was used
to anesthetize under the clavicle.  A 10-0 blade used to make curvilinear incision
about 3 cm down toward shoulder.....  Patient tolerated the procedure well.  We are
awaiting a postop chest X-ray to rule out pneumothorax.
@16/8 1 92/O5555
Patient was placed in supine position.  IV sedation was given as well as an intraoral
inferior alveolar nerve block using six cc of 2% Lidocaine without Epinephrine.  A
very small amount (approx 1.5 cc) of 1% Epinephrine was injected along the alveolar
ridge.  A 15 blade was used to incise the mucosa along the alveolar ridge and a
periosteal Freer elevator used to elevate the mucosa and periosteum off of the
alveolar ridge.  Using rongeurs and curets, several peices of bone were taken and put
in sterile specimen cup to be sent for culture.  The mucosa was closed with 2-0 Dexon
in a running fashion.  The patient's mouth was irrigated with saline and operation
concluded.  Patient taken to recovery room in satisfactory condition.
@###

Transmission completed.  Now sorting and storing dictation.
......
Finished.

Press <RET> to continue
```

2.0 Batch Print Transcripted Operation Notes

This option is used to print the transcribed operation notes that were transmitted to the **V***IST***A** Surgery files from a PC or word processor. A batch usually contains data for the many surgical cases transcribed in a day by one transcriptionist. Successfully transmitted transcription is merged with other data from the patient's file to form the Operation Report. This data then resides in the computer's print queue until replaced by a new batch.

With this option, the transcriptionist can print the stored data. The resulting transcript contains patient information pertinent to the case as well as the transcribed operation notes. Each case is on a different page. This transcript, when approved and signed by the surgeon, is a formal Operation Report, Replacement Form 516.

These reports have an 80-column format and must be sent to a printing device.

If a case's transcription did not successfully transmit, it will not print. See the option *List of Unmerged Operation Notes* to investigate.

Example: Batch Print Transcripted Operation Notes

```
Select Surgery Transcription Menu Option: P  Batch Print Transcripted Operation Notes

Print to Device: [Select Print Device]
```

..... *printout follows* .....

```
MEDICAL RECORD                          OPERATION REPORT     PAGE 1
CASE # 206

Preoperative Diagnosis:
  Primary: BRAIN TUMOR

Surgeon:        HOWARD,MOE          Surgical Priority: NOT ENTERED
Attend Surgeon: FINE,LARRY          Attend Code: 2. ATTENDING IN O.R. SUITE
1st Assistant:  MOODY,MARGARET      2nd Assistant: N/A

Anesthetist: WATSON,CHERYL              Asst. Anesthetist: N/A

Anesthesia Begin: APR 18, 1992  08:00   Anesthesia End: APR 18, 1992  10:30
Operation Begin:  APR 18, 1992  08:25   Operation End:  APR 18, 1992  10:15

Material Sent to Laboratory for Analysis: N/A

Postoperative Diagnosis:
  Primary: BRAIN TUMOR  ICD9 Code: NOT ENTERED

Major Operations Performed:
  Primary: CRANIOTOMY  CPT Code: NOT ENTERED

Date/Time of Dictation: AUG 30, 1992
Date/Time Transcribed:  MAR 29, 1993

Indications for Operation:
  DKDKD

Surgeon's Dictation:
Patient was placed in supine position.  IV sedation was given as well as an intraoral
inferior alveolar nerve block using six cc of 2% Lidocaine without Epinephrine.  A
very small amount (appox. 1.5 cc) of 1% Epinephrine was injected along the alveolar
ridge.  A 15 blade was used to incise the mucosa along the alveolar ridge and a
periosteal Freer elevator used to elevate the mucosa and periosteum off of the
alveolar ridge.  Using rongeurs and curets, several pieces of bone were taken and put
in sterile specimen cup to be sent for culture.  The mucosa was closed with 2-0 Dexon
in a running fashion.  The patient's mouth was irrigated with saline and operation
concluded.  Patient taken to recovery room in satisfactory condition.

SURGEON'S SIG:                                      MAR 29, 1993 15:48

BASS,EARNEST T.                                     AGE: 64   ID#: 123-45-5119
WARD: 1 NORTH                                       ROOM-BED: 162-4

VAMC: BIRMINGHAM ISC                                REPLACEMENT FORM 516
```

```
MEDICAL RECORD                          OPERATION REPORT     PAGE 1
CASE # 207

Preoperative Diagnosis:
  Primary: ESOPHAGEAL CANCER, METASTASIS LUNG

Surgeon:        FINE,LARRY          Surgical Priority: NOT ENTERED
Attend Surgeon: FINE,LARRY          Attend Code: 1. ATTENDING IN O.R.
1st Assistant:  DAVIS,PAULETTE      2nd Assistant: REED,JAMES

Anesthetist: WATSON,CHERYL              Asst. Anesthetist: N/A

Anesthesia Begin: APR  1, 1992  14:06   Anesthesia End: N/A
Operation Begin:  NOT ENTERED           Operation End:  APR  1, 1992  15:20

Material Sent to Laboratory for Analysis: N/A

Postoperative Diagnosis:
  Primary: ESOPHAGEAL CANCER, METASTASIS LUNG  ICD9 Code: NOT ENTERED

Major Operations Performed:
  Primary: PLACEMENT OF PORTACATH, LEFT SUBCLAVIAN  CPT Code: NOT ENTERED

Date/Time of Dictation: AUG 30, 1992
Date/Time Transcribed:  MAR 29, 1993

Indications for Operation:
  TEST

Surgeon's Dictation:
Procedure:  After placing a roll under patient's shoulders, patient was draped and
prepped in Betadine fashion.  5cc of 1% plain Xylocaine used to anesthetize the right
subclavian area.  On one stick attempt, left subclavian vein was cannulated and guide
wire was placed down toward the subclavian superior vena cava.  4cc of Xylocaine was
used to anesthetize under the clavicle.  A 10-0 blade used to make curvilinear
incision about 3 cm down toward shoulder....  Patient tolerated the procedure well.
We are awaiting a postop chest X-ray to rule out pneumothorax.

