

**University of Colorado Hospital Nursing Practice**

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

**Introduction:**

**Scope:**

The Intraoperative EPIC Charting Standards are applicable to all Intraoperative care areas that utilize Op-Time throughout the University of Colorado Hospital Anschutz Campus.

**Charting Standards Details:**

1. Intraoperative Timing Events
2. Pre-op times should be documented by the Pre-op RN.
   1. Pre-op times will automatically populate into the intraoperative chart and should not be altered by the circulating nurse.
3. Intra-op times must be documented by the OR circulating nurse.
   1. “Cut Time” must be populated only when the surgical team makes an incision. If the procedure does not involve the creation of an incision (i.e. – cystoscopy), then “Cut Time” should be populated when the surgical team begins the surgical intervention on the affected part of the body
      1. 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” should be populated when the surgical team has completed a Methodical Wound Examination (MWE), prior to closing the surgical incision and therefore 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.
   3. “Close Time” should 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” should 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 documented on the anesthesia record.
   1. If there is only one panel of surgeons and/or procedures being performed, the circulating nurse should not change the auto-populated times.
   2. If the procedure has multiple panels of surgeons and/or procedures being performed on the same patient during one surgical encounter but at different times, then “Procedure Start” will auto-populate with the “In Room” time documented by anesthesia for the procedure performed first, and “Procedure End” will be documented 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 documented on the anesthesia record.
   3. If the procedure has multiple panels and/or procedures 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 are to be charted by the PACU nurse, and should not be charted by the circulating nurse.
6. Anesthesia times should be charted by the anesthesia provider.
   1. “In Room” time, which is documented by the anesthesia provider, will auto-populate “Procedure Start” time, and “Out of Room” time (also documented by the anesthesia provider) will auto-populate “Procedure End” time. Refer to section C above for further details.
7. Projected Times 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 section 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. Allergies
    1. Prior to procedure start time, the patient’s allergies must be reviewed by the circulating nurse.
       1. Mark the patient’s allergies as reviewed at the appropriate time.
          1. The circulating nurse should ensure there is documentation that the patient’s allergies were reviewed prior to start of the procedure.
       2. Confirm allergies (including reaction) with the patient, ensuring that the list of allergies in EPIC is up to date.
          1. Update the patient’s list of allergies and reactions to reflect any changes stated by the patient pre-operatively.
          2. If the patient denies the existence of a listed allergy, create a comment that indicates the patient’s denial of the allergy.
11. Implant History
    1. The circulating nurse should review this section to determine what (if any) implants the patient currently has.
    2. If the patient has had previous surgery at a UCHealth facility and received an implant, it should be displayed here.
       1. If the patient has had previous surgery and received implants but not at a UCHealth facility, these implants may not be displayed in this section.
       2. If the patient’s previous implants are being explanted during the current procedure and they are displayed in this section, then explanation date and time should be documented here.
12. Staff
    1. The circulating nurse must document the presence of any staff or visitors 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 has credentials in EPIC, inputting their name should allow them to populate into the correct section of the staff screen (i.e. surgeons, staff, anesthesia staff sections).
          1. If the person does not yet have credentials in EPIC, or the person is an industry representative or visitor (i.e. student, observer, researcher), then the person must be added to the record as a “Visitor” or “Vendor”.
             1. If the person is an industry representative, they should be documented as a “Vendor”. Otherwise, the person is documented 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. An accurate record of who is present in the OR at what time must be kept. “Time In” must be populated at the time the person enters the OR, and “Time Out” must be populated at the time the person leaves the OR.
       1. 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.
       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 timed 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.
13. 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. Document a reason for the count being performed (i.e. whether the count is initial, closing, final, relief, etc).
    3. Document 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. Document 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. Document the name of the staff member that observed and verified the count (circulating nurse).
    6. The circulator must document whether the count was correct or incorrect. It is not necessary to document the “Initial” count as correct or incorrect. 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, if the closing sponge count is incorrect but the needles/sharps and instrument count was correct, there must be two separate “Closing” count entries. One must specify that “Sponge” was incorrect, and one will specify that “Needles/Sharps” and “Instruments” was correct.
    7. Document whether the physician was notified of the outcome of the surgical count, whether it was correct or incorrect.
    8. 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.
       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.
    9. If a procedure is being performed in which no countable items are on the surgical field, then the “No counts needed” checkbox should be populated.
    10. 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 a fluoroscopy 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. Document a comment including the name of the surgeon reading the image, and that no retained instruments were read on the fluoroscopy image.
    11. 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.
    12. If a surgeon declines an x-ray in the OR in the event that one is needed, the circulating nurse must document a comment including the reason an x-ray was not taken. Please refer to the OR Surgical Count policy for situations in which this is acceptable.
    13. If items are retained intentionally in a patient upon discharge from the OR, the closing and final counts should be documented as correct (refer to OR Surgical Count Policy), yet a comment should be made referring to the type of item(s) retained and the number retained (i.e. abdominal packing).
14. Preop Skin

