PERIOPERATIVE NURSES SURGINET AND INTRAOPERATIVE DOCUMENTATION - CHW

POLICY©

DOCUMENT SUMMARY/KEY POINTS

- SurgiNet and intraoperative documentation is completed for each procedure performed in the Operating Suite and other periprocedure environments within the hospital
- Intraoperative documentation includes SurgiNet, the count sheet and the instrument tacking form
- Downtime intraoperative documentation includes the Clinical Procedure Checklist and Part A and Part B downtime form; and may also include the laser safety form and the green implanted prosthesis form
- Two nurses one of which is a Registered Nurse performs the count
- A Registered Nurse as circulating nurse supervises an instrument Endorsed Enrolled Nurse or Dental Nurse
- All segments of SurgiNet must be completed or discontinued, and then finalised at the end of the case
- All staff present in the Operating Room/Anaesthetic Bay or periprocedural environment must be recorded in SurgiNet
- All instrument/circulating nurses present during the procedure must print and sign their name on the count sheet
- The surgeon or proceduralist performing the procedure must print and sign their name on the count sheet to accept that all items used during the procedure have been accounted for
- Clinical Nurse Consultants, Advanced Practice Nurses, Nurse Practitioners performing

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	Operating Suite Management
Date Effective:	1st November 2019	Review Period: 3 years
Team Leader:	Nurse Educator	Area/Dept: CHW Operating Suite

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the procedure are recorded as the Principle Proceduralist in SurgiNet.

- It may not be practical to perform a count during an Emergency Procedure. An X-ray of the patient is performed as soon as practicable
- During an emergency situation when a patient does not have an encounter, intraoperative documentation shall be documented on paper and entered into SurgiNet retrospectively at a later time
- Discrepancies in the count are reported to the surgeon, Nurse Unit Manager (NUM), or floor supervisor, recorded on the count sheet and an incident reporting process commenced
- If a throat pack is inserted it must be documented on the count sheet by the circulating nurse. However, all members of the procedural team share the responsibility of ensuring the throat pack is removed on completion of the surgery
- Any implanted prosthesis or prosthesis that was used or used and not retained must be entered in SurgiNet. If the prosthesis is not available to select in SurgiNet then it must be documented on the green implanted prosthesis form (M17E)
- Procedures that occur in multiple locations under the same anaesthetic requires the use of ONE SurgiNet document
- When a patient is incorrectly checked-in into SurgiNet will require the case to be terminated or the check-in time to be amended by the IT helpdesk

CHANGE SUMMARY

- Reference - NSW Ministry of health (2014). The Department of Health Policy Directive – Register of surgical operations PD2014_049
- **24/9/20**: Minor review. Update to 'Retrospective data entry' page 16

READ ACKNOWLEDGEMENT

- Relevant identified CHW Operating Suite staff are to read and acknowledge they understand the contents of this policy.

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Introduction

SurgiNet is an electronic record of the patient's perioperative or procedural care. SurgiNet must be completed for any procedure undertaken in the Operating Suite and areas that are staffed by the Operating Suite. SurgiNet is completed by a nurse (Registered, Endorsed Enrolled or Burns).

SurgiNet encompasses intraoperative documentation of the following;

- Delays
- Case Times
- Case Attendance
- General Case Data
- Surgical Procedures
- Surgical Safety Checklist
- Catheters, Drains, Tubes
- Diathermy
- Dressing/ Packing
- Irrigation
- OT Medications
- Patient Positioning
- Skin Prep
- Specimens/ Cultures
- Laser Data/ Laser Safety
- Prosthetic Devices/ Implants
- Tourniquet
- Unplanned Theatre Events
- Cardiac Operation Type (cardiac procedures only)

All mandatory segments marked by a red exclamation mark (!) in SurgiNet shall be completed. For interrupted cases or a death of a child in the operating theatre, please refer to page 16 of this policy for procedures to be undertaken. All remaining non-mandatory segments are to be completed where relevant or discontinued if procedural care was not given. The SurgiNet document shall be finalised at the end of the case when the patients leaves the operating room.

In addition to SurgiNet, the following paper-based documentation encompasses intraoperative documentation;

- Count Sheet (SMR090.030)
- Instrument tracking form (M17B)

The instrument and circulating nurses have a duty to be responsible for the management of items used during surgery and procedures in the perioperative environment. The count sheet is checked and signed by the nurses responsible for the count. The instrument and circulating nurse must ensure all items remain in the room where the procedure is undertaken until the procedure is complete and all counts have been performed and deemed correct. All fields of the count sheet must be completed.

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Staff present in the room during the procedure

All staff present in the room where the procedure took place must be recorded in SurgiNet (Segment - Case Attendance) and all nurses responsible for the count must legibly document their name and sign the count sheet. All procedures that have included accountable items must be signed by the surgeon or proceduralist (See table 1).

All operating suite nursing staff present in the room where the procedure took place shall be recorded in SugiNet as an instrument nurse, circulating nurse or anaesthetic nurse. The instrument nurse can be an operating Suite Registered Nurse, Endorsed Enrolled Nurse or Dental Nurse. SurgiNet shall be completed by an operating suite Registered or Endorsed Enrolled nurse or a Burns Nurse.

Clinical Nurse Consultants (CNC), Advanced Practice Nurses (APN), Nurse Practitioners (NP) who are assisting in the surgery shall be recorded in SurgiNet as 'Proceduralist – Assisting'. If the CNC, APN or NP are performing the procedure they shall be recorded in SurgiNet as 'Proceduralist- Principle'.

For names of staff present in the room that cannot be found in SurgiNet, e.g. Medical Student, are to be recorded in SurgiNet as 'SurgiNet, Attendee' and their full name entered into the comments box.

Recording case times

All times for the procedure must be recorded in SurgiNet (segment - 'Case Times') with the case time definitions found in table 2.

Instrument nurse relief

Should it become necessary to permanently relieve any instrument nurse, a complete count is conducted and documented on the count sheet. The changeover count shall be performed by the two Instrument Nurses and the Circulating nurse. The total items and items unsighted during the count are noted on the count sheet as 'in use'. The names and relief times of the relieving instrument nurse shall be recorded in SurgiNet and legibly documented on the count sheet.

Circulating nurse relief

Should it become necessary to relieve any circulating nurse during a procedure then a handover must be provided by the outgoing circulating nurse. The handover should include;

- Patient details such as; allergy status, weight and age
- Time out performed
- The type of procedure

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- Accountable items
- Specimens
- Risk factors
- Medications given to the instrument nurse
- Requirements for the rest of the procedure and operating list.

The name and relief times of the relieving circulating nurse shall be recorded in SurgiNet and legibly documented on the count sheet.

Type of procedure

The type of procedure shall be selected in SurgiNet (Segment – 'General Case Data'). The procedure is either a;

- **Elective Scheduled Procedure**
  A procedure that has been booked through the elective booking system
- **Emergency Procedure**
  A procedure that requires urgent attention and is booked through the emergency booking system

Unplanned Return

An unplanned return is a patient who returns to the Operating Suite within 24hrs of anaesthetic. To document an unplanned return to theatre, you will need to document the procedure in SurgiNet as you normally would, and add the segment 'Unplanned Theatre Events' and provide a reason.

Wound classification

Wound classification codes are followed using the Centre for Disease Control (CDC) wound classification guidelines where the wounds are rated between one and five (See table 3).

Delays

A delay reason and duration of delay in minutes shall be given to any procedure that is delayed. Delay reasons are to be selected from the drop down list in SurgiNet (segment – delays).

For a morning list an on-time start is defined as the team brief (i.e. huddle) to occur at 08:05 hours and the patient to enter the anaesthetic bay by 08:30 hours. For an afternoon list an on-time start is defined as the team brief (i.e. huddle) to occur at 13:00 hours and the patient to enter the anaesthetic bay directly after the team brief.

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Procedure

At the completion of the procedure, the circulating nurse shall confirm the procedure performed with the instrument nurse and procedural team and that it matches the consent. The circulating nurse shall free text the procedure performed in full in SurgiNet (segment – 'General Case Data'). No abbreviations are to be used.

Surgical/procedural count

Whenever accountable items are used and documented on the count sheet for a procedure, a minimum of two (2) counts shall be performed. These items are counted by two nurses, one of whom is a Registered Nurse. The count is undertaken by both nurses counting aloud, simultaneously and visualising all items.

