SELF-GUIDED PRACTICE WORKBOOK [N32] CST Transformational Learning

WORKBOOK TITLE:

# Provider: Anesthesia (Workbook #2)







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## **SELF-GUIDED PRACTICE WORKBOOK**

Duration	3 hours
Before getting started	<ul> <li>Sign the attendance roster (this will ensure you get paid to attend the session)</li> <li>Put your cell phones on silent mode</li> </ul>
Session Expectations	<ul> <li>This is a self-paced learning session</li> <li>A 15 min break time will be provided. You can take this break at any time during the session</li> <li>The workbook provides a compilation of different scenarios that are applicable to your work setting</li> </ul>
	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 1** – Access and Set-up

#### **Learning Objectives**

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

- Create an Anesthesia record
- Associate BMDI
- Assign macros
- Continue administering/documenting on infusions/medications from pre-operative unit.

#### SCENARIO

This scenario will address how to set-up to document within the SA Anesthesia module. Please note that regardless of an elective or emergency case, almost all aspects of utilization of SA Anesthesia are the same. Differences for emergency cases will be specifically pointed out throughout the various scenarios and activities.



**NOTE:** This workbook will only address Intra-operative aspects of the Anesthetic chart within SA Anesthesia. Pre-operative and Post-operative documentation is addressed in workbook 1 (P1).

As an Anesthesiologist, you will be completing the following 4 activities:

- Creating an Anesthesia Record
- Bedside Management Device Integration (BMDI) Association
- Setting Macros
- Continuing Infusions/Medications

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## Activity 1.1 – Creating an Anesthesia Record

SA Anesthesia is a specific module within PowerChart which is designed to replace the current state paper charts Anesthesiologists use. This module is mainly used by Anesthesiologists but may be used by surgeons and other providers who perform procedural sedation within surgical and endoscopic departments where an Anesthesiologist is not present.

🖉 Iask Yiew Document Window Help			-										- 8
Select Case Views Finalize Case Signatures Sons	nd Case Channe Ever Macros Medications In	take Output Actie	Di Personel Med/	Rud View Charting M	ade Patient's Ch	8							
NEN. CSTSNSAMBORA, STRITCHIE	Case # 40H09-2017-713	ore corper man	OH	LOHOR GAR	VOL PRODUCTION	6	ndar	Man			Argen Ct. 111	-	
DOE 1900-84-19 Ass 37 warm	Procedure Deter 2017-Jun 19 14:00		Surgeon Disarcosi	Exggool Alan Kirth Abdominal hemia		45 Av	A Cine						
NFIN 700004252	Weight (kg) 90 kg		Avestvesologist	Ls. Charles		hiP	ю.				Airds 0		
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To Do List	+ midazolam 2 mg/2 mL ini iv	13:30	129	2	14:00	14:15		14:	30	14:45	15:00	15:15	
To Do List	fentanyl 250 mcg/5 mL inj iv	150 mcg				150 mcg •							
Event Decals	HYDROmorphone 2 mg/mL inj 🗤	0 mg						0.5 mg					
Emergence	g proPOPol 200 mg/20 mL inj IV	150 mg				150 mg •	10						
5	B rocuronium 50 mg/5 mL inj iv	35 mg		3		55 mg	£•						
be	neostigmine 5 mg/10 mL inj IV	0 mg		•						2.5 mg +			
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0	ondansetron 4 mg/2 mL in) //	0 mg							4 m				
	+ hydrocortisone 100 mg inj (anes)	/ 75 mg						75 mg#					
	+ FLO2 - Anes N	-				20 🛊	0.	0.					
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	Fi Desflurane - Anes In						2.	- 2.					
	Fi Sevofiurane - Anes N					25.		2.					
	+ FIN2O - Anes %			4			Q.	0.		_			
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	FEEP - ADes cmH20					4.	0.	.0.					
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The screen is divided into various areas that are similar to the current paper charts that capture medications, vital signs, IVs, etc.

- 1. **Demographics Bar-** similar to the banner bar within PowerChart.
  - The main difference here is that the OR, ASA Class and Anes Type can be accessed directly by clicking on the name within the demographics bar to update those values.
- 2. **Workflow Pane** contains the To Do, Documentation and Reminders views which you can easily toggle between.
  - To Do list of all actions/events that may need to be documented for the case. The tabs on the left toggle between To Do and Completed Actions

To add components to the To Do List use a **Macro** (common tasks bundled together) or use manual entry for individual components.

• **Documentation** – contains the complete lists of medications, actions, and monitoring options that may be charted to the record.

This window can be used to manually populate the To Do List or document directly from this window.



- **Reminders** timer reminders can be set manually as required.
- 3. **Medications-** will appear at the top and display the drug name including concentration, dosage, when it was administered and the cumulative amount of drug administered.
- 4. Gases and Monitors- values are captured via Bedside Medical Device Integration (BMDI).
- 5. **Vital Signs Graphing** equivalent of the graphical component of the paper record used to capture vital signs. This data is also captured through BMDI.
- 6. **Event Pane -** Actions/Events from the To Do List can be dragged and dropped here to capture the event details and times (i.e. staff presence in the room, surgical start/stop times, start of anesthesia, etc.).
- 7. The buttons in this area allow you to toggle between the To Do List, Documentation and Reminder views.
- 8. The section at the top is the toolbar which allows access to specific documentation elements.
- 2 To open an Anesthetic record, the first step required is to associate the record to a specific patient. The Selection Case window is where you associate the Anesthesia record to a particular patient. This is the equivalent of taking a paper chart and placing the appropriate patient label on the record.

All cases booked through surgical scheduling will appear in the Select Case window.

1. If prompted select the area as being Main OR.



• This only occurs the first time you login.



Select Case								0	
Search Criteria	_							_	
Surgical area:	LGH	Main OR	(25	Start date:	04-Jan-3	2018	÷	0000	-
Operating room:			M 🛤	End date:	04-Jan-2	2018	12.8	2359	
Patient name:			M 渊						
MRN	1		M 😣						
Anesthesiologist			S 🖉						
Last documented			S 2						
Case number:								Sear	ch
Cases									
FIN	Record Created	Surgery	Name		MEN	Pro	nary Pro	edure	
	ET.	11-55	CATECUTEST JEAC		200006	322 Arth	hotomy	Ener .	

- 2. Find and click on your patient name (see your login card provided at the start)
- 3. Click OK

Search Criteria									
Surgical area:	LGH	Main OR				15	Start date.	13-Dec-2017	
Operating room:						*	End date:	13-Dec-2017	
Patient name:	<b></b>					*			
MRN						-			
Anesthesiologist	-								
Last documented									
One contraction	-			- T					
Case number.	<u> </u>								
Cases									11
FIN C	becord rested	Surgery Time	Name		MEN	Primary Procedure		Case Number	CR
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7000000016211	0	9:30	CSTPRODECSN; AN	ESTHESIA	700000702	Repair Hernia Inguinal		LGHOR-2017-1730	LOHOR SEV
700000005150	21	12:25	CSTPRODECSN, ISA	AC.	700003699	Tonsilectomy		LGHOR-2017-1726	LGHOR GRS
700000016539		12:35	CSTSNWORKBOOK	REGISCHED	700008714	Open Reduction Intern	el Fixation Hip	Dyn LGHOR-2017-1724	LIGHOR KC
700000015706		13:17	CSTPRODBCSN, JAN	AES	700003317	Open Reduction Intern	el Fixetion Ank	le LGH08-2017-1727	LGHOR GRS
700000016574	14	15:00	CSTSNWORKBOOK	PREOP	700008577	Repair Hernia Inguinal		LGHOR-2017-1729	LOHOR KC
						2)			
* L									



**NOTE:** If for any reason you cannot locate your patient in the Select Cases window, ensure the surgical location, start and end date and times are entered correctly. Alternatively, the patient name or MRN can be searched. If you cannot locate a scheduled case for your patient, a Blank Record can be initiated (button in the right lower corner) and the patient information can be assigned at any time after the case has started but before it is completed. This will be reviewed in Scenario 4, Activity 1.



A verification window will appear. This is an opportunity to verify that the correct patient is selected prior to creating a record.

Once you have verified you have the correct patient:

1. Click green checkmark icon 🗸

C	STPRODBCS	SN, ANESTHE	SIA
MRN: 70000 Allergies: amoxicillii	10702 DOB	: 01-Oct-1970	AGE: 47 years
Operating Room:	LGHOR SEY		
Surgeon:	Hunter, James McPhalen		
Anesthesiologist(s):	<none></none>		
Surgery Date/Time:	13-Dec-2017 9:30		
Procedure	Procedure	Surgeon	
	Repair Hernia Inguinal	Hunter, James McPhalen	
Case Number	LGHOR-2017-1731		

#### Key Learning Points

The SA Anesthesia module captures all the elements of a current state paper Anesthesia record.

When associating an Anesthesia record to a patient, all booked cases will appear within the Case window.

- If cases are missing, ensure your search criteria are correct.
- You can search for your patient by date or name.



### Activity 1.2 – Bedside Management Device Integration (BMDI) Association

Once you have associated the Anesthesia record to a patient, the next window to appear is the Select Device window. Within this window, the Bedside Medical Device Integration (BMDI) is the next step to associate to the record.

BMDI automatically records data from bedside monitors into PowerChart.

SA Anesthesia will capture physiological parameters, ventilation parameters and settings, and inhaled and exhaled gas measurements. Manual entry may be required for some parameters.

