Title: DOCUMENTATION OF PATIENT CARE IN THE OR

Responsibility: All employees and students in the OR

Purpose of Guidelines: Consistent documentation and communication of patient care in the OR shall be provided through the completion of the electronic medical record in Allscripts Surgical Manager (ASM) or the paper forms Operative Record and Perioperative Nurses Notes during computer downtime.

Procedure Documentation

1. 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.
2. Each form in the OR record will have a patient identification sticker in the upper right corner.

AREA #1
3. Record all times in military time (i.e. 7:30 A.M. = 0730; 2:50 P.M. = 1450) Accurately record all times in spaces provided that are applicable to that patient or procedure.
   a) Times must be recorded to within one minute; do not round up or round down.
   b) The electronic charting system, Allscripts Surgical Manager (ASM), will date and time stamp fields as they are filled in. Fields should be documented in real time.

AREA #2
5. Accurately record the name and title of each surgeon and medical resident.
6. 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 (Physical Assistant).
7. Designate medical students as C.C. I, II or III.

AREA #3 Anesthesiologists and Anesthesia
8. 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).
9. Record the name of the surgeon and/or the surgical resident if they administer the anesthetic agent for local procedures.
   c) Record the anesthetic agent, amount, concentration, and method of administration for local anesthesia under the medications leaf page of ASM or the paper form Operative Room Nurses Notes during computer downtime.

AREA #4 CDC Classification and ASA Classification
10. 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.”

11. Record the ASA (American Society of Anesthesiologists) class as determined by the Anesthesiologist present on paper forms during computer downtime, if needed.

**AREA #5  Circulator and Scrub Roles**
12. Accurately record the name and title (i.e. RN (Registered Nurse), ST (Surgical Technologist), CST (Certified Surgical Technologist) of all personnel providing care.
13. Record the name and title of all relief personnel; include accurate relief times.
14. 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.

**AREA #6  Pre and Post-Op Diagnosis - Procedure**
15. Record the preoperative diagnosis in the appropriate location before the start of the procedure as determined by the primary surgeon. If incorrect, verify the correct pre-op diagnosis with the primary surgeon and chart the correct diagnosis.
16. The circulator will confirm with the primary surgeon the postoperative diagnosis and document the procedure performed in the designated space.

**AREA #7  Specimens**
17. Specimens are numbered consecutively regardless if it is a culture or specimen.
18. Record all specimens sent to pathology including:
   - frozen sections
   - routine histology
   - indicate “fresh” if no preservatives are used
19. Assure the pathology request, specimen container, and documentation on the OR record match.
20. 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.

**AREA #8  Cultures**
21. Record all cultures sent to the laboratory.
22. Number all cultures consecutively on the culture, the lab slip, and the OR Record.
23. Record source of specimen
   - i.e. wound swab anaerobic, tissue (and source) for C & S

**AREA #9  Other Specimens**
24. Record any specimens other than histology and cultures, i.e. cytology, cell count.
   It is not necessary to record lab work sent if results are to be called back to OR during the procedure i.e. stat blood gasses.

**AREA #10  Immediate Use Steam Sterilization**
25. If immediate use steam sterilization is performed in the OR, document which autoclave is used. (4/5, 5/6, 11/12 or ASC)
26. **AREA #11 High Level Disinfection**
   Document the Steris unit when used. Steris (1, 2, 3)

**AREA #12  Implants**
27. Record all items surgically implanted into the patient. Include the 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.

26. The paper OR record and nurses notes will be completed, all lines will be filled in, if using paper forms during computer downtime. Place the white copy with the patient chart. Return the yellow and pink copies to the OR desk to be distributed to the surgeon and to Medical Records.

2.
3. The ASM electronic medical record has a phase button which allows the user to see what has been documented in each phase: PAT, PRE-OP, INTRA-OP, and POST-OP. If any of the following fields have documentation done by PAT or PRE-OP, it will not be required for the circulating nurse in the OR to document these items again:
   a) Communicable Diseases/Isolation Precautions
   b) Allergies
   c) Patient Limitation
   d) Patient Belongings
4. Any field left blank is considered not applicable for that patient/procedure.
5. Surgical Team refers to all medical and nursing staff involved in direct patient care during the procedure.
6. When multiple positional devices are applied to one anatomical site during a surgical procedure, it is appropriate to choose one or more positional devices and only one anatomical site. When the positional devices chosen are applied to one anatomical site, each of the positional devices will be considered applied to the initial site chosen.
7. When multiple dressings are applied to one surgical area following a surgical procedure, it is appropriate to choose one or more dressings and only one surgical site. When all of the dressings chosen are applied to one surgical site, each of the dressings will be considered dressings applied to the initial site chosen.
8. For electrosurgical unit (bovie), ‘site’ refers to the dispersive pad site (bovie site), ‘administered by’ refers to the person placing the dispersive (bovie) pad.
9. For tourniquet, ‘site’ refers to the location where the tourniquet cuff was placed, ‘administered by’ refers to the person placing the tourniquet cuff.
10. On the medications leaf page, the field ‘Time Given’ automatically fills in when the page is opened with the current time. This time will be considered the time the medication was charted.
11. On the medications leaf page, the circulator must scan their badge in order to save the medication in the ASM electronic chart. This does not mean that the circulator gave the medication; it means that a licensed person gave the medication to the sterile field.
12. On the tubes, drains, catheters leaf page, the field ‘Time Inserted’ automatically fills in when the page is opened with the current time. This time will be considered the time the tube, drain, or catheter was charted.