**Assessment of Current/New Hire & Service Specialist and Current Staff Charting Practices**

**Survey Monkey Key**

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
* Grounding (if applicable)
* Operative
* Positioning
* Tourniquet (if applicable)
* Warming (if applicable)
* Other (please specify)
* Rationale: Selection of it least *overall, operative and positioning* must be documented for every case other than a Cysto/EUA procedure. As highlighted in the selections, any additional options should be documented when the intervention is applicable.

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
* False
* Rationale: Room turnover time is generated from the action of “wheel out to wheels in” meaning when the previous patient leaves the OR suite until the following patient enters the OR suite. This process has been allotted a 30 minute timeframe to be completed. When room turnover is completed in the allotted 30 minutes or less, despite a previous case running over the scheduled time, no delay is appropriate.

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
* Pre-op Skin tab
* Nursing Notes tab
* It is not important to document this interview
* Rationale: Patient education is a required JCAHO expectation and necessitates documentation. The Nursing Notes tab is the correct place to document patient education in that it is the most readily accessible section of the intraoperative chart for all other healthcare providers to review.

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

* True
* False
* Rationale: The Braden Scale Assessment is a valuable calculated tool that utilizes several specific criteria to assess a patient’s current risk for skin breakdown. The OR Nurse should review the Braden Scale and/or complete the assessment for the patient if not completed in the Pre-Op to assure an accurate record of patient’s capacity and risk for breakdown are documented and may be utilized as baseline for future assessment and care.

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

* ESU/Force Triad
* Malis Bipolar
* Harmonic/Gyrus
* Bair Hugger/Warming Blanket Machine
* SCD’s
* Drill (Stryker, Anspach etc.)
* Laser
* C-Arm/O-Arm
* Other (please specify)
* Rationale: All equipment options listed above, other than C-Arm/O-Arm must have a serial number documented within the intraoperative chart. The Association of Operating Room Nurses (AORN) Recommended Practices address that any piece of equipment that has the potential to harm/injury the patient related to operational characteristics and/or settings must be documented. The Radiology Technologist withhold the responsibility to document all mobile radiology equipment serial numbers and dosage including the C-Arm/O-Arm.

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

* Critical lab value result
* Frozen section result
* Critical test report
* All of the above
* None of the above
* Rationale: The Clinician Communications tab is to be utilized when the OR RN must assume the responsibility and accountability either through physician order or in an emergency setting to received either critical lab and/test results. This tab facilitates an organized template for accurate documentation and is also accessible for other healthcare providers to review.

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
* I chart the time the incision was first assessed but I do not chart an assessment of the incision
* I do not chart the time the incision was first assessed and I do not chart an assessment of the incision
* Rationale: The time of initial incision assessment should be documented and should match procedure “Start Time”. It is important to document this time in that it also contributes to building a provider’s average procedure time for that specific case. No assessment of the incision is necessary in that the first assessment is to be completed post-operatively at first dressing change.

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

* True
* False
* Rationale: The “Close Time” button is to be selected when the wound is completed closed, dressing are applied and the drapes have been removed. This signifies that the surgical procedure has been completed and the patient is being prepared for the next phase of care, either transfer to the recovery room or back to the Unit.

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
* False
* Rationale: The OR Pre-Op Checklist is a comprehensive tool that is utilized to review a patient’s readiness to either be admitted or transferred to the intraoperative phase of care. This checklist includes significant screening questions to help prepare both the patient and OR Nurse for the patient’s transfer. The OR Nurse may complete this checklist either with the patient and/or the patient’s family, caregiver or primary nurse in order to assure all required screening areas have been addressed and reviewed for the safety of the patient.

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: