UHS FUSION
Forming Universal Solutions by Integrating Our Network

SurgiNet®
AnesthesiaProvider

Participant Guide

Universal Health Services
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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.

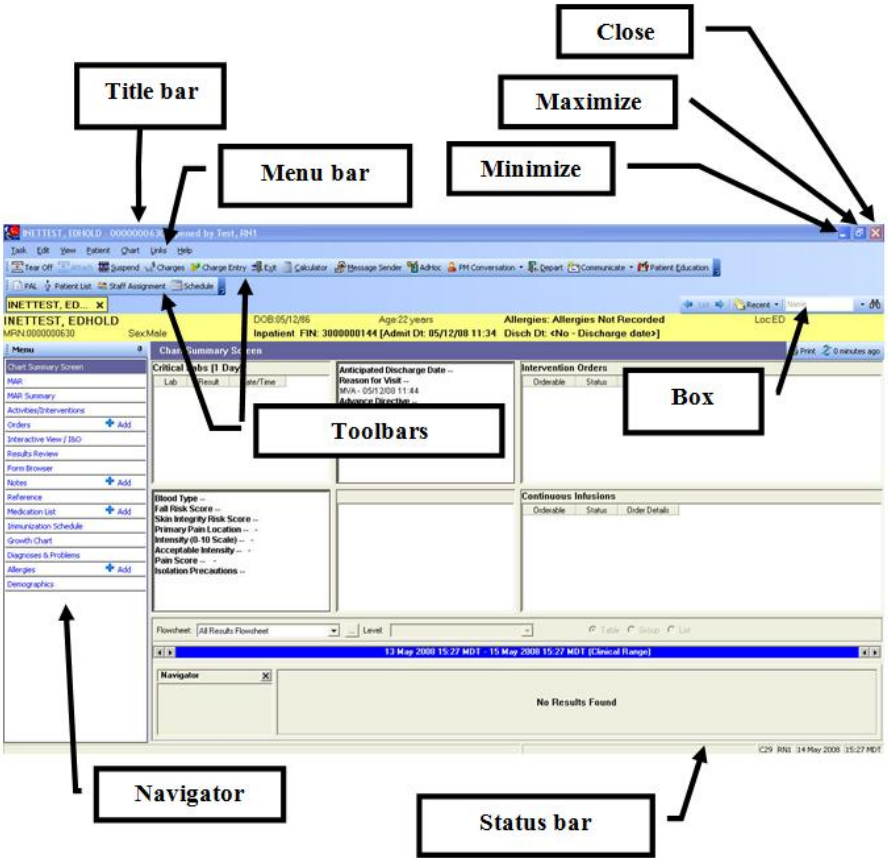
Windows Terms

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.

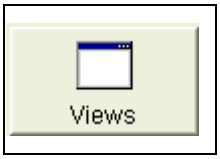
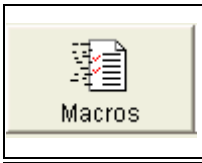
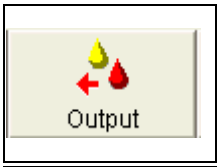
- **Left-click.** To click the left mouse button. When instructions call for you to click a window element, a left-click is what is meant.
- **Log on.** The process of accessing an application through the use of user credentials, such as a user ID and password.
- **Maximize.** Located on the menu bar 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.

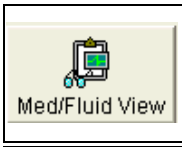
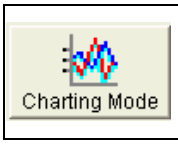
See the diagram below to review basic Windows terminology.


Close
Title bar
Maximize
Menu bar
Minimize
Box
Toolbars
Navigator
Status bar

Solution Icons

Listed below are the icons on the *SurgiNet* Anesthesia toolbar.

Button	Description
	Select Case. Opens the Select Case window so you can select the case to be displayed.
	**Views.** Opens the Select View Item dialog box so you can select the view to be applied to the record.
	**Macros.** Opens the Select Macro dialog box so you can specify the macros to b executed.
	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. 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.** 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. Opens the Select Action dialog box so you can specify the actions to b displayed. You also are able to add, modify, or remove actions in this dialog box
	Inventory. Opens the Inventory dialog box so you can specify the inventory to b displayed. You also are able to add or remove inventory in this dialog box.
	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
	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. Opens the patient's chart in Surgical *PowerChart*®.
	**Charting Mode.** Changes the view to Chart Mode so you can quickly indicate w values are to be charted or uncharted.

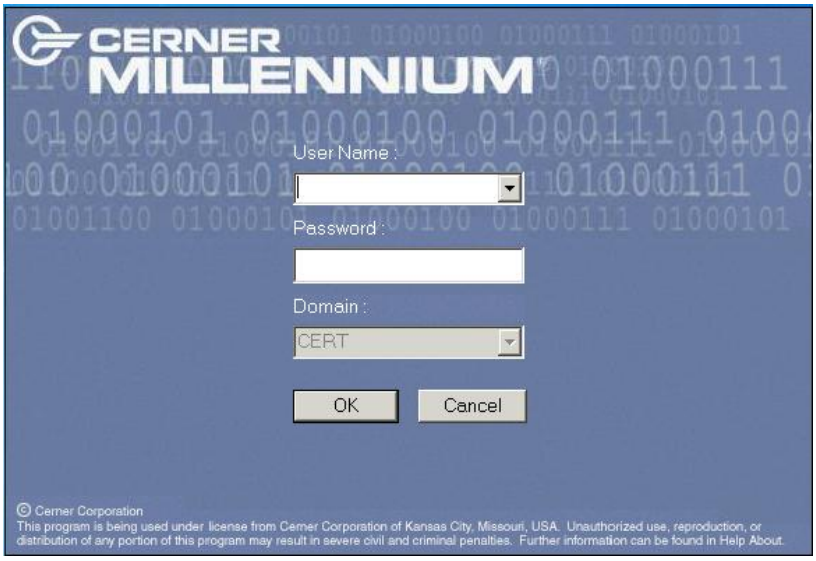
Getting Started

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.



