

**University of Colorado Hospital Nursing Practice Recommendation**

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| **Intraoperative EPIC Charting Standards** | |
| **Effective Date: June, 2015** | **Replaces Policy/Guideline:**  N/A |
| **Approval Date:** | **Approved By:** |

**Introduction:**

(Brief overview of the guideline. Start text for all heading on the line after the heading itself as shown here with left justify. Please *use Times New Roman 12pt. except as noted.*

**Scope:**

(Description of who the guideline applies)

**Practice Guideline Details:**

1. Intraoperative Timing Events
2. Pre-op times, including “In Pre-op” and “Pre-op Complete” are to be populated by the Pre-op RN.
   1. “In Pre-op” time is populated when patient arrives in assigned bay in pre-op area.
   2. “Pre-op Complete” time is populated when the patient is ready for surgery, in that all pre-operative paperwork is complete, an H&P and/or pre-op note is available in EPIC, the pre-op RN has completed their OR Pre-op Checklist, preparations and assessments, and the patient has been marked by the surgery team.
   3. Pre-op times will automatically populate into the intraoperative chart and should not be altered by the circulating nurse.
      1. The circulating nurse should only populate these times if the procedure is performed at a time when the patient does not have a pre-op nurse and the circulating nurse is responsible for preparing the patient for surgery pre-operatively.
3. Intra-op times, including “Cut Time”, “Sweep of Operative Site Completed by Surgeon”, “Close Time”, and “Ready for OR Discharge” are to be populated by the OR circulating nurse.
   1. “Cut Time” is to be populated only when the surgical team makes an incision. If the procedure does not involve the creation of an incision (i.e. – cystoscopy), “Cut Time” is to be populated when the surgical team begins the surgical intervention on the affected part of the body
      1. “Cut Time” will not be populated prior to incision or time that surgical intervention begins
         1. Time of injection of local anesthesia prior to incision or intervention should not be charted as “Cut Time”.
         2. Time that a patient is positioned for the procedure (i.e. flipped from supine to prone or supine to lithotomy) should not be charted as “Cut Time”.
         3. If intraoperative imaging (i.e. fluoroscopy, x-ray) is taken prior to creation of incision or start of intervention, time of imaging is not be charted as “Cut Time”.
         4. If pins are placed in the patient’s skull prior to positioning (i.e. Mayfield pins, Gardner-Wells tongs), time of placement should not to be charted as “Cut Time”.
      2. The anesthesia provider and the circulating nurse should ensure that the anesthesia record and the nursing record include the same time for start of procedure.
   2. “Sweep of Operative Site Completed by Surgeon” is to be populated when the surgical team has completed a Methodical Wound Examination (MWE), prior to closing the surgical incision and prior to the closing count.
      1. The surgeon should announce to the circulating nurse that a MWE has taken place prior to closing the surgical incision.
         1. The circulating nurse should only populate “Sweep of Operative Site Completed by Surgeon” if the surgeon has completed the MWE.
         2. If the surgeon does not announce that a MWE has taken place, the circulating nurse should determine if a MWE took place by initiating a conversation with the surgeon, and determine the time this took place.
         3. If a MWE was never completed, the circulating nurse should not populate the “Sweep of Operative Site Completed by Surgeon” time.
   3. “Close Time” is to be populated when the surgical incision is closed, prior to application of wound dressings.
      1. If the surgical procedure does involve creation and closure of a surgical incision, then “Close Time” should be populated when the last stitch, staple, or other method of closure is completed.
      2. If the surgical procedure does not involve creation and closure of a surgical incision (i.e. cystoscopy), then “Close Time” should be populated at the time when the surgical intervention is complete (i.e. cystoscope removed from urethra).
   4. “Ready for OR Discharge” is to be populated when the patient is stable and ready to be transferred to the next area of care (i.e. PACU, ICU). “Ready for OR Discharge” should always be populated.
      1. If the patient is ready to be transferred out of the OR, but the next area of care is not ready to receive the patient (i.e. the room is on “PACU hold” or the ICU bed/room is not ready for a direct transfer), “Ready for OR Discharge” should be populated at the time when the patient is stable and ready to be transferred, even if the patient will not leave the OR until the receiving unit is ready (i.e. there will be a delay between “Ready for OR Discharge” and “Out of Room” time).
      2. If there is no delay in transferring the patient to the next area of care, the time “Ready for OR Discharge” is populated will likely be just before (or will match) the “Out of Room” time.
4. Procedure-specific times, including “Procedure Start” and “Procedure End”, will auto-populate with the “In Room” time and “Out of Room” time that are charted on the anesthesia record.
   1. If there is only one panel of surgeons and/or procedure being performed, the circulating nurse should not change the auto-populated times.
   2. If the procedure has multiple panels of surgeons and/or procedures (i.e. an ORIF Radius and an ORIF Femur being performed on the same patient during one surgical encounter), then “Procedure Start” will auto-populate with the “In Room” time charted by anesthesia for the procedure performed first, and “Procedure End” will be charted by the circulating nurse when that procedure ends. Then, “Procedure Start” for the following procedure will be populated by the circulating nurse when that procedure begins, and “Procedure End” will auto-populate with the “Out of Room” time charted on the anesthesia record.
   3. If the procedure has multiple panels and/or procedures but the procedures are being performed simultaneously, then “Procedure Start” for both procedures should match “In Room” time and “Procedure End” for both procedures should match “Out of Room” time.
5. Post-op times, including “In PACU”, “Out of PACU”, “In Phase 2”, “In PACU Hold Inpatient”, “Out PACU Hold Inpatient”, “In PACU Hold Observation”, “Out PACU Hold Observation”, and “Clear from Board” are to be charted by the PACU nurse, and should not be charted by the circulating nurse.
6. Anesthesia times, including “Anesthesia Start”, “In Room”, “Out of Room” and “Anesthesia Finish” are to be charted by the anesthesia provider.
   1. “In Room” time, which is charted by the anesthesia provider, will auto-populate “Procedure Start” time, and “Out of Room” time (also charted by the anesthesia provider) will auto-populated “Procedure End” time. Refer to section C above for further details.
7. Projected Times, including “Start Time”, “End Time”, and “Estimated End Time” will auto-populate according to the allotted time predicted for the procedure. The circulating nurse should not populate or change these times.
8. Summary / SBAR
9. The circulating nurse should review the Summary / SBAR section of the patient’s chart prior to and throughout the surgical procedure. This tab offers an overview of the patient, including (but not limited to) their medical history, surgical history, medication history, and other pertinent information related to the patient’s care.
10. Notably, the circulating nurse can find the lines that the anesthesia provider documented in the anesthesia record near the bottom of the Summary / SBAR tab in the “All Flowsheet Templates” section.
    1. Find the “All Flowsheet Templates” section, click on “Lines Inserted”, and then click on the proper date of surgery.
       1. Type of line, laterally and location, size, placement specifics, and how the line was secured can be found here.
       2. Line placement that is documented by the anesthesia provider does not flow into the “Lines/Drains/Airways” section of the nurse’s intraoperative chart, therefore this method of finding lines is more up-to-date and accurate.
11. Allergies
    1. Prior to beginning care of the intraoperative patient, including opening supplies to the sterile field, preparing medications, and visiting the patient pre-operatively, the patient’s allergies should be reviewed by the circulating nurse.
       1. The circulating nurse should review the patient’s allergies and ensure that other affected members of the surgical team (i.e. surgical technologist) are aware of the patient’s allergies before setting up for the procedure.
       2. When the circulating nurse reviews the patient’s allergies, the “Mark as Reviewed” button should be pressed in the Allergies screen.
          1. The circulating nurse should ensure there is documentation that the patient’s allergies were reviewed prior to start of the procedure.
       3. When the circulating nurse interviews the patient pre-operatively, allergies should be reviewed and confirmed with the patient.
          1. The circulating nurse should ensure that all allergies stated by the patient match the allergies listed in the chart.
             1. If the patient states an allergy that is not already included on the list of allergies, discuss the discrepancy with the patient’s pre-op nurse, as they may have already discovered this new reported allergy and added it to the chart.
             2. If the newly reported allergy has not been added by the pre-op nurse, this can be done by the circulating nurse.
             3. If the patient denies the existence of an allergy already documented on the patient chart, the pre-op nurse (or circulating nurse) should make a comment on this allergy that the patient states it no longer exists.

The allergy should remain in the chart because the allergy was added purposefully at some point during the patient’s care.

* + - 1. The circulating nurse should ensure that all allergic reactions stated by the patient match the reactions listed in the chart.
         1. If the patient lists an allergic reaction that is not already included on the list of allergies, discuss the discrepancy with the patient’s pre-op nurse, as they may have already discovered this difference and added it to the chart.
         2. If the newly reported allergic reaction has not been added by the pre-op nurse, this can be done by the circulating nurse.

