SELF- GUIDED PRACTICE WORKBOOK [N38]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: Intra-Operative

Last update: January 31, 2018 (v2)

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	3 hours
Before getting started	- Sign the attendance roster (this will ensure you get paid to attend the session) - Put your cell phones on silent mode
Session Expectations	- This is a self-paced learning session - A 15 min break time will be provided. You can take this break at any time during the session - The workbook provides a compilation of different scenarios that are applicable to your work setting - Work through different learning activities at your own pace
Key Learning Review	- At the end of the session, you will be required to complete a Key Learning Review - This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.

Using Train Domain

You will be using the train domain to complete activities in this workbook. It has been designed to match the actual Clinical Information System (CIS) as closely as possible.

Please note:

- Scenarios and their activities demonstrate the CIS functionality not the actual workflow
- An attempt has been made to ensure scenarios are as clinically accurate as possible
- Some clinical scenario details have been simplified for training purposes
- Some screenshots may not be identical to what is seen on your screen and should be used for reference purposes only
- Follow all steps to be able to complete activities
- If you have trouble to follow the steps, immediately raise your hand for assistance to use classroom time efficiently
- Ask for assistance whenever needed

PATIENT SCENARIO

Learning Objectives

At the end of this Scenario, you will be able to:

- Demonstrate the steps to locate a patient on the Perioperative Tracking View, open a patient's chart, and assign a relationship
- Navigate the Patient chart.
- Locate the different components of the Perioperative Summary page to review patient information.
- Review the Procedure Consent form and Perioperative Pre-Op Pre-Procedure Checklist.
- Administer a medication with the Medication Administration Wizard (MAW)
- Use PM Conversation to complete the patient's bed transfer into the OR.
- Complete the Surgical Case Check-in process.
- Complete and Finalize the IntraOp documentation (IntraOp Record)
    - Complete an order for specimen collection
    - Implant Scanning
    - Set an Event on the Perioperative Tracking board
    - Update the Pick List
- Utilize the Perioperative Summary page for handoff reporting

SCENARIO

A 54-year-old male patient with an inguinal hernia. He meets with a General Surgeon and is scheduled for an elective right inguinal hernia repair. The patient has a medical history of seizure disorder; and a surgical history of appendectomy followed by a violent episode on emergence which was associated the anesthetic drugs. The chart is screened by the PAC nurse and is booked for a Nurse and Anesthesia PAC Appointment. He attends his PAC appointment and is determined fit for surgery. Surgery is scheduled three weeks from the date of the PAC appointment.

As an IntraOp Nurse, you will be completing the following 9 activities:

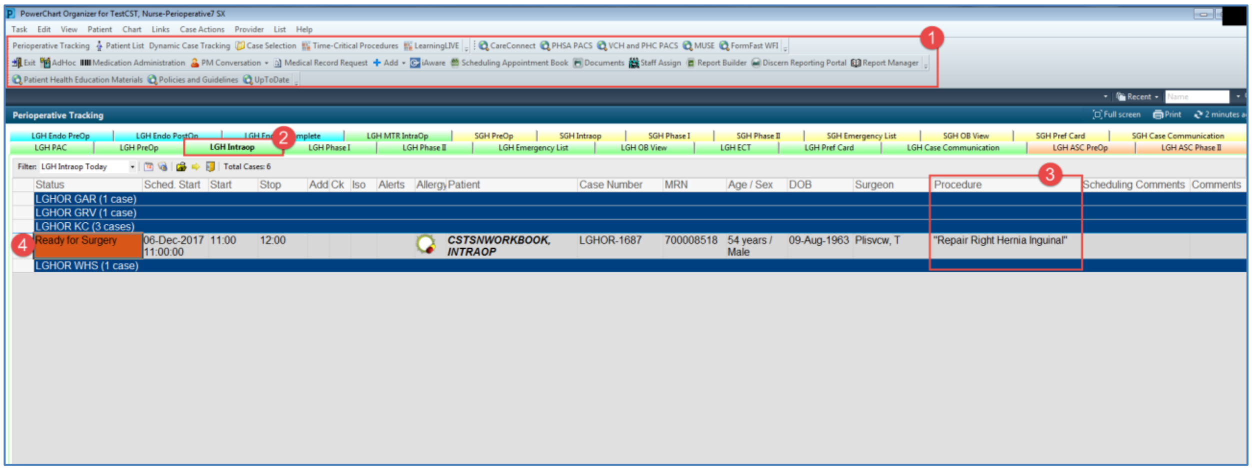
- Look up patient information in Perioperative Tracking
- Navigate to the Perioperative Summary page and review the patient information
- Utilize the Perioperative Summary page for patient handoff reporting
- Review the Consent Procedure and Perioperative PreProcedure Checklist

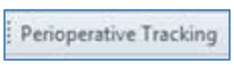
- Administer a medication via Medication Administration Wizard (MAW)
- Use PM Conversation to complete the patient's Bed Transfer into the OR
- Complete the Surgical Case Check-In process
- Complete the Perioperative Documentation – IntraOp Record by completing the required segments (including completing an order for a Pathology Specimen collection, Implant Scanning, Setting an Event, and updating the Picklist)
- Finalize the IntraOp Record

Activity 1.1 – Navigate Perioperative Tracking

1 When you login to PowerChart it will open to **Perioperative Tracking**.

Perioperative Tracking will display various views (or tabs) depending on your area/login. Utilization of Perioperative Tracking **LGH Intraop** view is recommended to access patient charts within the **LGH Intraop** unit. This view acts as a slate, a communication tool, and eliminates the need to search for patients individually.



1. Any time you need to navigate back to Perioperative Tracking you can click 

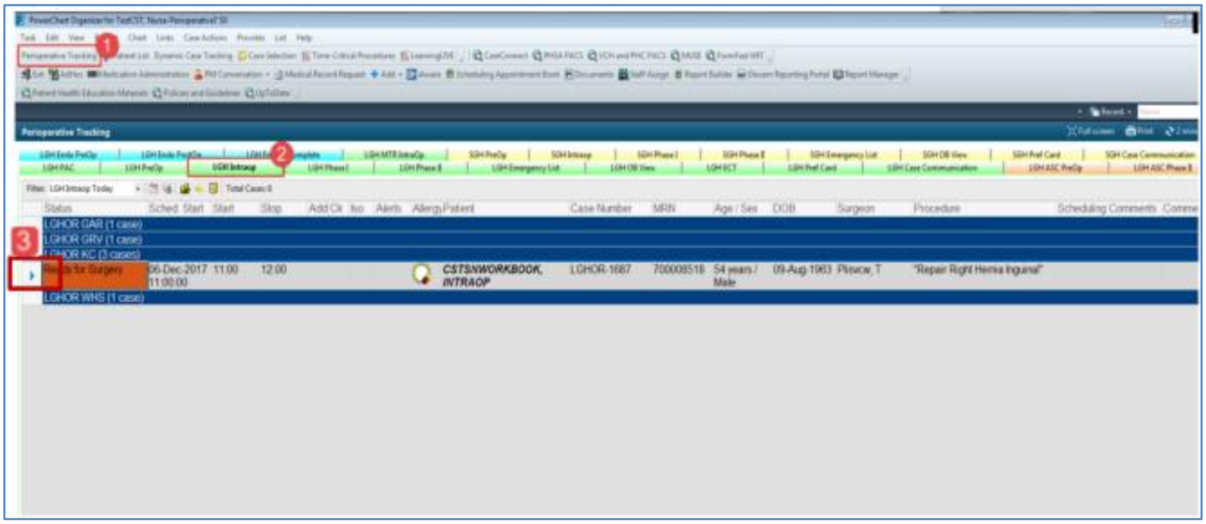
from the Toolbar
2. IntraOp patients will display in **LGH Intraop** tracking view.
3. Each row within this table represents a patient. They are typically arranged by room (e.g. OR, PAC).
4. Patient status will be updated based on Setting of Events and documentation.

Key Learning Points

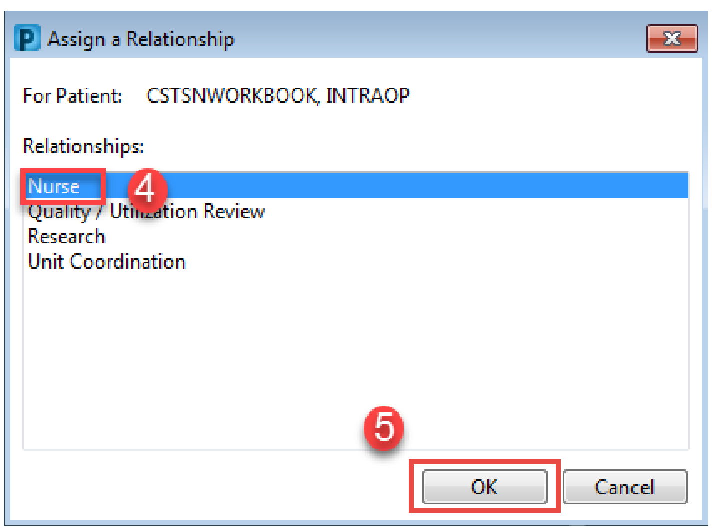
- You can use the Perioperative Tracking within the toolbar to return to this view from any other area of the application.

Activity 1.2 – Access the Chart from Perioperative Tracking and Establish a Relationship

1 Opening the patient's chart via **Perioperative Tracking**



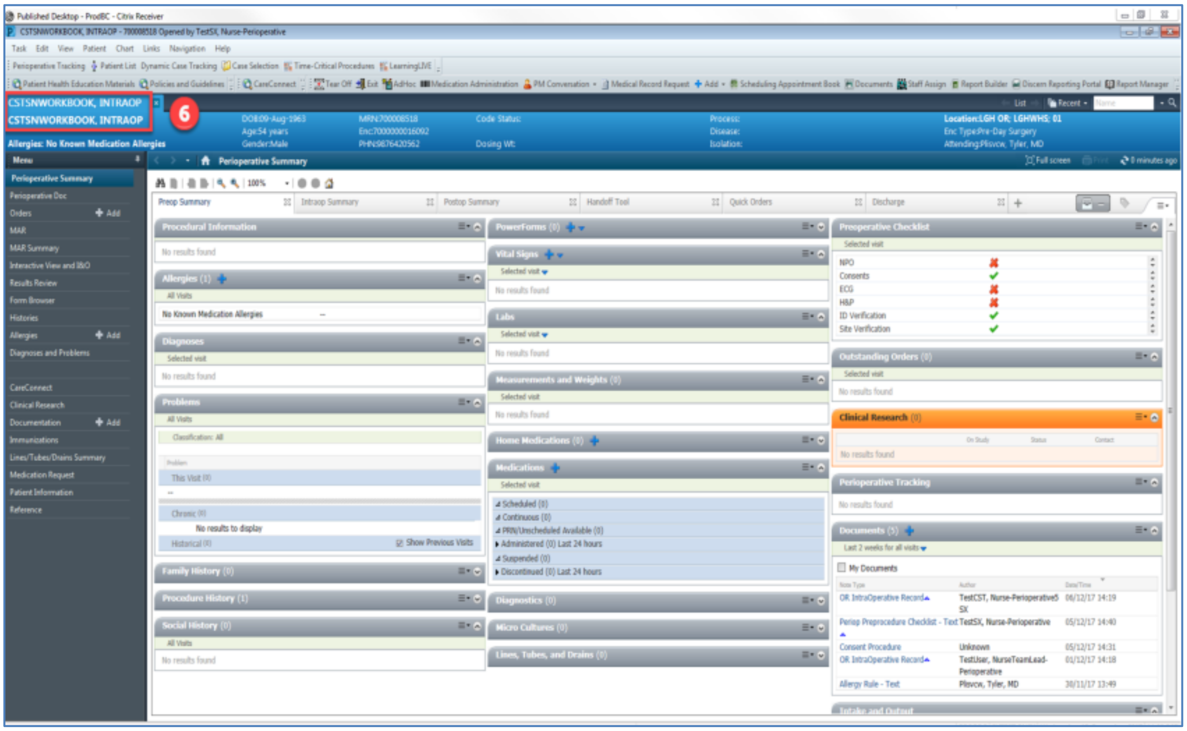
1. Select the **LGH Intraop** view
2. Select the appropriate patient by clicking on the row. Blue forward arrow will appear
3. Double- click the blue forward arrow next to the patient's chart to open their chart



If this is the first time logging into a patient's chart, the **Assign a Relationship** window will display, verify this is the correct patient.

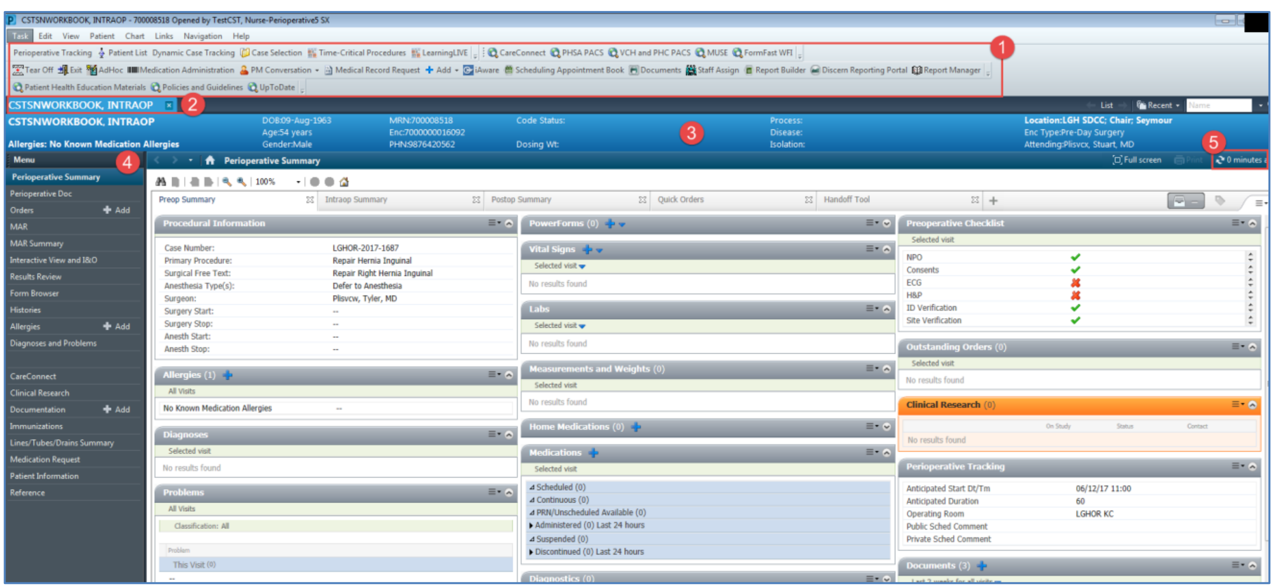
4. Select **Nurse** to assign relationship.
   Note: If this is the wrong patient, you would click the cancel button to return to Tracking View.

5. Click **OK**. The **Perioperative Summary** displays when you access a patient's chart.



6. Verify this is the correct patient's chart that has opened.

2 Overview of Patient's Chart



1. The **Toolbar** is located above the patient's chart and it contains buttons that allow you to access various tools within the Clinical Informatics System.
2. The patient tab displays the patient's name and clicking on ✖ will close the chart.

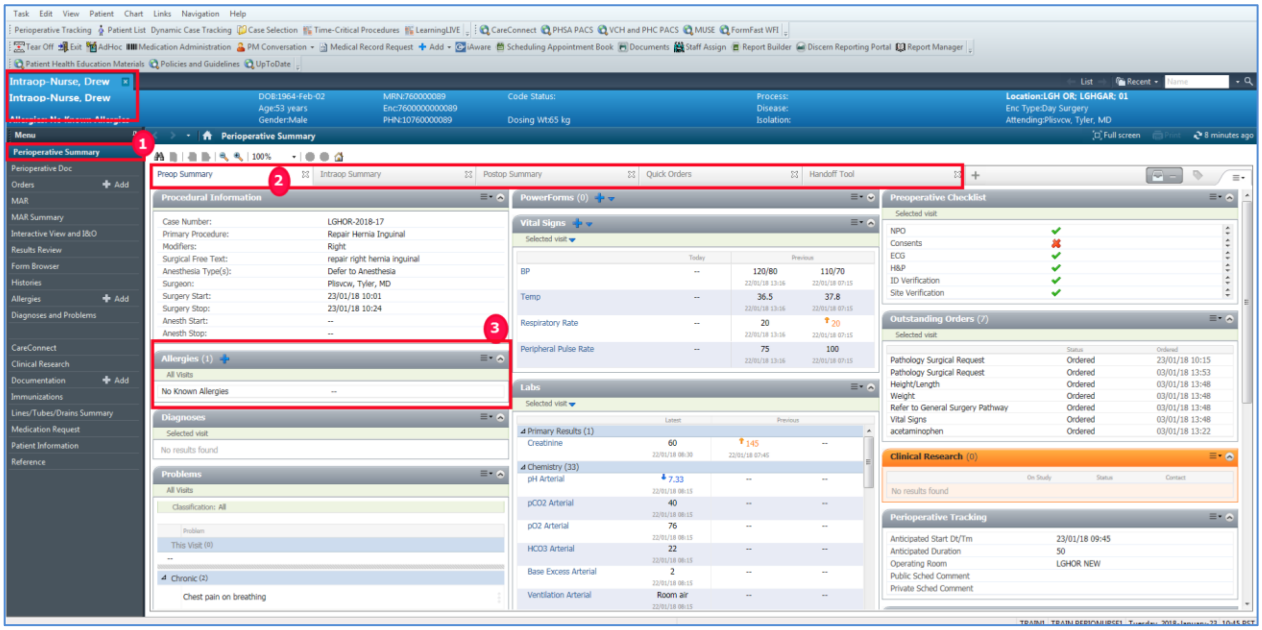
3. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information displayed includes:
   - Name
   - Allergies
   - Age, date of birth, etc.
   - Encounter type and number
   - Code status
   - Weight
   - Process, disease and isolation alerts
   - Location of patient
   - Attending Physician
4. The **Menu** on the left allows access to different sections of the patient chart. This is similar to the coloured dividers within a paper-based patient chart. Examples of sections included are Orders, Medication Administration Record (MAR) and more.
5. The **Refresh** icon updates the patient chart with the most up to date entries when clicked. It is important refresh the chart frequently especially as other clinicians may be accessing and documenting in the patient chart simultaneously.

Key Learning Points

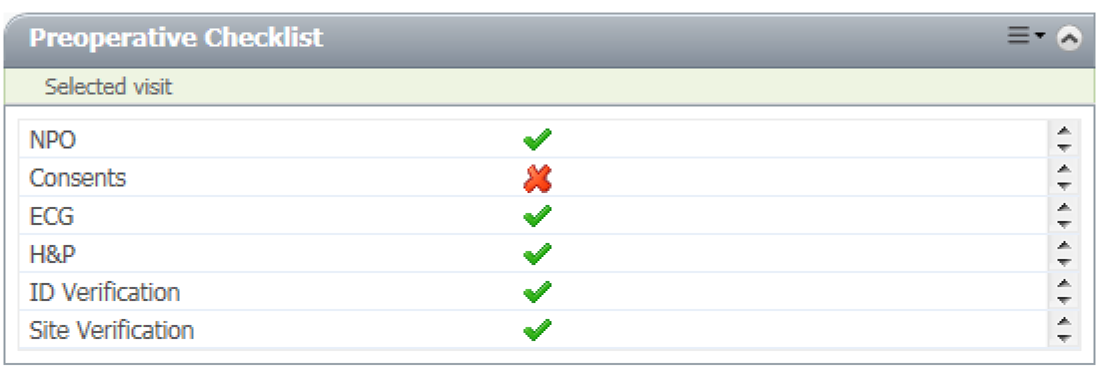
- The blue forward arrow indicates that you have selected a patient in the tracking view
- Users accessing a patient's information for the first time are prompted to assign the relationship with the patient e.g. Nurse.
- Always verify the correct patient's chart has opened.
- The patient's chart consists of several components containing pertinent patient data.

Activity 1.3 – Perioperative Summary

1 Use the **PreOp Summary** tab to review patient information prior to the surgery.

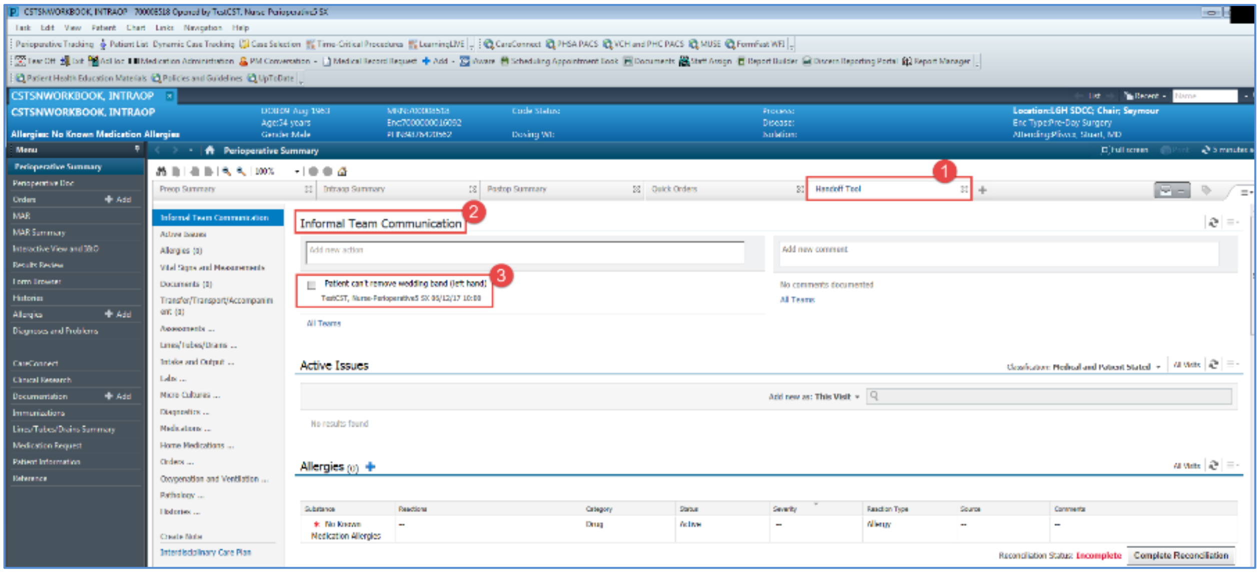


1. Select **Perioperative Summary** from the Menu.
2. Select **Preop Summary** tab and review.
   Note: There are different tabs (e.g. Preop Summary, Intraop Summary, Postop Summary, Quick Orders, Handoff Tool, and Discharge) that can be used to learn more about the patient.
3. Scroll down the page or access each component by clicking within the components
   Note: Each tab has different components. You can navigate to different components within in the tab by clicking on the component link(s) e.g. clicking on the Allergies link Allergies (1) or Add is the same as clicking on the Allergies band in the Menu.



4. Review the Preoperative Checklist Component
   Note: Some tasks may always show as incomplete e.g. It will show as incomplete if there is a Procedure Consent but not a Blood Consent even though this may be appropriate for certain procedures.

2 The Perioperative Summary Page contains a **Handoff Tool tab**, with **an Informal Team Communication** component that can be documented to and viewed by all team members to communicate concerns. Use this to leave a comment for the oncoming nurse or other team members.



On the Perioperative Summary **Handoff Tool** tab

1. Select the **Informal Team Communication** component
2. Note if any information has been entered by the PreOp nurse.
3. Enter the following data = *Pt can't remove wedding band*
4. Click **Save**

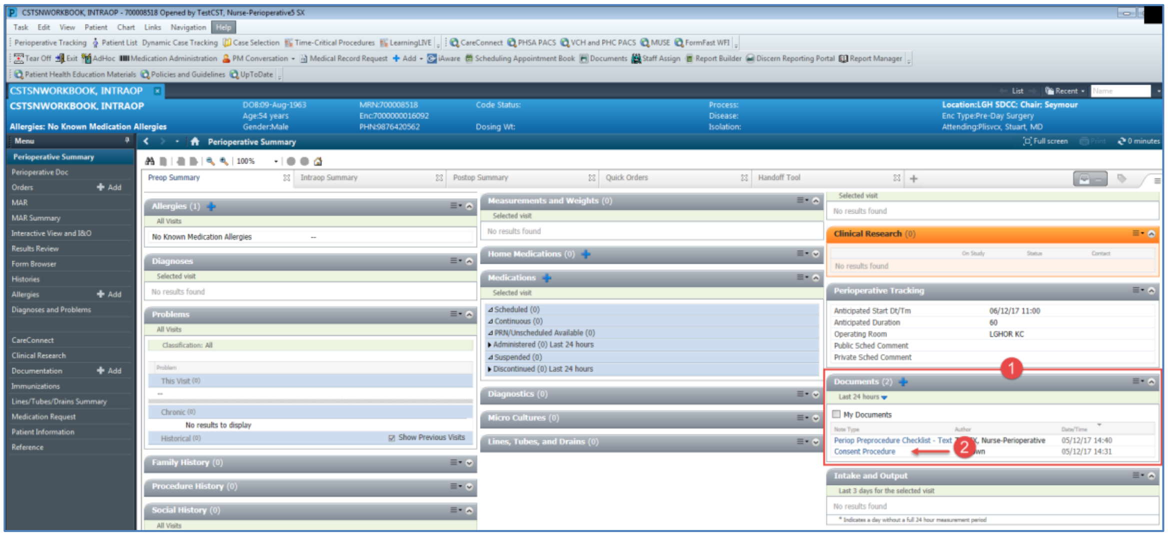
Key Learning Points

- Use the Preop Summary to review patient information with the oncoming nurse.
- Headings within Preop Summary page can be clicked to access the corresponding part of the chart.
- Use Informal Team Communication to leave a comment for the oncoming nurse or other team members.

