



AnesthesiaProvider

Participant Guide

Universal Health Services 367 South Gulph Road King of Prussia, PA 19406-0958 © 2012 All Rights Reserved

Contents

Overview	5
Learning Objectives	5
Course Length	5
Prerequisites	6
Information Security and Confidentiality	6
SurgiNet Anesthesia Overview	6
Tips and Tricks	7
Help Pages	7
Windows Terms	7
Solution Icons	10
Getting Started	11
Logging In to SurgiNet Anesthesia	11
Logging Out of SurgiNet Anesthesia	12
MPages Overview	13
Preoperative Summary	13
NPO	15
Consents	15
ECG	16
H&P	16
Prep Verified	17
ID Verification	17
Site Verification	18
Intraoperative Summary	
Postoperative Summary	20
Surgical Case Selection	23
Selecting a Surgical Case	23
Blank Anesthesia Records	24
Creating a Blank Anesthesia Record	24
Associating a Blank Record with a Case	25
Macros	26
Starting a Macro	
Medications	28
Adding Medications	
Medications Already on a Record	28

Medications Not Already on Record	29
Adding Medications: Bolus or Infusions	
Modifying Medications	31
Deleting Medications	34
Intakes and Outputs	35
Adding Intakes	35
Adding Intakes Already on Record	35
Adding Intakes Not Already on Record	
Modifying Intakes	38
Modifying Intakes Using the Toolbar	
Modifying Intakes Using Fluids Already on the Record	
Removing Intakes	40
Removing Intakes Using the Toolbar	40
Removing Intakes Using Recorded Fluids	41
Removing Intakes Using the Recorded Fluids Option	41
Adding Outputs	42
Adding Outputs	42
Adding Outputs Not Already on Record	43
Modifying Outputs	44
Modifying Outputs Using the Toolbar	44
Modifying Outputs Already on the Record	45
Deleting Outputs	46
Associate Devices	46
Associating Devices	46
Monitored Values	47
Adding Monitors	47
Modifying Monitored Values	50
Chart and Unchart	53
Chart Mode	53
Chart and Unchart in Chart Mode	53
Modify Time Bar	54
Actions	55
Using the Action List	55
Personnel	57
Adding Personnel	57
Printing Records	59

Print Setup	59
Print Preview	64
Printing a Record	65
Alerts	66
Viewing and Managing Alerts	66
Finalize a Record	68
Finalizing the Case	68
Run Record Viewer Reports	76
Viewing Concurrency	76
Viewing Concurrency for Multiple Providers	76
Viewing Concurrency for One Provider	78
Viewing Concurrency on a Specified Date	81
Viewing Billing Summaries	
Billing Summary Panel	85
Finalized Cases Panel	
Batch Printing	
Viewing Discrepancies	
Viewing Finalized Cases	
Viewing Open Cases	
Viewing Unassociated Cases	97
Viewing Unfinalized Cases	100
Viewing Unsynchronized Records	103
Appendix A	104
Reference Pages Overview	

Overview

Welcome to the *SurgiNet*® Anesthesia Training Course. The purpose of this course is to teach you to use the *SurgiNet* Anesthesia solutions in your department. During this course, you will view several demonstrations and practice different activities that stimulate your day-to-day tasks.

Learning Objectives

At the end of this session, you will be able to complete the following tasks:

- Log on to Cerner Millennium®.
- Log on and off *SurgiNet* Anesthesia.
- Use MPages®.
- Select a case.
- Start a macro.
- Document medications.
- Document intakes and outputs.
- Associate devices.
- Document monitored values.
- Document actions.
- Document personnel.
- Print a record.
- View and manage alerts.
- Finalize a record.
- Run Record Viewer reports.

Course Length

This course is designed as a one half-day class.

Prerequisites

All participants are expected to be competent in the following areas:

- Computer basics
- Microsoft® Windows

Information Security and Confidentiality

When dealing with computerized health care records, specific confidentiality and security issues must be followed to protect the patient. There are increasing HIPAA and JCAHO regulations that dictate how these records are handled.

- When selecting a password, do not choose anything obvious, such as your birth date, Social Security number, or spouse and children's names.
- Do not tell anyone your password.
- Your system may require you to change your password at regular intervals.
- When you open a chart you will be asked to identify your relationship to the patient; for example, primary RN, consulting physician, and so on. The system keeps an audit trail, or record, of who enters each chart and when. It records who read the chart and who recorded each piece of information in the chart.
- Security should be designed so that employees can only perform functions within the system that are necessary for their position or role. Also, employees should only be able to view data that is necessary to perform their job.
- Do not leave the computer while still signed on.
- Do not access any charts that do not apply to your current job and caseload.
- Each facility has its own specific confidentiality and information security policy. It describes the repercussions of not following these rules. Tips and Tricks

SurgiNet Anesthesia Overview

SurgiNet Anesthesia provides access to patient records and test results, automatic methods to capture information, and reporting tools. The solution streamlines the anesthesia care process by allowing complete access to the information necessary to adequately prepare for cases, set daily priorities, and accurately complete documentation.

SurgiNet Anesthesia provides automation for the following major functions: staff assignment, schedule access, daily case overview, pre-anesthesia evaluation, intra-anesthesia record, post-anesthesia documentation, remote monitoring, management reporting and charge processing.

Tips and Tricks

Below are a few tips if you cannot recall how to perform a task.

- Press and release the secondary (usually right) mouse button and see if any of the menu items apply.
- Position your pointer over the buttons to see if any of the button names jog your memory.
- If a single mouse click does not work, try to double-click.

Help Pages

You can access Help from a *Cerner Millennium* application's Help menu. A typical Help home page for an application includes the following sections:

- **Overview.** Provides an overview of the application.
- Tasks. Provides steps to demonstrate how to perform application tasks.
- Menus and Toolbars. Provides a description of menu commands and toolbar buttons.
- Tips. Provides tips and keyboard shortcuts for Cerner® applications.
- Troubleshooting. Provides an explanation of system messages.

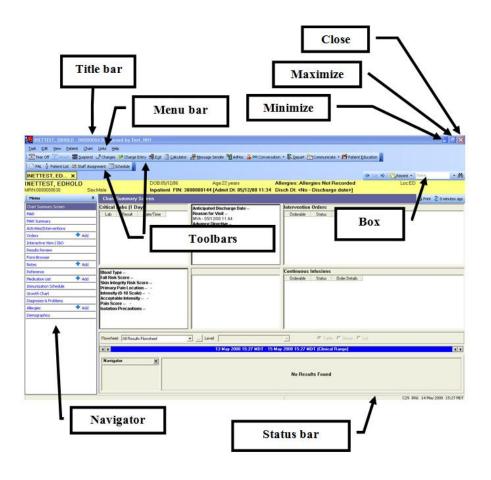
Windows Terms

Cerner Millennium is based on the *Microsoft* Windows style. If you are not clear on how to use Windows, speak with your manager or instructor.

- Active window. The window selected for current work. You can identify the window as active by looking at the top bar; it should be displayed in dark blue.
- **Click.** To press on a mouse button, pressing it down and then immediately releasing it. Note that clicking a mouse button is different from pressing (or dragging) a mouse button, which implies that you hold the button down without releasing it.
- Context menu. A menu that is available when you right-click text, objects, or other items.
- Cursor. The flashing marker that tells you where you are on the window.
- **Default.** Preset information in the system that automatically displays when you sign on to the system or when you access certain cells that must be completed.
- **Demographics.** Patient information.
- **Double-click.** Press the primary (usually the left) mouse button twice, very quickly. Note that the second click must immediately follow the first; otherwise, the application interprets them as two separate clicks rather than one double-click.
- **Episode or encounter.** A patient interaction with the healthcare system. An episode or encounter can happen as an inpatient, an outpatient, with a clinic visit, or in the emergency department.

- Left-click. To click the left mouse button. When instructions call for you to click a window element, a left-click is what is meant.
- Log on. The process of accessing an application through the use of user credentials, such as a user ID and password.
- **Maximize.** Located on the menu bar or title bar of the active window, it is used to maximize the window.
- **Menu.** Displays a list of commands. Some of the commands have images next to them so you can quickly associate the command with the image. Menus are located on the menu bar at the top of the viewing window.
- **Minimize.** Located on the menu bar or title bar of the active window, it is used to minimize the window to a button on the Windows task bar.
- **Mnemonic.** In general, a mnemonic is an acronym or abbreviation for a much longer piece of information. The mnemonic format should be based on a standard established by the organization.
- Mouse. A device used to move the cursor around in the window.
- **Patient demographics.** Information defined for the person or episode. Demographic information includes the current location (nursing station, room, and bed, for example), age, birth date, gender, and maiden name.
- PC. A personal computer.
- **Perform.** To carry out a test and record the results. Performed results are available only inside the laboratory and to those who have permission to see performed but not verified results.
- **Queue.** One or more items waiting to be acted on by the computer.
- **Right-click.** Click the right mouse button. A right-click action opens the context menu with a list of options.
- Scroll bar. Located on the right and bottom of some windows, and is used to adjust the view in the window.
- Shortcut menu. Available when you right-click text, objects, or other items.
- **Title bar.** Located at the top of the each window and is used to identify in which window you are currently working.
- **Toolbar.** A window element containing buttons or other window elements to facilitate accomplishing a task.

See the diagram below to review basic Windows terminology.



Solution Icons

Listed below are the icons on the SurgiNet Anesthesia toolbar.

Button	Description
Select Case	Select Case. Opens the Select Case window so you can select the case to be displayed.
Views	Views. Opens the Select View Item dialog box so you can select the view to be applied to the record.
Macros	Macros. Opens the Select Macro dialog box so you can specify the macros to t executed.
Medications	Medications. Opens the Select Medications dialog box so you can specify the medications to be displayed. You also are able to add, modify, or remove administrations from this dialog box.
Intake	Intake. Opens the Select Intake dialog box so you can specify the intake fluids displayed. You also are able to add, modify, or remove administrations from this dialog box.
Output	Output. Opens the Select Output dialog box so you can specify the output fluid displayed. You also are able to add, modify, or remove administrations from this dialog box.
Actions	Actions. Opens the Select Action dialog box so you can specify the actions to t displayed. You also are able to add, modify, or remove actions in this dialog box
Inventory	Inventory. Opens the Inventory dialog box so you can specify the inventory to the displayed. You also are able to add or remove inventory in this dialog box.
۴ ۴ ۴ Personnel	Personnel. Opens the Personnel dialog box so you can specify the personnel t displayed. You also are able to add or remove personnel in this dialog box.

Button	Description	
00 1	Charge Preview. Opens the Charge Preview dialog box so you can view or mo charges.	
	Med/Fluid View. Opens the Medication /Fluid View dialog box so you can view medication and fluid information recorded for the case.	
Patient's Chart	Patient's Chart. Opens the patient's chart in Surgical PowerChart®.	
- * * *	Charting Mode. Changes the view to Chart Mode so you can quickly indicate v values are to be charted or uncharted.	

Getting Started Logging In to SurgiNet Anesthesia

Log on to the TRAIN domain by following the steps given to you by your instructor. The steps you use to log on to the TRAIN domain might vary from the steps you use to log on to the production or live domain. The instructions to access the production domain are included below for future reference.

- **Note:** You should access the application through the most logical place in your workflow; for example, if you are working in another application, you should access *SurgiNet* Anesthesia from within the application instead of exiting the application to open *SurgiNet* Anesthesia.
- 1. Double-click the SurgiNet Anesthesia icon.



- 2. In the Cerner Millennium log-in window, enter your user name in the User Name box.
- 3. Press TAB to move to the next box and enter your password in the Password box.

0,1,0,0,0,1,0,1,0,0,0,0,0,0,0,0,0,0,0,0
00000000000000000000000000000000000000
Domain :
OK Cancel
© Cerner Corporation This program is being used under license from Cerner Corporation of Kansas City, Missouri, USA. Unsuthorized use, reproduction, or distribution of any portion of this program may result in severe civil and criminal penalties. Further information can be found in Help About.

4. Click OK or press ENTER. SurgiNet Anesthesia opens.

Logging Out of SurgiNet Anesthesia

Once you are done working in *SurgiNet* Anesthesia, you must log out of the application. From the Task menu, select Exit to close the application. It is suggested to exit the application from the Task menu instead of using the X located at the top left of the window.

MPages Overview

MPages provides the ability to customize the display of *Cerner Millennium* data at the Organizer or Chart Level from within *PowerChart* or *SurgiNet*. With *MPages*, you can perform ad hoc queries against the clinical decision support system of *Cerner Millennium*, which allows you to proactively and interactively monitor real-time patient scenarios crossing many different roles, venues, and conditions within an organization.

The following *MPages* are available in *SurgiNet* Anesthesia:

- Preoperative Summary
- Intraoperative Summary
- Postoperative Summary

Preoperative Summary

The Preoperative Summary displays the status of key required information and activities that must be completed prior to the start of surgery.

To open the Preoperative Summary, select Preop Summary from the Menu.

Menu	д
Clinical Notes 🛛 🕂 A	.dd
Perioperative Doc	
Form Browser	
1 & O / Documentation	
MAR	
MAR Summary	
Medication List 🛛 🕈 A	.dd
Orders/Plan of Care 🛛 🕂 A	.dd
Patient Info	
Patient Overview	
Refer Text	
Results	
Specialty Flowsheet	
Vital Signs	
Preop Summary 🧹 💳	
Intraop Summary	
Postop Summary	

The Preop Summary contains the Preoperative Checklist, which is displayed in the middle of the window.

Preoperative Communication			Expand All
	25 MRN: 6002288 FIN: 880000104070 Isolation: Standard Precauti	ons Visit Reason: TESTING	
Procedural Information	 Preoperative Checklist 	 Home Medications (0) + Add 	
No results found	NPO #	No results found	
Perioperative Tracking No results found	Consents # ECG A	Vedications + Add Scheduled (0)	
Allergies (0) + Add	- Prep Verified	Continuous (0) IRN (0)	
No results found	ID Verification 🗱	idministered (0) useended (0)	
Vital Signs Last 7 days 🕂 Add 🌄	_ Site Verification 🗱	Discontinued (0)	
No results found	Documents (0) Last 6 months + Add *	- Intake and Output Last 2 days	
Measurements and Weights Last 2 weeks	_ No results found	Blood (mL)	
No results found	Problems (0)	Fluid (mL)	
no reacto toono	No results found	- Diagnostics (0) Last 30 days	
	Diagnoses (0)	EKG (0) - Chest/Abd XR (0)	
	No results found	Other Diagnostics (0)	
	Labs Last 2 weeks	_ (Microbiology (0) Last 6 months	
	No results found	No results found	
	Lines, Tubes, and Drains (0) Last 3 days Lines (0) Tubes/Drains (0)	-	

The Preoperative Checklist contains two columns.

- The first column contains the label, which includes the following predefined labels:
 - o NPO
 - o Consents
 - ECG
 - o **H&P**
 - Prep Verified
 - o ID Verification
 - Site Verification

Preoperative Checklis	st	-
NPO	*	
Consents	*	
ECG	Δ	
H&P	Δ	
Prep Verified	Δ	
ID Verification	*	
Site Verification	*	

The second column displays icons for each row to indicate whether the required values for that row have been documented. The symbols represent the following information:

- vindicates this section is complete.
- A indicates this section is partially incomplete.
- Kindicates this section is missing required information.

• Yes/No. If the section contains a single value, then when that value is present a green Yes is displayed; if it is not present, then a red No is displayed.

Position your pointer over a particular row to display the details of the individual results that are compiled to generate the high-level stoplight result for each row.

NPO

dural Information		-	Preoperative Cl	hecklist	-
s 26 mins past anticipated	d start time		NPO	*	N
Jumphor:	COLITH-2011-170			44	_ \s
*Last Food Intake	Patient Info	Docui	mented Date/Time	Within Surg Anticpt Start	
1E					
*Last Fluid Intake:					
Classic Classic			rrep vermeu	<u> </u>	
ry Start:			ID Verification	X	
ry Stop:			Site Verification	*	
b Start:	09/20/2011 14:31			••	

When you position the pointer over NPO, the following information is displayed:

- Event code name
- Event code result
- Date and time of the event code result
- How much time has passed (current time minus the result's date and time)

Any result that makes this section stoplight yellow is displayed in bold text with an asterisk on the event code name. Any result that makes this section stoplight red is displayed in bold red text with an asterisk on the event code name.