To associate the appropriate anesthetic monitor and machine to the record:

- Typically, the Anesthetic machines are labelled based on the location (site specific e.g. OR 1, OR 2, etc.).
  - In this case, click on AN-AnesCart-XX (Anesthetic delivery unit/ventilator) and AN-Monitor-XX (physiologic monitor) assigned to you on your login card.
- 2. Once you have selected the appropriate device(s), the associated devices will appear in this window. If you happen to select the incorrect one, you can remove it by clicking on the device name and then **Remove** located under the Selected Devices window.

Select Dev	vice				23
LGH Ma	in OR LGH	Out of OR			Selected Devices
LGH	IOR01	LGHOR02	LGHOR03	LGHOR04	Device
AN-Ar M	nesCart-01 ODEL 1	AN-Monitor-01 MODEL 1			
	1		<b>.</b>		
					2
					4 III >
					Remove
Other				3	OK Cancel

3. When the correct devices have been selected, click OK.



**NOTE:** Please ensure you associate the correct devices to your patient. The name of the device should also be visible on a label physically located somewhere apparent on each machine.



2 After the BMDI devices have been associated, the start user window will display.

This will capture the role of the person logged in (in this case you are the supervisor) for this record and the start time.



**NOTE:** There is always a supervisor in the case, even if there is only one provider. Other roles will be discussed at a later time.

Start User - SXCSTTEST.AN2	2	<b>.</b>
Do you wish to start your	time?	
Activity Type: Supervisor	Start Time: 2017-Sep-01	▲ ▼ 1433 ▲
	Ye	s No

- 1. Ensure that your login as shown by the name next to Start User. In this case it will be the login provided on your logon card.
- 1. Ensure the Activity Type is supervisor and document Start Time as appropriate.
- 2. Click Yes and the chart will now open with relevant information entered appearing.

#### Key Learning Points

BMDI automatically records data such as vital signs from bedside monitors into the Anesthesia record.

Ensure the correct device(s) are associated to the chart.

• Labels to the names of the machines should be clearly visible on the physical machines.



### Activity 1.3 – Continuing Infusions/Medications

Patients who are being transferred into the OR with an existing IV infusion and/or running medications will have a prompt to the Anesthesiologist on whether or not the IV/medications will continue to run while in the OR. IV infusion and medication orders do not have to be discontinued from the pre-operative area (ED, ward, SDCU) which will allow it all to continue to run and flow into the Anesthesia record if required. To capture this, a window will appear which will display all the medications and IV infusions currently running.

These are active orders that will continue within PowerChart in the electronic MAR.

This window represents all the medications and IV infusions being administered to the patient from the pre-operative area, the orders are still active. This window will automatically appear if there are currently infusions/medications running within the system.

- 1. For orders that the Anesthesiologist would like to continue/finish in the OR, click the appropriate box(es) in the **Continue?** column.
  - In this activity, click the box for **Continue** for sodium chloride 0.9% 1000 mL.
- 2. When all orders to be continued have been selected, click **OK**.

Continuing Order	s									- • ×
-				Infu	usions					
Name		Details		Status	Ordered By	Last	Bag Start	Volume	Continue?	
sodium chloride 0.9% (NS) continuous infusion 1,000 mL		replace losses 1:1, start: 2017-Sep-21 volume (mL): 1,000	.IV, drug form: bag, 11:19 PDT, bag	Ordered	Test, Surger	ry 2017	-Sep-21 11:21	1000 mL		
				Med	ications					
Name	Detai	ls	Status Orde	ered By	Last Dose	Last Admin	Frequency	Stop DtTm	Volume	Continue?
+			Ot	her Sche	aduled O	rders				
			01	ner sone		uers				
									OK	Cancel



2 Once all medications/infusions to be continued from the pre-operative area into the OR have been identified. These will automatically populate within SA Anesthesia.

Notice the sodium chloride solution is already populated. The "XXX" signifies solution administered in the pre-op area prior to entering the OR (data pulled from electronic MAR). The "C" indicates that this item has been continued into the Anesthetic record.

Berlin ETCO2 - Anes mmHg       Air Flow - Anes L/min       VO       VO Flow - Anes L/min       VO Flow - Anes L/min       VO Flow - Anes L/min	9 • • • •
드 🖕 sodium chloride 0.9% 1000 mL 0 mL	
EKG - Anes     Heart Rate - Anes bpm     SPO2 - Anes bpm     SAnesthesia Depth Monitor - Ane     Mean Airway Pressure - Anes     Peak Inspiratory Pressure - Ane	76 •

#### Key Learning Points

- Orders for medication/infusions which began in any pre-operative area do not have to be discontinued to enable a smooth transition of the documentation between PowerChart and SA Anesthesia.
- The Anesthesiologist has the option to continue infusions/medications into the Anesthetic record.



## Activity 1.4 – Setting Macros

At this point, the Anesthetic record has opened. To begin documentation, you must select the appropriate macros. Macros are a bundle of actions and events that are commonly required together for anesthetic care. A macro is required for physiological parameters to begin to populate the anesthetic record.

By selecting the appropriate macros, several actions including medications, fluids, and events can be documented rapidly.

Ensure the most appropriate macro is selected as there are various tabs to organize the categories.

Each line within the window is referred to as a component (i.e. SPO2 – Anes, PEEP – Anes, EKG – Anes, etc.). Each component of the macro can be set start upon execution of the macro (by selecting the Execute checkbox) or to manual be activated only when selected from the To Do List.

To execute a macro:

- 1. Click on the **Macros** icon Macros from the toolbar or you can click F3 on your keyboard to open the macro window. The window to select macros will appear.
- 2. You will notice the various tabs of macros available to choose from as displayed in the long rectangular red box.
  - Click on the **Monitors** tab from the toolbar
  - Click General Monitors

Arterial Préssuré	Monitors	Central Venous Pressure	*General Monitors	Regional Monitors
Sedation Monitors	TIVA Monitors			

- The details to the macro are now open.
- Click on SPO2 Anes and PEEP Anes in the To Do column
- Click **Execute**.





**NOTE:** Clicking Execute will distribute all components to the appropriate sections of the chart.

Macros									
				*Ger	neral Monitor	rs			
Execute	To Do	Allergy Interacti	on Event	Туре	Details	Date Time	Edit		
			SPO2- Anes	Monitors	Monitor On	2018-Jan- 9:38			
			Fi O2- Anes	Monitors	Monitor On	2018-Jan- 9:38			
			ETCO2- Anes	Monitors	Monitor On	2018-Jan- 9:38			
			ET Desflurane-	Monitors	Monitor On	2018-Jan- 9:38			
			ET Sevofluran	e- Monitors	Monitor On	2018-Jan- 9:38			
			Peak Inspirato	n Monitors	Monitor On	2018-Jan- 9:38			
			Mean Airway I	Pr Monitors	Monitor On	2018-Jan- 9:38			
			PEEP- Anes	Monitors	Monitor On	2018-Jan- 9:38			
			Resp Rate (ETC	C Monitors	Monitor On	2018-Jan- 9:38		E	
			VT Exhaled- Ar	ne Monitors	Monitor On	2018-Jan- 9:38			
			Fi N2O- Anes	Monitors	Monitor On	2018-Jan- 9:38			
			Heart Rate- Ar	e Monitors	Monitor On	2018-Jan- 9:38			1
			Pulse Rate <mark>(</mark> Sp	O Monitors	Monitor On	2018-Jan- 9:38			
			NIBP Systolic-	A Monitors	Monitor On	2018-Jan- 9:38			
			NIBP Diastolic	- Monitors	Monitor On	2018-Jan- 9:38			
			NIBP Mean- A	n Monitors	Monitor On	2018-Jan- 9:38			
			Temperature 1	L- Monitors	Monitor On	2018-Jan- 9:38			
			EKG- Anes	Monitors	Monitor On	2018-Jan- 9:38			
									7
Mainta	in Macr	o				Set All Times to Current	Execute	Can	icel

3. Click on the Macro icon again and select the **General ETT** macro located under the General tab.

🕸 Select Macro	x
Transplant       Other         Monitors       Medications       Regional Anesthesia       General       Cardiac       Obstetrics       Orthopedics       Pediatric	
General ERAS 🗃 General ETT General Trauma	
Cancel	



					General E	TT			
[	Execute	To Do	Allergy	Interaction	Event	Туре	Details Date 🔺		
					Monitors and Machine Safety	Actions	Checked and Passed, Yes, Standa 2018-Jan-		
					midazolam 2 mg/2 mL inj	Medication	ns		
					fentanyl preserv free 250 mcg/5 mL inj	Medication	ns		
					lidocaine preservative free 2% 5 mL inj	Medication	ns		
					proPOFol 200 mg/20 mL inj	Medication	ns		
					rocuronium 50 mg/5 mL inj	Medication	ns		
					HYDROmorphone preservative free 2 mg/mL inj	Medication	ns		
					dexamethasone 20 mg/5 mL inj	Medication	ns 🗉 💼		
					ondansetron 4 mg/2 mL inj	Medication	ns		
					neostigmine 5 mg/10 mL inj	Medication	ns 📕		
					glycopyrrolate 0.2 mg/mL inj	Medication	ns		
			🍫		ceFAZolin 1 g inj (anes)	Medication	ns		
					sodium chloride 0.9%	Intake			
					PLASMALYTE	Intake			
					Orotracheal Intubation	Actions	2018-Jan-		
					Anesthesia Ready	Actions	2018-Jan-		
					Multiple Care Items	Actions	Supine, Secured, Padded, Taped 2018-Jan-		
					Emergence	Actions	2018-Jan- 🔻		
l	•								
	Mainta	in Macro	D			[	Set All Times to Current Execute Cancel		

- 4. Determine what you would like to Execute or have on your To Do List from the macro. In this scenario, change the following:
  - Click on Monitors and Machine Safety to the To Do List.
  - Click on cefazolin and add it to the To Do List.
  - Click on **propofol** to delete the checkmark on the Execute column. There should now be no checkmarks within the Execute column for propofol.
  - Click Execute



Macros allow for several actions/events (such as a medication, fluid, or actions) to be documented with a single execution.

