SELF- GUIDED PRACTICE WORKBOOK [N46]
CST Transformational Learning

WORKBOOK TITLE:

Local Room Procedural Sedation (IntraOp Add-On)

CLINICAL + SYSTEMS
TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL
LEARNING

📄 TABLE OF CONTENT

🎬 SCENARIO 1

Learning Objectives

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

- 🟩 Navigate Perioperative Tracking
- 🟩 Update the patient's status in Perioperative Tracking
- 🟩 Document Vital Signs in IView
- 🟩 Administer pre-op medication utilizing barcode scanning

** Some or all of this content may be a review if you have completed any of the other IntraOp workbooks, however the Activities will differ slightly.

SCENARIO

Patient X has been scheduled for a hysteroscopy dilatation and evacuation today and has arrived in the waiting room for their procedure. You greet the patient in the waiting area and prepare them for their procedure.

Hint: Always remember to REFRESH your screen any time you modify the patient's chart in order to see your changes, when in doubt or when something is not working, REFRESH your screen!
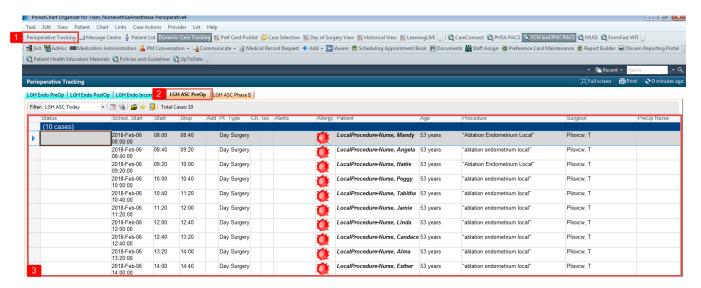
NOT Refreshed 🔄 1 hours 32 minutes ago vs. Refreshed 🔄 0 minutes ago

🧩 **Activity 1.1 – Navigate Perioperative Tracking**

All perioperative nursing logins within PowerChart will open to **Perioperative Tracking** as the landing page.

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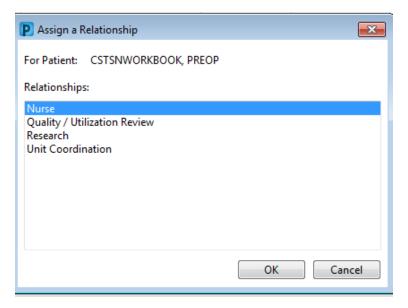

1. Any time you need to navigate back to Perioperative Tracking you can click Perioperative Tracking from the Toolbar
2. Patients will reside in **LGH ASC PreOp** tracking view for this scenario. You will see different Perioperative Tracking views depending on your login.
3. Each row within this table represents a patient, and will display important information on the patient's status.

Opening the patient's chart via the Perioperative Tracking

4. Select the **LGH ASC PreOp** tab

5. Select your patient by clicking on the row. A blue arrow ▶ will appear

6. Double-click the blue arrow ▶ next to the patient's chart to open their chart

   - Assign a Relationship window will display (if first-time accessing a patient's chart)
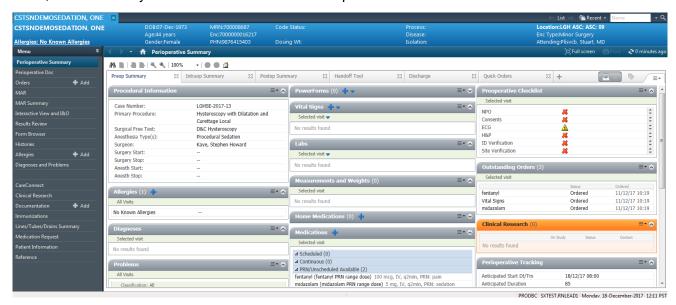
7. Select relationship of **Nurse**

   Note: Every time you open a patient's chart for the *first time*, you will be asked to assign your relationship to the patient

8. Click **OK**

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

As an Intraop Nurse the **Perioperative Summary** is the landing page when you open a patient's chart; this is where you will find an overview of the patient's information.

🔑 Key Learning Points

- Patients will reside in **LGH ASC PreOp** tracking view for this scenario. You will see different Perioperative Tracking views/tabs depending on your login

- Users accessing a patient's information for the *first time* are prompted to assign the relationship with the patient, for example, **Nurse**.

- Perioperative Summary is the landing page when you open a patient's chart.

🧩 Activity 1.2 – Set an Event to Update Patient Status in Perioperative Tracking
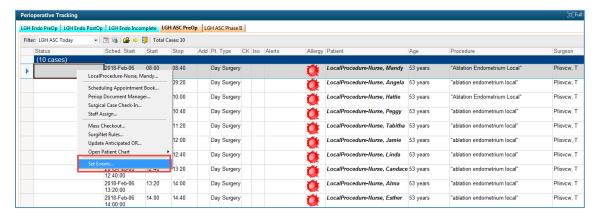
The advantage of **Perioperative Tracking** is that real time patient status can be immediately communicated as they occur. The functionality is referred to as **Setting an Event**.

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

As the nurse greeting the patient in the waiting room, you can use a Perioperative Tracking status to alert the nurse and provider in the procedure room that their patient has arrived and ready to go in for their procedure.

To set an event to update a patient's status in Perioperative Tracking:

1. In **Perioperative Tracking**, Select the **LGH ASC PreOp** view

2. Click anywhere on the line of the relevant patient to select

   - Patient's line will be highlighted gray
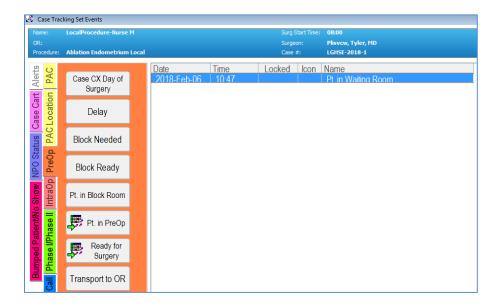
3. Right-click anywhere on the patient's line

4. Select **Set Events** from the drop-down list

   - Case Tracking Set Events window opens

5. Select the **PreOp** tab

6. Click Pt. in Waiting Room

   - The **Pt. in Waiting Room** button disappears from the PreOp tab and appears in
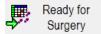
     the details window on the right