Consents

al Information	1	 Preoperative Checklist 	_
mins past anticipa	ted start time	NPO	6
ier:	SOUTH-2011-170	Consents	K N
predure:	Resection Eirst Rih		
Consent	Signed?	Documented Date/Time Comment	
*Anesthesia			
*Blood:			
*Surgical:			
, su grean			

When you position the pointer over Consents, the following information is displayed:

- Event code name
- Event code result
- The date and time of the event code result
- How much time has passed (current time minus the result's date and time)

Any result that makes this section stoplight yellow is displayed in bold text with an asterisk on the event code name. Any result that makes this section stoplight red is displayed in bold red text with an asterisk on the event code name.

ECG

ocedural Informatio	n	 Preoperative Checkl 	list	-
nours 26 mins past anticip	pated start time	NPO	2	
ise Number:	SOUTH-2011-170	Consents	*	
imary Procedure:	Resection First Rib	ECG	A	Ν
jesthesia Tyne(s)	3-General Endo	LIGE	A	43
*Current ECG in Med	lical Record?:			
Documented Date/Time	e:			
Documented By:				

When you position the pointer over ECG, the following information is displayed:

- Order
- DTA or event code name
- Order state or DTA result
- Date and time of the order, DTA, document, or event code result
- Documented by person name

Any result that makes this section stoplight yellow is displayed in bold text with an asterisk on the order or DTA name. Any result that makes this section stoplight red is displayed in bold red text with an asterisk on the order or DTA name.

H&P

lura	al Information	-	Preoperative Checklist		-
26 (mins past anticipated	start time	NPO	*	
ımb	er:	SOUTH-2011-170	Consents	*	
Pro	cedure:	Resection First Rib	ECG	Å	
∘sia	Type(s):	3-General Endo	H&P	A	N
		Woode MD. Timothy		<u>^</u>	, hł
s	*Current H&P in I	Medical Record?			
s	Documented Date/1	Time:			
St St	Documented By:				_

When you position the pointer over H&P, the following information is displayed:

- DTA or event code name
- DTA or event code result
- Date and time of the event code result
- Documented by person name

Any result that makes this section stoplight yellow is displayed in bold text with an asterisk on the order or DTA name. Any result that makes this section stoplight red is displayed in bold red text with an asterisk on the order or DTA name.

Prep Verified

edural Informatio	n	 Preoperative Checklist 	-
irs 26 mins past anticip	ated start time	NPO 🕌	
Number:	SOUTH-2011-170	Consents 🕌	
ary Procedure:	Resection First Rib	ECG	
hesia Type(s):	3-General Endo	H&P	
eon:	Woods MD, Timothy	Prep Verified	
erv Start:			1
*Surgical Prep Ve	erified?		. 0
Documented Date/1	Time:		
Documented By:			-

When you position the pointer over Prep Verified, the following information is displayed:

- DTA or event code name
- DTA or event code result
- Date and time of the event code result
- Documented by person name

Any result that makes this section stoplight yellow is displayed in bold text with an asterisk on the order or DTA name. Any result that makes this section stoplight red is displayed in bold red text with an asterisk on the order or DTA name.

ID Verification

edural Informatio	n	-	Preoperative Checklist		-
rs 26 mins past anticip	ated start time		NPO	*	
Number:	SOUTH-2011-170		Consents	*	
iry Procedure:	Resection First Rib		ECG	Â	
hesia Type(s):	3-General Endo		H&P	Ā	
ion:	Woods MD, Timothy		Prep Verified	Ā	\mathbf{k}
ry Start:			ID Verification	*	~~
*Allergy Band: *Blood Band: *ID Band:	Verified?	Docum	nented Date/Time Commen	t	-

When you position the pointer over ID Verification, the following information is displayed:

- DTA or event code name
- DTA or event code result
- Date and time of the event code result

Any result that makes this section stoplight yellow is displayed in bold text with an asterisk on the order or DTA name. Any result that makes this section stoplight red is displayed in bold red text with an asterisk on the order or DTA name.

Site Verification

mation	 Preoperative Checklist 	-
anticipated start time	NPO 💥	
SOUTH-2011-170	Consents 🗸	
Resection First Rib	ECG	
3-General Endo	H&P	
Woods MD, Timothy	Prep Verified	
	ID Verification	
	Site Verification 🕺	N
09/20/2011 14:31		6
Site Verified by: Verified/Who *Patient/Family:	Verified? Documented Date/Time Comment	-
*RN:		_
*Physician:		
RN Verified Site:		
Physician Verified Site:		

When you position the pointer over Site Verification, the following information is displayed:

- DTA or event code name
- DTA or event code result
- Date and time of the event code result

Any result that makes this section stoplight yellow is displayed in bold text with an asterisk on the order or DTA name. Any result that makes this section stoplight red is displayed in bold red text with an asterisk on the order or DTA name.

Intraoperative Summary

The Intraoperative Summary provides key data documented during the surgical case. This includes activities that occurred that can impact the care provided to the patient during recovery or post-procedure.

To use the Intraoperative Summary, select Intraop Summary from the Menu.

Menu	д
Clinical Notes 🛛 🕈 Add	
Perioperative Doc	
Form Browser	
I & O / Documentation	
MAR	
MAR Summary	
Medication List 🛛 🕈 Add	
Orders/Plan of Care 🛛 🕈 Add	
Patient Info	
Patient Overview	
Refer Text	
Results	
Specialty Flowsheet	
Vital Signs	
Preop Summary	
Intraop Summary < 💳	
Postop Summary	

The Intraoperative Summary is displayed in the center of the window.

	50% 🗸 🔍 🖨 🙆					
ntraoperative Comm	nunication				Expand A	<u>dl</u>
ESTINGCER, ONLY M 6 his page is not a complete source of	0 years DOB: 06/11/1951 MRI visit information.	N: 5354722 FIN: 9000000022533 Isolation: Standard Precautions	Visit Reason:			
Procedural Information		- Intraoperative Summary	- Home Medications (0) 🕂 Add		-
3 hours 25 mins past anticipate	ed start time	Dressing/Packing (0)	No results found	,		
Case Number :	SOUTH-2011-170	Implant/Prosthetic (0)	-			
Primary Procedure :	Resection First Rib	Cultures/Specimens (0)	- dedications + Add			-
nesthesia Type(s):	3-General Endo	Devices (0) Tourniquet (0)	- cheduled (0)			- 4
iuraeon:	Woods MD. Timothy	Loumiquet (0)	- iontinuous (2) nsulin lispro 300 Units s	1.0		-
Surgery Start:		Documents (0) Last 6 months 🖷 Add 💌	oxytocin 20 units/1000 m			
Surgery Stop:		No results found	PRN (1)	IL-LIK SUL 20 Units 20) Units IV	
nesth Start:	09/20/2011 14:31	6.11	Meruvax II 0.5 mL SubO Uns	ale and the d		÷
nesth Stop:	00,20,2012 11101	Problems (3)	Administered (32)	chequied		
alead Joop.		Active Meniere's disease NOS (386.00)	acetaminophen 500 mg By	mouth ADHOC		
Perioperative Tracking		 CONGESTIVE HEART FAILURE, UNSPECIFIED (428.0) 	acetaminophen 500 mg By			
Anticipated Start	14:25	Hypertension (64176011)	decidina lopiton storing by	induit Abrilore		
Anticipated Stop	16:50	(Diagnoses (2)	_ Intake and Output L			-
Operating Room	07 South OR	Active Meniere's disease NOS (386.00)		09/20/11 07	7:00- 09/19/11 0	7:00
All Procedures	Resection First Rib	Hypertension (64176011)	Blood (mL)	09/20/11 1/	7:50 09/20/11 0	0159
Primary Surgeon	Woods MD, Timothy	Thyper derivation (extraort)	Blood Transfused	0	0	
Anesthesiologist	Austin MD, Craig	Labs Last 2 weeks	- Est, Blood Loss	0	0	
Anesthesia Type	3-General Endo	No results found	Blood Balance	0	ő	
Current Event	Anes Start	Lines, Tubes, and Drains (0) Last 3 days	Fluid (mL)	0	0	
		Lines, rubes, and brains (0) Last 3 days	- Fluid Intake	2975	0	
Allergies (11) 🕂 Add		- Tubes/Drains (0)	- Fluid Output	475	0	
amoxicillin	rash		Fluid Balance	+2500	0	
ampicillin	rash					
Bactrim Pediatric			Diagnostics (0) Last 30 c	lays		-
capreomycin			EKG (0) Chest/Abd XR (0)			_
dust			Other Diagnostics (0)			-
Hemorrhoidal Suppository	rash					_
(Oualitest)			Microbiology (0) Last 6	months		-

The Intraoperative Summary contains the following information:

- Dressing/Packing
- Implant/Prosthetic
- Cultures/Specimens
- Devices
- Tourniquet

Intraoperative S Dressing/Packing (1)			
creasing roowing (a)	12/09/09 16:43		
Type:	Dressing		
Items:	4x4, abd		
Site and Details:	midline abd, dry		
	and intact		
Implant/Prosthetic (4)	Show All	Constant of the Constant	
	12/09/09 16:43	12/09/09 06:43	12/09/09 16:43
Implant / Explant:	Implant	Implant	Implant
Description:	umbrella	aortic stent placed	valve
Serial Number:	1234	3455	445-90
Lot Number:	45678	678999	38
Manufacturer:	Cordis	Cordis	Cordis
Catalog Number:	336	334	899
Size:	7	1	1
Expiration Date:	2/11/10	2/11/10	2/11/10
Implant Site:	abd	abd	abd
Quantity:	1	1	1
Cultures/Specimens (1)			
	12/09/09 16:43		
Culture Orders	Yes		
Placed:			
Specimen Orders	No		
Placed:			
Devices (1)			
	12/09/09 16:43		
Type:	Cautery		
Setting:	60 deg C		
Tourniquet (2)			
	12/09/09 16:43	12/09/09 06:43	
Type:	Arm cuff	Leg cuff	
Total Time:	20 minutes	12 minutes	

The first column displays the name of the item being reported on. The second column contains the latest results for each item, while columns three and four can contain up to two previous values for each item.

This component is activated by positioning the cursor over the latest or previous results data rows. When you position the pointer over a data row, the system selects the entire result column, and displays who documented the results and the date and time.

Postoperative Summary

The Postoperative Summary provides key data documented during the surgical case. This includes activities that occurred that can impact the care provided to the patient during recovery or post-procedure.

To use Postoperative Summary, select Postop Summary from the Menu.

Menu 4
Clinical Notes 🛛 🕈 Add
Perioperative Doc
Form Browser
I & O / Documentation
MAR
MAR Summary
Medication List 🛛 🕈 Add
Orders/Plan of Care 🛛 🕈 Add
Patient Info
Patient Overview
Refer Text
Results
Specialty Flowsheet
Vital Signs
Preop Summary
Intraop Summary
Postop Summary

The Postoperative Summary is displayed in the center of the window.

Postop Summary			🕞 Print 🦧 2 hours 23 mi	inutes a
AA 🗃 🖨 🕞 🔍 🔍 🗉	50% 🗸 🔿 🖨			
Postoperative Comm	unication		Expand A	
TESTINGCER, ONLY M 6 This page is not a complete source of		N: 5354722 FIN: 9000000022533 Isolation: Standard Precau	autions Visit Reason:	
Procedural Information		 Postoperative Summary 	- Home Medications (0) + Add	-
3 hours 25 mins past anticipati	ed start time	Implant/Prosthetic (0)	No results found	
Case Number:	SOUTH-2011-170	Dressing/Wound Assessment (0)		
Primary Procedure:	Resection First Rib	Pain Assessment (D)	- Medications 🕂 Add	-
Anesthesia Type(s):	3-General Endo	Documents (0) Last 6 months + Add	cheduled (0) Continuous (2)	-
Surgeon:	Woods MD, Timothy	No results found	insulin lispro 300 Units subo	-
Surgery Start:		No results Ibunu	oxytocin 20 units/1000 mL-LR SOL 20 Units 20 Units IV	
Surgery Stop:		Problems (3)	PRN (1)	
Anesth Start:	09/20/2011 14:31	Active Meniere's disease NOS (306.00)	Meruvax II 0.5 mL SubO Unscheduled	-
Anesth Stop:	00,00,0011 11101	CONGESTIVE HEART FAILURE, UNSPECIFIED (428.0)	Administered (32)	
alosti otop.		Hypertension (64176011)	acetaminophen 500 mg By mouth ADHOC	
Perioperative Tracking -		-	acetaminophen 500 mg By mouth ADHOC	-1
Anticipated Start	14:25	Diagnoses (2)		-
Anticipated Stop	16:50	Active Meniere's disease NOS (386.00)	Intake and Output Last 2 days	-
Operating Room	07 South OR	Hypertension (64176011)	09/20/11 07:00- 09/19/11 07	
All Procedures	Resection First Rib	Labs Last 2 weeks	- Blood (mL)	1:59
Primary Surgeon	Woods MD, Timothy	No results found	Blood Transfused 0 0	
Anesthesiologist	Austin MD, Craig		Est, Blood Loss 0 0	- 7
Anesthesia Type	3-General Endo	Lines, Tubes, and Drains (0) Last 3 days	- Blood Balance 0 0	_
Current Event	Anes Start	Lines (0)	- Fluid (mL)	
		Tubes/Drains (0)	- Fluid Intake 2975 0	
Allergies (11) 🕂 Add		-	Fluid Output 475 0	
amoxicillin	rash		Fluid Balance +2500 0	_
ampicillin	rash			
Bactrim Pediatric			Diagnostics (0) Last 30 days	-
capreomycin			EKG (0) Chest/Abd XR (0)	-
dust			Other Diagnostics (0)	
Hemorrhoidal Suppository	rash		Microbiology (0) Last 6 months	-

The Intraoperative Summary contains the following information:

- Implant/Prosthetic
- Dressing/Wound Assessment
- Pain Assessment

Postoperative Su Implant/Prosthetic (4)				-
Implant/Prosuleuc (4)	12/09/09 16:43	12/09/09 06:43	12/09/09 16:43	-
Implant / Explant:		Implant	Implant	
Description:	umbrella	aortic stent placed	valve	
Serial Number:	1234	3455	445-90	
Lot Number:	45678	678999	3B	
Manufacturer:	Cordis	Cordis	Cordis	
Catalog Number:	336	334	899	
Size:	7	1	1	
Expiration Date:	2/11/10	2/11/10	2/11/10	
Implant Site:	abd	abd	abd	
Quantity:	1	1	1	
Dressing/Wound Assess				-
	12/09/2009 22:43			
Dressing:	1			
Location:	abdomen			
Condition:	intact			
Drainage:	scant drainage			
Care:	first dressing to			
	change			
Pain Assessment (1)				-
	12/09/2009 22:43			
Pain Location:	abdominal			
Pain Intensity Scale	6			
Rating:				
Pain Intensity Scale	NRS, Numeric			
Used:	Rating Scale			
Pain Quality:	Dull			
Interventions:	Rest and			
	Repositioning			

The first column displays the name of the item being reported on. The second column contains the latest results for each item, while columns three and four can contain up to two previous values for each item.

Each section includes a count in the heading for the total number of values documented (for example, the total number of implants or total number of dressings). If there are more values available than the default display allows, a Show All link is available.

This component is activated by positioning the cursor over the latest or previous results data rows. When you position the pointer over a data row, the system selects the entire result column, and displays who documented the results and the date and time.

Surgical Case Selection

When you open SurgiNet Anesthesia, the Case Selection window is displayed. You can select the surgical case you want to use from this window. The system enters the operating room number by default, depending on which room the application is being opened in, and searches for the day's cases scheduled for that room.