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.

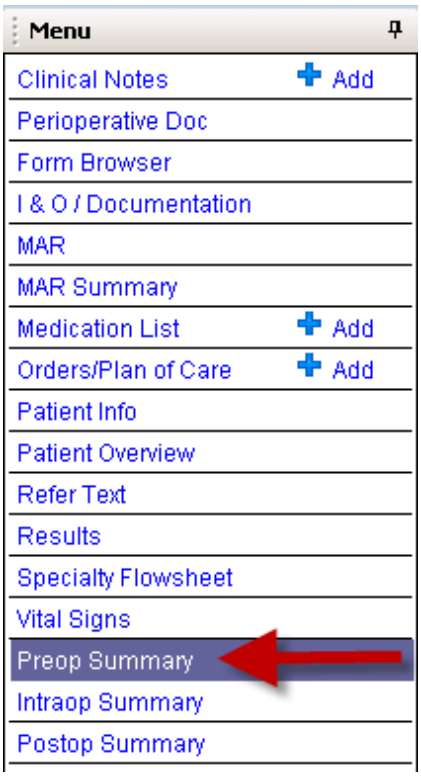
The following *MPages* are available in *SurgiNet* Anesthesia:

- Preoperative Summary
- Intraoperative Summary
- Postoperative Summary

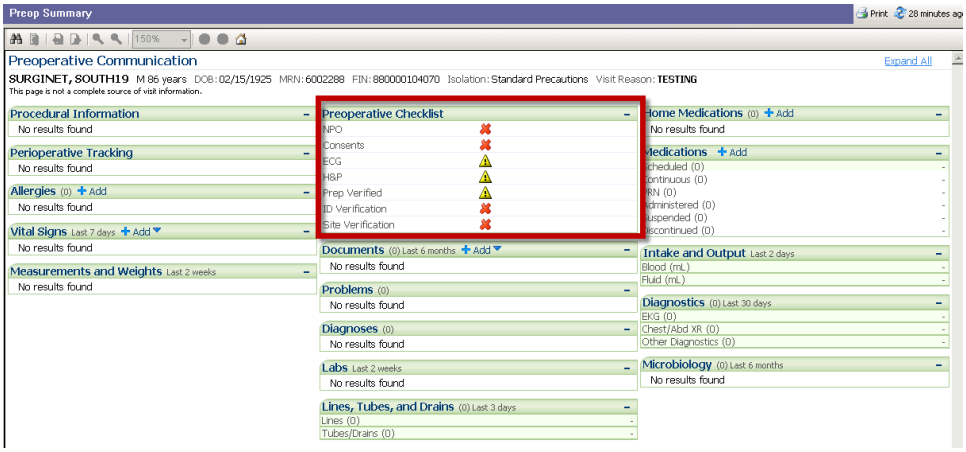
Preoperative Summary

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.



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



The Preoperative Checklist contains two columns.

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

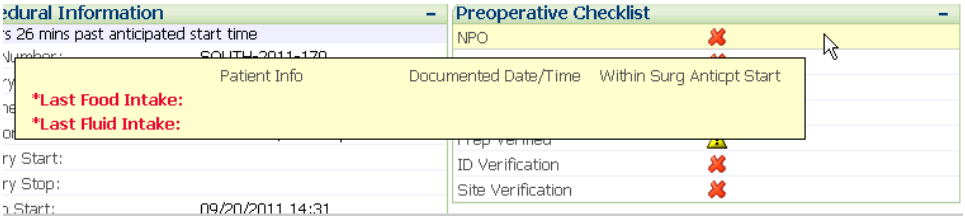
The second column displays icons for each row to indicate whether the required values for that row have been documented. The symbols represent the following information:

- indicates this section is complete.
- indicates this section is partially incomplete.
- indicates 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

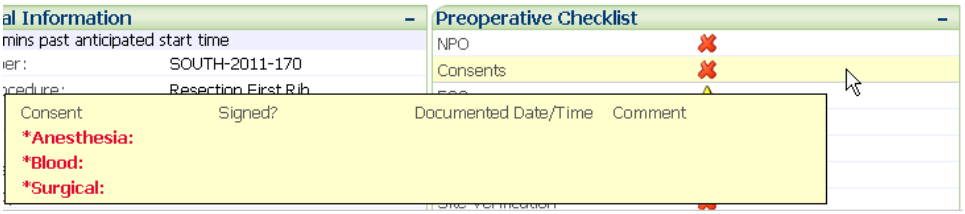


When you position the pointer over NPO, the following information is displayed:

- 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

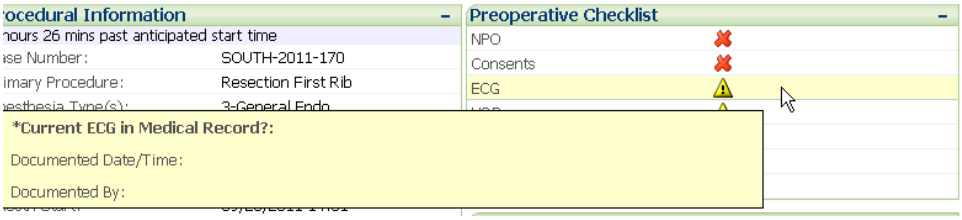


When you position the pointer over Consents, the following information is displayed:

- 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

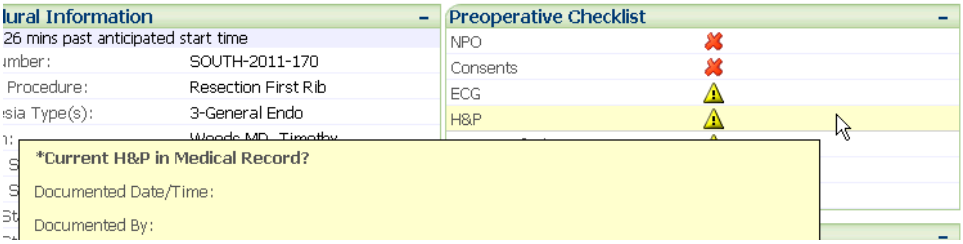


When you position the pointer over ECG, the following information is displayed:

- 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

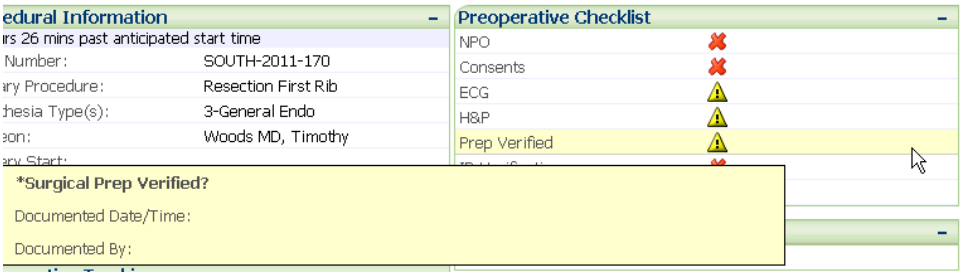


When you position the pointer over H&P, the following information is displayed:

- 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

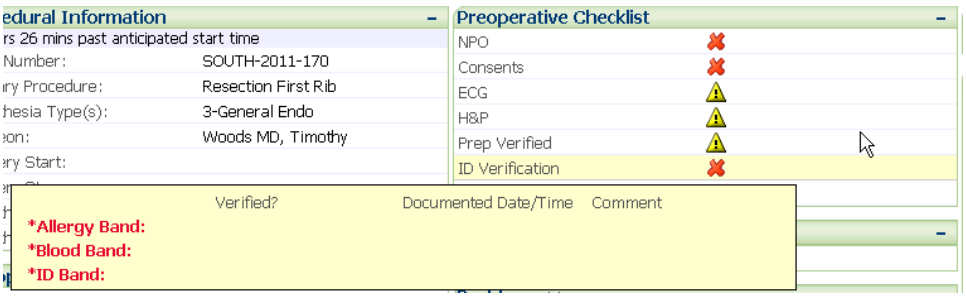


When you position the pointer over Prep Verified, the following information is displayed:

- 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

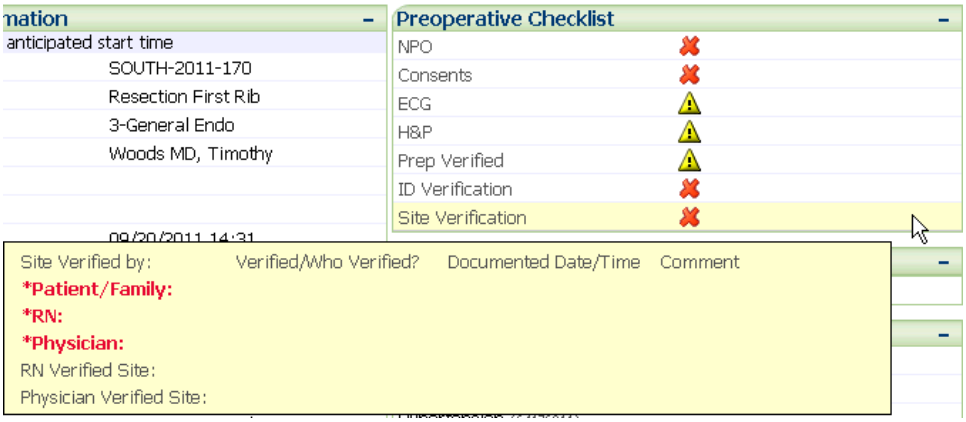


When you position the pointer over ID Verification, the following information is displayed:

- 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



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

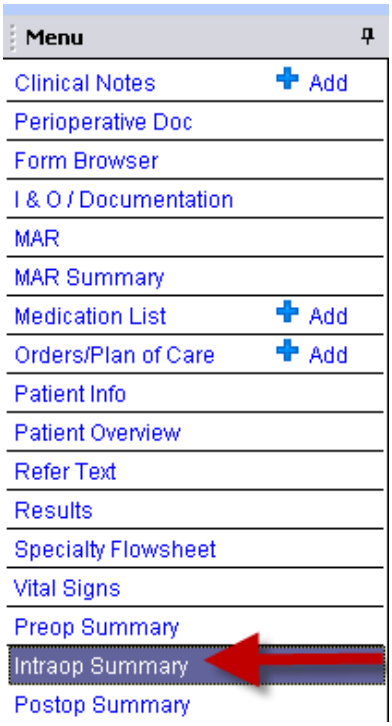
- DTA or event code name
- DTA or event code result
- Date and time of the event code result

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.