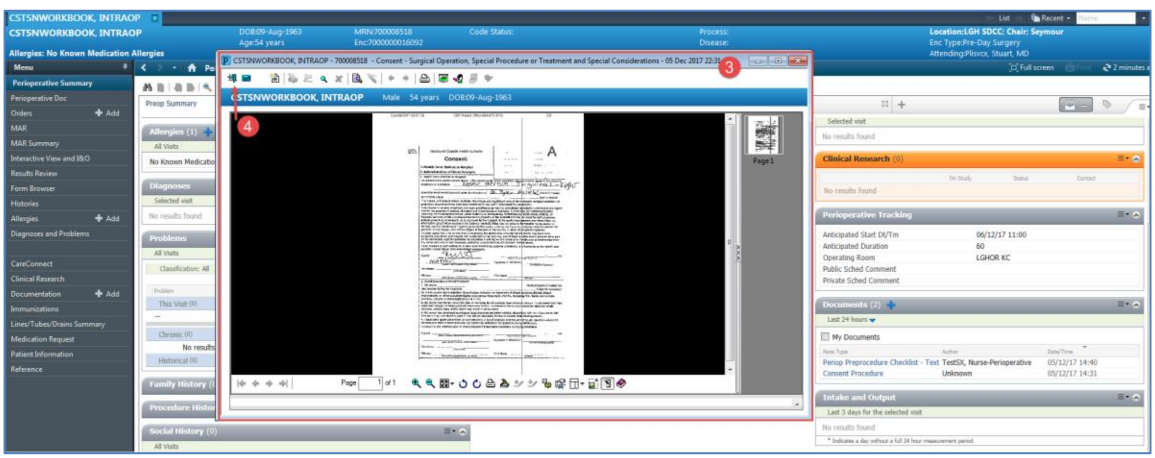
Activity 1.4 – Review the Consent Procedure form and Perioperative PreProcedure Checklist

1 Opening the **Consent Procedure**

From the Perioperative Summary page, in the Preop Summary tab:



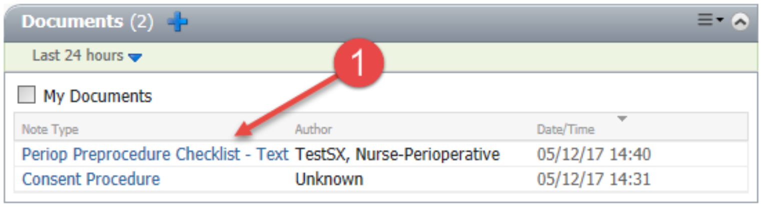
1. Locate the **Documents** component
2. Click on the **Consent Procedure** link.



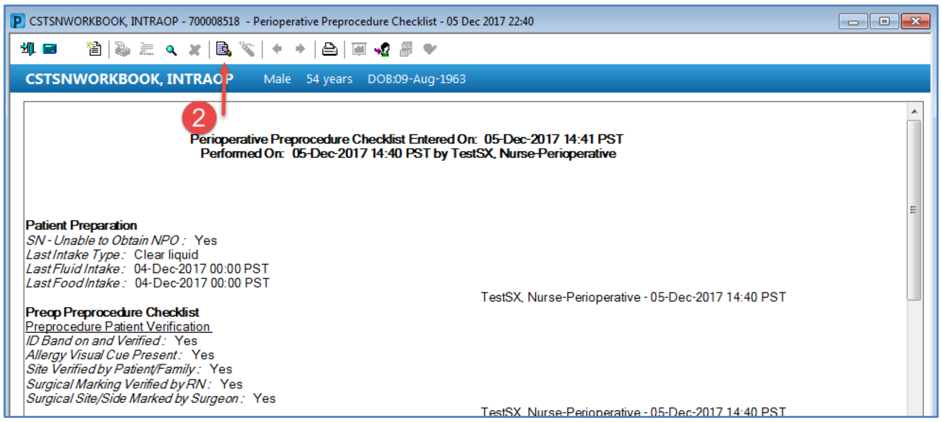
3. The consent will open as a scanned document
4. To close the consent, click on the **Exit** icon in the top left-hand corner.

2 **Opening the Perioperative PreProcedure Checklist**

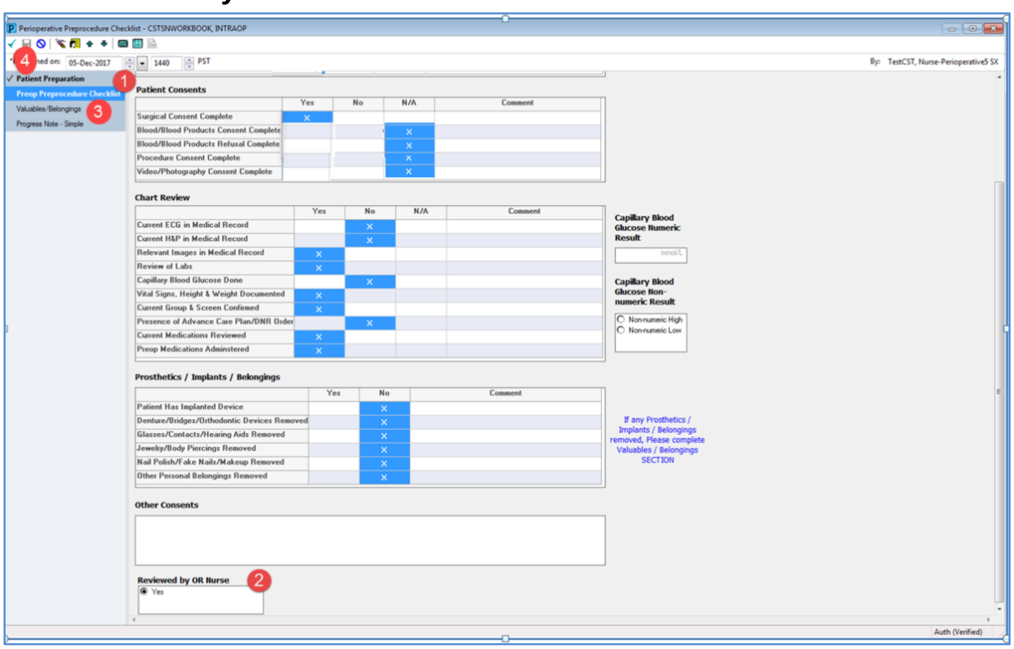
The Perioperative PreProcedure Checklist is a PowerForm. From the Documents component of the Perioperative Summary:



1. Click on the **Periop PreProcedure Checklist** link in the Documents component of the Preop Summary tab.



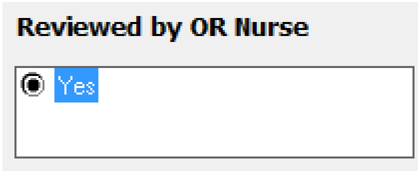
2. Click **Modify**



Review what has already been documented in **all** sections. Verify and update any necessary information:

1. Click the Patient Preparation section (if not yet displayed) and verify all information with the patient.

2. Click Reviewed by OR Nurse radio button at the bottom of the Patient Preparation page.



3. Click on the Preop Preprocedure Checklist section. Verify and update any information, and complete step 2.
   Note: Review Valuables/Belongings and Progress Note sections at a later time.
4. Click the icon to sign the Perioperative PreProcedure Checklist.

Key Learning Points

- Access to the Periop PreProcedure Checklist from the Perioperative Summary page.
- After reviewing the Patient Preparation and Periop PreProcedure Checklist, remember to click the Reviewed by OR Nurse radio button at the end of each section and click Sign.

Activity 1.5 – Administering Medication using the Medication Administration Wizard (MAW) and the Barcode Scanner

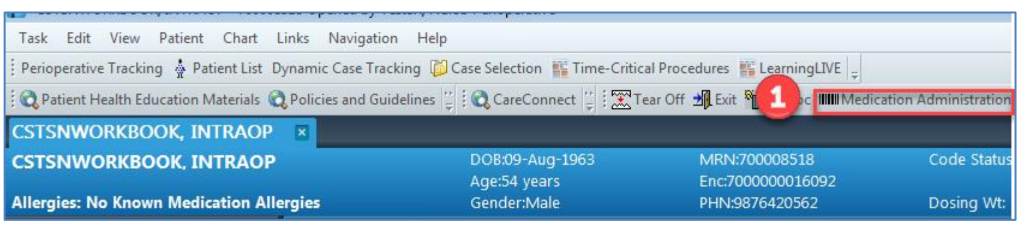
Medications will be administered and recorded electronically by scanning the patient's wristband and the medication barcode. Scanning of the patient's wrist band helps to ensure the correct patient is identified. Scanning the medication helps to ensure the correct medication is being administered. Once a medication is scanned, applicable allergy and drug interaction alerts may be triggered, further enhancing your patient's safety. This process is known as closed loop medication administration.

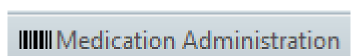
1 Tips for using the barcode scanner:

- Point the barcode scanner toward the barcode on the patient's wristband and/or the medication (Automated Unit Dose- AUD) package and pull the trigger button located on the barcode scanner handle
- To determine if the scan is successful, there will be a vibration in the handle of the barcode scanner and/or, simultaneously, a beep sound
- When the barcode scanner is not in use, wipe down the device and place it back in the charging station

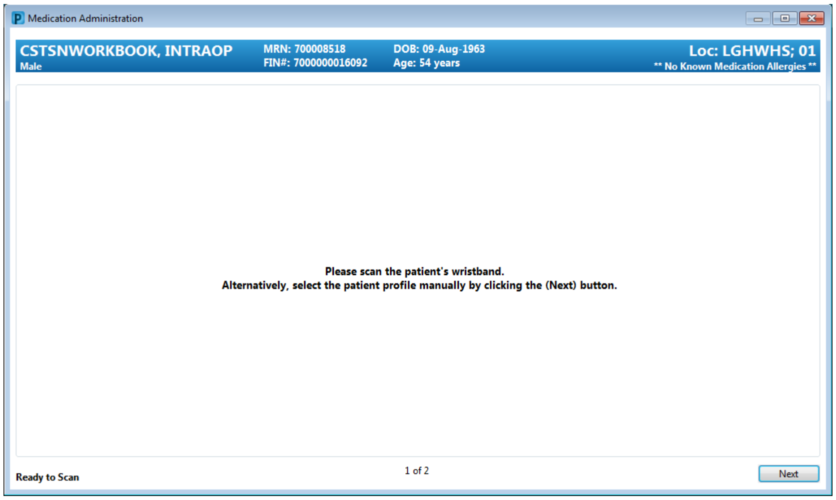
2 Administer **IV Cefazolin 1g**:

Review medication information in the MAR and identify medications that are due.

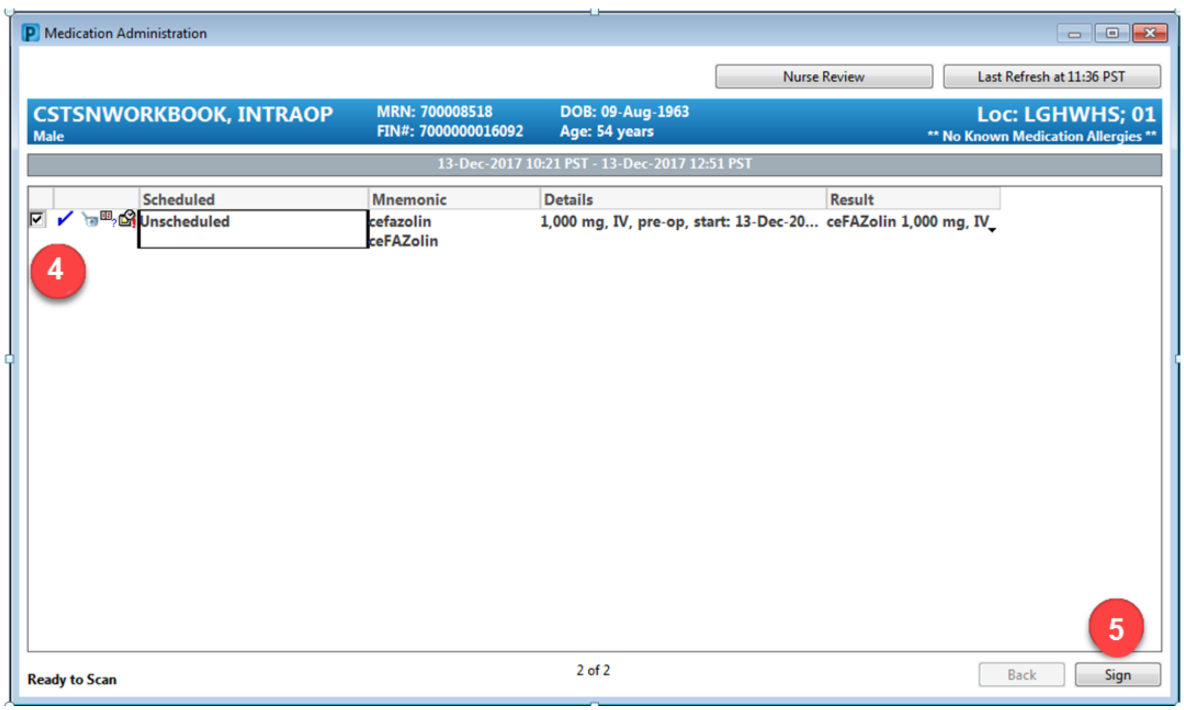


1. Click Medication Administration Wizard (MAW)  in the toolbar.

   - The **Medication Administration** pop-up window will appear.



2. Scan the patient's wristband. It will now display the medication that you can administer.
3. Scan the barcode for **Cefazolin 1 g IV**. The system will select the medication that was just scanned.



4. A check mark and a blue check mark will now appear beside the **Cefazolin** in the Results column.
5. Click **Sign**
   - Now that you have scanned the patient and scanned the Cefazolin, you would complete your medication checks and administer the medication. Assuming this is complete now you can sign for the medications administered.

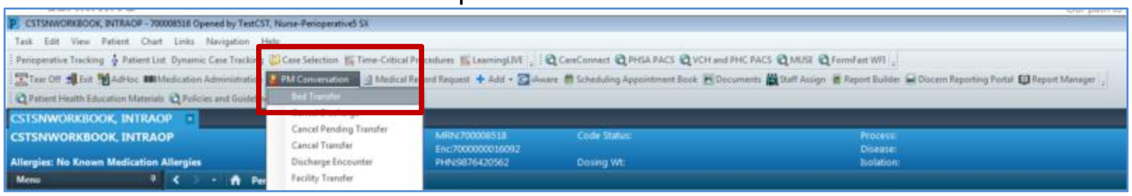
Key Learning Points

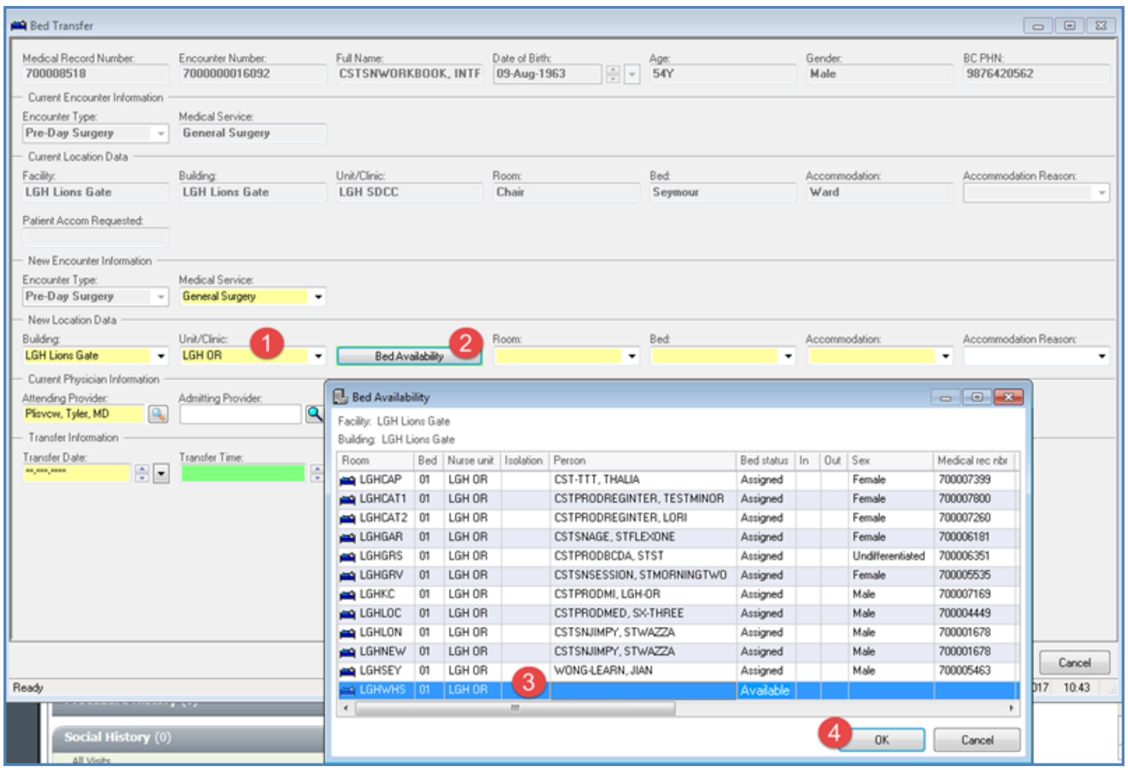
- Use barcode scanner to administer medications.
- Often, additional information will be required upon administration.

Activity 1.6 – Use PM Conversation to complete the Bed Transfer

1 Use PM Conversation to complete the bed transfer to the OR.

1. Click the arrow next to **PM Conversation** from the tool bar and Select **Bed Transfer.**
   - **Bed Transfer** window will open



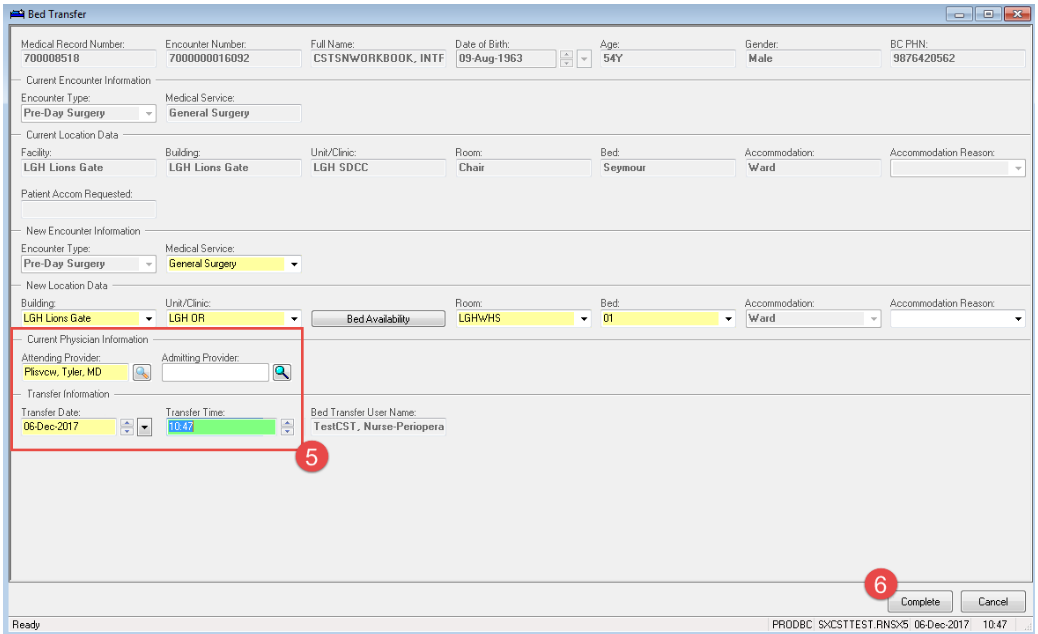


1. Click **Unit/Clinic** and select **LGH OR** from the list of options in the drop down list
   - The fields highlighted in Yellow are mandatory

2. Click Bed Availability
   - Bed Availability Window Opens

3. Click the appropriate room (e.g**. LGHWHS)** which has a status column as "Available"

4. Click **OK**
   - The **Room**, the **Bed** and **Accommodation** will all be auto populated



5. Complete the remaining fields:
   - Attending Provider: <Surgeon’s Name>
   - Transfer Date: <Enter Today’s Date>
     Hint: Typing “T” will auto populate the current Date
   - Transfer Time: <Enter Applicable Time>
     Hint: Typing “N” will auto populate the current Time

6. Click Complete

7. Click **Refresh** 

8. Verify that the he patient’s bed location is now displayed on Blue Banner Bar in the patient’s chart (i.e. has changed location).

Key Learning Points

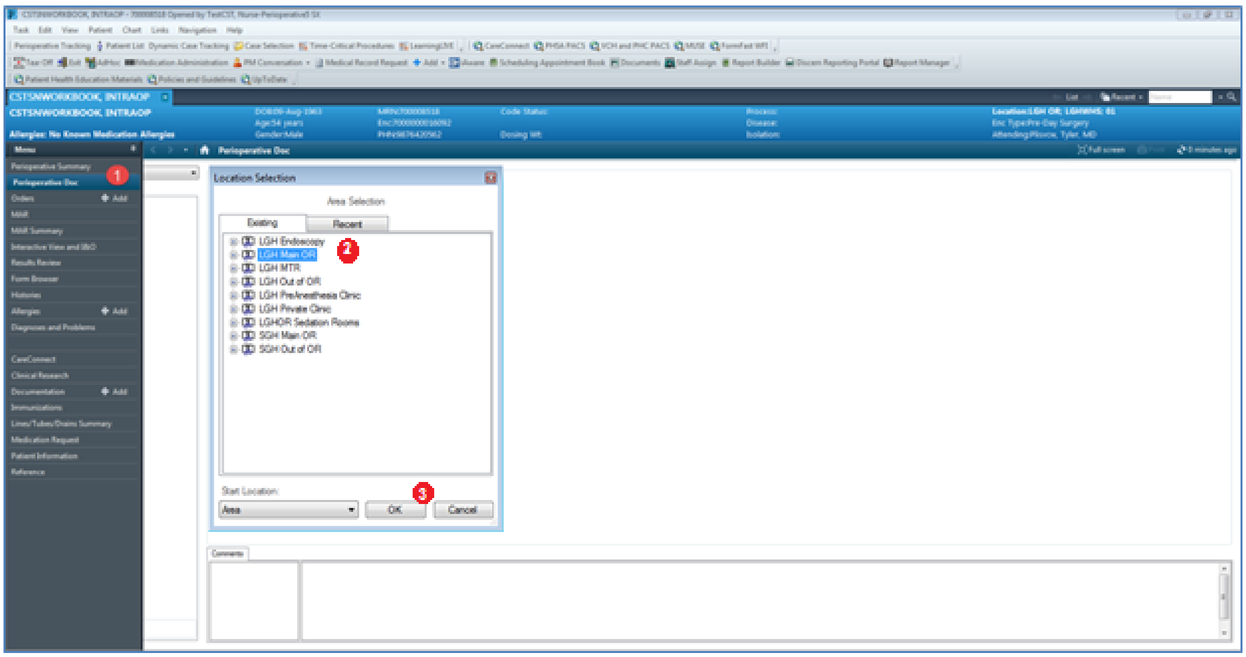
- The fields highlighted in Yellow indicate mandatory criteria that must be entered to proceed to the next step.
- Remember to select beds that show the status column as ‘Available’.
- Click Refresh icon to verify updated patient location.

Activity 1.7 – Complete the Surgical Case Check-In process

In this activity, you will complete the **Surgical Case Check-In**. The Surgical Case Check-In is not equivalent to the patient check-in process completed in Activity #1.4. Surgical Case Check-In is a term used to define the process of obtaining **access** to Perioperative Documentation.

