

**University of Colorado Hospital Teaching Standard**

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| **Intraoperative EPIC Documentation** | |
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| **Approval Date:** | **Approved By:** OR Nurse Manager, Associate OR Nurse Manger, OR Clinical Educator, Senior Risk Manager |

**Introduction:**

The purpose of the Intraoperative EPIC Documentation Teaching Standard is to regulate documentation practices of the OR Registered Nurse (RN) through identification and clarification of Op-Time documentation criteria.

**Scope:**

The Intraoperative EPIC Documentation Teaching Standard is pertinent to all Intraoperative care areas that utilize Op-Time, including OR RN’s and EPIC Trainers throughout the University of Colorado Hospital Anschutz Campus.

**Charting Standards Details:**

1. Intraoperative Timing Events
2. Pre-operative (Pre-op) times should be documented by the Pre-op RN, and will automatically populate into the intraoperative chart.
3. Intra-operative (Intra-op) times must be documented by the operating room (OR) RN.
   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” must be populated when the surgical team begins the intervention on the affected part of the body.
      1. The anesthesia provider and the OR RN should ensure that the anesthesia record and the nursing record include the same procedure start time.
   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 OR RN should only populate “Sweep of Operative Site Completed by Surgeon” if the surgeon has completed the MWE.
   3. “Close Time” must be populated when the surgical incision is closed, prior to application of wound dressings.
      1. If the surgical procedure involves creation and closure of a surgical incision, then “Close Time” must 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” must be populated at the time when the surgical intervention is complete (i.e. cystoscope removed from urethra).
   4. “Ready for OR Discharge” must 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” must 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), then “Ready for OR Discharge” must 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 the procedure has multiple panels of surgeons and/or procedures being performed during one surgical encounter at different times, then “Procedure Start” will auto-populate with the “In Room” time for the procedure performed first, and “Procedure End” will be documented by the OR RN when that procedure ends. Then, “Procedure Start” for the following procedure must be populated by the OR RN, and “Procedure End” will auto-populate with the “Out of Room” time documented on the anesthesia record.
   2. 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 should be charted by the post-anesthesia care (PACU) RN, and should not be charted by the OR RN.
6. Anesthesia times should be documented by the anesthesia provider.
7. Projected Times will auto-populate according to the allotted time predicted for the procedure. The OR RN should not populate or change these times.
8. Summary / SBAR
9. The OR RN 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 OR RN.
       1. Mark the patient’s allergies as reviewed at the appropriate time.
          1. The OR RN 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 OR RN should review this section to determine existence of prior implants.
    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 prior implants are explanted during the procedure and they are displayed in this section, then explanation date and time should be documented here.
12. Staff
    1. The OR RN 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).
       3. If the person does not have credentials in EPIC, they must be documented as a “Visitor” or “Vendor”.
          1. If the person is an industry representative, they must be documented as a “Vendor”.
          2. If the person is not an industry representative, and they do not have credentials in EPIC (i.e. medical student, nursing student), they must be documented as a “Visitor”.
          3. Support staff members such as radiology technicians and neuromonitoring personnel should have credentials in EPIC and must 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. The OR RN must 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.
    3. 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. The OR RN must document the following in the “Count” section:
       1. A reason for the count being performed (i.e. whether the count is initial, closing, final, relief, etc)
       2. All categories of items being accounted for on the surgical field (i.e. sponges, needles/sharps etc).
       3. Name of staff member that is scrubbing the procedure and physically counting the items on the surgical field (i.e. scrub nurse or surgical technologist).
       4. Name of the staff member that observed and verified the count (circulating nurse).
       5. Whether the count is correct or incorrect.
       6. Whether the physician was notified of the outcome of the count.
    3. If the count is incorrect, specify that only the incorrect item category is incorrect (for example, document “Sponges” as “Incorrect” but “Instruments” as “Correct”, as appropriate).
    4. Per the OR Surgical Count policy, the OR RN must document action taken, including the following:
       1. Notifying the physician
       2. Searching the room
       3. Re-counting
       4. Taking an x-ray
    5. If an x-ray is taken due to an incorrect count, per the OR Surgical Count policy, the name of the radiologist who read the x-ray must be documented.
    6. 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 must be made in the “Closing” count specifying that a final fluoroscopy image was read by a credentialed surgeon to determine that no instruments were retained, per the OR Surgical Count policy.
    7. If the procedure being performed was deemed “emergent” and no counts were performed, the OR RN must document that the procedure was declared an emergency and therefore no counts were performed, per the OR Surgical Count policy.
    8. If a surgeon declines an x-ray in the OR in the event that one is needed, the OR RN 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.
    9. If items are retained intentionally in a patient upon discharge from the OR (i.e. abdominal packing), the closing and final counts should be documented as correct (refer to OR Surgical Count Policy), yet a comment must be made referring to the type of item(s) retained and the number retained.
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 OR RN.