1. Implant History
   1. The circulating nurse should review this section to determine what the patient has previously had implanted.
   2. If the patient has had previous surgery at a UCHealth facility and received an implant, it will be displayed here.
      1. If the patient has had previous surgery and received implants but not at a UCHealth facility, these implants will not be displayed in this section.
      2. If the patient’s previous implants are being explanted during the procedure and they are displayed in this section, then explanation should be documented here.
         1. To document the item as explanted, open the implant desired, populate the “Explanted Date” section, the “Explanted By” section with the name of the surgeon, and the “Number Explanted” with the number of implants being explanted.
2. Staff
   1. The circulating nurse must document the presence of any people that are in the OR, whether they are an active member of the surgical team or are not directly involved in the patient’s care.
      1. Documentation must include the full name, credentials, and role of the person present in the OR (Giarrizzo-Wilson, 2012).
      2. If the person is a staff member that has credentials in EPIC, entering their name in the search bar at the top of the screen should allow them to populate into the correct section of the staff screen (surgeons, staff, anesthesia staff).
         1. If the person is a staff member that does not yet have credentials in EPIC, or the person is an industry representative or visitor (i.e. student, observer, researcher), then the person will be added to the record from the “Add Visitor” button at the top of the screen.
            1. The person must be entered as a “Vendor” or a “Visitor”. If the person is an industry representative, they should be charted as a “Vendor”. Otherwise, the person is charted as a “Visitor”.
            2. The full name and credentials of the person must be documented (i.e. nursing student, medical student, company name that person represents).
         2. Support staff members such as radiology technicians and neuromonitoring personnel should have credentials in EPIC and should be documented accurately.
   2. “Time In” should be populated at the time the person enters the OR, and “Time Out” should be populated at the time the person leaves the OR.
      1. An accurate record of who is present in the OR at what time must be kept. If a person leaves the OR, the circulating nurse should populate “Time Out”. If the same person returns, the circulating nurse should populate the “Time In” section for the new arrival time of the person.
         1. To populate a new set of times for a person that has left the OR and then returned, click the door with a green plus sign icon to the right of the “Time Out” section for that person. This will allow the circulator to populate a new “Time In” for that person.
         2. An exception to this is the documentation of anesthesia staff. The circulating nurse should ensure that the correct names and credentials of anesthesia staff are documented, however anesthesia staff is responsible for keeping an accurate record of “Time In” and “Time Out” on their separate anesthesia record. No timing events are necessary for the circulating nurse to document related to anesthesia providers.
      2. If a staff member is relieved, that staff member must be timed out of the chart while relieved, and timed in upon return.
         1. A temporary relief person should be documented as “Circulator Relief” or “Scrub Relief”, and the full-time “Circulator” or “Scrub” needs to be time out while out of the room.
         2. A permanent relief person should be documented as “Circulator” or “Scrub”, to indicate that they are permanently taking over the specified role.
3. Counts
   1. All surgical counts performed during a procedure must be documented in EPIC. Please refer to the OR Surgical Count policy for detailed information on when surgical counts must be performed.
   2. To document a new count, “Reason for count” must be populated.
      1. Initial: Document a count as “Initial” if it is the pre-procedure count.
      2. Additional: Document a count as “Additional” if the count does not necessarily pertain to other categories and is being performed at the discretion of the surgical team.
      3. Relief: Document a count as “Relief” if a count is being performed as part of shift change or temporary relief between the circulating team and/or the scrub team.
      4. Cavity: Document a count as “Cavity” if a cavity within a cavity is being closed (i.e. – an organ is being closed within the abdomen).
      5. Closing: Document a count as “Closing” if it is the first count being performed upon closure of the incision.
      6. Final: Document a count as “Final” if it is the second count being performed upon closure of the incision, usually when skin is being closed.
      7. 2nd Procedure Initial, Additional, Cavity, Closing and Final: Document a count as “2nd Procedure” when there is more than one operative site and the count is related to the second site being closed.
         1. If there is more than one operative site, specify which operative site that particular count is being performed for in the “Comments” section.
      8. Other: If the count does not fall into the categories above, document it as “Other” and offer a comment as to why the count is being performed in the “Comment” section. This could include but is not limited to when there are more than two surgical sites to account for.
   3. “Items Counted” pertains to which items are being accounted for on the surgical field. Select all categories that apply to the count being performed. Please refer to the OR Surgical Count policy for definitions of the categories (Sponges, Needles/Sharps, Instruments, Other).
   4. “Counted by” should be populated with the name of the staff member that is scrubbing the procedure and is physically counting the items on the surgical field (scrub nurse or surgical technologist).
   5. “Verified by” should be populated with the name of the staff member that is observing the count (circulating nurse).
   6. “Correct” should be documented as “Yes” when the surgical count is correct and “No” if the surgical count is not correct. This does not need to be populated for an “Initial” count, but must be populated for any form of closing counts. Please refer to the OR Surgical Count policy for rules on determining whether a count is correct or incorrect.
      1. If the count is incorrect, the item category that was incorrect must be specified as incorrect.
         1. For example, during the closing count if the sponge count is incorrect but the needles/sharps and instrument count was correct, there will be two separate “Closing” count entries. One will specify that “Sponge” was incorrect, and one will specify that “Needles/Sharps” and “Instruments” was correct.
         2. Per the OR Surgical Count policy, when an incorrect count occurs, action taken must be documented. This may include notifying the physician, searching the room, re-counting, and taking an x-ray.
   7. “Physician Notified” should be documented as “Yes” anytime the circulator or scrub informs the physician of the outcome of a surgical count, whether the count was correct or incorrect.
   8. “Room Searched” should be documented as “Yes” if an incorrect count has occurred, in which an attempt is being made to find an item that has not been accounted for in the room.
   9. “X-ray taken” should be documented as “Yes” if an incorrect count has occurred (or when an x-ray is taken based on the procedure meeting several high-risk criteria outlined in the OR Surgical Count policy) in which a flat-plate x-ray was taken and read by a radiologist.
      1. If an x-ray is taken, per the OR Surgical Count policy, the name of the radiologist who read the x-ray must be documented. This can be done in the “Comments” section of the count that was incorrect.
   10. If a procedure is being performed in which no countable items are on the surgical field, then the “No counts needed” checkbox can be populated.
   11. If the procedure being performed is an Anterior Lumbar Interbody Fusion (ALIF), in which no instruments are counted despite entering the abdominal cavity, then a comment should be made in the “Closing” count specifying that an image was read to determine that no instruments were retained.
       1. Fluoroscopy images taken during an ALIF procedure may be read by a credentialed surgeon to determine the presence of retained instruments at the conclusion of the procedure, per the OR Surgical Count policy.
          1. This action should be documented by the circulating nurse in the “Comments” section. Document the name of the surgeon reading the image, and that no retained instruments were read on the fluoroscopy image.
          2. Per the OR Surgical Count policy, the surgeon must document this in their operative note, but it is recommended that this event be documented by the circulating nurse as well.
   12. If the procedure being performed was deemed “emergent” and no counts were performed, the circulating nurse must document that the procedure was declared an emergency and therefore no counts were performed, per the OR Surgical Count policy.
   13. If a surgeon declines an x-ray in the OR in the event that one is needed, the circulating nurse must document the reason an x-ray was not taken in the “Comments” section. Please refer to the OR Surgical Count policy for situations in which this is acceptable.
   14. If items are retained intentionally in a patient upon discharge from the OR, the closing and final counts should still be documented as correct (refer to OR Surgical Count Policy), yet a comment should be made in the “Comments” section as to the type of items retained and the number retained.
4. Preop Skin
   1. The preoperative skin assessment is a comprehensive head to toe assessment of the patient’s skin integrity and is to be completed in the Preop area during the preoperative interview by the circulating nurse.
      1. The single selection of “Overall” is appropriate to chart if the patient denies any variance in skin integrity and/or no variance is assessed by the circulating nurse throughout the preoperative interview.
      2. The single selection of “Overall” with the condition of “Other (see Comments)” is appropriate to chart if the patient recognizes a break in skin integrity and/or additional variances in skin integrity are assessed by the circulating nurse and/or members of the surgical team upon patient positioning prior to the start of the surgical procedure.
         1. When selecting the condition “Other (see Comments)” the circulating nurse is responsible to chart a free text comment addressing the variances in skin integrity including anatomical location and condition.
         2. When selecting the condition “Other (see Comments)” the circulating nurse is responsible to chart a free text comments addressing additional interventions provided to care for or protect variances in skin integrity.
5. Site Prep
   1. Prep of the surgical site(s) should be performed by the circulating nurse and/or by a designated surgical team member after the patient has been safely and correctly positioned, according to surgeon preferences.
      1. The prep site should include the surgical site(s) and anatomical laterality, if applicable.
         1. If hair removal is required at the surgical site(s) or is requested per surgeon preference, it should be completed intraoperatively by clipping. The surgical team member who implements the clipping prep should be documented in EPIC.
         2. If razor prep is requested, the surgical team member who completed the shaving prep must also be documented in EPIC. A free text comment recognizing surgeon request for razor prep should also be documented.
      2. The circulating nurse and/or designated surgical team member prepping the surgical site(s) should follow the manufactures recommendations for prep usage including application technique, required dry time and proper disposal of prep.
         1. The type of surgical prep solution utilized must be documented in EPIC.

If an alcohol-based prep solution is utilized to prep the surgical site(s), the Fire Reduction Strategies must be implemented and documented.

* + - * 1. If multiple preps are utilized on the same surgical site, each prep solution may be selected with a free text comment addressing the application of each prep solution (i.e. Ortho prep: Betadine scrub/paint prior to draping and Chloraprep on the sterile field).
      1. If multiple surgical site(s) are planned for a procedure(s), each prep site must be entered in individually including each surgical site, anatomical laterality, hair removal (if applicable), and prep solution.