1 Completing the Surgical Case Check-In process

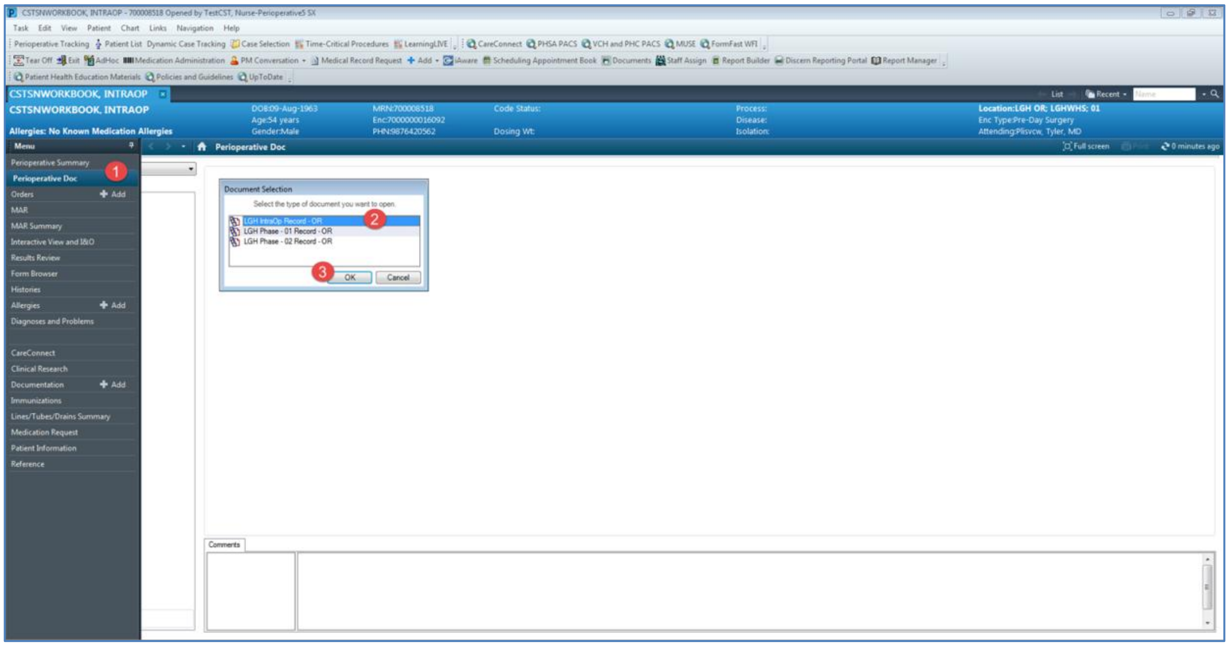
Note: This step should not occur until the patient is physically present in the OR room to begin the procedure. Once the Surgical Case Check-In is executed, the Perioperative Documentation is made available.



1. Click on Perioperative Doc from the Menu
   Note: The very first time the user accesses Perioperative Doc, the Location Selection window pops up.

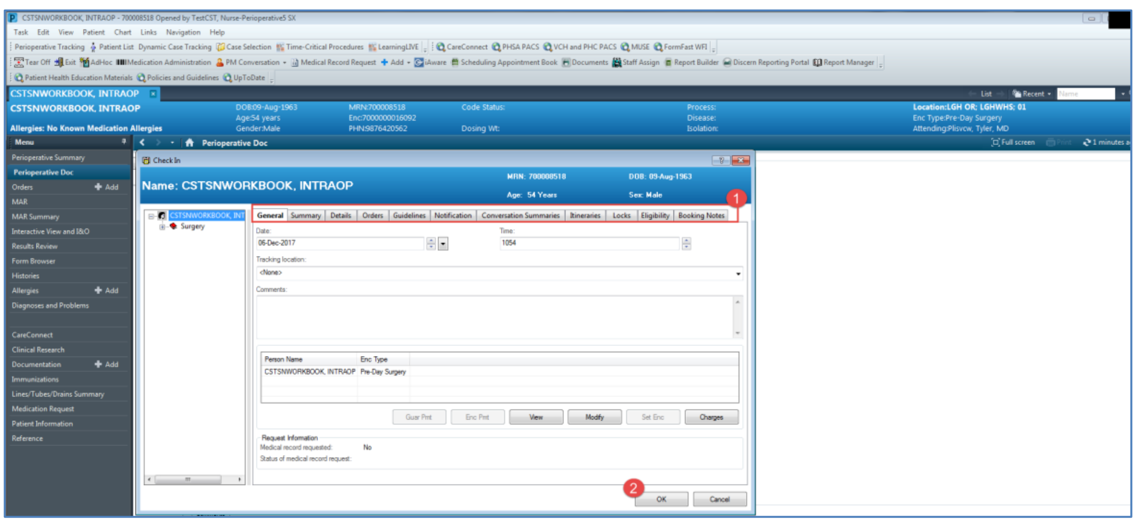
2. Select the **LGH Main OR**

3. Click **OK** to close this window

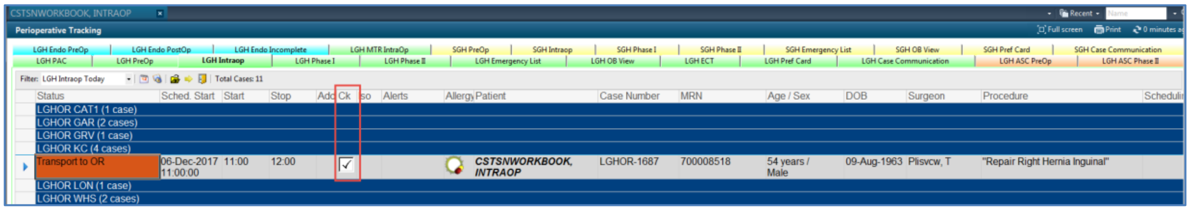


After the first login, clicking on Perioperative Doc will open:

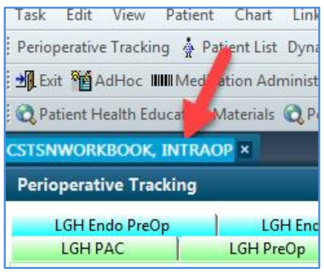
1. The **Document Selection** window
2. Select the **LGH IntraOp Record – OR**
3. Click **OK**



1. The **Check-In** window will open.
2. Click **OK**



1. From the Toolbar, click on **Perioperative Tracking**; on the **LGH IntraOp** tab, the patient now has a check mark in the CK column.
2. Return to **Perioperative Doc** by clicking the name of the patient on top of the Perioperative Tracking header.



Key Learning Points

- Access to the IntraOp Record is dependent on the Surgical Case Check-In being completed.
- Navigate from Perioperative Tracking back to the patient chart by clicking the tab with the patient's name.

Activity 1.8 – Complete the Perioperative Documentation

1 **Overview of Perioperative Documentation – IntraOp Record**

Perioperative Documentation – IntraOp Record is used for documentation during surgery.

The IntraOp record is designed to be comparable to the current paper record/documentation. Each segment represents a section of the paper record (e.g. Case Times, Case Attendees, Patient Positioning, Skin prep, etc.).

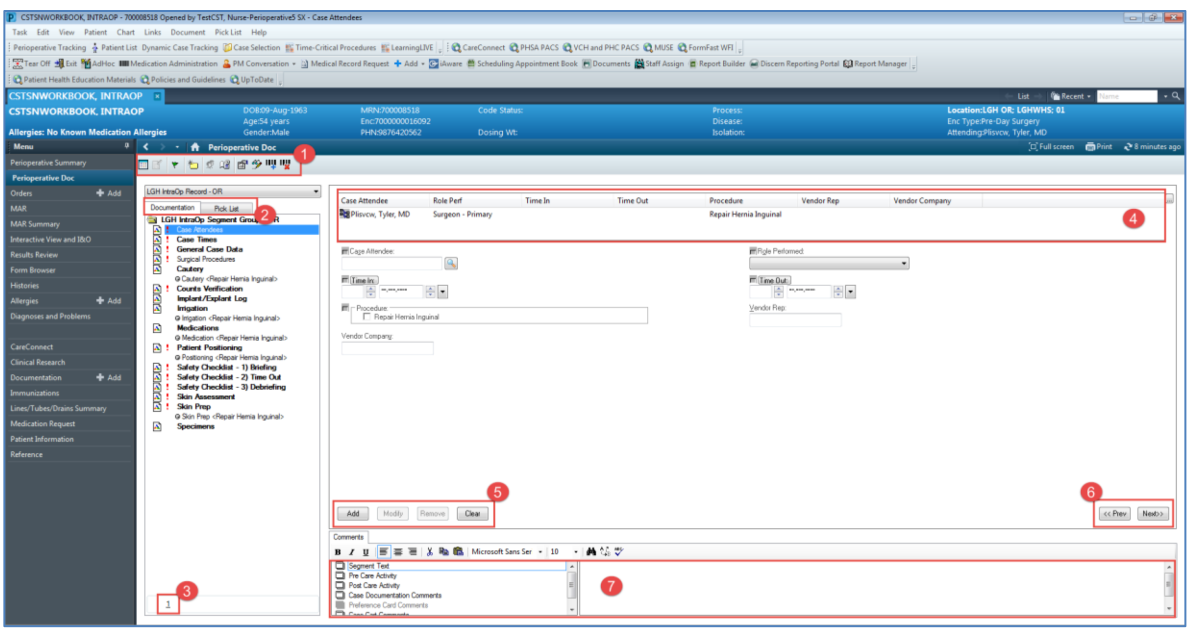
The segments available on the IntraOp Record will be specific to the operative procedure and surgeon.

Note: It is possible to add or discontinue segments as required – this will be covered toward the end of this activity.

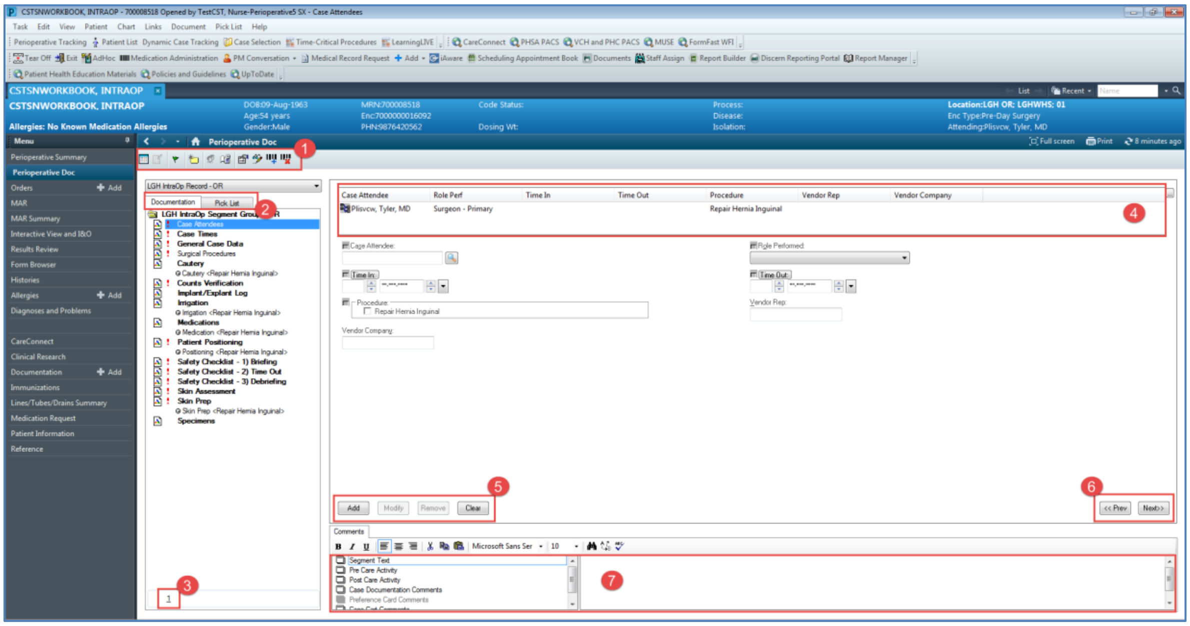
2 **Overview of Perioperative Doc – IntraOp Record screen**

Note: Vertical Display of the computer monitor will allow viewing of a segment in one page. If the segment has a number of fields for data entry e.g. positioning segment, a horizontal monitor would display the segment as multiple pages rather than one.

The following is important information about the details within the segments in Perioperative Doc. As you work through the activities refer back to this page if needed.



1. **Icon Bar** – Icons for quick access information within the IntraOp Record e.g. Case Overview, Case Times. Segments, Bar Code Scanning, Finalizing the record



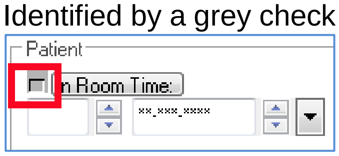
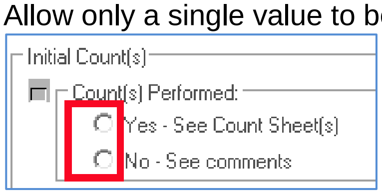
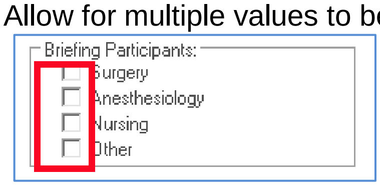
2. **Tabs – Documentation and Pick List**

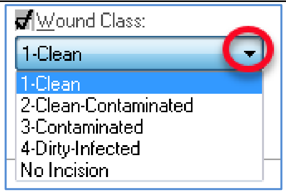
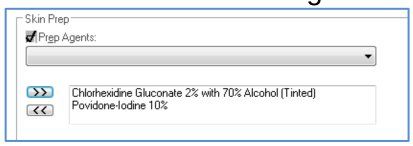
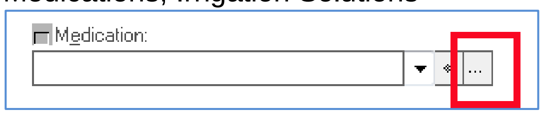
   - **Documentation –** Contains the IntraOperative segments to document care provided.
   - **Pick List –** Contains the Pick List where utilization of supplies and items are listed and usage documented

3. **Pages** – The number of pages within the current segment.
   Note: if the screen is in the vertical display, there should only be 1 page.

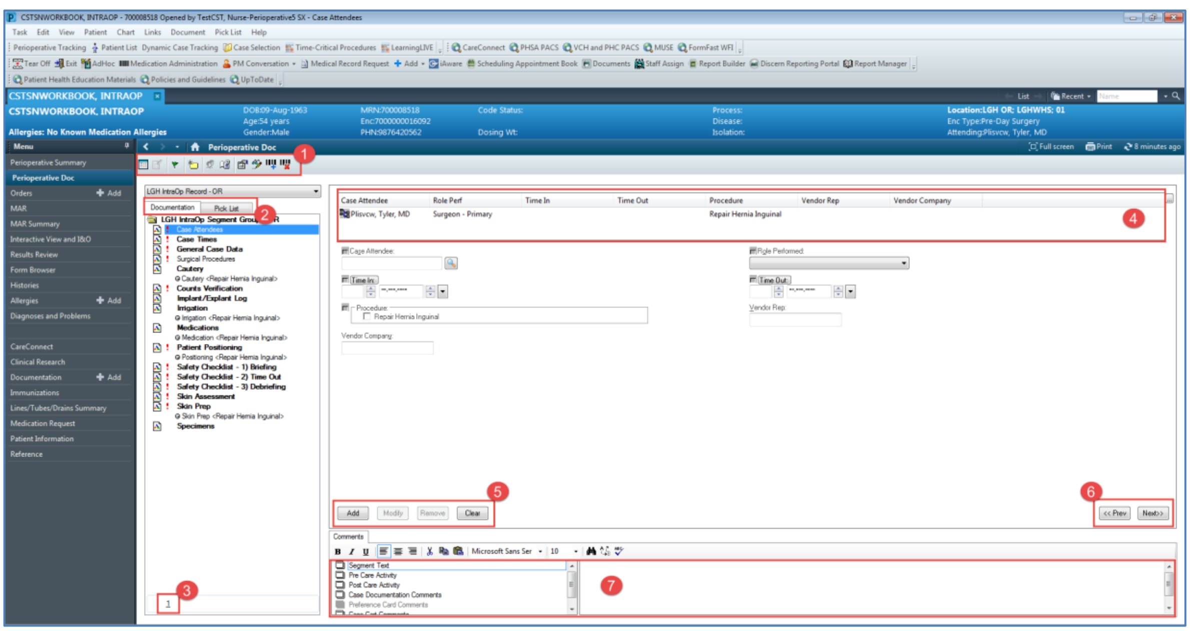
4. **Multi Entry Box –** The Multi-Entry box contains documented information. The column headings in the Multi-Entry box correspond to the metric details listed below it.

   The types of metrics/details may contain one or more of the following:

Required fields	Identified by a grey check box e.g. 
Radio buttons (circular)	Allow only a single value to be selected e.g. 
Multi-select (square) **boxes**	Allow for multiple values to be selected e.g. 
Drop down boxes	Contain a list of options – only one selection can be chosen e.g.

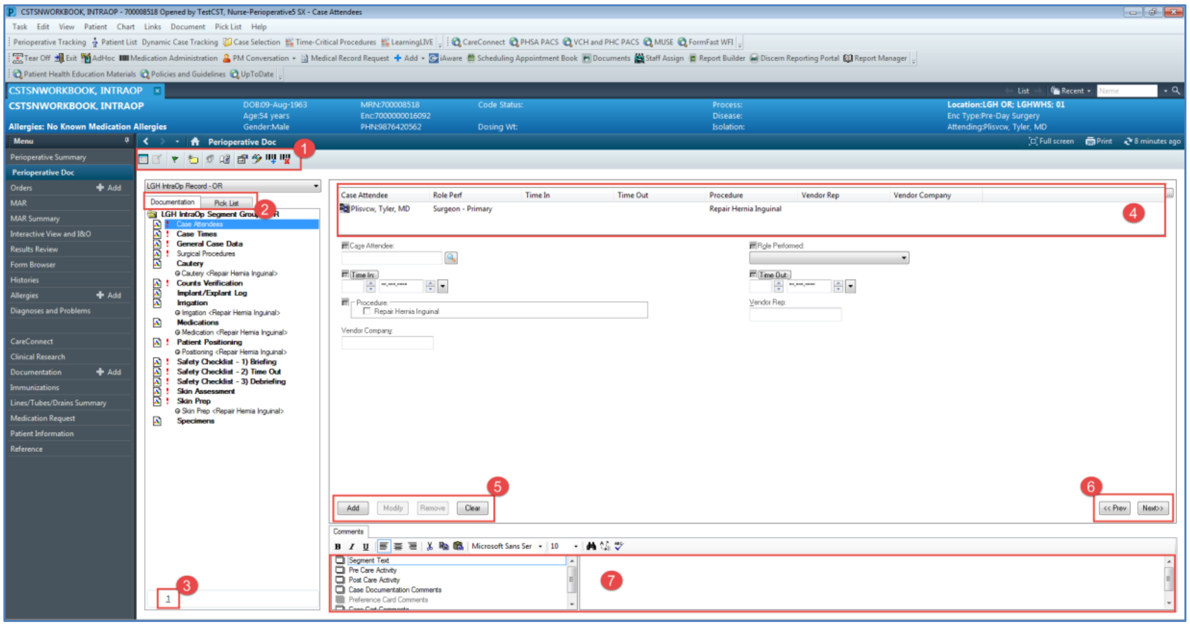
	
Drop down list selection boxes	Contain a list of options from a drop down box – multiple selections can be made. Clicking on the arrows will add or remove the selection e.g. 
Inventory Control Field	Contains an ellipsis button for searching Inventory items e.g. Medications, Irrigation Solutions 

Note: Fill in all fields within a segment prior to clicking the **Add** button, otherwise details will not display across under each column heading, but rather on separate lines in the Multi-Entry box.



5. **The Add** button, is used after metrics have been entered, and will populate the Multi-Entry box.

   The **Modify** and **Remove** buttons are used to perform those functions on entries listed in the Multi-Entry box (the entry must be highlighted and changes made prior to clicking these buttons). The **Clear** button will clear data entered into any field (prior to clicking **Add**).



6. **<<Prev and Next >>** buttons will move your documentation to the next segment (or if the monitor is in the horizontal view - the next page of a multi-page segment)

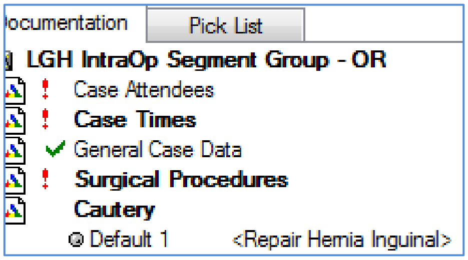
   Note: The sequence of segments was determined by design based on the procedure and workflow requirements*. **It is only a guide through documentation***.
   You will notice segments do not open based on the alphabetical sequence listed within the Documents tab. By clicking **Next** you may be returned to a previously opened segment (e.g. Case Times). Recognizing not all cases will have the exact same workflow; segments may be accessed manually at any time by clicking on the name of any specific segment.

7. **Comments** - This is a free text box area where additional notes can be typed.

   - **Case Documentation Comments** – clicking this folder and typing text here will allow the comments to be visible on all segments like your current Nursing Notes section on your paper chart.
   - **Segment text** – clicking this folder and typing text here will only show the comments on the current segment only.
   - **Preference Card Comments** – prepopulated information about the surgeon preferences for the surgical procedure.

Note: Items to remember while completing the IntraOp Record:

- Segments which have not been viewed will appear in **bold**.
- Segments that have been viewed but are not complete will not be bold.
- Segments with mandatory fields which have not been completed will appear with a ! beside it.
- Completed Segments: ✔ will appear beside the segment to denote that there are no deficits
- Any segment can be returned to by clicking on it.
- The document cannot be finalized unless all segments have been completed



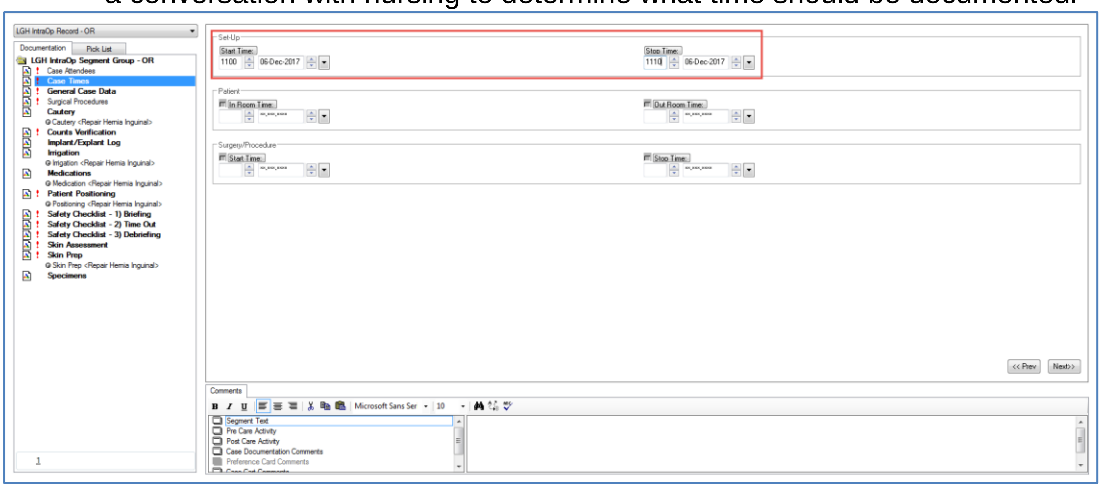
3 Case Times – Set-Up Start and Stop Times

Case Times is the first segment. The IntraOp Record defaults to this segment when opened.

- Set-Up Start and Set-Up Stop Times are listed first.

  Note: Not all Hospitals document these times – hence the times do not have a required field (grey check box indicates it is a required field).

- Certain case times such as Surgery/procedure Start/Stop time is also captured within **SA Anesthesia** (the Anesthesia documentation). As a result, the times captured between the 2 documents **must be in sync**. Any differences will appear as an alert to the Anesthesiologist where they can accept to sync with nursing documentation or have a conversation with nursing to determine what time should be documented.



The current date is documented as soon as the time field is clicked. A modification to the current date is possible by clicking the arrow for a calendar view or manual entry.

The current time will also be documented when the time field is clicked. (You do not have to enter N for the current time). A modification to the currently documented time is possible by clicking the arrows for manual adjustment or manual entry via the keyboard.

1. Enter the following times:
   - **Set-Up Start Time** = Enter a time 30 min in the past
   - **Set-Up Stop Time** = *Enter at time10 min later than the Set-Up Start Time*
   - Click **Next**. The **Case Attendees** segment is displayed.

