**Assessment of Service Specialist and Current Staff Charting Practices**

**Survey Monkey Results**

N=41 (of 115 OR RN’s)

1. It is important to assess the patient's skin both pre-operatively and post-operatively. Please select each skin site that you currently chart in BOTH the pre-op skin and post-op skin assessment tab:

* Overall 97.56% (40)
* Grounding (if applicable) 56.10% (23)
* Operative 24.39% (10)
* Positioning 41.46% (17)
* Tourniquet (if applicable) 31.71% (13)
* Warming (if applicable)21.95% (9)
* Responses Other (please specify) 26.83% (11)
* Any baseline changes, i.e. skin tears or unexpected cuts.
* I chart additional items as needed
* my post op skin assessment includes grounding, positioning, warming etc. based on the procedure.
* The only one Pre-op is the overall. The rest I complete Post-op
* I chart warming, grounding and positioning post op
* I only chart overall condition in preop. In postop I chart the other categories as indicated.
* Only chart overall in both, chart others if applicable in post-op
* For operative, I chart "incision".
* To be clear I chart overall in preop and all others in postop
* I get specific with grounding, positioning at the end. Overall is for the preop stage.

1. It is appropriate to chart a delay when the start time of a second case is later than the scheduled start time due to a first case running late, but the room was turned over appropriately in 30 minutes.

* True 41.46% (17)
* False 58.54% (24)

1. An essential component of the OR Nurse's case preparation includes a pre-operative interview with the patient to assess health, safety and knowledge of the expected care plan. This interview and patient education is documented within what section of the Intra-Operative chart?

* Clinician Communication tab 7.32% (3)
* Pre-op Skin tab 4.88% (2)
* Nursing Notes tab 73.17% (30)
* It is not important to document this interview 14.63% (6)

1. The Braden Scale Assessment is to be completed only by the Pre-Op Nurse and does not affect the OR Nurse.

* True 43.90% (18)
* False 56.10% (23)

1. Please select all of the following equipment for which you currently document serial numbers, if used:

* ESU/Force Triad 92.68% (38)
* Malis Bipolar 63.41% (26)
* Harmonic/Gyrus 80.49% (33)
* Bair Hugger/Warming Blanket Machine 63.41% (26)
* SCD’s 56.10% (23)
* Drill (Stryker, Anspach etc.) 19.51% (8)
* Laser 56.10% (23)
* C-Arm/O-Arm 2.44% (1)
* Responses Other (please specify) 21.95% (9)
* any trial equipment/ devices
* Never. If there is a problem with the unit, I will take it out of service and call biomed. If it is functioning properly, I don't record serial numbers. This is a complete waste of time for the RN.
* Serfas
* Anything cautery esp.
* Thunderbeat, Aquamantys, etc.
* ABC
* I'm not even sure why it is necessary to document the electrocautery items because if there was a problem you would do an incident report at the time of injury and document this. It shouldn't be necessary to document SN for bair huggers or scd's because if it was a legal issue the rest of the units in the hospital would also document this and they do not.So it doesn't make sense that this is done in the O.R
* I've been told by multiple people that serial numbers do not matter because if there is a problem you'll then make sure to get that unformation. I'd say about half the nurses who have precepted me chart the serial numbers.
* gyrus, thunderbeat, tourniquet

1. Please select all of the following scenarios where the Clinician Communication tab should be utilized:

* Critical lab value result 29.27% (12)
* Frozen section result 0.00% (0)
* Critical test report 17.07% (7)
* All of the above 39.02% (16)
* None of the above 34.15% (14)

1. When adding a new incision to your chart, do you chart the time the incision was first assessed and do you chart an assessment of the incision (i.e. "within defined limits, WDL")?

* I chart both the time the incision was first assessed and an assessment of the incision 14.63% (6)
* I chart the time the incision was first assessed but I do not chart an assessment of the incision 53.66% (22)
* I do not chart the time the incision was first assessed and I do not chart an assessment of the incision 31.71% (13)

1. The "Close Time" button in the Intra-Operative event timing section is to be recorded when the surgeon begins closing the incision.

* True 21.95% (9)
* False 78.05% (32)

1. The OR Pre-Operative Checklist tab of the Intra-Operative chart is to be reviewed by the OR Nurse and can be completed by the OR Nurse if necessary (i.e. patient is direct transport from the ICU, night shift etc.)