SURGEON'S SIG:                                      MAR 29, 1993 15:48

FUDD,ELMER                                          AGE: 58   ID#: 251-08-6718
WARD:                                               ROOM-BED:

VAMC: BIRMINGHAM ISC                                REPLACEMENT FORM 516
```

3.0 List Operation Notes in the 'Print' Queue

This option lists the most recently transmitted operation notes that were successfully merged with a case in the Surgery file. These notes will reside in this print queue until they are printed and other operation notes are transmitted from the PC.

This list can be printed remotely or viewed on your terminal screen.

Example: List Operation Notes in the 'Print' Queue

```
Select Surgery Transcription Menu Option: Q  List Operation Notes in the 'Print'
 Queue


Print queue information to which Device ? [Select Print Device]
```

..... *printout follows* .....

```
                          Transcribed Operation Notes

Case #   Patient (ID #)                        Number    Date of    Last Date
                                                of Lines  Surgery    Printed
-------------------------------------------------------------------------------
206      BASS,EARNEST T. (123-45-5119)            14      04/18/92    03/29/93
207      FUDD,ELMER (251-08-6718)                 10      04/01/92    03/29/93
```

4.0 List of Unmerged Operation Notes

This option lists all transcribed operation notes that failed to merge with the **V***IST***A** Surgery files.

If a case does not merge, you may need to return to the stored document on your PC and double check the heading for errors. An incorrect date, case number, or patient identifier will prevent the case from merging. Simply correct the heading and re-transmit. If none of your cases transmitted, you may have left off the end-of-text characters (@###).

When you are transmitting, if any of the transmitted operation notes failed to merge with the Surgery files, the computer will tell you which cases did not match up. The following message will appear:

```
Transmission completed.  Now sorting and storing dictation.

Case # 16629 does not match.  This case cannot be processed.
Case # 16713 does not match.  This case cannot be processed.

Finished.
```

Example: List of Unmerged Operation Notes

```
Select Surgery Transcription Menu Option: U  List of Unmerged Operation Notes
Print to device: [Select Print Device]
```

..... *printout follows* .....

```
                        List of Unmerged Operation Notes

Case #   Patient (ID #)                                  Date of Operation
         Procedure
==============================================================================
16713  OAT,WILLIE  (449-34-555)                          AUG 16, 1992
       CHOLECYSTECTOMY
```

5.0 Transcribe Surgeon’s Dictation (FileMan)

This option allows you to transcribe dictated operation notes directly into the patient's **V***IST***A** Surgery file. It displays the patient's Operation Report and attaches an area for adding the surgeon's dictation. This option concludes by printing a hardcopy Operation Report, Replacement Form 516. This entire procedure is demonstrated below.

At the prompt "Select Patient", enter the patient name and choose the case.

View Operation Report
The next prompt, "Device", allows you to view the Operation Report section on your computer terminal. If you do not wish to see the Operation Report before you add the dictation, you can enter an up-arrow (^) at this first "Device" prompt to jump to the dictation area.

Is this the correct operation?
You must confirm that you are looking at the correct case. If it is not the correct case, enter "No" at the prompt "Is this the correct operation?" and you will be returned to the "Select Patient" prompt. If it is correct, accept the yes default by pressing the Return key.

Type in the dictation
Finally, you can enter the word processing fields to add the dictation. The notation 1> indicates row 1 of an open-text word processing field. You can enter as many lines (rows) as needed. Remember, with this type of word processing the sentences do not automatically wrap and you must press the Return key at the end of each line.

Print the Operation Report
You can print the Operation Report, including the dictation just entered, by responding yes to the prompt "Do you want to print the Operative Report ?”. This hard copy report is submitted to the surgeon for approval, signed by the surgeon, and the report is made a permanent part of the patient's medical record.

Example: Transcribe Dictation and Print the Operation Report

```
Select Surgery Transcription Menu Option: TFM  Transcribe Surgeon's Dictation
(FileMan)


Select Patient: BODEAN,JETHRO         08-16-51     123457212
```

```
 BODEAN,JETHRO   123-45-7212

1. 03-29-93   FRONTAL CRANIOTOMY (COMPLETED)

2. 12-01-92   REPAIR DIAPHRAGMATIC HERNIA (REQUESTED)

3. 03-17-92   REPAIR DIAPHRAGMATIC HERNIA (NOT COMPLETE)


Select Operation: 1

DEVICE: [Select Print Device]
```

..... *printout follows* .....

```
     MEDICAL RECORD                          OPERATION REPORT     PAGE 1
     CASE # 257

Preoperative Diagnosis:
  Primary: INTRACEREBRAL HEMORRHAGE

Surgeon:        HOWARD,MOE          Surgical Priority: URGENT
Attend Surgeon: FINE,LARRY          Attend Code: 1. ATTENDING IN O.R.
1st Assistant:  LAMB,SHARON         2nd Assistant: REED,JAMES


Press RETURN to continue, or '^' to quit: <RET>
```

```
     MEDICAL RECORD                        OPERATION REPORT        PAGE 2



Anesthetist: WATSON,CHERYL              Asst. Anesthetist: N/A
Attending Anesthesiologist: JENNINGS,GEORGE A

OR Support Personnel:
  Scrubbed                              Circulating
  NURSE,NANCY (FULLY TRAINED)           GEORGE,SUSAN ()


Press RETURN to continue, or '^' to quit: <RET>
```

```
     MEDICAL RECORD                        OPERATION REPORT        PAGE 3


Anesthesia Technique(s):
  GENERAL  (PRINCIPAL)
     Agent:  ENFLURANE

Anesthesia Begin: MAR 29, 1993  10:00   Anesthesia End: MAR 29, 1993  13:00
Operation Begin:  MAR 29, 1993  11:00   Operation End:  MAR 29, 1993  13:15

Material Sent to Laboratory for Analysis:
Specimens:
  Excision of permanent sect from cortical intertubular
  capillary plexuses.