The initial count is performed prior to the commencement of surgery. Additional items that are added to the procedure must be counted and documented on the count sheet. A count is to be performed at the commencement of the closure of each body cavity. Additional counts may be performed and documented at the discretion of the instrument or circulating nurse. The instrument nurse has the responsibility to notify the surgeon or proceduralist of the outcome of each closure count, including any discrepancies. On completion of each closure count, a verbal statement must be made to the surgeon/proceduralist by the instrument nurse to the effect that all accountable items, instruments and other items are accounted for.

Where items cannot be seen clearly by the circulating nurse during the closure of a cavity, a count is performed of the visible items but not recorded until all items are visible. A full count is performed when all items are visible to both Instrument and circulating nurse.

If a mistake is made on the count sheet, a single line is placed through the mistake and initialled beside the mistake.

All nurses responsible for the count must legibly document their name and sign the count sheet.

The count sheet is to remain in the patient's medical record.

No count required

For procedures where no accountable items are used and no count is performed, e.g. hip spica or closed reduction of a fracture does not require a count sheet to be used. To indicate that no count was required for the procedure, the 'final count status' in SurgiNet shall be documented as 'not applicable' (Segment – General Case Data).

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Counts accepted as correct

The names and signatures of the surgeon, circulating nurse and instrument nurse at final count must appear on the count sheet for a procedure where a count has been performed acknowledging all items are accounted for and the count is correct. The outcome of the count is documented in SurgiNet as being 'correct' (Segment – General Case Data).

Incorrect count

In the case of an incorrect count, the instrument nurse has a duty to immediately report any discrepancy in the count to the surgeon/proceduralist. A thorough visual and manual search of the sterile field and surrounding areas shall be performed to locate the item/s. If there has been no success in locating the item then a thorough visual and manual search of the immediate areas, such as the bagged swabs/sponges, rubbish bins, linen bags and floor, is performed to locate the item. If there is no success in locating the item then;

- The NUM/Nurse Supervisor/Team Leader is notified of the discrepancy
- A patient X-ray is obligatory prior to the patient leaving the Operating Room
- An incident management report must be completed at the earliest convenience.

The outcome of the count is documented in SurgiNet as being 'incorrect' (Segment – General Case Data).

Emergency situations

Extreme emergency situations may prevent normal counting and documentation processes being followed. The instrument and circulating nurse have a duty to attempt a count, if and when appropriate. If a normal count cannot be followed, the nurses are to document the events on the count sheet and notify the surgeon/proceduralist at an appropriate time that a count has not been completed. An x-ray of the surgical/procedural site must be taken prior to the patient leaving the operating room to assist in ensuring there are no unintentionally retained accountable items. The count status is documented in SurgiNet as being 'not done' (Segment – General Case Data).

Intraoperative medications

Operating Suite staff shall only document intraoperative medications listed in the OT medications segment in SurgiNet. It is the responsibility of the proceduralist and/or anaesthetist to document all other intraoperative medications in EMM that have been administered (See table 4).

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Tourniquet pressure

For pressures where a tourniquet is used and a pressure cannot be recorded, such as the use of a rubber band or esmarch bandage, the nurse shall record the numerical value 'zero' as the tourniquet pressure in SurgiNet (segment - Tourniquet).

Accountable items used by the surgical team

Mandatory accountable items are those in which are included in the PD2013-054. In addition to these the following items must be considered mandatory;

- All blades including
  - Saw blades
  - Dermatome blades
  - Cobbett's knife blades
  - Goullian blades
- Electrodes including (but not limited to)
  - Spinal monitoring
  - Facial nerve monitoring
  - ECOG
- Scalp clips

Throat pack

The anaesthetist is responsible for the insertion of the throat pack when required for protecting the airway during surgery. The insertion and removal of the throat pack shall be documented on the count sheet by the circulating nurse. All members of the procedural team share the responsibility of ensuring the throat pack is removed on completion of the surgery. Therefore, the placement and removal of the throat pack shall be communicated by the procedural team. The medical officer who removes the throat pack from the patient is to show the throat pack to the instrument and circulating nurses. The count is not correct until the throat pack is removed and sighted.

