EPIC QUESTIONS / CONCERNS

- 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

TIMEOUT TYPE
↳ OR PRE-INCISION
↳ ? ARE WE UTILIZING ABO PRE-ORGAN ARRIVAL VERIFICATION (RECIPIENT INTENDED RECIPIENT VERIFICATION
ABO POST-ORGAN RECOVERY VERIFICATION (DONOR)

1-2 PT IDEN

PROCEDURE TIMEOUT
BRIEFING QUESTIONS

1. CORRECT pt identity verified c 2 identifiers
2. CORRECT procedure per procedural consent
3. CORRECT site (anatomical)
4. CORRECT laterality
5. CORRECT position
6. SITE marked
7. CODE STATUS reviewed
8. RETURN TO OR/ bring back

1. Team members introduced
2. ver. surg plan & antic. length of surg.
3. RISK of BL addressed
4. Is a foley required
5. addr. Anesth. conc based on hic/meds
6. Allergies reviewed
7. PRE-OP antibio status verif & infus if ord.
8. BB given
9. VTE precaution initiated
10. PT warming initiated
11. Safety precaution reviewed?
12. meds on field lab. & verif.
13. solution for IRR available
14. Relevant image/film availe appropriate display
15. Access equip avail
16. implant(s) for proc. avial
17. consensus on delay, 1st case
↑ RECON

Kaci to educate ← MUST CHART EACH PERSON "encourage communication/continuity of care"

- 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? > YES
  - Clock people in and out when they leave even if for temporary relief

2/23/15

- Counts 1, 2, 5, & 1, 2, 3, 4, 5
  - "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) MULTI PROCEDURE CAN USE OTHER (COMMENT) Utilize comment box
  - 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? BUILD TEMPLATE
    - Make sure to document only the right section as "incorrect" (if instrument count is incorrect, don't also include sponge/sharps as incorrect) (+) new count for what was correct
  - Spine – ALIFs – document that fluoro image was read by Dr? "COMMENT" "CHART" MWE
  - "Other" tab needs to be checked when item does not fit into sponge/sharp/instrument? Ex – vessel loops, clip bars (UTILIZE) PLEASE CHECK
  - "No counts needed" checked only when no countable items are on the field? (CYSTO)
- Pre-op Skin → HIGH RISK CRITERIA
  - Overall assessment must be charted (MAKE COMMENTS PRN)
  - What is the expectation for Grounding/Positioning/Warming/Operative/Tourniquet? 1, 5 ↑ 1, &, 3, 4, 5
    - Operative pre – W/D/I and post – incision?
- Site Prep → 1, 5, 7 & 1, 0, 3, 4, 5
  - PREP TIMED
  - PT DRAPE

"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. (+) D check box about 3 min dry time (LEARN FOLLOW UP)

- Positioning 1, 2, 5, 7 & 1, 2, 3, 4, 5
  - Be sure to delete "extra" positions. Ex – crani positioning sometimes includes supine, prone, etc – and people do not delete the positions not in use YES
  - 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. _____"? DUE TO BEING DIRECTED BY ATTENDING/RESIDENT
  - Include material of mattress / pads!

ANY VARIATIONS CONCERNS ADDRESSED

"DIRECTED & APPROVED PER. ____"

- Timeout 1, 2, 3, 5, 7 & 1, 2, 3 4 5
  - 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"

A WORD TO ADDRESS THE ITEMS.

*** ORIN TO FOLLOW UP C EPIC & KRISTA TERPYL

- BB NEVER NO YES FOR PT TOOK TODAY OR ON ITTEM ↳ N/A IF NOT ON MED

- 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

Meeting 3/2 KS

- 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?

- 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?
- Equip/Instr
  - 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)?

KEZIA FOLLOW UP

→ @ PROCEDURE START

DOES IT FLOW INTO MAR?

- Intra-op Meds
  - PRN meds
    - Chart administered time as when it was given to field? ↑ yes PRN
    - 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?