7. Click **OK**

   - **Case Tracking Set Events** window will close

8. Navigate back to **Perioperative Tracking** and click **Refresh**

9. Verify that the Patient's Status has been updated on Perioperative Tracking

10. Now let's say you have prepped the patient for their procedure. You'd like to notify the nurse and provider in the procedure room, repeat the above steps and **Set the Event Ready for Surgery**:
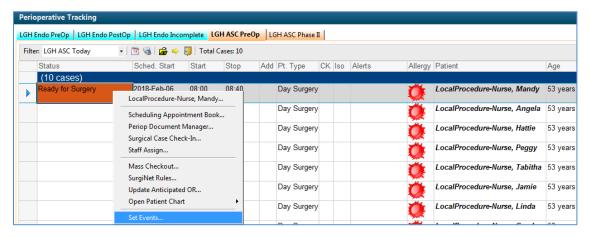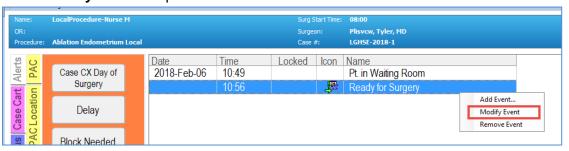
It is possible to modify the date and time after it the event has been set (e.g. the patient arrived 10 minutes ago):
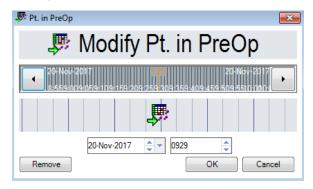
To modify an event:

1. Select your patient again in **Perioperative Tracking**

2. In the **Case Tracking Set Events** window, right-click the patient Event to modify

3. Select **Modify Event** to open the details window
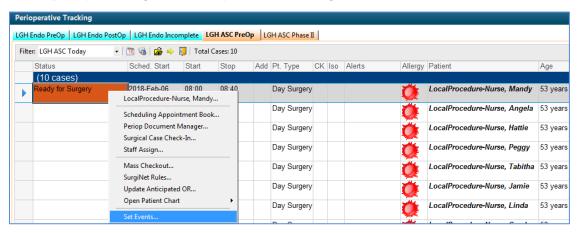

4. Modify the time 10 minutes back

5. Click **OK**

Similarly, events set may be removed all together (e.g. it was mistakenly set). To remove an Event:

1. Select your patient again in Perioperative Tracking

2. Right-click **Set Events** from the **LGH ASC PreOp** tab

   - **Case Tracking Set Event window** opens

3. Right-click on **Pt in Waiting Room** to remove it

4. Select **Remove Event**

5. Click **OK**

6. Navigate back to **Perioperative Tracking** and click **Refresh**

7. The most recent Event you set will display, in this case: **Ready for Surgery**.

🔑 Key Learning Points

- Right-click anywhere on the line with your patient to Set an Event(s).
- Perioperative Tracking will be modified to show the patient status.
- Events can also be modified or removed after it has been set.
- The most recent Event added will always display on Perioperative Tracking
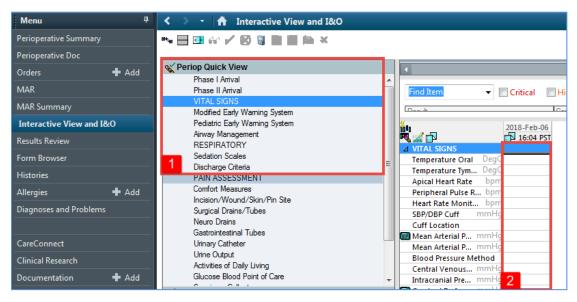
🧩 Activity 1.3 – Documenting Vital Signs in IView

Interactive View and I&O (IView) is the electronic equivalent of current state paper flow sheets.
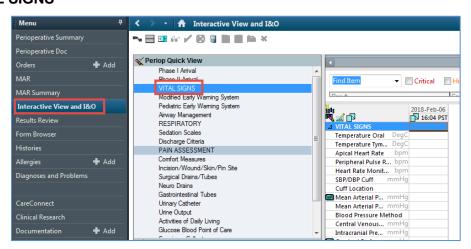
To access IView, Select **Interactive View & I&O** from the Menu. Let's look at the components in IView:

IView at a Glance

1. **A band** is the a heading with a collection of flowsheets organized beneath it. In the image above, **Periop Quick View** band is expanded displaying the sections within it. A band is indicated by the pencil 🖊 icon.

2. A **cell** is the individual field where data is documented.

The procedural sedation pre-op nurse will be documenting vital signs in IView under the "Periop Quick View" band. IView opens to **VITAL SIGNS** section, if not, click **Periop Quickview** and then **VITAL SIGNS**
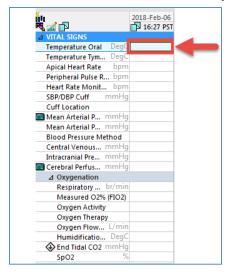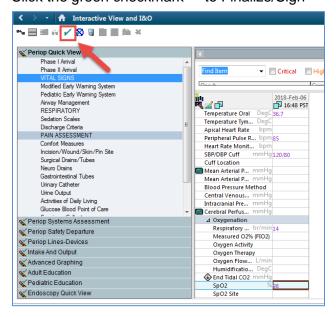
To document vital signs in IView:

1. Double-click the cell next to **Temperature Oral**
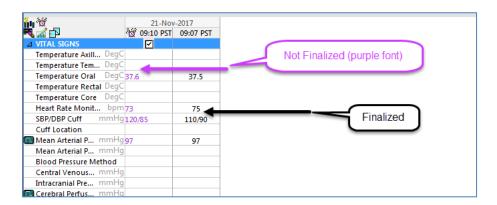
2. Type *<36.7>* into the cell

3. Now that you have input the patient's temperature, enter the rest of the patient's vitals with the following:

- Peripheral Pulse Rate (bpm) = *<85 >*

- SBP/DBP Cuff (mmHg) = *<120/80>*

- Respiratory (br/min)= *<14>*

- SPO2 (%) = *<98>*

4. After inputting all the data, notice that the data you entered is in purple, this means it has not been finalized yet

5. Click the green checkmark ✔ to Finalize/Sign

Once you **Finalize/Sign**, the data will now appear in black font. You may lose your data if you navigate elsewhere before signing so always remember to complete this step.

Key Learning Points

- Interactive View and I&O (IView) is the electronic equivalent of current state paper flow sheets
- The procedural sedation pre-op nurse will be documenting vital signs in IView under the "Periop Quick View" band
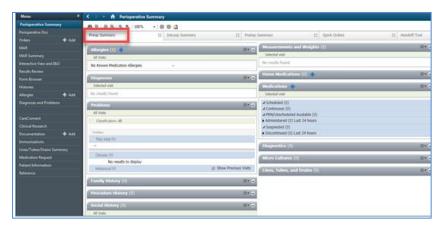- IView documentation is not officially inputted in the system until it is finalized (signed).

🧩 Activity 1.4 – Review the Patient's Chart for Consent Form

To access the patient's Procedure Consent:
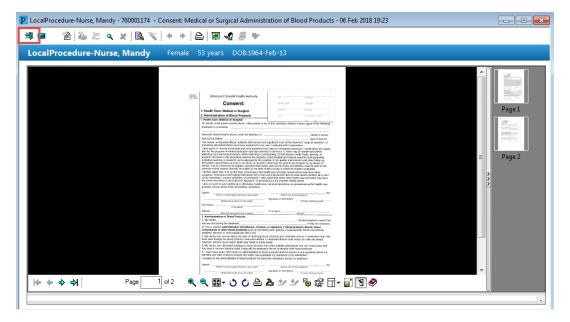
1. Select **Preop Summary** tab

2. Locate **Documents**

Note: If there is no Consent Procedure under Documents, it means none was loaded to the patient's chart, the below screenshot is what it would look like if the patient has one.