Methods to prevent the throat pack being inadvertently retained include:

- Recording the pack on the whiteboard
- Tying the throat pack to the endotracheal tube
- Placing an indicator label on the patients forehead

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Accountable items used by the anaesthetic team

When anaesthetic procedures are performed in the operating room and an accountable item is used, the anaesthetist must communicate this to the instrument nurse and circulating nurses. The accountable item must be sighted by both the instrument and circulating nurse and documented on the count sheet. If the accountable item is a suture needle, it will be secured safely within a rigid container where it can be visualised by the instrument and circulating nurses for counting purposes.

Items deliberately left in the patient

Accountable items deliberately retained in a patient are to be documented on the count sheet with the number of retained accountable items and their location by the circulating nurse. An asterisk (*) is placed next to the count minus the item/s in the wound (i.e. the number documented in the relevant count columns must reflect the number of accountable items visualised at the count). An asterisk (*) shall then be placed in the comments section and an explanation given and the time recorded.

For an example, if a raytec swab has to be sent to pathology with a specimen, the nurse shall document in the following way;

Initial count	Added	Total	Count	Added	Total	Count	Total	Final count
5	5	10	9*	5	15	13*	15	13*

** 1 raytec with uterine curretting's specimen at (time)*

*** 1 raytec with breast biopsy specimen at (time)*

Counting of multiple or complex instrument trays

It is recognised that completing post-operative tray lists of multiple and/or complex trays by the instrument and circulating nurses is time consuming and that patient acuity may require the transfer of the patient from the operating room before this process is complete. The final instrument checks may be completed immediately post procedure and before the next patient enters the Operating Room and before the patient leaves the Post Anaesthetic Recovery Unit (PACU). An x-ray may be used as an additional check towards the completion of surgery or post operatively to assist in instrumentation accountability. The timing of this x-ray should be documented in the comments section of the count sheet.

All tray lists and separate instruments must be counted by two (2) nurses, one of whom is a Registered Nurse, prior to the commencement of the procedure and at the completion of the procedure. Instruments with component parts must be counted single not as a whole unit with all parts listed (e.g. 1 Balfour, 1 blade, 3 screws).

The date, patients' MRN, theatre number and the instrument and circulating nurse name must be recorded on the instrument tray list.

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Prosthesis

Any implanted prosthesis or prosthesis that was used or used and not retained must be entered in SurgiNet (segment - Prosthetic Devices/ Implants).

Entering prosthesis into SurgiNet;
- All prosthesis must be searched for by a reference number and must not be free texted into the description box
- If an item cannot be found then a green Implanted Prosthesis form (M17E) is to be completed instead

Entering used but not implanted prosthesis into SurgiNet;
- Search prosthesis by a reference number
- Place '0' in quantity
- Write the quantity used but not implanted into the comments box (e.g. 'x1 used but not implanted')
- Discard the implant
- If an item cannot be found then a green Implanted Prosthesis form (M17E) to be completed instead

Two or more surgical procedures

In the case of two or more surgical procedures being performed on the same patient simultaneously or sequentially will utilise the same electronic intraoperative document in SurgiNet, even if two or more teams are involved.

Documentation of count sheet/s;
- Where ***simultaneous*** procedures are undertaken on the same patient and more than one procedural team is involved, one instrument nurse shall be responsible for the count and one count sheet shall be used.
- Where ***sequential*** procedures are undertaken on the same patient which requires ***two 'set ups'*** and the ***operating room is cleared*** between procedures, will require a separate count sheet for each procedure.
- Where ***sequential*** procedures are undertaken on the same patient with the ***same 'set up'*** being used and the ***operating room is not cleared*** between procedures, will require the final count of the first procedure to be carried over to be the first count of the second procedure on a separate count sheet. The continuation of the count will require the second count sheet to be stapled to the first count sheet and the words 'count continued' written on it, and the pages numbered sequentially.

Documentation of case times;
- **Case times segment –** The surgical start time will be when the first procedure starts and the surgical stop time will be when the last procedure finishes.
- **Surgical procedure segment -** The surgical start and stop time shall be documented to reflect each procedures surgical start and stop time.