3/16/15

↳ time for spliting meds (local)

Yes will be @ meeting?
Emailing Bebe today about survey results to validate course
Sending email to SS about nominating members of their
teams to "beef up"/ represent team more evenly on ORPC.
Yes. I will schedule a time w David to (next week) to
train him on the PP.

Donovan L. ELLISON

SS PICKLIST REMOVE, ADD TO MEDS

RN ↑ → med ONLY

JOANNE BACK INTO MERS ONLY

- 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" (directly to pt)
    - 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

* refer to MAR ↳ call pharm to populate

NN - formulary NON

ADD COMMENT ↳ foley transplant
↑ ANAT. LOCATION ↳ foley Wilson

↓ OTTER (transplant) back table

(↳ removed may remove)

- Implants
  - Tissue tracking section – what is the expectation? How much is necessary to fill out for tissues? YES/NO, anything occurred in your phase of care
- Specimens SMDA → FDA/OFF LABEL USE? (INDICATIONS FOR USE)
  - 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 Comm
  - To chart critical lab values / test results and communication to attending.
- Timing Events
  - Only used for robotics?
- 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? - CUT TIME
- Site completion
  - What are the manufacturer recommendations for which preps should be cleaned from the patient's skin vs left on skin? - chlorapprep > left - DURA long acting / beta baby shampoo chlorahex
- 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

2 copies "dirty" copy & final copy

STUFF NOT IN? ERIN TO FOLLOW UP.

TISSUE ID# → SERIAL # (ASHLEY/WALSH/WATSON ON SR CM!)

TISSUE TO REMOVE

↳ BREAST SPECIMENS TO SPECIFIC

NAME OF SPECIMEN & TIME.
↳ RESEARCH TAB
· COMMENT WHERE & WHO

* expectation chart to complete path log.

INDIVIDUAL EACH
↳ Rationale mult: 2 each ab lap case

washer

(+) Jen Allen /

↳ turning
- pressure points assess in applicable
↳ add section WNL VS. NOT IN NORMAL PROMPT COMMEN

3/30 SPINE DOCS & RIGHTS

BURGER - ?

CAIN - ?

KLECK - ? (NONE)

PATEL - OPERATION OF FLUOROSCOPY EQUIPMENT (REQUIRES SUCCESSFUL COMPLETION OF FLUORO-SCOPY RADIATION SAFETY MODULE IN HEALTHSTREAM 2/1/14 - 1/31/16)

WITT - LASER (FLUOROSCOPY 6/1/13 - 8/31/15)
↳ 6/1/13 - 8/31/15

FINN - LASER (7/1/14 - 6/30/16) ?

SEINFIELD - LASER (9/1/13 - 8/31/15) FLUOROSCOPY 9/1/13 - 8/31/15)

EXTENDED PRIVILEGES
& DIAGNOSTIC, MUSCULOSKELETAL, NEURO, VASCULAR / IR,

# UCH PRACTITIONER DIRECTORY

Peds
ELDER

- ERIN TO FOLLOW UP ON WASTING
- SKIN
  ↳ 2ND ENCOUNTER ON IMPLANTED THEN #2 WASTED

EXPLANTED IN IMPLANT
# / type

- If in implant hx explant
- if not in implant hx, explant in implant screen as new encounter

↳ legal
- pathology ↑ ask surgeon on fresh / perm.
  - hip
  - vag mesh etc.
  (↳ FORMALIN)

1. IMPLANT / OR IMPLANT HX
2. PATH

& TRANSPLANT TOO! ex. redo liver
↳ out of ice time. is implant time

cadaveric / live donor ←

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?