3. Click on the **Consent Procedure** link

4. The patient's completed consent will be displayed.

- Only COMPLETED consents will be associated to patient charts. If the patient does not have a signed consent, you will need to print a blank paper consent from FormFast

5. To close the consent, Click ⬛ in the top left-hand corner

🔑 Key Learning Points

🟩 Completed Procedure Consent can be found under Documents for review.

🟩 Blank consents can be printed from FormFast.

🧩 Activity 1.5 – Utilize Barcode Scanning to Administer Medications

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.
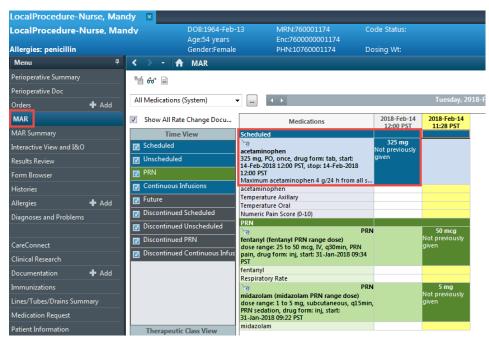
Once a medication is scanned, applicable allergy and drug interaction Alerts may be triggered, further enhancing your patient's safety. This process is known as closed loop medication administration.

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

In this activity, you will be using medication administration to give a dose of pre-op acetaminophen:
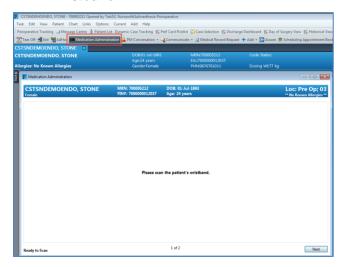
1. First review the medication information in the **Medication Administration Record (MAR)**, Click **MAR** from the Menu
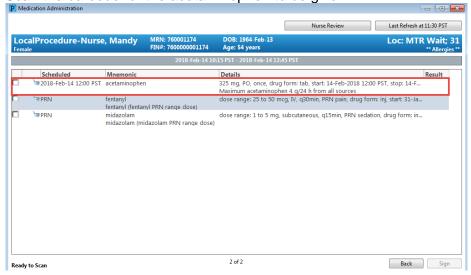
2. Verify the medication you are about to administer is in the MAR

3. From the Toolbar, Click [IIIIII Medication Administration]

- The Medication Administration window opens prompting you to scan the patient's wristband

4. Scan the barcode on the patient's wristband

- A list of ordered medications appear on the Medication Administration window

5. Scan the barcode for the acetaminophen to be given

6. Click **Sign** to complete your documentation

Note: You will still be able to document medication administration *without* barcode scanning, but you must provide a reason to override and move onto the next step.

Override Reason

⚠ Patient has not been verified by a scan.
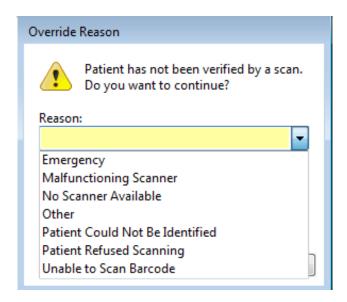Do you want to continue?

Reason:

Emergency
Malfunctioning Scanner
No Scanner Available
Other
Patient Could Not Be Identified
Patient Refused Scanning
Unable to Scan Barcode

🔑 Key Learning Points

■ Before giving medications verify that there was an order placed for the medication by viewing the patient's Medication Administration record (MAR).

■ Use Medication Administration to document medications given. Medication Administration utilizes barcode scanning to administer medication.

📋 SCENARIO 2

| Learning Objectives |
|---|
| At the end of this Scenario, you will be able to:

🟩 Initiate Procedural Sedation Medication Orders
🟩 Complete a Surgical Case Check-In (Review)
🟩 Create a Sedation Record
🟩 Document in the Sedation Record
🟩 Complete Perioperative Documentation
🟩 Finalize All Documentation

** Some or all of this content may be a review if you have completed the any of the other IntraOp Workbook, however the Activities will differ slightly. |

SCENARIO
As the procedural sedation perioperative nurse you see on Perioperative Tracking that the patient has arrived in the waiting room and is ready for the procedure. You bring the patient into the procedure room.
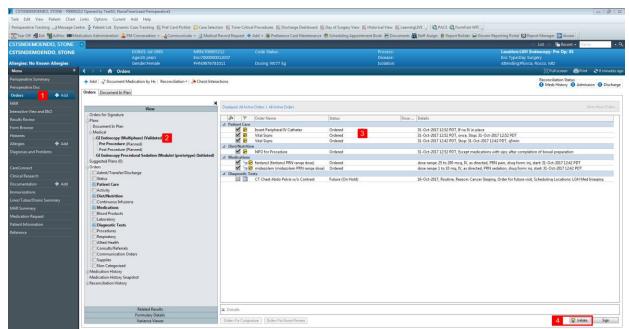
🧩 **Activity 2.1 – Initiate Procedural Sedation Orders**

Planned orders (orders placed ahead of time) are only to be initiated in the appropriate phase when a nurse is about to carry them out.

You will be initiating a procedural sedation order set. Depending on whether procedural sedation orders were placed by the provider, you may or may not need to complete this step.
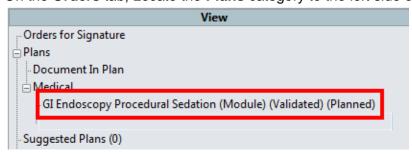
If sedation medication orders were not placed, you will still be able to administer and document them; they will be co-signed *after* the procedure by the provider.

* Screenshots will show the GI Endoscopy Procedural Sedation order set to demonstrate the steps in this Activity. The details in this order set are similar to ones used in any procedural sedation case.

To initiate the planned order:

1. Select **Orders** from the Menu

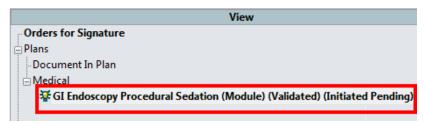2. On the **Orders** tab, Locate the **Plans** category to the left side of the screen under **View**

3. Click **GI Endoscopy Procedural Sedation (Planned)**

4. Review order details on the right pane

5. Click **Initiate**

- Procedural Sedation orders are now Initiated Pending, you need to sign

6. Click **Orders for Signature**

7. Click **Sign**

8. Click **Refresh**

- The order now appears as Initiated:

🔑 Key Learning Points

■ Planned orders (orders placed ahead of time) are only to be initiated in the appropriate phase when a nurse is about to carry them out.