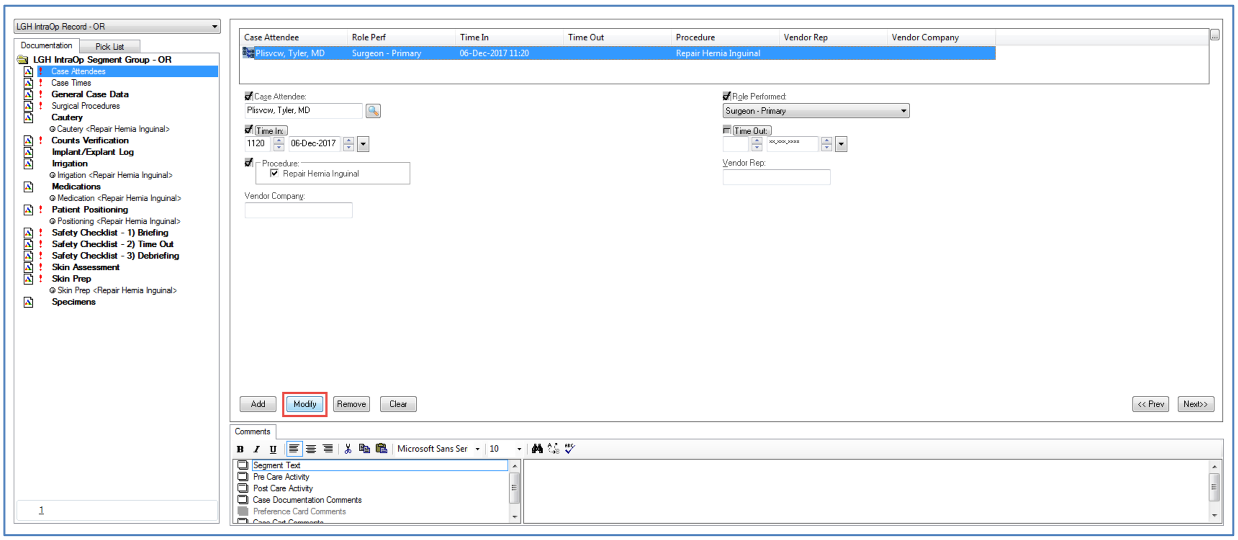
Note: The Case Times segment will appear at different points during the documentation process when the **Next button** is clicked, therefore the segment does not display a as the Case Times (e.g. Out Room Time) are complete.

4

Case Attendees

In the Case Attendees segment, document all personnel present, their role and their **time in** and **time out.**

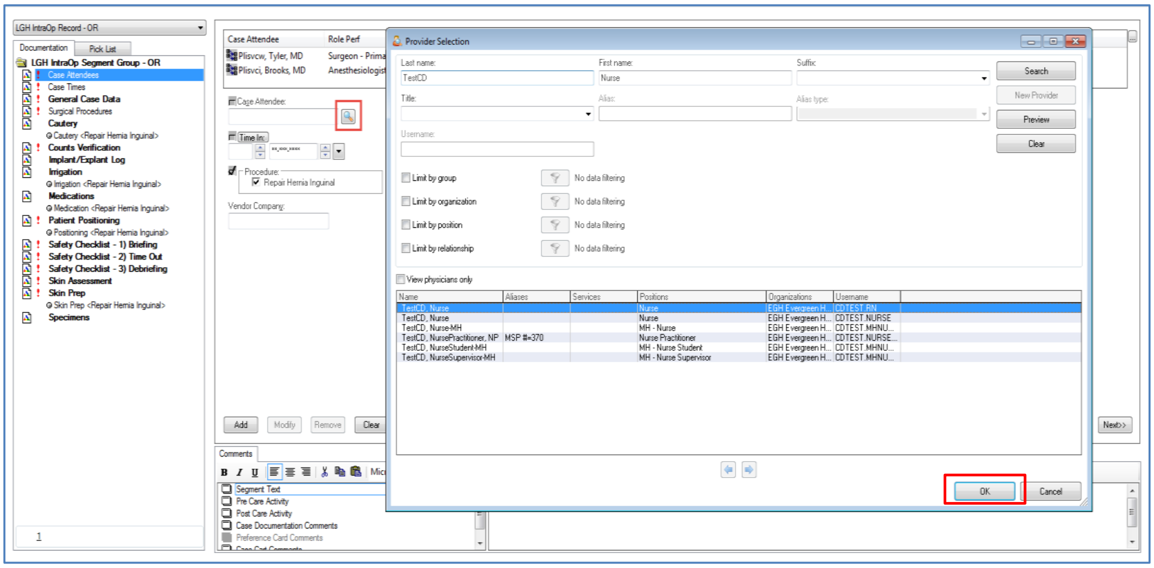
Within the segment for the Case Attendees, the Surgeon's and Anesthesiologist's name will be automatically populated from the patient records and from the booking/scheduling phase. Always validate this information, as errors or a change of surgeon is possible.



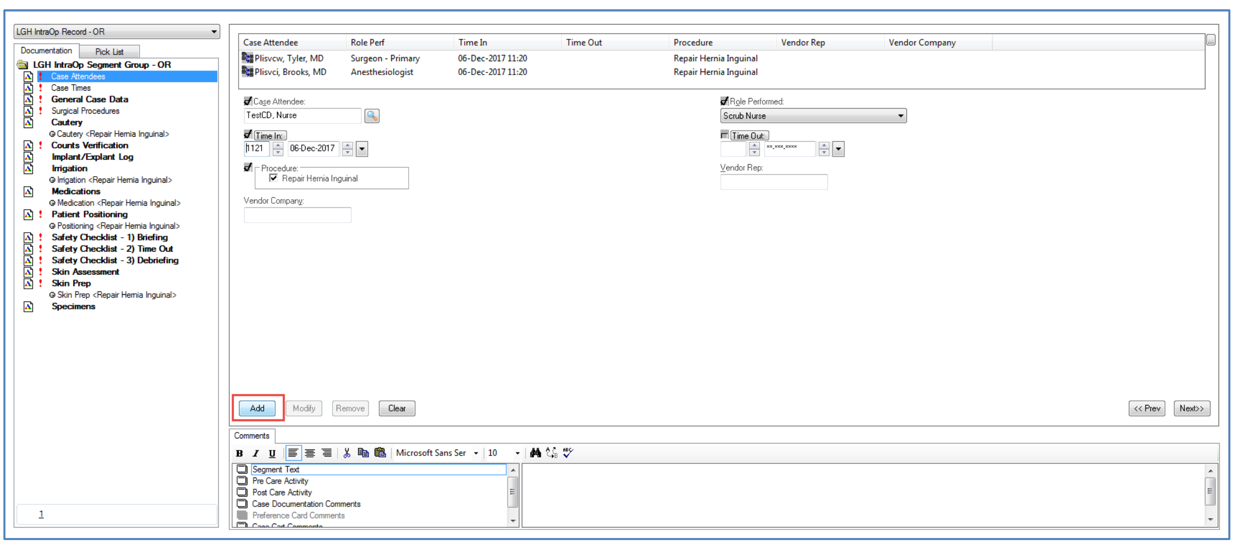
1. **Surgeon Information:**
    - **Click** on the Surgeons name from the Multi-Entry Box. The line will be highlighted. Some fields are autopopulated from case booking
    - **Case Attendee:** Verify the Surgeon
    - **Role Performed:** Verify *Surgeon Primary*
    - **Time In:** Autopopulated from Case Times Patient In Room Time. Review and adjust accordingly using the up or down arrows to modify the time if necessary.
    - **Procedure:** Verify the correct procedure
    - Click **Modify** Button

2. **Anesthesiologist Information**:
    - **Click** on the Anesthesiologist name from the Multi-entry Box. The line will be highlighted.
    - **Role Performed** = Verify *Anesthesiologist*
    - **Time In**: Autopopulated from Case Times Patient In Room Time. Review and adjust accordingly using the up or down arrows to modify the time if necessary.
    - **Procedure:** Verify the correct procedure
    - Click **Modify** Button

Note: Attendees may be added, modified or removed.



3. **To add an Attendee** e.g. The Scrub Nurse
   - Click the magnifying glass icon
   - Enter Last Name: ***TestCD***
   - Enter First Name: ***Nurse***
   - Click **Search**
   - Select **TestCD, Nurse**
   - Click **OK**
   - Click the drop-down **Role Performed** select **Scrub nurse**
   - **Time In**: Review and adjust accordingly using the up or down arrows to modify the time.



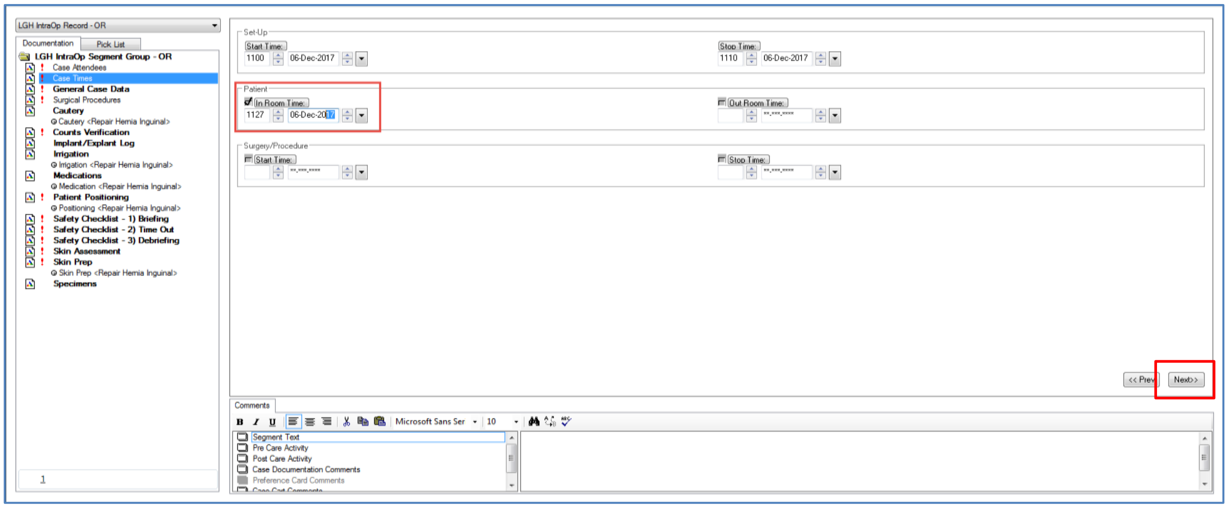
   - Click the **Add button**

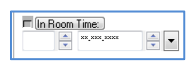
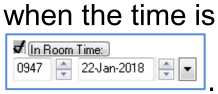
4. **To modify an entry on an Attendee**:
   - Click on the name of the Case Attendee from within the Multi-Entry box
   - The Multi-Entry box will highlight the details of the Case Attendee

- Update the information. In this case, modify the **Time in** = *click arrow to show time as 1 min earlier*
- Click **Modify** to update any of the information in the Multi-Entry box
- After adding the Case Attendee click **Next**. The **Case Times segment** is displayed.

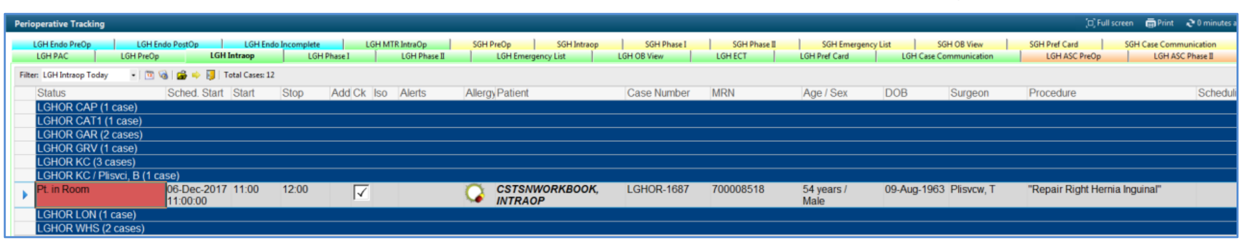
Note: The segment does not display a ✔ as the times (e.g. Time Out) for the Case Attendees are not completed.

5 Case Times – Patient in Room Time

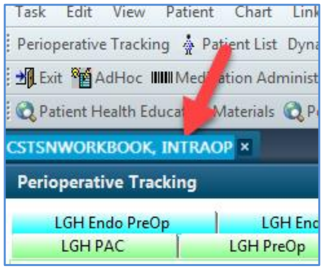


1. Enter the following Time:
   - **Patient in Room Time** = <Click Patient in Room Time> and update it to later than the Set-Up Stop Time.
   - This field has a grey check box indicating a mandatory field e.g.  – when the time is entered a 'Checkmark' appears indicating the field is complete e.g. .
   - Click **Next**

Verify Case Times entered updated on the patient's status on the Tracking View

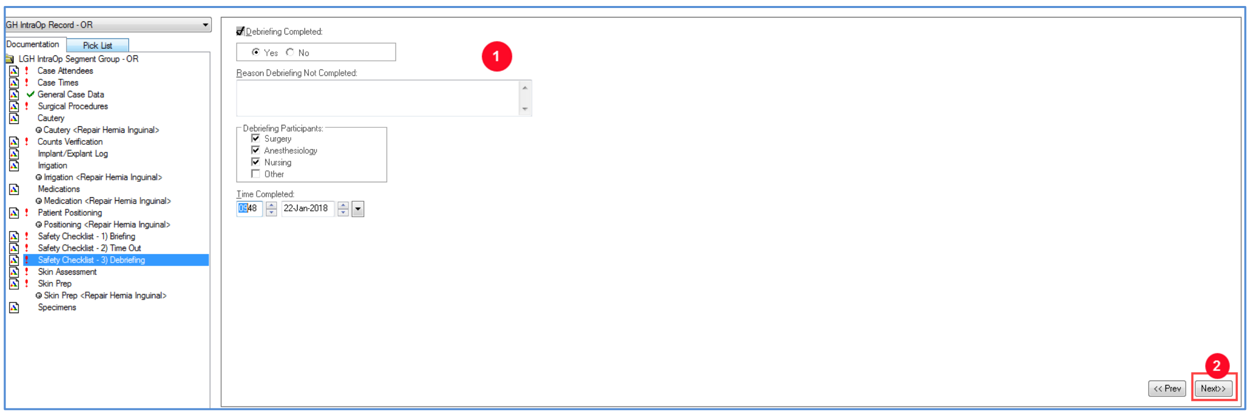


- Click on **Perioperative Tracking** button and navigate to **LGH IntraOp** Tracking View
- Note the change in patient status – **Pt. In Room**



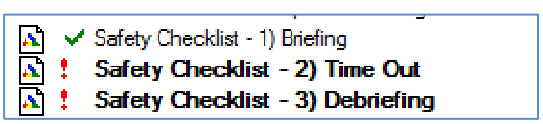
- Return to **Perioperative Doc** by clicking the name of the patient on top of the Perioperative Tracking header.

6 Safety Checklist – Briefing



1. Enter Briefing details:
   - Briefing Completed: *Yes*
   - Briefing Participants (click on multi-select buttons): click on *Surgery, Anesthesiology, Nursing*
   - Briefing Time/Date: Click either the Time Box or Date Box – Both the Current Time and Date appears automatically
2. Click **Next** button. The **Counts Verification** segment is displayed.

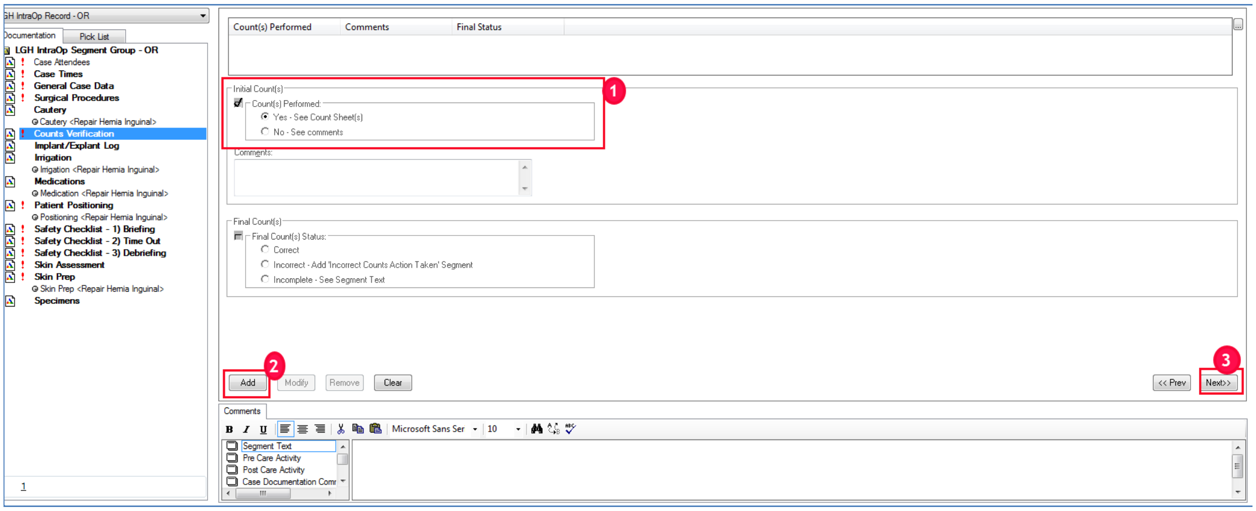
   Note: A **Green checkmark** icon appears next to **Safety Checklist – Briefing** indicating completion of the segment.



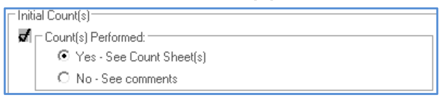
7 Counts Verification – Initial Count(s)

Count sheets will remain on paper and will be kept in the patient's paper chartlet.

The count sheet will be scanned into the electronic record upon discharge.

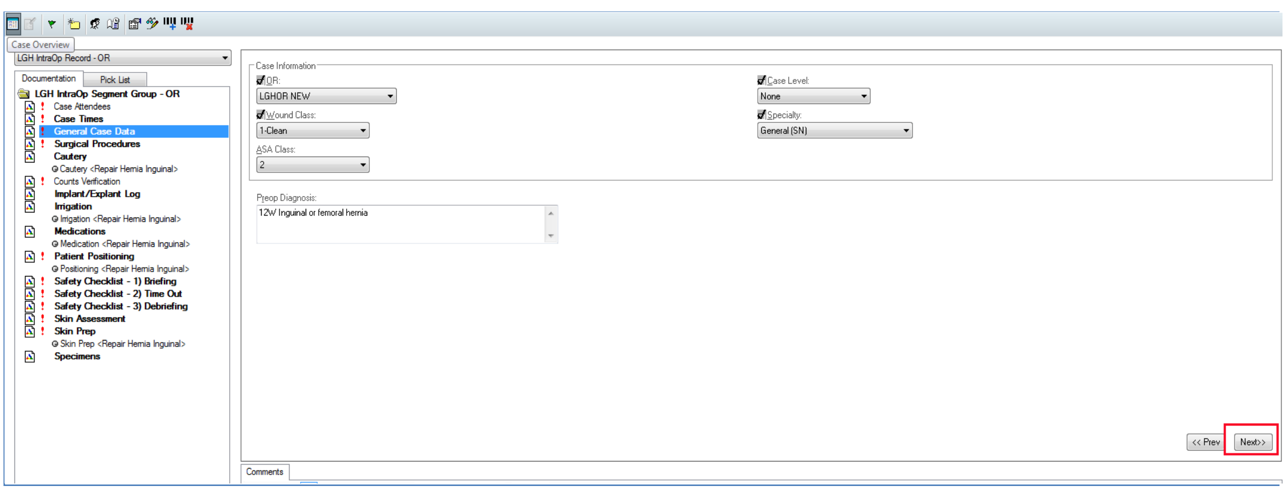


1. Click **Yes – See Count Sheet(s)** in the Count(s) Performed field.
    - A check mark appears on Count(s) Performed



2. Click the **Add** button. The Initial Counts entry will appear in the Multi-Entry box.
3. Click **Next**. The **General Case Data** segment is displayed.

8 General Case Data



1. Verify the information populated in each of the fields below:
    - **OR:** LGHOR
    - **Case Level: None**
    - **Wound Class:** 1 – Clean (Wound Class is prepopulated from the Procedure but may be modified)
    - **Specialty:** General (SN)

- **ASA Class:** (Note: This will pull in from SA Anesthesia (Anesthesia module) when the Anesthesiologists documents).
- **Preop Diagnosis:** May be populated from scheduling. This isn't a required field for Nursing to document.

2. Click **Next**. The **Surgical Procedures** segment is displayed.

Note: The **Green checkmark** icon that appears next to the **General Case Data** segment once you complete it.

Note: even though the segment is showing as complete the Wound Class may need to be modified at the end of the surgery, which is why it will display again.

9 **Surgical Procedures**

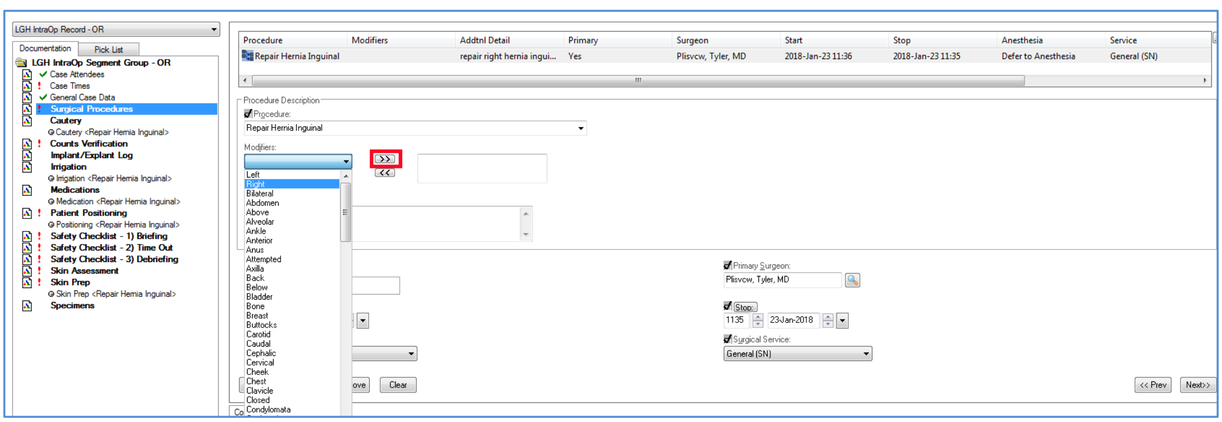
Drop-down List Selection fields

Similar to a drop-down box, this type of documentation contains a list to choose from. However, more than one option from the list can be selected.

Adding: Click >> to move the selected option to the document box (as highlighted in the picture below).

Removing: Options selected to be documented that are not appropriate can be removed by:

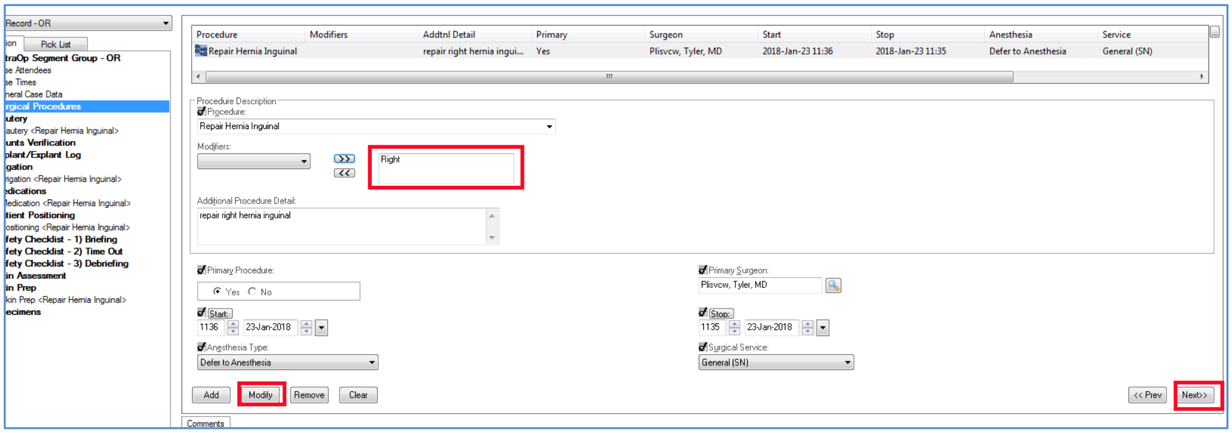
Select the option to be removed and click <<. Confirmation of the removal is verified from when the option is no longer visible in the document box.



Within the Multi-Entry Box

1. Click on the Primary Procedure – Information populates the fields.
   - Verify Surgical Procedure Information.
2. **Modifiers** = Select *Right* from the drop-down list and click >> to move the modifier into the window.

Note: If the modifier was entered during the scheduling process the modifier will already be displayed.