Selecting a Surgical Case

To select a surgical case, complete the following steps:

 If the Select Case window is open, select the case and click OK to open the case. If you are opening a different anesthesia record, choose Select Case from the Task menu to open the Select Case window. The boxes in the upper portion of the window allow you to enter information to narrow your search for cases to be displayed. Enter information in one or more boxes to narrow the search.

earch C <u>r</u> iteria								
urgical area:	South Surgery		🚺 🙀 Start gate:	09/03/2011			÷ • 🚥	000
Operating room:		å	🖌 💢 End date:	09/12/2011			÷ 🗸 23	359
Patjent name:		4	4 🗶					
IRN:			4 <u>×</u>					
-								
ynesthesiologist:			4 X					
Last documented:		<u>#</u>	<u>م 🗶</u>					
Case nu <u>m</u> ber:			×					Search
Cases								
Checked Record	4		1		[Surgery	Surgery	Case
In Creater		MRN	Anesthesiologist	SSN	Birthdate	Date	Time	Number Prim
	04 South CTESTERMAN, WENDY LEE	5021139		496-70-2939	10/10/70	09/04/2011	16:07	SOUTH-2011-Appe
🗹 🗹	02 South CTESTERMAN, YESSICA E	5727844		498-25-4947			07:25	SOUTH-2011-Appe
Image:	03 South CPATIENT, TEST MIDDLENAME			999-99-9999		09/07/2011	07:25	SOUTH-2011- Chole
✓ ✓	03 South CPATIENT, TEST MIDDLENAME 02 South CTESTERMAN, ADAM C	5573875 5301038		999-99-9999 490-98-3327	02/01/34 01/19/88	09/07/2011 09/07/2011	07:25 08:20	
								SOUTH-2011- Appe
V 🗌	02 South CTESTERMAN, ADAM C							SOUTH-2011- Choir SOUTH-2011- Appe SOUTH-2011- Appe SOUTH-2011- Appe
	02 South CTESTERMAN, ADAM C 02 South CTESTERMAN, ASHLEY NICHOLE					09/07/2011 09/07/2011		SOUTH-2011- Appe SOUTH-2011- Appe SOUTH-2011- Appe
	02 South CTESTERMAN, ADAM C 02 South CTESTERMAN, ASHLEY NICHOLE 04 South CSURGINET, SOUTH8					09/07/2011 09/07/2011 09/08/2011		SOUTH-2011- Appe SOUTH-2011- Appe SOUTH-2011- Appe SOUTH-2011- Cole
	02 South CTESTERMAN, ADAM C 02 South CTESTERMAN, ASHLEY NICHOLE 04 South CSURGINET, SOUTH8 08 South CSURGINET, SOUTH5	5301038 6002274 6002286			01/19/88 02/25/85 01/25/25	09/07/2011 09/07/2011 09/08/2011 09/08/2011		SOUTH-2011- Appe SOUTH-2011- Appe SOUTH-2011- Appe SOUTH-2011- Cole SOUTH-2011- Appe
Y	02 South CTESTERMAN, ADAM C 02 South CTESTERMAN, ASHLEY NICHOLE 04 South CSURGINET, SOUTH& 03 South CSURGINET, SOUTH& 22 South CTESTERMAN, TIMOTHY N	5301038 6002274 6002286 5303898		490-98-3327	01/19/88 02/25/85 01/25/25 10/19/94	09/07/2011 09/07/2011 09/08/2011 09/08/2011 09/08/2011	08:20 10:16 07:00 07:13 09:02	SOUTH-2011- Appe SOUTH-2011- Appe

- **Note:** If you cannot find the case using the default room and want to start a new search, click the red X next to one of the boxes and then click Search to find all of the day's cases. If the case still is not found, enter different search criteria (such as patient name, case number, or date) and try to search again.
- 2. Select the case and click OK.

Note: If multiple document types exist, the Choose Document Type window opens. Select the appropriate document type, and click OK.

- 3. *SurgiNet* automatically associates appropriate devices based on the location. If there are no default devices, a Choose Devices dialog box opens. Select the appropriate devices and click OK.
- 4. Verify that the record opens in the SurgiNet Anesthesia window.

Blank Anesthesia Records

When the SurgiNet Anesthesia application is opened, the Select Case window is displayed so you can select the appropriate anesthesia record. You also can select to open a blank record or cancel out of the Select Case window.

Note: There should be a case already set up in the system; you should not have to create a blank record. The steps below are intended for use in the event that you do need to create a blank anesthesia record.

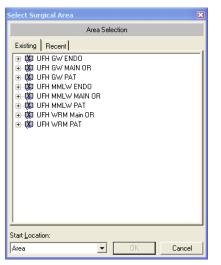
Creating a Blank Anesthesia Record

If the case has not been created yet, you can create a blank anesthesia record can be created. To create a blank anesthesia record, complete the following steps:

- 1. Click Blank Record located in lower right corner of the Select Case window.
- 2. In the Create Blank Record dialog box, click the binoculars button next to the Created Location. The Select Operating Room dialog box opens.

Create Blank Record		×
Created by:	SNANES	
Created date:	9/21/2011	
Created time:	11:41	
*Created location:		<i>8</i> 4
* <u>D</u> ocument Type:	📄 Anesthesia	- 1
* <u>R</u> ecord Description:	SNANES - 9/21/2011 11:41	
	OK	Cancel

3. Scroll down to find the appropriate operating room for the case.



- 4. Select the location, and click OK. The Create Blank Record dialog box is displayed with the location you selected next to Created Location.
- 5. From the Document Type list, select the appropriate document type.

Create Blank Record		X
Created by:	SNANES	
Created date:	9/21/2011	
Created time:	11:41	
*Created location:		<i>0</i> 4
* <u>D</u> ocument Type:	🔳 Anesthesia	- 1
* <u>D</u> ocument Type: * <u>R</u> ecord Description:	Anesthesia	▼ 1

- 6. Modify the record description if necessary.
- 7. Click OK to create the blank record.

Associating a Blank Record with a Case

If a blank record is created, you must associate it with the appropriate case once it becomes available in the system. After the record is associated with the correct case, it becomes a permanent part of the patient's record and available for review.

1. From the Task menu, select Associate Case to Record.



2. Search for and select the case.

3. Click Verify in the Verify Case dialog box to associate the record with the case.

🔮 Verify Case - 50	_		<u>×</u> IT⊔2
MRN: 6 Allergies: aspirin	3UR 5002255	GINET, SOU	AGE: 10 years
Operating Room: Surgeon: Anesthesiologist(s): Surgery Date/Time: Procedure(s): Case Number:	9/8/2011 13:54 Procedure	<u>Surgeon</u> Smith MD, Jacob	

Macros

After opening the case, you can start a macro to assist in documentation efforts. A macro enters all of the medications, fluids, monitored values, actions, and inventory related to the case with the click of a button. It reduces the time it takes to get items onto a record, and it is a pretty easy step in the application.

Starting a Macro

To work with macros, complete the following steps:

- 1. Click on the toolbar.
- 2. In the Select Macro dialog box, click the button with the name of the macro.

a Select Macro	X
Case Set Up Gen Anesthesia	
Масто	
	cel 📗

Note: A category is displayed only display if it contains macros that are relevant for the document type being documented. The components of the macro will display and can be verified or excluded, depending on the procedure.

3. Check the appropriate box to select the component, place it on the To Do list, or ignore it and not execute that item.

a 🔁 Macros			
	Macr	Ö	
Execut To Do Allergy Interaction	Event Type Normal Saline (:Intake Tidal Volume In: Monitors Normal Saline (:Intake	Details Monitor On	Date Time Edit 9/24/201 18:18 3 3 3 3
Maintain Macro			Execute Cancel

4. If any of the items included in the macro need to be modified prior to executing the macro (for example, adding a dosage to a medication because it is already known at the time of macro execution), click Edit to the right of the item.

	Macros					
			BMT CSC			
23	Event Pre-Op Checl IV Regional B Chart Person LMA/Mask Times - Anest Times - Anest Emergence	Actions Actions Actions Actions Actions	Details Yes, Plan & Medications disc Mask, Yes, Equal, Observed Cart, PACU, RN	9/23/201 9/23/201	11:13 11:13 11:13 11:13 11:13 11:13	F + + + +
	▲ Maintain Macr	o			Execute	 ▶ ancel

You can set up default macros to give values to these details, or they can be modified here for addition to the record.

- 5. Once the contents of the macro are verified, click Execute and the contents are recorded.
 - **Note:** All of the medications, gases, fluids (intakes, outputs, or both), monitors, and actions are displayed on the record. You can view any inventory added through the macro by opening the inventory dialog box. Monitor values are displayed on the graph as they are collected from the devices.

Note: The watermark boxes that are displayed indicate that nothing was received from the device at that time.

Medications

In SurgiNet Anesthesia you are able to add medications, view administrations, and modify or remove medications or administrations, as well as look up specific details associated with medications.

Adding Medications

There are several different ways to add medications and their dosages to a record. The steps involved vary depending on whether the medication is already on the record itself.

Medications Already on a Record

To add a medication already on a record, complete the following steps:

1. Click the name of the medication to insert a dosage at the current time. The Add Medication Administration dialog box opens. **New** is displayed to the left of the medication name to indicate that this is a new administration being added to the record.



2. Enter a dose amount, and then click OK. The medication is displayed on the record.

Note: The other fields on the Add Medication Administration dialog box are optional, but if they are not documented now they will have to be documented later. The Route and Site lists have numerous options; the Route list default value is IV, and the Site list default value is None.

- 3. To modify the height and weight for a patient, click the height and weight links.
- 4. You also can modify the units by clicking on the units that follow elements, such as height, weight, dose amount, and volume.
- 5. Modifying the units in the medication concentration also makes the corresponding updates in the dose amount, volume, and weight base dose boxes.

Medications Not Already on Record

To add medications not displayed on the medication list, complete the following steps:



1. Click Medications on the toolbar. The Select Medication dialog box opens. The tabs running across the dialog box above the medications are the categories that medications have been built in.

Select Medication
_ Medication
C Add Admin C Remove Admin C Remove Medication
Local Pulmonary Antibiotic Other Steroid
Induction Narcotic Paralytic Sedation Cardiovascular Antiemetic Non-Narcotic Analgesia Obstetrics Reversal
Decadron BENADRYL Pepcid Pepcid Pepcid Pepcid Pepcid IV Regian 20 mg/5 nL Song/1 nL 20 mg/1 tab 20 mg/2 nL 20 mg/2 nL 20 mg/50 nL 10 mg/2 nL Zofran Transdern Scop Scopolarine Transdern 1.5 mg/1 patch 1.5 mg/1 patch 1.5 mg/1 patch
Other T Multi-Select

- 2. If you cannot find the medication that you are looking for in any of the categories, click Other to search the entire formulary.
- 3. Click the category, search for the medication, and click the button containing the medication name. The Add Medication Administration dialog box opens so that you can add the medication.

Adding Medications: Bolus or Infusions

There are different ways to look at the administrations of medications, depending on whether the med is given as a bolus or as an infusion

Bolus

Listed below are additional Bolus infusion-related notes.

- Allows for volume to be documented as administered in one single minute.
- If the concentration and weight are correct, entering the dose amount or volume will cause the rest of the fields to be calculated.
- Route and site are not required fields; the default value for the Route list is IV and the default value for the Site list is None.

Add Medical	ion Administration				X
Notond	ansetron 2mg/r 2 mg/1	nl mdv/ mL	ZOF	RA	N
	Concentration Product: 2 mg / Diluent: (None) Final: 2 mg / 1 mL	1 <u>mL</u>	mL	W	eight: <u>O</u> eight: <u>O kg</u>
	9/16/2011 10:30 10:45	11:00	11 14)/ 11.:15	16/2011	
			•		
Bolus					
Admin time:	11:14		7	8	9
Dose amount:			4	5	6
⊻olume: Weight based	0 <u>mL</u> dose: Weight required		1	2	3
				0	«
<u>R</u> oute: IV □ Sho	w all routes	<u>S</u> ite: (No ⊡ s	ne) 6 <u>h</u> ow all s	ites	•
<u>C</u> omment:					▲ ▼
			OK		Cancel

Infusions

Listed below are additional infusion-related notes.

- Allows for volume to be shown as administered over time.
- If concentration and weight are correct, entering the dose infusion rate or the pump infusion rate will cause all other fields' values to calculate over time.

Add Medication Administration			×	
ondansetron 2mg/ml vl 2ml 4 mg/2 mL	/ZO	FRA	٨N	
Concentration Infusion Concentration Product: 4 mg / 2 mL Diluent: (None) ▲ ● X Einal: 4 mg / 2 mL	0 m		jht: <u>6</u> ght: <u>190</u>	_
I<	9/ 11:30	/16/2011		
Infusion Start time: 11:30	7	8	9	
Dosing infusion rate: 10 mg/minutes	4	5	6	
Weight based dose: 0.11603 mg/kg/minutes	1	2	3	
Pump infusion rate: 5 mL/minutes Duration: 0 hr Amount infused: 0 mg		0	«	
Volume infused:	it Arm			
	how all s	ites		
			A	
	OK		Cancel	

- Route and site are not required fields; the default value for the Route list is IV and the default value for the Site list is None.
- The blue triangle (delta symbol) A allows rate changes to be made. Click the blue delta and then click the time frame that the rate needs to be changed in. Enter the correct rate in the appropriate field and a blue separator is displayed in the bar, indicating a change was made.
- The red circle solution allows you to enter the stop time of the infusion. Click the red circle and then click at the proper time to indicate the conclusion.
- The red X \times deletes any rate change indicators that might be present in the bar.

Modifying Medications

You can use either the Medication toolbar button or the record to modify medications.

Modifying Medications Using the Toolbar

To modify medications using the toolbar, complete the following steps:

- 1. Click Medications on the toolbar. The Select Medication dialog box opens. Notice that the first tab is the Current tab. This tab contains all of the medications that have currently been recorded on the anesthesia record.
- 2. To modify any of the medication administrations, select the Modify Admin option.

Select Medication	×
Medication	
C Add Admin C Modify Admin C Remove Admin C Remove Medication	
Current	
Zofran Ondansetron 2mg/ml VL 4 mg/2 mL	
Other 🗖 Multi-gelect	<u>C</u> ancel

- **Note:** The dialog box is updated to show just the Current tab and the administered medications. This is a very important step in modifying medications. If the Modify Admin option is not selected, there is a high probability that a medication will be added again.
- 4. Click the medication that you want to modify. The Administration dialog box opens.
- 5. Modify the dose amount to the correct value, and click OK to apply your updates.

Modifying Medications Using the Record

To use the record, complete the following steps:

- 1. Find the medication on the record.
- 2. Click the dosage that needs modification. The Modify Medication Administration dialog box opens.

Modify Medication Administration			X
ondansetron 2mg/ml vl 2m 4 mg/2 mL	I/ZC)FR/	AN
● Bolus Concentration ● Infusion Product: 4 mg / 2 mL Diluent: (None) Final: 4 mg / 2 mL	mL		ight: <u>0</u> eight: <u>0 kg</u>
B I ≤ 9/24/2011 15:30 15:45 16:00	16 14)/ 16:15	/24/2011	
Admin time: 16:14	7	8	9
Dose amount: 45 mg Volume: 22.5 mL	4	5	6
Weight based dose: Weight required	1	2	3
		0	«
Route: IV Site: (No Show all routes	ne) i <u>h</u> ow all s	ites	-
			4
Re <u>m</u> ove Admin	OK		Cancel

3. Make the necessary modifications, and then click OK to apply your updates.

Deleting Medications

You can use either the Medication toolbar button or the record to delete medications.

Removing Medications Using the Toolbar

To delete the medications administered, complete the following steps:

- 1. Click Medication on the toolbar to open the Select Medication dialog box. The Select Medication dialog box opens. The Current tab contains all of the medications that have currently been recorded on the anesthesia record.
- 2. To delete any of the medication administrations, select the Remove Admin option.

Note: You also can select the Remove Medication option, which will remove all administrations of a medication from the record whether there were multiple dosages given.

Select Medication				×
Medication				
C Add Admin	© <u>M</u> odify Admin	• <u>R</u> emove Admin	C Remove Medication	
Current				
Zofran Ondansetron 2mgin 4 mg/2 mL	IVL			
Other 🗖 M	iulti- <u>S</u> elect			Cancel

- **Note:** The Select Medication dialog box is updated to show just the Current tab and the administered medications. This is an important step in removing medication administrations. If the Remove Admin option is not selected, there is a high probability that a medication will simply be added again.
- 4. Click the medication that needs an administration removed.

Note: If a medication only has one administration, this dialog box is not displayed. The medication is removed from the record after you click the name of the record.