■ You will be initiating a procedural sedation order set. Depending on whether procedural sedation orders were placed by the provider, you may or may not need to complete this step.
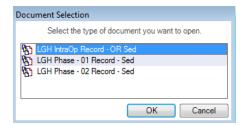
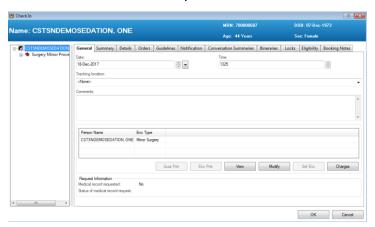## 🧩 Activity 2.2 – Complete Surgical Case Check-In

The first time you access Perioperative Doc, the system requires a process called a **Surgical Case Check-In**. The Surgical Case Check-In is not equivalent to the patient bed transfer process covered previously. The Surgical Case Check-in process is necessary to obtain access to Perioperative Documentation, but it should not occur until the patient is in the procedure room.

To complete the Surgical Case Check-In:

1. Click on **Perioperative Doc** from the Menu

   - The Document Selection Window opens

2. Select **LGH IntraOp Record – OR Sed**

3. Click **OK**

   - The Check In window opens

4. Verify the patient's information in the Check-In window, as necessary

5. Click **OK**

Once you refresh, the patient will now appear as Checked-In on Perioperative Tracking indicated by ☑ under the CK Column

🔑 Key Learning Points

- The Surgical Case Check-In process is necessary to obtain access to Perioperative Documentation.

- The Surgical Case Check-in process should not occur until the patient is in the procedure room.

- A patient's Surgical Case Check-In status can be viewed on Perioperative Tracking.
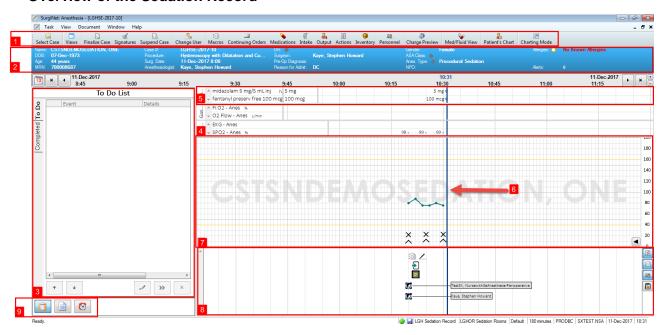
🧩 Activity 2.3 – Create a Sedation Record

So far, you have become familiarized with PowerChart. You will now be introduced to a different module that you will use in conjunction with PowerChart in order to make procedural sedation documentation more streamline.

SA Anesthesia is mostly used by Anesthesiologists with the exception of specific nurses in some perioperative areas. As an intra-op nurse working in a procedural sedation area with a provider, you will be using SA Anesthesia to document patient's **vital signs** and **sedation medications**.

The patient's procedural sedation document you create using SA Anesthesia is called the 'Sedation Record.'

Overview of the Sedation Record

1. **Toolbar** – Each icon allows access to specific actions.
2. **Banner Bar** – Shows patient demographics like in Powerchart.
3. **Workflow Pane** – Contains the To-Do List (list of actions to complete during the case).
4. **Monitors** – Displays the vital signs and NAPCOMS documentation.
5. **Medication Pane** – Displays medication administration
6. **Current Time** - The Sedation Record is dynamic in that it will automatically scroll as time passes. The vertical line always represents the current time.
7. **Vital Signs Graphing** – Displays the graphical component of BMDI.
8. **Event Pane** – Displays actions completed from the To-Do List (ie. staff presence in the room, procedure start/stop time etc.).

Views Buttons – The icons allow you to toggle between the To Do List and other functionality you will not be utilizing in this training
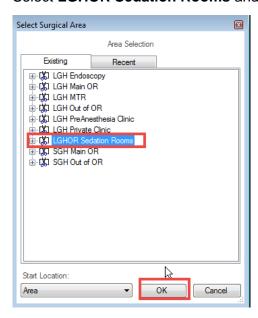
To access SA Anesthesia from PowerChart:

1. Click the **SA Anesthesia** [SaAnesthesia] icon from the Toolbar
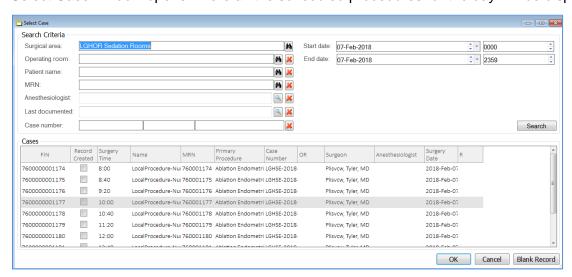

** Depending on the resolution of your screen, the icon may be hidden

2. Select **LGHOR Sedation Rooms** and click **OK**

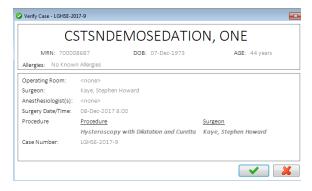Select Case window opens where all the scheduled procedures for the day will be displayed:

2. Select your patient in the Cases window and double-click on their name

   - If you cannot find your patient in Select case, ensure that the Surgical Area field is set to LGHOR Sedation Rooms. You can also search a patient by name or MRN.

   Surgical area: LGHOR Sedation Rooms

3. Verify the patient information is correct in the Verify Case window and click the green checkmark.

   - The Select Device window opens to associate the appropriate BMDI device

BMDI (Bedside Medical Device Integration) automatically records data from bedside monitors into SA Anesthesia. Once the monitors are attached to the patient and BMDI is associated, the patient's vital signs will be automatically charted to the Sedation Record.

It is important to associate the correct device to your patient. It is crucial so you are not documenting the wrong patient's vital signs.
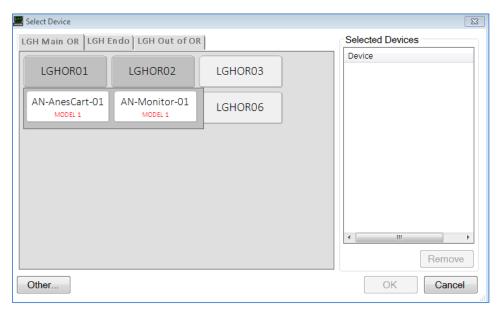
**In the training environment, you may not be able to associate BMDI, however you will still be able to see where vitals will be documented and what this may look like. If BMDI is not associated or working, you will need to document vitals manually.

To associate BMDI:

1. Select **LGH Main OR** tab [SS]
2. Click **LGHLOCAL** icon [SS]

3. Select the BMDI device for your procedure room *AN Monitor-01*

- The device selected will appear under **Device**

Ensure you associate the correct device to your patient, this is crucial so you are not documenting the wrong patient's vital signs.