Marking components in the Execute column means these are actions written to the chart

Marking components in the To Do column means these actions will be listed on the To Do List until they are executed during the case or acknowledged prior to the record being finalized.



## **PATIENT SCENARIO 2 – Basic Functionality**

#### **Learning Objectives**

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

- Toggle between PowerChart and SA Anesthesia
- Utilize the workflow pane to document
- Suspend, finalize and print a record

#### SCENARIO

This scenario will address basic functionality within SA Anesthesia.



**NOTE:** This workbook will only address Intra-operative aspects of the Anesthetic chart within SA Anesthesia. Pre-operative and Post-operative documentation is addressed in workbook 1 (P1).

As an Anesthesiologist, you will be completing the following 4 activities:

- Accessing PowerChart from SA Anesthesia
- Workflow Pane To Do List
- Creating Reminders
  - Suspending the record

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## Activity 2.1 – Accessing PowerChart from SA Anesthesia

SA Anesthesia is an application CIS. As a result, you can easily toggle between SA Anesthesia and PowerChart to be able to easily review aspects of the chart that cannot be viewed within the SA Anesthesia module.

To toggle to PowerChart from SA Anesthesia simply click the **Patient's Chart** icon located in the toolbar.



Click on the Patient's Chart icon.

If prompted assign your relationship as an Anesthesiologist.

Assign a Relationship
For Patient: SA-Elective, Fernando
Relationships:
Anesthesiologist
Covering Provider Education Quality / Utilization Review Referring Provider Research Triage Provider
OK Cancel

When you are in the Anesthetic record and toggle to PowerChart (patient's chart), you can easily toggle back to the Anesthetic record. This method can be used to toggle back and forth between the two applications.

To toggle back from PowerChart to the Anesthesia record:

Menu	4	< > - 者 Provider View	v			j;	) Full screen 👘 Four	ninutes ago
Provider View		A B B B 4 4 100%						
Intensivist Workflow		Anesthesia Summary 22	Anesthesiologist Wor 52 Anesthesia Ord	ers 52 Pain Service Workflow 52 Electroconvulsive Th	52 D	ischarpe 💱 🛨		
Perioperative Summary								
Results Review		Procedural Information	=• •	Allergies (1) 🌲		Documents (0) 🍦		=• 0 ÷
Orders	+ Add	Case Number:	LGH08-2017-1182	All Visits		Last 6 months for all visits -		
Medication List	+ Add	Primary Procedure:	Tonsillectomy and Adenoidectomy	No Known Allergies		No results found		
Documentation	🕈 Add	Surgical Free Text: Anesthesia Type(s):	Tonsillectomy and Adenoidectomy Defer to Anesthesia	Vital Signs 🖕 =		Anesthesia Records (2)		
Allergies	+ Add	Surgeon: Surgery Start:	Baggoo, Alan Kieth 	Last 24 hours for all visits  No results found		Clinical Trials (0)		=• @
Diagnoses and Problem		Anesth Start:	-		-	On Study	Status Gr	HACE
Histories		Anesth Stop:		Measurements and Weights (0)	_ • •	No results found		
MAR Summary				Imaging (0)	≡• ♥	New Order Entry		ET O
MAR		Perioperative Tracking	=•0					
Form Browser		Anticipated Start Dt/Tm	13/09/17 10:00	Labs	≡• ∞	Inpatient •		
Patient Information		Anticipated Duration	56	Selected visit 🗸		A You are currently viewing a future	ntly viewing a future encounter. Any order you place wi	
Interactive View and 180		Operating Room LGHOR LON		No results found		apply to this encounter.		
Lines/Tubes/Drains Sum		Private Sched Comment						
Growth Chart				Preoperative Checklist		Search New Order		
Immunizations		Home Medications (0)	=-0	Lines, Tubes, and Drains (0)	≣• ♥	Mine Public	Shared	1
Clinical Research		All Visits				Favorites		
CareConnect		No conductioned		Intraoperative Catheters and Drains	=* ^	💋 My Plan Favorites		
		No results found		No results found				
		A		4		Problem List		
Opens the MyExperience	_				_	PRODBC SXTEST.AM	Wednesday, 2017-Septe	mber-13 09:48 PDT
🚱 🔎 🚥		💋 SurgiNet: Anesthe 😢	CATISHEEPPER, ST					09:48 2017-Sep-13

• The BLUE arrow indicates the icon to toggle to PowerChart.



- Click on the SA-Elective, Ferna...
- Located at the bottom of the screen, there are icons which indicate what you have opened within Windows. The RED arrow indicates the icon to toggle back to SA Anesthesia.
  - Click on the SurgiNet: Anesthe...

## Key Learning Points

Navigation between PowerChart and SA Anesthesia is can be completed through a single click.

1



## Activity 2.2 – Workflow Pane – To Do List

The To Do List can be utilized as a prompt to remind anesthesia providers of the tasks that are potentially required throughout the case. Not all items within the To Do List have to be executed at the time of finalization.

Macros are one way to include actions in the To Do List. You may also add actions through the Actions icon on the toolbar at any point in time within the active case. Actions selected individually from their respective menu can be left click and dragged to the To Do List or left double clicked onto the chart immediately.

When you are ready to execute a component from the To Do List. Ensure you are on the To Do

List, if not, click on 🛄 to access the To Do List:



- 1. Double click cefazolin.
  - Cefazolin was set-up to populate in the To Do List from the macro set-up in Scenario 1, Activity 3.
- 2. Notice it has now dropped off the To Do List. It has moved to the Completed tab and appears on the Medications List to the right of the workflow pane.



		To Do List	1	lidocaine preservative free 2%
Completed To Do	Event ceFAZolin 1	Details g inj (anes)	Medications	rocuronium 50 mg/5 mL inj HVDROmorphone preservativ dexamethasone 20 mg/5 mL i ondansetron 4 mg/2 mL inj neostigmine 5 mg/10 mL inj glycopyrrolate 0.2 mg/mL inj cef A20in 1 g inj (anes)
			Gas	ETCO2 - Anes mmHg
			Montors	Presk Inspiratory Pressure - Anes Mean Airway Pressure - Anes Resp Rate (ETCO2) - Anes VT Exhaled - Anes m. Temperature 1 - Anes Degt EKG - Anes

3. The medication window will appear and details may be completed. Completion of this window will be reviewed in Scenario 3, Activity 3. Click **Cancel** to leave this window.

Cefazolin 200 mg/1 mL           Bolus         Concentration Product:         Product:         200 mg / I mL Weight:         Height:         187 or Weight:         Or Weight:         Or           Datent:         (None)         Imal:         Imal: <th>Add Medici</th> <th>ation Administra</th> <th>ition</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>	Add Medici	ation Administra	ition						
Bolus         Concentration         Height         167 cr           Infusion         Product         200 mg / 1 mL         Weight         0 H           Buint         None         mt         mt         Weight         0 H           Bill         200 mg / 1 mL         mt         mt         0 H           Bolus         Admin time         11:30         11:15         11:30         11:16 8-Jan-24         1 h <td< th=""><th>Q 620</th><th>44</th><th>3</th><th>cefazolin 200 mg/1 m</th><th>L</th><th></th><th></th><th></th><th></th></td<>	Q 620	44	3	cefazolin 200 mg/1 m	L				
Image: Weight Required         7         8         9           Bolus         11:30         11:30         11:45         In 1:45         In 1:45           Bolus         Admin time:         11:30         11:45         In 1:45         In 1:45 <t< th=""><th><ul> <li>Bolus</li> <li>Infusion</li> </ul></th><th>Concentr Product: Diluent: Final</th><th>ation 200 mg (None) 200 mg / 1</th><th>n / [] r • [ mL</th><th>nl.</th><th>mL</th><th>1</th><th>Height: Weight:</th><th>167 cm 0 kg</th></t<>	<ul> <li>Bolus</li> <li>Infusion</li> </ul>	Concentr Product: Diluent: Final	ation 200 mg (None) 200 mg / 1	n / [] r • [ mL	nl.	mL	1	Height: Weight:	167 cm 0 kg
Bolus     7     8     9       Admin time:     11:36     7     8     9       Dose amount:     mg     4     5     6       Volume:     0     mL     1     2     3       Weight based dose:     Weight required     1     2     3       Route:     N     Site     No Site Specified       Show all routes     Show all sites	<b>B</b>	<ul> <li>2018-Jan</li> <li>10:45</li> </ul>	-24 11:00	11:15	1	11:30	8 <b>8</b> -J	an-24 11:45	F B
Admin time:         11:36         7         8         9           Dose amount:         mp         4         5         6           Volume:         0         mt,         1         2         3           Weight based dose:         Weight required         5         6         1         2         3           Route:         N         Site         No Site Specified         5         8         9           Show all routes         Show all sites         5         5         5         1         2         3         1         0         «	Bolus				-		_		······
Dose amount:         mg         4         5         6           Volume:         0         ml,         1         2         3           Weight based dose:         Weight required         1         2         3           Route:         IV         IN         Site:         No Site Specified           Show all routes         Show all sites         Integer to the site site of the site site site site site site site sit	Admin tim	e [1	1:36			10	7	8	9
Weight based dose:     Weight required       1     2       3     .       0     «   Route: No Ste Specified       Show all routes	Dose amo	ount:	ing 🖸			1	4	5	6
Route: N  Site No Site Specified Show all sites	Weight ba	sed dose: N	Veight required			- 17	1	2	3
Router W Site No Site Specified								0	«
E COMPRIME T	Route: N	Show all rout	•)	8	ite:	No Site S	pecil Il siti	fied 65	1

• Whenever you click an action/event from the To Do List, it will drop off this list and move to the Completed list. In this case, medications will also then populate into the Medications section of the chart. Although the medication administration details were not completed by clicking cancel, you can always access the details window again by clicking on the medication name.