Press RETURN to continue, or '^' to quit: <RET>
```

```
     MEDICAL RECORD                        OPERATION REPORT        PAGE 4


Postoperative Diagnosis:
  Primary: INTRACEREBRAL HEMORRHAGE  ICD9 Code: 432.9

Major Operations Performed:
  Primary: FRONTAL CRANIOTOMY  CPT Code: 61312

Date/Time of Dictation: NOT ENTERED
Date/Time Transcribed:  MAR 29, 1993  16:40


Press RETURN to continue, or '^' to quit: <RET>
```

```
     MEDICAL RECORD                        OPERATION REPORT        PAGE 5


Indications for Operation:
  CT scan reveals presence of large left basal ganglionic hemorrhage
  medial to the internal capsule.

Surgeon's Dictation: N/A

Press RETURN to continue: <RET>
```

```
Is this the correct operation ?  Y//  <RET>
```

[The following dictation is entered by the Transcriptionist]

```
Surgeon's Operation Notes:
  1>Patient prepped and draped in usual manner.  Linear skin incision
  2>made just anterior to the coronal suture on the left side.  Sharp
  3>dissection taken down to bone and a 2 cm diameter craniotomy was
  4>started using Midas Rex instrument.  A 1 cm cortical incision was
  5>then made towards clot bed where hand held retractors were
  6>put in place and clot was aspirated from the wound.  Several large
  7>pieces of coagulum were removed with brain matter taped on the
  8>edges & sent to permanent section.  Residual clot was removed
  9>piecemeal and with sucker and coagulation was attempted with
 10>Gelfoam & cotton ball soaked in Thrombin.  Bleeding under control
 11>after 25 minutes of periodic tamponading.  New area of Gelfoam
 12>applied at wound with homeostatis adequately obtained and the
 13>wound then closed.  The dura was closed using interupped Nurolon
 14>sutures and the bone was replaced using 0 silk.  The skin was
 15>closed using 3-0 Vicryl inverted interrupted fashion on subcutaneous
 16>layer and skin staples to close the skin.  At the time of closure,
 17>the brain was lax and pulsating easily.  Sterile dressing was
 18>applied to the wound.  Patient was taken to the recovery room
 19>prior to being taken to ICU.
 20><RET>
EDIT Option: <RET>

Date of Transcription: MAR 29,1993@16:40//  <RET> (MAR 29, 1993@16:40)

Do you want to print the Operative Report ?  YES//  <RET>
DEVICE:
```
[Select Print Device]

..... printout follows .....

```
MEDICAL RECORD                          OPERATION REPORT     PAGE 1
CASE # 257

Preoperative Diagnosis:
  Primary: INTRACEREBRAL HEMORRHAGE

Surgeon:        HOWARD,MOE          Surgical Priority: URGENT
Attend Surgeon: FINE,LARRY          Attend Code: 1. ATTENDING IN O.R.
1st Assistant:  LAMB,SHARON         2nd Assistant: REED,JAMES

Anesthetist: WATSON,CHERYL              Asst. Anesthetist: N/A
Attending Anesthesiologist: JENNINGS,GEORGE A

OR Support Personnel:
  Scrubbed                              Circulating
  NURSE,NANCY (FULLY TRAINED)           GEORGE,SUSAN ()

Anesthesia Technique(s):
  GENERAL  (PRINCIPAL)
     Agent: ENFLURANE

Anesthesia Begin: MAR 29, 1993  10:00   Anesthesia End: MAR 29, 1993  13:00
Operation Begin:  MAR 29, 1993  11:00   Operation End:  MAR 29, 1993  13:15

Material Sent to Laboratory for Analysis:
Specimens:
  Excision of permanent sect from cortical intertubular
  capillary plexuses.

Postoperative Diagnosis:
  Primary: INTRACEREBRAL HEMORRHAGE  ICD9 Code: 432.9

Major Operations Performed:
  Primary: FRONTAL CRANIOTOMY  CPT Code: 61312

Date/Time of Dictation: NOT ENTERED
Date/Time Transcribed:  MAR 29, 1993  16:40

Indications for Operation:
  CT scan reveals presence of large left basal ganglionic hemorrhage
  medial to the internal capsule.