5. Click OK to remove that instance of the medication from the record.

Removing Medications Using the Record

To remove medications using the record, complete the following steps:

1. If the medication has already been documented on the record, click the dosage that you want to remove.

2. Click Remove Admin. The corresponding dosage is removed from the record. If it is the only dosage recorded for that medication, it completely removes the medication from the record.

Intakes and Outputs

Adding Intakes

There are several different ways to add intakes, outputs, and their volumes to a record. The steps involved vary a little bit depending on whether or not the fluid is already on the record itself.

Adding Intakes Already on Record

To add intakes already on a record, complete the following steps:

1. If a fluid already exists on the record, perhaps through a macro, click the name of the fluid to start another bag at the current time interval. The fluid Intake dialog box opens.

T Intake			×			
Eactated Ringers IV Sol 1000 mL						
Bag volume: 1000 mL		Heig Weig				
I 33/16/2011 16:45 17:0 16:30 16:45 17:0	00	16/2011 17:15	• •			
Intake Start time: 17:11	_	_				
Start time: 17:11	7	8	9			
Volume rate: mL/minute	4	5	6			
Weight based rate: Weight required	1	2	3			
Volu <u>m</u> e: <u>mL</u>	-	-	_			
Duration: 1+ minute	•	0	«			
Route: IV Site Show all routes	: (None) IT Sho) wajisite	• 8			
<u>C</u> omment:			4			
Multiple Bag	Start	Bag	Cancel			

2. Click Start Bag to get the bag started at the time represented in the time bar.

- 3. Complete the fields as needed. The volume rate and weight-based rate are not required, but help in calculating volume given over time. The route and site fields are not required; the default value for the Route list is IV, and the default value for the Site list is None.
- 4. Click Start Bag to begin the bag.

Adding Intakes Not Already on Record

To add intakes not already on record, complete the following steps:

1. Click on the toolbar. The Select Intake dialog box opens.

Ta Select Intoke	×
- Intake	
Current Crystalloid Colloids	
Lactated Ringers IV Sol 1000 mL	
Other T Multi-Select	Çancel

2. Find the necessary fluid by browsing through the different tabs above the fluids.

Select Intake	X
_ Intake	
<u>Add Admin</u> C Modify Admin C Remove Admin C Remove Intake Fluid	
Crystalloid Colloids Blood Products	
Autologous Cryoprecipitat Fresh Frozen Packed Red Intake e Intake Plasma Intake Cell Intake Platelet Intake	
Other	Cancel

3. Click the button for the appropriate fluid. The Fluid Intake dialog box opens.

1 Inteke				×	
Sectated Ringers IV Sol 1000 mL					
<u>B</u> ag volume: 1000	mL.	Heig Weig		0 0	
	03/ 00 17:15	16/2011			
Intake Start time: 17:17 • Stog time: • 4	7	8	9		
Volume rate: mL/minute	4	5	6		
Weight based rate: Weight required Volume: mL	1	2	3		
Duration: 1+ minute		0	«		
Boute: IV Site: (None) Show all routes Comment:					
				2	
Multiple Bag	Start	Bag	Canc <u>e</u> l		

Note: A category is displayed only if it contains intakes that are relevant for the document type being documented.

- 4. Click Start Bag. You do not need to complete the route, site, and different intake routes to start the bag.
- 5. Once a fluid has been running, it is easy to start another bag of the same fluid. If you click toward the end of a fluid's bar, the Fluid Intake dialog box opens with a Start Next Bag button. Click Start Next Bag to start another bag.

Modifying Intakes

Modifying Intakes Using the Toolbar

To modify intakes using the toolbar button, complete the following steps:



1. Click

Intake on the toolbar. The Select Intake dialog box opens.

2. Select the Modify Admin option.

Select Intake				×
_ Intake			1	
C Add Admin 📀 Modify Admin	C <u>R</u> emove Admin	C Remove Intake Fluid		
Current				
Lactated Ringers 1000ml				
Other 🗖 Multi-Select			k	<u>C</u> ancel

- 3. The Select Intake dialog box displays only the Current tab.
- 4. Click the name of the fluid that needs modification.
- 5. If there are multiple administrations, select the appropriate one and click OK.
- 6. Modify the values in any of the fields as necessary.

7. Modify the times by dragging and dropping the green section of the bar to the correct time interval.

Modify Intake)	×		
Lactated Ringers 1000ml						
<u>B</u> ag volume: 1000 mL		Heig Weig		0 0		
Image: style="text-align: center;">9/12/2011 115 16:30 16:45	9/ 17:00	12/2011 17:)]		
Intake Start time: 17:05	7	8	9			
Volume rate: <u>mL/minutes</u>	4	5	6			
Weight based rate: Weight required Volume: mL	1	2	3			
Duration: 7+ <u>minutes</u>		0	«			
Route: IV Site: (None)						
A						
Remove Bag Multiple Bag QK St	tart <u>N</u> ext	Bag	Canc <u>e</u> l			

8. Click Again in the yellow bar, and then enter the correct fluid rates when the individual sections of the bar are selected. Verify that the rate at which the fluid is administered is updated.

Modifying Intakes Using Fluids Already on the Record

To modify intakes using fluids already on the record, complete the following steps:

1. If a fluid has already been documented, click the green starting mark or anywhere along the white bar to open the Modify Intake dialog box.



2. Make the necessary modifications, and click OK to save your updates.

Modify Intake			6	8	
Lactated Ringers IV Sol 1000 mL					
Bag volume: 1000 mL ▲ ● × 100/16/2011 10:30 16:45	03/ 17:00	Heig Weig 16/2011 17:11			
Intake Start time: 12:35 . Stop time: .	7	8	9		
Volume rate: mL/minute	4	5	6		
Weight based rate: Weight required	1	2	3		
Duration: 4604+ minute		0	«		
Show all routes	te: (None) E Sho	v all site	•]	
Qomment:			() ()	Ĩ	
Remove Bag Multiple Bag QK	Start Next	Bag	Cancel		

Removing Intakes

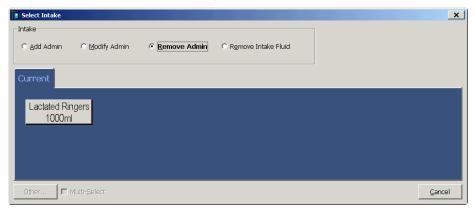
Removing Intakes Using the Toolbar

To remove intakes using the Intake button on the toolbar, complete the following steps:



Intake on the toolbar. The Select Intake dialog box opens.

2. Select the Remove Admin option.



- 3. Click the medication that needs to have an administration removed, and the corresponding value is removed from the graph.
- 4. If there are multiple administrations of the same fluid, select the one that needs to be removed, and click OK to remove it from the record.

Removing Intakes Using Recorded Fluids

To remove intakes using the recorded fluids, complete the following steps:

1. If a fluid has already been documented, click anywhere along the white bar to open the Modify Intake dialog box.

_			
		0	
a 5	📥 Normal Saline (SC 0.9%)	0 mL	
- ×		<u> </u>	
Intake	Lactated Ringers 500ml	0 mL	
12			
	Packed Red Cell Intake	0 mL	
		O THE	

2. Click Remove Intake Fluid to remove the administration.

Select Intake	×
Intake	
C <u>A</u> dd Admin C Modify Admin C Remove Admin C Remove Intake Fluid	
Current	
Autologous Intake 500ml	
Other	Cancel

The administration is removed from the record. If there was only one bag hung for that particular fluid, the entire fluid is removed from the record.

Removing Intakes Using the Recorded Fluids Option

Complete the following steps to remove intakes using recorded fluids:

1. Click

on the toolbar. The Select Intake dialog box opens.

2. Select the Remove Intake Fluid option.

Select Intake	X
Intake	
Current	
Autologous Intake Lactated Ringers 500ml 500ml	
Other	

3. On the Current tab, click the fluid that needs to be removed. Verify that the fluid is removed from the record.

Adding Outputs

Adding Outputs

The addition of outputs occurs very similarly to that of intakes; there are just less available fields (such as rates, duration, and so on) to complete.

1. If an output is already on the record, perhaps through a macro, click the name of the output to enter another value at the current time interval.



The fluid Output dialog box opens.

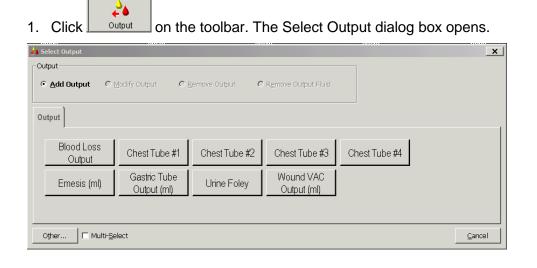
2. Enter the new output volume and the time verified. The site is not a required field; the Site list defaults to None. Note that that output will be displayed on the graph.

2 Output			X
🤲 🕺 Blood Loss Outp	out		
		Heig Wei	
I<	9,	/16/2011 13:15	
Output Time: 12:44			
Prior Blood Loss Output: 0 mL	7	8	9
Incremental Blood Loss Output:	4	5	6
Total Blood Loss Output: <u>mL</u> Total weight based Blood Loss Output: Weight required	1	2	3
Total weight based blood Loss output, meight required		0	«
Site: (None) ▼ Show all sites			
Comment:			
	Ōĸ		Canc <u>e</u> l

3. Click OK to add the output.

Adding Outputs Not Already on Record

To add outputs not already on the record, complete the following steps:



Note: A category is displayed only if it contains outputs that are relevant for the document type.

2. Click the output that you need to document. The fluid Output dialog box opens.

👍 Output			×			
Blood Loss Output						
		Heig Weig				
Ⅰ 9/13/2011 15 09:30 09:45 10:00	9, 1	/13/2011 0:15				
•						
Output Time: 09:46						
	7	8	9			
Prior Blood Loss Output: 0 mL Incremental Blood Loss Output: 0 mL	4	5	6			
Total Blood Loss Output: <u>mL</u> Total weight based Blood Loss Output: Weight required	1	2	3			
		0	«			
Site: (None)						
	<u></u> k		⊂ Canc <u>e</u> l			

3. Enter the appropriate values, and click OK. The volume you entered is added to the record the time indicated.

Modifying Outputs

Modifying Outputs Using the Toolbar

To modify outputs using the Output button on the toolbar, complete the following steps:



on the toolbar. The Select Output dialog box opens.

2. Select the Modify Output option.

👍 Select Output			×
C <u>A</u> dd Output	C <u>R</u> emove Output	C Remove Output Fluid	
Current			
Blood Loss Output			
Other 🗖 Multi-gelect			Cancel

3. Click the name of the output that needs modification to display the next screen.

👌 Modify Output			×
Blood Loss Outpu	t		
		Heig Wei	
Image: 15 9/13/2011 09:30 09:45 10:00	9, 1	/13/2011 0:15	
Time: 09:46	7	8	9
Prior Blood Loss Output: 0 mL Incremental Blood Loss Output: 0 mL	4	5	6
Iotal Blood Loss Output: 0 mL	1	2	3
Total weight based Blood Loss Output: Weight required		0	«
Site: (None)			
Comment:			<u>~</u>
Remove Output	<u>O</u> K		Canc <u>e</u> l

4. Modify the volume value in the Output box, and click OK to update the record.

Modifying Outputs Already on the Record

To modify outputs already on the record, complete the following steps:

- 1. If an output has already been documented, click the white dot marking its documentation on the record. The Modify Fluid Output dialog box opens.
- 2. Modify the volume of the output as needed, and then click OK.

Deleting Outputs

To delete outputs, complete the following steps:

1. Click

on the toolbar. The Select Output dialog box opens.

2. Select the Remove Output Fluid option.



3. Click the output that needs to be removed from the Current tab. The output is deleted from the record.

Associate Devices Associating Devices

You can associate additional devices during a case. To select a device for the case in progress, complete the following steps:

1. From the Task menu, select Associate Devices.

Select Case Select Blank Record	Ctrl+L
Select Remote View Cases	Ctrl+R
Associate Devices	
Charge Preview	
Signatures	
Finalize Case	
Maintain Views	
Maintain Demographics View	
Maintain Remote View Sequence	
Maintain Macros	
Synchronize Records	
Print Setup	
Print Preview	
Print	Ctrl+P
Suspend Case	
Change User	

- 2. From the Select Device dialog box, select the appropriate device from the available devices.
- 3. Click OK.

Note: If the provider forgot to select a device at the beginning of the case or hit cancel they can choose their initial devices under associate device.

Monitored Values

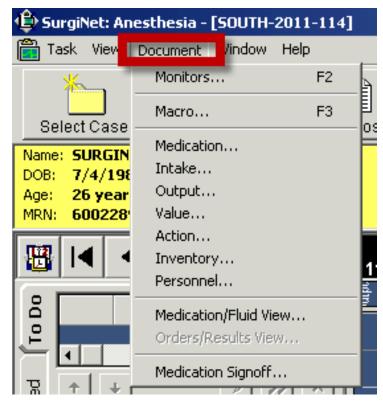
The bedside medical devices play a large role in the documentation of an anesthetic record, so the values that these devices are monitoring are very important to the application. Most of the monitored values that need to be recorded during the case will probably be started via a macro at the beginning of the case. However, there is always the possibility that a monitor and its values will need to be added to the record.

Note: There are standard values that already exist that you can use. Use the steps below in case you need to add or modify a value.

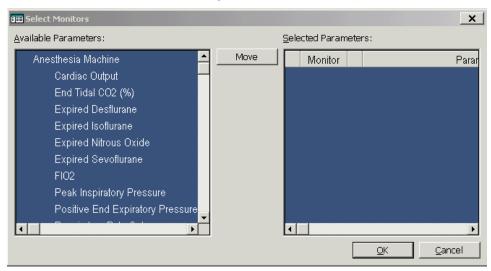
Adding Monitors

To specify the information to be displayed, complete the following steps:

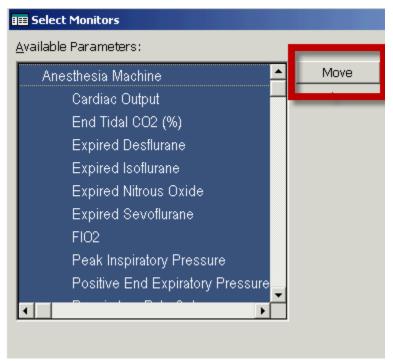
1. From the Document menu, select Monitors.



2. The Select Monitors dialog box opens. The list on the left shows the available device parameters to select from. The list on the right side shows those parameters that are currently being monitored.



3. Select the values from the Available Parameters list and click Move to move them to the Selected Parameters list. This also can be done in the reverse direction if you want to take monitored values off of the record.



Note: The red checks marks indicate whether to turn on or off monitors. If there are values that do not need to be displayed during a portion of the case, click the check box containing the red check mark to remove the check mark and turn off the monitor. This might needed during the bypass portion of the cardiac procedure, for example.

		×
1	Fo Selected	
Move >	Monitor	Pa <mark>≜</mark>
		Tidal Volume Inspiratory
		Respiratory Rate Set
		Positive End Expiratory
		Peak Inspiratory Pressu
		F102
		Expired Sevoflurane
		Expired Nitrous Oxide
		Expired Isoflurane
		Expired Desflurane
	•	
		<u>O</u> K <u>C</u> ancel

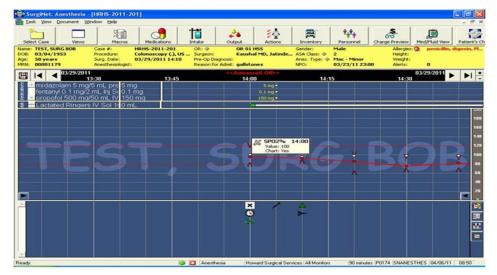
- 4. Symbols are displayed next to those parameters that have been designated as graphical values. If a parameter does not have a symbol next to it, it is displayed in the Monitors section of the record.
- 5. Click OK to save your monitors preferences.

Modifying Monitored Values

There is always a possibility that the values that populate the electronic record are erroneous or incorrect due to a number of different reasons. Because this interference or artifact is possible, there are ways to adjust the values on the record so that they more accurately represent the patient's vitals.

To modify a monitored value, complete the following steps:

1. In the Monitors section, click any of the values displayed.



The Modify Monitor Value dialog box opens.