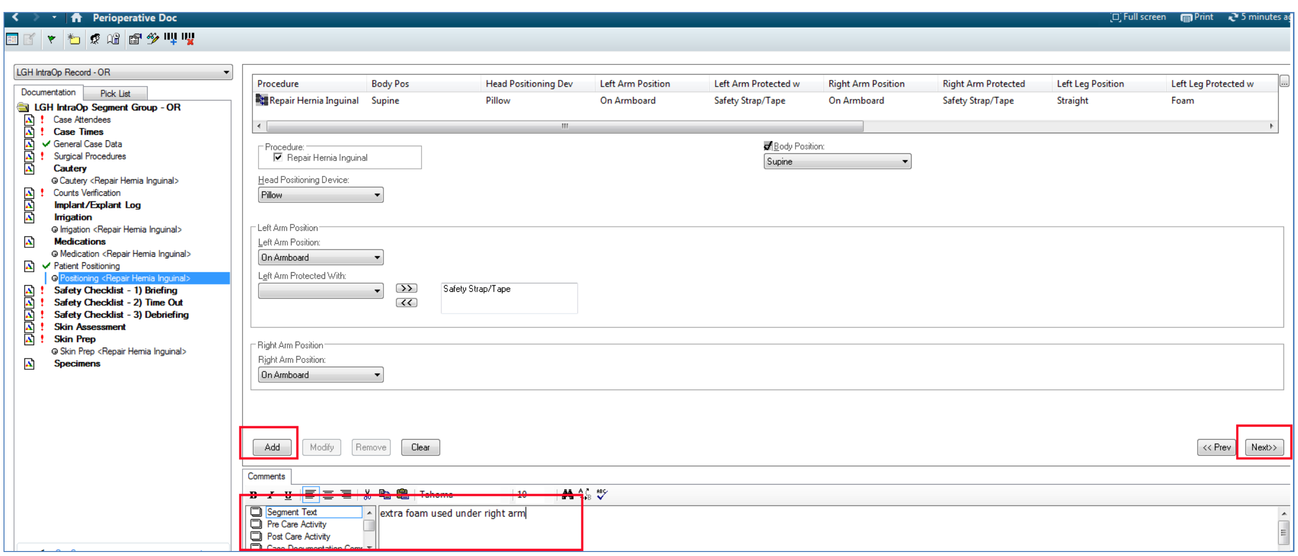
3. **Anesthesia Type** = *Defer to Anesthesia*
4. Click **Modify**
5. Click **Next**. The Patient Positioning Segment is displayed.

Note: The Start and Stop times on this page will be populated as the Case Times segment is updated. They can however be manually utilized if there are multiple procedures to show when each procedure started and stopped.

10 **Patient Positioning**

__Default Documentation__

This information assists in the speed/timing of documenting as segmental fields are “pre-filled”, but it **does not** however, replace your **nursing diligence and responsibility of verifying all the information is correct.**



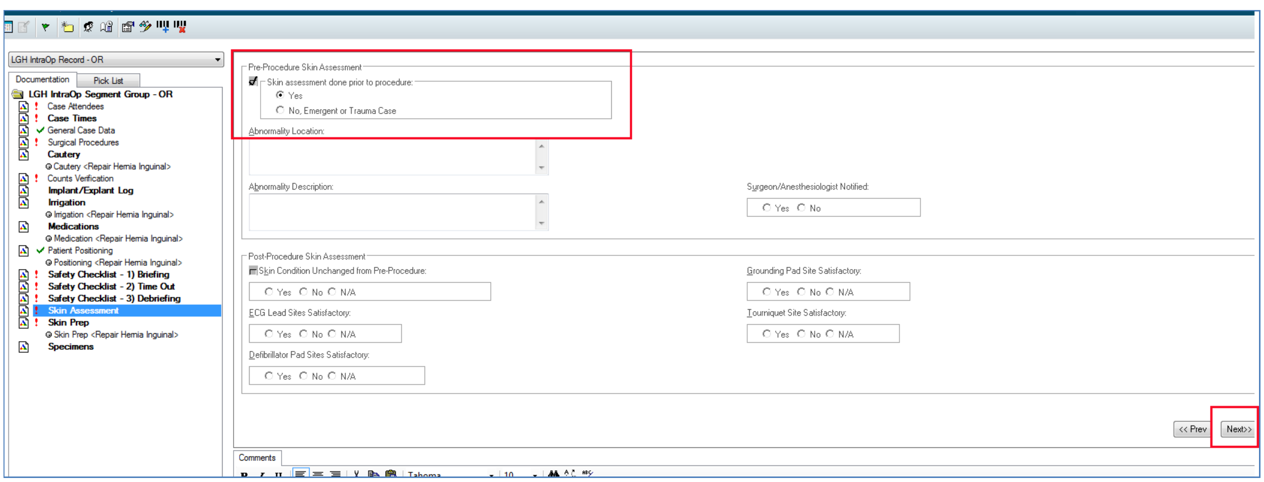
1. Click on **Positioning Default** below the Patient Positioning Segment
2. Verify the following information (make adjustments if information differs from Default)

- **Procedure** = *Repair Hernia Inguinal(Right)*
- **Body Position** = *Supine*
- **Head Positioning Device** = *Pillow*
- **Left Arm Position** = *On Arm Board*
- **Left Arm Protected with** = *Safety Strap/Tape*
- **Right Arm Position** *On Arm Board*
- **Right Arm Protected with** = *Safety Strap/Tape*
- **Left Leg Position** = *Straight*
- **Left Leg Protected** *with Foam*
- **Right Leg Position =** *Straight*
- **Right Leg Protected** *with Foam*
- **Positioned By** = *Defaulted to Surgeon Anesthetist and Circulating Nurse you can add others as necessary* (List populates from Case Attendees documented)

3. In the **Comments section**. Click on the **Segment Text** folder.
   Enter: *Extra foam padding used under right arm.* This segment text is now associated specifically for the positioning segment and is a useful tool if you cannot document something specifically within your segment.
4. Click **Add**. **Note:** If you Click **Next** before clicking Add, the **Add Entry to List Box** window will display, click **Yes**.
5. Click **Next**

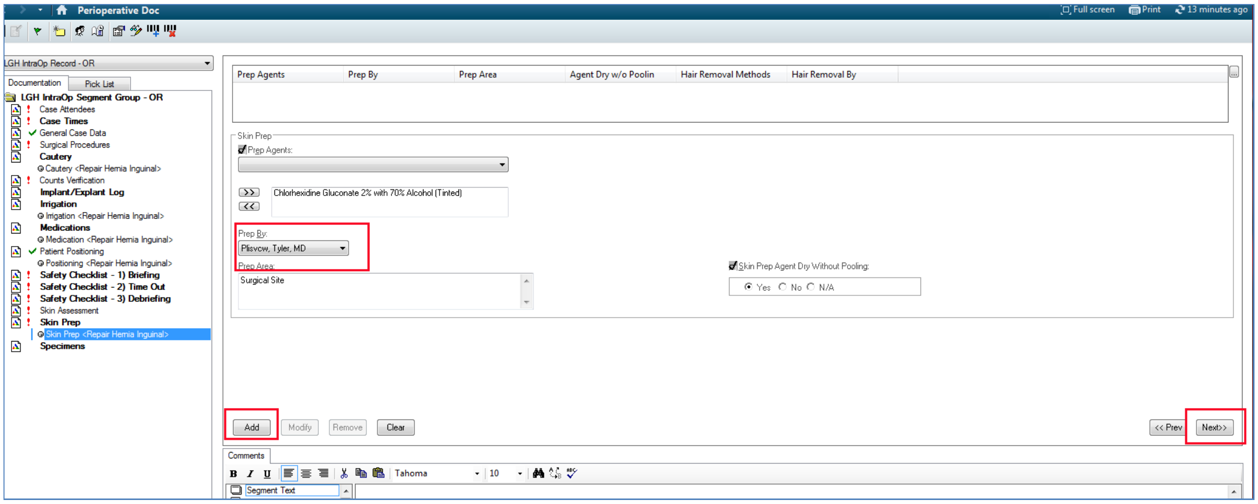
Note: the **Green checkmark** icon appears beside **Patient Positioning** and not the Default. The **Skin Assessment** segment is displayed.

11 Skin Assessment

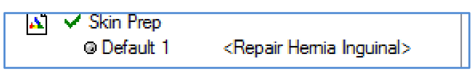


1. Click **Yes** for Skin assessment done prior to procedure.
2. Click **Next**
   The **Skin Prep** segment is displayed.

12 Skin Prep

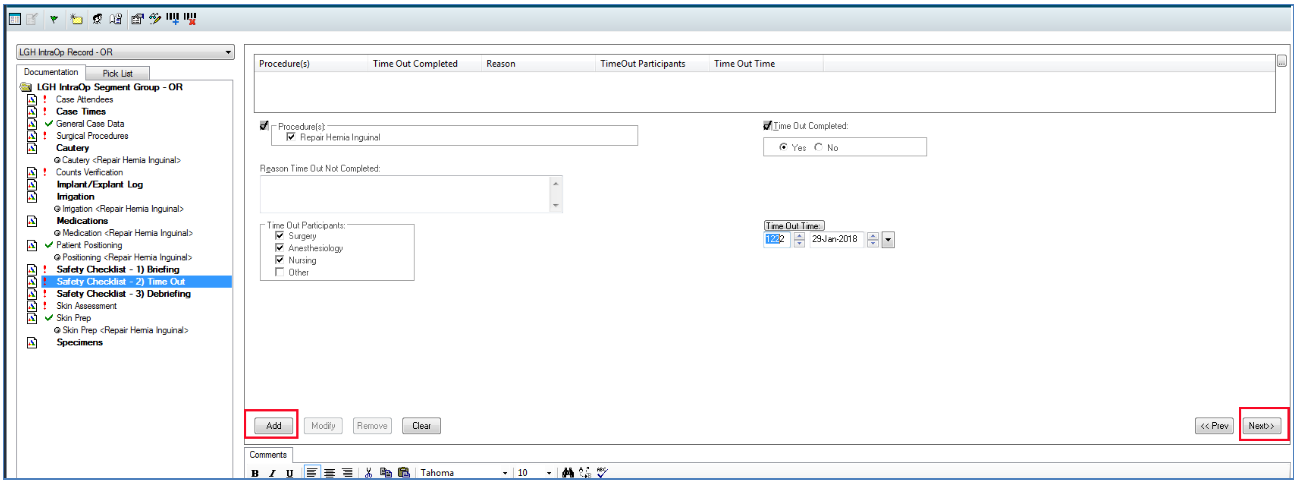


1. Click on **Skin Prep Default** below the Skin Prep Segment.
2. Verify the default information as shown below:
   - **Prep Agents:** Chlorhexidine Gluconate 2% with 70% alcohol (Tinted)
   - **Prep Area:** Surgical Site
   - **Skin Prep Agent Dry Without Pooling:** Yes
   - **Hair Removal Methods** : Clipper
     Hair Removal By: *Select from drop down of case attendees*
3. Click **Add**. If you Click **Next** before clicking Add, the **Add Entry to List Box** will display, click **Yes**
4. Click **Next**
   - The Skin Prep segment now displays a **Green checkmark** icon 



The **Safety Checklist – 2) Time Out segment** is displayed

13 Safety Checklist – 2) Time Out



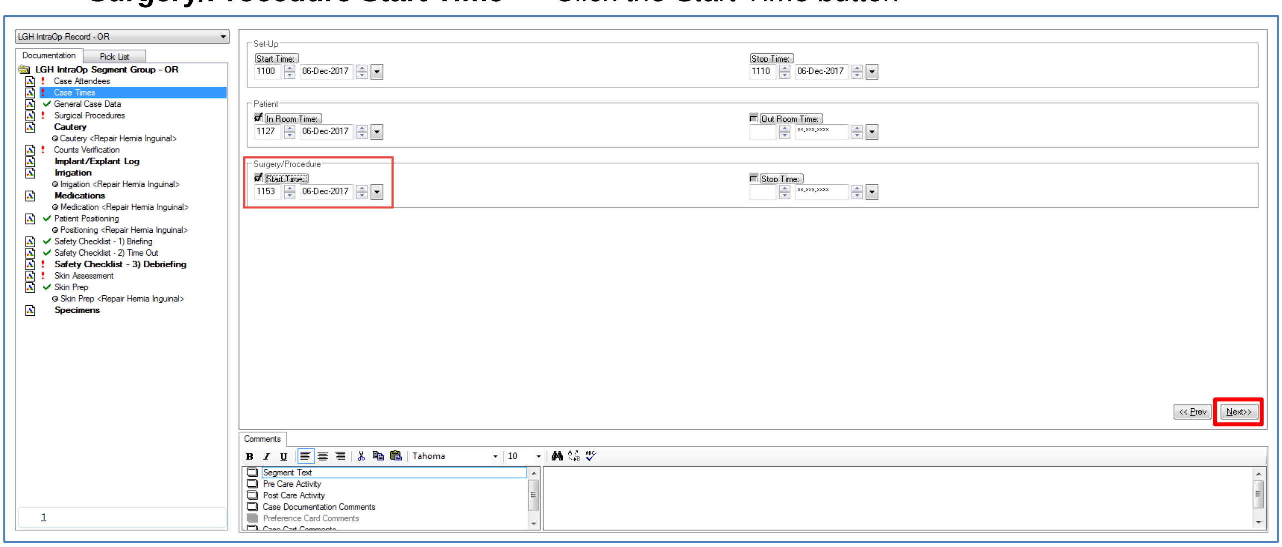
1. Enter the Time Out Information:
   - **Procedure(s)** = *Repair Hernia Inguinal (Right) Verify* correct procedure listed by clicking the checkbox.
   - **Time Out Completed** = Click *Yes*
   - **Time Out Participants** = Click *Surgery, Anesthesiology, Nursing*
   - **Time Out Time** = *<Click on the Time Out Time>*
2. Click **Add**
3. Click **Next**

   The **Case Times** segment is displayed

14 Case Times

1. Enter the Surgery/Procedure Start Time

   Surgery/Procedure Start Time= *<Click the Start Time button>*



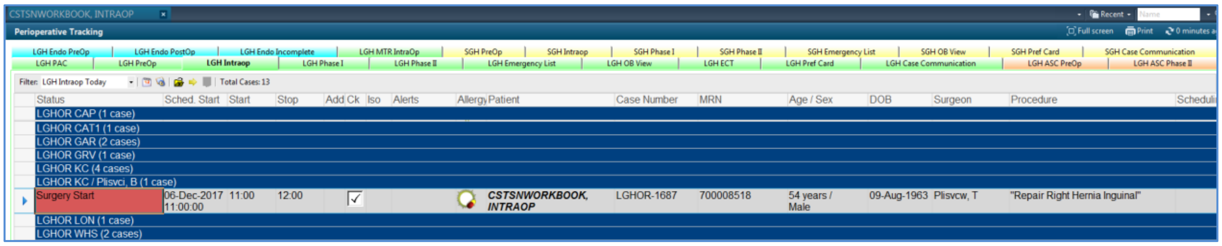
2. Click **Next**. The **Cautery Segment** is displayed

   Note: When Case Times are entered they will update the patient's status on the Tracking

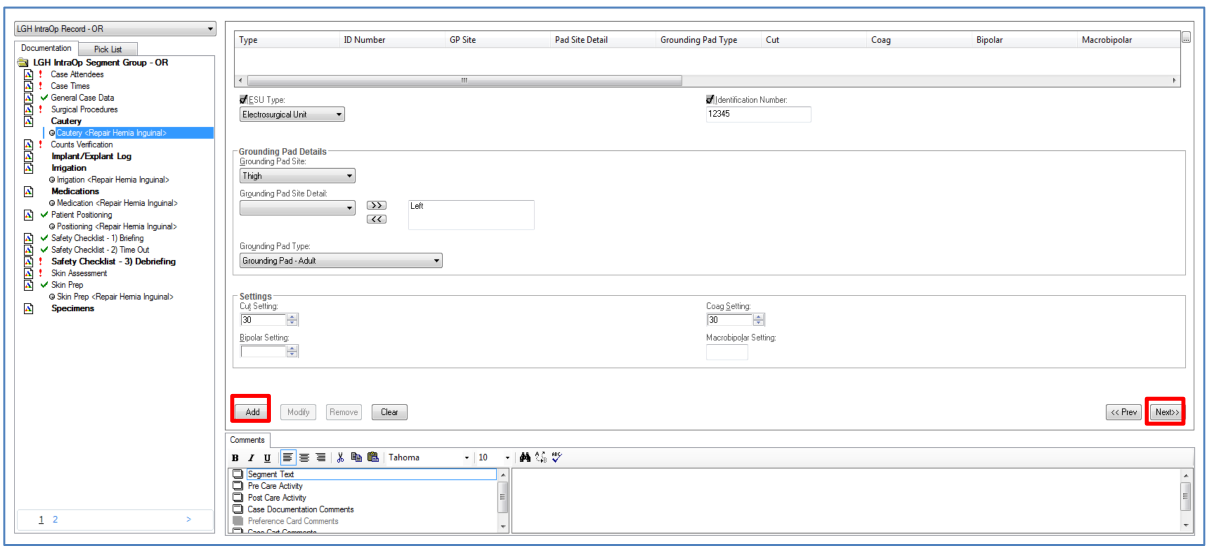
View

Click on **Perioperative Tracking button and navigate to LGH IntraOp Tracking View**

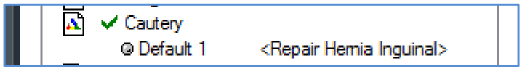
- Note the change in patient status – **Surgery Start**
- Return to **Perioperative Doc**.



15 **Cautery**

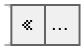


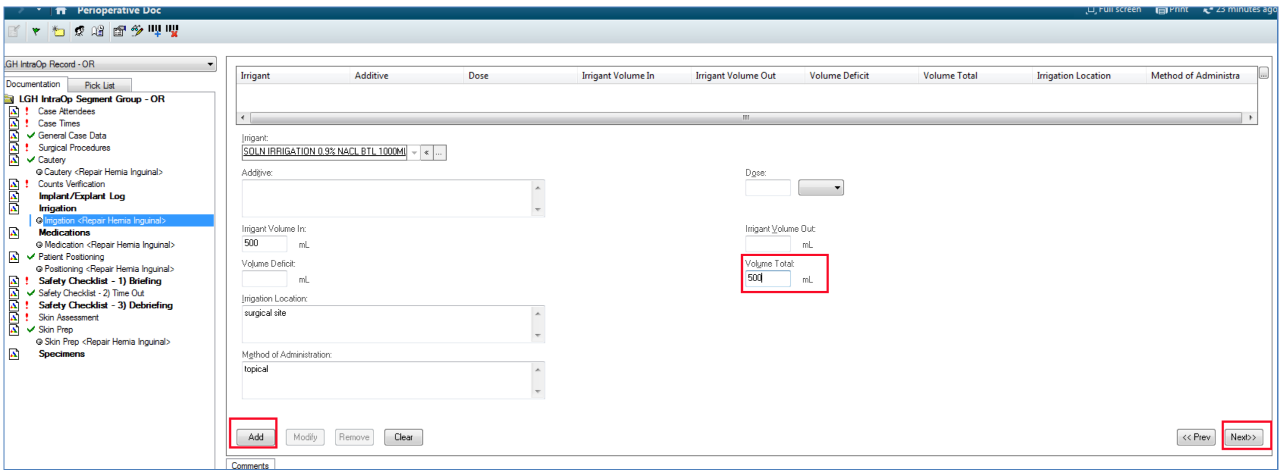
1. Click on **Cautery Default** below the Cautery Segment.
2. Verify the information:
   - **ESU Type** = Electrosurgical Unit
   - **Identification Number:** 12345
   - **Grounding Pad Site** = Thigh
   - **Grounding Pad Site Detail** = Left
   - **Grounding Pad Type** = Grounding Pad - Adult
   - **Cut Setting 30**
   - **Coag Setting 30**
   - **Smoke Evacuator Used** = Yes – Intermittent
   - **Smoke Evacuator Identification Number** = 12345
   - **Safety Holster Used** = ensure checkbox is Checked
3. Click **Add**. (**Note**: If you click **Next** before clicking Add the **Add Entry to List Box** will display, click **Yes**.)
4. Click **Next.** The **Cautery** segment now displays a **Green checkmark** icon .



The **Irrigation** segment is displayed

16 **Irrigation**

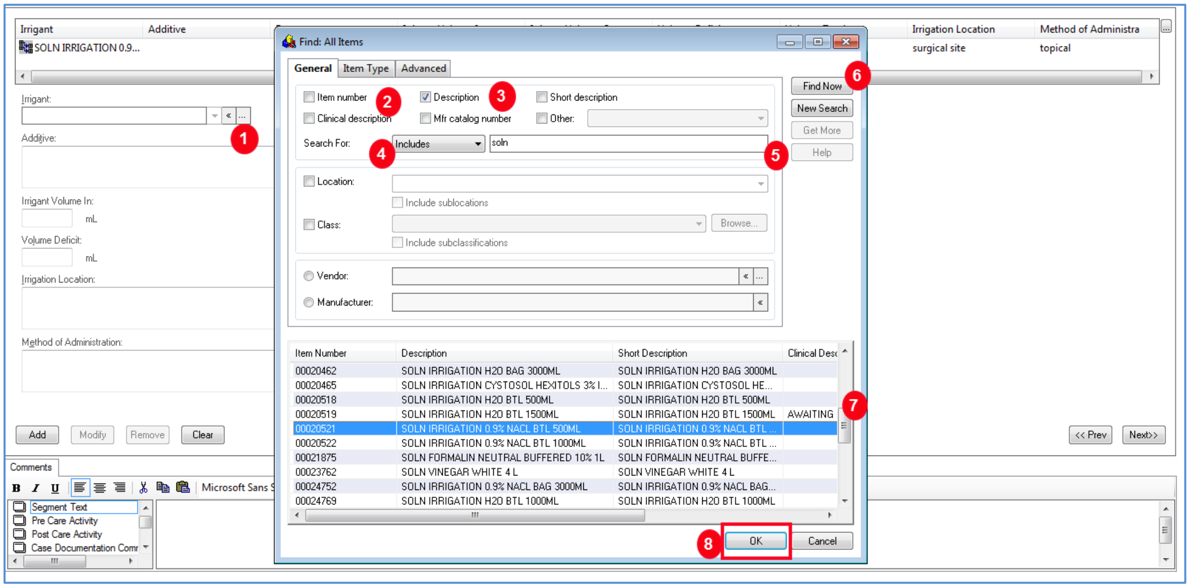
The **Find All Items**  is not specific to irrigation. This window will also appear when manually searching for medications, implants or additional supplies.