Aside from populating the To Do List from macros. Actions may also be added to the To Do List by simply toggling to the Documentation Workflow Pane.



1. Clicking on **Documentation Workflow Pane** icon.

During Scenario 1, Activity 3, propofol was removed from appearing on any list. In this case, you as the Anesthesiologist changed your mind and would like to add it to the To Do list.



In this screenshot, you are now in the Documentation window (of the Workflow Pane) within the Medications tab and have the list of Sedative/Anesthetic open.

#### 1. Click on Sedative/Anesthetic

The correct medication has been located. You would like to add it to the To Do List as you do not want to administer it now, but want a reminder to do so later.

- 2. Click on proPOFol 10mg/mL (anes) and hold down the left mouse button.
- 3. While holding the left mouse button, drag it to the To Do List icon and then release the left mouse button (as indicated in the screenshot above). A prompt will appear that you can drop to add the medication to the To Do List (Screenshot below).





3 Components within the To Do List can be edited/removed at any time as requirements for the patient may change throughout the case.

To edit/modify any component within the To Do List:

- 1. Right click on the component you would like to edit. A window will appear with options of actions.
  - As the patient already has a NS infusion going there is no need to have a Plasma-Lyte infusion.
  - Click on Remove PLASMA-LYTE 1000mL bag (anes).

Edit PLASMA-LYTE 1000 mL bag (anes) Execute PLASMA-LYTE 1000 mL bag (anes)

Remove PLASMA-LYTE 1000 mL bag (anes)

## Key Learning Points

- The To Do List serves as a reminder of all the medications and tasks that were set for the case.
- The To Do List items can be ignored at the time of finalization.

1



## Activity 2.3 – Creating Reminders

The Reminders panel is where you can set reminders for tasks. It is a free text box to capture what you would like a reminder in regard to. The time of when the task is due can also be set and the repeat reminders functionality is also available.

The To Do List only captures the tasks that are still required; however do not capture when they are due. This functionality can be used in conjunction to the To Do List. An example of this would include re-dosing of antibiotics 4 hrs after the initial pre-incision prophylactic dose. Setting a reminder to re-dose might be helpful.

1. Toggle from the Documentation List to the Reminder window by clicking on the Reminder Icon in the workflow pane.

	To Do	List
Completed To Do	Details Monitor On Monitor On g	
Ê		



2 While within the Reminder workflow pane, you may view, edit or add additional reminders.

Click on the highlighted icon to add a reminder.

	 Reminders	
mpleted Active	Reminders	C
<u>8</u>		× X

3 This window will appear when you click to add a reminder. Details to the reminder are to be completed here.

● In	4 ෫ Hours	0 🚔 Min	utes	
At	****_***			
Alert 5 Minu	tes	✓ before	ore due	
Repeat	reminder every	Hou	rs 0 🔺 N	linutes
Alert	5 Minutes		- before due	e

For this example, we will utilize a case which is expected to last 7 hours (skin-to-skin time). The antibiotic prophylaxis of Cefazolin 1000 mg will need to be re-dose 4 hours after the last dose (0745 – based from the electronic MAR). Set a reminder to re-dose the Cefazolin.

Utilizing the example of setting a reminder to re-dose a prophylactic antibiotic for a longer case.

- 1. Reminder: Repeat Cefazolin
  - Notice the yellow background in the free text box a yellow background indicates that this is a required field.
  - Click on the Reminder text box to enter = Repeat Cefazolin
- 2. Due ln = 15 min.
  - Ensure you have the correct time choice as there are 2 options. If you enter the number of hours, it will be based on the time the reminder is set, not the time of the last dose based on the electronic MAR.
  - If timing is critical you can calculate the 4 hours from current and set it based on the Due At time.
- 3. Alert = 1*5 minutes* before due
  - Choose the alert interval you would like from the drop-down list.
- 4. Click OK



4 Once a reminder has been added, the reminder will appear in the reminder window and display the Due In time.

To mark tasks off as Complete:

- 1. Click Repeat Cefazolin
  - Click green checkmark icon ✓ to sign your documentation.

Reminders	Due In
Repeat Cefazolin	15 minute:
< III	•
8	🖌 🖌 🗙

5 Aside from the repeat window available from the workflow pane. A pop-up will also appear when the reminder time has come based on what was set.

There is a choice to snooze, complete, dismiss or dismiss all.



**NOTE:** Selecting **Complete** does not link you to the details window to document a re-dose. Manual access to document the re-dosing is required.

	Reminders	Due In	Repeat every
0	Repeat Cefazolin	3 minutes overdu	e
ick Sr	nooze to be reminded in :		

Click Complete



6 As tasks are completed and marked off as completed, it will move from the Active tab to the Completed tab.

	Reminders	
e	Reminders	Due In
Completed Activ	Repeat Cefazolin	4 hours

#### Key Learning Points

- Reminders can be used in conjunction with the To Do List.
- The To Do List captures tasks to complete only; whereas, reminders will have a specific reminder available for each task including the time the task is due.
- Selecting **Complete** does not link you to the details window to document a re-dose. Manual access to document the re-dosing is required



## Activity 2.4 – Suspending the Record

The functionality of suspending a case is possible for situations such as transfer of a patient from the block room to the OR. The case can be suspended while in the block room prior to transfer to OR, and then open the record up again in OR on another terminal.

Suspending a case will let you choose what you would like to continue to chart and what to discontinue. For instance, the IV will continue to administer whereas, all medications may be discontinued.

The record will not be available to other users through documentation within PowerChart until it has been finalized. It will only be viewable to Anesthesiologists.

To suspend a case:

- 1. Click on the super case icon located in the toolbar.
- A window will appear which will ask you if you are sure you want to stop charting. Connection to Bedside Medical Device Integration (BMDI) devices will be lost and data will stop following. BMDI will be reviewed at a later time (Skill Sharpener).

	Parestriction			
?	Are you sure yo be lost and dat	ou want to stop ch ta will stop flowing	rting? Any connect into the record.	ion to devices will

- Click Yes
- Most patients will have to be disconnected from devices to be transported. Patients transported with monitoring will be associated to a new device in the receiving unit.

Stop User - SXT	EST.ANA				
Do you wish to	o stop your tir	me?			
Start Time:			Stop Time:		
14-Dec-2017	÷ * 0836	0	14-Dec-2017	2 - 0920	0

3. Click **No** for the Stop User time as you are still the provider for this patient during transport.



**NOTE:** For transition of care to another Anesthesia Provider, Yes would be selected for this window.

4. An alert will pop up that indicates that any issues are present. In this case the NS infusion has no stop time, however since this infusion is ongoing click **OK** to acknowledge this.

Contractory of		
PURINTS	g taken have been found is processing the Alic	charted methodose Turk
Delcana	*	
They in	Security .	
interio	applicer infrarrate (LPN-2416) and 14 (does mint a required for posture character () the observague (2016) can be (1) and	
Daneya	ent.	
7.00	Dear-years	
Ches Car	need to about change and convert the insules. O	os DK to geven and sonthan doorng
(bulou) implicate	DK will not just the shows medications/fails to tree	the WAR which used flows againtized patient rafes



SurgiNet: Anesthesia		
	Click OK to close the case.	
	ОК	

5. Click OK

2 When you arrive in the PACU, you can open the Anesthesia documentation again.

It is possible to suspend a case on multiple occasions.

To re-open the Anesthesia record suspended for the patient, first ensure SA Anesthesia module is open.

1. Click on Select Case



2. The Select Case window will open.

Search Criteria	40					· · · · · · · · · · · · · · · · · · ·		12	
Surgical area:	LGH	LGH Main OR			Start date:	01-Dec-2017	÷ *	0000	÷
Operating room		24 A			End date:	03-Jan-2018	\$ *	2359	4
Patient name:									
MRN.			24	×					
Anesthesiologist			9	×					
Last documenter	t.			×					
Case number:		1	1	×			1	Search	1
Cases									
FIN	Record Created	Surgery Time	Name			MRN	Primary Proc	edure	
7000000015957		11:00	CSTSNFETT, STJA	NGO		700008402	Repair Hernia	a Inguinal	
7000000015815	1	11:30	PITSEVEN, AND	RΕ		700008497	Open Reduct	don Interna	d E
700000015754		11:46	CSTPRODBCSN,	JANE		700007868	Arthrodesis F	inger	
7000000015432		12:00	CSTSNORGANA,	STLE	IA	700007395	Cesarean Sec	tion	
7000000010215		15:04	CSTSNULY, STTE	STTW	0	700006517	Insertion Sec	ondary Intr	ra
7000000010215		15:27	CSTSNULY, STTE	STTW	0	700006517	Extraction Ca	taract with	Ir
4									

- 3. Click on the correct patient located in the Cases window in the bottom section.
- 4. Notice in the Record Created column, there is a checkmark with a blue background. This indicates a record has already been started for this patient and this case.
- 5. Click **OK** after the correct patient has been selected. The existing record will open.