**A.** 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.

1. Site Prep
   1. Prep of the surgical site(s) should be performed by the Circulator 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.
2. 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).
       2. 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.
3. 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.
4. 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.
5. 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.
   * + 1. All surgical team members involved in positioning the patient must be documented.

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.

* + - 1. 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.
   * + 1. If additional positioning will occur throughout a single procedure, a supplementary positioning entry is required.
       2. If additional procedures are planned where the patient’s position will change from the primary position, each procedure requires an individual positioning entry.
     1. If no additional positioning will occur or pre-populated positioning screens are present due to surgeon preferences, each additional positioning entry may be deleted.
        1. 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 “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 OR 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. A free text comment 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. Document the accurate date and time the note is reflecting. If the event being documented occurred in the past, time must 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).
      2. After a Nursing Note is written and accepted, it may be edited. The version of the note before revision will remain visible and will remain part of the legal record.
      3. After a Nursing Note is written and accepted, it may be deleted. A reason for deleting the note must be provided, and a comment may be made along with the deletion. The deleted note will remain visible and will remain part of the legal record.
      4. The circulating nurse must document pre-op patient education (Giarrizzo-Wilson, 2012). Documentation 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 and date of birth on wrist band, with verbal confirmation from patient. Patient verbalizes understanding of procedure. Reviewed chart, confirmed consents signed. Discussed consent for blood products. Discussed patient positioning for procedure and range of motion concerns. Met patient’s \_\_(family/friend/significant other)\_\_\_, discussed when to expect updates during procedure. Patient educated and oriented to OR environment and denies further questions”.
         2. When documenting from a pre-made template, add or subtract portions of the pre-op interview as necessary to accurately reflect the specific patient (i.e. do not chart what did not happen).
      5. Sign the note when complete. Signing the note will finalize the note and it will then become part of the legal record.
      6. Document communication with the patient’s family.
         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 (i.e. peripheral IVs, arterial lines, central venous catheters, epidurals, etc.) are placed and documented either by the preoperative nurse or by the anesthesia provider intraoperatively. Documentation of lines is not the responsibility of the OR nurse.
      1. 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).
         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 placed intraoperatively by the surgeon must be documented by the OR nurse in the LDA screen.
      1. Document a drain as “Open” (i.e. penrose drain) or “Closed/Suction” (i.e. Hemovac, Blake or Jackson Pratt to bulb suction).
         1. Document the date and accurate placement time of the drain.
         2. Drain type, orientation, location, size, and name of person inserting the drain must be documented.
         3. A number should be assigned to the drain. If there is only one drain, the number assigned should 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.
      2. Document intraoperative removal of drains including accurate date and time of removal.
      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.
      4. The OR nurse should document an assessment of pre-existing drains that the patient arrives to the OR with already in place.
         1. “Intake” and “Output” do not need to be documented by the OR nurse, as the anesthesia provider will document drain output.
      5. 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. It is an expectation that an assessment of urine color and appearance is documented upon insertion.
      6. 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, Gastrostomies, External Ventricular Drains, External Urinary Catheters, Fecal Collection Pouches, Pain Busters, Lumbar Drains, Wound Vacs (Negative Pressure Wound Therapy), Nephrostomies, Non-Wound Packing, Peritoneal Dialysis Catheters, Subdural Drains, Suprapubic Catheters, and Ureteral Drains.
         1. Assessment of these LDAs that were placed intraoperatively will be completed by the nurse on the receiving unit, and does not need to be completed by the OR nurse upon insertion/creation.
         2. 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 documented by the anesthesia provider. The OR nurse is not responsible for documenting airways placed by the anesthesia provider.
      1. 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 of the inner cannula, and person performing the initial placement.
   4. If the patient has too many items documented in the LDA screen, any new LDAs must be documented in the “Doc Flowsheets” section.