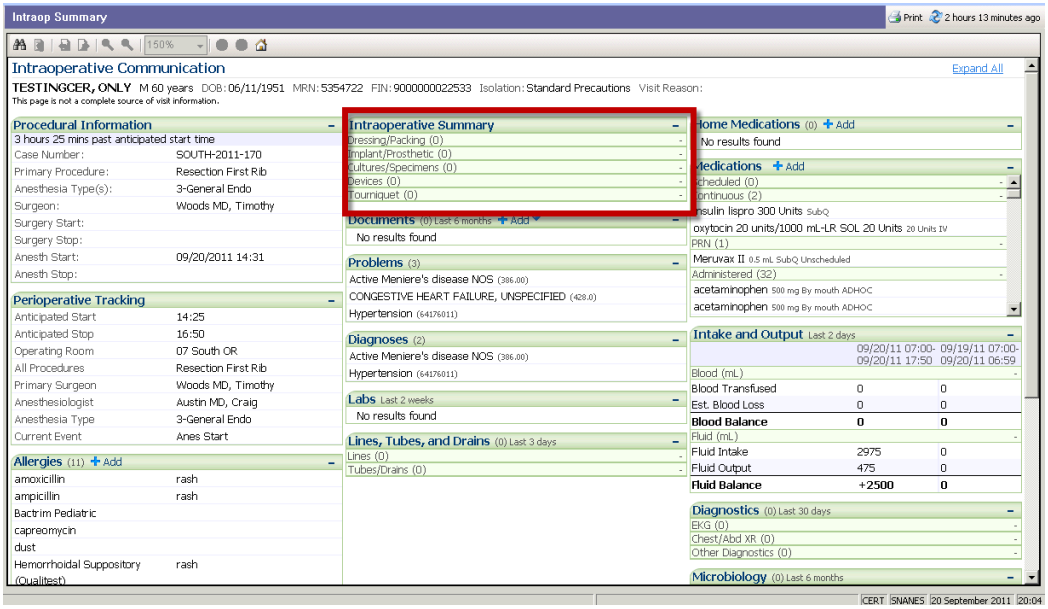
Intraoperative Summary

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.

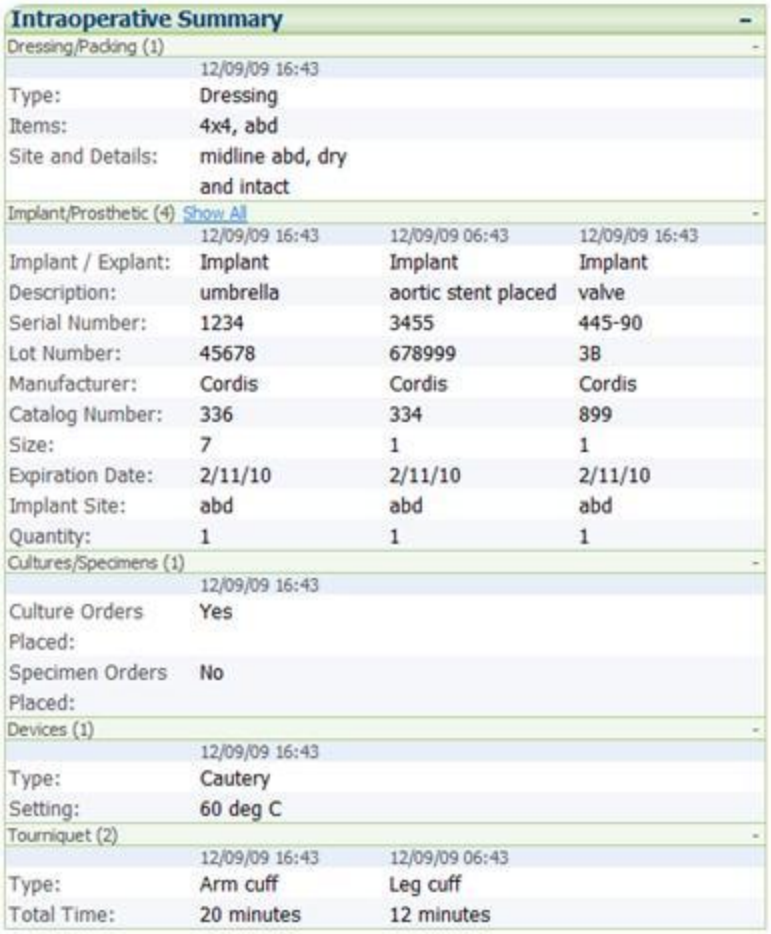


The Intraoperative Summary is displayed in the center of the window.



The Intraoperative Summary contains the following information:

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



Intraoperative Summary

Dressing/Packing (1)			
	12/09/09 16:43		
Type:	Dressing		
Items:	4x4, abd		
Site and Details:	midline abd, dry and intact		
Implant/Prosthetic (4) Show All			
	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 Placed:	Yes		
Specimen Orders Placed:	No		
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	

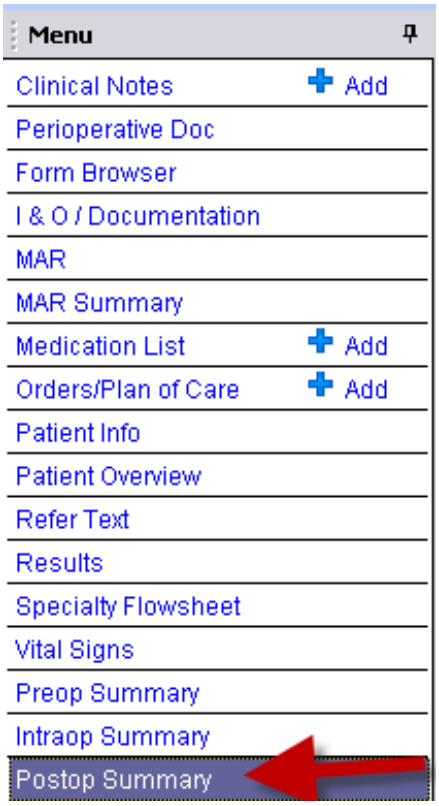
The first column displays the name of the item being reported on. The second column contains the latest results for each item, while columns three and four can contain up to two previous values for each item.