1. Positioning
   1. The primary positioning and any subsequent positioning of the patient required for a surgical procedure(s) is to be documented in EPIC.
      1. The primary position of the patient should include use of all positioning devices, surgical team members involved and the time final positioning occurred.
         1. Charting the specific placement and materials utilized in positioning is required and should reflect the interventions utilized to safety position the patient.
            1. Devices and materials used in positioning should be selected from the pre-populated options and/or a free text comment should be charted to recognize each device and/or safety measure utilized, as needed.
            2. Devices or materials that are pre-populated in the positioning screen that are not utilized in the final positioning of the patient should be removed from chart.
         2. All surgical team members involved in positioning the patient must be documented.
            1. Anesthesia staff must be included as a surgical team member involved in patient positioning related to their responsibility supporting the patient’s head/neck, Anesthesia monitors and control of the patient’s airway.
         3. The time final positioning or any additional positioning of the patient occurs must be documented.
            1. Charting the time final positioning occurred or position changes occur is important to determine the length of time a patient has been in that position and may support additional assessment and care to maintain a patient’s skin integrity and perfusion.
      2. If additional positioning will occur throughout a single procedure, a supplementary positioning entry is required.
      3. If additional procedures are planned where the patient’s position will change from the primary position, each procedure requires an individual positioning entry.
      4. If no additional positioning will occur or pre-populated positioning screens are present due to surgeon preferences, each additional positioning entry may be deleted.
   2. Any variation or concern with positioning related to surgeon preference or denial of additional positioning safety measures requires the Circulator to document a free text comment recognizing final positioning approved by the attending surgeon.
2. Timeout
   1. The surgical timeout is a pre-procedure implementation of patient safety and care that must be completed prior to the start of any procedure.
      1. The Procedures link of the Timeout tab will identify the procedure(s) that require a timeout to be completed.
         1. The timeout type must be selected to identify the category of care the patient is receiving.
            1. Selecting Preop/Postop Procedure as the timeout type is appropriate when a procedure including regional blocks, epidural or transfusion is completed in the Preop or PACU phase of care.
            2. Selecting OR-Pre Incision as the timeout type is appropriate for all surgical procedures completed in the Operating Room or completed as a bedside procedure.
         2. The procedure timeout questions must be completed prior to timeout verification and includes seven hard-stop questions and one case specific question that must be addressed prior to procedure start.
            1. “YES” must be selected when the patient identity is correctly identified with two patient identifiers.
            2. “YES” must be selected when the surgical team agrees and verifies that the correct procedure per procedural consent will be applied as the primary intervention for patient care.
            3. “YES” must be selected when the correct anatomical site is addressed in both the surgical consent and has been marked on the patient or marked on the anatomical body consent form.
            4. “YES” must be selected when the correct anatomical laterality is addressed in the surgical consent and marked on the patient or marked on the anatomical body consent form.
            5. “YES” must be selected when the patient is in the correct position required for or to start the surgical procedure per surgeon preference.
            6. “YES” must be selected when the surgical site has be marked and initialed on the patient’s body or on the anatomical body consent form by a member of the surgical team.
            7. “YES” must be selected when the surgical team addresses the code status of the patient during the time the patient will receive care in the Operating Room.
            8. “YES” may be selected if the patient is returning to the Operating Room within twenty-four hours of an initial procedure. No may be selected if the planned procedure is the patient’s first encounter in their admittance.
         3. The briefing questions should all be addressed and charted as “Yes” when members of the surgical team discuss if the patient requires the briefing care interventions and/or if the patient does not require the briefing care interventions.
      2. The Timeout may be pended by the Circulator after completion of the Timeout. The time, date and names of the surgical team members that participated must be documented prior to pending.
         1. The Timeout must be verified by the circulating nurse prior to completion and verification of the chart.
3. Delay
   1. A delay that prevents either a first case from starting at the scheduled time or causes a turnover time to be greater than thirty minutes must be documented in EPIC.
      1. The delay type must be selected to recognize the phase of care and/or team responsible for the prevention of an on-time first case start or a turnover greater thirty minutes.
         1. “No Delay” is appropriate when the patient arrives in the Operating Room on time or when a room turnover is completed and the surgical team is ready within thirty minutes or less.
            1. If a “to-follow” scheduled case starts later than the originally planned but the turnover time from the previous case was completed in thirty minutes or less, “No Delay” is charted.
            2. If a “RFT” follows a completed scheduled case, “No Delay” is charted.
      2. The delay reason must be selected to recognize the primary factor that contributes to the prevention of an on-time first case start or a turnover greater than thirty minutes.
         1. The delay reason should match the delay type and should be identified and/or clarified with all members of the surgical team.
            1. The Circulator is responsible to ensure the delay type and delay reason reflects the Anesthesia record’s delay type and delay reason.
      3. The delay length is the amount of time, charted in minutes that passed before the patient was brought back to the OR and/or the number of minutes over thirty minutes allotted for turnover.
      4. The comments section may be utilized as needed to chart a free text comment recognizing the rationale and contributing factors to the delay.
         1. Free text comments should identify facts and titles but should refrain from the use of names and/or opinions.
4. Nursing Notes
   1. Free text can be documented in the Nursing Notes section. Consider documenting a comment in this section when an event occurs that may not fall into other areas of the intraoperative chart or may require longer documentation than will fit in a comment section in other areas of the intraoperative chart.
      1. When creating a Nursing Note, “Service”, “Date” and “Time” must be populated.
         1. Under “Service”, the OR nurse may choose “Not Assigned”, as there currently is no option that reflects intraoperative nursing.
         2. Be sure to accurately document the date and time the note is reflecting. If the event being charted occurred in the past, time may be changed to reflect this (i.e. time the pre-op interview was completed may be different than time the OR nurse enters a note about the pre-op interview). Be aware that the time the note was filed (“File Time”) as well as the time the note is reflecting (“Note Time”) are both visible on the note written.
      2. When a Nursing Note is written and accepted, it can be edited by clicking the “Addend” button. Be aware that the date and time of revision, as well as the version of the note before revision can still be seen under the “Revision History” link that will generate once a revision has been made, and will become part of the legal record.
      3. When a Nursing Note is written and accepted, it can be deleted by clicking the “Delete” button. A reason for deleting the note must be provided (there is one option of “Entered in Error”) and a comment may be made along with the deletion. Be aware that deleting the note will not remove it from the legal record. The note can still be read under the “Notes” tab once deleted, but it will specify the date and time the note was deleted.
         1. Deleting a note is not recommended due to admittance of making an error in documentation.
      4. It is an expectation that the OR nurse document pre-op patient education (Giarrizzo-Wilson, 2012) under Nursing Notes, and a description of the pre-op interview is also recommended. Consider using and adapting the following template to describe the pre-operative interview:
         1. \*\*\*\*\*\*\*\*\*\*”Patient interviewed in pre-op area. Correct patient identified by name, date of birth, and verbal confirmation. Reviewed chart, confirmed consents signed. Patient verbalizes understanding of procedure. Patient educated and oriented to OR environment and denies further questions”.
         2. When documenting from a pre-made template, care must be taken to add or subtract parts of the pre-op interview to accurately reflect the specific patient (i.e. do not chart what did not happen).
      5. To build a template, follow the instructions below.
         1. Click the green “plus” button to add a new “SmartPhrase”.
         2. A name must be assigned to the template.
         3. Under the “Content” tab, type the template to be saved for continued use.
         4. Once the template is complete, click “Accept & Stay” to save the template but continue editing. Click “Accept & Insert” to save the template and also use the template to create a note for the current patient. Click “Accept” to save the template.
      6. To use a previously created template, click the “List my phrases” button to the left of the green plus sign. Select the template to be added as a Nursing Note, and select “Add to text” or “Add and Close” to add populate the free text section of the Nursing Note with the pre-made template.
         1. A previously made template can also be edited by clicking the “List my phrases” button, selecting the desired template, then clicking the “Edit” button.
      7. When a note is in progress but needs to be returned to later, click the “Pend” button. This will save the progress already made on the note, and will allow the note to be edited at a later time.
         1. To edit a pending note, return to the nursing notes section. The note should pre-populate in the free-text area to be edited. If the note had been closed, the note will appear under “Incomplete OR Nursing Notes”. If the note is to be edited from here, click the “Edit” button to continue working on the note.
      8. When finished with a note, click “Sign”. Be aware that clicking “Sign” will finalize the note and it will then become part of the legal record.
      9. It is recommended that communication with the patient’s family be documented in the Nursing Notes.
         1. The Debrief/Handoff section of the chart has a specified area for documentation of family communication, yet this does not appear in the patient’s legal record. It is therefore recommended that this be charted as a Nursing Note.
5. Lines/Drains/Airways (LDA)
   1. Lines
      1. Lines (i.e. peripheral IVs, arterial lines, central venous catheters, epidurals, etc.) are generally placed either by the preoperative nurse before the patient arrives to the OR, or by the anesthesia provider intraoperatively. If a line is placed preoperatively, the pre-op nurse will document the line in the LDA screen. If the line is placed by the anesthesia provider, the line will be documented in the anesthesia record (which does not populate into the LDA screen). Documentation of lines is not the responsibility of the OR nurse.
         1. To find the record of lines documented by anesthesia for reference, scroll to the bottom of the Summary/SBAR tab to the “All Flowsheets Templates” section. Click the blue hyperlink entitled “Lines Inserted”. Click the blue hyperlink of the date of surgery. This page displays the lines inserted and charted by the anesthesia provider.
            1. When the patient is transferred to PACU, the PACU nurse is responsible for documenting the lines placed by the anesthesia provider in the LDA screen.
   2. Drains
      1. Drains placed intraoperatively by the surgeon should be documented by the OR nurse in the LDA screen.
         1. The drain should be charted as an “Open Drain” if there is no device collecting the drainage (i.e. a penrose drain). The drain should be charted as “Closed/Suction drain if there is a device collecting the drainage (i.e. Hemovac, bulb suction).
         2. Populate the correct date and accurate placement time of the drain.
         3. To populate “Drain Tube Type” for a Closed/Suction drain, choose “Accordion” for a Hemovac drain, and “Bulb” for a Blake, Jackson-Pratt (JP), or any type of drain connected to a bulb reservoir. Document the drain as “Other” if the drain type does not fall into these categories, and document a comment describing the drain.
         4. Document the “Orientation” and “Location” of the drain accurately. Specify the laterality (if applicable).
         5. If the drain is an “Open Drain”, populate the “Size” box with the correct drain size. This box specifies that the size should be in “fr”, or “french”, and will not allow fractions to be documented (i.e. ¼” penrose). However, a comment can be made indicating the correct size.