#### Key Learning Points

- Suspending a case is used when transferring a patient between units or for interrupted workflows (e.g., labour epidural management)
- A case can be suspended more than once.
- The record will not be available to other users through documentation within PowerChart until it has been finalized. It will only be viewable to Anesthesiologists.



## **PATIENT SCENARIO 3** – Initial Documentation

#### Learning Objectives

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

Complete initial documentation required for a case.

#### **SCENARIO**

This scenario will address the specific areas which can be documented within SA Anesthesia.



**NOTE:** This workbook will only address Intra-operative aspects of the Anesthetic chart within SA Anesthesia. Pre-operative and Post-operative documentation is addressed in workbook 1 (P1).

As an Anesthesiologist, you will be completing the following 8 activities:

- Documenting Anesthesia equipment checked
- Enter ASA and Anesthesia Type from the Demographics bar
- Documenting Medications
- Documenting IV fluids
- Documenting Output
- Documenting Action/Events
- Documenting Personnel
- Documenting Point of Care (POC) test result

1



## Activity 3.1 – Documenting Anesthesia equipment checked

One of the first things that may be documented is that the Anesthesia equipment is present, checked and ready prior to the patient entering the OR.

To complete documentation on equipment checks:

Double clicking on **Monitors and Machine Safety** to document on it and execute to the appropriate time.



**NOTE:** The timeframe for when items are executed can be changed at any time.





2 When documenting Monitors and Machine Safety, double click on the icon in the action panel and the details window will appear. Documentation of details will be captured at this time.

<b>E</b>	

Some basic metrics will be selected.

E Macros 17-1228 omy Lap: 1 11:30	Action Details	
<ul> <li>▲ prop mide rocu</li> <li>← cefa</li> <li>▲ ETC N2C O2 F ET C</li> <li>← Sodi</li> <li>▲ EKC</li> <li>→ Heai SPC Tem Peai</li> <li>← PEE</li> </ul>	Anesthesia Machine Checked and Passed No Anesthesia Machine at Location Note Suction Working and Available Yes N/A Comment Monitors Standard CAS Monitors BP EKG Pulse Oximeter ETCO2 FiO2 Airway Equipment Yes N/A Note Emergency Medications Present ECG 3 Lead 5 Lead N/A BP Cuff Applied Left Right Upper Arm (Brachiocephalic) Forearm (Radial) Lc Temperature Esophageal Rectal Axillary Skin Blood Nasopharyngeal Gas Analyzer Yes Comment Note Processed EEG Monitor BIS/PSI Bilateral EEG Monitoring N/A	12:
C	Time:       1135       11:00       11:15       11:20       12:15       2017-Sep;21:4       Convent:         Comment:	

Select the following:

- BP cuff on left
- 5 lead ECG
- No Nerve Stimulator

Click OK when done

#### Key Learning Points

Documentation of Monitors and Machine Safety will have a specific details window to do document upon.



## Activity 3.2 – Enter ASA and Anesthesia from the Demographics bar

1 At any point in your intra-operative workflow, the ASA class and Anesthesia type can be updated in the system. These metrics are located in the Demographics bar. Metrics you can update within the Demographics bar are apparent by the + icon next to it.

These metrics must be completed to prior to Finalizing the case, if not an error will pop up and you will have to complete it.

To enter an ASA or Anesthesia type:

1. Click the + icon beside ASA Class located within the Demographics bar.

SurgiNet: Anesthesia - [LGHOR-2017-1108]					- 2 ×
Z Task View Document Window Help					. 8 ×
Select Case Views Finalize Case Signatures Suspend Case	Shange User Macros Continuing Orders	Medications Intake Output Actions Person	nnel Med/Fluid View Patient's Chart Charting Mode		
Name: CSTSNPEPPER, STRED DOB: 1999-Nov-30 Age: 17 years	Gender: Male Procedure Date: 2017-Sep-06 10:00 Weight (kg):	Procedure: Surgeon: Anesthesiologist:	Cholecystectomy Laparoscopic Queh, Peter Test, Surgery	Alergies: 4 ASA Class: 4 Anes. Type: 4	
2017-Sep-06					2017-Sep-06

2. Click the **box** next to 2.

ASA Class	×
Select ASA Class:	
1         1E         2E         3         3E         4         4E         5         5E         6         See Comments	
	OK Cancel

- 3. Click OK.
- 4. Click the + icon beside Anes Type
- 5. Click the **box** next to General
- 6. Click OK.

The updates should now be visible.





#### Key Learning Points

- Certain metrics from the Demographics bar can be updated from this area as denoted from the + icon beside the metric.
- These metrics must be completed prior to finalizing the case, if not an error will pop up and you will have to complete it.



## Activity 3.3 – Documenting Medications

Once particular medication has been selected, details of the administration can be completed through this specific window.

If this is a new administration being added to the record, the word NEW will appear in the top lefthand corner of the Add Administration dialogue box.



**NOTE:** All medications and dosages recorded within SA Anesthesia will flow into the electronic MAR.

Documenting Infusions will be similar to the steps as documenting medications.

Hen		pr 10 n	opofol 🚺 ng/1 mL			
Bolus Infusion 2 F	Concentration Product: Diluent: (No Final: 10	10 mg / me) mg / 1 mL	1 mL	3 mL	Height: Weight	167 c 100 l
т н 1	018-Jan-25 10:00	10:15	10:30	10 48   10:45	8-Jan-25 11:(	•
Bolus Admin time:	10:48	0		7	8	9
Dose amount		p mg		6 4	5	6
Weight based	dose:	mg/kg		1	2	3
					0	«
Route: N Shov	w all routes	•]	Site:	No Site Spe	cified sites	

Orientation to the medication details window:

1. The name of the medication and strength of the medication as determined by the pharmacy formulary.

- 2. This is where you indicate if you are administering a bolus or infusion.
  - In this activity, we will review a bolus of a medication. Documenting a medication infusion is similar to the documentation of an IV fluid (reviewed in Scenario 3, Activity 4).
- 3. Details to the concentration of the medication.

4. Height and weight of the patient. These components can be modified within this window by clicking on the blue value (i.e. <0> or <50kg>).

• These values are typically pulled from PowerChart and do not require to be edited in this window.

5. This window will adjust based on whether it is a bolus or infusion. The details of the bolus/infusion are documented here.



6. Keypad to click on to update numbers within the window.

7. Additional details on where the medication is being administered. Based on the routes and sites you have previously documented.

2 To document the details of the medication:

- 1. Double click Propofol from the To Do list.
- 2. Find your medication in the medication list and then click on the medication.

			 _
	٠	rocuronium 50 mg/5 mL inj	
		HYDROmorphone preservative	
SU US		dexamethasone 20 mg/5 mL ii	
atio		ondansetron 4 mg/2 mL inj	
dic		neostigmine 5 mg/10 mL inj	
ž	_	glycopyrrolate 0.2 mg/mL inj	
	Ξ	ceFAZolin 1 g inj (anes)	
	٦	proPOFol 10 mg/mL inj (anes)	

- 3. Ensure **Bolus** is selected.
- For the Bolus details window: enter the administration time, click on the time box and press N on your keyboard.
  - Pressing "N" on your keyboard when you are in any box that contains a time will automatically populate the current time – N=Now
- 5. Enter a dose amount of **200** mg.
  - You will notice based on the dose amount you entered and the weight within the system, the weight based dose is automatically calculated.
- 6. The administration route is IV.
- 7. Site is Hand Right.
- 8. Click OK.

Herry			prop 10 mg/	ofol '1 mL				
Bolus Infusion	Concentr Product Diluent Final	ation (None) 10 mg	10 mg /	1 mL	mL	эн Эv	leight: Veight:	167 cm 100 kg
TT N	2018-Jan	-24 4:15	14:30	14:45	14 58	8-J	an-24	ъ į н
					0			
Bolus Admin time	. 1	4:58	0			7	8	9
Dose amo	unt:	20	0 mg		-	4	5	6
Weight ba	sed dose:	3	2 mg/kg			1	2	3
						•	0	«
Route: N			-	Site	No Site Sp	ecifi	ed	
Comment:	Show all rout	05			🖺 Show al	site	s	



3 Once the details to the bolus have been added, it will appear on the Anesthetic record.

The bolus of Propofol has been charted for the time that was entered. Hover the mouse cursor ("hover to discover") over the bolus, a temporary window will appear to display additional details to the bolus.



4

All medications/infusion administered by Anesthesia are entered into SA Anesthesia. This data will flow into the electronic MAR of the patient chart to make it easily accessible for all to view the medication administered intraoperatively by Anesthesia. This data will flow through to the electronic MAR with a 30 minute lag time as well as anything remaining at suspend or finalize.

All Anesthesia medications/infusions will be in a grey background under the Discontinued section as these medication orders were only for Anesthesia purposes. Anesthesia related orders will also be noted by (ANES). Below is an example of this.





#### Key Learning Points

- Medications can be added to the To Do List via a macro or drag and drop from the Documentation List.
- When documenting a new medication being administered, NEW will appear in the administration window on the top left-hand corner as an indicator.

1



## Activity 3.4 – Documenting Output

Outputs which can be documented include estimated blood loss (EBL), urine from a catheter, EVD, chest tube, gastric or drain outputs.

To select the output documentation window in the workflow pane:

- 1. Click on the **Output** tab.
- 2. Double click on the appropriate source of output, in this case, **Estimated Blood Loss**.