📅 Modify Monitor Value				×
Modify Oxyger	n Sati	urati	ion	
* <u>V</u> alue:	Keypad			
99 %	7	8	9	
	4	5	6	
	1	2	3	
		0	«	
*Value time: 13:16 💌				
	3:30	2/11 13:4	/2010 5	
Comment: Minutes a	go: <u>30</u> 1	5 10	5 Nov	N
				*
Remove	OK		Cancel	

- 2. Enter the correct value.
- 3. Click OK to update the value on the record.
- 4. If one of the graphical values (such as blood pressure or heart rate) needs to be adjusted, select Value from the Document menu. The Maintain Monitor Values window opens. This allows you to modify all of the monitored values that have been recorded for the case.

Haintain Monitor Values	_				
Maintain Monitor Valu	Maintain Monitor Values				
Interval (minutes): 1 5 10 15					
Monitor Values Monitor Name Monitor 17:05 17:10 17:15 BP Systolic Image: state of the stat		Details.,, Pull Values Chart Unchart			
Add Monitor Remove Monitor Accept Imported Values	<u></u> K	Cancel			

- 5. Click the value that you want to modify.
- 6. Make the necessary modifications. You can modify the value interval c clicking the 1, 5, 10, and 25 buttons above the main part of the sheet. This helps narrow or expand the values so that you can locate the values to modify.

Interval (minutes): 1 5 10 15

7. Click OK. The record is updated with the correct value.

You can perform the following actions from the dialog box as needed:

• Details. Select any of the values and then click Details. The dialog box opens for that specific value where you can modify the value and time or add a comment for that value.

Haintain Monitor Values	
Maintain Monitor Values	
Interval (minutes): 1 5 10 15	
Monitor Values Monitor Name Monitor 17:00 17:10 17:15 BP Systolic ✓ 70 ● BP Diastolic ✓ 70 ● SV02 ✓ ✓ ● Respiratory Rate Set ✓ ● ●	Details Pull Values Chart Unchart
Add Monitor Remove Monitor Accept Imported Values	Cancel

• Pull Values. Click the gray box to the left of any of the monitor names and then click Pull Values to add all of the values that have been collected so far by the device.



- **Note:** An example of when this might be used: a temperature probe was attached early in the case but the temperature monitor was not selected for the record. While it might not be displayed on the record, the application is still collecting all values that are tied to this parameter. This will display the values on the graph
- Chart/Unchart. Allows you to select multiple cells and then select whether the cells should be included in the permanent record.



• Add/Remove Monitors. Allows you to add monitors to the record without having to close the window and return to the monitor-related dialog boxes.

Add Monitor	<u>R</u> emove Monitor	Accept Imported Values	<u>0</u> K	Cancel

Chart and Unchart

SurgiNet Anesthesia allows an anesthesia provider to document quickly and accurately throughout the procedure. Bedside medical device interfaces default collected values from the patient monitors onto the anesthesia record. These values can be modified for accurate charting. Increased charting efficiencies can be accomplished using touch screen as a user input method and macros to document several events in one execution.

Chart Mode

The Chart Mode functionality allows you to select values very quickly to be charted or uncharted. This is another way to view the chart without all the other details, such as buttons and to do list. The Chart Mode shows only the monitors, gases, and graphs sections of the record. Use this view during long cases after most or all of the documentation has been completed and you just want to view the values being pulled in. You are not able to document in Chart Mode, but you are able to chart and unchart values from the anesthesia record.

To use Chart Mode, complete the following steps:



- 1. To access Chart Mode, click Charting Mode on the toolbar.
- 2. When you activate Chart Mode, the values from the anesthesia record are displayed, but the values to be charted are indicated with yellow circles around them.
- 3. When you are finished, click Charting Mode on the toolbar again to revert to the normal view.

Chart and Unchart in Chart Mode

To chart and unchart in Chart Mode, complete the following steps:



- 1. To access Chart Mode, click Charting Mode on the toolbar.
- 2. Use your mouse to select an area with values in it. When you do this, you are able to select options from the displayed context menu.
- 3. After selecting values, you are able to select from the following Chart and Unchart options:
 - **Chart Displayed Values in Range.** Selecting this option charts all displayed values in the indicated range (the range within the highlight box you created).
 - **Chart All Values in Range.** Selecting this option charts all (displayed or not displayed) values in the indicated range (the range within the highlight box you created). This option also is available from the Unchart submenu except it uncharts values.
 - Chart All Values From <time> to <time>. Selecting this option is basically the same as the previous option. However, it lists the specific times included in the indicated range. This option also is available from the Unchart submenu except it uncharts values.

- Chart All Values From <time> to <current time>. Selecting this option charts all values from the earliest time in the range you indicated through the current time. This option also is available from the Unchart submenu except it uncharts values.
- 4. When you have finished making your changes in Chart Mode, click Charting Mode on the toolbar again to revert to the normal view.

Modify Time Bar

To modify the time bar, complete the following steps:

1. Click Date and Time on the toolbar (located next to the time bar).



2. Modify the date and time.



🔹 SurgiNet: Anesthesia - [SOUTH-201	1-165 < <charting mode="">>]</charting>
📸 Task View Window Help	
Select Case Views	
Name: SURGINET, SOUTH8	Case #:
DOB: 6/30/1982	Procedure:
Age: 29 years	Surg. Date:
MRN: 6002278	Anesthesia Provider:
1 ◀ 9/15/2011	19:15

Actions

Using the Action List

Note: This section is for informational purposes only. If you use an action, it currently will not display in the case or documentation.

Actions will make up a majority of the anesthesia record outside of medications and fluids. Actions might include items such as times, positions, airway management, procedures, notes, and billing modifiers.

There are actions that have details built behind them (such as add IV regional block), and there are also actions that do not have any details (such as add anesthesia start time).

<mark>۶</mark>

1. Click Actions on the toolbar. A list of actions is displayed. Several methods exist to view the actions that have been documented.

View By: Date/Time Category Completion Signature Pre Operative Pre-Op Check List Pre-Op Check List Oral Endotracheal Intubation Oral Endotracheal Intubation Oral Endotracheal Intubation One Lung Ventilation One Lung Ventilation One Lung Ventilation One Lung Ventilation Nasal Endotracheal Intubation Nasal Endotracheal Intubation Nasal Endotracheal Intubation Nasal Endotracheal Intubation Nasopharyngeal Airway Abit Documented> Suctioning Avator Documented> Cricothyrotomy Not Documented> Fast Track LIMA Bronchoscopy Fiberoptic Airway Management Viet Vot Documented> RSI Avit Documented> Jet Ventilation Not Documented> Refrograde Wire		Δc	ion List	
View By: Date/Time Category Completion Signature Pre Operative Pre-Op Check List Viot Documented> Airway Management Oral Endotracheal Intubation Alto Documented> O2 Supplementation Alto Documented> O2 Supplementation Alto Documented> One Lung Ventilation Alto Documented> One Lung Ventilation Alto Documented> Suctioning Alto Documented> Suctioning Alto Documented> Suctioning Alto Documented> Comment: Comment: Comment: Comment: Signed by: Fiberoptic Airway Management Alto Documented> RSI Alto Documented> Alto Documented> Alto Documented> Fiberoptic Airway Management Alto Documented> 				
Pre Operative Pre-Op Check List <not documented=""> Airway Management Oral Endotracheal Intubation <not documented=""> LMA/Mask <not documented=""> O2 Supplementation <not documented=""> One Lung Ventilation <not documented=""> Nasal Endotracheal Intubation <not documented=""> Suctioning <not documented=""> Suctioning <not documented=""> Gastric Tube Insertion <not documented=""> Cricothyrotomy <not documented=""> Fast Track LMA <not documented=""> Bronchoscopy <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not></not></not></not></not></not></not></not></not></not></not></not>	iew By: Date/Time Category Comple	tion Signature	Details	
Pre-Op Check List <not documented=""> Airway Management Oral Endotracheal Intubation <not documented=""> LMA/Mask <not documented=""> O2 Supplementation <not documented=""> One Lung Ventilation <not documented=""> Nasal Endotracheal Intubation <not documented=""> Suctioning <not documented=""> Suctioning <not documented=""> Suctioning <not documented=""> Gastric Tube Insertion <not documented=""> Cricothyrotomy <not documented=""> Fast Track LMA <not documented=""> RSI <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not></not></not></not></not></not></not></not></not></not></not></not></not></not></not></not></not>				
Airway Management Oral Endotracheal Intubation LMA/Mask O2 Supplementation One Lung Ventilation One Lung Ventilation Nasal Endotracheal Intubation Nasal Endotracheal Intubation Nassel Endotracheal Intubation Nassel Endotracheal Intubation Nassel Endotracheal Intubation Nassepharyngeal Airway Nasopharyngeal Airway Nato Documented> Gastric Tube Insertion Nato Documented> Fiast Track LMA Ronchoscopy Not Documented> RSI Avit Documented> Jet Ventilation Avit Documented> Jet Ventilation Avit Documented> RSI Avit Documented> Jet Ventilation Avit Documented> Jet Vent		allele Deservedende		
Oral Endotracheal Intubation <not documented=""> LMA/Mask <not documented=""> O2 Supplementation <not documented=""> One Lung Ventilation <not documented=""> Nasal Endotracheal Intubation <not documented=""> Suctioning <not documented=""> Suctioning <not documented=""> Nasopharyngeal Airway <not documented=""> Gastric Tube Insertion <not documented=""> Gastric Tube Insertion <not documented=""> Fast Track LMA <not documented=""> Bronchoscopy <not documented=""> RSI <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not></not></not></not></not></not></not></not></not></not></not></not></not>		<not documented=""></not>		
LMA/Mask <not documented=""> O2 Supplementation <not documented=""> One Lung Ventilation <not documented=""> Nasal Endotracheal Intubation <not documented=""> Suctioning <not documented=""> Suctioning <not documented=""> Nasopharyngeal Airway <not documented=""> Gastric Tube Insertion <not documented=""> Cricothyrotomy <not documented=""> Fast Track LMA <not documented=""> Bronchoscopy <not documented=""> RSI <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not></not></not></not></not></not></not></not></not></not></not></not>				
O2 Supplementation <not documented=""> Image: Supplementation <not documented=""> Image: Supplementation <not documented=""> Image: Supplementation <not documented=""> Image: Supplementation <not documented=""> Image: Supplementation <not documented=""> Image: Supplementation <not documented=""> Image: Supplementation <not documented=""> Image: Supplementation <not documented=""> Image: Supplementation</not></not></not></not></not></not></not></not></not>				
One Lung Ventilation <not documented=""> Nasal Endotracheal Intubation <not documented=""> Suctioning <not documented=""> Nasopharyngeal Airway <not documented=""> Gastric Tube Insertion <not documented=""> Cricothyrotomy <not documented=""> Fast Track LMA <not documented=""> Signed by: Fiberoptic Airway Management <not documented=""> Signed by: Fiberoptic Airway Management <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not></not></not></not></not></not></not></not></not>				
Nasal Endotracheal Intubation <not documented=""> Suctioning <not documented=""> Suctioning <not documented=""> Nasopharyngeal Airway <not documented=""> Gastric Tube Insertion <not documented=""> Cricothyrotomy <not documented=""> Fast Track LMA <not documented=""> Bronchoscopy <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not></not></not></not></not></not></not></not>				
Suctioning <not documented=""> Image: Chot Documented> Nasopharyngeal Airway <not documented=""> Comment: Gastric Tube Insertion <not documented=""> Comment: Gastric Tube Insertion <not documented=""> Comment: Gricothyrotomy <not documented=""> Signed by: Fast Track LMA <not documented=""> Signed by: Fiberoptic Airway Management <not documented=""> Signed by: RSI <not documented=""> Fiberoptic Airway Management Jet Ventilation <not documented=""> Fiberoptic Airway Management Retrograde Wire <not documented=""> Fiberoptic Airway Management</not></not></not></not></not></not></not></not></not></not>				
Suburnity Choice Documented > Nasopharyngeal Airway <not documented=""> Gastric Tube Insertion <not documented=""> Cricothyrotomy <not documented=""> Fast Track IMA <not documented=""> Bronchoscopy <not documented=""> Fiberoptic Airway Management <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not></not></not></not></not></not>	Nasal Endotracheal Intubation			
Gastric Tube Insertion <not documented=""> Cricothyrotomy <not documented=""> Fast Track LMA <not documented=""> Bronchoscopy <not documented=""> Fiberoptic Airway Management <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not></not></not></not></not>				F
Cricothyrotomy <not documented=""> Fast Track LMA <not documented=""> Bronchoscopy <not documented=""> Fiberoptic Airway Management <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not></not></not></not>	Nasopharyngeal Airway	<not documented=""></not>	Comment:	
Fast Track LMA <not documented="">> Bronchoscopy <not documented="">> Fiberoptic Airway Management <not documented="">> RSI <not documented="">> Jet Ventilation <not documented="">> Retrograde Wire <not documented="">></not></not></not></not></not></not>	Gastric Tube Insertion	<not documented=""></not>		
Bronchoscopy <not documented=""> Signed by: Fiberoptic Airway Management <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not></not>	Cricothyrotomy	<not documented=""></not>		
Fiberoptic Airway Management <not documented=""> RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not></not>	Fast Track LMA	<not documented=""></not>		
RSI <not documented=""> Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not></not>	Bronchoscopy	<not documented=""></not>	Signed by:	
Jet Ventilation <not documented=""> Retrograde Wire <not documented=""></not></not>	Fiberoptic Airway Management	<not documented=""></not>		
Retrograde Wire <not documented=""></not>	RSI	<not documented=""></not>		
	Jet Ventilation	<not documented=""></not>		
Procedures	Retrograde Wire	<not documented=""></not>		
	Procedures.			
				Clos

When looking at the actions with the view set to Date/Time, it displays all of the actions that have been documented on the record in the order of the time associated with the documentation.

Action List	🖗 Action List	X
View By: Date/Time Category Completion Signature 9/13/2011 15:14 Pre-Op Check List O2 Supplementation 15:15 O2 Supplementation Edit Sign Delete <add> Comment:</add>	Action	List
	View By: Date/Time Category Completion Signature 9/13/2011 15:14 Pre-Op Check List 15:15 O2 Supplementation Edit Sign Delete	Details
	x	

- 2. Click Edit to modify an action. Click Delete to remove that action from the record and the list of actions.
- 3. If an action has details documented with it, you can view those details in the Details group box in the Action List window.

-Details	
O2 Supplementation	
	Þ
Comment:	

The actions are displayed in the Action Bar and are represented as symbols. If the action does not have a symbol associated with it, the red circle with a white X is displayed.

4. If any actions need to be added to the record while the view is set to display by Date/Time, click <Add> at the bottom of the list to select the row, and then click Document. The Select Action dialog box opens. The first tab shows what has currently been recorded. 5. Click the other tabs to locate the action, and then select the action check box to add it to the record.

Note: A category is displayed only if it contains actions that are relevant for the document type being documented.

6. You also can view the Action List by clicking Category. This displays all of the available action categories and the actions that have been documented beneath them. It also indicates if and when they have been documented with the date and time listed in the column on the right.

If an action needs to be added to the record (like one of the ones listed as Not Documented), click that action to select it and then click the gray Document button that is displayed.

- 7. Edit the action dialog box that is displayed, and it will be added to the record.
- 8. If fields have been made mandatory on an action, that action is displayed in the list with a red asterisk by it. When viewing the actions by completion, those actions that have required fields not yet documented will be separated from the rest of the completed actions.
- 9. Click Edit and complete the required fields and that action will then fall into the Complete category of actions.

Personnel

Personnel can be added to the record to show how many providers have been involved in a particular case and the times they were involved. Personnel can be seen on the record in the Action Bar area, or it can be viewed in a separate dialog box by selecting the Personnel toolbar button.