         6. Assign a “Tube Number” to the drain. If there is only one drain, the number assigned will be “1”. If there are multiple drains, assign a number up to the number of existing drains (i.e. assign the number “1” to one of the drains, “2” to another drain, and so on). Assigning a number to a specific drain allows accurate documentation when the patient is transferred to the ICU or floor.
         7. Indicate the name of the person placing the drain in the “Inserted by” box.
         8. Populate the “Supply” box with the specific name and size of the drain being placed. This will assure that the size of the drain is accurately reflected.
      2. Drains removed intraoperatively by the surgeon should be documented by the OR nurse in the LDA screen.
         1. Click on the already existing drain that is being removed. Then, populate the “Removal Date” and “Removal Time” boxes with the accurate date and time the drain was removed.
      3. It is not necessary for the OR nurse to document an assessment of a drain that was just placed by the surgeon intraoperatively. The receiving unit will document a first assessment of the drain placed during surgery. However, an assessment of pre-existing drains that the patient arrives to the OR with should be documented.
         1. Assessment of the drain should include “Site Description”, “Dressing Status”, and “Drainage Color”, and “Status”. “Intake” and “Output” do not need to be documented by the OR nurse, as the anesthesia provider will document drain output (the anesthesia provider does not document further assessment of existing drains, only volume of output).
      4. The OR nurse is responsible for documentation of Foley catheter placement intraoperatively, whether the catheter is placed by the RN or is placed on the field by the surgeon.
         1. Populate the correct date and accurate time of insertion.
         2. Specify the “Catheter Type” to accurately reflect which catheter is being placed. The standard Foley Catheter Kit used in most cases includes a Latex, Double-Lumen catheter. The Temperature Probe Foley kit includes a Latex, Double-Lumen, Temperature Probe catheter. The Latex-Free Foley kits include a Silicone, Double-Lumen, Non-Latex catheter. If a standard kit is not used, or the catheter from a kit is replaced with another type, specify which catheter type is used.
         3. Specify the “Tube Size” of the catheter placed. All Foley kits mentioned above are 16Fr. If a standard kit is not used, or the catheter from a kit is replaced with another type, specify which size of catheter is used.
         4. Specify the balloon size. The packaging of the catheter as well as the physical port of the catheter should specify what size balloon the catheter has.
         5. Specify the “Collection container”. If a Foley kit was used for placement, or a standard urine collection bag is being used, then “Dependent gravity bag” should be chosen. If a standard urine collection bag is not used, specify what kind of collection container is being used.
         6. It is an expectation that an assessment is charted upon insertion of the Foley catheter. Populate the “Reason for Insertion/Maintenance”, “Care”, “Urine Color”, and “Urine Appearance”. “Output” does not need to be documented, as anesthesia documents urine output in their record.
      5. The OR nurse is responsible for documentation of any and all “other” therapies placed by the surgeon intraoperatively in the LDA screen. This includes, but is not limited to: Bladder Diversions, Bowel Diversions, Chest Tubes, Gastrostomy, External Ventricular Drains, External Urinary Catheters, Fecal Collection Pouches, Pain Busters, Lumbar Drains, Wound Vacs (Negative Pressure Wound Therapy), Nephrostomy, Non-Wound Packing, Peritoneal Dialysis Catheters, Subdural Drains, Suprapubic Catheters, and Ureteral Drains.
         1. Follow similar steps to documentation on drains and Foley catheters listed above for these therapies. Ensure that the charting is as accurate and complete as possible, including accurate insertion or creation time.
         2. Assessment of these LDAs will be completed by the nurse on the receiving unit, and does not need to be completed by the OR nurse upon insertion/creation. However, if the patient arrives to the OR with any of these LDAs already in place, the OR nurse should complete an assessment of the LDA.
   3. Airways that are placed by the anesthesia provider are charted by the anesthesia provider. The OR nurse is not responsible for charting placement of airways placed by the anesthesia provider. However, the OR nurse is responsible for documentation of airways placed by the surgeon (i.e. tracheostomy)
      1. Documentation of tracheostomy should include an accurate date and time of placement, as well as “Size”, “Brand”, “Style”, status of the “Inner Cannula” and who performed the “Initial Placement”.
   4. Doc Flowsheets
      1. If the patient has too many items documented in the LDA screen, any new LDAs will need to be documented in the “Doc Flowsheets” section.
         1. Click the blue “Go to Doc Flowsheets” hyperlink from the LDA screen.
         2. At the top of the screen, click the “Add LDA” button, then proceed with entering the new LDA as would be done from the LDA screen.
         3. To edit existing LDAs from Doc Flowsheets, find the correct entry and click the blue hyperlink that indicates the “Placement Date/Time” for that line. Then, proceed with editing the LDA as would be done from the LDA screen.
6. Braden Scale
   1. The Braden Scale is a tool to help identify patients that are at risk for pressure ulcer formation. The patient’s pre-op nurse is responsible for completing the Braden Scale. When completed by the pre-op nurse, the OR nurse can see the Braden Scale score to determine if the patient is at increased risk for developing a pressure ulcer.
      1. If the Braden Scale has not been completed by the pre-op nurse or if the OR nurse was responsible for acting as the pre-op nurse (i.e. on a holiday or night shift when there may not be a pre-op nurse), then the OR nurse is responsible for completing the Braden Scale.
         1. The Braden Scale is not effective at predicting pressure ulcer risk for an intraoperative patient (Price, Whitney & King, 2005) because patients are immobile and generally anesthetized during surgery.
            1. The Braden Scale should therefore be completed to reflect the patient pre-operatively, not intra-operatively.
         2. To generate the patient’s Braden Scale Score, populate the Sensory Perceptions, Moisture, Activity, Mobility, Nutrition, and Friction & Shear sections as related to the pre-operative patient (see Figure 1 for a guide on completing the Braden Scale). The associated score will self-populate in the Braden Scale Score box.
         3. Select a Risk Status for the patient.
            1. Choose “Yes based on Braden” if the Braden Risk Score for the patient is less than 19, indicating that the patient is at least a mild risk for a pressure ulcer.
            2. Choose “Yes based on clinical factors” if the patient’s Braden Risk Score is above 19, but the patient presents with other risk factors that are not addressed in the Braden Scale that could increase the risk of a pressure ulcer.
            3. Choose “No patient not at risk” if the Braden Risk Score is above 19 and the patient does not exhibit other risk factors for pressure ulcer formation.
         4. Populate “Actions Taken” based on the Braden Risk Score generated for the patient as it relates to activity, moisture, mobility or nutrition.
         5. If a pressure ulcer prevention method is being used for the patient, document this in the “Pressure Ulcer Prevention” and/or “Therapeutic Management” section.
7. Procedures
   1. If the procedure is being performed by one service only (i.e. General Surgery), there will be only one “Panel” for the procedure. This panel may include several surgeons and/or residents of the same specialty.
      1. A surgeon may be added to the panel by searching for the name in the search box, but if the surgeon was added in the “Staff” tab, their name will automatically populate here.
   2. If the procedure is being performed by multiple services (i.e. Plastics and ENT), there will be multiple “Panels” for the procedure.
      1. To add a new panel, click the “Add Panel” button in the top left corner of the page, and search for the surgeon that will comprise the new panel.
   3. Populate the procedure information section for each scheduled procedure, including each panel.
      1. “Procedure Description” should be pre-populated based on how the procedure was scheduled.
      2. Indicate the “Laterality” of the procedure, or choose “N/A” if there is no laterality.
         1. Indicate that the procedure is “Bilateral” only if two sides of the body are being operated on (i.e. bilateral legs).
         2. Indicate “N/A” if the incision is midline (i.e. midline abdomen) or the body part does not have a left and right side (i.e. urethra).
      3. Select the “Anesthesia Type” from the provided options. If unsure of the type of anesthesia being used, speak to the anesthesia provider in the room.
      4. Indicate the “Wound Class” for the procedure (Garner, 1985).
         1. The wound should be indicated as “Clean” if it meets the following criteria: The wound is clean (not infected or inflamed); the wound was the result of a non-penetrating trauma; the procedure was free from entry to the respiratory, alimentary or genitourinary tract; the wound was primarily closed or drained with closed drainage
         2. The wound should be indicated as “Clean/Contaminated” if it meets the following criteria: The respiratory, alimentary, or genitourinary tract were entered under controlled conditions without evidence of infection, contamination, or major break in technique.
         3. The wound should be indicated as “Contaminated” if it meets the following criteria: The wound is fresh, open, or accidental; there is gross spillage from the gastrointestinal tract; there is non-purulent inflammation; there was a major break in sterile technique.
         4. The wound should be indicated as “Dirty, Infected” if it meets the following criteria: The wound is old (more than 4-6 hours) with devitalized tissue (i.e. necrosis) or existing clinical infection (i.e. purulence) or perforated viscera.
      5. If the scheduled procedure is not the procedure actually being performed, the “Replace Procedure” button (two arrows pointing opposite directions) may be clicked. Then, search for the correct procedure being performed to replace the incorrect procedure. Be aware that this may change or erase sections of the chart that have previously been populated (i.e. positioning, supplies, equipment)
         1. If a procedure is changed from the originally scheduled procedure, the “Rebuild Procedure Information?” checkbox may be checked to rebuild positioning, supplies, equipment, etc.
      6. A panel or procedure that was added in error may be deleted by clicking the grey “x” button. Be aware that deleting a panel or procedure may change or erase sections of the chart that have previously been populated (i.e. positioning, supplies, equipment).
8. Supplies
   1. An accurate list of supplies opened for the procedure must be kept in the “Supplies” section, whether the supply was used or wasted.
      1. This section will pre-populate with supplies from the doctor’s preference card. Quantity will also pre-populate from the preference card based on the “usual” number of the supply used.
         1. Ensure that quantities for pre-populated supplies are accurate, as the “usual” number may not apply to the procedure being performed.
      2. To add supplies that are not already on the list, search for the name in the search box at the top of the screen.
         1. If the supply is not found by the name, consider using the reference or model number to search for the correct supply.
      3. To add a supply that is provided by a vendor, or that has not yet been added to our system, input the supply as a “One Time Supply”
         1. Click the green plus button to the right of the search field, then press “One Time Supply”.
         2. A supply name must be added. Include as much information as possible to make the entry accurate.
         3. Indicate the quantity “Used” or “Wasted”, as appropriate.
         4. Indicate the “Type” of the supply
         5. Indicate the “Manufacturer”. If the name of the manufacturer does not populate, this can be indicated in the “Free text comments” or along with the name of the supply.
         6. Document the “Manufacturer number”, which is generally listed as the Reference Number or Model Number on the packaging.
      4. If a supply was wasted, indicate the number wasted versus the number used.
         1. If a certain number of the supply was used, but one was wasted, indicate the number used accurately (not including the wasted supply), then indicate the number of the supply wasted separately.
         2. If the supply was only wasted (i.e. no number of the supply was used but only wasted), then document the “Used” number as “0”, and the “Wasted” number as the quantity wasted.
         3. If a supply is wasted, click the blue hyperlink name of the supply to indicate the reason wasted (Contaminate, Dropped, Opened Not Used, Other, Package Damaged, Wrong Size).
            1. Providing the reason wasted is important to ensure that the patient is not charged for the use of the item.
      5. If the patient has a Latex allergy, items that are identified as containing Latex will be high-lighted in yellow. Ensure that these items are not used and are not charged to the patient (it could appear that the item was given to the patient inappropriately if it is charged for). It is acceptable to delete these items from the supply screen by clicking the grey “x” on the line of the supply.
      6. Attempt to keep an accurate list of all items, including “small” items like suture, gloves, and gowns.