4. Click **OK**

- The **Start User** window opens; the procedural sedation nurse is the Attendee. Start Time refers to when the monitors will start its documentation. These are defaulted entries and you do not need to change this.
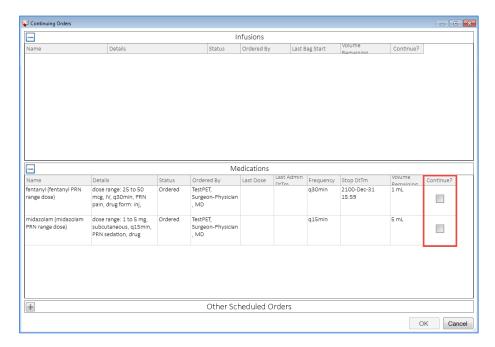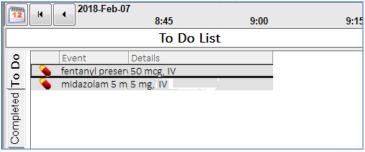

5. Click **Yes** to continue

Recall that you may have initiated procedural sedation orders, you will need to 'pull in' these medications to SA Anesthesia in order to document its administration:

1. Check the box next to the 2 procedural sedation medications we are pulling into the Sedation Record: Fentanyl and Midazolam

2. Click **OK**, the medications will be populated to the **To Do List** in the Sedation Record

If there were no procedural sedation orders the Continuing Orders window will be blank, click [×] to close the window and skip to the next step.

The Sedation Record is now open; you still need to complete a few more steps before you start can start documenting.

You will need to assign the Provider as a Supervisor. If you will be documenting any medications that have not been ordered previously, this ensures that the Provider can co-sign these medications after the procedure.

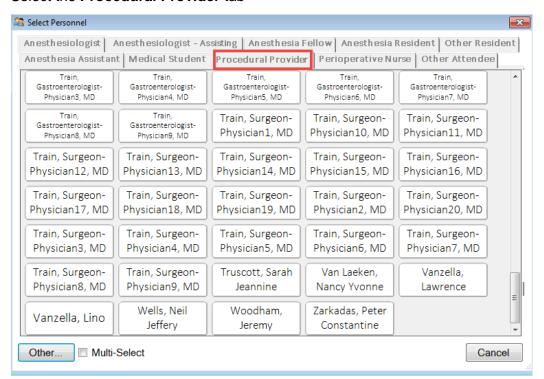To assign the Provider as a Supervisor in the Sedation Record:

1. Select icon from the toolbar

2. Select **Add** in the Modify Personnel window

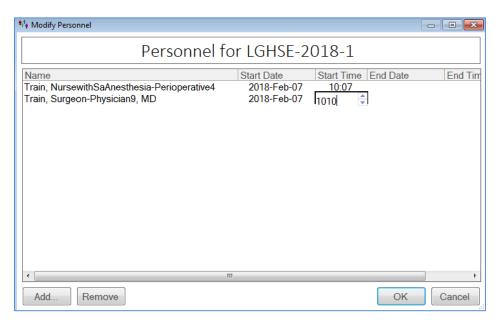   - The Select Personnel window opens

3. Select the **Procedural Provider** tab

4. Click any **Train, Surgeon**, the Provider selected will be added as a Supervisor with the current time populated

5. The Nurse and Provider times *must* match, double-click the Provider Start Time

6. Adjust the Provider Start Time to match your Start Time

7. Click **OK**

- In the Sedation Record, notice the two personnel icons appear in the Events pane, these represent you and the provider.

When a **Macro** is executed, the system runs a pre-defined number of events and actions in the Sedation Record automatically so you do not have to populate them individually (ie. adding medications to the To Do List and routine vital signs documentation).

The macro you will select will depend on whether or not medications were pulled in from the procedural sedation orders:
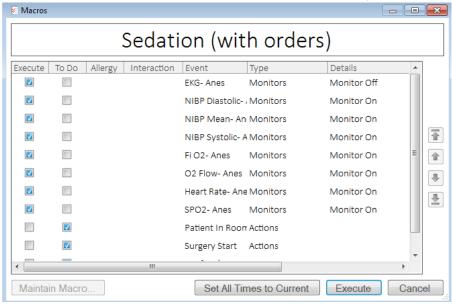

Sedation (with orders) – Choose this macro if procedural sedation orders were placed.
Sedation (no orders) – Choose this macro if no procedural sedation were placed.
No Sedation – Choose this macro if the patient is not receiving sedation.

To execute the sedation macro:

4. Select **Macros** from the Toolbar

5. Select Sedation (with orders)

6. Review the contents in the Macros window, as necessary

7. Click **Execute**

The sedation record is now ready for documentation of sedation medications.

🔑 Key Learning Points

■ The patient's procedural sedation documentation in SA Anesthesia is called the 'Sedation Record'

■ SA Anesthesia is a different application than Powerchart with a different layout and functionalities

■ Creating the Sedation involves:

- Selecting the right patient to associate to the record

- Associating BMDI

- Pulling in Procedural Sedation medications

- Assigning yourself as an Attendee

- Assigning the Provider as Supervisor
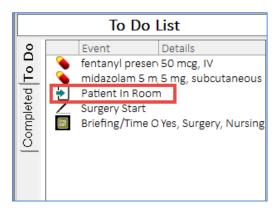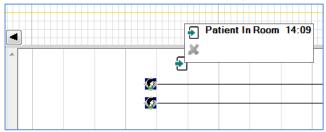
- Executing the sedation macro

Activity 2.4 – Document in the Sedation Record

To document times in the Sedation Record:

1. Double Click ⟥ Patient In Room from the To Do List

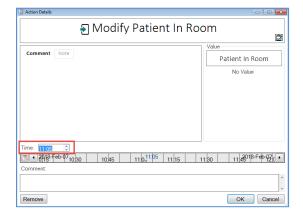

2. The Patient in Room ⟥ icon will populate the current time and appear in the Event pane

    Hover over the Patient in Room ⟥ icon to see the detail

3. To modify the time, double-click the Patient in Room ⟥ icon in the Event pane

4. Enter **Time** = *current time less 10 minutes*

5. Click **OK**, the icon's position in the Event pane will be adjusted

For practice, repeat the same steps for the following times. This should be charted as necessary for the area you are working in:

- Briefing/Time Out Briefing/Time O Yes, Surgery, Nursing

- Surgery Start Surgery Start

To document medications in the Sedation Record:

1. Double-click *midazolam* on the To Do List
2. Double-click *fentanyl*

Once you double-click the medication, they will disappear from the To Do List and appear in the Completed tab.

Each medication dose will be populated to the current time in the Medications pane.
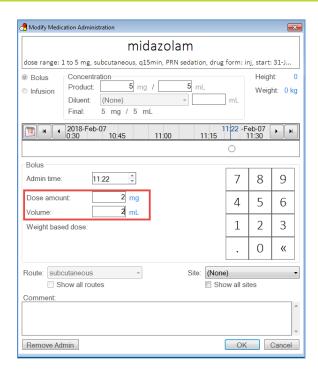

If 2mg of Midazolam was actually given, to adjust the dose:

3. Click directly on the dose 5 mg ○
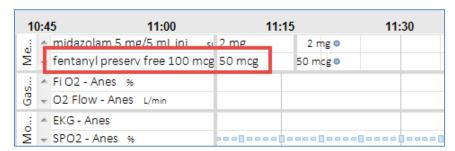   - Modify Medication Administration window opens

4. Adjust the dose from 5 ml to 2 ml

5. Click **OK**

If you did not administer the medication, you will need to note that the doses were administered by the provider.