      1. Management and assessment of existing LDAs must also be completed in the “Doc Flowsheets” section when the LDA screen has too many items.
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.
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.
   2. If the procedure is being performed by multiple services (i.e. Plastics and ENT), there will be multiple “Panels” for the procedure.
   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. Document the laterality of the procedure, indicating “N/A” if there is no laterality (i.e. midline abdominal incision).
      3. Document the type of anesthesia used from the provided options.
      4. Indicate the “Wound Class” for the procedure (Garner, 1985).
         1. The wound should be documented 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 documented 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 documented 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 documented 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.
8. Supplies
   1. Document an accurate list of supplies opened for the procedure, indicating whether the supply was used or wasted.
      1. The supply section will pre-populate 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.
      2. Add any supplies that were not pre-populated.
      3. A supply that is provided by a vendor or has not been added to the EPIC system must be documented as a one time supply.
         1. Document the supply name, quantity used or wasted, name of the manufacturer, and manufacturer number (i.e. reference number or model number).
      4. If a supply was wasted, indicate the number wasted versus the number used.
         1. If a certain number of the supply was used and a certain number 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), then document the quantity used as “0” and indicate the number wasted.
         3. Provide the reason the supply was wasted.
      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).
      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.
       2. The surgical team member that directly administers the medication to the patient must be documented.
       3. The medication dose administered to the patient must be documented.
          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”.
       4. The route the medication is being administered to the patient must be documented.
       5. 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.
       6. 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 sterile field and required for the procedure to start.
             1. Any medication administration that occurs as a pre-procedure intervention (i.e. prior to “CUT TIME” 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. If 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 chart as a “One Time Implant”.
             1. If an implant is added as a “One Time Implant”, the implant’s reference number or product must be documented as the model/catalog number in the chart.
       2. The expiration date of an implant must be documented, if applicable.
       3. The size of an implant must be documented, if applicable.
       4. The serial number of an implant must be documented, if applicable, both for tracking and reordering purposes.
       5. The LOT number of an implant must be documented, if applicable, both for tracking and reordering purposes.
       6. The Manufacturer of the implant should be documented.
          1. If the Manufacturer of the implant is not a choice from the pre-populated list, a descriptive free text comment including the Manufacturer’s name is appropriate.
       7. The Supplier of the implant should be documented.
          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 pre-populated 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 documented.
          1. If 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. If xenograft or allograft skin is being implanted, the “number used” must be recorded in square centimeters.
    2. The action of an implant either on the sterile field or that has reached the patient must be documented.
       1. An implant that is inserted into the patient and will remain with the patient once they leave the OR must be documented 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 documented as “Explanted”.
          1. If an implant is removed 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. If an implant is removed that was not placed at a facility within the UCH system occurs, the Circulator may add the implant to the Implant section of the chart and record as much information as possible about the implant, charting the action as “Explanted”.
          3. If an implant is being removed from a patient for lawsuit/legal reasons, it must be documented as an “Explanted” in either the Implant History screen if applicable, or within the Implant screen.
             1. A Pathology Requisition may also be completed for implants explanted for lawsuit/legal reasons, 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 documented as “Wasted”.
          1. If either xenograft or allograft skin graft will be wasted, a second encounter must be added to the Implant section with one entry including the square centimeters of skin not being implanted to the patient recorded as “number used” and charting the action as “Wasted”.
          2. If an implant 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 documented.
    4. The surgical staff team member who inserts the implant into the patient should be documented.
    5. The time the implant was inserted into the patient should be documented.
       1. The time an implant was removed or explanted from a patient should also be documented.