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Procedures in multiple locations

Procedures undertaken in multiple locations under the same anaesthesia, i.e. a procedure undertaken in a satellite area that then proceeds to the operating suite for an additional procedure, will require the **same** SurgiNet document. Therefore, the care provided to the patient from both locations is combined into one SurgiNet document.

The staff member completing the SurgiNet document for the first procedure will begin the documentation. When the patient leaves the procedure room of the first procedure, the staff member shall close the SurgiNet document and ensure the document remains unfinalised. The staff member from the next location will open the same SurgiNet document and shall begin their documentation. If this is the last location for the patient, then the staff member must finalise the case at the end of the procedure.

Case Times	**Anaesthetic start** – Time patient arrives in anaesthetic bay of the *first procedure* **Patient in OT** – Time patient enters the room in which procedure is to occur of the *first procedure* **Start time** - Time when the *first procedure* begins **Stop time** – Time when the *last procedure* finishes **Patient out of OT** - Time patient leaves the room in which the procedure occurred for the *last procedure* **Anaesthetic stop** - Time patient leaves the room in which the *last procedure* occurred **NOTE: The patient out of OT for the first procedure and the patient in OT for the last procedure times is not captured in the documentation**
Case Attendance	All staff members of both locations are to be entered and only the procedure the staff member was present for shall be ticked
General Case Data	All procedures from each location are included in the 'actual procedure' text box
Surgical Procedures	All procedures from each location are listed in the list box. The surgical start and surgical stop time for each procedure shall be individually entered and shall reflect the actual start and stop time of each procedure
Surgical Safety Checklist	The surgical safety checklist (time-out) will be performed in each location by the designated proceduralist and all surgical safety checklists shall be entered for each procedure into the list box

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Booking cases in multiple locations

Procedures undertaken in multiple locations under the same anaesthesia require all procedures to be scheduled in their respective locations. However, it is the scheduled case from the operating suite location that shall be used when documenting into SurgiNet.

For example;

- A patient requires a pre-operative MRI under general anaesthetic and a craniotomy to immediately follow in the operating suite
    - The MRI procedure should be scheduled into the satellite location of the scheduling appointment book
    - The MRI and craniotomy procedure should be scheduled into a theatre in the operating suite location of the scheduling appointment book
    - The staff member should use the scheduled case from the operating suite location when documenting into SurgiNet for **both** procedures
    - The scheduled case from the satellite location remains blank

Booking a pre and post-operative MRI

When a patient requires a pre-operative MRI and post-operative MRI under general anaesthesia, will require the same procedure scheduled twice into the same booking. When the procedure is scheduled twice, one MRI procedure must be the primary procedure and the other as a secondary procedure to ensure there are no user interruptions.

Errors

All errors or changes on paper based documentation shall have a single line through them and are to be initialled by the person who made the error, the correction must be legible.

All errors or changes to be made in SurgiNet after the case has been finalised will require the case to be unfinalised and then the correct changes can be made. After the corrections are made the case shall be finalised again. A reason for unfinalising the document must be given at time of unfinalising, in which 'correct documentation' should be selected.

Catheterisation

Urethral Catheterisation requires the use of swabs. Green swabs can be used for catheterisation in the anaesthetic bay and must be discarded in the anaesthetic bay. Radiopaque swabs (such as raytec) must be used if urethral catheterisation is carried out in the operating or procedure room and be document on the count sheet.

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Clinical Procedure Safety Checklist

The Clinical Procedure Safety Checklist is documented in SurgiNet. The proceduralist addresses each item of the checklist while the circulating nurse marks each item addressed as complete in SurgiNet. The circulating nurse shall provide the name of the surgeon who led time-out in SurgiNet.

Refer to the following policy for the procedures to be undertaken when performing the Clinical Procedure Safety Checklist;

- The Department of Health Policy Directive - *Clinical Procedure Safety* PD2017_032 https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_032.pdf

Planned or unplanned eMR downtime

Operating Suite staff must comply with Theatres eMR Downtime Policy for the activities to be undertaken in the operating suite when SurgiNet is not available during a planned or unplanned eMR downtime.