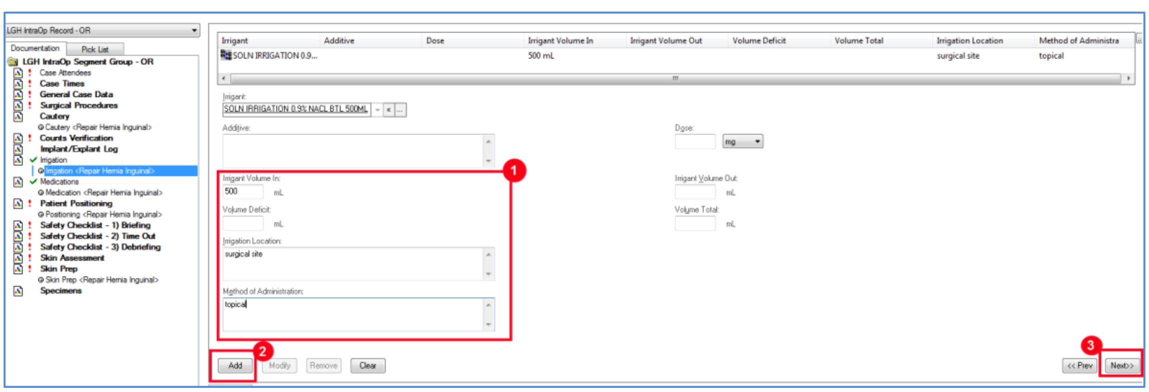
1. Click on the Irrigation Default below the Irrigation Segment.
2. Verify the information:
   - **Irrigant:** *Soln Irrigation 0.9% NACL BTL 1000ml*
   - **Volume Total:** *<**Enter** 500mls>*
   - **Irrigation Location:** *Surgical Site*
   - **Method of Administration:** *Topical*
3. Click **Add**

To add an Irrigant

If another Irrigation was used and there is no default for it. It can be added by:



1. Click on the **Inventory Control Field (ellipsis** …). **The Find: All Items** window displays.
2. Unselect Item Number
3. Select Description
4. From the drop down menu select Includes (Note: for future logins, steps 1-2 will not need to be completed once these settings have been applied).
5. In the Search For field type: *Soln*
6. Click **Find Now**
7. Scroll down and click to highlight: Soln Irrigation 0.9% NACL BTL 500ML
8. Click **OK**

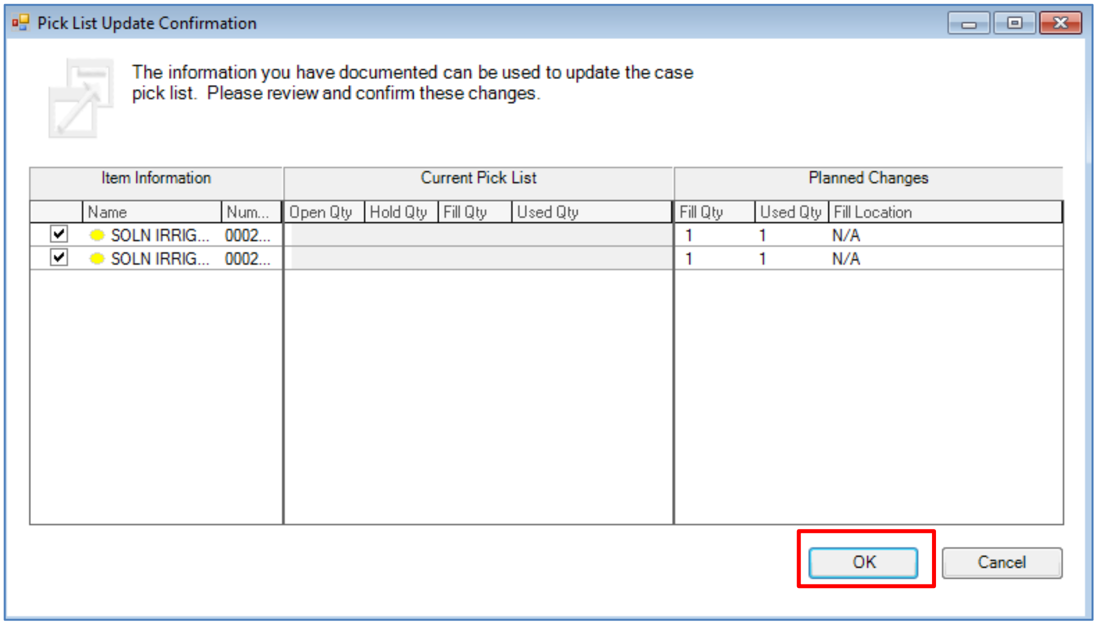


1. Enter the information:

- **Volume Total:** *<**Enter** 500mls>*
- **Irrigation Location:** *Surgical Site*
- **Method of Administration:** *Topical*

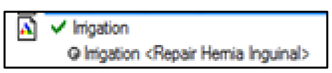
2. Click **Add**
3. Click **Next**

The Pick List Update Confirmation window opens.



4. Click Click **OK** to add to the items currently used on the picklist

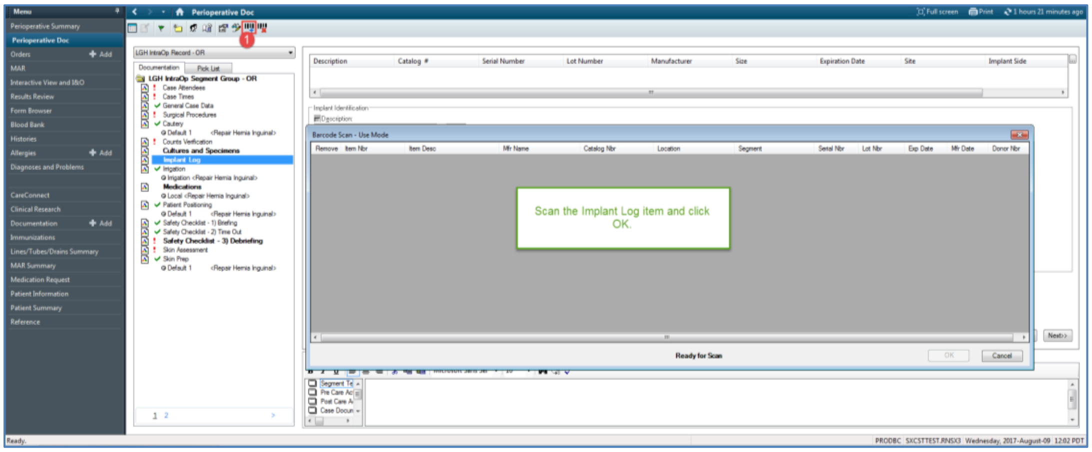
The **Irrigation** segment now displays a **Green checkmark** icon  .



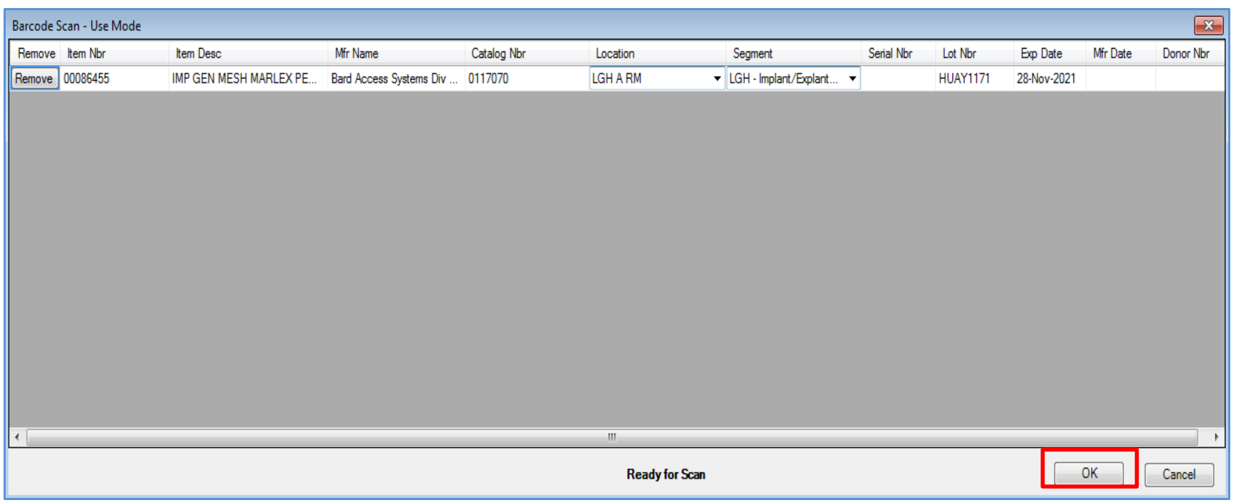
The **Implant/ Explant Log** segment is now displayed.

17 Implant/ Explant Log

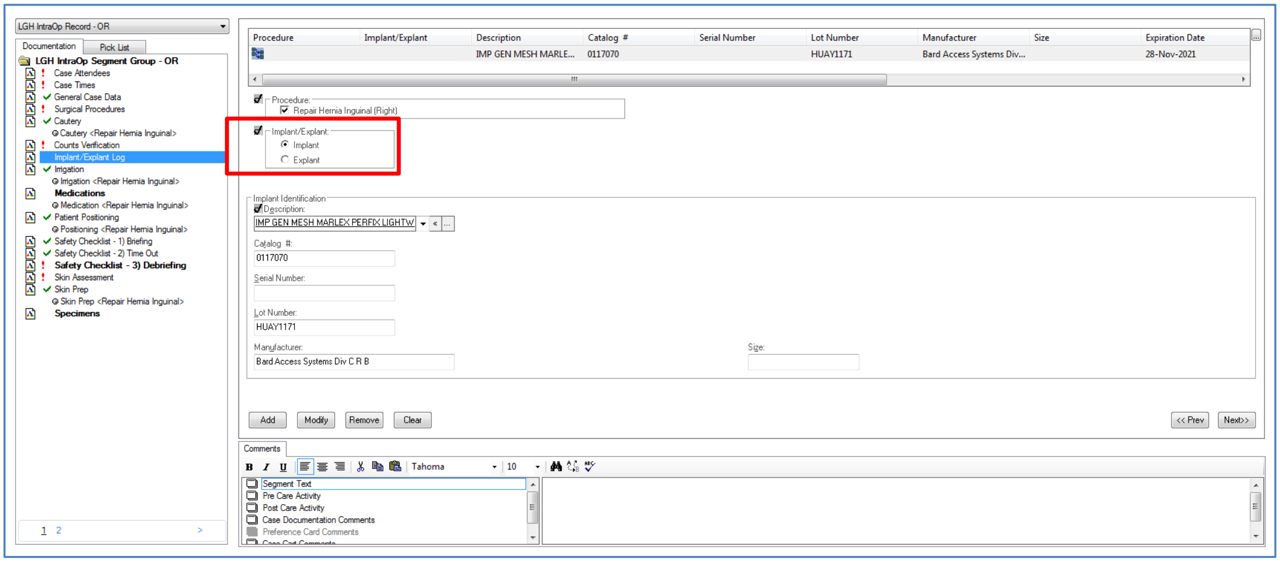
The paper Implant Log Record will be retained initially whilst scanning is being first implemented. If there are implant labels - and the implant is scanable - the labels should still be placed on the paper Implant Log.



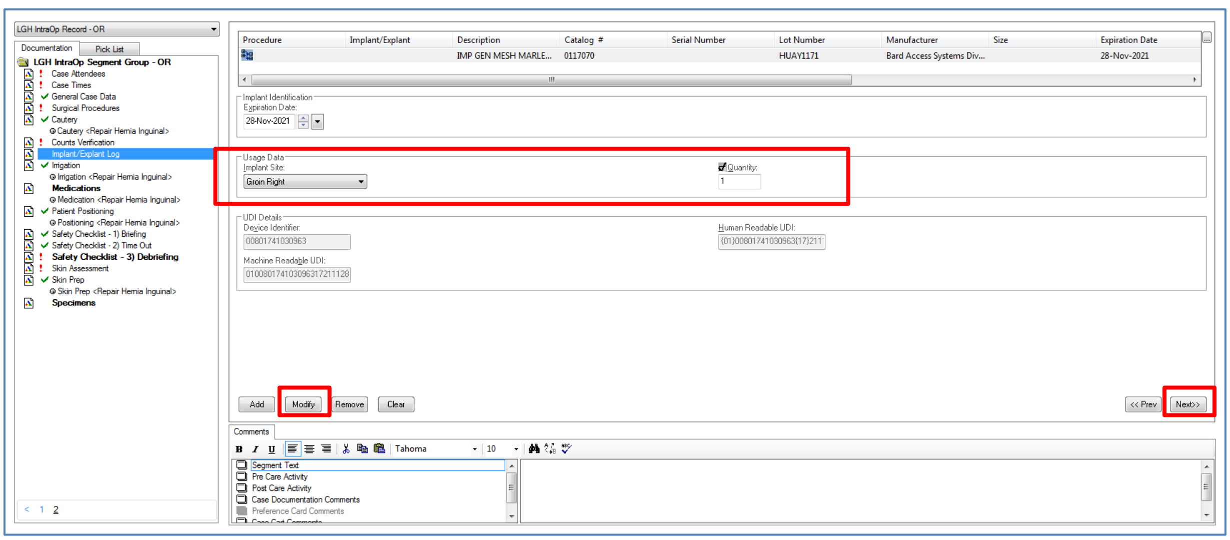
1. Click the **Barcode Scan - Use Mode** icon from the Icon Bar as shown in the above screenshot
2. Scan the Implant Barcode using a Barcode scanner.
    - The scanned information will display in the **Barcode Scan - Use Mode** window



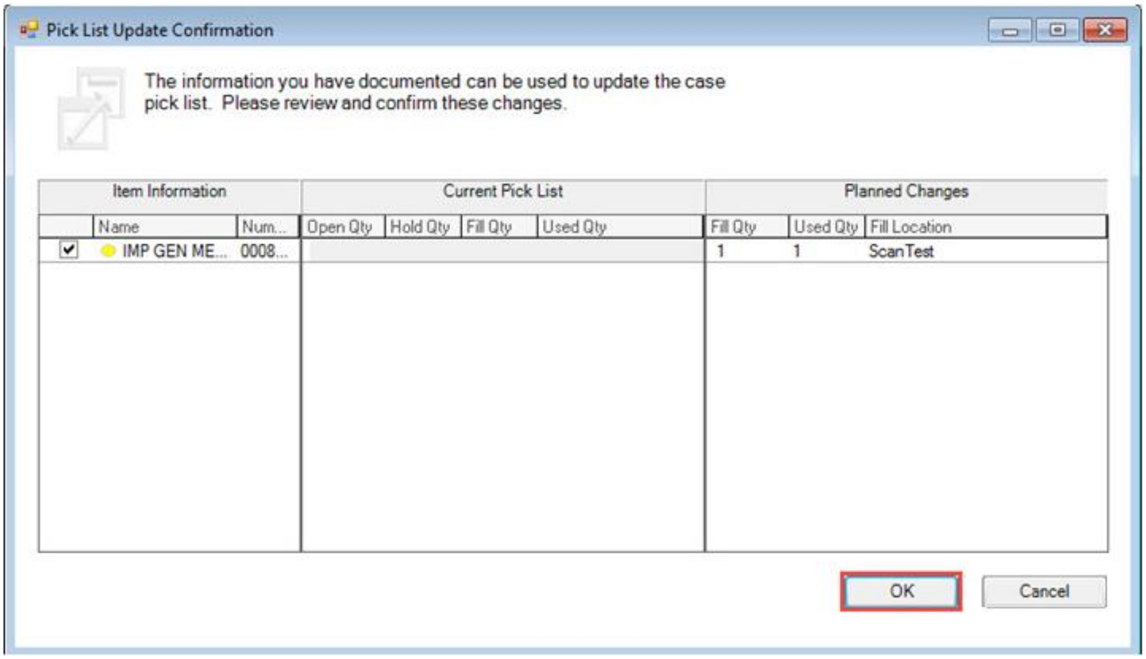
3. Click **OK**



4. Click on the Implant/Explant Log Segment
5. Select the Scanned Implant from the Multi-Entry Box:
6. Verify the information in the Implant Identification fields
7. Click the Implant radio button in Implant/Explant Field

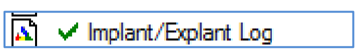


8. Enter the following data in the Usage Data Field:
   - **Implant Site:** Select **Groin Right** from the drop-down
   - **Quantity:** Type *1*
9. Click **Modify**
   Note: Click Modify not Add as data entry is being modified to the an existing entry.
10. Click **Next**
    - The Picklist Update Confirmation window opens.



11. Click **OK**.
    Note: Clicking OK adds the implant to the current case picklist. By performing this step, this does not mean that the implant is added to the Preference Card.

The **Implant/ Explant Log** segment now displays a **Green checkmark** icon  .



The **Specimens** segment now displays.

18

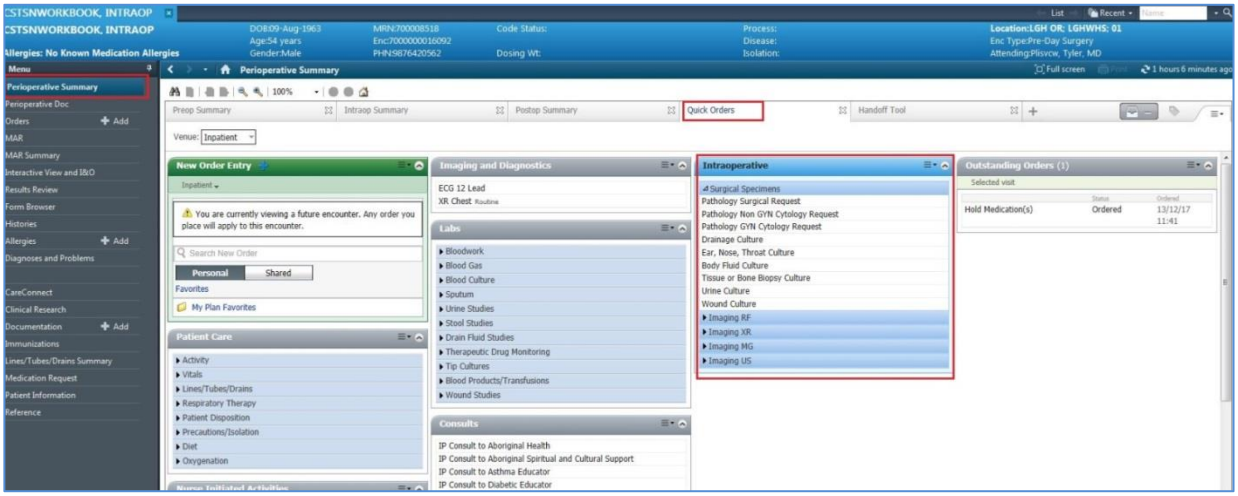
Specimens

During surgery if the surgeon requests an order for pathology, the Intra operative nurse will have to place an order and complete the requisition. To do this, the nurse will need to place an Adhoc order.

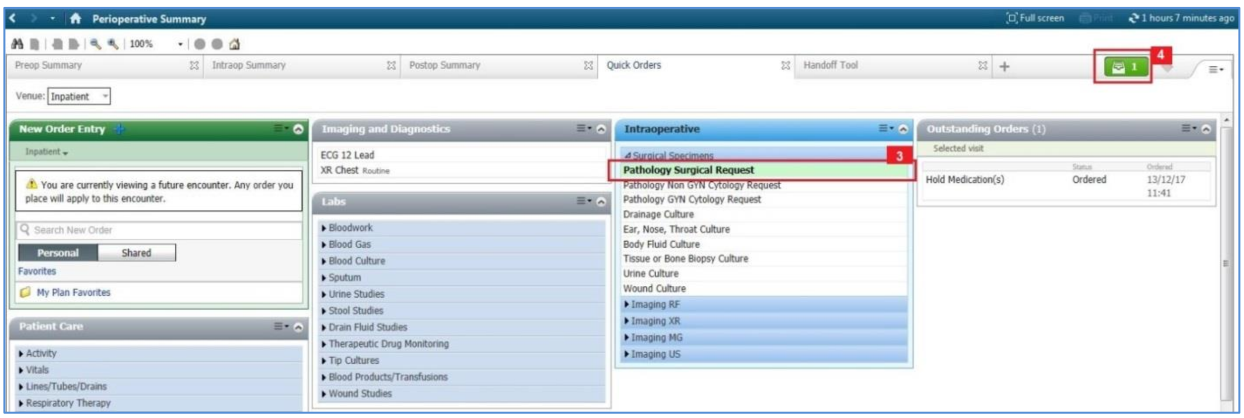
Specimen labels can be printed in the Operating Room or may come with the patient.

Aside from the requisition and order, the **Specimens Segment** within the IntraOp Record will require documentation also.

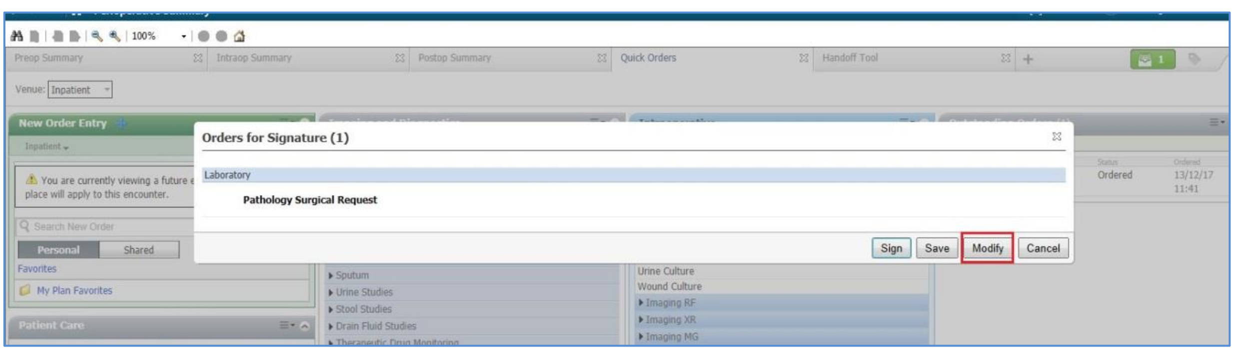
To place a Pathology Specimen Adhoc Order :



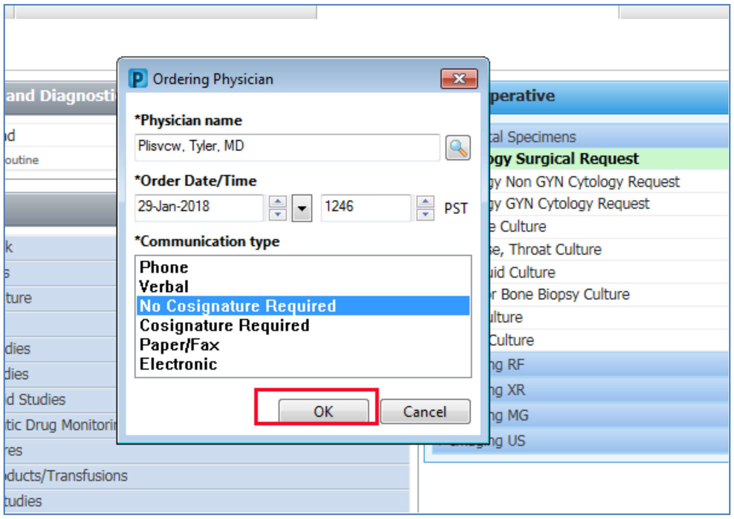
1. Navigate to the **Perioperative Summary** page
2. Click on **Quick Orders** tab



3. In the Intraoperative component click on Pathology Surgical Request.
4. Click on the **Orders for Signature** icon.



5. Click **Modify**.
    - The Ordering Physician window appears.

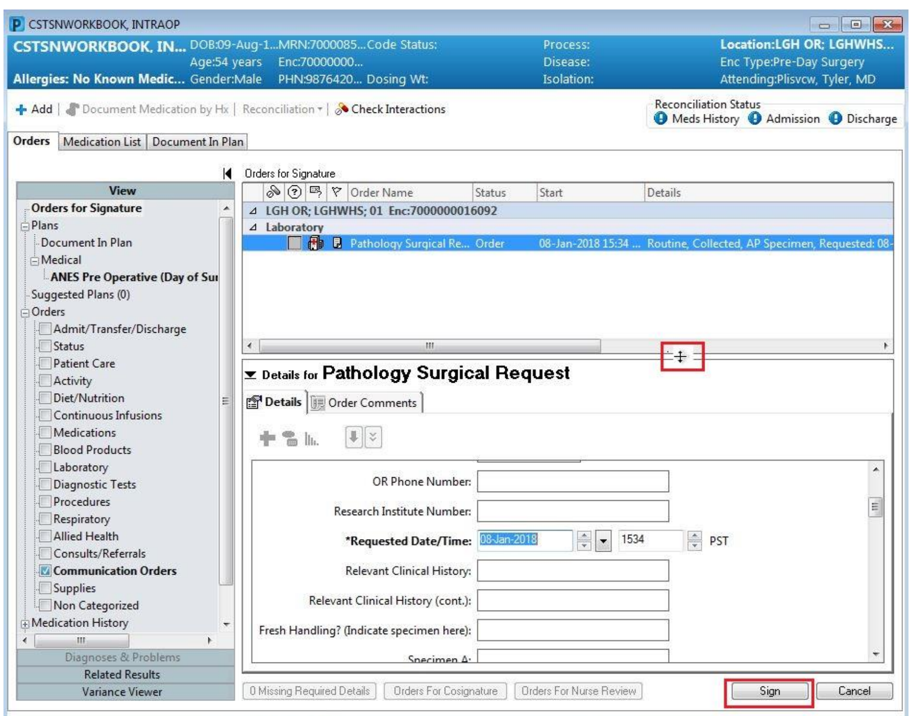


6. The nurse will add the order (choose **No Cosignature Required** when prompted in the Ordering Physician window, as the surgeon will be signing the paper requisition.)

   Enter into mandatory fields:

   - Physician name: Enter <*Plisvcw, Tyler*> (**Note**: type, full name Physician or the Provider Selection box will display: search for name, select name, and click **OK**).
   - Communication type: select **No Cosignature Required**

7. Click **OK**



8. Click on the Order. The Details for Pathology Surgical Request will open.

   The nurse can complete the specimen order details on this screen, which will then be printed out once you click Sign. Any additional specimens collected will need to be documented on the paper requisition.

Note: Alternatively, you can click sign and print a blank requisition to fill the specimen details out by hand.