- 2 Details to the EBL are now required through the details window.
  - Output time this captures the time the EBL was documented.
  - Prior Estimated Blood Loss cumulative volume of EBL documented prior.
  - Incremental EBL The current EBL that you are documenting to add to the total EBL.
  - Total EBL total volume calculated including current documented volume + prior EBL.
  - Total weight based EBL total volume calculated in mL/kg in EBL. Automatically calculated based on patient weight.



**NOTE:** Definitions of the metrics across all outputs are the same.

🔒 Output			×
Refer to the second Los	s		
		Heig Wei	ght: 0 ght: 70 kg
2017-Sep-18 12/21 12:15 12:30 12:45 1	2017- 13:00	Sep-18	<b>H</b>
0			
Output			
12:21 ÷	7	8	9
Prior Estimated Blood Loss: 0 mL		_	0
Incremental Estimated Blood Loss:	4	5	6
Total Estimated Blood Loss: 0 mL	1	2	3
Total weight based Estimated Blood Loss: 0 mL/kg		0	
	•	0	"
Site: (None)    Site: Show all sites			
Comment:			
			Ĵ.
	0	ж	Cancel



3

Enter the details to estimated blood loss.

					Heigt	e. M	162 0
T + 14-Dec-2017 111 11:00 11	3 15 1	1:30	11:45	14-Dec	-2017	•	
0	-						
Output Time:	11:13			7	8	9	9
Prior Estimated Blood Loss. Incremental Estimated Blood Los	25 m			4	5	(	6
Total Estimated Blood Loss.	50 m	c.	_	1	2	1	3
Total weight based Estimated Blo	od Loss: 0.6	7 mL/kg			0	1	«
Site (None) • Show all sites Comment.							

Please enter the following:

- Output time 5 minutes ago
- Incremental EBL 200 mL
- Click OK

Enter a second EBL occurrence:

- Output time Now
- Incremental EBL 25 mL
- Click **OK**

Total EBL calculated and documented in the record.



Outputs include: Estimated Blood Loss, Urine Catheter, EVD, Chest Tubes, Gastric Tubes and Drains.

Time and Incremental metrics are the only details to add. All other details will automatically be calculated by the system.

1



## Activity 3.5 – Documenting Action/Events

Documenting times of actions or events throughout the case is possible within the SA Anesthesia.

Typically, the list of actions/events is best to work from the To Do List as it will serve as a reminder to ensure required fields are documented. This can be populated via a macro; however, it can also be created manually by dragging and dropping actions/events from the documents list.

The following case times are also being captured by the Circulating Nurse and flow to the Anesthetic record:

- Patient in/out of room time
- Procedure start/stop time

To document an action/event, choose the action/event to document and drag and drop it into the lowest window pane.

In this case, the Anesthesia Start time is what you would like to document.

- 1. As Anesthesia Start is not in the To Do List, click on the Documentation icon.
- 2. Click the Actions Tab.
- 3. Click Case Times.
- 4. Click and hold down on the left mouse button on **Anesthesia Start** in the Documentation window. Drag and drop the Anesthesia Start to the appropriate time in the lower section of the record.

	05-Jan-2018	1000	1.5.5	CALCULATION OF	12,200,00	ana an	9:54	201201	32000	05.Jan.2018	
	8:15	8:30	8:45 9:00	9:15	9:30	9:45	10:00	10:15	10:30	10	<u> </u>
	Documentation		<ul> <li>midazolam 2 mg/2 mL inj</li> <li>feataaul armsea free 350 met/5 r</li> </ul>	mi lei							
lenn	Case Times		idocaine preservative free 2% S n	mu inj mu inj							
e   Medicati	Anesthesia Ready Anesthesia Start Anesthesia Stop Anesthesia Stop	E	<ul> <li>proPOF01200 mg/20 mL inj v rocuronium 50 mg/5 mL inj WVDROmorphone preservative fin dexamethasione 20 mg/5 mL inj</li> <li>ondansetron 4 mg/2 mL inj</li> </ul>	ee 2 mg/mi, inj	6.3333		0.0044 mg/kg/n	unute			
Intak	Aprtic Cross-Clamp On     Arterial Clamp Off		G + FLO2 - Anes N C + ETCO2 - Anes mmHg								
cions 🔒 Output 🕅 Montors 🕅	<ul> <li>√ Arterial Clamp On</li> <li>Block Start</li> <li>Block Stop</li> <li>Burst Suppression</li> <li>Cannulation of Aorta</li> <li>Cannulation of Vena Cava</li> <li>Circulatory Arrest Start</li> <li>Circulatory Arrest Stop</li> <li>Circulatory Arrest Stop</li> <li>Controlled Hypotension Stop</li> </ul>		Peak Inspiratory Pressure - An Mean Anway Pressure - Ans Incop Res (FCO2) - Ans nos tpsied - Ans Temp Res (FCO2) - Ans Temp Re								150 150
A.	Patient Care Anway Management Postioning Regionaria	Access Monitoring Obstations									
2	Emergency Case Times Documentation Point of Care	Case End/Transport									
ä			·		Pa						



Once an action item has been placed, double click the icon to add details.

- Anesthesia Start only contains a free text note box for additional comments. The level of detail will depend on the action/event.
- Click OK

3 Action Details	- • •
🕋 Modify Anesthesia	Start
,	2
	Value
	Anesthesia Start
	No Value
Time: ng 36	
■ 15-Jan-2018.00 9:15 9:30 <sup>9:36</sup> 9:45	10:00 10:15 Jan-2018 >
Comment:	
	<u></u>
Remove	OK Cancel

When the "hover to discover" functionality is utilized, the additional details will appear temporarily on the chart without clicking anything. You must move the cursor over the details popup for it to persist. Moving away from the popup will allow it to close.



If changes to the details are required, you can re-open the Details Window by clicking on the Bold Event Name.



#### Key Learning Points

- Documenting action/events by drag and drop from the To Do List.
- Details available to document is specific based on each action/event.
- "Hover to discover" can be utilized to have a quick view of the details documented.



## Activity 3.6 – Documenting Personnel

1

To document the Anesthesia Department Personnel in the room. Locate the Personnel icon in the toolbar. The Modify Personnel window will appear and the personnel documented will already be populated in the window.

Anesthesia personnel captured will be viewable to the Nursing staff to ensure accuracy. If not, discrepancies in documentation will be noted.

- 1. Click the Personnel toolbar button.
- 2. Click on the Add button to add person to the chart.
  - To remove personnel, select the provider and then click **Remove** (Not required for the activity).

Task View Document Window Help	
Select Case Views Finalize Case Signatures Suspend Case Change	User Macros Medications Intake Output Actions Inventory Personnel Med/Fluid View Charting Mode
	No Case Associated
2017-Sep-19 8:30 8:45	9-00 9-15 9-30 9
To Do List	N+ Modify Personnel
Event         Details           Patient In Room         Acastric parts	Personnel for SXTEST.AN - 2017-Sep-19 8:36
Anesthesia Ready Contacheal Hubbalon Surgical Airway	Name     Start Date     Start Time     End Date     End Time     Activity Ty       Conners, MD, Anne Cerner     2017-Sep-19     9:57     Superviso
	Add Remove OK Cancel



2 The Anesthesia staff list will appear and be organized based on roles. The various tabs at the top represent the different roles to locate the appropriate staff member. The list of staff names is based on individual logins.

To add a provider(s):

- 1. To add multiple staff members, click on **Multi-Select** first, then select the appropriate staff members.
- 2. Select the staff names to add the person to the list. Add the following personnel.
  - Anesthesia Fellow Test User, Perioperative Anesthesia Fellow
  - Medical Student TestUser, MedicalStudent
  - Click OK.



**NOTE:** You can only have one supervisor at a time.

Select Personnel					x
Other Resident An Anesthesiologist	esthesia Assistant   Anesthesiologist - As	Medical Student   O sisting   Anesthesia	therAttendee	a Resident	
Ahmadi, Hazhir	ATT, Physician - Anesthesiologist ATT.PHYSANES	Bohn, David Allan	Chatterson, Kelly Schalin	Conners, MD, Anne Cerner	
Dipboye, Keith	Eksteen, Ben	eLearn, ANESTHESIOLOGIS T, MD	Fingland, Robert Murray	Hewgill, Randolph Thomas	
Hudson, Jacqueline Taryn	Jamieson, James David	Klar, Marta Joanna	Kuca, Tomas	Lamb, Jeffery Charles	Ш
Lipowska, Magdalena Maria	Lo, NOLDAP, Charles	Masselink, William Stephen	McAlpine, John Claude	McCarter, Bryon Douglas	
McDiarmid, Adam Pope	Morrison, Clare	Pantel, Richard James	Peck, Marcus	Plisvci, Brooks, MD	
Plisvcr, Carlton, MD	Plisvda, Amber, MD	Plisvdb, Betty, MD	Plisvdc, Cody, MD	Plisvdd, Dave, MD	
Rajan, Yasmin Abdul	Ripley, Teresa Marion	Roos, Henk De	Roos, Martin Robert	Schellenberg, Kenneth Lyle	÷
Other Dther	Select			Can	cel

#### Key Learning Points

- Documenting Anesthesia personnel can be accessed through the Personnel icon on the toolbar.
- Personnel documented in SA Anesthesia flows into the intra-operative documentation for nursing. Discrepancies will be flagged for nursing to address.
- You can only have one supervisor at a time.