Surgeon's Dictation:
Patient prepped and draped in usual manner.  Linear skin incision was
made just anterior to the coronal suture on the left side.  Sharp
dissection taken down to bone and a 2 cm diameter craniotomy was
started using Midas Rex instrument.  A 1 cm cortical incision was


SURGEON'S SIG:                                      OCT 06, 1998 12:35

BODEAN,JETHRO                                       AGE: 47   ID#: 123-45-7212
WARD: 1 SOUTH                                       ROOM-BED:

VAMC: MAYBERRY, NC                                  REPLACEMENT FORM 516
```

then made towards clot bed where hand held retractors were
put in place and clot was aspirated from the wound. Several large
pieces of coagulum were removed with brain matter taped on the
edges & sent to permanent section. Residual clot was removed
piecemeal and with sucker and coagulation was attempted with
Gelfoam & cotton ball soaked in Thrombin. Bleeding under control
after 25 minutes of periodic tamponading. New area of Gelfoam
applied at wound with hemostatis adequately obtained and the
wound then closed. The dura was closed using interupped Nurolon
sutures and the bone was replaced using 0 silk. The skin was
closed using 3-0 Vicryl inverted interrupted fashion on subcutaneous
layer and skin staples to close the skin. At the time of closure,
the brain was lax and pulsating easily. Sterile dressing was
applied to the wound. Patient was taken to the recovery room
prior to taken to ICU.

SURGEON'S SIG: OCT 06, 1998 12:35

BODEAN,JETHRO AGE: 47 ID#: 123-45-7212
WARD: 1 SOUTH ROOM-BED:

VAMC: MAYBERRY, NC REPLACEMENT FORM 516

6.0 Enter/Edit Date of Dictation

This option allows the transcriptionist or surgeon to enter the date of dictation for a particular case. After selecting the patient and operation, enter the date and time of dictation at the appropriate prompt.

Example: Enter Date of Dictation

```
Select Surgery Transcription Menu Option: DIC  Enter/Edit Date of Dictation

Select Patient: FUDD,ELMER         12-00-34     251086718
```

```
Select Patient: FUDD,ELMER           12-22-34     251086718


 FUDD,ELMER   251-08-6718

1. 05-29-99   I+D OF CERVICAL ABCESS, REPAIR OF MENINGOCELE (COMPLETED)

2. 04-01-94   PLACEMENT OF PORTACATH, LEFT SUBCLAVIAN (COMPLETED)


Select Case: 1
```

```
Patient:            FUDD,ELMER (251-08-6718)
Case Number:        313
Operation Date:     MAY 29, 1998 08:15
Attending Surgeon:  FINE,LARRY
Surgeon:            HOWARD,MOE
-------------------------------------------------------------------------------

Date/Time of Dictation: 5/29@0815  (MAY 29, 1999@08:15)

Press RETURN to continue <RET>
```

How to Use Screen Server

Introduction

Screen Server is a screen-based data entry utility. It allows the user to display and select data elements for entering, editing, and deleting information. The format is designed to display a number of data fields at one time on a menu. With Screen Server, a number of data elements are displayed at one time on a menu and the user is able to choose which element to work on. This document contains a description of the Screen Server format and gives examples of how to respond to the unique Screen Server prompts. The screen facsimiles used in the examples are taken from the Surgery software; however, these screens might not appear on your terminal monitor exactly as they appear in this manual, as the Surgery package is subject to enhancements and local modifications. In this document the different ways to respond to the Screen Server prompt, to perform a task, and to utilize shortcuts are explained. The shortcuts are listed below:

Enter Data
Edit Data
Move Between Pages
Enter/Edit a Range of Data Elements
Multiples
Multiple Screen Shortcuts
Word Processing

We assume that you are familiar with **V*IST*A** conventions. **In the examples, the user's response is underlined.**

Getting Out

You can press the Return key to move through a prompt and go to the next page or item. To return directly to the Surgery Menu, enter an up-arrow (^) unless you are in a multiple field. In that case, enter two up-arrows (^^).

Basic Parts Each Screen Server arrangement consists of three basic parts: a heading, data elements, and an action prompt. The following is an example of a Screen Server display with help text.

Heading

```
** SHORT SCREEN **   CASE #16  OAT,WILLIE         PAGE 1 OF 2
```

Data Elements

```
1    DATE OF OPERATION:     AUG 01, 1991
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               HOWARD,M.
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    OTHER PREOP DIAGNOSIS: (MULTIPLE)
6    PRIN OPERATIVE PROCEDURE: REMOVE FACIAL LESIONS
7    PRINCIPAL OP CODE:
8    OTHER OPERATIVE PROCEDURES: (MULTIPLE)
9    TIME PAT IN OR:
10   TIME OPERATION BEGAN:
11   ASA CLASS:
12   TIME OPERATION ENDS:
13    TIME PAT OUT OR:
14    OR CIRC SUPPORT:        (MULTIPLE)
15    OR SCRUB SUPPORT:       (MULTIPLE)(DATA)
```

Prompt

```
Enter Screen Server Function:  ?
```

Help Text

```
To change entries, enter your choices (numbers) separated by a ';', or
use a ':' for ranges.  i.e. 2;3 or 1:3.  Enter 'A' to enter/edit all.

If there is more than one page to this screen, entering a '+' or '-'
followed by the number of pages or entering 'P' followed by the page
number will take you to the desired page.

Enter '^' to quit, or '^^' to return to the menu option.
```

Heading The screen heading contains information specific to the record with which you are working. This can include the patient name or case number. The information in the heading is programmed and cannot be easily changed.

Data Elements Each Screen Server display contains from 1 to 15 data elements (or fields). If information has been entered for any of the data elements defined, it will appear to the right of the element. Some data elements are multiple fields, meaning they can contain more than one piece of information. These multiple fields are distinguished by the word "Multiple" next to the data element. If the multiple field contains information, the word "Data" will be next to the data element.

Prompt The action prompt is at the bottom of each screen. From the prompt "Enter Screen Server Functions:" you can enter, edit, or delete information from the data elements. The possible responses to this prompt are explained in more detail on the following pages. Enter a question mark (?), for help text with possible prompt responses.

How to Enter Data

To enter or edit data, type the item number corresponding with the data element for which you are entering information and press the Return key. In the following example, we typed the number 10 at the prompt and pressed the Return key. A new prompt appeared allowing us to enter the data. The computer immediately processed this information and produced an updated menu screen and another action prompt.

