NURSING SERVICES GUIDELINE
OPERATING ROOM

Guideline: **Documentation of patient care in the OR**

Policy Number Superseded: N/A

Effective Date: 5/2026

Responsibility: All employees and students in the OR

Initial Effective Date: July 2002

Purpose of Guidelines: Consistent documentation and communication of patient care in the OR shall be provided through the completion of the electronic medical record (EMR) or the paper forms operative record and peri-operative nurse's notes during computer downtime.

Procedure:

Documentation.

(A) The OR record is used to document care delivered to patients in the operative suite or when a procedure is done at another location (bedside, ICU, CT/MRI, etc.), whenever OR personnel provide care. Accurate, legible, correctly spelled documentation is imperative.

(B) Each paper form in the OR record will have a patient identification sticker in the upper right corner.

(1) Area #1 Events tab.

(a) Accurately record all times in spaces provided that are applicable to that patient or procedure.
(b) Times must be recorded to within one minute; do not round up or round down.
(c) The EMR will date and time stamp fields as they are filled in. Fields should be documented in real time.

(d) Peri-operative nurse is responsible for charting "procedural charting complete" time in EPIC if patient goes anywhere but recovery (i.e., SICU, MICU, etc.).
(e) Peri-operative nurse is responsible for "discharging" patient in EPIC EMR if patient expires in the operating room.
(f) Document delay and reason for first case starts.

(2) Area #2 Pre-incision Section

(a) Staff.
(i) Accurately record in and out of the room times for all staff and visitors present in the operating room.
(ii) Accurately record the name and title of each surgeon and medical resident.
(iii) Include any/all assistants who are present during the procedure. Document assistants according to their certification, i.e., RNFA (registered nurse first assistant), CSA (certified surgical assistant), SA-C (surgical assistant-certified), CSFA (certified surgical first assistant), PA (physician assistant). Designate medical students as C.C. I, II or III.
(iv) Accurately record the name and title of all anesthesia personnel, including residents, students, anesthesia assistants, CRNAs (certified registered nurse anesthetist), and CAAs (certified anesthesiology assistant).
(v) Record the name of the surgeon and/or the surgical resident if they administer the anesthetic agent for local procedures.
(vi) Accurately record the name and title (i.e., RN (registered nurse), ST (surgical technologist), CST (certified surgical technologist), of all personnel providing care.
(vii) Record the name and title of all relief personnel; include accurate relief times.
(viii) Record the name and title of all students, observers or visitors present in the OR and their role during the procedure. Record the name and title of vendors and diagnostic technologists present during the procedure.

(b) Belongings collected. Accurately document any belongings with patient in the procedure area.

(c) Counts. Accurately document counts as applicable including items counted (i.e., sponge, needle/sharps, and instruments), counted by,

verified by, and outcome of the count (i.e., "count correct?"). If adjunct technology is used, per policy nurse will chart RFID.

(d) Pre-op skin. Accurately document assessment of patient skin prior to procedure.

(e) Site prep. Accurately document use of skin prep, if applicable.

(f) Positioning. Accurately document position of patient, devices used and staff assisting with positioning.

(g) LDA avatar.
  (i) Accurately document and assess LDA's (wound, incision, catheter, drains, etc.).
  (ii) When assessing the LDA on the LDA avatar, the field "time taken" automatically fills in when the page is opened with the current time. This time will be considered the time the wound, incision tube, drain, catheter, etc. was charted.

(h) Timeout. Accurately document "pre-procedure check-in," "time out," "fire safety," and "sign-out," as appropriate.

(3) Area #3 Procedure section.

In procedure tab, accurately record CDC (Center for Disease Control) wound classification. If a surgeon disputes classification, note the disparity on the record. "Dr. X states CDC class should be X."

The circulator will confirm with the primary surgeon the postoperative diagnosis during "sign-out" and document the procedure performed in the designated space.

(a) Intra-op medications.
  (i) Record the anesthetic agent, amount, concentration, and method of administration for local anesthesia under the "intra-op meds" or the paper form "operative room nurse's notes" during computer downtime.
  (ii) On the intra-op medications "time administered" automatically fills in when the page is opened with the current time. This time will be considered the time the medication was charted.

(b) My med review. Click “sign” to confirm the accuracy of the medication list or click “needs update” to request administrative follow-up on inaccuracies. Either action removes the message from your in-basket.

(c) Supplies. The peri-operative RN will accurately update the supply section with supplies opened for the procedure as appropriate.

(d) Equipment. Accurately chart equipment used and settings for the procedure with biomed numbers as applicable.

(e) Specimens.
  (i) Document all clinical specimens including frozen sections, routine histology (indicate “fresh” if no preservatives are used), cultures, microbiology, etc.
  (ii) Assure the pathology request, specimen container, and documentation on the OR record match. Indicate if no specimen is sent on the paper pathology form if it is used during computer downtime by writing “no specimen” on the form.

(f) Implants. Record all items surgically implanted into the patient. Include the site, laterality, manufacturer, lot #, catalog #, model #, serial #, type and size as appropriate. Pre-printed adhesive labels supplied with the product may be used, but the information must be on all 3 copies of the paper operating room record if the paper form is used during computer downtime. Any applicable preparation of said implant must also be documented; including but not limited to lot #, expiration # and type of fluids used in preparation per manufacturer’s instructions for use.

(4) Area #4 Closing section.

(a) The peri-operative nurse will document the assessment of the post-op skin condition.

(b) The peri-operative nurse will appropriately document the care plan.

(c) After completing the chart and addressing all issues, the peri-operative nurse will verify the chart after completion of documentation.

The paper OR record and nurses' notes will be completed, all lines will be filled in, if using paper forms during computer downtime. Follow Computer downtime guideline for guidance on documentation in EPIC once downtime has been resolved. Any field left blank is considered not applicable for that patient/procedure. On the intra-op medications "time administered" automatically fills in when the page is opened with the current time. This time will be considered the time the medication was charted.

Approved by:
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