Comments from SurveyMonkey (New Hires)

I chart my pre-op patient interview in the pre-op checklist, so I chose "nursing notes" because the checklist wasn't an option.
12/26/2014 9:36 AM View respondent's answers

We need more direction and uniformity with Epic charting (i.e., what is a hard stop/must, what is optional, where things are supposed to be charted and how). Something I've noticed when I'm relieving in a room: In the initial counts the "Miscellaneous" tab isn't marked even though those items have been counted (ex: open belly cases with clip bars or vessel loops. Per policy they're under the "miscellaneous" category but it wasn't marked by the circulator whom I relieved. I think most people just consider these items "Sharps/Sponges" or something, but if policy states X then what is it? I've seen so many variations even with how people put in their break personnel (some put themselves out and the break person in; some just leave themselves in the whole time and just put the break person in and out). Also, Can we educate staff about wound classifications? Where I came from this was very important as it affects patient care through the course of their hospital stay, O.R. reimbursement from insurance companies, etc (ex: Gastric bypass, Lap Chole due to cholelithiasis or vaginal cases marked "Clean" when they're in fact considered "Clean contaminated" according to AORN. The Epic charting class that new orientees had to go to is not conducive to learning OR charting. It was Epic basics and the teacher deferred all specific questions to "your OR preceptor." God bless you ladies for taking on this project! XOXO
12/23/2014 3:58 PM View respondent's answers

This survey is exceptional! I am curious as to the results as I know the processes for pretty much all of this stuff varies widely among staff. So many people do all of these things so differently it would be nice to have a standardized way of documentation (and everybody doing it uniformly).
12/23/2014 3:57 PM View respondent's answers

3/23

ORDERS
↳ HOLD vs. SIGN
unclick box to find the correct surgeon phase of care

ORDER SET
↳ cultures → talk to BRI
- PRESET
- ROUTINE (unless indicate)
- select correct source

CLINICIAN COMM → Anesthesia (1) → entire readback
- in case of emergency (2).
↳ not the current patient
↳ find out who can take it (intern)
↳ ↓ culture of safety
(course of action ō this)

TIME EVENTS
↳ STILL ONLY ROBOTICS
↳ TRASPLANT → WILL HAVE OWN

ORDER MODE
↳ VERBAL ō Read back
telephone ō R b verification
☑ Filter providers by treatment team members

helpful. I think we all need clarification on when to check "sweep of operative site", "closing time," and "ready for OR discharge." We need a better way to track when the surgery is completed (dressings on, drapes off)

1. Equipment-too many #'s on equipment list on epic needs to be updated 2.Implants-Too bad we don't have a bar code scanner! 3. Medications-Are the med charges done from our charting or Pyxis? 4. Allergy every 2 hour check-~~needs to go away~~! 5. Anesthesia should ~~have the~~ Bair hugger & warmers on their charting! and especially the tournaquet!!! 6. Could we have included ~~in our~~ screen a "sponge verification by: MD & nurse".

It would be really helpful if all of the serial numbers for the equipment was up-to-date in the chart (there are a lot of them that aren't in there). It would also be nice if we could "copy" an implant the way we can copy a pathology sheet - so we can easily make an entry for something of the same that was implanted and explanted or something.

#1 Is it policy to document serial numbers? Has there EVER been a time where those numbers were used for anything? For quick cases this seems to be a hassle, especially for new people. Personally, I will just choose any number if I am in a hurry. Taking care of my patient is more important than tracking down serial numbers for my charting. I would love for someone to look into this and to see if we are doing this because we always have? Does this need to be done? #2 I feel to have accurate skin documentation, there should be seperate pre-op and post-op tabs. It should be charted seperately so that there is a clear distinguish between the two. #3 When would there ever be a new incision thats not "WDL"? It seems like over-charting to document this on a new incision. And, the skin around the incision should be documented under skin, so if you charted something under incision it would be double charting. #4 I feel if you are documenting under the OR Pre-operative checklist, then you do not need to chart a paragraph in the nurses notes restating everything you filled out in the checklist. Again, overcharting, which is not always a good thing.

More supplies, especially in hybrid/cardiac, guidewires etc need to be in the computer. Too time consuming to put in one time supply for everything.

I do not do a braden scale assesment because it is done on the unit and I treat every patient as if they are high risk for skin breakdown with appropriate padding and this is charted in the positioning section. I do not chart the assessment of a new incision other than the time and date it was made in surgery because it is new there is nothing to asses. When it is closed and bandaged the patient leaves the room.