6. Type *<administered by Dr. XYZ >* in the comment box

7. Click **OK**

8. Repeat the same steps for the fentanyl `100 mcg` . Change the dose to 200 mcg and that it administered by Dr. XYZ

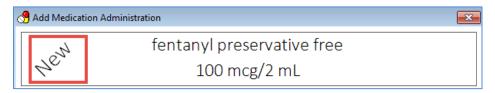If another dose of medication is given, to document an additional (new) dose of medication:

1. In the far left of the Medication pane, Click on *fentanyl*

Since you are administering an additional dose, 'New' displays next to the drug name on the top banner:

2. Enter Dose Amount *50 mcg*

3. Enter *<administered by Dr. XYZ >* in the comment box

4. Click **OK**, and the new dose will be added to the Medication pane

🔑 Key Learning Points

◻ Double-click medications from the To Do List to document their administration.

◻ Any medication-related actions will appear in the Medications pane

◻ Medication administration documentation can be modified in the Modify Medication Administration window

◻ If you did not administer the medication, you will need to note that the doses were administered by the provider

◻ Additional doses are documented in the New Medication Administration window

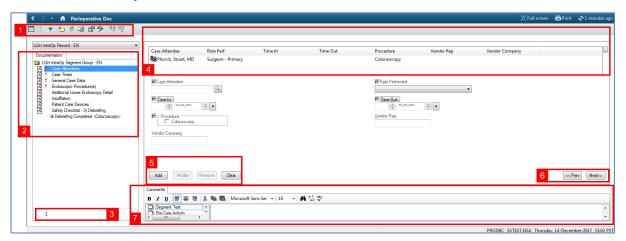# Activity 2.5 – Complete Perioperative Documentation

You last left off on Powerchart having completed the Surgical Case Check-In.

SA Anesthesia will remain open as you monitor the patient's vitals and document additional medications as necessary. At the same time, you will be completing procedure charting in Perioperative Documentation (or Perioperative Doc).

To navigate back to Powerchart from SA Anesthesia:

1. Select **Patient's Chart** from the Toolbar
2. Select Perioperative Doc from the Menu (if not already in Perioperative Doc)

Overview of Perioperative Doc

1. **Icon Bar** – Icons for quick access of certain Perioperative Doc functions.
2. **Documentation** – Contains a list of segments for documentation. Segments are listed alphabetically.
3. **Pages** – The number of pages within the current segment.
4. **Multi-Entry Box** – enables multiple entries of certain fields to be documented in Perioperative Doc. Where relevant procedure data already documented in other applications (e.g., SA Anesthesia), an entry in the **Multi-Entry Box** will be pre-populated.
   - When default data is appears in the **Multi-Entry Box**, clicking the item in the **Multi-Entry Box** will auto-populate the segment data
   - To add a new entry in the **Multi-Entry Box**, complete the fields first then Click **Add**
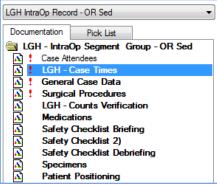   - To modify an existing entry in the **Multi-Entry Box**, select the entry in you are

modifying in the **Multi-Entry Box**, document the modifications then Click Modify

- To remove an entry from the **Multi-Entry Box** Click Remove
- **Note:** Fill in all fields within a segment prior to clicking Add, otherwise details will display on separate lines in the Multi-Entry box.

5. **Add / Modify / Remove / Clear Buttons** – used add/change entries in the Multi-Entry Box.

6. **<<Prev and Next >> Buttons** – to navigate to the next segment or the next page of a multi-page segment.

7. **Comments** – This is a free text box area where additional notes can be typed while on any segment.
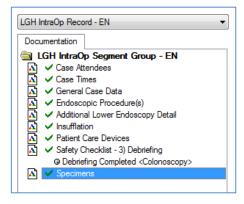
Note: Depending on the orientation of your computer screen and its resolution, the layout of each segment's fields will vary and the number of **Pages** displayed will differ. Most Perioperative Doc segments, are optimally displayed when the screen is oriented vertically.

Perioperative Doc Segments Explained

Perioperative Doc segments are grouped to resemble different sections of an intra-procedure record. The exclamation marks ! next to the first 4 segments are mandatory segments that must be completed in order to finalize.

Once a segment's mandatory fields are completed, a green checkmark ✓ will replace the exclamation to indicate there are no documentation deficits in that segment.

Which segments appear by default is dependent on the procedure scheduled; you may add or discontinue segments if your documentation requirements change during a case.

There are also required fields *within* each segment which have light gray highlighting of the field. A checkmark in the gray box ☑ will appear once the required field is completed. These fields also need to be completed in order to finalize Perioperative Doc at the end of the case.
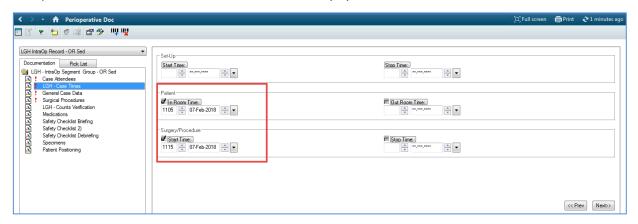
Note: You may navigate each Perioperative Doc segment by selecting each segment from the Documentation pane; however, you can also choose to click the Next [Next>>] button within the segment. The sequence of the segments is predetermined based on a specific endoscopy workflow. If the sequence does not match how you work, you may click into each segment from the list.

Document Case Times

The patient's In Room Time and Start Time auto-populates from SA Anesthesia.

You will be asked to correct discrepancies if any Case Times/ Attendees Times do not match with Perioperative Doc. You will not be able to Finalize the Sedation Record (SA Anesthesia) until all Time fields match.
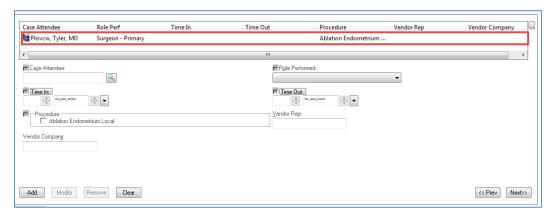
For now, we will document other segments, select **Case Attendees**

Document Case Attendees

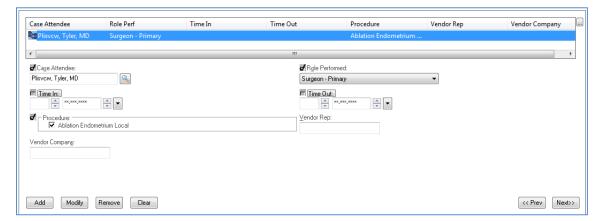1. Select *Plisvcw, Tyler* from the **Multi-Entry Box**

Notice the provider's Time In is already populated in the **Multi-Entry Box**, as you recall this was entered in SA Anesthesia.