Adding Personnel

In *SurgiNet* Anesthesia you are able to add or remove personnel. To add personnel, complete the following steps:



1. Click Personnel on the toolbar. The Modify Personnel window opens.

2. Click Add to open the Select Personnel dialog box.

🙀 Modify Personnel			_ □ ×
Personnel fo	or SOUTH	-2011-1	14
Name	Start Date	Start Time	End Date
Test , SurgiNet:CRNA	09/13/2011	09:41	
			Þ
Add			<u>OK</u> Cancel

3. Locate the provider.

🙀 Select Personnel	×
Anesthesiologist CRNA Local Monitor RN Medically Directing Anesthesiologist Monett CRNA	
Austin MD, Craig SurgiNet-Anesthesiologist	
Other Multi-Select	<u>C</u> ancel

4. Select the provider who you want to add to the list.

🖣 Modify Personnel			_ □ ×
Personnel fo	or SOUTH	-2011-1	14
Name	Start Date	Start Time	End Date
Test , SurgiNet:CRNA	09/13/2011	09:41	
Test , SurgiNet:Anesthesiologist	09/13/2011	16:07	
Austin MD, Craig	09/13/2011	16:07	
			Þ
Add <u>R</u> emove		<u> </u>	<u></u> ancel

5. Adjust the dates and times as needed, and then click OK to save your updates.

Note: To remove personnel, select the personnel that you want to delete and click Remove.

Printing Records

Print Setup

You are able to set print parameters to be used in printing your anesthesia records. To prepare your records for printing, as well as printing the actual record, complete the following steps:

1. Select Print Setup from the Task menu to display the Print Setup dialog box, in which you can specify print parameters.

<u>ه</u>					
📮 Sı	IrgiNe	t: Anesthes	sia		
Task	View	Document	Window	Help	
Sel	ect Cas	se		Ctrl+L	
Sel	ect Bla	nk Record			
Sel	ect Rer	mote View Ca	ases	Ctrl+R	acro
Ass	sociate	Devices			Cas
Ch	arge Pr	eview			Pro
Sig	nature:	s			Sur
Fin	alize Ca	ase			Ane
Ма	intain V	/iews			
Ma	intain D	emographics	s View		
Ma	intain R	Remote View	Sequence.		16:
Ma	intain M	Aacros			
Syr	nchroni	ze Records			− D€
Deir	nt Setu	-			
	nt Prev	•		à la companya de la compa	
	nt n	1011		Ctrl+P	
				carri	
	spend (
Ch	ange U	ser			
Exi	t				
Σ			~		

2. To specify the printer to print the record to, select the printer from the Printers list.

🚔 Print Setup	×
Document Type: Anesthesia	
Printers ✓ Microsoft XPS Document Writer	Orientation Portrait Landscape Span Shrink text to fit Span text vertically Page size: Letter, 8 1/2 x 11 in
	Pages across: 2 🗲
	# of copies:
Import Settings	OK Cancel Save As Default

3. To indicate the orientation you want the report printed in, select the Portrait or Landscape option from the Orientation group box.

🚔 Print Setup	×
Document Type: Anesthesia	
Printers ☑ Microsoft XPS Document Writer	Orientation • Portrait • Landscape
	Span Span text to fit Span text vertically
	Page size: Letter, 8 1/2 x 11 in 💌
	Pages across: 2
	# of copies:
Import Settings	OK Cancel Save As Default

4. To indicate the span and text layout of the printed record, select the Shrink Text to Fit or Span Text Vertically option.

🚔 Print Setup	×
Document Type: Anesthesia	
Printers ☑ Microsoft XPS Document Writer	Orientation © Portrait © Landscape
	Span Shrink text to fit Span text vertically
	Page size: Letter, 8 1/2 x 11 in 💌
	Pages across: 2
	# of copies:
Import Settings	OK Cancel Save As Default

Note: Selecting the Shrink Text to Fit option specifies the entire printed anesthesia record to print on the designated page size. Selecting the Span Text Vertically option specifies the printed anesthesia record to print on multiple pages if the text does not fit on a single page.

5. To specify the page size, select the page size from the Page Size list.

Document Type: Anesthesia	
Printers ✓ Microsoft XPS Document Writer	Orientation • Portrait • Landscape Span • Shrink text to fit • Span text vertically
	Page size: Letter, 8 1/2 x 11 in Letter, 8 1/2 x 11 in Letter, 8 1/2 x 11 in. Legal, 8 1/2 x 14 in.
	# of copies:
Import Settings	OK Cancel Save As Default

6. To specify the number of pages to print the record to, enter the number of pages in the Pages Across spin box.

🚔 Print Setup	×
Document Type: Anesthesia	
Printers ✓ Microsoft XPS Document Writer	Orientation Portrait Landscape Span Span Shrink text to fit Span text vertically Page size: Letter, 8 1/2 x 11 in
	Pages across: 2
	# of copies: 1
Import Settings	OK Cancel Save As Default

7. To indicate the number of copies to be created, enter the number of copies in the # of Copies spin box.

🚔 Print Setup	×		
Document Type: Anesthesia			
Printers ✓ Microsoft XPS Document Writer	Orientation Portrait Landscape Span Shrink text to fit Span text vertically		
	Page size: Letter, 8 1/2 x 11 in 💌		
	Pages across: 2		
	# of copies:		
Import Settings	DK Cancel Save As Default		

8. To use a previously-defined view, click Import Settings in the Print Setup dialog box. This allows you to select from a defined print view.

🚔 Print Setup	X
Document Type: Anesthesia	
Printers ✓ Microsoft XPS Document Writer	Orientation © Portrait © Landscape
	Span Shrink text to fit Span text vertically
	Page size: Letter, 8 1/2 x 11 in 💌
	Pages across: 2
	# of copies: 1
Import Settings	OK Cancel Save As Default

9. After you have made the appropriate specifications in the Print Setup dialog box, click OK to close the dialog box and save your settings, click Cancel to close the dialog box without saving your settings, or click Save as Default to make your settings the default next time you want to print an anesthesia record.

🚔 Print Setup	_×
Document Type: Anesthesia	
Printers ✓ Microsoft XPS Document Writer	Orientation • Portrait • Landscape Span • Shrink text to fit • Span text vertically Page size: Letter, 8 1/2 x 11 in Pages across: 2 • # of copies: 1 •
Import Settings	OK Cancel Save As Default

Print Preview

To preview the record prior to printing it, complete the following steps:

1. Select Print Preview from the Task menu to preview the record online before sending it to the printer.

🖨 SurgiNet: Anesthesia	
Task View Document Window Help	
Select Case Ctrl+L Select Blank Record	Tatita a
Select Remote View Cases Ctrl+R Associate Devices	a
Charge Preview	
Signatures	
Finalize Case	H
Maintain Views	
Maintain Demographics View	Γ
Maintain Remote View Sequence	
Maintain Macros	F
Synchronize Records	ŀ
Print Setup	
Print Preview	
Print ^I VS Ctrl+P	┝
Suspend Case	F
Change User	
Exit	F

In the Print Preview window, you can zoom in or out of the window to see information in more detail.

2. Click Print Setup to make modifications to the page format, or click Print to send the record to the printer. Click Close to close the Print Preview window without sending the record to the printer.

Cox Health Systems	Anesthesia Date Printed: 9/14/2011 18:27 Page 1 of 2	TESTING, MEDHOST 5867149 SOUTH-2011-138 Appendectomy Laparoscopic
OR: 01 South OR Surgery Date: 9/14/2011 10:26	DOB: 1/1/1901 Age: 110 years	
Surgeon: Buckner MD, John	Gender: Female	
Anesthesiologist:	Pre-Op Diagnosis:	Height:
Anesthesia Type: 3-General	Reason for Admit: TESTING	Weight:
ASA Class: Name Total ^{9/142011}	NPO: 18:30 18	Allergies: :45 19:00
Legend 195 192 188 184 180 176 172 163 164 164 155		

Printing a Record

To print a record without modifying any settings, complete the following steps:

1. From the Task menu, select Print.

🔹 SurgiNet: A	nesthesia			
Task View Do	cument W	indow	Help	
Select Case Select Blank R Select Remote	ecord View Cases	ş	Ctrl+L Ctrl+R	acros
Associate Dev Charge Previe Signatures Finalize Case				Case #: Procedure: Surg. Date: Anesthesia P
Maintain View: Maintain Demo Maintain Remo Maintain Macri	ographics Vie Dte View Seq			16:15
Synchronize R	ecords			Details
Print Setup Print Preview				
Print		A_	Ctrl+P	
Suspend Case Change User.				
Exit		_		

Note: The system may not print all documented actions if printed actions exceed one page.

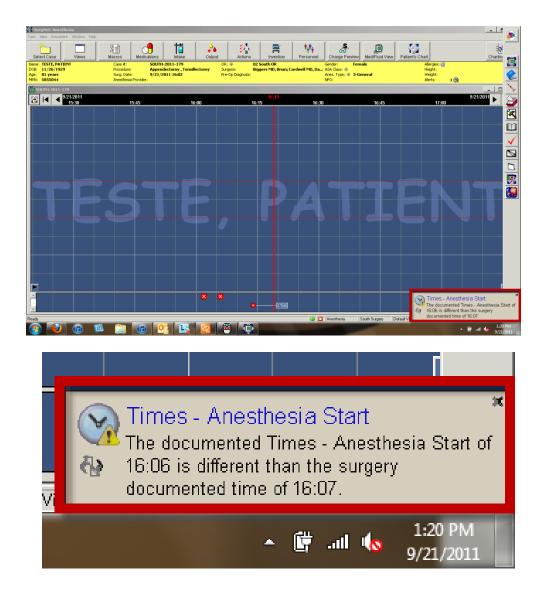
- 2. Modify any print settings as needed, such as specifying the printer to which the record should be sent.
- 3. Click OK to send the record to the printer.
- 4. If the printing data exceeds one page, the system will print the following message: **Refer to** electronic record for complete data in the Actions Label.

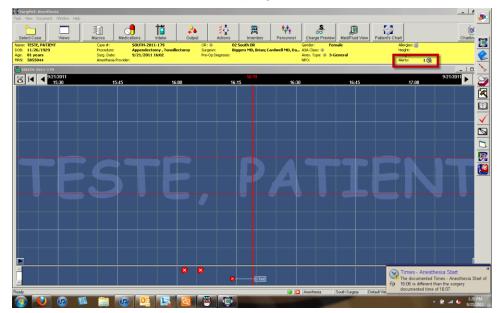
Alerts

Viewing and Managing Alerts

Alerts display only if information regarding the anesthesia record and the anesthesia documentation do not correlate. The discrepancy then fires an alert that is displayed in two locations on the anesthesia record.

1. The first location is displayed in the bottom right of the window.





2. The second alert is located in the top right of the banner bar.



Finalize a Record

Finalizing the Case

When you have finished your documentation, you are able to finalize a case. To finalize a case, complete the following steps:

1. After your documentation is complete, select Finalize Case from the Task menu to open the Finalize window.

😩 SurgiNet: Anesthesia					
Task	View	Document	Window	Help	
	ect Cas ect Blar	Ctrl+L			
Select Remote View Cases Ctrl+R Associate Devices					
Ch	Charge Preview				
Signatures					
Finalize Case					
Ma	intain V	iews	3		
Maintain Demographics View					
Maintain Remote View Sequence					
Maintain Macros					

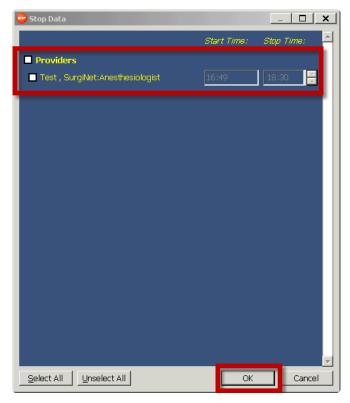
2. If any current tasks or administrations are being conducted on the anesthesia record that finalizing the record will interrupt, the Stop Data dialog box is displayed.



3. To stop the task and proceed, select the check box adjacent to the task, complete any required fields, and click OK.

Stop Data		<u> </u>
	Start Time:	Stop Time: 🔺
🛛 Providers		
Test , SurgiNet:Anesthesiologist	16:49	18:30

4. To proceed without stopping the administration, deselect the check box adjacent to the task and click OK.



- 5. To add values directly from this dialog box, click Edit in the Type row and add the values as appropriate.
- 6. In the Finalize dialog box, review any documentation deficits in the Deficiencies list and duplicate actions that may be restricted to being documented only once, if any exist. The Finalize dialog box indicates required information that has not been entered, but is needed before the case is considered complete, or actions which have been documented more than once when they have been designated as being able to be documented only once.

Finalize				_	
		Deficiencies			
No deficiencies					
Required Documentation					
No Missing Required Documentation					
Personnel					
		No Running Person	nel		
		ToDo List			
		No Items on ToDo I	list		
Ignore All					
		Signatures			
Name	Date				
Sign					
Print record		Einalize	elect Charted <u>V</u> alues	Charge Preview	Close

Note: If there are any fluids that need stop times or actions that have required fields on them, they will be seen in the Deficiencies section. Click Edit to edit the fluid or action. Once the deficiency is accounted for, that item is removed from the Finalize dialog box.

7. If authorized, you are able to ignore the documentation deficits. To ignore a specific deficit, select the check box in the Ignore column. Click Ignore All to ignore all the deficits in the Deficiencies list.

🕨 Finalize				_ □ ×	
		Defici	encies		
No deficiencies					
Required Documentation					
		No Missing Requir	ed Documentation		
		Perso	onnel		
Name	Activity	Start Time			
Test , SurgiNet:Anesthe	Provider	9/14/2011 16:49			
		ToDo) List		
		No Items o	n ToDo List		
Ignore All					
		Signa	tures		
Name	Date	olgha			
Test , SurgiNet:Anesthe					
rest, ourginet.restile	0/14/2011 10:40				
Sign					
Print record		Einaliz	Select Charted Values	Charge Preview <u>C</u> lose	

- 8. In the Finalize dialog box, review all required documentation. Required documentation is predefined in SADBBuild.exe.
- 9. Review the personnel or documented providers that are not assigned to a stop time.
- 10. In the Finalize dialog box, review your to-do list.

11. Click Sign to sign the case record and mark it as complete.

Finalize			_ D X
		Deficiencies	
		No deficiencies	
		Required Documentation	
		No Missing Required Documentation	
		Personnel	
Name	Activity	Start Time	
est , SurgiNet.Anesthe	∋ Provider	9/14/2011 16:49	
		ToDo List No Items on ToDo List	
gnore All			
		Signatures	
Name est , SurgiNet.Anesthe	Date 9/14/2011 15:49		
Sign			

The HNAM Authorizing Signature dialog box is displayed.

12. Enter your Cerner Millennium user name and password in the appropriate boxes, and click OK.



Finalize				_	
		Deficier	cies		
		No deficie	ncies		
		Required Docu	Imentation		
		No Missing Required			
		Person			
Name	Activity	Start Time			
est , SurgiNet Anesthe	Provider	9/14/2011 16:49			
gnore All	_	ToDo I No Items on	ToDo List		
		Signat.	ires		
Name est , SurgiNet Anesthe					
<u>S</u> ign					
Print record		Einalize	Select Charted Values	Charge Preview	Close

13. Select the Print record option to print the record when it is finalized.

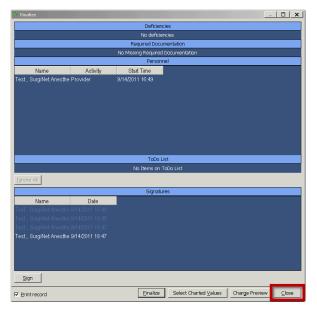
Note: The record will also be put into a read-only phase so that nothing can be modified on the record. If changes do need to be made to the record, select Unfinalize Case from the Task menu. This refreshes the application and record so that they no longer are in a read-only status.

14. Click Finalize to finalize the document. Depending on your system settings, a system message may be displayed requiring you to accept imported values before finalizing. Click OK to open the Maintain Monitor Values dialog box. Click Accept Imported Values to accept the values displayed in the Monitor Values list. Click OK to finalize the case.

 Finalize 		C	×
		Deficiencies	
		No deficiencies	
		Required Documentation	
		No Missing Required Documentation	
		Personnel	
Name	Activity	Start Time	
Test , SurgiNet Anesth	e i Tovidei	9/14/2011 16:49	
Ignore All	-	ToDo List No Items on ToDo List	
		Signatures	
Name	Date		
fest , SurgiNet:Anesth	e 9/14/2011 18:47		
Cian			
Sign			

Note: If the Reopen Record After Finalization option has been set in SADBBuild.exe, the record will reopen after the case is finalized.