## Activity 3.7 – Documenting Point of Care (POC) test results

Point of Care (POC) testing is often used in the intra-operative environment as Anesthesia requires real time data on the patient status.

To document POC results:

1

- 1. Click the **Actions** icon tab from the Documentation section of the workflow pane.
- 2. Click on **Point of Care** at the bottom of the workflow pane.
- 3. Select the POC test you would like to add
- midazolam 2 mg/2 mL inj
   fentanyl preserv free 250 mcg Documentation lidocaine preservative free 2% proPOFol 200 mg/20 mL inj rocuronium 50 mg/5 mL inj Point of Care Intake | 💊 Medications ADS Blood Gas Hat Hgb Au Blood G HYDROmorphone preservativ dexamethasone 20 mg/S mL - ondansetron 4 mg/2 mL inj Med Fi O2 - Anes % - ETCO2 - Anes M B Actions & Output Monitors If \* SPO2 - Anes % Me. Airway Pressure - An PEEP - And Airway Peak Inspiratory Pressure - An Resp Rate (ETCO + VT Exhaled - Anes ABC t N A Personnel Patient Care Airway Management Pos Regio 0b ning Emergency Case Time Case End/Te 1 pet-Physican3, MD Point of Care n.
- In this case, add a **Blood Gas** by dragging the icon to action pane.



2 Values received from the results can be manually entered into SA Anesthesia. POC devices are not interfaced with the PowerChart or SA Anesthesia.

2017-Sep-15 30 9;45 Documentation	🖁 Action Details	11:03 11:00	2017-Sep-15
Point of Care	🐭 Add Blood Gas	100 mcg • 50 mg •	
ter in the second seco	Source         Aterial         Peripheral         Venous         Capillary         Value         Blood Gas         No Value           Pa02         mmitg         Pa02         mmitg         No Value         E         E         E         E         E         E         Item 1         No Value         E	5 000 C	180 160 140 100 100 100 100 100 100 100 100 10
Case Times Airway Positioning	хиннин А		
Image: Image and the image			

- 1. Select a specific result received to be entered.
  - Click on **mmol/L** next to Na+
- 2. The section on the right hand side of the window is where the result value is entered.
  - Enter 140 mmol/L for Na+.
- 3. Click OK.

I Action Details			-	
All Add Blood Gas				7
Source Arterial Peripheral Venous Capillary Minute Ventilation U/min pH pH	Value Na	+: m	mol/L	
PaO2 mmHg = PaCO2 mmHg	7	8	9	
HCO3 mEq/L	4	5	6	
Base Excess mmo/L	1	2	3	
K+ mmo//	•	0	«	
2017-Sep-19 0.00 10.15 10.30 10/10.45 11.00	11:15	20	17-Sep-1 1:30	9 🕨
Comment:				^ 
		ОК	Са	ncel



3 The charted Arterial Blood Gas (ABG) will appear in the same section of the chart as the actions/events.

Hover to discover to view additional details.



#### Key Learning Points

POC results have to be manually entered into SA Anesthesia to appear on the finalized record.



## PATIENT SCENARIO 4 – Advanced Functionality and Documentation

#### Learning Objectives

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

- Creating and associating blank records for emergency cases
- Advanced functionality for documenting

#### **SCENARIO**

This scenario will review more advanced functionality and troubleshooting for common discrepancies.

As an Anesthesiologist, you will be completing the following 3 activity:

- Modifying an Infusion
- Finalizing a record
- Creating and Associating Blank Record



## Activity 4.1 – Modifying an Infusion

To change the rate of IV solution.

The following are quick buttons to identify the action you would like associated to the solution.

: This icon allows rate changes to be made. Click this blue triangle and then click in the time frame that the rate needs to be changed in. Enter the correct rate in the appropriate field and a blue separator appears in the bar, indicating a change was made.

This icon allows the stop time of the infusion to be entered. Click the red circle and then document the proper time to indicate the conclusion.



: This icon deletes the rate change indicators that might be present in the bar.

: This icon allows documentation of incremental doses over a time frame. Click this icon and then click the medication line to document incremental volumes.

To modify the rate of an existing infusion.

🏹 Modify Intake						x
sodium c	hloride 0.9	% 10	000 r	nL k	ag	
Bolus     Inf     D     X	Bag volume: 100	00 mL	2010	Height Weigh	t: 167 it: 60	_J cm kg
<sup>™</sup> 4 20 :45	18-Jan-16 14:00 14:	15	2018-J 14:30	an- Io	н	
	2					
Start time: Stop time:	13:38 🗘		7	8	9	
Volume rate:	150 mL 3		4	5	6	
Weight based rat Volume:	e: 2.5 mL/kg/hor 45 mL	ur	1	2	3	
Duration: 0.3+	hour		•	0	«	
Route: IV	▼ Ill routes	Site	Hand	- Right	ites	•
Comment:						* +
Remove Bag	Multiple Bag OK	S	tart Next	t Bag	Cance	:

- 1. Click somewhere along the line of the existing solution to open the details window. In this activity, we will utilize the IV solution of Sodium Chloride 0.9% 1000mL bag.
- 2. Click on the  $\bigtriangleup$  icon to signify you are changing the infusion rate.
- 3. Move your mouse cursor to the time bar the cursor arrow will turn into the blue triangle. Move this to the time the infusion rate was changed and click the left mouse button to place



the change.

- 4. Change the volume rate, weight based rate or volume.
  - For this activity, change the infusion rate to 200mL/hour.
  - The blue section of the bar indicates when the change in infusion rate was changed.

Fi O2 - Anes %			
😇 🚽 ETCO2 - Anes mmHg			
드 💲 sodium chloride 0.9% 1000 m 1041.67 mL 😮	a 100 mi/hour a	150+ mL/hour	

#### Key Learning Points

IV infusions can continuously be charted seamlessly. The infusion rate of the previous bag will be visible on flowsheet.



### Activity 4.2 – Finalizing the record

Upon completion of the case, the last step with the Anesthesia record is to finalize the record. Finalizing a record will trigger 2 tasks to occur that cannot be executed before finalization.

- Data is now viewable from the Documents section of PowerChart.
- During finalization, you can complete the unfinished documentation including medications, fluids, or actions.

To finalize a case:

1



- 1. Click on the Finalize Case icon in the toolbar.
  - This will open a Stop Data window.
  - All data elements that will stop will appear. There is a column to capture what can be continued under the Continue? column. You may choose to click the box to add a checkmark to indicate that you would like to continue something.
- 2. When complete and satisfied with the Stop Data window, click **OK**.
  - This will open the next window Finalize window.

Ľ	SurgiNet: Anesthesia - [LGH	OR-2017-1108]			0 @ X
$\mathbb{Z}$	Task View Documen	t Window Help			_ 8 ×
Se	elect Case Views Finalize	Case Signatures Suspend	d Case Change User Micros Continuing Orders Medications Intake Output Actions Personnel Med/Fluid View Patient's Chart Charting Mode	0	an Mandar
DO	Inte: CSTSNPEPPER, STR 08: 1999-Nov-30	ED	Gender: Male Procedure: Universities up and Alegent		wn Atergies
Ag	e: 17 years		🗢 Stop Data	Gener	al de la constante de la const
1	2017-Sep-0 14:	5 15	Start Time: Stop Time: Volume: Continue?	11	31 2017-Sep-06
	Docume	ntation	2 Medications		
stions	Case	Times	☑ propotol (Hand - Right)           1526         1531         □		
Medice	✓ IVC Clamp On € One Lung Ventilation	n Start	☑ Intake Fluids		
9	One Lung Ventilation     Patient In Room	n Stop	62 sodium chloride 0.9% 1000 mL beg (Hend - Right) 10.40 15.31 € 727.5 mL		-
01 Intel	Patient Out Room Patient Ready to Tr	ansport	☑ Providers	11.	
onitors	Surgery Stop		27 1531 C		
N N	Throat Pack Out	i 1	☑ Monitors	100 +	150+ mL/hour
tp nt	G Tourniquet Inflated	107	☑ SPO2 - Anes	- 14 +	t
0	Vascular Clamp/Sh	unt On	2 Fi O2 - Anes	2 • 293 •	
su su	Venovenous Bypas	is Stop	D ETCO2 - Anes	88 •	200
Actio	Case Times	Airway Management	D ET Desflurane - Anes	-	140 150 120
2	Positioning	Patient Care	E ET Sevoflurane - Anes		100 100
l e	Access/Monitoring	Regional/Neuraxial		-	80
3rso	Obstetrics	Emergency	Petroda Alli Characteria Alli		50 60
l di	Case End/Transport	Documentation	Select All Orselect All OK Cancel		
	Point of Care			Ð	1 1
	İ 📄 👩				



- Prior to finalizing a record, this window will inform you of items that may require to be addressed prior to be finalized. Some tasks are a hard stop and must be addressed in order to be finalized.
  - Review any documented deficiencies. Example: Missing amount for documented medications
  - Review all required documentation. Example: ASA and Anes Type
  - Review personnel, or documented providers that are not assigned to a stop time. Ensure a Supervisor signs the document.
  - Review your To Do list. Tasks listed on your To Do List are required to be completed before finalization. Can either document upon it or ignore it.

This window is separated into 2 main sections:

- 1. The top window will display deficiencies.
  - If there are no deficiencies, the screenshot below (A) is what will appear.

	Deficiencies	
	No deficiencies	
	Required Documentation	
	No Missing Required Documentation	
	Personnel	
	No Running Personnel	
	To Do List	
	No Items on To Do List	
Ignore All		
	Signatures	
	<b>U</b>	
	•	

• If there are deficiencies to address, something similar to the screenshot below (B) will appear with deficiencies listed. The type of deficiency will determine how it may be addressed. For this scenario click **Ignore All**.