         1. If a “Suture Grouping” is charged to the patient, then a separate charge list of suture used is not necessary. If no suture is used for the patient, populate the “Suture Grouping” to “0”.
9. Equipment/Instruments
   * 1. Any equipment that is applied directly to the patient and has the risk to cause a thermal injury must be documented.
        1. The name of the device, the serial number and/or hospital code attached to the device and the initial settings the device will be applied to the patient at must be documented.
           1. If the settings of the device change or will change throughout the procedure based on surgeon preference or tissue type, a free text comment may be documented to capture additional settings.
10. Intraop Medication
    1. Intraoperative medication administration in the OR may occur through direct administration or from the sterile field and must be documented in EPIC.
       1. A medication may be selected from the surgeon’s preference list associated with the procedure or may be searched for by medication trade name through the Pharmacy Formulary.
          1. A medication that is requested for the patient that is not on the preference list and cannot be found by searching for the medication in the Pharmacy Formulary or MAR should be added to chart by a Pharmacist.
          2. A medication that is requested for the patient that is not on the preference list, cannot be found by searching for the medication in the Pharmacy Formulary or MAR and is not able to be added to the chart by a Pharmacist must be charted as a Nursing Note.
          3. The surgical team member that directly administers the medication to the patient must be documented.
       2. The medication dose administered to the patient must be recorded in the EHR.
          1. If a medication is administered to a patient in multiple doses (i.e. local injection prior to incision or local injection prior to dressing application), each individual administration must be recorded as a separate entry.
          2. If a medication is provided to the patient throughout the procedure on an “as-needed basis” such as irrigation or as an “application” such as Surgilube, it is appropriate to document a free text comment of “PRN”.
       3. The route the medication is being administered to the patient must be documented.
       4. The anatomical site including laterality, if applicable, where the medication administration is provided to the patient must be documented.
          1. It is appropriate to select “Other” under site when medication administration is provided indirectly to the patient (i.e. bladder irrigation).
          2. When multiple surgical sites are required for a procedure(s), the Circulator should document a free text comment addressing which anatomical site the medication administration is being applied to.
       5. The time the medication is administered to the patient must be documented.
          1. It is appropriate to record procedure “CUT TIME” as the time administered for medications that are present on the field and are required for the procedure to start.
             1. Any medication administration that occurs as a pre-procedure intervention (before “CUT TIME”) such as local injection must be recorded at the time it is administered to the patient.
11. Implants
    1. Any implantable item that reaches the patient or that will remain within the patient after they leave the OR must be documented in EPIC.
       1. An implant may be added by either searching for the implant by name or utilizing the implant’s reference number, product number, model number or catalog number.
          1. When an implant is inserted into the patient and cannot be found by searching the implant name, reference number or product number, the implant may be added to the EHR as a “One Time Implant”.
             1. When an implant is added as a “One Time Implant”, the implant’s reference number or product must be recorded as the model/catalog number in the EHR.
       2. The expiration date of an implant must be recorded in the EHR, if applicable.
       3. The size of an implant must be recorded in the EHR, if applicable.
       4. The serial number of an implant must be recorded in the EHR, if applicable, both for tracking and reordering purposes.
       5. The LOT number of an implant must be recorded in the EHR, if applicable, both for tracking and reordering purposes.
       6. The Manufacturer of the implant must be recorded in the EHR.
          1. If the Manufacturer of the implant is not a choice from the populous drop-down list, a descriptive free text comment including the Manufacturer’s name is appropriate.
       7. The Supplier of the implant must be recorded in the EHR.
          1. The Supplier of the implant is a vendor company that distributes a Manufacturer’s implant.
             1. If the Supplier of the implant is not a choice from the populous drop-down list, a descriptive free text comment including the Supplier’s name is appropriate.
       8. The number of an implant inserted into the patient must be recorded into the EHR.
          1. When two or more of the same implant are being inserted into the patient and have the same reference number, product number, model number or catalog number as well as the same serial number and/or LOT number and expiration date (if applicable), it is appropriate to chart the number of the implant under a single entry.
          2. When xenograft or allograft skin is being implanted to a patient, the “number used” must be recorded in square centimeters.
    2. The action of an implant either on the sterile field and/or that has reached the patient must be recorded in the EHR.
       1. An implant that is inserted into the patient and will remain with the patient once they leave the Operating Room must be charted as “Implanted”.
       2. An implant that is removed from the patient from a previous surgery and will not be re-implanted into the patient must be charted as “Explanted”.
          1. When the removal of an implant that was originally placed at a facility within the UCH system, the implant may be reviewable within the Implant History section and should be explanted in the Implant History screen. (Please refer to IV. Implant History, section B. #2, a.)
          2. When the removal of an implant from a previous surgery that was not placed at a facility within the UCH system occurs, the Circulator may add the implant to the Implant section of the EHR and record as much information as possible about the implant, charting the action as “EXPLANTED”.
          3. When an implant is being removed from a patient for lawsuit/legal reasons, it must be recorded in the EHR as an “EXPLANTED” in either the Implant History screen if applicable, or within the Implant screen and a Pathology Requisition may be completed, per surgeon preference. (Please refer to XX. Specimens, section A, #4, b.)
       3. An implant that is either damaged, dropped or opened to the sterile field and not used in the patient must be charted as “Wasted”.
          1. When either xenograft or allograft skin graft will be wasted, a second encounter must be added to the implant screen with the square centimeters of skin not being implanted to the patient recorded as “number used” and charting the action as “WASTED”.
          2. An implant that is damaged during insertion and is removed from the patient must be charted as “WASTED”.
       4. An implant that is inserted into the patient and then is removed from the patient within a single procedure must be charted as “Implanted & Explanted”.
    3. The anatomical location of the implant, including laterality, if applicable, must be recorded in the EHR.
    4. The surgical staff team member who inserts the implant into the patient must be recorded in the EHR.
    5. The time the implant was inserted into the patient must be recorded in the EHR.
       1. The time an implant was removed or explanted from a patient must also be recorded in the EHR.
    6. The Circulator may utilize the Implant Description box to chart a descriptive free text comment or additional information about an implant or implant anatomical location if needed.
    7. When an implant is a tissue, organ or tissue derivatives, the Circulator must select “YES” in the EHR for tissue tracking.
       1. When the tissue is grafted from the patient “Autologous” must be selected.
       2. If “YES” is selected, the Circulator is expected to record any information of the tissue and preparation that occurs within the Intraoperative phase of care.
          1. The surgical team member who prepares the tissue and/or implants the tissue into the patient must be recorded in the EHR.
          2. The preparation method applied to the tissue must be recorded in the EHR.
             1. When the tissue is reconstituted or rinsed on the sterile field, the solution type, LOT number and expiration date must be recorded in the EHR.
          3. The tissue type must be recorded in the EHR.
             1. When the tissue implant is “OTHER”, the Circulator may utilize the Tissue Description box to chart a descriptive free-text comment about the implant.
12. Specimens
    1. Specimens include tissue, bone, medical devices, and/or foreign body objects removed from the patient through surgical intervention. Specimens are examined and tested, as ordered, for the progressive and supportive care of the patient.
       1. When a specimen is obtained, the surgeon will request the type of pathology examination required.
          1. When a specimen is obtained but the surgeon requests that the specimen not be sent for pathology examination, the Circulator must document a Nursing Note acknowledging the surgeon’s request.
       2. The Circulator must select the ordered pathology testing tab from the pre-populated choices including Pathology, Cytology, Other, Outside Labs, Eye Pathology and Tissue Bank to complete the specimen requisition.
          1. When the appropriate pathology testing tab is selected, a specimen requisition is created.
             1. The specimen ID should be identified as a numerical or alphabetical value to support the organization of specimen collection as well as validate different pathology testing within the EHR (i.e. Permanent pathology 1,2,3 etc., Frozen Section A,B,C etc., Fresh pathology I,II,III etc.)
             2. The specimen description should be the given name of the specimen by the attending surgeon and must be reviewed by the Circulator through the completion of a verbal read back verification for correct naming and spelling.
             3. Specimen type must be selected from the pre-populated choices specific to the appropriate pathology testing tab.
             4. Specimen tests must be selected from the pre-populated choices specific to the pathology testing tab.
             5. The priority of the specimen may be selected as “Routine”.
          2. The Circulator must type “UCH PATH” into the “Insert SmartText” box and select the “UCH OR Specimen-Surgical Pathology Requisition” to complete the specimen form. (The Circulator may utilize the F2 key function to tab through the additional requisition questions of the specimen form.)
             1. The OR room phone number must be provided to assure the Laboratory has an immediate contact for questions/concerns with a specimen(s).
             2. The Circulator should provide the attending surgeon’s name as the primary contact name for the specimen.
             3. The Circulator should provide the attending surgeon’s pager number or cell phone number as a secondary contact for questions/concerns regarding a specimen(s).
             4. The Circulator must select if the patient has a history of a prior malignancy. If yes is selected, the Circulator must include a descriptive free text comment specifying the type of malignancy.
             5. The Circulator must select if the patient has a history of Chemotherapy use/treatments.
             6. The Circulator must select if the patient has a history of Radiation use/treatments.
             7. The Circulator must select if the patient is HIV positive.
             8. The Circulator must select if the patient has current infectious/respiratory precautions. If yes, the Circulator must specify the precautions.
             9. The Circulator must record the total number of containers/specimens sent by completing a verbal read back verification with the surgical team prior to sending or dropping off the specimens.
             10. The Circulator must provide a pertinent clinical history of the patient that provides a rationale to why the surgical procedure is being performed. The Circulator may obtain a pertinent clinical history related to the procedure from the H&P, Physician Notes or through verbal communication with the attending surgeon.
             11. The Circulator may provide additional comments and/or special handling instructions via attending surgeon orders, as needed.
             12. The Circulator must then select “Accept” to complete the requisition entry.
          3. When multiple specimens will be sent as the same “type” and for the same “test”, the Circulator may select “New” to generate a second requisition form following the same numerical or alphabetical value assigned to that testing (i.e. Thyroid for permanent pathology, fixed in formalin and Lymph Nodes for permanent pathology, fixed in formalin).
          4. When multiple specimens will be sent for multiple testing, the Circulator may select “Copy” to generate a second requisition form that has a complete entry, including the “UCH OR Specimen-Surgical Pathology Requisition”. The Circulator must proactively select/change the “Specimen ID”, “type” an “test’ to assure the information and orders requested for the specimen are accurate.