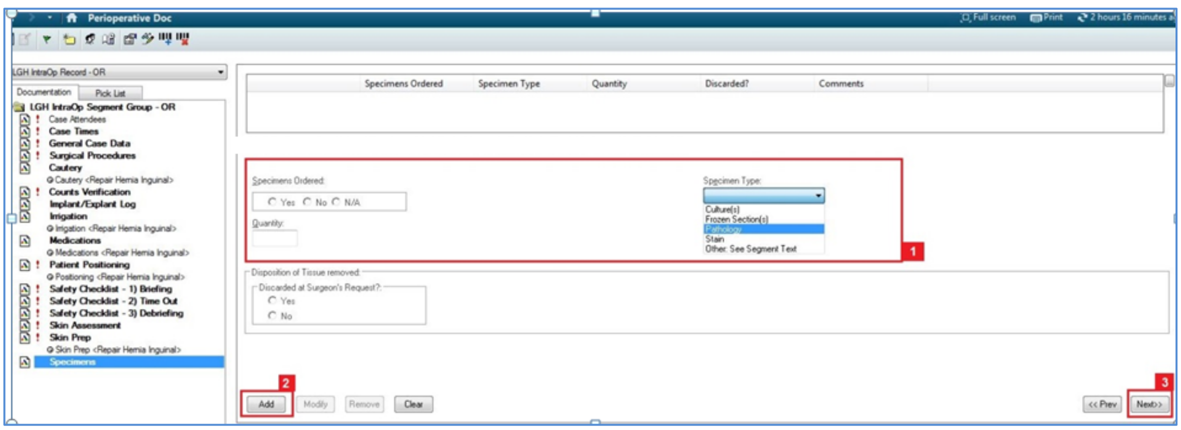
9. Hover over the Details for Pathology Surgical Request section & expand the section using to fill in the specimen details:

    - Relevant Clinical History: Right Inguinal Hernia x 1 year
    - Specimen A: Enter Right Inguinal Hernia Sac
    - Specimen A Collection time: <*Enter Time*>
    - Specimen A Fixative Time: <*Enter Time*>

10. Click **Sign**. The Pathology Surgical Request paper form and labels will print to an associated printer upon clicking the Sign button.

    - Clicking sign triggers an automatic printout of the requisition.

    After the case is over, the surgeon will fill out the Relevant Clinical History and any necessary details before signing the paper requisition.



1. Return to **Perioperative Doc**. Return to **Specimens** segment by clicking the Specimen Segment and document the specimen details on the IntraOp Record.

    Enter the following:

    - **Specimen Ordered**: *Yes*
    - **Specimen Type**: *Pathology*
    - **Quantity**: *1*

2. Click **Add**
3. Click **Next**

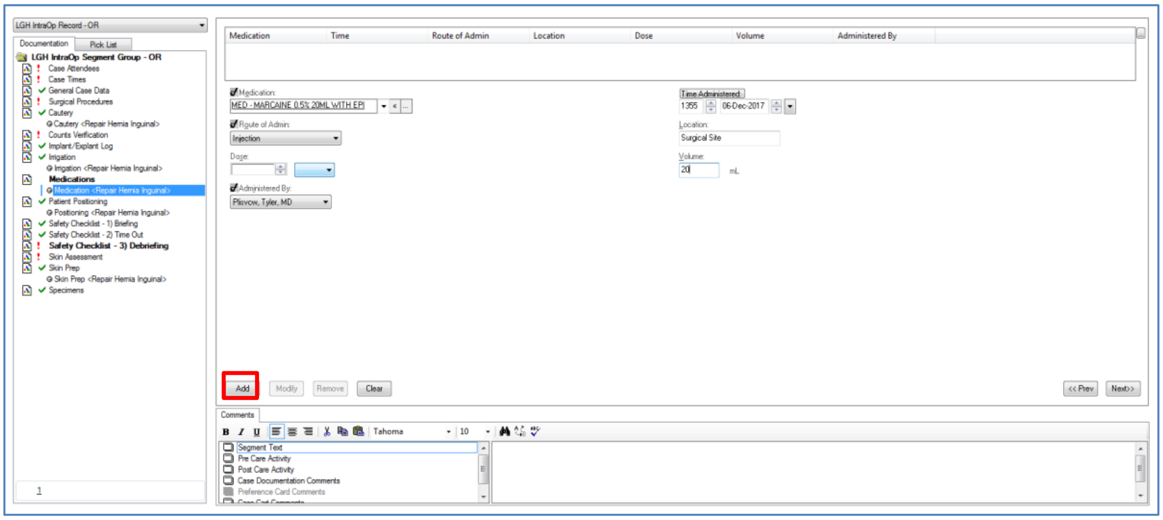
The **Specimens** segment now displays a Green checkmark icon .

The **Medications** segment now displays.

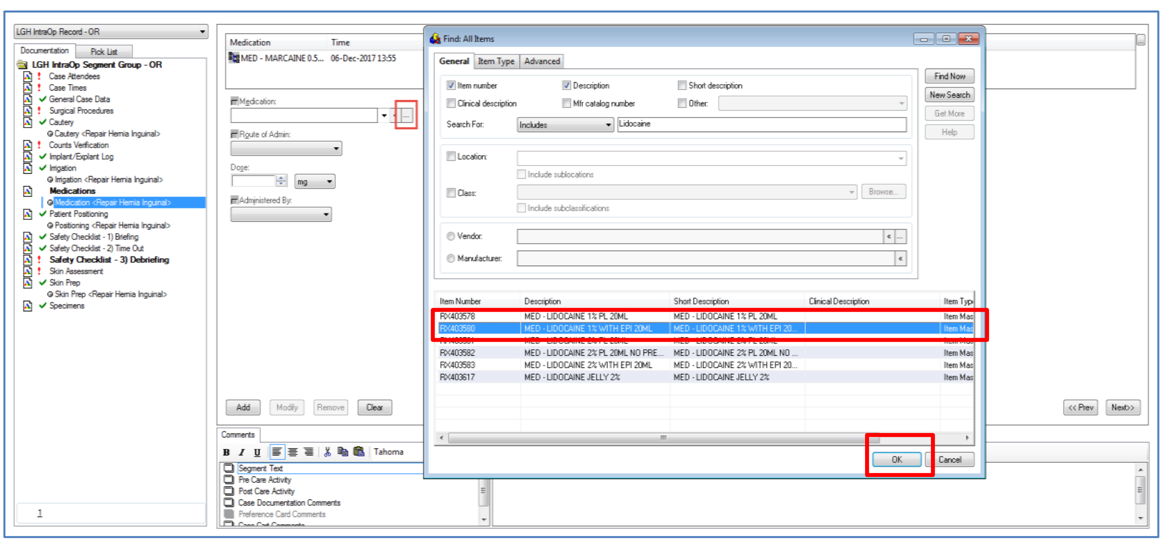
19

Medications

Medications dispensed to the sterile field and administered by the Surgeon will only be documented within the IntraOp document. This data will not be pulled into the MAR.



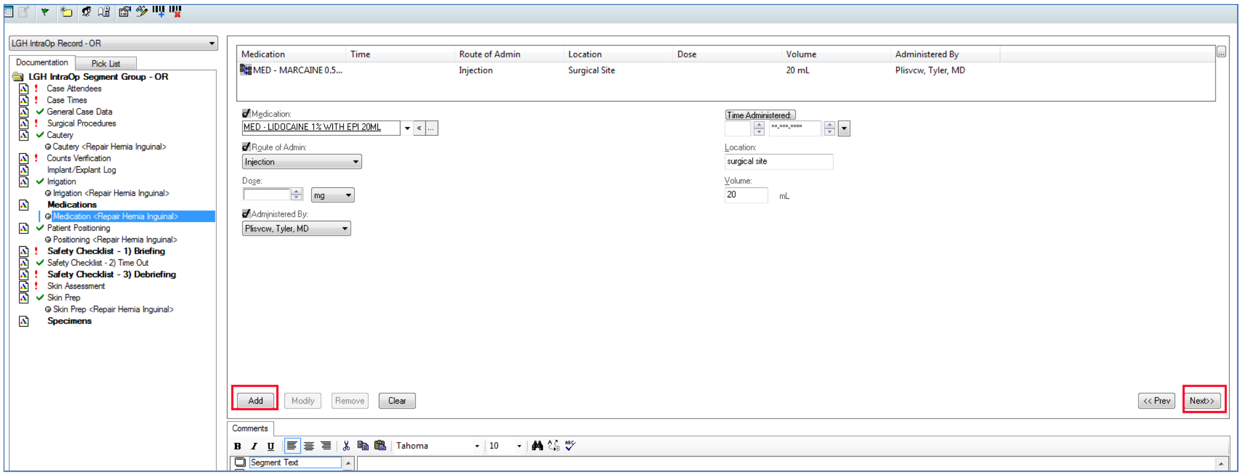
1. Click on the **Medication Default**
2. Verify the information:
    - **Medication**: MED – MARCAINE 0.5% 20ML WITH EPI
    - **Time Administered:** Click <Time Administered >
    - **Route of Administration**: Injection
    - **Location**: Surgical Site
    - **Volume**: Enter <20>
    - **Administered By**: <Plisvcw, Tyler, MD>
3. Click **Add**



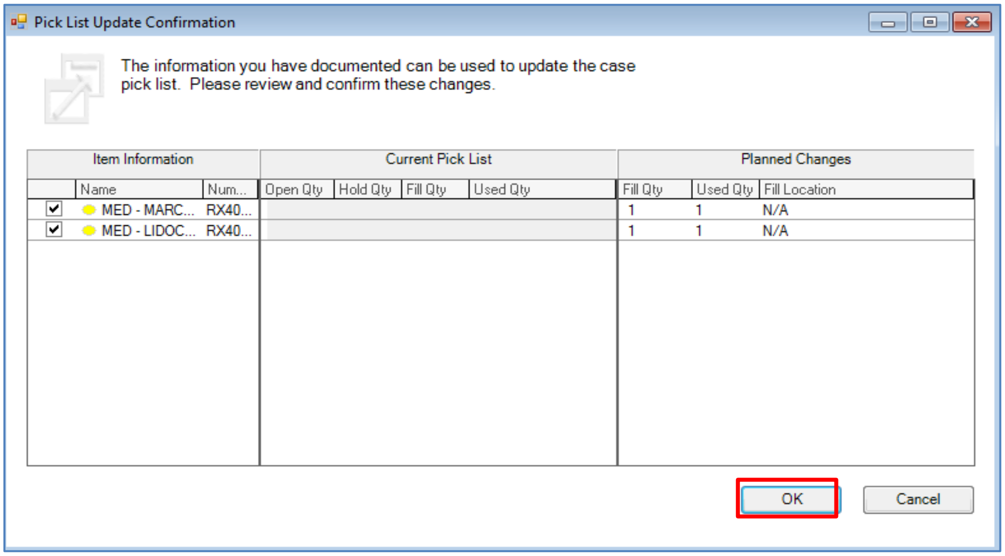
If another Medication was used or there was no default, this can be added by following the steps below:

1. Adding a Medication:
   - Click on the **ellipsis** on the Inventory Control Field
   - The **Find: All Items** window will appear

2. The **Find: All Items** window is used to search for the item
   - Within the Search For field: Enter ***Lidocaine***
   - Click **Find Now**
   - Click to highlight: **MED – LIDOCAINE 1% WITH EPI 20ML**
   - Click **OK**

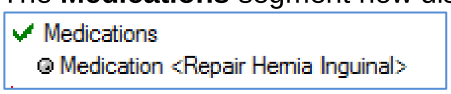


3. Enter the following information to complete the segment:
   - **Time Administered**: Click <Time Administered>
   - **Route of Admin**: Injection
   - **Location**: Enter <Surgical Site>
   - **Volume**: 20 mL
   - **Administered By**: Select surgeon’s name (from drop down list)
4. Click **Add.** The medication is now in the multi entry box.
5. Click **Next**
6. The Picklist Confirmation window opens



7. Click **OK**

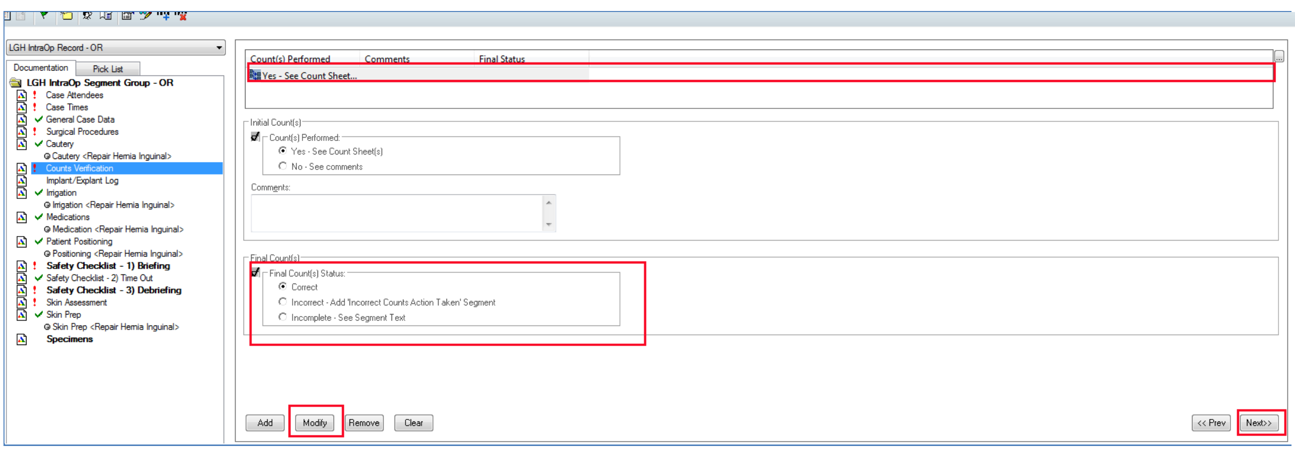
The **Medications** segment now displays a **Green checkmark** icon  .



The **Counts Verification** segment now displays.

20 Counts Verification – Final Count(s)

At this point, the case is closing and the final count has been completed without issue.



In the Counts Verification Segment:

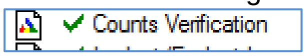
1. Click the Existing entry within the multi entry box to highlight it

2. In the Final Count(s) Status:
    - Click ***Correct*** Radio Button
    - A check mark appears
    - Click **Modify**

Final Status in the list box will be updated to **Correct.**

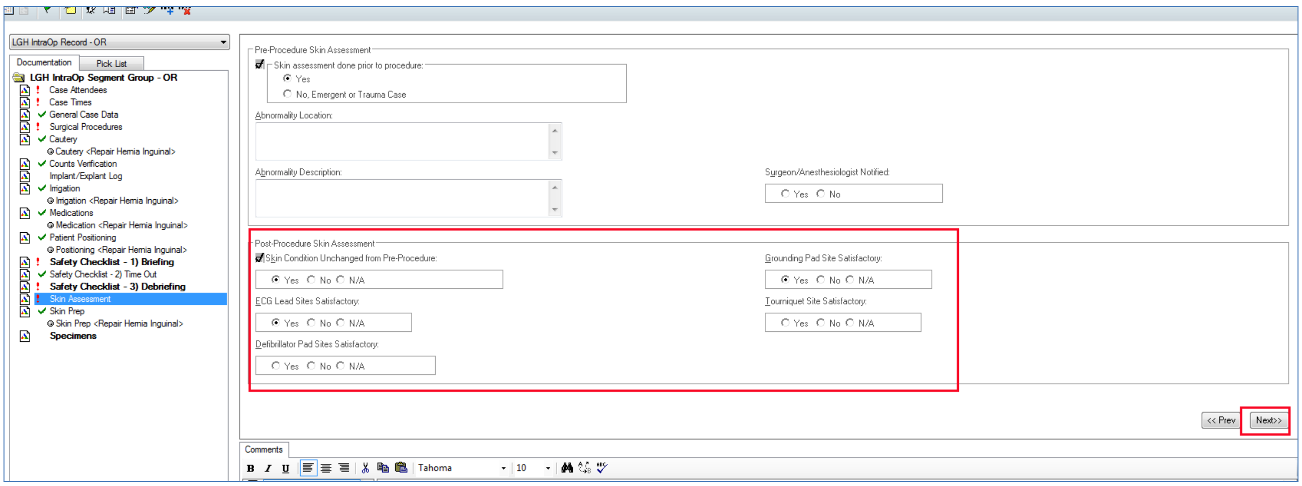
3. Click **Next**

The **Counts Verification** segment now displays a **Green checkmark** icon .



The **Skin Assessment** segment now displays.

21 **Skin Assessment - Post Procedure**

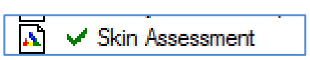


1. Enter the Post-Procedure Skin Assessment:

   - **Skin Condition Unchanged from Pre-Procedure**: *Yes*
   - **Grounding Pad Site Satisfactory**: *Yes*
   - **ECG Lead Site Satisfactory**: *Yes*

2. Click **Next.**

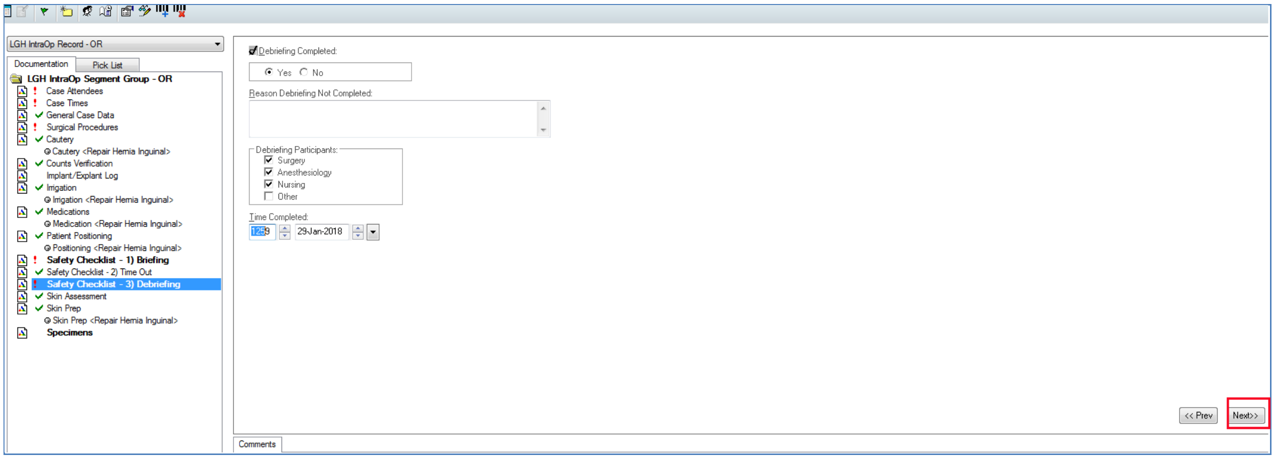
   The **Skin Assessment** segment now displays a **Green checkmark** icon .



The **Safety Checklist – 3) Debriefing** segment is displayed.

22

Safety Checklist – 3) Debriefing

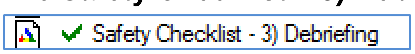


1. Enter the information as shown below:

    - **Debriefing Completed**: *Yes*
    - **Debriefing Participants**: click on *Surgery, Anesthesiology, Nursing*
    - **Time Completed**: *Enter current time*

2. Click **Next**

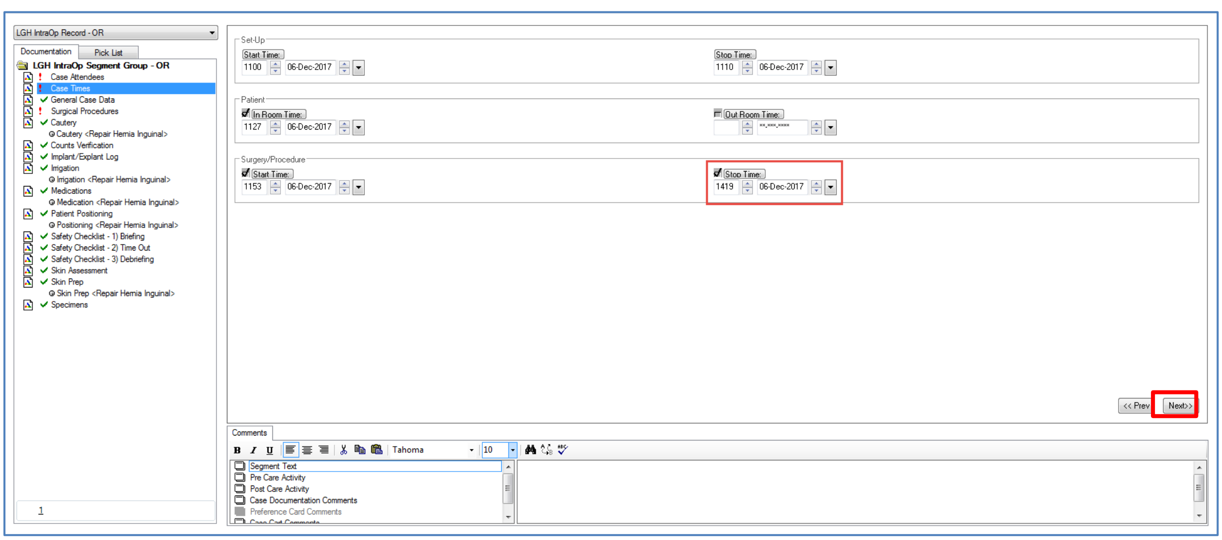
    The **Safety Checklist – 3) Debriefing** segment now displays a **green checkmark** icon ✔ .

    The **Case Times** segment is displayed

23

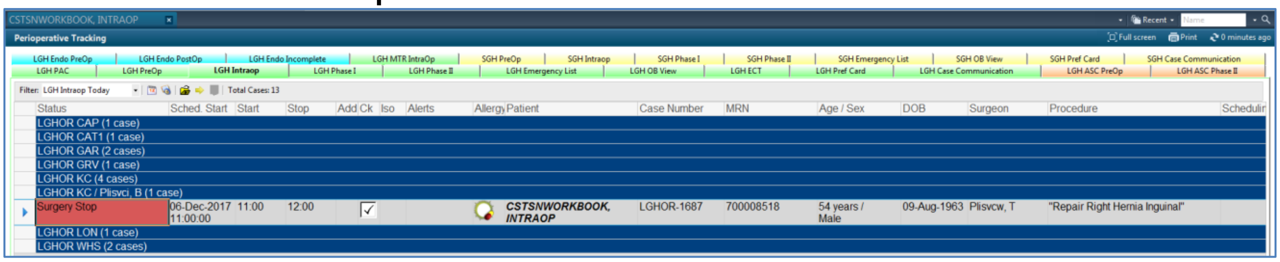
Case Times - Surgery/Procedure Stop Time



1. Enter the Surgery/procedure Stop Time:
    - Surgery/Procedure Stop Time= Click<*Stop Time*>

Note: When Case Times are entered they will update the patient’s status on the Tracking View

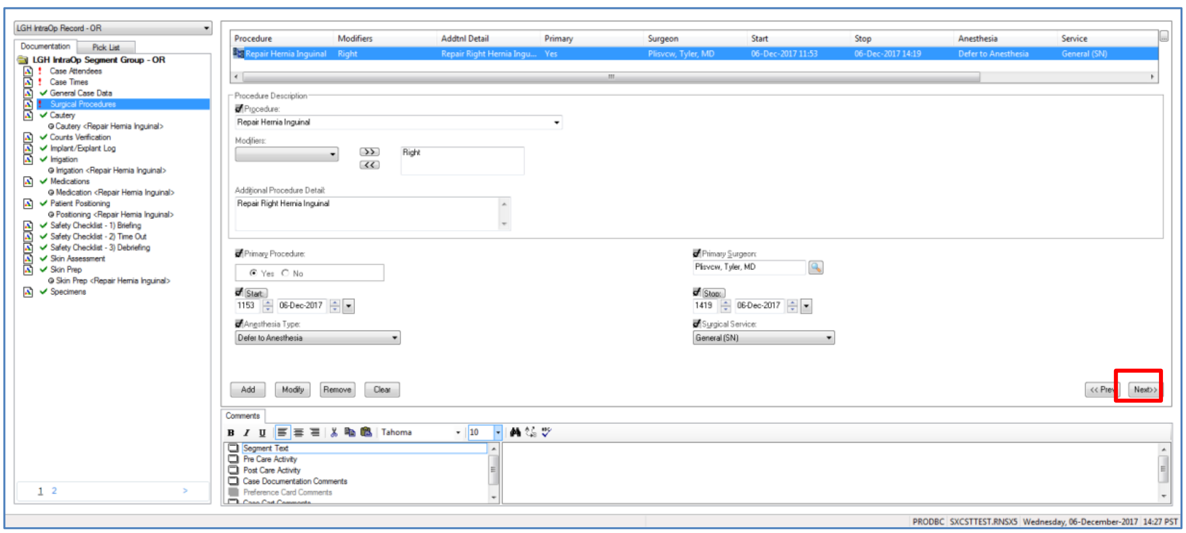
2. Click **Next**
3. Click on **Perioperative Tracking** button and navigate to LGH IntraOp Tracking View
    - Note the change in patient status – **Surgery Stop**
    - Return to **Perioperative Doc**



24 Surgical Procedures

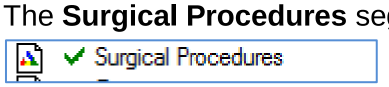
1. **Click** on the Procedure within the multi entry box to highlight it.