* + 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 OR RN 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 OR RN 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 OR RN 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 OR RN is responsible to chart a free text comment 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 OR RN 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 following information:
         1. surgical site(s)
         2. anatomical laterality, if applicable
         3. hair removal, if applicable
            1. 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 implements 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 type of surgical prep solution utilized must be documented in EPIC.
         1. If an alcohol-based prep solution is utilized to prep the surgical site(s), the Fire Reduction Strategies must be implanted and documented.
         2. If multiple preps are utilized on the same surgical site, each prep solution may be selected with a free text comment addressing the application site and order of each prep solution (i.e. Ortho prep: Betadine scrub/paint prior to draping and Chloraprep on the sterile field).
         3. If multiple surgical site(s) are planned for a procedure(s), each prep site must be entered in individually.
2. 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.
3. 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.
4. 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 a specific position and may support additional assessment for injury and care to maintain the 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 addressed and confirmed prior to timeout verification and include the following:
            1. Patient identity is correctly identified with two patient identifiers
            2. Surgical team agrees and verifies that the correct procedure per procedural consent
            3. Correct anatomical site is addressed in both the surgical consent and has been marked on the patient or on the anatomical body consent form
            4. Correct anatomical laterality is addressed, if applicable, in the surgical consent and marked on the patient or marked on the anatomical body consent form
            5. Patient is in the correct position per surgeon preference
            6. Surgical site has be marked and initialed on the patient’s body or on the anatomical body consent form
            7. Surgical team addresses the code status of the patient during the Intraoperative phase of care.
         3. “YES” may be selected if the patient is returning to the Operating Room within twenty-four hours of an initial procedure.
         4. 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 OR RN 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 OR RN 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 documented.
            2. If a “RFT” follows a completed scheduled case, “No Delay” is documented.
      2. The delay reason must be selected to recognize the primary factor that contributed 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 OR RN 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 document a free text comment recognizing the rationale and contributing factors to the delay.
4. Nursing Notes
   1. Free text can be documented in the Nursing Notes section. Document 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. The OR RN must document the following in the Nursing Notes section, ensuring accurate date and time are documented:
         1. Pre-op patient education (Giarrizzo-Wilson, 2012) and interview
         2. Communication with the patient’s family
      2. Consider using and adapting the following template to describe the pre-operative interview and patient education:
         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”.
      3. After a Nursing Note is written and accepted, it may be edited or deleted. A reason for deleting the note must be provided, and a comment may be made along with the deletion. The version of the note before being deleted or edited will remain visible and will remain part of the legal record.
      4. A completed note must be signed. The note will then become part of the legal record.
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 pre-op nurse or by the anesthesia provider intraoperatively.
      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 RN 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 RN in the LDA screen.
      1. The OR RN must document the following related to drain placement, if applicable:
         1. Date and accurate placement time of the drain.
         2. Drain type
         3. Drain orientation
         4. Drain location
         5. Drain size
         6. Name of person inserting the drain
         7. An assigned number to distinguish between drains
         8. Date and time of intraoperative removal
      2. The OR RN must document an assessment of drains only if the patient arrives to the OR with a drain already in place.
         1. “Intake” and “Output” do not need to be documented by the OR RN, as the anesthesia provider will document drain output.
      3. The OR RN must document Foley catheter placement intraoperatively.
         1. An assessment of urine color and appearance must be documented upon insertion.
      4. The OR RN must document any and all “other” therapies placed by the surgeon intraoperatively in the LDA screen. This includes, but is not limited to:
         1. Bladder Diversions
         2. Bowel Diversions
         3. Chest Tubes
         4. Gastrostomy
         5. External Ventricular Drains
         6. External Urinary Catheters
         7. Fecal Collection Pouches
         8. Pain Busters
         9. Lumbar Drains
         10. Wound Vacs (Negative Pressure Wound Therapy)
         11. Nephrostomy
         12. Wound and Non-Wound Packing
         13. Peritoneal Dialysis Catheters
         14. Subdural Drains
         15. Suprapubic Catheters
         16. Ureteral Drains
   3. Airways that are placed by the anesthesia provider are documented by the anesthesia provider. The OR RN is not responsible for documenting airways placed by the anesthesia provider.