          5. When the attending surgeon requests that the specimen(s) are ready to be sent or dropped off, the Circulator must select each specimen entry so that it is highlighted green. The Circulator may then select the “Print Requisition” tab and change the number of copies to print to “2”. The Circulator is responsible to obtain the requisition copies from the printer to accompany the specimen(s) to the Laboratory/testing site.
       3. If a specimen entry needs to be permanently removed from the EHR, the Circulator must select the specimen’s title name (blue hyperlink) to open the entry.
          1. The Circulator may then select “Delete” in the bottom left hand corner of the requisition screen.
             1. The Circulator must then select a reason that the specimen requisition is being permanently removed from the EHR.
       4. Specimens that are removed from a patient for lawsuit/legal reasons must be recorded in the EHR as a requisition per surgeon preference or per legal obligations.
          1. When a specimen/evidence is to be given to the responsible law enforcement officer, a Nursing Note must be charting acknowledging the transfer of the specimen/evidence.
          2. If the law enforcement officer is not immediately available or the surgeon’s preference includes specimen/evidence testing/preservation, the Circulator will follow the guidelines for a permanent specimen and label the specimen/evidence as “store for potential legal action” or as ordered per the attending surgeon.
13. Orders
    1. The Orders section is utilized by the Circulator to complete additional testing and to obtain additional supplies from Central Supply as needed for the patient under the direction of the surgical staff team members.
       1. The Circulator may search for a single laboratory by entering the name of the test into the search box or may select multiple tests in one entry by utilizing the Preference List tab.
          1. The Preference List tab includes testing for Microbiology, Thoracic Microbiology, Blood Transfusion, Chemistry Panels, Hematology, Coagulation and Miscellaneous (i.e. stone analysis).
          2. When a laboratory test is selected, the order entry must be completed by selecting the blue hyperlink.
             1. The priority of the test must be selected as either “Routine” or “STAT” per the surgeon’s preferences.
             2. The frequency of the test must be selected as “Once”.
             3. The time the test was drawn from the patient or the culture handed off the sterile field and date of the test must be recorded.
             4. The specimen source must be selected from the populous choices. It is appropriate to complete a verbal read back verification with the surgical team to correctly identify and record the specimen source.
             5. The comments section is to be utilized to identify the name of the specimen source, if applicable. It is appropriate to complete a verbal read back verification with the surgical team to correctly label and record the name.
       2. The Circulator may search for a single item in Central Supply by entering the name of the item into the search box or may select multiple items in one entry by utilizing the Preference List tab.
          1. The Preference List tab includes Nursing and Procedures sections populated with routine Central Supply items requested in the OR (i.e. Wound Vac and supplies, cervical collar, knee brace etc.).
             1. The priority of the supply should be selected as “STAT” to assure the item(s) are readily available for the case and patient.
             2. The quantity of the item must be recorded to assure the correct amount of item(s) is selected, delivered and charged to the patient.
             3. The frequency of the item must be selected as “Once”.
             4. The time the item is requested for the case or patient and date of the request must be recorded.
             5. The comment section is to be utilized to identify which OR is requesting the item(s) and should include a reference to who will pick up the item(s) and a phone number to contact with questions regarding the Order.
       3. Any Laboratory order or Central Supply order requested or completed within the OR must be signed.
          1. The order mode appropriate for intraoperative Orders include:
             1. “Verbal, with read back verification”.
             2. “Telephone, with read back verification”.
          2. The name of the attending surgeon or provider who delegates the order must be recorded in the EHR.
             1. If the primary attending or provider who delegates the order does not auto-populate, the checkbox “Filter providers by treatment team members” must be deselected and the primary attending or provider may be searched for by name.
14. Order Sets
    1. The OR nurse does not need to document anything in the “Order Sets” section. Orders to be entered by the OR nurse (i.e. microbiology, items from central supply) should be entered in the “Orders” section.
15. Clinician Communication
    1. It is recommended that the circulator transfer any phone call related to critical lab results to the anesthesia provider. If the critical communication is then received by the anesthesia provider, no documentation in the “Clinician Communication” tab is necessary. However, in case of emergency in which the circulator does communicate the information to the surgeon, document as described below.
    2. Document communication of critical lab values, critical test reports, or other important information communicated to the circulating nurse, and subsequently from the circulating nurse to the surgeon in the “Clinician Communication” section.
       1. Indicate the reason for communication. Most often, this will be a critical lab value or critical test report called to the OR, which the circulator will communicate to the anesthesia provider and/or the surgeon.
       2. Populate the “Name of Care Provider” and “Provider Role” sections with the name of the person receiving the information (i.e. surgeon, resident, anesthesia provider).
       3. Indicate what kind of information is being communicated – either in the “Critical Lab Values” section or the “Critical Test Report” section.
       4. Indicate the time the information was received by the circulator in “Time Critical Result Received”. “Time of Notification” should be populated with the time the circulator communicated the information to the surgeon (or anesthesiologist, resident, etc.).
       5. Indicate whether the communication was critical and if the MD is aware in “Critical Notification”
    3. Document communication between the pathologist and the surgeon in this section. If frozen section results are called to the circulator and then communicated to the surgeon, it is recommended (but not required) that this communication is charted. If the pathologist speaks directly to the surgeon, no documentation is recommended.
       1. For frozen section communication, the “Notification Reason” would be “Other”, and a comment should be added indicating that the communication was related to frozen section results.
       2. The type of communication should be charted as “Other” in the “Critical Test Report” section. Make a comment that the communication is for frozen section results.
       3. Under “Critical Notification”, indicate “MD Aware”.
    4. The circulating nurse is not responsible for documentation of clinician communication related to another patient that is not currently undergoing surgery.
16. Timing Events
    1. Document times for docking and undocking the robot console in this section.
       1. Document docking time for the robot console under “Robot Console Start”. Document un-docking time for the robot console under “Robot Console Stop”.
    2. All other timing events in this tab do not require documentation.
17. Incisions/Wounds
    1. Document the patient’s surgical incision in this section by clicking “Add LDA” and searching for “Incision”.
       1. Document the date the incision was created and the time the incision was created.
       2. Document the orientation and location of the incision as accurately as possible, including laterality (if applicable).
       3. Document the type of incision.
          1. “Donor Site” should be documented when skin is removed from a certain site (i.e. skin removed to be used as autograft to another area of the body).
          2. “Episiotomy” should be documented if an obstetric procedure is being performed in which an episiotomy is created.
          3. “Graft Site” should be documented when skin is placed on a certain area on the body (i.e. autograft skin, allograft skin, xenograft skin).
          4. “Incision” should be documented if a surgical incision is created.
          5. “Scope Sites” should be documented if the case is laparoscopic and there are multiple trocar incision sites made.
          6. “Puncture Site” should be documented if a small puncture is made, but no incision (i.e. insertion of a spinal needle, k-wire puncture)
       4. “Number of Scope Sites” should be populated if the surgery is laparoscopic and includes multiple trocar sites on the same body part (i.e. three scope sites on the abdomen for a laparoscopic appendectomy).
          1. Indicate the accurate number of trocar sites made during the procedure. If the procedure includes a mixture of scope sites and larger incisions (i.e. hand-assisted laparoscopic procedure), document the number of scope sites in addition to a separate entry of an incision, which should not be included as a scope site.
          2. If the procedure is not laparoscopic, yet many incisions exist on the same part of the body, the incisions all must be documented as separate incisions. Incision sites should be differentiated with accurate “Orientation” and “Location” descriptors. The number of incisions should not be documented as “Scope Sites” because no scopes were used during the procedure.
       5. Document whether the incision is “Pre-existing”.
          1. If the patient has had recent surgery in which the incision is not yet fully healed, the surgeon will be using the same incision for the current procedure, and a “Final Assessment” date and time have been documented for the incision (i.e. the patient had been discharged from the hospital and has returned), then a new incision should be created and marked “Yes” under “Pre-existing”.
          2. If the patient has had recent surgery in which the incision is not yet fully healed, the surgeon will be using the same incision for the current procedure, and a “Final Assessment” date and time have not been documented for the incision (i.e. the patient has not been discharged from the hospital), then a new incision should not be created. An assessment of the existing incision should be documented.
          3. If the incision is new, document “No” under “Pre-existing”.
       6. If no incision was made during the procedure (i.e. cystoscopy), then no incision should be documented.
    2. Document any wounds in this section by clicking “Add LDA” and searching for the appropriate wound (i.e. “Wound”, “Burn”, “Pressure Ulcer”, “Flap”). Often a patient with a pressure ulcer, burn, or large wound will already have documentation in this section, especially for an inpatient. Ensure that the wound does not already exist in the chart before adding a new entry. If the wound does already exist, document an assessment of the wound.
       1. Many types of wounds, including but not limited to abrasions, amputations, arterial/venous/diabetic ulcers, blisters, gunshot wounds, fissures, fistulas, lacerations, lesions, skin tears, stab wounds, and tube sites should be documented as a “Wound”.
          1. Document the date and time the wound was first assessed.
          2. Document whether the wound is “Pre-Existing”.
             1. If the patient arrived to the OR with the wound, then the wound is pre-existing. If the patient incurred the wound while in the OR, then the wound is not pre-existing.
          3. Document the wound type (as indicated above), including accurate orientation and location of the wound.
       2. If the patient has a burn, document the date and time first assessed, the burn type and accurate location. Burn patients often arrive to the OR with pre-existing documentation of their burn (unless this is the first operation for the burn), in which case an assessment of the burn should be completed and a new entry is not necessary.
          1. If documenting care of an existing burn entry, include a “Dressing Assessment” (often this will be “Removed” when the surgeon will be working on that particular burn). Also document the type of graft used (if applicable) on the burn (i.e. Xenograft, Allograft, Autograft) and the “Wound Products Used” (i.e. what kind of dressing is being used).
          2. If creating a new entry for a burn, document as described above, and also include the type of graft used (i.e. Xenograft, Allograft, Autograft), and “Wound Products Used”.
          3. If the burn encompasses several areas of the body (i.e. face, chest, abdomen) and the surgeon is putting the same type of graft and dressing on the burn, then the burn can be documented in one entry with several “Locations”. If the burns on different parts of the body are being treated differently, then a new entry for each body part should be documented.
          4. If autograft skin is taken from the patient, this should be documented under “Incision” and specified as “Donor Site”.
       3. Document existence of a “Pressure Ulcer” using the same guidelines as for a “Wound”, with the addition of “Staging”.
       4. If a free flap is created during the procedure, documentation of the donor site and flap placement site must be completed.
          1. Document the site the flap was taken from by adding an “Incision”, then specify the “Type” as “Donor Site”.
          2. Document the site the flap is placed by adding a “Flap”.
             1. Document the accurate date and time the flap was first assessed.
             2. Document the “Orientation”, “Location”, and whether it is “Pre-Existing”.