    6. The Circulator may utilize the Implant Description box to chart a 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” for tissue tracking purposes.
       1. If the tissue is grafted from the patient “Autologous” should 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 should be documented.
          2. The preparation method applied to the tissue must be documented.
             1. When the tissue is reconstituted or rinsed on the sterile field, the solution type, LOT number and expiration date must be documented.
          3. The tissue type must be documented.
             1. When the tissue implant is “OTHER”, the Circulator may utilize the Tissue Description box to chart a free text comment about the implant.
12. Specimens
    1. When a specimen is obtained, the attending 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 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 should document the total number of containers/specimens to be sent.
             10. The Circulator must provide a pertinent clinical history of the patient that provides a rationale to why the surgical procedure is being performed.
             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 the specimen(s) are ready to be sent or dropped off, the Circulator must select each specimen entry 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 EPIC, 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 provide a reason that the specimen requisition is being permanently removed from EPIC.
       4. Specimens that are removed from a patient for lawsuit/legal reasons must be documented as a requisition per surgeon preference or per legal obligations.
          1. If a specimen/evidence is to be given to the responsible law enforcement officer, a Nursing Note must be charted 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.
       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 documented.
             4. The specimen source must be selected from the pre-populated 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 is 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 documented 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 and date of the request should be documented.
             5. The comment section can be utilized to identify which OR is requesting the item(s), 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 documented.
14. Order Sets
    1. The OR nurse does not need to document 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 or anesthesia provider, 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 or anesthesia provider in the “Clinician Communication” section.
       1. Document the reason for communication, the name and role of the person receiving the information, the type of information being communicated, and the time the information is communicated.
    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 that this communication is documented. If the pathologist speaks directly to the surgeon, no documentation is recommended.
       1. For frozen section communication, document the notification reason with a comment indicating that the communication was related to frozen section results.
    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 as “Robot Console Start”. Document un-docking time for the robot console as “Robot Console Stop”.
    2. All other timing events in this tab do not require documentation.
17. Incisions/Wounds
    1. Document creation of a surgical incision.
       1. Document the date and 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, including whether it qualifies as a donor site, episiotomy, graft site, incision, scope site, or puncture site.
       4. Number of scope sites should be documented 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 does not involve creation of scope sites, yet multiple incisions exist on the same part of the body, the incisions all must be documented as separate incisions. ]
             1. Differentiate multiple incisions with accurate documentation of orientation and location. 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 that the incision is not pre-existing.
       6. If no incision was made during the procedure (i.e. cystoscopy), then no incision should be documented.
       7. 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 new entry as “Flap”.
             1. Document the accurate date and time the flap was first assessed.
             2. Document the orientation, location, and whether the flap 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 existence of wounds in this section (i.e. “Wound”, “Burn”, “Pressure Ulcer”). 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 type of dressing being used.
        2. 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 should 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.
        3. 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 for a “Wound”, with the addition of “Staging”.
     4. Document packing that is not placed in the surgical wound as “Non-Wound Packing”.
        1. Document the placement date, time, and name of person placing the packing.
        2. “Location” must be specified as ear, eye, mouth, nose, or vagina.
        3. If packing is removed while in the OR, document the date and time it was removed.
     5. 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, and the name of the person placing the packing.
        2. “Location” may not fall into the offered options. Document a comment in this section that specifies where the packing is placed.
        3. If packing is removed while in the OR, document the date and time it was removed.