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.

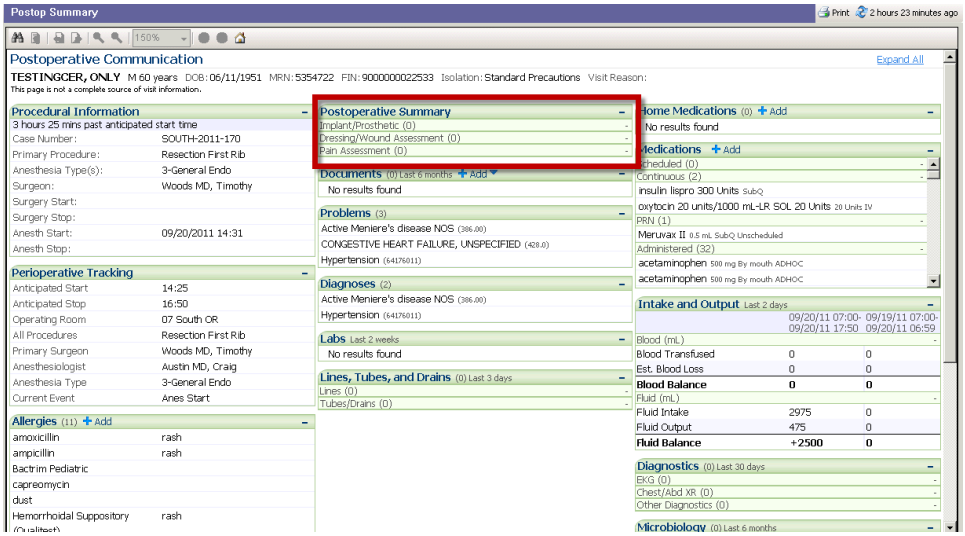
Postoperative Summary

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.



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



The Intraoperative Summary contains the following information:

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

Postoperative Summary

Implant/Prosthetic (4) Show All

	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	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 Assessment (1)

	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 Rating:	6
Pain Intensity Scale Used:	NRS, Numeric 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.

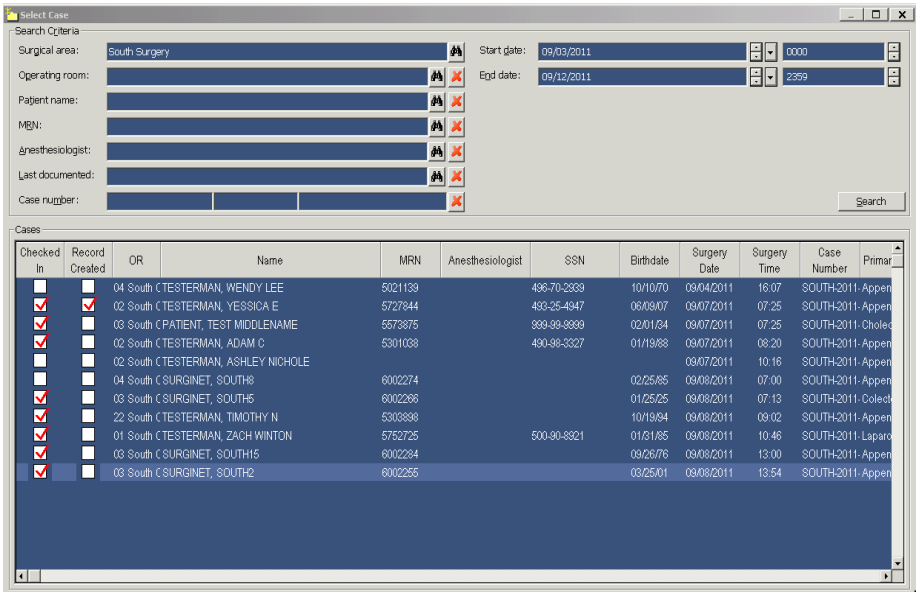
Surgical Case Selection

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:

1. 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.



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.

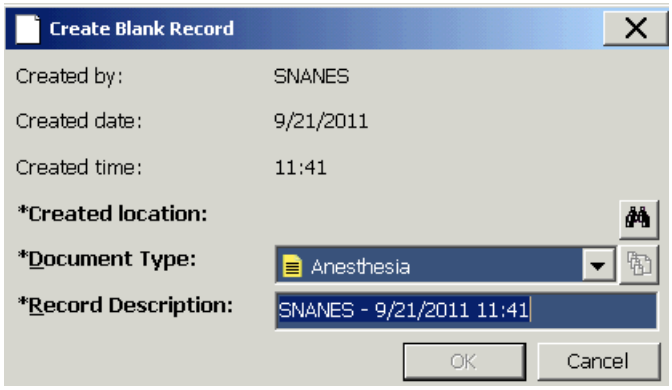
Note: There should be a case already set up in the system; you should not have to create a blank record. The steps below are intended for use in the event that you do need to create a blank anesthesia record.