If the flap is created during the current procedure in the OR, then it is not “Pre-Existing”. If the patient arrived to the OR with the flap, it is “Pre-Existing”.

* + 1. Document packing that is not placed in the surgical wound as “Non-Wound Packing”.
       1. Specify the placement date and time.
       2. Document the name of the person placing the packing.
       3. “Location” must be specified as ear, eye, mouth, nose, or vagina.
       4. If packing is removed while in the OR, document the date and time it was removed.
    2. Document packing that is placed in the surgical wound (i.e. packing an open abdomen with lap sponges) as “Non-Wound Packing” until a “Wound Packing” option is added to EPIC.
       1. Specify the placement date and time.
       2. Document the name of the person placing the packing.
       3. “Location” may not fall into the offered options. Do not choose an option, but created a comment in this section that specifies where the packing is being placed.
       4. If packing is removed while in the OR, document the date and time it was removed.
       5. Documenting wound packing in this section will allow nurses later in the phase of the patient’s care to see that packing exists and document on this packing. It is recommended that a Nursing Note also be made about this packing.

1. Site Completion
   1. Document surgical dressings on any and all surgical sites in this section.
      1. The surgical site chosen from the “Site Prep” section will appear on the top of the page with a green “plus” button. To document site completion for this site, click this button.
         1. Choose laterality for the surgical site. This will self-populate from “Site Prep” as well. Choose “N/A” if there is no laterality for the surgical site (i.e. midline abdominal incision).
         2. “Site” will self-populate from what was chosen in the “Site Prep” section.
         3. Choose the appropriate dressing used for the surgical site.
            1. If there is no dressing for the surgical site, choose “None”. If the dressing used does not appear in the “Dressings” section, choose “Other” and create a comment.
      2. Fill out a site completion section for each separate surgical site.
      3. Document whether the prep was cleaned from the patient.
         1. Choose “Prep Cleaned from Patient” if the prep is completely cleaned from the surgical site.
         2. Choose “Prep Cleaned from Patient Except at Incision Site per Manufacturer Recommendations” if the patient’s skin around the surgical site is cleaned, but the incision site is not cleaned.
         3. Choose “Prep Left on Skin per Manufacturer Recommendations” if the prep is not cleaned from the surgical site or the skin surrounding the surgical site.
         4. If there was no prep for the surgical site, choose “N/A”.
         5. Manufacturers Recommendations for Duraprep: Can remove if desired, yet Duraprep will continue to kill bacteria for 48 hours after application and is therefore recommended to remain on skin. (“3M Duraprep surgical solution, 2009).
         6. Manufacturers Recommendations for Chloraprep: It is recommended that Chloraprep remain on the skin, especially at the incision site, in order to continue providing antimicrobial activity. Tint will slowly fade from the skin. If Chloraprep is removed from the skin, remove with alcohol or soap and water (“Chloraprep FAQs”, 2015).
         7. It is recommended that Betadine, Chlorhexidine Gluconate, and Baby Shampoo be cleaned from the patient’s skin due to the irritating residue left when these solutions dry.
2. Postop Skin
   1. The postoperative skin assessment is a comprehensive head to toe assessment of the patient’s skin integrity after interventions have been applied to the patient. The postop skin assessment is completed by the circulating nurse at the end of the surgical procedure once interventions have been removed and/or the patient has been positioned onto their bed or stretcher.
      1. The preop skin assessment will pre-populate from the preoperative assessment completed in the Pre-Incision section of the EHR.
      2. The Circulator must add each additional skin condition by selecting “New Skin Condition” and assessed the applied interventions to the patient including site(s) of tourniquet, grounding, positioning, warming, and operative skin assessment, if applicable, and recorded in the EHR.
         1. Each new skin condition must also recorded assessment conditions.
            1. When selecting the condition “Other (see Comments)” the circulating nurse is responsible to chart descriptive free text comments addressing the variances in skin integrity including anatomical location and condition related to the intervention.
3. PNDS
   1. The Perioperative Nursing Data Set (PNDS) is a research-based application of standardized nursing vocabulary designed by AORN and recognized by ANA as an organized tool for application of nursing diagnoses, interventions and patient outcomes.
      1. The standardized nursing language provides a structure to manage nursing data relative to the patient and the care provided within the OR.
         1. The Circulator must review the pre-populated “Outcome Group” phrases to ensure that the nursing contributions applied are recorded and reviewed as an integral component of the EHR.
            1. When a pre-populated diagnosis in the “Outcome Group” does not apply to the procedure requirements or is not necessary in the care of a patient, it is appropriate to deselect the phrase.
            2. When an “Outcome Group” phrase needs to be added to the EHR due to unique patient needs or per surgeon preferences, the Circulator may add one by selecting “Add Outcome” and choosing the appropriate phrase from the pre-populated outcomes.
            3. When a pre-populated intervention(s) in the descending list of an “Outcome Group” phrase does not apply to the procedure requirements or is not necessary in the care of a patient, it is appropriate to deselect the intervention(s).
            4. When an intervention needs to be added to the EHR due to care provided to the patient, the Circulator may add one by selecting “I+” and choosing the appropriate intervention from the pre-populated interventions.
         2. The Circulator must review the pre-populated “Diagnoses” to ensure that the diagnoses are pertinent to the patient and the care and interventions applied to the patient.
            1. When a pre-populated diagnosis does not apply to the patient due to nursing contributions and/or interventions provided to the patient, it is appropriate to deselect the diagnosis.
4. Verify
   1. Verification of the EHR is the Circulator’s legal electronic signature authenticating the information in the chart is accurate, reflecting the factual events of the procedure and care provided to the patient within the OR.
      1. Verification is to be completed after the patient has been safely transferred to the next phase of care (i.e. PACU, Phase II, ICU etc.), handoff report has been completed and a final review of the EHR has been done.
         1. The Circulator must return to the OR to complete a final review of the EHR.
            1. During the final review of the EHR, the Circulator must complete “Required Items Missing” and resolve each error and/or missing item.
            2. During the final review of the EHR, the Circulator may review “Recommended Items Missing” and resolve each error and/or missing item, if applicable.
         2. After the final review of the EHR, the Circulator may verify the chart by providing their personal user name and password, selecting “Verify”, completing the entry and closing the chart.
5. Debrief/Handoff
   1. Debrief/Handoff is a systematic organizational tool to assist in relief, shift-to-shift and phase of care report as well as procedure completion authentication.
   2. Handoff report requires the Circulator to relay information including correct & complete procedure name, LDA’s, local/regional anesthetics, patient belongings and/or special needs.
      1. The Circulator must utilize this tool during staff changes such as breaks/lunches or permanent shift relief as a means to provide standardized report.
         1. Handoff report during staff changes including breaks/lunches or permanent shift relief must be completed.
            1. When report has been completed during staff changes, the Circulator giving the report must document the report by charting “Care Handoff” and recording the type of report as well as documenting the name of the new Circulator receiving report on the patient.
      2. The Circulator must utilize this tool during phase of care changes when the patient is going to be transferred from the ICU/Unit to the OR.
         1. Handoff report during phase of care change must be completed either at the bedside with a verbal report or via telephone report.
            1. When phase of care change report has been completed, the Circulator must document the report by charting “Care Handoff” and recording the type of report as well as documenting the name of the primary nurse giving report.
   3. The Circulator must complete the Debrief/Handoff for procedure completion authentication.
      * 1. Completion of the Debrief/Handoff must be done at the end of the case after the patient has been safely transferred to the next phase of care (i.e. PACU, Phase II, ICU etc.), and handoff report has been completed.
        2. The Circulator may record if communication occurred with the patient’s family or significant other during the procedure.
        3. The Circulator may record Debriefing of the procedure.
           1. When the sponge, sharp and instrument count have been completed the Circulator should select “Yes”.
           2. When the name of the operative procedure has been verified the Circulator should select “Yes”.
           3. When the specimens have been labeled and verified, the Circulator should select “Yes”. When there is no specimen collection for a procedure, it is appropriate for the Circulator to select “N/A”.
           4. When the surgical team identified what went well/what did not, and formulates a response plan, if applicable, the Circulator should select “Yes”.
           5. When the surgical team identifies key concerns for recovery and management of the patient, the Circulator should select “Yes”.
        4. The Circulator may record Care Handoff to document phase of care changes when the patient is going to be transferred from the OR to the PACU/Phase II or the ICU/Unit.
           1. The Circulator should select the report type utilized.
           2. The Circulator should record the name and credentials of the primary nurse receiving report on the patient.
           3. The Circulator should select the Handoff Communication format utilized for the report.
           4. The Circulator should select the transfer method utilized for the patient.
           5. The Circulator should select the staff that accompanied the patient during the transfer of phase of care.
6. OR Preop Checklist
   1. The OR Preop Checklist is a comprehensive checklist utilized to review the patient’s preparation for surgery.
      1. The Preop Checklist is to be completed by the admitting nurse in the Preop area.
         1. It is appropriate for the Circulator to complete the Preop checklist with the patient and/or in conjunction with the primary nurse caring for the patient when the Circulating Nurse will act as the primary nurse for the patient throughout the Intraoperative care setting (i.e. nights, weekends, ICU/floor patients bypassing Preop, coming via direct transport).
            1. When the Circulator will act as the primary nurse caring for the patient, the Circulator must document the Preop Checklist by selecting “+ New Reading”. The Circulator should review each question with the patient and/or primary nurse for an incapacitated (i.e. intubated patient, developmentally delayed patient etc.), if applicable, to assess the patient’s preparation for surgery.
            2. When the Circulator completes the Preop Checklist, the Circulator must select “OR Nurse” under the “Reviewed by Nurse” section of the Checklist and then may close and complete the Preop Checklist entry.
      2. When the OR Preop Checklist is completed in the Preop area, the Circulator must review the OR Preop Checklist prior to interviewing the patient.
7. Additional Information
   1. Transferring a Patient
      1. If the patient is a direct transfer from the ICU to the OR (i.e. the patient will not be going to pre-op), the circulating nurse must transfer the patient to perioperative services in EPIC. It is the responsibility of the receiving unit to transfer the patient in EPIC, therefore if the patient is then directly transferred to the ICU (i.e. the patient does not go to PACU), the nurse on the receiving unit will transfer the patient from perioperative service to the correct unit.
         1. To transfer the patient, click the “Patient Station” button at the top of the screen in EPIC.
         2. If the chart of the correct patient is already open, the name of the patient will populate in the “Patient Lookup” screen. If not, search for the patient by name or MRN.
         3. Under “Encounter”, click the patient’s “Admission” encounter. The patient’s room number will show up under “Admission Information”. If the patient has arrived to the OR but still shows up as in their hospital room, the patient must be transferred.
         4. Click the “Transfer” button.
            1. Populate date and time with the accurate time the patient entered the OR.
            2. “Hospital Area” should be populated with AIP Inpatient Services. “Unit” should be populated with “AIP Periop Services”. Click the magnifying glass on “Room” and “AIP Periop” should populate.
            3. If the patient will be returning to their previous room after the procedure, put a checkmark in the “Hold old bed” checkbox.
            4. Populate the “Accommodation Code” section with “OR Hrly”. This changes the hourly charges for the patient for perioperative services.
            5. Press the “Transfer” button. Now the patient should be transferred to Perioperative Services.
   2. Editing the Chart
      1. If a change to the patient’s chart needs to be made at a later time, this can be done in two ways.
         1. If OR Billing has not yet posted the log for the chart, the nurse can pull up the patient’s chart, edit/add any information necessary, save the information, and close the chart.
         2. If OR Billing has already posted the log for the chart, some sections will display as “read-only” and cannot be edited without creating an addendum.
            1. To create an addendum, click the “More Actions” button in the EPIC sidebar, then click “Create Addendum”.
            2. Sections that were previously “read-only” can now be edited.
            3. When finished editing, the system will prompt the nurse to file the log. Click “Yes” to close the chart.
            4. The chart does not need to be re-verified.
   3. Procedure Not Performed\*\*\*\*\*
      1. If a procedure is canceled while a patient is still in pre-op and did not enter the OR, the pre-op nurse is responsible for charting that the procedure was not performed.
         1. The OR nurse may have already documented a pre-op interview, staff times, review of allergies, etc. This is appropriate because this care was completed. Do not pre-document care that has not yet been completed.
      2. If a procedure is canceled after the patient arrives to the OR, but before cut time, document information about care that was given to the patient (i.e. the nurse most likely did complete a pre-op interview, skin assessment, initial count, etc).
         1. To indicate that the procedure was canceled, click “More Actions” on the intra-op sidebar, then click “Procedure Not Performed”.
         2. The nurse will be prompted to choose the time the case was canceled, which will be “In Preop”, “Before Induction” or “After Induction”. Choose the correct option, then click “Accept”.
         3. “In Room” time, “Out of Room” time, and “Staff” times must be appropriately documented.
         4. If a closing and final count were not performed because there was no beginning to the procedure, the closing and final count may be deleted in order to close the chart.
         5. The chart does not need to be verified by the circulating nurse if the procedure was canceled before “Cut Time”. In this case, there will be no “Cut Time” or “Procedure End” time, and these times do not need to be documented.
   4. Transplant Charting
      1. If the patient is a transplant recipient (during the current procedure and/or previously received a transplant), a new cluster of charting options will populate in the Intra-op sidebar labeled “Transplant”.
      2. If the patient is not undergoing a transplant during the current procedure, no documentation is necessary in this section.
      3. If the patient is undergoing a transplant during the current procedure (i.e. Liver, Kidney, Pancreas, Lung, Heart, etc), then documentation is to be completed in the “TXP Surgical Forms” section.
         1. In this section, an episode for the organ being transplanted will populated (i.e. “Liver Episode”, “Kidney Episode”, etc). Under this section, click the blue hyperlink that will say “UCH Txp Kidney Surgical Information” (or Liver, Lung, Heart, etc).
            1. Complete all information under the “Circulating Nurse Documentation” section. This includes all timing events for the organ. Do not complete any information under the “Surgeon Documentation” section.
         2. If an organ is not already populated in the chart for a transplant, click the “Organ” button with a green plus sign to add an organ encounter.

