**EPIC QUESTIONS / CONCERNS**

**Pre-Incision**

* **Timing events**
  + Procedure start / procedure end (NOT cut time/close time)
    - Automatically populates with “in room time / out room time” unless there are multiple panels / procedures. Ex – if procedure panels include ORIF Radius and TKA, with the ORIF Radius being performed first, what does timing look like? Would the “procedure start” for ORIF Radius be in room time, then “procedure end” be when the surgeons finish closing the arm, then “procedure start” for TKA be when incision is made there and “procedure end” be when the patient is out of the room?
    - For cases that include multiple incisions but are built into one case (ex – anterior/posterior spine) – should a note be made when the anterior was closed, posterior was cut and closed?
  + Cut time
    - Is it always when incision is made?
      * Neuro – is it when Mayfield pins are placed?
      * Is it when surgeon starts x-ray with a spinal needle in the patient’s back?
      * Is it when local is injected prior to incision?
    - Sweep of operative site
      * Is this when closing count begins or ends?
      * Is this to be charted during closure when the surgical site can’t be “swept”? (ex – eye case, cysto, etc)
      * If the surgeon did not verbalize a sweep, should this still be charted when closing?
    - Close time
      * Is this always when the drapes come off the patient?
      * Neuro – is it when Mayfield pins come out?
      * Prone – is it when patient is flipped back supine?
    - Ready for OR Discharge
      * When is this used? Have heard these 2 different scenarios:
        + Used when patient is ready to be rolled out of OR – patient is extubated, sats are solid, etc
        + Used only when patient is ready to be rolled out of OR but there is nowhere to transfer patient to (PACU hold, ICU bed/room not ready, etc)
* **Allergies** 
  + Allergies to be reviewed prior to cut time and again before closing?
  + If patient states that they are NOT allergic to something listed in allergy screen, can we remove the allergy?
* **Staff**
  + How are radiology techs to be charted? They are often “in and out” and staff changes constantly
  + Expectations for breaks / relief person
    - “Circulator/scrub relief” to be used only for temporary relief, whereas “circulator/scrub” to be used for permanent relief?
    - Clock people in and out when they leave even if for temporary relief
* **Counts**
  + “2nd procedure closing / final” to be used for closing of additional incision? (ex – anterior / posterior spine where there is a closing and final for anterior and closing and final for posterior)
  + Incorrect counts
    - How detailed should comments be for incorrect counts? Name of radiologist and MD that reviewed films included, but should the lost item be documented?
    - Make sure to document only the right section as “incorrect” (if instrument count is incorrect, don’t also include sponge/sharps as incorrect)
  + Spine – ALIFs – document that fluoro image was read by Dr?
  + “Other” tab needs to be checked when item does not fit into sponge/sharp/instrument? Ex – vessel loops, clip bars
  + “No counts needed” checked only when no countable items are on the field?
* **Pre-op Skin**
  + Overall assessment must be charted
  + What is the expectation for Grounding/Positioning/Warming/Operative/Tourniquet?
    - Operative pre – W/D/I and post – incision?
* **Site Prep**
  + “Fire Risk Reduction strategies for use of alcohol based preps have been implemented prior to initiating the surgical procedure” – does this need to be more specific? Have heard that other hospitals chart the time the patient was prepped and the time the patient was draped so dry time can be calculated.
* **Positioning**
  + Be sure to delete “extra” positions. Ex – crani positioning sometimes includes supine, prone, etc – and people do not delete the positions not in use
  + Be as specific as possible – instead of “foam pad”, use “foam pad elbow”, etc
  + Positioned by: Some people will only chart that the surgeon positioned. Need to include anesthesia (if applicable), residents, nurses, techs, and everyone that was involved?
  + Expectation for comments
    - “Positioning approved and directed by Dr. \_\_\_\_\_\_” ?
  + Include material of mattress / pads!
* **Timeout**
  + Briefing
    - Have heard staff say that all of this is “yes” if it was ADDRESSED – ex – even if the patient did not receive a Foley, they still mark “Is Foley required” as “yes” because it was addressed instead of “no – a Foley is not required”
    - Can there be an N/A for “images/films displayed” and “implants available”?
    - Consensus on delay, first case – is this ONLY to be “yes” if it is the first case? What if there was a delay on the second case and there was consensus?
* **Delay**
  + If a patient is brought back to the room later than their scheduled start time due to the previous case running late, BUT room turnover was completed in the proper 30 minute timeframe, should a delay be charted?
  + If the case to follow your room is an RFT and turnover time was greater than 30 minutes, should a delay be charted?
* **Nursing Notes**
  + Patient education and preop interview to be charted here?
    - What should be included in a “template” to present to staff? How specific does it need to get? Should we include specifics about WHAT they were educated about (SCDs, Foley, etc). Need to include if family was present?
      * My example – “Patient interviewed in preop 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”
        + I make changes as necessary (Patient interviewed in ICU / patient identified by spouse if patient intubated / Interviewed with assistance from translator / only chart that consents are signed if they really have been signed
    - OR should this be charted in OR Pre-op Checklist?
* **Lines / Drains / Airway**
  + Anesthesia is responsible for charting lines that THEY have added / DC’d?
  + Reminders of what needs to be charted by OR RN if new (commonly missed in bold)
    - **Bladder Diversion, Bowel Diversion**, Burn, Chest Tube, Drains**, Gastrostomy**, External Ventricular Drain, Foley, **Flap**, Incision, Intrathecal Catheter, Pain Buster, Lumbar Drain, **Wound Vac** (Negative pressure wound therapy), Nephrostomy, **Tracheostomy**, Open Drain, Peritoneal Dialysis Catheter, Pressure Ulcer, Incontinence Associated Dermatitis, Suprapubic Catheter, Ureteral drain / stent, Packing (non-wound packing)
  + Drain # - this should assign the drain a number for future charting.
    - Ex – put in 3 JP drains – assign each one either a 1,2, or 3 so they can be labeled
      * Some nurses have stated they chart this as “number of drains” – so all three drains get the number 3 because there are 3 drains
  + Foley – Assessment of urine?
  + Drain – Assessment of output?
    - What do we need to chart as assessment of LDAs?
* **Braden Scale**
  + If pre-op nurse / ICU nurse has completed the Braden scale assessment, does the OR nurse need to complete it as well?
  + If pre-op / ICU nurse has NOT completed the Braden scale, does the OR nurse need to complete it? And will it be filled out as a “pre-op” patient and not an anesthetized patient?