Creating a Blank Anesthesia Record

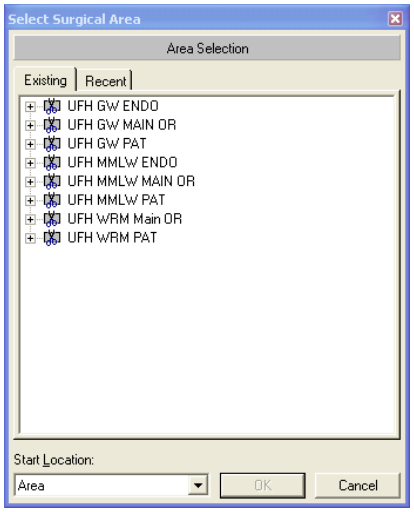
If the case has not been created yet, you can create a blank anesthesia record can be created. To create a blank anesthesia record, complete the following steps:

1. Click

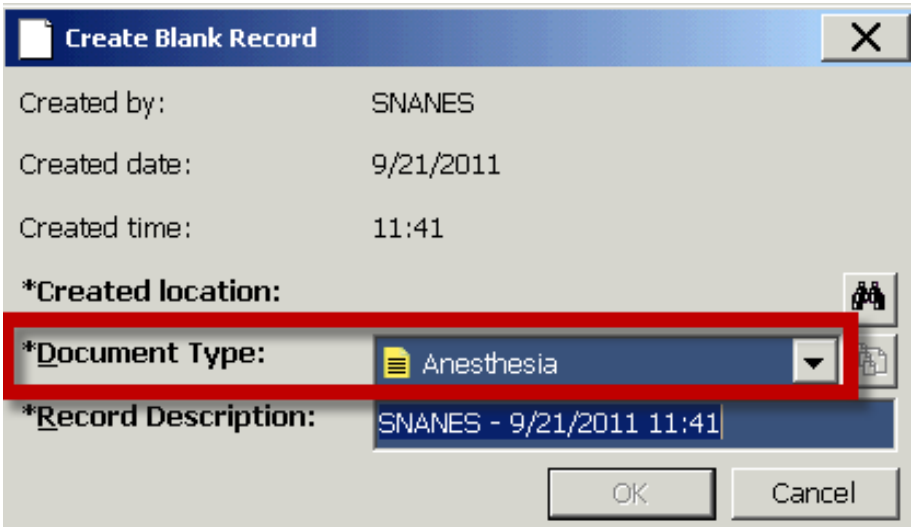
located in lower right corner of the Select Case window.
2. In the Create Blank Record dialog box, click the binoculars button next to the Created Location. The Select Operating Room dialog box opens.



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.

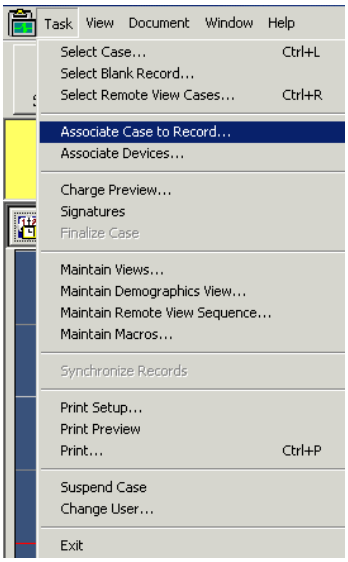


6. Modify the record description if necessary.
7. Click OK to create the blank record.

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.

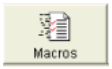
3. Click Verify in the Verify Case dialog box to associate the record with the case.

Macros

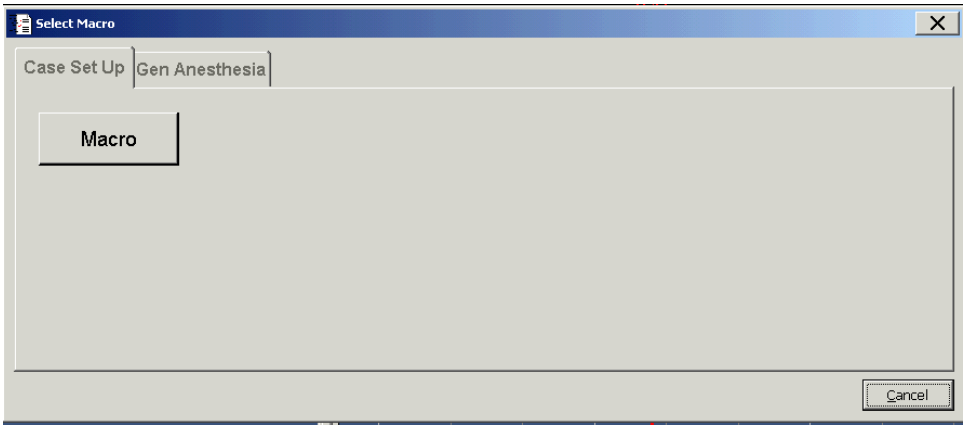
After opening the case, you can start a macro to assist in documentation efforts. A macro enters all of the medications, fluids, monitored values, actions, and inventory related to the case with the click of a button. It reduces the time it takes to get items onto a record, and it is a pretty easy step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

Starting a Macro

To work with macros, complete the following steps:

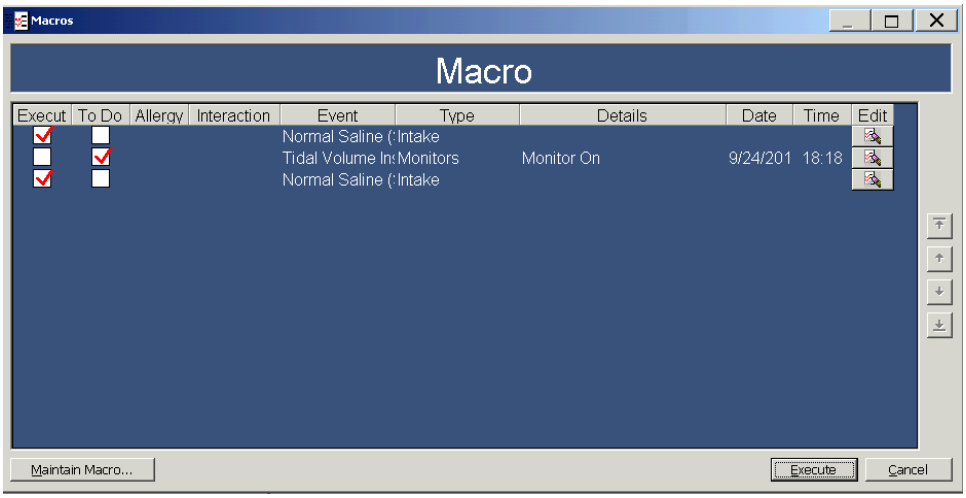
1. Click 

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

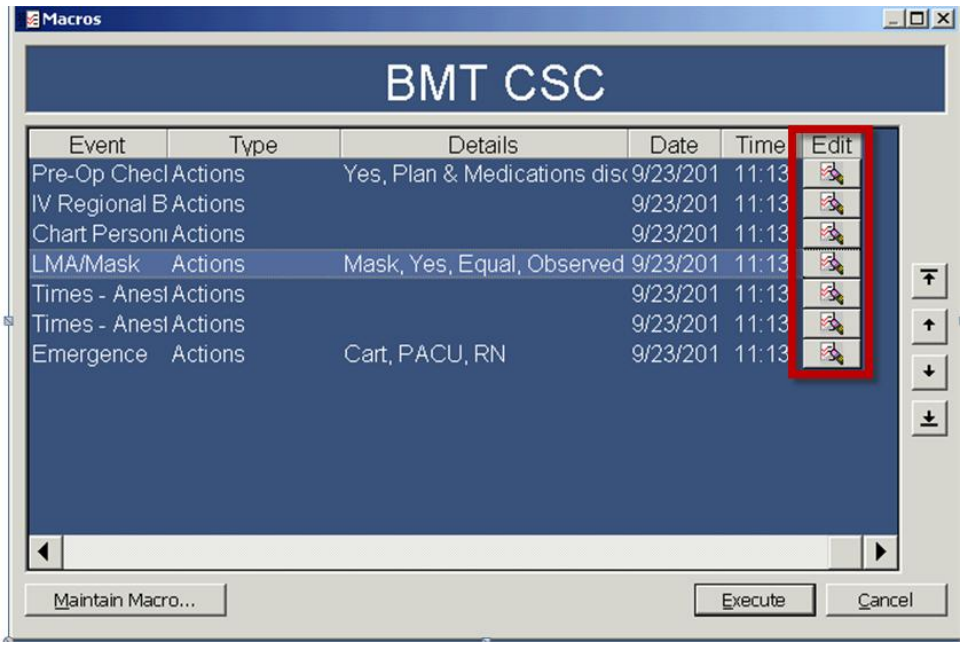


Note: A category is displayed only display if it contains macros that are relevant for the document type being documented. The components of the macro will display and can be verified or excluded, depending on the procedure.

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



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.



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.

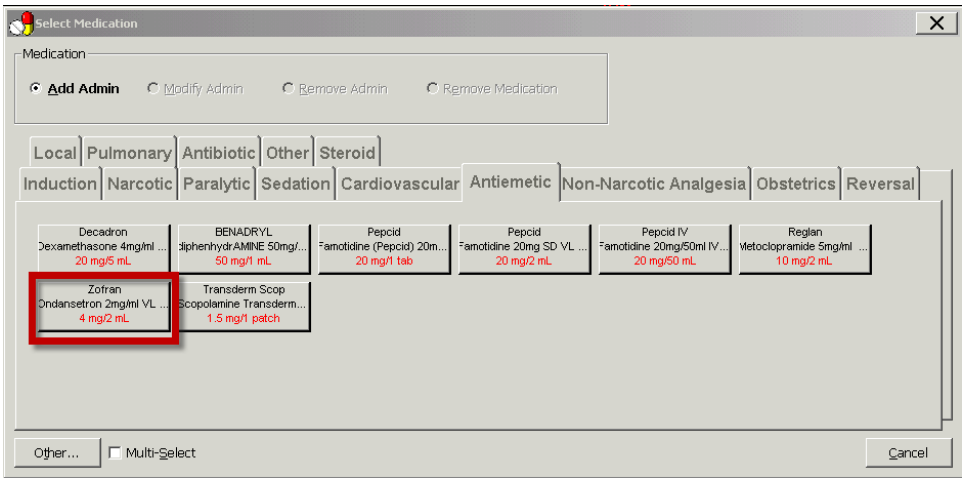
3. To modify the height and weight for a patient, click the height and weight links.
4. You also can modify the units by clicking on the units that follow elements, such as height, weight, dose amount, and volume.
5. Modifying the units in the medication concentration also makes the corresponding updates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

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.



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.