In the event of a planned or unplanned downtime and/or power failure when clinicians cannot access SurgiNet, operating suite staff will document intraoperative care provided to patients on the downtime paper based intraoperative documentation. The eMR downtime documentation must remain with the patient in their hardcopy medical record folder and a copy will remain with the Data Manager. Any documentation occurring during eMR downtime needs to be replicated into SurgiNet at a later date/time. Refer to 'Retrospective Data Entry' of this policy for more information.

Downtime paper based documentation includes;

- Operation/ Procedure Nursing Care Record – Part A (SMR090.025) - mandatory
- Operation/ Procedure Nursing Care Record – Part B (SMR090.026) – mandatory
- Clinical Procedure Safety Level 3 Checklist (SCN091.101) – mandatory
- Implanted Prosthesis form (M17E) – if applicable
- Laser Log form (SCN090.001) – if applicable

Documentation for category 1 emergency

A Category 1 emergency (Immediately life threatening) is a patient being transferred to the operating suite within 1 hour for a life-saving procedure or treatment, e.g. Intracerebral bleed requiring urgent surgery.

In the event of a category 1 emergency where there is no patient encounter available on PowerChart and/or no time to schedule the case in SurgiNet, operating suite staff shall follow the same process as you would during eMR downtime.

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Retrospective data entry

There are instances where data needs to be entered retrospectively into SurgiNet. This may be due to a planned or unplanned eMR downtime or a category 1 emergency.

Retrospective data is to be entered into SurgiNet once eMR is available for normal use or when a category 1 emergency procedure has been scheduled into SurgiNet.

To enter retrospective data for a planned or unplanned eMR downtime:

- Navigate to Surgical Case Data in PowerChart
- Enter Check In Date/Time
- From the toolbar, click 'Document' and select 'retrospective'
- Enter the date from when the procedure occurred and click 'OK'
- In SurgiNet, add the Retrospective Data Entry segment and select the reason for retrospective data entry.
- Transcribe the data from the downtime forms into SurgiNet and finalise the case. All original downtime forms stay with the patient files and all copies of the downtime forms go to the Data Manager.

To enter retrospective data for a category 1 emergency:

- Navigate to Surgical Case Data in PowerChart
- Enter Check In Date/Time (See notes below)
- From the toolbar, click 'Document' and select 'retrospective'
- Enter the date from when the procedure occurred and click 'OK'
- In SurgiNet, add the Retrospective Data Entry segment and select the reason for retrospective data entry.
- Transcribe the data from the downtime forms into SurgiNet and finalise the case. All original downtime forms stay with the patient files and all copies of the downtime forms go to the Data Manager.

NOTES:

- **The SurgiNet check In is used to document the date and time of when checking in a patient to the Operating Theatre. This data is used to report Key Performance Indicators (KPI's) of Emergency Procedure breach times to the Ministry of Health (MOH). It is imperative that this date and time is documented accurately. Nursing staff are to inform the Floor Supervisor in hours or the Nurse In-Charge after hours of the check in date/time to ensure it is accurately documented.**
- **The Floor Supervisor (in hours) or the Nurse In-Charge (after hours) must ensure the surgeon booking the retrospective emergency procedure in PowerChart records the 'Emergency Request Date/Time' accurately. The date/time should reflect when the decision was made to perform the emergency surgery.**

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The person responsible for retrospective data entry shall be the instrument/circulating nurse who is part of that procedure, if still on shift and time permits. If the instrument/circulating nurse is no longer on shift or time does not permit then it shall be the responsibility of the Data Manager.

Incorrect patient check-in/ terminated Case

When a patient has been incorrectly checked into SurgiNet, there is a process that needs to be followed which is dependent on whether the incorrect patient is scheduled for a procedure on the same day or a different day.

If the patient is scheduled for a procedure on the same day, the patient shall remain checked in and an IT service desk request shall be logged to change the check-in time.

If the patient is scheduled for a procedure on a different day, the case will need to be terminated. To terminate the case, navigate to 'Document' in the toolbar from surgical case data and select 'Terminate'. Contact the booking admin to schedule the procedure again to the original scheduled date and time.