**Procedure**

* **Procedures**
  + Review of wound class
  + Procedure description –
    - Should notes be made to reflect the procedure performed? Ex – if procedure is “posterior lumbar surgery”, should a note be made that indicates “L4-5 Decompression”?
    - If hardware is removed, some people document that here – should it be specified in procedure section that “3 screws and 1 plate were removed from lumbar spine”?
  + Surgical site
    - Is this where skin incision is made or part of body being operated on? (ex – skin incision on neck but “spine cervical” can be the operative site)
* **Supplies** 
  + Charge accurately for gowns / gloves / **suture**?
  + What if case is canceled and supplies were opened? “waste” all supplies?
  + If supply is wasted, “used” goes to 0 and “wasted” to 1?
* **Equipment/Instruments**
  + What equipment needs to have documented serial numbers?
    - ESU / Force Triad
    - Bipolar
    - Harmonic / Gyrus etc
    - Bair hugger / warming blanket
    - SCDs
    - Drill (Stryker, Anspach, etc)
    - Laser
    - C-arm / O-arm
    - Other?
  + Need to keep accurate list of instrument pans that were used? If we call for an instrument pan that was not on the card do we need to document it in instruments if it was opened?
  + Need to keep accurate list of equipment (equipment list can include headlights, suture carts, suction dolly, etc)?
* **Intra-op Meds**
  + PRN meds
    - Chart administered time as when it was given to field?
    - Should “for prn use” or something similar be stated in a comment if med (ex – irrigation) was not necessarily all given at time it was administered to field?
  + Specific amount of med used –ex irrigation - may open 1000mL saline and only use 100cc. Still chart 1000mL for charge purposes? How are we to specify that only 100cc used?
    - Same for Floseal – now that there are 2 sizes, we need to specify that we opened a “10mL” but what if the surgeon only uses 5mL of the 10mL? Does that need to be specified in the chart?
  + “Given by”
    - Have seen charts specify the circulating RN as the one that administered the med because it was opened to the field. Need to specify that the surgeon gave the med because they are the ones giving it to the patient ?
      * Unless the RN REALLY DOES administer the med (ex – Bactroban in cardiac cases)
  + Site: Operative site
    - Need to specify WHICH operative site if there are multiple!
  + If med is mixed (50,000 units Bacitracin and 1L LR), do not need to chart separate liter of LR – already accounted for
* **Implants**
  + Tissue tracking section – what is the expectation? How much is necessary to fill out for tissues?
* **Specimens**
  + People often pre-populate the specimen sheet if they know a specimen will be taken, but this then pre-populates the time the specimen was taken. Should nurses be reminded to change the time of the specimen to reflect accurately?
* **Orders**
* **Order Sets**
* **Clinician Communication** 
  + To chart critical lab values / test results and communication to attending.
* **Timing Events**
  + Only used for robotics?

**Closing**

* **Incisions/Wounds**
  + If there are several incisions on the same body part and in the same area (but it is not a “scope site”), do different incisions need to be charted or can you specify “two incisions to right lateral ankle”? The “number” buttons only reflect “scope sites”
  + When should the nurse chart that the incision was first assessed? Many people chart the date first assessed and leave the time blank
    - Should the OR nurse chart an assessment of the incision?
* **Site completion**
  + What are the manufacturer recommendations for which preps should be cleaned from the patient’s skin vs left on skin?
* **Post-op Skin**
  + Should we chart a comment that pressure points were observed post-procedure? Ex – if pt supine – observed patient’s sacrum, shoulders, head and heels, WDI? Diane made a comment about skin SI’s – other units write SIs that say the patient received a pressure ulcer while in the OR – when she then reviews the charts they just say “WDI” but don’t specify that the nurse ACTUALLY looked at the patient’s sacrum (or other problem area).
* **PNDS**
  + Uncheck the laser section?
* **Verify**
* **Debrief/Handoff**
  + Is this the appropriate place to chart that the family was contacted INSTEAD of in the nursing notes?
  + Some RNs chart the time they call the PACU to inform them of the procedure being done as the time of handoff report – should this actually be charted when the nurse hands off IN the PACU unless ICU report is given over the phone?
  + Should nurses fill out the “shift to shift” handoff report section when handing off to another nurse?
    - There is also a “relief” button – should this be used during breaks / lunches?
* **OR Pre-op Checklist**
  + If preop nurse has filled this out, is it only necessary to review it and chart “previous entry reviewed by OR nurse”?
  + Appropriate to chart OR nurse preop assessment here or in the nursing notes?