Education should have it's own spot. I document it in my preop assessment in the Pre-op checklist. i've heard that the notes get in the way of others so I do not chart there regularly.

What is the Clinician communication tab. Do we have to chart the blanket warmer?

People are too focused on charting.

if not found in other areas of chart, documentation is done under nurses notes

I have never used the clinician communication tab. I'm not sure what/where it is or what it should be used for. I also have never been told to document any kind of assessment of the incision.

Clarification of guidelines would be helpful. I believe that there are inconsistencies across the staff with respect to charting.

need more standardization

In general, different preceptors interpret the charting requirements differently and thus teach conflicting information to the orientees. One major area is time-out documentation - some RNs instruct to mark yes/no based on whether an item is needed (eg, foley) while others say to mark yes regardless of whether it is needed to show that it was addressed during the timeout. Delays and skin assessment charting are also very different based on who you ask. It would be helpful to have a basic outline of exactly what the minimum/required/acceptable documentation is for each tab (or an objective explanation of what each documentation section is asking for). Also, our EPIC instructor was not from an OR background and taught us to document some extraneous information that is normally documented in PACU "to help the PACU nurses."
12/12/2014 3:01 PM View respondent's answers

LDA FORWARD KACI

OMG! I'm so glad you are looking into this. EVERYONE Charts so differently- and some have good reasons for doing so and others have no reason at all. In regardst to the questions: #2- i was told delay was if longer than the 30 min turnover, and only really applied to first cases. #3 i chart preop stuff under the Pre-op checklist tab and document education in a comment box. #4 i was told the braden scale is NOT charted by the OR nurse. however if they have a poor score it is realitve to the OR nurse. #6 I don't even know what the clinician communication tab is #8 as i understand it: sweep is when closing starts, close is when drapes are off and dressings are on again thanks so much. i'm looking forward to some consistency!!
12/11/2014 7:22 PM View respondent's answers

INN

? (review)

I definetly think there are a lot of inconsistencies in our charting training..I believe the nurse educator should outline the basics at set standards..the person that gave me the most useful info regarding charting and best practice was a traveler!

GUIDELINE

Comments from Survey Monkey (Staff RN's)

epic is not user friendly.

-can we review what the clinical communication tab is for? this was not a part of my initial 'epic' training - can we also review what 'WDL' means for incisions means? what is 'excpected' for an incision to look like? -for the braden scale, I look at what the pre op rn charted, but do not chart my own assessment. is this something we are supposed to be doing? -what ARE the appropriate times to chart 'sweep of incision' and 'closing' ? i chart the sweep when we are closing, or right before if the surgeon tells me that he/she is sweeping with intentions of closing next. i chart 'closing' when we are actually closer to being out of the room or putting on dressings since 'closing' is misleading i think.. it may take 45 minutes or it might take 5. I see the 'closing' tab as a sign that we are much closer to being out of the room rather than the closing of the wound. -can we review what a 'pre op interview' should include and where that should be charted? some sort of scripting or outline maybe

KACI TOOL SHAUNA ERIN JESSIE

I did not know what "Clinician Communication" was.

Regarding question #6, I don't chart these results because I will have the surgeon come to the phone/put patholgy on speaker phone for frozen section results, or for lab values, I transfer the call to anesthesia. The nurse should not have to be put in the middle. Critical information like this should be communicated directly to the person it is intended for.

What is Clinician Communication?

It would be extremely helpful to have an area on the EPIC screen to chart who completed the methodical wound examination (sweep) and if the "pause for the gauze" was completed and by which surgeon. I know it is an act of God to get the EPIC screen changed but this would be very

DIAGNOSES

- ANXIETY
- RISK FOR INF.
- RISK FOR INJ.
- DEFICIENT KNOW
- RISK FOR allergic response to latex
- Acute pain
- RISK FOR perioP posit injury
- Impaired skin integrity
- RISK FOR " "
- RISK for imbal. body temp
- urinary retention
- RISK for falls