        4. 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 previously documented as prepped will pre-populate in this section.
         1. Laterality will pre-populate from previous documentation of prep.
         2. If no dressing for the surgical site is used, select “None”. If the dressing used does not appear in the “Dressings” section, choose “Other” and create a comment.
      2. Document a site completion section for each separate surgical site.
      3. Document whether the prep was cleaned from the patient.
         1. If no prep as completed for the surgical site, select “N/A”.
2. Postop Skin
   1. The postop skin assessment of the patient’s skin integrity 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 chart.
      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.
         1. Each new skin condition must also recorded assessment conditions.
            1. When selecting the condition “Other (see Comments)” the Circulator is responsible to chart a free text comment addressing the variances in skin integrity including anatomical location and condition related to the intervention.
3. PNDS
   1. The Perioperative Nursing Data Set (PNDS) tool for application of nursing diagnoses, interventions and patient outcomes should be documented.
      1. The Circulator must review the pre-populated “Outcome Group” phrases to ensure that the nursing contributions applied are documented.
         1. If 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. If an “Outcome Group” phrase needs to be added to the 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. If 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. If an intervention needs to be added 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’s care.
         1. If 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. The Circulator’s must provide a 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.
         1. The Circulator must return to the OR to complete a final review of the chart.
            1. During the final review, the Circulator must complete “Required Items Missing” and resolve each error and/or missing item.
            2. During the final review, the Circulator may review “Recommended Items Missing” and resolve each error and/or missing item, if applicable.
         2. 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. The Circulator should utilize this tool during staff changes such as breaks/lunches or permanent shift relief or during handoff report during phase of care change as a means to provide standardized report.
      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 should utilize this tool during phase of care changes when the patient is going to be transferred from the ICU/Unit to the OR or from the OR to the PACU/Phase II, ICU/Unit.
         1. Handoff report during phase of care change must be completed either at the bedside with a verbal report or via telephone report.
         2. When phase of care change report has been completed, the Circulator must document the report by charting “Care Handoff” and documenting the type of report, the name of the primary nurse giving/receiving report, the transfer method utilized for the patient and the staff that accompanied the patient during transfer.
   2. The Circulator should complete the Debrief/Handoff for procedure completion authentication.
      * 1. Completion of the Debrief/Handoff should 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 should record if communication occurred with the patient’s family or significant other during the procedure.
        3. The Circulator should record Debriefing of the procedure.
           1. If the sponge, sharp and instrument count have been completed the Circulator should select “YES”.
           2. If the name of the operative procedure has been verified the Circulator should select “YES”.
           3. If 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. If the surgical team identified what went well/what did not, and formulates a response plan, if applicable, the Circulator should select “YES”.
           5. If the surgical team identifies key concerns for recovery and management of the patient, the Circulator should select “YES”.
6. OR Preop Checklist
   1. The OR Preop Checklist is to be completed by the admitting nurse in the Preop area to review the patient’s preparation for surgery.
      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 Circulator 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 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.
         1. It is the responsibility of the receiving unit to transfer the patient in EPIC. Therefore, if the patient is transferred directly to the ICU from the OR (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.
   2. Editing the Chart
      1. Changes to a chart may be documented after previous verification of the chart if necessary.
         1. If OR Billing has not yet posted the log for the chart, the nurse should 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. Create an addendum to the chart, and make necessary edits.
         3. It is not necessary to re-verify the chart after edits are complete.
   3. Procedure Not Performed
      1. If a procedure is canceled while a patient is in pre-op and did not enter the OR, the pre-op nurse is responsible for documenting 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. Document “Procedure Not Performed” and include the phase of care during which the procedure was canceled (i.e. “In Preop”, “Before Induction”, or “After Induction”).
         2. 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 complete transplant related documentation in the “TXP Surgical Forms” section.