```
  ** SHORT SCREEN **   CASE #16  OAT,WILLIE         PAGE 1 OF 2

  1    DATE OF OPERATION:     AUG 01, 1991
  2    IN/OUT-PATIENT STATUS: OUTPATIENT
  3    SURGEON:               HOWARD,M.
  4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
  5    OTHER PREOP DIAGNOSIS: (MULTIPLE)
  6    PRIN OPERATIVE PROCEDURE: REMOVE FACIAL LESIONS
  7    PRINCIPAL OP CODE:
  8    OTHER OPERATIVE PROCEDURES: (MULTIPLE)
  9    TIME PAT IN OR:
  10   TIME OPERATION BEGAN:
  11   ASA CLASS:
  12   TIME OPERATION ENDS:
  13   TIME PAT OUT OR:
  14   OR CIRC SUPPORT:       (MULTIPLE) (DATA)
  15   OR SCRUB SUPPORT:      (MULTIPLE)

Enter Screen Server Function:  10
TIME OPERATION BEGAN:  13:00   OCT 18, 1991 AT 13:00
```

[The computer processes the information and produces an update]

```
  ** SHORT SCREEN **   CASE #16  OAT,WILLIE         PAGE 1 OF 2

  1    DATE OF OPERATION:     AUG 01, 1991
  2    IN/OUT-PATIENT STATUS: OUTPATIENT
  3    SURGEON:               HOWARD,M.
  4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
  5    OTHER PREOP DIAGNOSIS: (MULTIPLE)
  6    PRIN OPERATIVE PROCEDURE: REMOVE FACIAL LESIONS
  7    PRINCIPAL OP CODE:
  8    OTHER OPERATIVE PROCEDURES: (MULTIPLE)
  9    TIME PAT IN OR:
  10   TIME OPERATION BEGAN:  OCT 18, 1991 AT 13:00
  11   ASA CLASS:
  12   TIME OPERATION ENDS:
  13   TIME PAT OUT OR:
  14   OR CIRC SUPPORT:       (MULTIPLE) (DATA)
  15   OR SCRUB SUPPORT:      (MULTIPLE)

Enter Screen Server Function:
```

How to Edit Data

Changing an existing entry is similar to entering. Once again, type in the number for the data element you want to change and press the Return key. In the following example, the number 3 was entered to change the surgeon name. A new prompt appeared containing the existing value for the data element in a default format. We entered the new value, "FINE, LAWRENCE." The computer immediately processed this information and produced an updated screen.

```
  ** SHORT SCREEN **   CASE #16  OAT,WILLIE         PAGE 1 OF 2

  1    DATE OF OPERATION:     AUG 01, 1991
  2    IN/OUT-PATIENT STATUS: OUTPATIENT
  3    SURGEON:               HOWARD,M.
  4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
  5    OTHER PREOP DIAGNOSIS: (MULTIPLE)
  6    PRIN OPERATIVE PROCEDURE: REMOVE FACIAL LESIONS
  7    PRINCIPAL OP CODE:
  8    OTHER OPERATIVE PROCEDURES: (MULTIPLE)
  9    TIME PAT IN OR:
  10   TIME OPERATION BEGAN:  OCT 18, 1991 AT 13:00
  11   ASA CLASS:
  12   TIME OPERATION ENDS:
  13   TIME PAT OUT OR:
  14   OR CIRC SUPPORT:       (MULTIPLE) (DATA)
  15   OR SCRUB SUPPORT:      (MULTIPLE)

Enter Screen Server Function:  3
SURGEON:  HOWARD,M. // FINE, LAWRENCE
```

[The computer processes the information and produces an update]

```
  ** SHORT SCREEN **   CASE #16  OAT,WILLIE         PAGE 1 OF 2

  1    DATE OF OPERATION:     AUG 01, 1991
  2    IN/OUT-PATIENT STATUS: OUTPATIENT
  3    SURGEON:               FINE, LAWRENCE.
  4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
  5    OTHER PREOP DIAGNOSIS: (MULTIPLE)
  6    PRIN OPERATIVE PROCEDURE: REMOVE FACIAL LESIONS
  7    PRINCIPAL OP CODE:
  8    OTHER OPERATIVE PROCEDURES: (MULTIPLE)
  9    TIME PAT IN OR:
  10   TIME OPERATION BEGAN:  OCT 18, 1991 AT 13:00
  11   ASA CLASS:
  12   TIME OPERATION ENDS:
  13   TIME PAT OUT OR:
  14   OR CIRC SUPPORT:       (MULTIPLE) (DATA)
  15   OR SCRUB SUPPORT:      (MULTIPLE)

Enter Screen Server Function:
```

Turning Pages

No more than 15 data elements will fit on a single Screen Server formatted page, but there can be as many pages as needed. Since many screens contain more than one page of data elements, the screen server provides the ability to move between the pages. Pages are numbered in the heading.

To go back one page, enter minus one (-1) at the action prompt. To go forward, enter plus one (+1). You can move more than one page by combining the minus or plus sign with the number of pages you wish to go backward or forward.

Enter/Edit a Range of Data Elements

Colons and semicolons are used as delineators for ranges of item numbers. This allows you 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 computer what elements to display for editing.

Colons are used when you want to respond to all numbers within a sequence (e.g., 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: Semicolon