Interrupted case

When intraoperative documentation has already commenced in SurgiNet for a patient and the procedure does not go ahead, the case is considered to be interrupted, e.g. emergency case takes priority or the neurophysiologist cannot obtain spinal monitoring.

In the segment 'Surgical Procedure', modify the procedure to 'interrupted case – *reason*'.

The following mandatory segments in SurgiNet must be completed;

- Case Times
- Case Attendance
- General Case Data
- Safety Checklist Sign in
- Safety Checklist Team Brief

The following segments in SurgiNet can be discontinued (if applicable, as it will be case dependent) with a reason provided;

- Safety Checklist Time Out
- Safety Checklist Sign out
- Patient Positioning
- All remaining non-mandatory segments

Death of a child in the operating theatre

In the event of a death in the operating theatre, the 'Death of a Child' policy (2006-8059 v6) provides detailed procedures that are to be followed. There are relevant forms to be completed which are not available electronically. These forms can be found in the 'Purple Folder' in the alcove labeled 'Completion of care: Procedures to be followed in the event of a death of a child'.

The nurse shall enter the following data in SurgiNet;

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- **Case Times**
  Anaesthestic Start Time – Time patient arrives in anaesthetic bay
  Patient In OT Time – Time patient enters the room in which procedure is to occur
  Surgical Start Time – Time the procedure begins
  Surgical Stop Time – Time of Death
  Anaesthestic Stop Time – Time of Death
  Patient Out of OT Time – Time patient leaves the room in which the procedure occurred

- **General Case Data**
  In 'actual procedure' description, enter the time of death and any procedures which occurred prior to the death. Complete all remaining fields within the segment.

For the remaining segments, discontinue all non-mandatory segments where relevant. For all mandatory segments that had not occurred prior to the death, discontinue the segment and select 'Deceased' as the reason for discontinuing the mandatory segment.

Ensure the Data Manager is notified of the death verbally or via email.

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Table 1: Surgeon/Proceduralist

Procedures	Consultant	Proceduralist - Principle	Proceduralist – Assisting
Surgical procedure	Surgical consultant that the team performing the procedure is under. The consultant is listed as the role of the consultant only if he/she is 'not present in the theatre' or 'present in the theatre and not scrubbed'. If the consultant is scrubbed he/she will be listed as the Proceduralist – Principle or Assisting	Proceduralist performing the procedure (can be the surgical consultant, surgical registrar/fellow, CNC or NP)	Proceduralist assisting the procedure (can be surgical consultant if registrar/fellow is performing the procedure, Nurse assisting NP, CNC)
Anaesthetic line	N/A	Anaesthetist performing the procedure (can be the anaesthetic consultant or anaesthetic registrar/fellow)	Anaesthetist assisting the procedure
Oncology	Oncology consultant that the team performing the procedure is under	Proceduralist performing the procedure (can be the oncology consultant or oncology registrar/fellow)	Proceduralist assisting the procedure
CT/MRI	Radiologist Consultant that the team performing the procedure is under	Radiologist checking the scan and giving contrast (can be the radiology consultant)	Radiographer performing scan

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Table 2: Case Times definitions

Anaesthetic Start Time	Time patient arrives in anaesthetic bay. Anaesthetic commenced time can be the same as enter OR time.
Patient In OT Time	Time patient enters the room in which procedure is to occur
Surgical Start Time	Time the procedure begins (e.g. incision for a surgical procedure, insertion of scope for a diagnostic procedure, beginning of exam under anaesthesia, taking of x-ray for radiological procedure)
Surgical Stop Time	Time when all counts are completed and verified as correct, all dressings and drains are secured and the surgeon has completed all procedure related activities on the patient
Patient Out of OT Time	Time patient leaves the room in which the procedure occurred
Anaesthetic Stop Time	Time patient leaves the room in which the procedure occurred