**Related Policies and Nursing Practice Guidelines:**

1. Surgical Counts

**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.

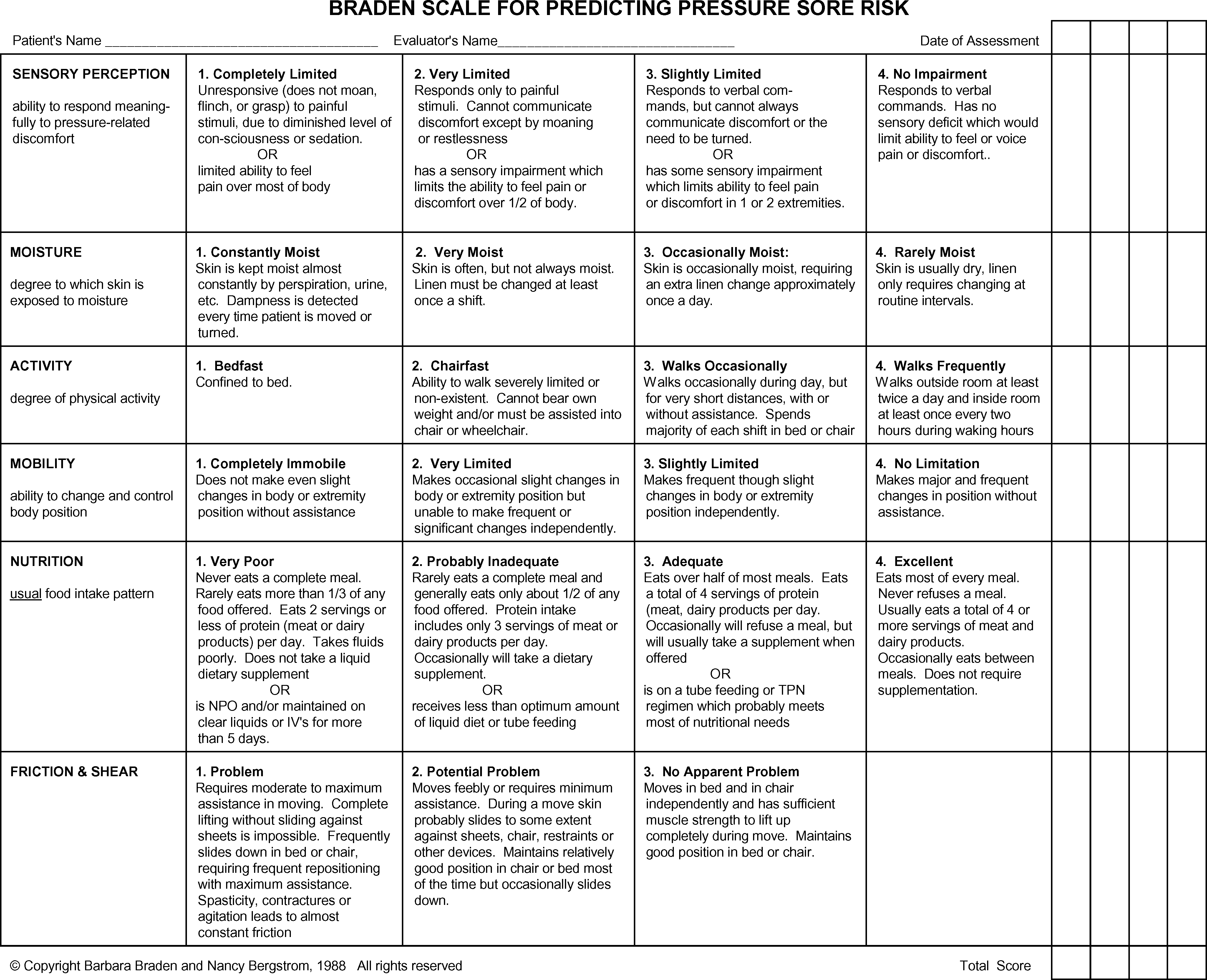
**PACU:** Post Anesthesia Care Unit, commonly known as the recovery room, where patients are recovered from anesthesia.

**ICU:** Intensive Care Unit

**MRN**: Medical Record Number

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

Figure 1:



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