15. Click Close to close the Finalize window without finalizing the document.



Run Record Viewer Reports

SurgiNet Anesthesia Record Viewer is a tool used to display records that currently are being documented, have no cases associated, have records that need to be synchronized, and cases that are not finalized. You can view details for the record, filter, and print the information displayed. SurgiNet Anesthesia Record Viewer contains the following system management reports to assist you with tracking this information:

- Billing Summary
- Concurrency
- Discrepancies
- Finalized Cases
- Open Cases
- Unassociated Records
- Unfinalized Cases
- Unsynchronized Records

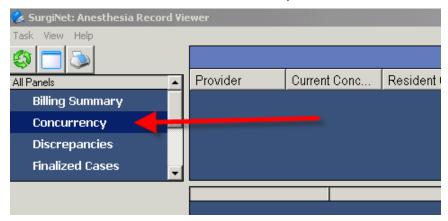
Viewing Concurrency

Viewing Concurrency for Multiple Providers

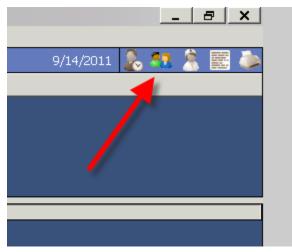
Your *SurgiNet* Anesthesia system allows you to define the ratio limits of providers to cases to comply with federal, state, local and facility-specific regulations and standards of care. These limits are set in *SurgiNet* Anesthesia Database Build Tool. *SurgiNet* Anesthesia Record Viewer allows you to view these concurrency reports.

To view all providers currently supervising cases and how many cases they are supervising, complete the following steps:

1. From the All Panels list, select Concurrency.



2. Click the Current Providers icon. All providers currently supervising cases are displayed in the providers list. The provider's current concurrency and resident concurrency are displayed in the providers list. All providers currently over the concurrency limits have P displayed adjacent to their names.



- 3. Select the provider from the providers list. All cases that provider currently is supervising are displayed in the records list. To view the case details, click the plus sign and double-click the case to view that record's details.
- 4. To end the provider's attendance of a case, right-click the record in the providers list and select Open for Documentation to open *SurgiNet* Anesthesia. You also can open the record in read-only or remote view in *SurgiNet* Anesthesia from the context menu.
- 5. Select the case in the records list to highlight that case's timeline in the timeline box. Arrows displayed in the timeline indicate the case is ongoing. The color of the timeline indicates concurrency alerts.
 - Green indicates the provider is more than one case away from the maximum concurrency limit.
 - Yellow indicates the provider is one case away from the maximum concurrency limit.
 - Red indicates a provider at the maximum concurrency limit.
- 6. Scroll through the timeline as needed.
- 7. To print the report, click the Print Concurrency icon. To print the concurrency summary report, click the Concurrency Report icon.



Viewing Concurrency for One Provider

Your *SurgiNet* Anesthesia system allows you to define the ratio limits of providers to cases to comply with federal, state, local and facility-specific regulations and standards of care. These limits are set in *SurgiNet* Anesthesia Database Build Tool. *SurgiNet* Anesthesia Record Viewer allows you to view these concurrency reports.

To view one provider's concurrency over a specified timeframe, complete the following steps:

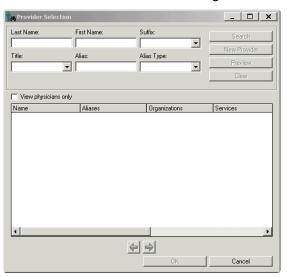
1. From the All Panels list, select Concurrency.

🔽 SurgiNet: Anesthesia Record Vie	ewer		
Task View Help			
(2)			
All Panels	Provider	Current Conc	Resident
Billing Summary			
Concurrency 🔶			
Discrepancies			
Finalized Cases 🚽			

2. Click the Provider with Timeframe icon.



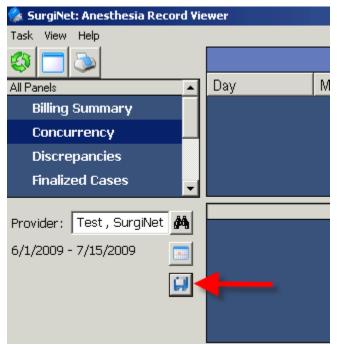
3. Enter the provider name in the Provider box, or search for the provider by clicking to open the Provider Selection dialog box. Enter the name of the provider and click Search. Select the provider and click OK to return to the *SurgiNet* Anesthesia Record Viewer window.



4. Click Select Date to open the calendar and select a date range. Click the beginning date of the range, press SHIFT, and click the end date of the range. Press ENTER.

Task View Help				
4 🗖 🍉				
All Panels	Day	Max	Concurre	Max Resi
Billing Summary				
Concurrency				
Discrepancies				
Finalized Cases				
Provider: Test , SurgiNet 🆓				
	-	_		
August 2011	Se	ptember 20:	11 🖻	
Sun Mon Tue Wed Thu Fri Sat	Sun Mon	Tue Wed Thu	Fri Sat	
		100 1100 1110	THE OUT	
31 1 2 3 4 5 6		1	2 3	
31 1 2 3 4 5 6 7 8 9 10 11 12 13	4 5	1 6 7 8	2 3 9 10	
31 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	11 12	1 6 7 8 13 14 15	2 3 9 10 16 17	16:05
31 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27	11 12 18 19	1 6 7 8 13 14 15 20 21 22	2 3 9 10 16 17 23 24	16:05
31 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	11 12 18 19 25 26	1 6 7 8 13 14 15 20 21 22 27 28 29	2 3 9 10 16 17 23 24 30 1	16:05
31 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 1	11 12 18 19	1 6 7 8 13 14 15 20 21 22	2 3 9 10 16 17 23 24	16:05
31 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27	11 12 18 19 25 26	1 6 7 8 13 14 15 20 21 22 27 28 29	2 3 9 10 16 17 23 24 30 1	16:05
31 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 1	11 12 18 19 25 26	1 6 7 8 13 14 15 20 21 22 27 28 29	2 3 9 10 16 17 23 24 30 1	16:05

5. Click Save to save your modifications and add them to the report. The provider's maximum concurrency and resident concurrency are displayed in the providers list.



6. Select the provider from the providers list. All cases that provider currently is supervising are displayed in the records list. To view the case details, click the plus sign and double-click the case to view that record's details.

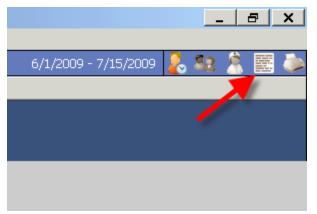


- 7. To end the provider's attendance of a case, right-click the record in the providers list and select Open for Documentation to open *SurgiNet* Anesthesia. You also can open the record in read-only or remote view in *SurgiNet* Anesthesia from the context menu.
- 8. Select the case from the records list to highlight that case's timeline in the timeline box. Arrows displayed in the timeline indicate the case is ongoing. The color of the timeline indicates concurrency alerts.
 - Green indicates the provider is more than one case away from the maximum concurrency limit.
 - Yellow indicates the provider is one case away from the maximum concurrency limit.
 - Red indicates a provider at the maximum concurrency limit.
- 9. Scroll through the timeline as needed.

10. To print the report, click the Print Concurrency icon.



11. To print the concurrency summary report, click the Concurrency Report icon.



Viewing Concurrency on a Specified Date

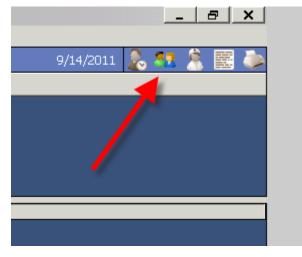
Your *SurgiNet* Anesthesia system allows you to define the ratio limits of providers to cases to comply with federal, state, local and facility-specific regulations and standards of care. These limits are set in *SurgiNet* Anesthesia Database Build Tool. SurgiNet Anesthesia Record Viewer allows you to view these concurrency reports.

To view a report of the providers that supervised cases and their maximum concurrency on a specified day, complete the following steps:

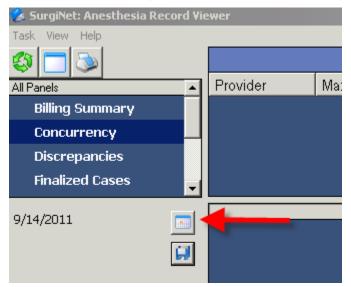
1. From the All Panels list, select Concurrency.

🐇 SurgiNet: Anesthesia Record Vie	ewer		
Task View Help			
🥴 🗖 🍉			
All Panels	Provider	Current Conc	Resident
Billing Summary			
Concurrency 🔶			
Discrepancies			
Finalized Cases 🚽			

2. Click the All Providers icon.



3. Click Select Date to open the calendar and select a date. Press ENTER. Click Save.



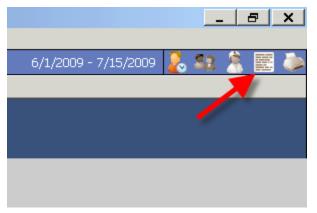
All providers that were supervising cases on the selected date are displayed in the providers list. The provider's maximum concurrency and maximum resident concurrency are displayed in the providers list.

- 4. Select the provider from the providers list. All cases that provider currently is supervising are displayed in the records list. To view the case details, click the plus sign and double-click the case to view that record's details.
- 5. To end the provider's attendance of a case, right-click the record in the providers list and select Open for Documentation to open *SurgiNet* Anesthesia. You also can open the record in read-only or remote view in *SurgiNet* Anesthesia from the context menu.
- 6. Select the case from the records list to highlight that case's timeline in the timeline box. Arrows displayed in the timeline indicate the case is ongoing. The color of the timeline indicates concurrency alerts.
 - Green indicates the provider is more than one case away from the maximum concurrency limit.
 - Yellow indicates the provider is one case away from the maximum concurrency limit.
 - Red indicates a provider at the maximum concurrency limit.
- 7. Scroll through the timeline as needed.

8. To print the report, click the Print Concurrency icon.



9. To print the concurrency summary report, click the Concurrency Report icon.



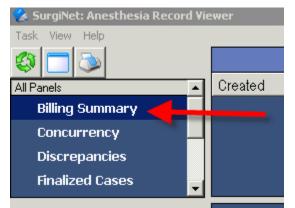
Viewing Billing Summaries

Your *SurgiNet* Anesthesia system allows you to view and print a Billing Summary report for a selected case. This report pulls information from various sources in *Cerner Millennium* and provides you the ability to collect billing information required to complete the CMS-500 form. Parameters for action items viewable in the Billing Summary report are set in *SurgiNet* Anesthesia Database Build Tool. You can view a billing summary report from the Billing Summary Panel and the Finalized Cases Panel in *SurgiNet* Record Viewer. Task access is required for billing summaries. See Record Viewer Panel Task Access for a list of panels and associated tasks.

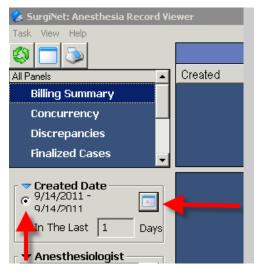
Billing Summary Panel

To view the billing summary for a case, complete the following steps:

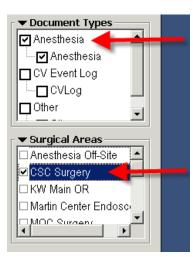
1. From the All Panels list, select Billing Summary.



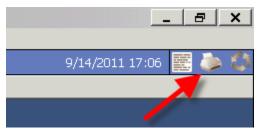
2. Select the case creation date or date range to filter the list for cases created on that date or within the specified date range.



3. Select the anesthesiologist, document type, and surgical area to filter anesthesia records in the Billing Summary records list.



- 4. Select the record from the Billing Summary records list you want view. The Anesthesia Billing Summary reports displays below the Billing Summary record list.
- 5. To view the billing summary for the selected case, click the Billing/Summary Record icon II. Click the Billing Summary Report icon in the lower right corner.
- 6. To print the billing summary for a single record, click the printer icon.



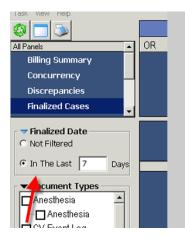
Finalized Cases Panel

You also can view a Billing Summary report and the anesthesia record from the Finalized Cases panel in *SurgiNet* Anesthesia Record Viewer.

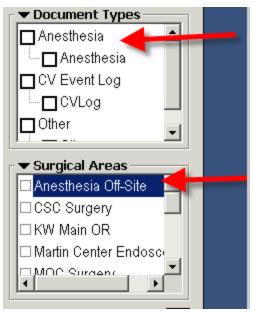
1. From the All Panels list, select Finalized Cases.



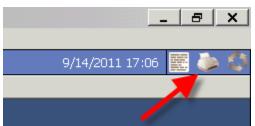
2. Select the case finalized date or date range to filter the list for cases finalized on that date or within the number of days range.



3. Select the document type and surgical area to filter anesthesia records in the Finalized Cases records list.



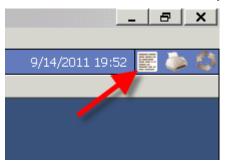
- 4. Select the record from the Finalized Cases record list you want view.
- 5. To view the billing summary for the selected case, click the Billing/Summary Record icon 1. Click the Billing Summary Report sign icon in the lower right corner.
- 6. To view the anesthesia record for the selected case, click the anesthesia record icon.
- 7. To print the billing summary or anesthesia record, click the printer icon.



Batch Printing

You can batch print billing summaries and anesthesia records. To batch print anesthesia records and billing summary reports, complete the following steps:

1. Click the Batch Print Summary and Records icon.



The Batch Print dialog box opens.

🔄 Batch Print 📉 🗙
🗹 Billing Summaries
🔽 Anesthesia <u>R</u> ecords
Filters
Created <u>D</u> ate:
6/16/2011 - 9/14/2011
 Anesthesiologist:
<u>A</u>
Document <u>Types:</u>
Anesthesia, CVLog, Other
<u>S</u> urgical Areas:
CSC Surgery, KW Main OR, Martin Center Endosc 🙀
☑ Include Discrepant Records
Print <u>C</u> ancel

2. Select the appropriate check box to designate whether you want to print billing summaries, anesthesia records or both.

😫 Batch Print	×
🗹 Billing Summaries	
🔽 Anesthesia <u>R</u> ecords	
Filters	
Created <u>D</u> ate:	
6/16/2011 - 9/14/2011	
Anesthesiologist:	
	# \$
Document <u>Types:</u>	
Anesthesia, CVLog, Other	8
<u>S</u> urgical Areas:	_
CSC Surgery, KW Main OR, Martin Center Endosc.	🗱
🔽 Include Discrepant Records	
<u>Print</u>	cel

3. Filter the batch of records you want to print by date, anesthesiologist, document types, surgical areas, or whether to include discrepant records.

🛱 Batch Print	x
🗹 Billing Summaries	
🔽 Anesthesia Records	
Filters	Т
Created <u>D</u> ate:	
6/16/2011 - 9/14/2011	
<u>A</u> nesthesiologist:	1
<u>d*</u>	
Document <u>Types:</u>	
Anesthesia, CVLog, Other	1
<u>S</u> urgical Areas:	
CSC Surgery, KW Main OR, Martin Center Endosc 🥻	
🔽 Include Discrepant Records	
<u>Brint</u> <u>Cancel</u>	

4. Click Print.

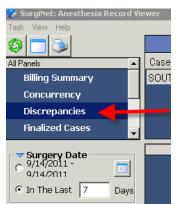


Viewing Discrepancies

You can view discrepant information between the anesthesia record and the surgery record for a patient in *SurgiNet* Anesthesia Record Viewer. The report is displayed in spreadsheet format with an indicator displayed for discrepant information. It is imperative these discrepancies are resolved or validated for continuity of care between anesthesia and surgery.

You can resolve the documentation discrepancies by opening *SurgiNet* Anesthesia directly from the report. While working with discrepancies, you also can filter the anesthesia records by document type, surgical area, or both.

To work with discrepancies between the anesthesia record and the surgery record, complete the following steps:



1. From the All Panels list, select Discrepancies.

2. Click Select Date to open the calendar and select a date range. Click the beginning date of the range, press SHIFT, and click the end date of the range. Press ENTER.

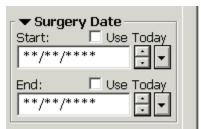


3. Click Save to save your modifications and add them to the report. You also can enter a value in the Number of Days box, select that option, and click Save to add the discrepancies to the report.