**Related Policies and Nursing Practice Guidelines:**

1. Surgical Counts
2. Specimen Submission Guidelines/Inpatient OR Pathology Guidelines

**Definitions:**

**Intraoperative (Intra-op):** Referring to events during surgery

**Pre-op:** Pre-operative, referring to either the Pre-op unit where a patient is prepared for surgery, or referring to an event taking place before surgery.

**OR:** Operating Room.

**Circulator/Circulating nurse:** The operating room nurse that is in charge of nursing documentation during surgery.

**RN:** Registered Nurse

**H&P:** History and Physical

**SBAR:** Summary, Background, Assessment, Recommendations.

**Methodical Wound Exam:** The point in a surgical procedure when the surgeon examines the operative site and ensures that no counted items have been left inside the patient.

**PACU:** Post Anesthesia Care Unit, commonly known as the recovery room, where patients are recovered from anesthesia.

**PNDS**: Perioperative Nursing Data Set

**ICU:** Intensive Care Unit

**ORIF:** Open Reduction Internal Fixation, a procedure performed to fix a fracture

**MRN**: Medical Record Number

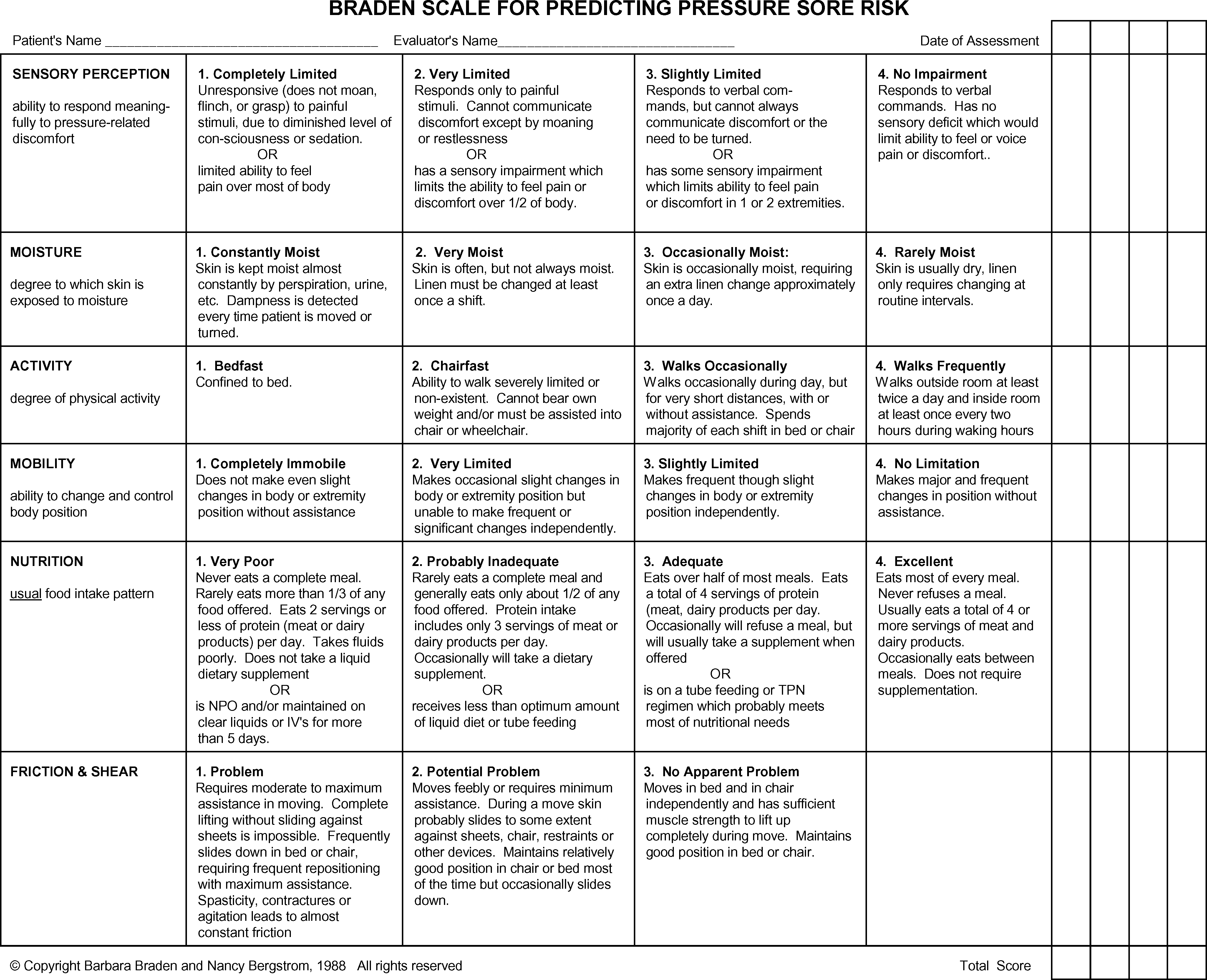
**EHR**: Electronic Health Record

**Laparoscopic:** A procedure performed under visualization of camera

**AORN**: Association of Operating Room Nurses

**ANA**: American Nurses Association

Figure 1:



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