Note: The Start and Stop times of the Procedure are documented



2. Click **Next**

The **Surgical Procedures** segment now displays a **Green checkmark** icon .



The **Case Times** segment is displayed

Scenario: A call to the PACU reveals that the patient cannot enter Recovery for 20 min.

25 Adding/Removing Segments

Typically, all the appropriate segments required are readily available based on defaults created.

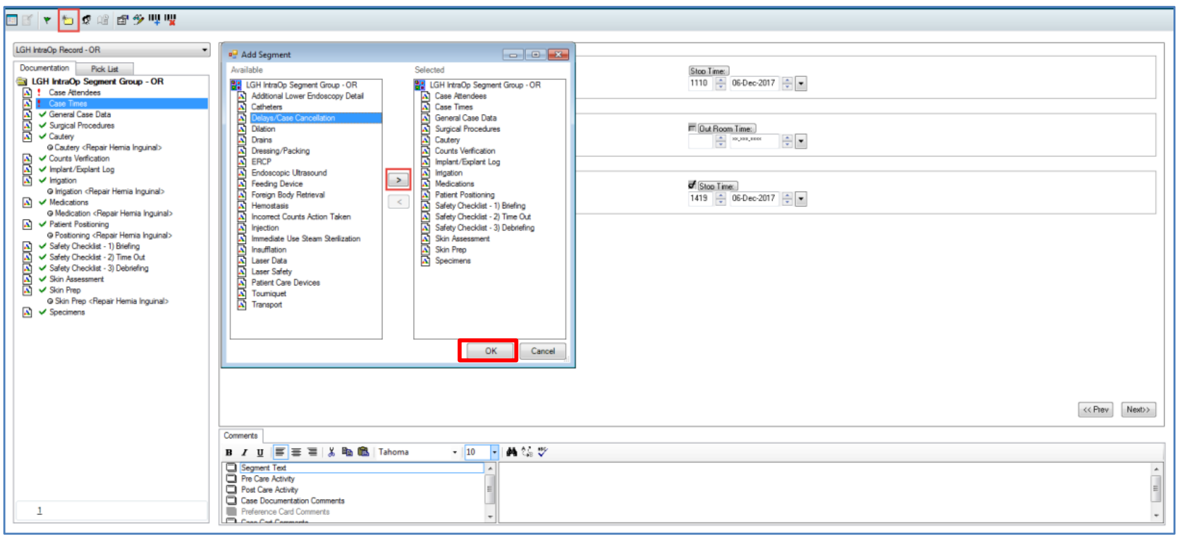
Where additional documentation is required segments can be added/ removed at any point in time.

The current page displaying is **Case Times**. The patient is on hold for the PACU and it is necessary to document a delay. In order to do so this we must **Add a segment - Delays/Case Cancellation**

To Add a Segment.

- Click **Add Segment** icon 
- The Add Segment window will appear.

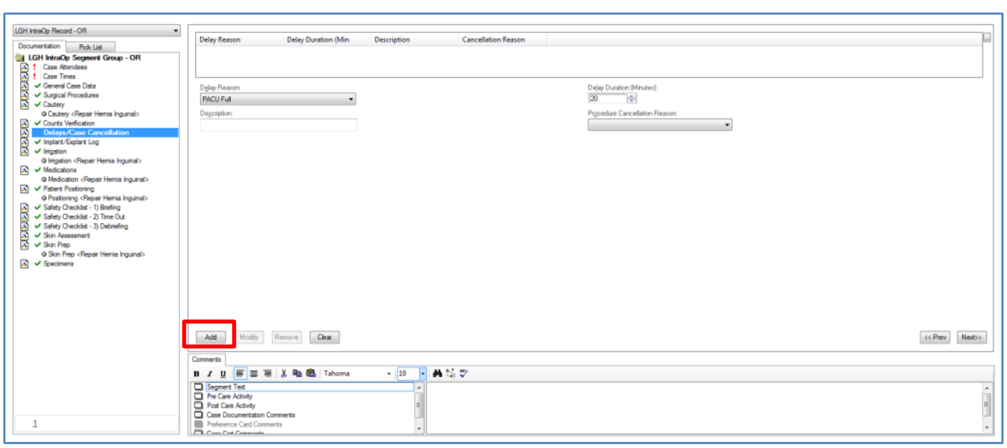
There is an Available list; this denotes the segments which are currently not available for this case which you may add to the document. The Selected list indicates the current segments which are already available for this case.



1. Add a segment:

   - Click **Delay/Case Cancellation** from the Available list
   - Click the arrow pointing from the Available list to the Selected list
   - Click **OK** to return to the document screen

26 **Delays/Case Cancellation**



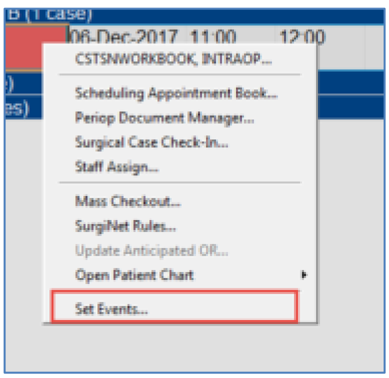
1. Document the Delay/Case Cancellation:
    - **Delay Reason**: from the drop down list select *PACU Full*
    - **Delay Duration:** *20*
2. Click **Add**

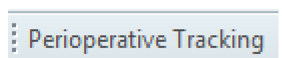
27 Update patient's status in Perioperative Tracking by setting an Event

The advantage of Perioperative Tracking is that real time patient status can be immediately communicated as they occur. The functionality is referred to as **Setting an Event.**

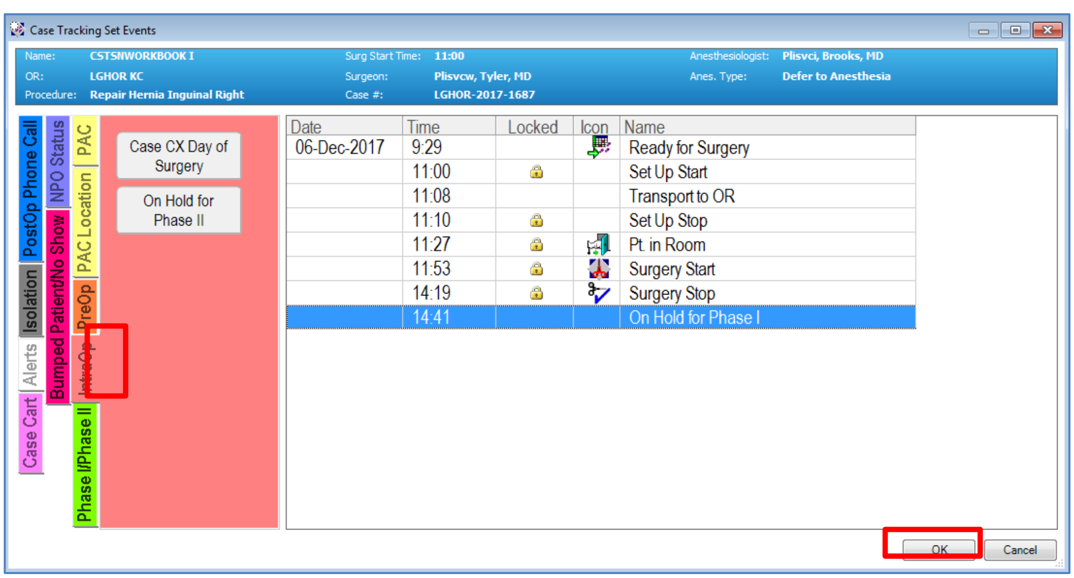
An Event can include an Alert (e.g. Violence Alert) or a patient Status (e.g. Pt. in Waiting Room), and notifications (e.g. Seen by Nurse)

To Set an Event:

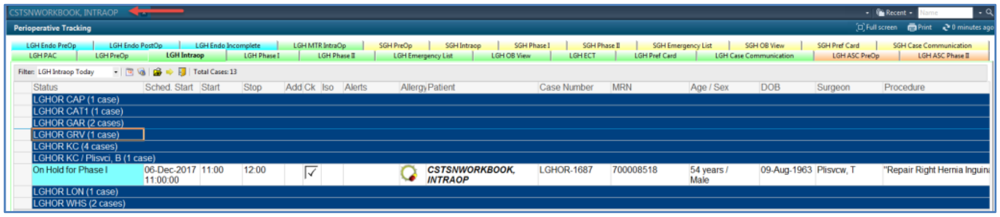


1. Click on **Perioperative Tracking**  from the Toolbar. Select the **LGH Intraop** Tracking view

Right click anywhere on the line with the relevant patient and Select **Set Events** from the drop-down list. The Case Tracking Set Events window opens.



- Click the **IntraOp** tab.
- Click the **On Hold for Phase I** button.
- Click **OK**.



2. Verify that the Intraop location has been updated on Perioperative Tracking
3. Return to **Perioperative Doc**.

28

Update the Pick List

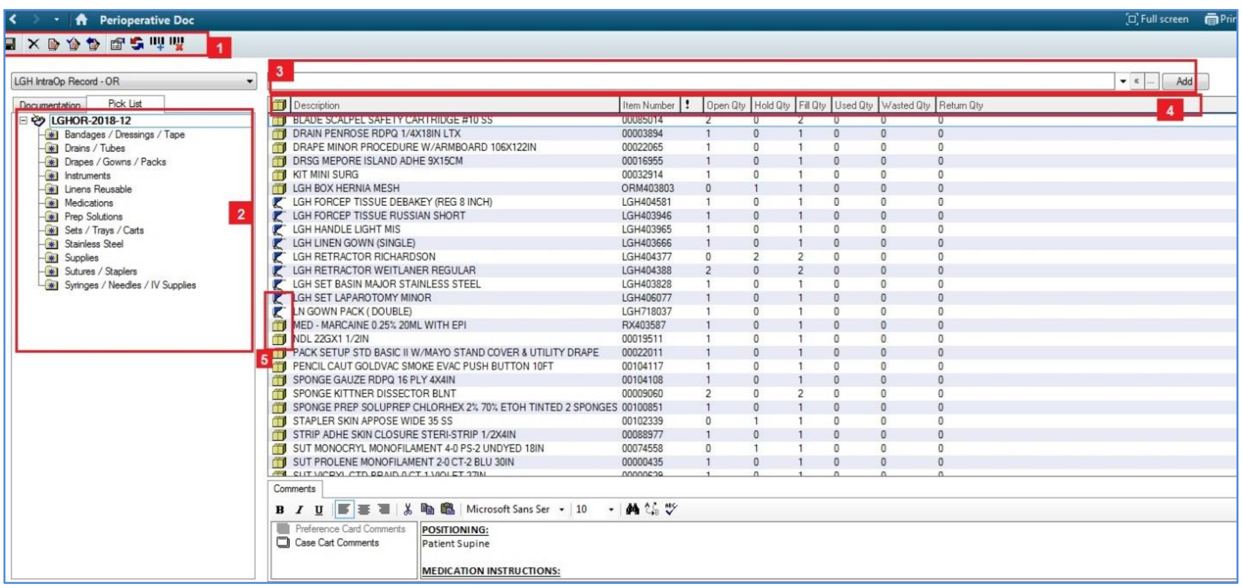
The **Pick List** is the list of all inventory items required for the specific case.

It can be used for inventory tracking and case costing.

Updating the picklist refers to documenting inventory items used, returned, or wasted:

Pick List tab

1. Click on the **Pick List** tab



Pick list screen:

1. **Quick access icons** – contains buttons that allow you to access various tools (e.g., Save, Fill, Used)
2. **Folders –** you can select a classification folder to see only items for that class
3. **Search field –** allows you to search for items not listed on the Pick List. Click Add once the item is located and selected to add to the picklist for the current procedure.

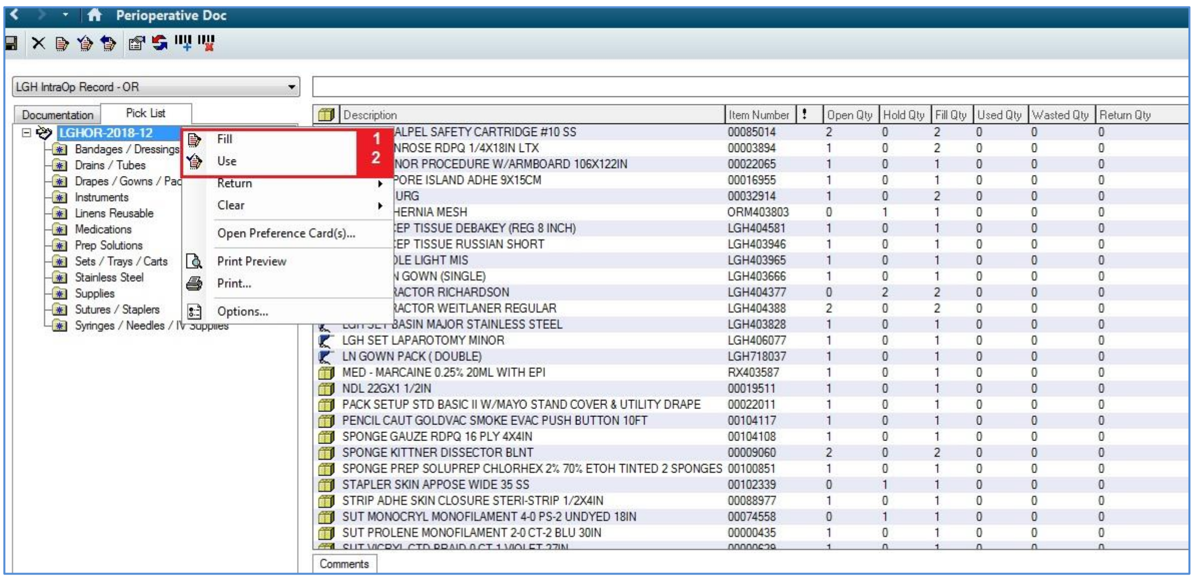
4. **Column headings** :

   - Item Number – Unique Identification number for each item
   - Open Qty – Items that are pulled for the case and will be opened prior to the case starting.
   - Hold Qty – Items that are pulled for the case but are not opened (i.e, PRN Items)
   - Fill Qty – displays the number of items picked for the case cart (= Open + Hold Qty)
   - Used Qty – can be adjusted to display the quantity of items used
   - Wasted Qty – can be adjusted to display the quantity of items wasted
   - Return Qty – Items that were unopened and returned.

5. **Item Symbols** – symbol icons designate the item type as either items (disposables) or equipment/instruments

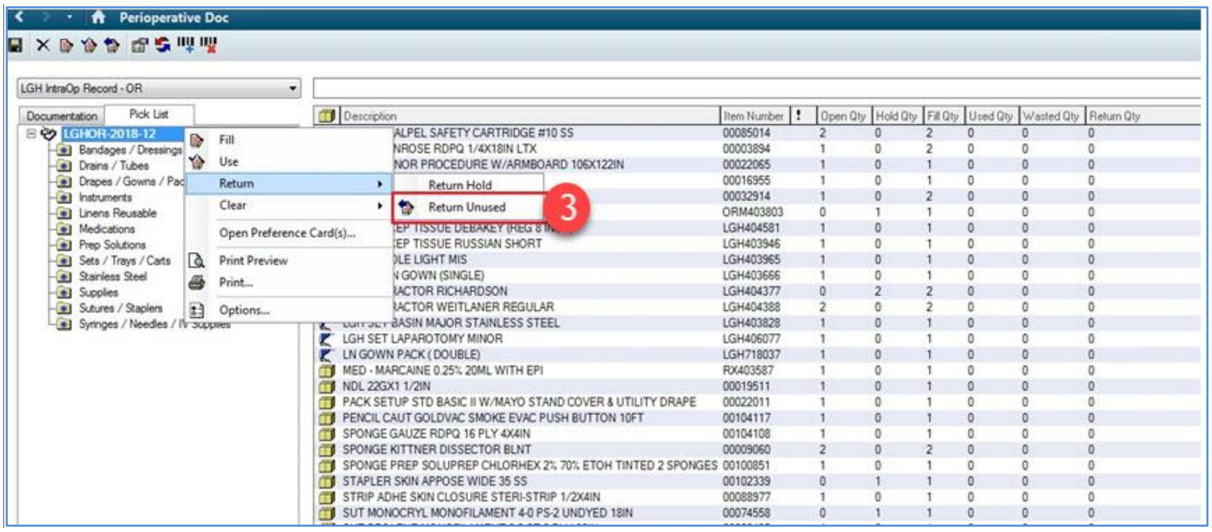
29

Updating the Pick List



1. Right-click the header of the Picklist Title Segment <LGHOR-Date>.
   Select **Fill**.
   - This will update the fill quantity column for any items added to the case that was not originally on the picklist. This allows you to set the Used Quantity for these items.

2. Right-click the header of the Picklist Title Segment <LGHOR-Date>.
   Select **Use**.
   - This will copy the number of open items from the Open Qty items to the Used Qty column.



3. Right-click the header of the Picklist Title Segment <LGHOR-Date>
   Select **Return**
   Select **Return Unused**.
   - This will move all of the Hold Qty items to the Returned Qty column.

Note: the icons in the quick access toolbar can also be used to complete the above 3 steps

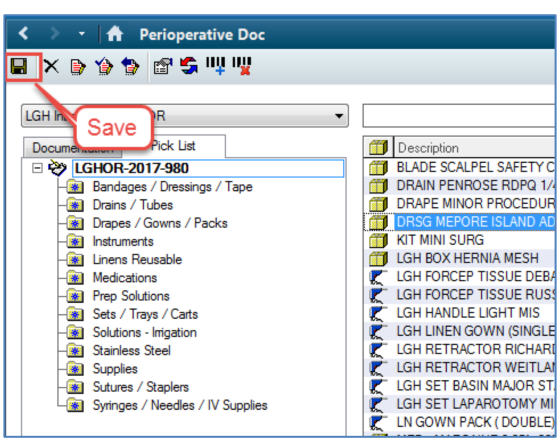
Charting By Exception

In this example we will document that one of the scalpel blades was not needed.

Description	Item Number	!	Open Qty	Hold Qty	Fill Qty	Used Qty	Wasted Qty	Return Qty
BLADE SCALPEL SAFETY CARTRIDGE #10 SS	00085014		3	0	3	2	0	1

1. Search for the item (**Blade Scalpel Safety Cartridge #10 SS**)
2. Edit the Quantity of Used Items by clicking in the **Used Qty** field and Enter 2
3. Edit the Return Quantity by clicking in the **Return Qty** field and Enter 1

To Save updated Picklist



4. Click the **Save** Icon from the Icons bar
5. Click the **Documentation** tab
6. Click the **Case Times** Segment.

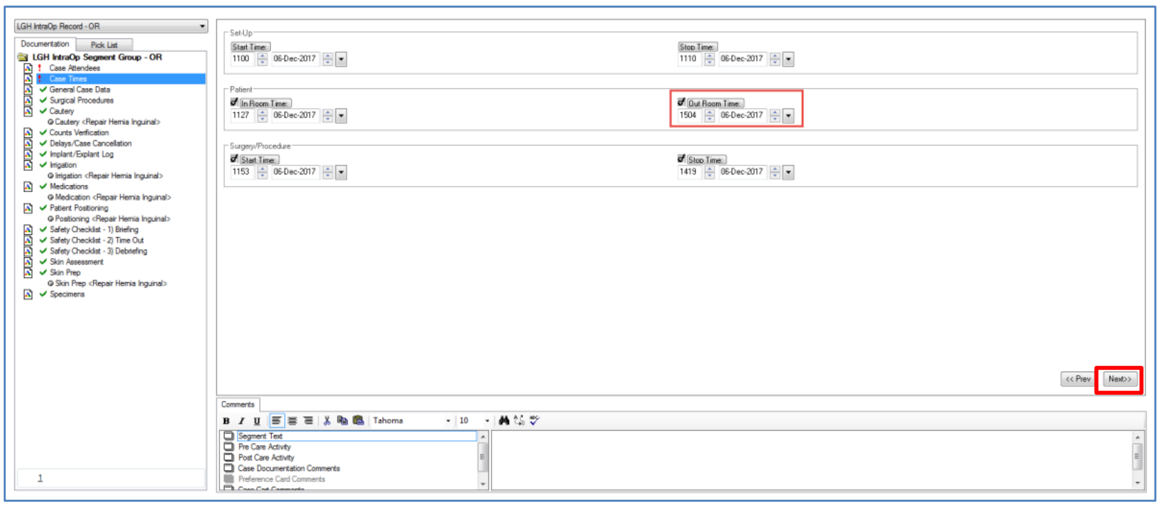
At this point in time, PACU will now accept the patient.

30

Case Times – Out Room Time

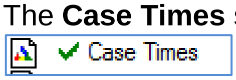
In the Case Times Segment:

1. **Patient Out Room Time** = *<Click Out Room Time>*



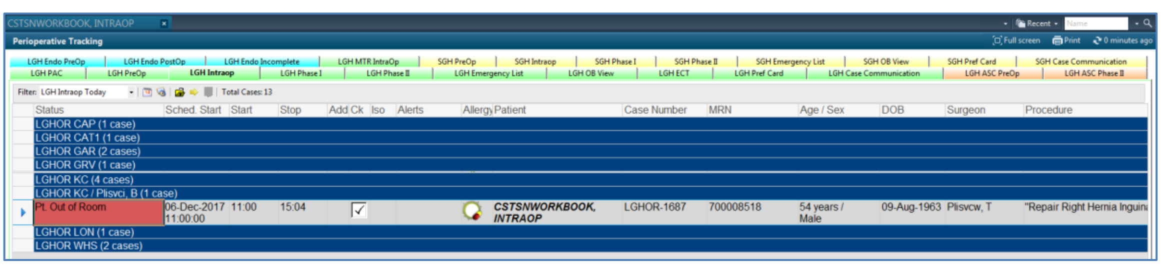
2. Click **Next**

The **Case Times** segment now displays a **Green checkmark** icon ✔.



The **Case Attendees** segment is displayed

3. Click on the **Perioperative Tracking** Board
4. The Perioperative Tracking Board will drop off the **On Hold for Phase 1** status and display **Pt. Out of Room**.



When **Patient Out Room Time** is entered the patient will fall off the Tracking View for that room (after a certain amount of time) – In our scenario the patient would now be visible on the **LGH Phase I** Tracking View.

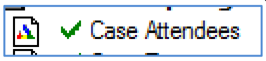
31

Case Attendees

Finalize Case Attendees

1. Click on **each Case Attendee** to associate the **Out Room Time** with their name.
2. Modify out of Room Times if necessary.
3. Click **Next**

   The **Case Times** segment now displays a **Green checkmark** icon .



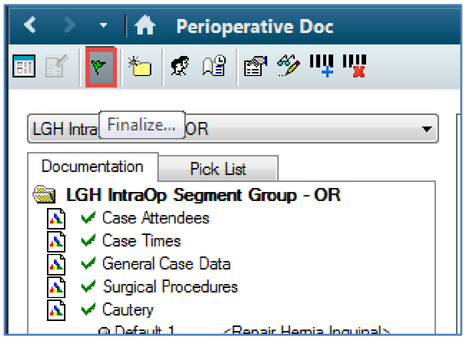
Key Learning Points

- Patient's status will need to be updated when there is a Delay/Cancellation; this is done by Setting an Event.
- Completion of the Picklist is accessed from the Picklist tab.
- Right click anywhere on the line with the relevant patient to set the Event(s).
- Perioperative Tracking will be updated to show the patient's status.

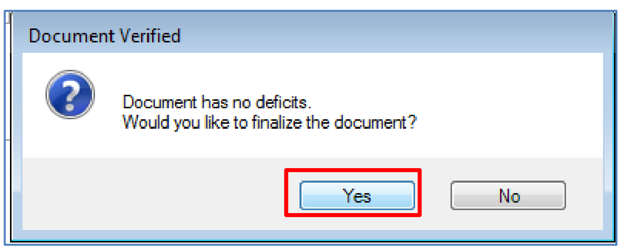
Activity 1.9 – Finalize the IntraOp Record

1 **Finalize IntraOp Record**

Finalizing the IntraOp Record checks to ensure that all required documentation is complete before continuing.



1. Check that all segments have a **Green checkmark** icon prior to finalizing the record and return to the segments that don't.
2. Ensure there is alignment between Anesthesia documentation and IntraOp documentation where necessary.
3. Click the Finalize Flag from the Icons Bar. The Document Verified window opens.



Note: If there are deficits in the charting then a window will appear noting deficiencies, you would click **OK,** and return and complete segments with deficits.

4. As there are no deficits, click **Yes**.
   The procedure will now be part of procedure history, which will flow to provider's documentation.

Key Learning Points

- Red exclamation mark beside a segment indicates it is a required field that has deficiencies.
- A **Green checkmark** icon appears next to each of the completed segments.
- Deficiencies must be addressed to be able to finalize the documentation.

End of Workbook

You are ready for your Key Learning Review. Please contact your instructor for your Key Learning Review.