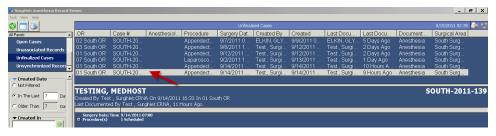


All anesthesia records that have a discrepancy with the surgery record are displayed in the Discrepancies list. The case number, operating room, procedure, surgeon, surgery date and time, name, and medical record number (MRN) are displayed in the Discrepancies list.

▼ Created In				
	🐂 Provider Selection			_ 🗆 🗙
<u> </u>	Last Name:	First Name:	Suffix:	Search
▼ Created By			•	New Provider
	 Title:	Alias:	Alias Type:	Preview
	-	I		Clear
				UIBAI
▼ Document Types	🔲 View physicians only			
Anesthesia	Name	Aliases	Organizations	Services
Anesthesia				
CV Event Log				
I □Other I				
Ģ				
	•			F
		1		Cancel
			UK.	Lancel

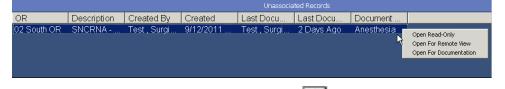


4. Select the record from the Discrepancies list. The discrepancies are displayed in spreadsheet format in the results list.



To expand the lists, click the plus sign to view the details in that list. The results list contains the result type, DI, anesthesia value, and surgery value. Any discrepant information is highlighted in red and indicated by an exclamation point (!). The Case Times list contains times that are on both the anesthesia record and the surgery record. The Single Case Times list contains times that are only on either the anesthesia record or surgery record.

5. To resolve the discrepant information in the record, right-click the record in the Discrepancies list and select Open for Documentation to open *SurgiNet* Anesthesia. You also can open the record in read-only or remote view in *SurgiNet* Anesthesia from the context menu.



6. To view a preview of the printed report, click 🖾. The discrepancies are shaded. The report is divided by surgical case. To print the report, click Print in the Discrepancy Report dialog box.



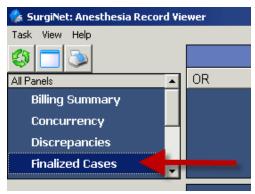
7. To refresh the discrepancy report with the most recent information, click Refresh All on the toolbar.

Viewing Finalized Cases

You can view all finalized cases in *SurgiNet* Anesthesia Record Viewer over a specified date range or in a comprehensive list. You also can filter finalized cases by document type, surgical area, or both.

To monitor finalized cases, complete the following steps:

1. From the All Panels list, select Finalized Cases.



2. To view all finalized cases in the system, select the Not Filtered option



3. Click Save to add the cases to the report.

 ✓ Discrepancies ✓ Include Discrepant Records 	

4. To view finalized cases over a date range, enter a value in the number of days box, select that option, and click Save to add the cases to the report.



All finalized cases are displayed in the Finalized Cases list. The OR, case number,

anesthesiologist, procedure, surgery date/time, who created the case, created date, who signed the case, and when it was finalized all are displayed in the Finalized Cases list.

Task View Help											
Ø 🗖 🕲											9/15/2011 02:39 🧼 🕻
All Panels	OR	Case #	Anesthesiol	Procedure	Surgery Dat	Created By	Created	Last Docu	Last Docu	Document	Surgical Area
	02 South OR			Appendect					5 Days Ago		South Surg
	03 South OR	SOUTH-20		Appendect		Test, Surgi		Test, Surgi	2 Days Ago	Anesthesia	South Surg
	01 South OR	SOUTH-20		Appendect	9/12/2011	Test, Surgi		Test, Surgi	2 Days Ago	Anesthesia	South Surg
Unfinalized Cases	07 South OR	SOUTH-20		Laparosco		Test, Surgi	9/13/2011	Test, Surgi	1 Day Ago	Anesthesia	South Surg
Unsynchronized Record	01 South OR			Appendect	9/14/2011	Test, Surgi	9/14/2011	Test, Surgi		Anesthesia	South Surg
	01 South OR	SOUTH-20	-	Appendect	9/14/2011	Test, Surgi	9/14/2011	Test , Surgi	9 Hours Ago	Anesthesia	South Surg
🗢 Created Date											
C Not Filtered			_								
	TESTING,	MEDHOST	ľ							S	OUTH-2011-13
In The Last 7 Dar	Created By Tes	t , SurgiNet:CRN	IA On 9/14/2011	16:33 In 01 Sou	uth OR						
C Older Than 7 Dar	Last Documente		gNet:CRNA, 11	Hours Ago							
▼ Created In	Surgery Date/	Time 9/14/2011 0 1 Scheduled	7:00								
	- rrocedure(s)										

5. Select the case from the Finalized Cases list. The case details are displayed in spreadsheet format. To expand the lists, click the plus sign (+) to view the details in that list.



6. To view more information on the finalized case, right-click the case in the Finalized Cases list and select Open for Documentation to open *SurgiNet* Anesthesia. You also can open the record in read-only or remote view in *SurgiNet* Anesthesia from the context menu.



7. To print the report, click the Print Finalized Cases icon.

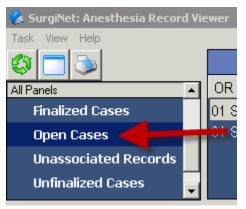
<u>.</u>		
1	M	
100	~	
- 14		

Viewing Open Cases

You can view all open cases in *SurgiNet* Anesthesia Record Viewer using various filtering methods or in a comprehensive list. You also can filter the list of open cases by document type, surgical area, or both.

To view open cases, complete the following steps:

1. From the All Panels list, select Open Cases.



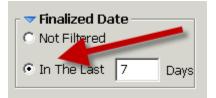
2. To view all open cases in the system, select the Not Filtered option.



3. Click Save to add the cases to the report.



4. To view open cases over a date range, enter a value In the Number of Last Days box.



5. Click Save to add the cases to the report.



6. To view open cases created in a specific OR, click 💼 to open the Select Operating Room dialog box. Select the OR and click OK to add the cases to the Created In list. Click Save to add the cases to the report.



To view cases opened by specific providers, enter the provider name in the Provider box, or search for the provider by clicking to open the Provider Selection dialog box.



Enter the name of the provider and click Search.

▼ Created In	👬 Provider Selea	ction		
	Last Name:	First Name:	Suffix:	Search
Created By	Title:	Alias:	_	New Provider
			Alias Type:	Preview
				Clear
✓ Document Types	View physician	s only		
Anesthesia	Name	Aliases	Organizations	Services
Anesthesia				
□ Other				
☐ Other				
	•			F
			OK	Cancel

8. Select the provider and click OK to return to the *SurgiNet* Anesthesia Record Viewer window. Click to add the provider to the Opened By list. Click Save to add the cases to the report.



9. Select the case from the Open Cases list. The case details are displayed in spreadsheet format. To expand the lists, click the plus sign to view the details in that list.

🍐 SurgiNet: Anesthesia Record Vi	ewer										_ 8 ×
Task View Help											
Ø 🗖 🍛											9/15/2011 02:39 🧼 🕻
Il Panels	OR	Case #	Anesthesiol	Procedure	Surgery Dat	Created By	Created	Last Docu	Last Docu	Document	Surgical Area
Open Cases	02 South OR	SOUTH-20		Appendect		ELKIN, GLY		ELKIN, GLY	5 Days Ago	Anesthesia	South Surg
Unassociated Records	03 South OR	SOUTH-20		Appendect	9/8/2011 1	Test, Surgi		Test , Surgi	2 Days Ago	Anesthesia	South Surg
Unfinalized Cases	01 South OR	SOUTH-20		Appendect	9/12/2011	Test, Surgi	9/12/2011		2 Days Ago	Anesthesia	South Surg
	07 South OR	SOUTH-20		Laparosco		Test, Surgi	9/13/2011	Test , Surgi	1 Day Ago	Anesthesia	South Surg
Unsynchronized Record		SOUTH-20		Appendect	9/14/2011	Test, Surgi	9/14/2011	Test, Surgi	10 Hours A	Anesthesia	South Surg
	01 South OR	SOUTH-20		Appendect	9/14/2011	Test, Surgi	9/14/2011	Test, Surgi	9 Hours Ago	Anesthesia	South Surg
🗢 Created Date 🔶											
C Not Filtered											
	TESTING,										SOUTH-2011-13
	Created By Tes				uth OR						
C Older Than 7 Dar	Last Documente	earby rest , Sur	ginet:ckina, 11	mours Ago							
▼ Created In	Surgery Date	Time 9/14/2011 0 1 Scheduled	7:00								
- Created III	Procedure(s)	1 Scheduled									

10. To view more information on the open case, right-click the case in the Open Cases list and select Open for Documentation to open *SurgiNet* Anesthesia. You also can open the record in read-only or remote view in *SurgiNet* Anesthesia from the context menu.



11. To print the report, click Print Open Cases on the toolbar.



Viewing Unassociated Cases

You can view all blank records that have not been associated to a surgical case in *SurgiNet* Anesthesia Record Viewer using various filtering methods or in a comprehensive list. Unassociated records can be filtered by Document Type.

To view open cases, complete the following steps:

1. From the All Panels list, select Unassociated Records.



2. To view all unassociated records in the system, select the Not Filtered option.



3. Click Save to add the records to the report.



4. To view unassociated records created in a specific OR, click to open the Select Operating Room dialog box.

Created In	
	Select Operating Room
	Existing Recent Image: Anesthesia Off-Site Image: Anesthesis Image:

5. Select the OR and click OK. Click Save to add the records to the Created In list. Click Save to add the cases to the report.



6. To view unassociated records over a date range, enter a value in the number of last days box, or in the number of older days box, select that option, and click Save to add the cases to the report.



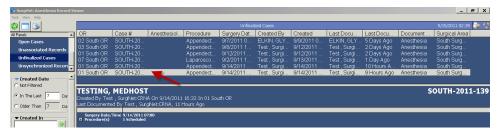
 To view records opened by specific providers, enter the provider name in the Provider box, or search for the provider by clicking to open the Provider Selection dialog box.

Created In		👬 Provider Selec	tion		_ D ×
<u>**</u>		Last Name:	First Name:	Suffix:	Search
▼ Created By					New Provider
	• • • · · ·	Title:	Alias:	Alias Type:	Preview
		1			Clear
▼ Document Types		View physician	s only		
Anesthesia		Name	Aliases	Organizations	Services
Anesthesia CV Event Log CV Event Log Other Other					
				6 9 OK	Cancel

- 8. Enter the name of the provider and click Search.
- 9. Select the provider and click OK to return to the SurgiNet Anesthesia Record Viewer window.
- 10. Click 🔜 to add the provider to the Created By list.
- 11. Click Save to add the records to the report.



12. Select the record from the Unassociated Records list and the record details are displayed in spreadsheet format.



13. To expand the lists, click the plus (+) to view the details in that list.

TESTING, ME	EDHOST
Created By Test , Si	urgiNet:CRNA On 9/14/2011 16:33 In 01 South OR / Test , SurgiNet:CRNA, 11 Hours Ago
Surgery Date/Time	9/14/2011 07:00
Procedure(s)	1 Scheduled

14. To view more information on the record, right-click the record in the Unassociated Records list and select Open for Documentation to open *SurgiNet* Anesthesia. You also can open the record in read-only or remote view in *SurgiNet* Anesthesia from the context menu.



15. To print the report, click Print Unassociated Records on the toolbar.

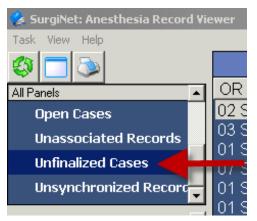
	-	2		
1				ч
l lb	-		~	r١
	~	-		

Viewing Unfinalized Cases

You can view all unfinalized cases in *SurgiNet* Anesthesia Record Viewer using various filtering methods or in a comprehensive list. You also can filter unfinalized cases by document type, surgical area, or both.

To monitor unfinalized cases, complete the following steps:

1. From the All Panels list, select Unfinalized Cases.



2. To view unfinalized cases created in a specific OR, click to open the Select Operating Room dialog box.

Created In	
	Select Operating Room
<u>#</u>	Room Selection
Created By	Existing Recent ⊡-ば Anesthesia Off-Site
Document Types Anesthesia Anesthesia CV Event Log CVLog Other Other Other	 □ □
	Start Location:

- 3. Select the OR and click OK.
- 4. Click Save to add the cases to the Created In list.
- 5. Click Save to add the cases to the report.



6. To view all unfinalized cases in the system, select the Not Filtered option and click Save to add the cases to the report.



7. To view unfinalized cases over a date range, enter a value in the number of last days box, or in the number of older days box, select that option, and click Save to add the cases to the report.



You also can select a start and end date in the Surgery Date/Time Between group box or select the Use Today option to use the current date as the start or end date.

▼ Surgery Date	
Start: 🗌 Use Today	
//***	
End: 🗌 Use Today	
//***	

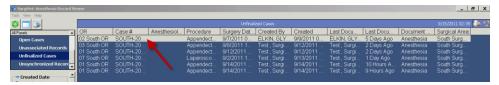
8. To view cases opened by specific providers, enter the provider name in the Provider box, or search for the provider by clicking to open the Provider Selection dialog box.

▼ Created In		👬 Provider Selection			_ _ X
✓ Created By		Last Name:	First Name:	Suffix:	Search New Provider
▲	1111 - C	Title:	Alias:	Alias Type:	Preview Clear
		View physicians only Name	Aliases	Organizations	Services
CV Event Log CV Event Log CV Event Log Other			1,18000		
		<u>.</u>	[ok	Cancel

Enter the name of the provider and click Search. Select the provider and click OK to return to the SurgiNet Anesthesia Record Viewer window. Click 🛃 to add the provider to the Created By list. Click Save to add the cases to the report.



9. Select the case from the Unfinalized Cases list and the case details are displayed in spreadsheet format. To expand the lists, click the plus sign (+) to view the details in that list.



10. To view more information on the record, right-click the record in the Unfinalized Cases list and select Open for Documentation to open *SurgiNet* Anesthesia. You also can open the record in read-only or remote view in *SurgiNet* Anesthesia from the context menu.

	Unassociated Records									
OR	Description	Created By	Created	Last Docu	Last Docu	Document				
02 South OR	SNCRNA	Test , Surgi	9/12/2011	Test , Surgi	2 Days Ago	Anesthesia	Open Read-Only Open For Remote View Open For Documentation			

11. To print the report, click the Print Unfinalized Cases icon.

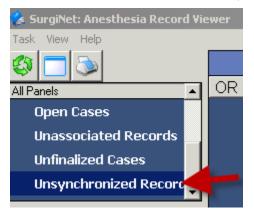


Viewing Unsynchronized Records

You can view all unsynchronized records that were documented in disconnected mode and have not been synchronized in *SurgiNet* Anesthesia Record Viewer.

To view unsynchronized cases, complete the following steps:

1. From the All Panels list, select Unsynchronized Records to add the cases to the report.



 To view more information on the record and synchronize the record with the respective room, rightclick the record in the Unsynchronized Records list and select Open for Documentation to open *SurgiNet* Anesthesia. You also can open the record in read-only or remote view in *SurgiNet* Anesthesia from the context menu.



3. To print the report, click the Print Unsynchronized Records icon.



Appendix A

Reference Pages Overview

You can access SurgiNet Reference Pages from the uCern Wiki

(<u>https://wiki.ucern.com/pages/releaseview.action?pageId=712649</u>). A typical Reference Page home page for a solution includes the following sections:

- **Overview.** Contains a brief introduction to the solution, list of benefits, and description of user and build applications.
- **Configure.** Provides the solution's build tasks, prerequisites, build tools, and considerations. To view detailed build steps, use the build application's Help.
- **Design.** Contains information about the design decisions made when implementing the solution. This information often is used along with the MethodM Design Decision Matrix.
- **Maintain.** Contains information about post-conversion database changes and considerations and also discusses post-conversion monitoring.
- **Troubleshoot.** Contains information for troubleshooting Cerner systems, including the troubleshooting process, tips and tricks, and diagnostic tools. This guide does not contain solution-specific scenarios. If you encounter a solution-specific issue, see the Knowledge Base Search.
- All About. Contains information on all aspects of a topic (such as design, configuration, and troubleshooting).