      1. The OR RN is responsible for documentation of airways placed by the surgeon (i.e. tracheostomy). Documentation of tracheostomy must include the following:
         1. Date and time of placement
         2. Size
         3. Brand
         4. Style of the inner cannula
         5. 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 patient’s pre-op RN is responsible for completing the Braden Scale. The OR RN can see the Braden Scale score to determine if the patient is at increased risk for developing a pressure ulcer.
   2. If the Braden Scale has not been completed by the pre-op RN, then the OR nurse is responsible for completing the Braden Scale.
   3. The Braden Scale should be completed to reflect the patient’s pre-operative function, rather than intraoperative function.
      1. To generate the patient’s Braden Scale Score, the OR RN must populate the following:
         1. Sensory Perceptions
         2. Moisture
         3. Activity
         4. Mobility
         5. Nutrition
         6. Friction & Shear
      2. A Braden Scale score will auto-populate after completion of the above sections.
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. The OR RN must document the following related to Procedures:
         1. Procedure Description (this should be pre-populated based on how the procedure was scheduled)
         2. Laterality of the procedure, indicating “N/A” if there is no laterality (i.e. midline abdominal incision).
         3. Type of anesthesia used
         4. Wound Class
8. Supplies
   1. The OR RN must document an accurate list of supplies opened for the procedure.
   2. 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” quantity of the supply used.
      1. The OR RN must change quantities of supplies used or wasted as necessary.
      2. Supplies used or wasted that were not pre-populated must be added by the OR RN.
      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. The OR RN must document the following related to a one time supply:
            1. Supply name
            2. Quantity used or wasted
            3. Name of the manufacturer
            4. Manufacturer number (i.e. reference number or model number)
      4. If a supply is wasted, the OR RN must document the following:
         1. Quantity wasted versus quantity used (if any)
         2. 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. 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” quantity 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 documented 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 OR RN 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 document procedure “CUT TIME” as the administration time for medications that are present on the sterile field and are 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 documented 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”.
       2. The following information regarding an implant or an “One Time Implant” must be documented:
          1. Reference number/product number/model number/catalog number
          2. Serial number
          3. LOT number
          4. Quantity of implant(s)
             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 document the quantity 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.
          5. Time implant was inserted
             1. The time an implant was removed or explanted from a patient should also be documented
       3. The Following information regarding an implant or an “One Time Implant” should be documented, if applicable:
          1. Expiration date
          2. Size of implant
          3. Manufacturer
          4. Supplier
             1. If the Manufacturer or Supplier of the implant is not a choice from the pre-populated list, a free text comment including the Manufacturer’s name or Supplier’s name is appropriate.
          5. Anatomical location, including laterality
          6. Surgical staff member inserting implant
    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 OR RN may add the implant to the Implant section of the chart and record as much information as possible about the implant, documenting 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 explanted items 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 documenting the action as “Wasted”.
          2. If an implant is damaged during insertion and is removed from the patient must be documented as “Wasted”.
       4. An implant that is inserted into the patient and then is removed from the patient within a single procedure but is not damaged, must be documented as “Implanted & Explanted”.
    3. The OR RN may utilize the Implant Description box to chart a free text comment or additional information about an implant or implant anatomical location, if needed.
    4. When an implant is a tissue, organ or tissue derivatives, the OR RN 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 OR RN is expected to document 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. 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. When the tissue implant is “OTHER”, the OR RN 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 OR RN must document a Nursing Note acknowledging the surgeon’s request.
       2. The OR RN 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 EPIC (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 OR RN 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 OR RN must type “UCH PATH” into the “Insert SmartText” box and select the “UCH OR Specimen-Surgical Pathology Requisition” to complete the specimen form. (The OR RN may utilize the F2 key function to tab through the additional requisition questions of the specimen form.)
          3. The follow information must be completed in the “UCH OR Specimen-Surgical Pathology Requisition” form:
             1. The OR room phone number
             2. Attending surgeon’s name as the primary contact
             3. Attending surgeon’s pager number or cell phone number
             4. Patient history of a prior malignancy. If “Yes”, the OR RN must include a free text comment specifying the type of malignancy.
             5. Patient history of Chemotherapy use/treatments.
             6. Patient history of Radiation use/treatments.