```
** STARTUP **   CASE #24  MOUSE,MICKEY            PAGE 1 OF 2

1    DATE OF OPERATION:     APR 19, 1991 AT 800
2    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE
3    OTHER PREOP DIAGNOSIS: (MULTIPLE)
4    OPERATING ROOM:        OR4
5    SURGERY SPECIALTY:     ORTHOPEDICS
6    MAJOR/MINOR:
7    REQ POSTOP CARE:       WARD
8    CASE SCHEDULE TYPE:    ELECTIVE
9    REQ CLEAN OR CONTAMINATED:
10   REQ ANESTHESIA TECHNIQUE: GENERAL
11   PATIENT EDUCATION:
12   CANCEL DATE:
13   CANCEL REASON:
14   DELAY CAUSE:
15   VALID CONSENT CONFIRMED BY:

Enter Screen Server Function:  4;6;9;14
OPERATING ROOM:  OR4// OR2
MAJOR/MINOR: MAJOR
REQ CLEAN OR CONTAMINATED: C  CLEAN
DELAY CAUSE: X-RAY REPORT LATE
```

Example 2: Colon

```
  ** STARTUP **   CASE #24  MOUSE,MICKEY            PAGE 2 OF 2

1     ASA CLASS:
2    PREOP MOOD:
3    PREOP CONSCIOUS:
4    PREOP SKIN INTEG:
5    TRANS TO OR BY:
6    PREOP SHAVE BY:
7    SKIN PREPED BY (1):
8    SKIN PREPED BY (2):
9    SKIN PREP AGENTS:
10   SECOND SKIN PREP AGENT:
11   ELECTROCAUTERY UNIT:
12   PRIMARY ELECTROGROUND POS:
13   SECONDARY ELECTROGROUND POS:
14   SURGERY POSITION:
15   RESTR & POSITION AIDS: (MULTIPLE)(DATA)

Enter Screen Server Function:  1:6
ASA CLASS:  2    2-MILD DISTURB.
PREOP MOOD: RELAXED          R
PREOP CONSCIOUS: ALERT-ORIENTED          AO
PREOP SKIN INTEG: INTACT          I
TRANS TO OR BY: STRETCHER
PREOP SHAVE BY: ROSE,DELLA          DR
```

Multiples

The notation MULTIPLE indicates a data element that can have more than one answer. Some multiple fields have several layers of screens from which to respond. Navigating through the layers seems tedious at first but you will soon develop speed. Remember, you can press the Return key at the prompt to go back to the main menu screen, or enter an up-arrow (^) to go back to the previous screen.

In the following examples, you can see there are other screens after the initial (also called top-level) screen. With the multiple screens, you build a new menu list with each entry.

```
  ** OPERATION **   CASE #14  NASIUM,JIM            PAGE 1 OF 2

1    TIME PAT IN HOLD AREA: AUG 15, 1991 AT 740
3    TIME PAT IN OR:        AUG 15, 1991 AT 800
4    ANES CARE START TIME:  AUG 15, 1991 AT 800
5    TIME OPERATION BEGAN:  AUG 15, 1991 AT 900
6    SPECIMENS AND CULTURES: (WORD PROCESSING)
7    THERMAL UNIT:          (MULTIPLE)
8    TOURNIQUET: (MULTIPLE)
9    PROSTHESIS INSTALLED:  (MULTIPLE)
10   REPLACEMENT FLUID TYPE: (MULTIPLE)
11   IRRIGATION:            (MULTIPLE)
12   MEDICATIONS:           (MULTIPLE)
13   SPONGE COUNT CORRECT ??: YES
14   SHARPS COUNT CORRECT ??: YES
15   INSTR. COUNT CORRECT ??: YES

Enter Screen Server Function:  9

   ** OPERATION **   CASE #14  NASIUM,JIM            PAGE 1
         PROSTHESIS INSTALLED
```

```
1    NEW ENTRY

Enter Screen Server Function:  1
Select PROSTHESIS INSTALLED ITEM: GLENOID COMPONENT
   PROSTHESIS INSTALLED ITEM: GLENOID COMPONENT//  <RET>
```

Notice the three user responses entered above. The first response, 9, told the computer that we want to enter data in the PROSTHESIS INSTALLED field. Then, at the next screen, we entered "1" since we want to make a new prosthesis entry for this case. The third response, GLENOID, told the computer what kind of prosthesis is being installed. The computer echoed back the full prosthesis name "GLENOID COMPONENT" and we accepted it by pressing the Return key. Because the PROSTHESIS INSTALLED field can contain multiple answers, a new screen immediately appeared as follows:

```
  ** OPERATION **   CASE #14  NASIUM,JIM            PAGE 1
         PROSTHESIS INSTALLED  (GLENOID COMPONENT)

1    ITEM:                  GLENOID COMPONENT
2    VENDOR:
3    MODEL:
4    LOT/SERIAL NO:
5    STERILE CODE:
6    STERILE NUMBER:
7    STERILE RESP:
8    SIZE:

Enter Screen Server Function:  2:8
VENDOR: KIRSCHNER MEDICAL
MODEL: NEER II
LOT/SERIAL NO: #F23101
STERILE CODE:  AA1
STERILE NUMBER:  N2034
STERILE RESP: M  MANUFACTURER
SIZE: 1081
```

The first response, 2:8, corresponds to data elements 2 through 8. We entered data for these elements one-by-one and the computer processed the information and produced this update:

```
** OPERATION **   CASE #14  NASIUM,JIM            PAGE 1 OF 1
         PROSTHESIS INSTALLED  (GLENOID COMPONENT)

1    ITEM:                  GLENOID COMPONENT
2    VENDOR:                KIRSCHNER MEDICAL
3    MODEL:                       NEER II
4    LOT/SERIAL NO:         #F23101
5    STERILE CODE:          AA1
6    STERILE NUMBER:        N2034
7    STERILE RESP:          MANUFACTURER
8    SIZE:                  1081