Table 3: Centre of Disease Control (CDC) wound classification codes

Type of Wound	Description
Clean	An uninfected operative wound in which no inflammation is encountered and the respiratory, alimentary, genital, or uninfected urinary tracts are not entered. In addition, clean wounds are primarily closed and, if necessary, drained with closed drainage. Operative incisional wounds that follow non-penetrating (blunt) trauma should be included in this category if they meet the criteria.
Clean-Contaminated	Operative wounds in which the respiratory, alimentary, genital, or urinary tracts are entered under controlled conditions and without unusual contamination. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in technique is encountered.
Contaminated	Open, fresh, accidental wounds. In addition, operations with major breaks in sterile technique (for example, open cardiac massage) or gross spillage from the gastrointestinal tract, and incisions in which acute, non-purulent inflammation is encountered including necrotic tissue without evidence of purulent drainage (for example, dry gangrene) are included in this category.
Dirty or Infected	Includes old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing post-operative infection were present in the operative field before the operation.
Unknown	If the wound classification does not fit any CDC criteria above then an unknown wound classification code is used.

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Table 4: Operating Theatre (OT) Medications

Anaesthetist Documentation in Anaesthetic Module	Nursing Documentation in SurgiNet	Surgeon Documentation in MAR/Operation note
Ampicillin 1g	Acetylcholine 20mg/2mL intraocular inj.	Adrenaline 1:10 000
Ampicillin 500mg	Amethocaine 1% minims eye drops	Adrenaline 1:10 000 (1mg in 10mL)
Bupivicaine 0.25% Plain	BIPP Paste Gauze 12.5mm	Adrenaline 1:1000
Bupivicaine 0.25% with Adrenaline	Celluvisc eye drops	Adrenaline 1:1000 (1mg in 1mL)
Bupivicaine 0.5% Plain	Chloramphenicol 0.5% eye drops	Adrenaline 1:1000 000
Bupivicaine 0.5% with Adrenaline	Chloramphenicol 1% eye ointment	Adrenaline1mg/mL(1:1000)in NaCl0.9%500mL
Bupivicaine Plain	Ciprofloxacin 0.3% eye/ear drops	Alteplase (TPA)
Cephazolin 1g	Cyclopentolate 1% minims eye drops	Celestone Chronodose 5.7mg/mL
Co-phenylcaine Forte Spray	Fibro-Vein 3% injectable solution	Cephazolin 1g in 10mL Water (100mg/mL)
Dexamethasone 4mg/mL	Fluorescein 2% minims eye drops	Cephazolin 1g in100mL NaCl 1mg/0.1mL
Gentamicin 80mg/2mL	Haemorol	Dehydrated Alcohol (Absolute)
Heparin 2500units in 250mLs 0.9% NaCl	Hydrocortisone 1% topical ointment	Gentamycin 20mg/0.5mL in 500mLs Ringers
Heparin 5000units in 1000mLs 0.9% NaCl	Kenacomb ear drops	Gentamycin 80mg in 1000mL NaCl
Heparin 5000units in 500mLs 0.9% NaCl	Kenacomb ear ointment	Heparinised Saline 50 units/5mL
Heparin Sodium 5,000 units/5mL	KY Jelly	Kenacort A-10 Triamcinalone
Lignocaine 1%	lignocaine-chlorhexidine 2%-0.05% gel	Kenacort A-40 Triamcinalone
Ropivicaine 0.2%	Lubricating Gel Sterile	Mitomycin C
Ropivicaine 100mg/10mL	Methylene Blue	Papaverine 12mg/mL injectable solution
Vancomycin 500mg/10mLs Water Inj	Omnipaque	Phenol 10% in Meglumine Iothalamate 60%

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Table 4: Operating Theatre (OT) Medications – *continued*

Anaesthetist Documentation in Anaesthetic Module	Nursing Documentation in SurgiNet	Surgeon Documentation in MAR/Operation note
Xylocaine 1% with Adrenaline 1:100 000	Oxymetazoline 0.05% nasal spray	Sodium chloride 0.9% with Adrenaline
	Paraffin liquid	Sodium Chloride 23.4%
	Paraffin soft white ointment	Talc Powder-Sterile (Steritalc)4g Powder
	Phenylephriene 2.5% minims eye drops	Triamcinalone 40mg/mL (Kenacort A-40)
	Povidone iodine 10% topical ointment	Triamcinolone (Kenacort A10)
	Silver sulfadiazine 1% topical cream	Triamcinolone Acetonide 40mg/mL
	Sodium chloride 0.9%	Ultravist 240
	Sofradex ear drops	
	Unlisted - See Comments	

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