             7. Patient is HIV positive/HIV negative.
             8. Patient has current infectious/respiratory precautions. If “Yes”, the OR RN must specify the precautions.
             9. Total number of containers/specimens to be sent.
             10. Pertinent clinical history of the patient that provides a rationale to why the surgical procedure is being performed.
             11. Additional comments and/or special handling instructions via attending surgeon orders, as needed.
          4. The OR RN must then select “Accept” to complete the requisition entry.
          5. When the specimen(s) are ready to be sent off or dropped off, the OR RN must select each specimen entry then select the “Print Requisition” tab and change the number of copies to print to “2”. The OR RN 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 OR RN must select the specimen’s title name (blue hyperlink) to open the entry.
          1. The OR RN may then select “Delete” in the bottom left hand corner of the requisition screen.
             1. The OR RN must 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 documented 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 OR RN 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 OR RN to complete additional testing and to obtain additional supplies from Central Supply, as needed.
       1. The OR RN may search for a single laboratory test 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.
          3. The following information must be provided to complete the laboratory testing order:
             1. Priority either “Routine” or “STAT” per surgeon’s preference
             2. Frequency selected as “Once”.
             3. Time and date test was drawn from the patient
             4. Specimen source. It is appropriate to complete a verbal read back verification with the surgical team to correctly identify and record the specimen source.
             5. 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 in the Comments box.
       2. The OR RN 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.).
          2. The follow information must be provided to complete the supply order:
             1. Priority selected as “STAT”
             2. Quantity of the item(s)
             3. Frequency selected as “Once”.
             4. Time and date of the item(s) request
             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 the OR phone number as a contact
       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 RN does not need to document in the “Order Sets” section. Orders to be entered by the OR RN (i.e. microbiology, items from central supply) should be entered in the “Orders” section.
15. Clinician Communication
    1. It is recommended that the OR RN 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.
    2. If the OR RN does communicate information to the surgeon or anesthesia provider related to critical lab results or critical test reports, document the following:
       1. Reason for communication
       2. Name and role of the person receiving the information
       3. Type of information being communicated
       4. Time the information is communicated
    3. Document communication between the pathologist and the surgeon in this section.
       1. If frozen section results are called to the circulator and then communicated to the surgeon, it is recommended that this communication is documented.
       2. If the pathologist speaks directly to the surgeon, no documentation is necessary.
       3. For frozen section communication, document the notification reason with a comment indicating that the communication was related to frozen section results.
    4. The OR RN 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. The OR RN must document the following when a surgical incision is created:
       1. Date and time the incision was created
       2. Orientation of incision
       3. Location of incision
       4. Laterality (if applicable)
       5. Type of incision (i.e. donor site, episiotomy, graft site, incision, scope site, puncture site)
       6. Whether the incision is pre-existing
          1. If the incision is new, document that the incision is not 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 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”.
          3. 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.
    2. Number of scope sites must 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. 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.
    3. If multiple incisions exist on the same part of the body (but are not scope sites), the incisions all must be documented as separate incisions.
       1. Differentiate multiple incisions with accurate documentation of orientation and location.
    4. If no incision was made during the procedure (i.e. cystoscopy), then no incision should be documented.
    5. 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”.
    6. Document existence of wounds (i.e. “Wound”, “Burn”, “Pressure Ulcer”). Ensure that the wound does not already exist in the chart before adding a new entry. If a wound entry does already exist, document an assessment of the wound.
       1. The OR RN must document the following when adding a new wound:
          1. Date and time the wound was first assessed
          2. 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. Wound type (i.e. stab wound, gunshot wound, pressure ulcer)
          4. Orientation
          5. Location
          6. Laterality (if applicable)
       2. The OR RN must document the following if the patient has a new burn:
          1. Date and time first assessed
          2. Burn type (i.e. thermal, chemical, electrical)
          3. Orientation
          4. Location
          5. Laterality (if applicable)
       3. If documenting care of an existing burn, the OR RN must include the following:
          1. Dressing assessment (often this will be “Removed” when the surgeon will be working on that particular burn)
          2. Type of graft used (if applicable) on the burn (i.e. Xenograft, Allograft, Autograft)
             1. If autograft skin is taken from the patient, document as an “Incision” and specify as “Donor Site”