		Deficiencies	
Type No Signature	Descrip Supervi	ition isor signature required for the document	Edit Sa
		Required Documentation	-
		No Missing Required Documentation	
		Personnel	
		No Running Personnel	
		To Do List	
G Orotracheal Anesthesia I Multiple Car Emergence	Intubation Ready e Items	Supine, Secured, Padded, Taped	
Ignore All			
		Signatures	
Name	Date		
Sign			

2. The bottom window will display staff members who have signed the record. Additional



signatures may be required. An example is that a first-year resident has been documenting on the record throughout the case; however, a first year resident requires the attending to sign prior to being able to finalizing the record.



**NOTE:** All medications and fluid administrations require Supervisor signature present for the entire duration of the administration.

• To add a signature to the record, click on Sign.

• Enter your personal login information and click **OK** (for training purposes use the login provided).

3 Once a case is finalized, it will be available to view by all other users within the patient chart and can also be printed.

This is an example of what a completed record looks like, a view from the Documents section of



PowerChart or the Anesthesia view within SA Anesthesia.

Baseline West Medical Center		Ane	esthesia Recor	d	DAVIS, MATTHEW				
5276 Rockcreek Parkway Kapaga City MO, 54117		Date I	Printed: 8/8/2013 12:3	8	00000481				
Kalisas City, MO 64117			Page 1 of 4		OR-2013-53				
					Adrenalectomy				
OR: OR 01	DOE	B:	10/12/1984						
Surgery Date: 7/12/2013 11:15	y Date: 7/12/2013 11:15 AGE								
Surgeon: Peeks MD, Krista Anasthasialagist: Connors MD, Anno	on: Peeks MD, Krista Gen basialagiat Connora MD Anno Pro-				Hoight				
Anesthesia Type: General	Anesthesia Type: General Rea				Weight				
ASA Class: 2	NPO	):	. Desirpan		Allergies:				
Name	Total	7/12/2013	11:00	11:15	11:30	11:45	12:00		
			Medications						
fentanyl 0.05 mg/mL Inj Sol 5 mL 🛛 IV	200 mcg		150 mcg 🔍			50 mcg 🔶			
propofol 10 mg/mL IV Emul 20 mL IV	337.5 mg		180 mg ⊜		15 m	rgįkg/minutes			
vecuronium 1 mg/10 ml IV syringe IV	2 mg		2 mg 🔍						
succinylcholine 20 mg/mL Inj Sol IV	120 mg		120 mg ©						
cefazolin 1 g Inj IV	1 g	1g 🖗							
			Gases						
02 - Anes L/min			98			94 🗗	98		
Inspired Desflurane - Anes			3		<b>_</b> <sup>2</sup> <b></b>				
Ventilation Mode - Anes									
			Intake						
Fresh Frozen Plasma Amount Transfused	250 mL						- 1000 mi jibr		
Whole Blood Amount Transfused	1350 mL				i inits i	-3			
Lactated Ringers IV Sol 1000 mL Right Hand	2325 mL				1000 mi /br		- 3000 mi /br		
			Output						
<							P.		

To view a Finalized copy of an Anesthesia Record (not available in Train Domain):

- 1. Open patient's chart and navigate to **Provider View**.
- 2. Click Anesthesiologist Workflow tab.
- 3. Scroll down to Anesthesia Record and click procedure name hyperlink.

			All Visits   🤁 🚍
v Surgeon(s)	*	v Case Status	
Chang, George, MD	02/03/2018 07:58	Finalized	
	Surgeon(s) Chang, George, MD	Surgeon(s) * Chang, George, MD 02/03/2018 07:58	Surgeon(s) Case Status Chang, George, MD 02/03/2018 07:58 Finalized

Anesthesia Record appears in new window.

#### Key Learning Points

- Finalizing a record will enable all users to view the record.
- Deficiencies need to be addressed prior to finalization.



## Activity 4.3 – Creating and Associating Blank Records

1

Cases that have been scheduled will automatically appear on the Select Case window. For Emergency cases which have not yet been scheduled, a blank anesthesia record can be created in the meantime to be merged with a scheduled case later.

Creation of a blank record does not affect access to functionality; it simply means that the record is not associated to a particular patient at this time.

To create a blank record:

- 1. Click on the Select Case icon on the toolbar.
  - The Select Case window will appear.
- 2. Click on Blank Record.

Select Care							
Search Criteria							
Surgical area:	LGH Mai	n OR	20	Start date:	2017-Sen-2	6	0000
Operating room:				End date:	2017.600.2	c ^ .	2250
Detiont nemo:				2.14 4410.	2017-30p-2	•	2333
MONI			<u> </u>				
MRN:			M 👗				
Anesthesiologist:			🔍 🗶				
Last documented:							
Last documented: Case number:							Search
Last documented: Case number: Cases							Search
Last documented: Case number: Cases FIN	Record	Surgery Time	Name			MRN	Search Prima
Last documented: Case number: Cases FIN 700000010880	Record Created	Surgery Time 8:15	Name CSTPRODBCSN	VICTORIA		MRN 700006909	Search Prim: Repa
Last documented: Case number: Cases FIN 700000010880 700000005150	Record Created	Surgery Time 8:15 8:30	Name CSTPRODBCSN CSTPRODBCSN	VICTORIA		MRN 700006909 700003699	Search Prima Repa Trans
Last documented: Cases number: Cases FIN 7000000010880 7000000005150 70000000010232	Record Created	Surgery Time 8:15 8:30 8:35	Name CSTPRODBCSN CSTPRODBCSN CSTSNSWIFT, S	VICTORIA ISAAC ITAYLOR		MRN 700006909 700003699 700001662	Search Prima Repa Trana Cesa
Last documented: Cases number: Cases FIN 7000000010880 7000000005150 7000000010232 7000000010885	Record Created	Surgery Time 8:15 8:30 8:35 9:53	Name CSTPRODBCSN CSTPRODBCSN CSTSNSWIFT, S CSTSNMAY, STA	VICTORIA ISAAC ITAYLOR UNT		MRN 700006909 700003699 700001662 700006914	Search Prima Repa Trans Cesa Repa
Last documented: Cases number: Cases FIN 7000000010880 700000005150 7000000010232 7000000010885 7000000010870	Record Created	Surgery Time 8:15 8:30 8:35 9:53 11:19	Name CSTPRODBCSN CSTPRODBCSN CSTSNSWIFT, S CSTSNMAY, STA	VICTORIA ISAAC ITAYLOR UNT E, STSTEVEN	IK	MRN 700006909 700003699 700001662 700006914 700006557	Search Prim Repa Tran Cesa Repa

3. Click on binoculars icon next to Created Location



- 4. Select appropriate OR room
- 5. Click OK



	noom seiectori	
Existing	Recent	
G LGH Endos	сору	
G LGH Main	DR	1
😑 🌼 LGH In	traOp - OR	
JL LG	H LD 01	
- J LG	H LD Epidural Request 01	
- LG	HOR AddOn 01	=
LG	HOR AddOn 02	
	HOR CAP	
- LG	HOR CAT1	
- J. LG	HOR CAT2	
- JL LG	HOR GAR	
LG	HOR GRS	
- LGI	HOR GRV	
LG	HOR KC	
- EL LG	HOR LON	
- B. LG	IOR NEW	
- BL LG	HOR SEY	-
L HILG		252
rt Location:		

#### 6. Click OK

• Notice the location is now populated.

Created by:	SXTEST ANA	
Created date:	14-Dec-2017	
Created time:	11:42	
Created location:	LGHOR CAP	ø4
*Document Type:	LGH Anesthesia Record -	8
*Record Description:	SXTEST ANA - 14-Dec-2017 11:42	

At any time within the case, when the patient has been created and booked within the system, the record can be associated back to the appropriate patient.

To associate a blank record to a patient:

1. Click on Task Associate > Case to Record...





The Select Case to Associate window will appear.

- 1. Ensure the appropriate surgical area is listed. This will ensure you are looking at the correct list to review the patients.
- 2. Search for the correct patient to associate the blank record to. Click to highlight the appropriate patient. Please use the patient that is provided on your login card.
- 3. Click OK.

Select Case to Associa	ste								• ×
Search Criteria				_					
Surgical area:	LGH M	ain OR		#4	Start date:	2017-Sep-19	÷	0000	*
Operating room:			*	×	End date:	2017-Sep-19	÷	2359	*
Patient name:			<b>P</b>	×					
MRN:			4	×					
Anesthesiologist:				*					
Last documented									
0				-					
Case number.				*				Sear	ch
Cases						-			
FIN	Record Created	Surgery Time	Name			MRN	Primary Pro	cedure	
700000010450		8:09	CSTSNMAKER,	STPA	ACE	700006699	Implant Initia	Pacema	ker
700000010468		9:00	CSTPRODBCSN	I. PO	STOPPAIN	700006707	Fusion Spine	e Posterio	r Cervi
700000009957		11:05	CSTSNFRANZ.	STKA	RL	700006452	Stapedector	my	
700000010408		15:00	CSTPRODBCSN	I. PER	PPER	700006679	Open Reduc	tion Intern	nal Fixa
e [			m						•
				-			014		
							OK	Ca	ncel

#### Key Learning Points

- In the event of an emergency, a blank record can be started regardless of whether or not a patient is scheduled for the case.
- The record can be associated back to a specific patient when the patient has been scheduled.



## 🔹 End Book Two

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