Enter Screen Server Function:  <RET>
```

Pressing the Return key will now bring back the top-level screen and allow us to make another entry. As many as 15 prostheses can be added to this list. If we were to add more prostheses, the N and R shortcuts discussed on the next two pages would come in handy, but it is a good idea to practice the steps just covered before attempting the shortcuts.

Multiple Screen Shortcuts

The help text for a multiple field mentions the N and R functions. You can enter a question mark (?) to view the help text at the prompt as seen below:

```
  ** OPERATION **   CASE #14  NASIUM,JIM            PAGE 1 OF 1
         PROSTHESIS INSTALLED

1    NEW ENTRY

Enter Screen Server Function:  ?
Enter 1N to enter only the top level of this multiple, or the number
of your choice followed by an 'R' to make a duplicate entry.
```

N Function

The N function allows you to enter *New* entries without going beyond the top level screen, whereas the R function allows you to *repeat* a previous top level response. In the following example we will build entries by entering the data element number and the letter N:

```
  ** OPERATION **   CASE #14  NASIUM,JIM            PAGE 1 OF 1
         PROSTHESIS INSTALLED

1    NEW ENTRY

Enter Screen Server Function:  1N
Select PROSTHESIS INSTALLED ITEM: GLENOID COMPONENT
   PROSTHESIS INSTALLED ITEM: GLENOID COMPONENT// <RET>
Select PROSTHESIS INSTALLED ITEM: HUMERAL COMPONENT
   PROSTHESIS INSTALLED ITEM: HUMERAL COMPONENT// <RET>
Select PROSTHESIS INSTALLED ITEM: INTRAMEDULLARY PLUG
   PROSTHESIS INSTALLED ITEM: INTRAMEDULLARY PLUG// <RET>
Select PROSTHESIS INSTALLED ITEM: <RET>
```

[The computer processes the information and produces an update]

```
  ** OPERATION **   CASE #14  NASIUM,JIM            PAGE 1 OF 1
         PROSTHESIS INSTALLED

1    ITEM:                  GLENOID COMPONENT
2    ITEM:                  HUMERAL COMPONENT
3    ITEM:                  INTRAMEDULLARY PLUG
4    NEW ENTRY

Enter Screen Server Function: <RET>
```

R Function

The R function saves you from typing in the top-level information again. In this example, we have the same anesthesia technique but different anesthesia agents. By entering the element number we want to repeat, and the letter R, we avoid having to enter the top-level data again. This feature can also be useful in cases where the same medication is repeated at different times. After you enter the item and the letter R, the computer responds with a default prompt. Press the Return key to accept the default.

```
  ** SHORT SCREEN **   CASE #10  CLEAVER,THEODORE   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE

1    ANESTHESIA TECHNIQUE:  GENERAL
2    ANESTHESIA TECHNIQUE:  LOCAL
3    NEW ENTRY
Enter Screen Server Function:  1R
    ANESTHESIA TECHNIQUE: GENERAL// <RET>
```

[The computer processes the information and produces an update]

```
  ** SHORT SCREEN **   CASE #10  CLEAVER,THEODORE   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE  (0)

1    ANESTHESIA TECHNIQUE:  GENERAL
2    PRINCIPAL TECH:
3    ANESTHESIA AGENTS:     (MULTIPLE)

Enter Screen Server Function:  3
```

```
 ** SHORT SCREEN **   CASE #10  CLEAVER,THEODORE   PAGE 1 OF 1
0)
           ANESTHESIA AGENTS

1    NEW ENTRY

Enter Screen Server Function:  1
Select ANESTHESIA AGENTS: PROCAINE HYDROCHLORIDE
    ANESTHESIA AGENTS: PROCAINE HYDROCHLORIDE // <RET>
```

```
  ** SHORT SCREEN **   CASE #10  CLEAVER,THEODORE   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE  (0)
           ANESTHESIA AGENTS

1    ANESTHESIA AGENTS:     PROCAINE HYDROCHLORIDE
2    NEW ENTRY

Enter Screen Server Function: <RET>
```

[The computer processes the information and produces an update]

```
  ** SHORT SCREEN **   CASE #10  CLEAVER,THEODORE   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE  (0)

1    ANESTHESIA TECHNIQUE:  GENERAL
2    PRINCIPAL TECH:
3    ANESTHESIA AGENTS:     (MULTIPLE)(DATA)

Enter Screen Server Function:  <RET>
```

[The updating continues through to the top layer]

```
  ** SHORT SCREEN **   CASE #10  CLEAVER,THEODORE   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE

1    ANESTHESIA TECHNIQUE:  INTRAVENOUS
2    ANESTHESIA TECHNIQUE:  LOCAL
3    ANESTHESIA TECHNIQUE:  INTRAVENOUS
4    NEW ENTRY

Enter Screen Server Function: <RET>
```

Word Processing

The phrase "Word Processing" in the menu means that you can enter as much data as you need to complete the entry. Refer to *DHCP Users Guide to Computing* if you are unfamiliar with standard **V*IST*A** conventions such as word processing.

Following is an example of how we entered text on a Screen Server word processing field. Notice that we pressed the Return key after each line of text as there is no automatic word-wrap:

```
 ** SHORT SCREEN **   CASE #25  BOB,BILLY B.       PAGE 2 OF 2

1    OPERATING ROOM:
2    FIRST ASST:
3    SPONGE COUNT CORRECT ??:
4    SHARPS COUNT CORRECT ??:
5    INSTR. COUNT CORRECT ??:
6    SPONGE, SHARPS, & INST COUNTER:
7    COUNT VERIFIER:
8    SURGERY SPECIALTY:     PLASTIC SURGERY (INCLUDES HEAD AND NECK)
9    ATTEND SURG:
10   ATTEND CODE:
11   SPECIMENS AND CULTURES: (WORD PROCESSING)
12   NURSING CARE COMMENTS: (WORD PROCESSING)
13   PRINC ANESTHETIST:
14   ANESTHESIA TECHNIQUE:  (MULTIPLE)