          3. Type of dressing used
       4. 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”.
       5. If the burns on different parts of the body are being treated differently, then a new entry for each body part should be documented.
       6. Document existence of a pressure ulcer using the same guidelines for a “Wound”, with the addition of “Staging”.
       7. The OR RN must document the following when non-wound packing is used:
          1. Placement date and time
          2. Name of person placing the packing
          3. Location (must be specified as ear, eye, mouth, nose, or vagina)
          4. Quantity of items being placed
          5. Date and time of removal (if removed while in the OR)
       8. A “Wound Packing” option does not exist in EPIC. Therefore, the OR RN must document the following in the Non-Wound packing section when packing is used in the surgical wound:
          1. Placement date and time
          2. Name of the person placing the packing
          3. Location (may not fall into the offered options)
             1. Document a comment in this section that specifies where the packing is placed.
          4. Quantity of items being placed
          5. Date and time of removal (if removed while in the OR)
18. 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”.
19. Postop Skin
    1. The postop skin assessment of the patient’s skin integrity is completed by the OR RN 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 OR RN 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 document assessment conditions.
             1. When selecting the condition “Other (see Comments)” the OR RN is responsible to chart a free text comment addressing the variances in skin integrity including anatomical location and condition related to the intervention.
20. PNDS
    1. The Perioperative Nursing Data Set (PNDS) tool for the application of nursing diagnoses, interventions and patient outcomes should be documented.
       1. The OR RN 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 OR RN 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 OR RN may add one by selecting “I+” and choosing the appropriate intervention from the pre-populated interventions.
       2. The OR RN 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.
21. Verify
    1. The OR RN 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 OR RN must return to the OR to complete a final review of the chart.
             1. During the final review, the OR RN must complete “Required Items Missing” and resolve each error and/or missing item.
             2. During the final review, the OR RN may review “Recommended Items Missing” and resolve each error and/or missing item, if applicable.
          2. The OR RN may verify the chart by providing their personal user name and password, selecting “Verify”, completing the entry and closing the chart.
22. Debrief/Handoff
    1. The OR RN should utilize the Debrief/Handoff tool during staff changes such as breaks/lunches or permanent shift relief or during handoff report in phase of care change as a means to provide standardized report.
       1. When report has been completed during staff changes, the OR RN 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 OR RN receiving report on the patient.
       2. The OR RN should utilize this tool during phase of care changes when the patient is going to be transferred from the ICU/Unit directly 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 OR RN 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 OR RN 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 following information should be discussed and documented during “Closing Time” of the procedure:
            1. Communication that occurred with the patient’s family or significant other
            2. If the sponge, sharp and instrument count have been completed and are correct
            3. If the name of the operative procedure has been verified
            4. If the specimens have been labeled and verified. When there are no specimen collection for a procedure, it is appropriate for the OR RN to select “N/A”.
            5. If the surgical team identified what went well/what did not, and formulates a response plan, if applicable
            6. If the surgical team identifies key concerns for recovery and management of the patient
23. OR Preop Checklist
    1. The OR Preop Checklist is to be completed by the admitting RN in the Preop area to review the patient’s preparation for surgery.
       1. It is appropriate for the OR RN to complete the Preop checklist with the patient and/or in conjunction with the primary nurse caring for the patient when the OR RN 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 OR RN 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 OR RN should review the OR Preop Checklist prior to interviewing the patient.
24. 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 OR RN must transfer the patient to perioperative services in EPIC.
       2. It is the responsibility of the receiving unit to transfer the patient in EPIC.
    2. Editing the Chart
       1. Changes to a chart may completed at a later time and/or date if necessary.
          1. If OR Billing has not yet posted the chart, the nurse can pull up the patient’s record, edit/add any information necessary, save the information, and close the chart.
          2. If OR Billing has already posted 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.
       2. 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 RN is responsible for documenting that the procedure was not performed.
       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”).
       3. The chart does not need to be verified by the OR RN 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:**

**Intra-op:** Intraoperative, referring to the phase of care in which the patient is undergoing 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.

**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.

**Braden Scale:** A tool to help identify patients that are at risk for pressure ulcer formation

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

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