SA Anesthesia feeds data into Powerchart every 5 minutes, if you do not see the Time In here, you can return later. If there are discrepancies between SA Anesthesia and Powerchart, you will be asked to fix them before finalizing.

2. The **Case Attendee**, **Role Performed** will be populated from your Multi- Entry Box selection.

    Note: You do not need to add yourself as a Case Attendee.

3. The Provider's Time In would normally populate from SA Anesthesia, but for training click to populate the current time

4. Click [Add] to add this to the provider's entry

5. Select **General Case Data** segment

At this point in the scenario, the patient is still undergoing their procedure; therefore you will not have a Time Out for the Provider so you will be returning to this later.

Document General Case Data

1. Complete this segment with the following data:

   OR = LGHOR LOC

   Case Level = *Minor*

   Wound Class = *No Incision*

   ASA = *1*

   Specialty = *Gynecology Obstetrics*

2. Click [Add]

3. Select **Surgical Procedures** segment

Note: The fields in this segment is normally pre-populated, this is practice for training purposes.

Document Surgical Procedures

1. Complete the segment with the following data:

   Procedure = *Ablation Endometrium Local*
   Primary Procedure = Yes
   Primary Surgeon = *Plisvcw, Tyler*
   Anesthetic Type = *Procedural Sedation*
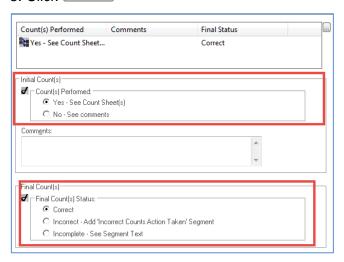   **Surgical Service** = *Gynecology and Obstetrics*

2. Click **Start** & **Stop** to populate the times

3. Click [Add]

4. Select **Counts Verification** segment

Note: The fields in this segment is also normally pre-populated, this is practice for training purposes.

Document Counts Verification

1. Under Initial Count(s), Enter **Count(s) Performed** = *Yes*
2. Under Final Counts(s), Enter **Final Count(s) Status** = *Correct*

3. Click [Add]

3. Select **Patient Positioning** segment

Document Patient Positioning

1. Complete this segment with the following data

    Body Positioning = *Lithotomy*

    Positioned By = *Plisvcw, Tyler ,*then Click [>>]

2. Click [Add]

Document Medications

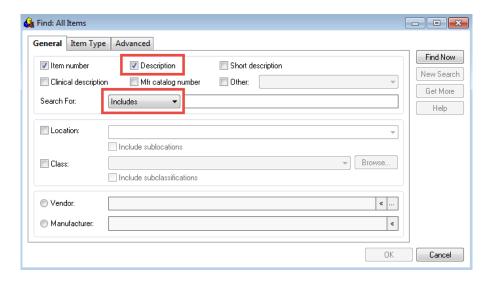Local anesthetics injected at the surgical site will be documented here:

1. Select the **Medications** segment

2. Click […]

- Find: All Items window opens

3. Ensure the **Description** box is *checked* and the **Search For**: is set to *Includes*
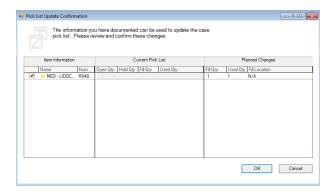

4. Type *<lidocaine>* into the **Search For:** field, and Hit **Enter**
5. Select *MED – LIDOCAINE 1% WITH EPI 20ML*
6. Click **OK**
7. Click [Time Administered:] to populate the current time
8. Complete the segment by entering the following data:

    Route of Admin = *Injection*
    Volume = *10 mL*
    Administered by = *Plisvcw, Tyler*

*9. Click **Add***
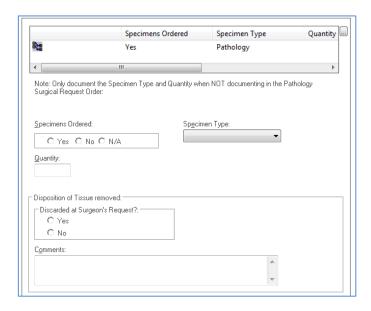- The Pick List Update Confirmation window may open

10. Click **OK**
11. Select the **Specimens** segment

Document Specimens

1. Enter the following:

   - **Specimen Type** = *Pathology from the drop down*

   - **Quantity =** *<Type 1>*

2. Click **Add**

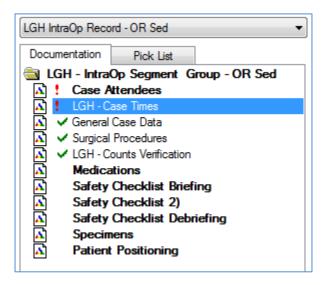   - Data entered will appear in the **Multi-Entry Box**

Note: You will still need to enter a Pathology Surgical Request to notify the lab a specimen is coming, this will be covered in the last Activity

Complete Outstanding Segment Documentation per Workflow

Notice at this point some segments are marked with a green checkmark and others remain an exclamation, you will not be able to Finalize this intraoperative record in Periop Doc till the required field are completed and all the segments have green checkmarks.

In the scenario, the provider is finishing the procedure; you will go back and complete outstanding fields in some segments:

1. Select the **Case Times** segment

2. Click Stop Time:

3. Click Out Room Time:

Once the **Out Room Time** is entered it should populate all attendee out of room times, however we will enter this manually as practice:
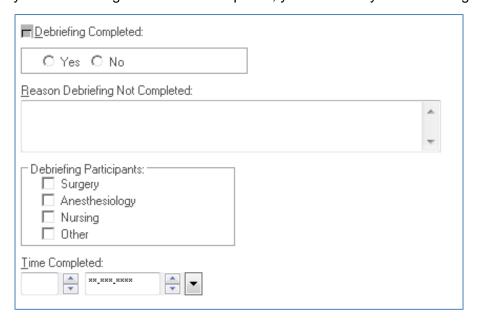
1. Select **Case Attendees** segment

2. Select *Plivcw, Tyler* from the Multi-Entry box

3. Click Time In:

4. Click Time Out:

Document Safety Checklist - Debriefing

You will recall that you entered the Briefing/Time Out information in the Sedation Record. Since you are finishing the case in Periop Doc, you will enter your Debriefing information here.