Enter Screen Server Function:  12
NURSING CARE COMMENTS:
  1>Patient arrived ambulatory from Ambulatory Surgery Unit.  <RET>
  2>Discharged via wheelchair.  Lidocaine applied topically.
<RET>
  3> <RET>
EDIT Option: <RET>
```

[The computer processes the information and produces an update]

```
  ** SHORT SCREEN **   CASE #25  BOB,BILLY B.       PAGE 2 OF 2

1    OPERATING ROOM:
2    FIRST ASST:
3    SPONGE COUNT CORRECT ??:
4    SHARPS COUNT CORRECT ??:
5    INSTR. COUNT CORRECT ??:
6    SPONGE, SHARPS, & INST COUNTER:
7    COUNT VERIFIER:
8    SURGERY SPECIALTY:     PLASTIC SURGERY (INCLUDES HEAD AND NECK)
9    ATTEND SURG:
10   ATTEND CODE:
11   SPECIMENS AND CULTURES: (WORD PROCESSING)
12   NURSING CARE COMMENTS: (WORD PROCESSING)(DATA)
13   PRINC ANESTHETIST:
14   ANESTHESIA TECHNIQUE:  (MULTIPLE)

Enter Screen Server Function:
```

Quick Reference Sheet

The following are some suggestions for answering prompts. For more information, please refer to the *DHCP Users Guide to Computing* or "How to Use Screen Server".

Menu Shortcuts

Jump ..... To jump to an option, enter an up-arrow (^) followed by an option name.
Do It Again.... To select the last option chosen on a menu, press the Space bar and then press the Return key.

Tips for Data Entry (or fields within options):

Jump ..... Enter an up-arrow (^) followed by a field name to jump directly to that field (so long as it is contained in that option).
Help ..... Enter one to two questions marks (?) to access varying degrees of help for the field or prompt.
Do It Again.... Pressing the Space bar followed by the Return key will usually bring up the last entry chosen. (This will not work for free text fields, date/time fields, or those requiring a code.)
Times ..... Entering a time but no date at Date/time fields makes the date the same as the date of operation. Entering "N" or "NOW" changes these fields to the present date and time. Entering a 'T' for Today makes the date the present day.
Delete ..... Delete an entry from the file by entering an at-sign (@).
Type Less ..... In many instances, it is only necessary to enter the first few characters of a field and the computer will fill in the rest.
Editing ..... When editing free text over 19 characters long, the prompt "Replace" will appear. At this prompt, type the letters you want replaced and press the Return key. Then, at the prompt "With" , type in the correct text and press the Return key. The line will reappear with the changes you have made.

```
PRINCIPAL PRE-DIAGNOSIS:  CHRONIC CHOLECYSTECTOMY
       Replace CHOLECYSTECTOMY  With CHOLECYSTITIS  Replace <RET>
PRINCIPAL PRE-DIAGNOSIS:  CHRONIC CHOLECYSTITUS
```

For longer words or sentences, a shortcut is to use ellipses (three successive periods):

```
PRINCIPAL PRE-DIAGNOSIS:  CHRONIC CHOLECYSTECTOMY
             Replace CHRO...  With CHOLECYSTITIS  Replace <RET>
PRINCIPAL PRE-DIAGNOSIS:  CHRONIC CHOLECYSTITUS
```

Screen Server Basics:

Enter/Edit ..... At the prompt, enter your choices of fields to edit by entering the field numbers. For a range of fields, use a colon (i.e., 1:12 for fields 1 thru 12). For several unconsecutive fields, separate the numbers with a semicolon (i.e., 1;8;10 for fields 1, 8, and 10). Or enter "A" for all fields.

Move Pages ... To go back and forth to different pages of a screen (most have more than one page), enter a plus (+) or minus (-) followed by the number of pages you wish to go.

Getting Out.... Enter one or two up-arrows (^) to return to the menu option.

Multiples When dealing with multiples, enter a number followed by "N" to enter

Glossary

Aborted	Case status indicating the case was cancelled after the patient entered the operating room. Cases with ABORTED status must contain entries in TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232), plus CANCEL DATE field (#17) and/or CANCEL REASON field (#18).
ASA Class	This is the American Society of Anesthesiologists classification relating to the patient's physiologic status. Numbers followed by an 'E' indicate an emergency.
Attending Code	Code that corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure.
Blockout Graph	Graph showing the availability of operating rooms.
Cancelled Case	Case status indicating that an entry has been made in the CANCEL DATE field and/or the CANCEL REASON field without the patient entering the operating room.
CCSHS	VA Center for Cooperative Studies in Health Services located at Hines, Illinois.
CICSP	Continuous Improvement in Cardiac Surgery Program.
Completed Case	Case status indicating that an entry has been made in the TIME PAT OUT OR field.
Concurrent Case	A patient undergoing two operations by different surgical specialties at the same time, or back to back, in the same operating room.
CPT Code	Also called Operation Code. CPT stands for Current Procedural Terminology.
CRT	Cathode ray tube display. A display device that uses a cathode ray tube.
Enter	To type in information on a keyboard and press the Enter key (or Return key for some keyboards) to send the information to the computer.
Intraoperative Ocurrence	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-OR 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 NSQIP or the CICSP 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	An illuminated display surface on which display images are presented.
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.

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