* True 90.24% (37)
* False 9.76% (4)

1. Please share any additional comments/concerns related to your service including equipment, implants, medications and/or comments/concerns with the current guidelines/expectations with Intra-Operative charting below:
2. epic is not user friendly.
3. can we review what the clinical communication tab is for? this was not a part of my initial 'epic' training - can we also review what 'WDL' means for incisions means? what is 'excpected' for an incision to look like? -for the braden scale, I look at what the pre op rn charted, but do not chart my own assessment. is this something we are supposed to be doing? -what ARE the appropriate times to chart 'sweep of incision' and 'closing' ? i chart the sweep when we are closing, or right before if the surgeon tells me that he/she is sweeping with intentions of closing next. i chart 'closing' when we are actually closer to being out of the room or putting on dressings since 'closing' is misleading i think.. it may take 45 minutes or it might take 5. I see the 'closing' tab as a sign that we are much closer to being out of the room rather than the closing of the wound. -can we review what a 'pre op interview' should include and where that should be charted? some sort of scripting or outline maybe?
4. I did not know what "Clinician Communication" was.
5. Regarding question #6, I don't chart these results because I will have the surgeon come to the phone/put patholgy on speaker phone for frozen section results, or for lab values, I transfer the call to anesthesia. The nurse should not have to be put in the middle. Critical information like this should be communicated directly to the person it is intended for.
6. What is Clinician Communication?
7. It would be extremely helpful to have an area on the EPIC screen to chart who completed the methodical wound examination (sweep) and if the "pause for the gauze" was completed and by which surgeon. I know it is an act of God to get the EPIC screen changed but this would be very helpful. I think we all need clarification on when to check "sweep of operative site", "closing time," and "ready for OR discharge." We need a better way to track when the surgery is completed (dressings on, drapes off).
8. 1. Equipment-too many #'s on equipment, list on epic needs to be updated. 2.Implants-Too bad we don't have a bar code scanner! 3. Medications-Are the med charges done from our charting or Pyxis? 4. Allergy every 2 hour check-needs to go away! 5. Anesthesia should have the Bair hugger & warmers on their charting! and especially the tournaquet!!! 6. Could we have included in our screen a "sponge verification by: MD & nurse".
9. It would be really helpful if all of the serial numbers for the equipment was up-to-date in the chart (there are a lot of them that aren't in there). It would also be nice if we could "copy" an implant the way we can copy a pathology sheet - so we can easily make an entry for something of the same that was implanted and explanted or something.
10. #1 Is it policy to document serial numbers? Has there EVER been a time where those numbers were used for anything? For quick cases this seems to be a hassle, especially for new people. Personally, I will just choose any number if I am in a hurry. Taking care of my patient is more important than tracking down serial numbers for my charting. I would love for someone to look into this and to see if we are doing this because we always have? Does this need to be done? #2 I feel to have accurate skin documentation, there should be seperate pre-op and post-op tabs. It should be charted seperately so that there is a clear distinguish between the two. #3 When would there ever be a new incision thats not "WDL"? It seems like over-charting to document this on a new incision. And, the skin around the incision should be documented under skin, so if you charted something under incision it would be double charting. #4 I feel if you are documenting under the OR Pre-operative checklist, then you do not need to chart a paragraph in the nurses notes restating everything you filled out in the checklist. Again, overcharting, which is not always a good thing.
11. More supplies, especially in hybrid/cardiac, guidewires etc need to be in the computer. Too time consuming to put in one time supply for everything.
12. I do not do a braden scale assesment because it is done on the unit and I treat every patient as if they are high risk for skin breakdown with appropriate padding and this is charted in the positioning section. I do not chart the assessment of a new incision other than the time and date it was made in surgery because it is new there is nothing to asses. When it is closed and bandaged the patient leaves the room.
13. Education should have it's own spot. I document it in my preop assessment in the Pre-op checklist. i've heard that the notes get in the way of others so I do not chart there regularly.
14. What is the Clinician communication tab. Do we have to chart the blanket warmer?
15. People are too focused on charting.
16. if not found in other areas of chart, documentation is done under nurses notes
17. I have never used the clinician communication tab. I'm not sure what/where it is or what it should be used for. I also have never been told to document any kind of assessment of the incision.
18. Clarification of guidelines would be helpful. I believe that there are inconsistencies across the staff with respect to charting.
19. need more standardization
20. I don't see the point in excessive charting, I feel we should chart by exception. Also charting the serial numbers of equipment is a waste of time. If there is a malfunction that causes injury, then you should note that for a PSN. If the numbers aren't readily available then I know people either omit them or make them up. I don't see how charting these numbers affects patient care
21. Esu settings, what setting do you chart the beginning (30/30) the time we changed it to 70/70 or the end? I chart no settings and put a note that the settings are per the surgeon and may change thought the case. What is considered cut time when local is used prior to incision, is cut time actually start time? Or actual cut time? Is everyone being mindful of the time with medication documentation? If we add meds 30 minutes into the case but gave them before the timeout is everyone making sure the documented time indicates it was actually given? If not then the time of NS given may contradict the verbiage in the timeout with regards to irrigation/solution on field.
22. I find there is constantly changes and no email to note changes. I sometimes find out from orientees of changes in charting.-not good There is no uniform charting process.
23. It would be nice to have an Epic "guru"/ hospital legal consultant go over the "intra op" charting and show what is "required". There currently isn't any uniformity in our charting.
24. We need to research/decide if all equipment serial numbers need to be charted, and identify which serial numbers are correct on the machines.