1. Enter the following:

    Debriefing Completed= *Yes*

    Time Completed = *Enter current time*

2. Once you navigate away from **Safety Checklist – 3) Debriefing** in the Segment List, you will notice the green checkmark ✔ **Safety Checklist – 3) Debriefing** indicating that this segment is complete
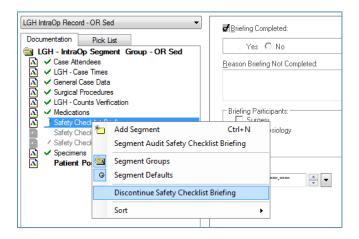
Discontinuing Segments

If a segment is irrelevant to your procedure (e.g. the case changes or provider changes their mind), you may discontinue a segment in order to Finalize Periop Doc. For learning purposes we will discontinue 3 segments, to discontinue a segment:

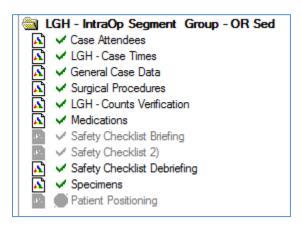1. Right-click **Safety Checklist Briefing**

2. Select **Discontinue Safety Checklist Briefing**

Also discontinue the following segments:

- **Safety Checklist 2)**
- **Patient Positioning**

The segments will now appear grayed out on the list

With all the segments showing green checkmarks and irrelevant segments discontinued, we are ready to finalize Periop Doc. However, we will cover this later after the next activity.

🔑 Key Learning Points

- In practice, you will still have SA Anesthesia open on one computer screen as you monitor the patient's vitals, comfort score, and administer additional meds (if necessary). At the same time, on another computer screen you will be completing the procedure charting in Perioperative Doc.

- In Perioperative Doc, which segments appear by default is dependent on the procedure that was scheduled.

- Segments with an exclamation mark are required segments.

- Segments indicated by a green checkmark means it is completed.

- Within each Segment, gray highlighting indicates a required field.

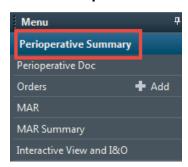- It is possible to discontinue an irrelevant segment

🧩 Activity 2.6 – Enter a Pathology Surgical Request

The following is a review of how to enter a Pathology Surgical Request, this Activity was originally covered in the IntraOp Nurse training.

If a specimen was removed to be sent for pathology, you will be placing an Order so that it cues the lab to expect a specimen to arrive for this particular patient. The **Pathology Surgical Request** is considered an **Ad Hoc** order.

To place a Pathology Surgical Request:

1. Select **Perioperative Summary** from the Menu

2. Select **Quick Orders** tab

3. Enter = *Pathology Surgical* in the Search box

4. Select **Pathology Surgical Request**, the order is now added to **Orders for Signature**

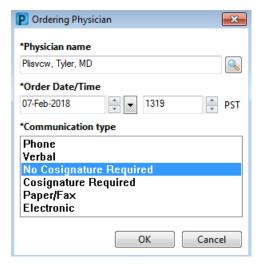5. Click Orders for Signature icon
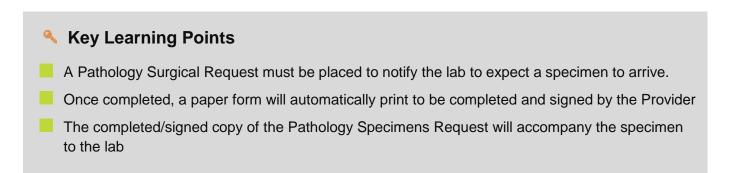
6. Click **Sign**

- Ordering Physician window opens

7. Enter *<PLISVCW, TYLER>*

8. Select **Communication Type** = *No Cosignature Required*

9. Click **OK** to complete

Once entered, a paper Pathology Surgical Request form will automatically print. The specimen should be processed and labeled per site policy. The paper form will be completed and signed by the procedural sedation provider to be sent with the specimen to be processed.
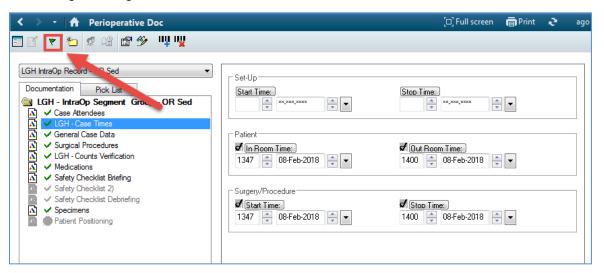
🔑 Key Learning Points

■ A Pathology Surgical Request must be placed to notify the lab to expect a specimen to arrive.

■ Once completed, a paper form will automatically print to be completed and signed by the Provider

■ The completed/signed copy of the Pathology Specimens Request will accompany the specimen to the lab

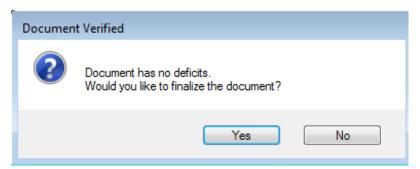## 🧩 **Activity 2.7 – Finalizing All Documentation**

Now that all documentation is completed in Perioperative Documentation & the Sedation Record, you will need to Finalize them.

To Finalize Perioperative Documentation:

1. Select **Perioperative Doc** from the Menu

2. Ensure all segments display a green checkmark ✔ in the Segment List

3. Click the green flag 🚩

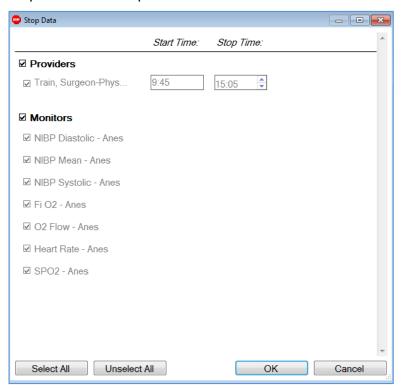4. Click Yes in the Document Verified window

The Document Deficits window will show if you try to Finalize Periop Doc with incomplete segments, you will be asked to fix any deficits before you can finalize again.

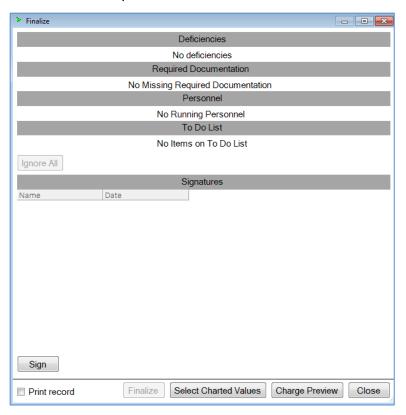To Finalize the Sedation Record, switch back to SA Anesthesia:

1. Select the Finalize Case ![Finalize Case] icon

   Stop Data window opens

2. Verify that you are stopping all your documentation then Click **OK**

Finalize window opens

2. Click **Sign**

Authorizing Signature window opens

4. Enter your *username* and *password*

5. Your signature will appear under the Signatures Section, Click **Finalize**

The Sedation Record is now finalized.

The Sedation Record will close and bring you back to the SA Anesthesia screen where you can Click the Select Case icon to open your next case

🔑 Key Learning Points

■ Ensure all the Periop Doc segments display a green flag in the Segment List before attempting to Finalize.

■ The Document Deficits window will show if you try to Finalize Periop Doc with incomplete segments, you will be asked to fix any deficits before you can finalize again.

■ You will also need to switch back to SA Anesthesia to Finalize the Sedation Record.

■ BMDI will automatically dissociate once the Sedation Record is finalized

🧩 End of Workbook

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