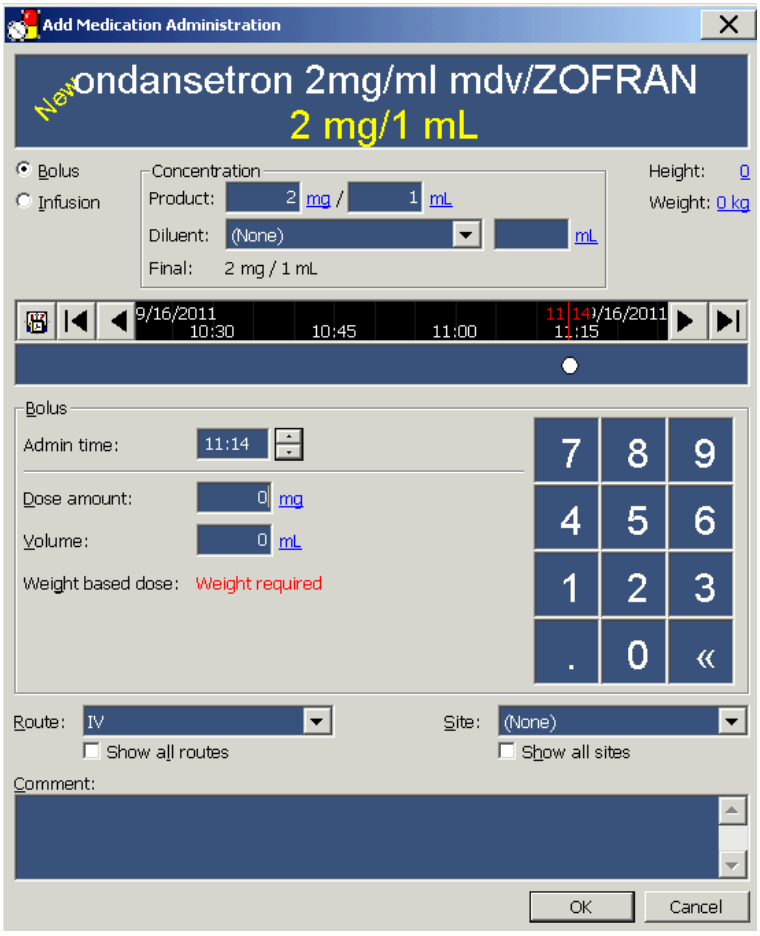
Adding Medications: Bolus or Infusions

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.

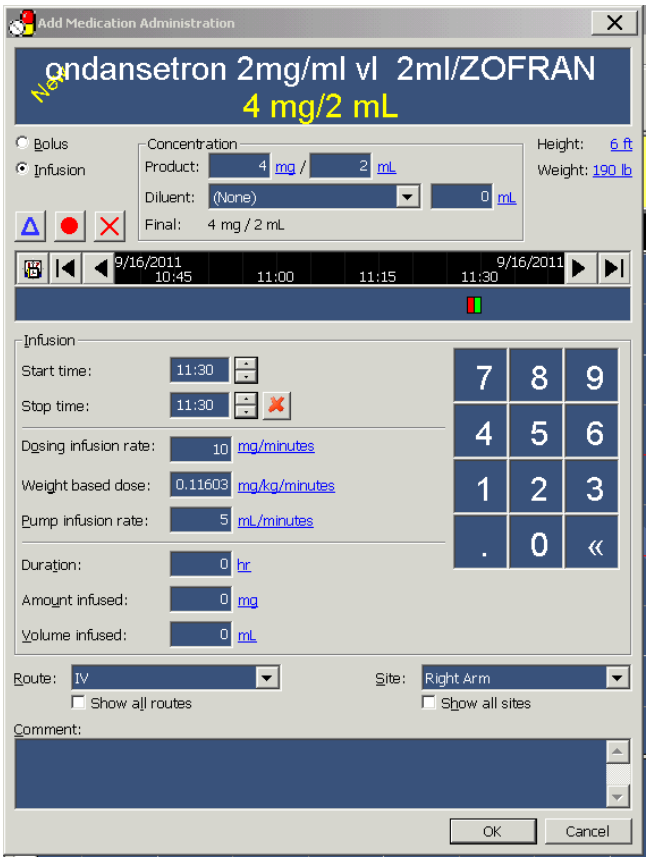
- Allows for volume to be documented as administered in one single minute.
- If the concentration and weight are correct, entering the dose amount or volume will cause the rest of the fields to be calculated.
- Route and site are not required fields; the default value for the Route list is IV and the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



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.



- 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) 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 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 deletes any rate change indicators that might be present in the bar.

Modifying Medications

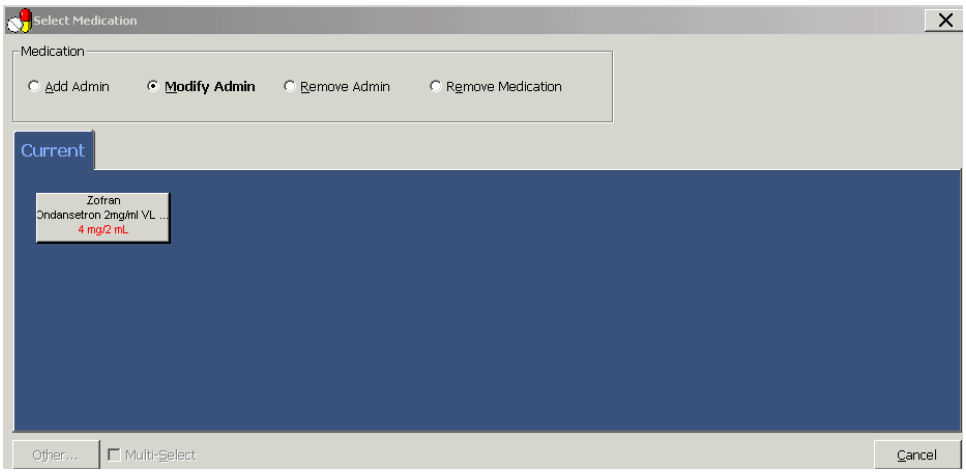
You can use either the Medication toolbar button or the record to modify medications.

Modifying Medications Using the Toolbar

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

1. Click

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.



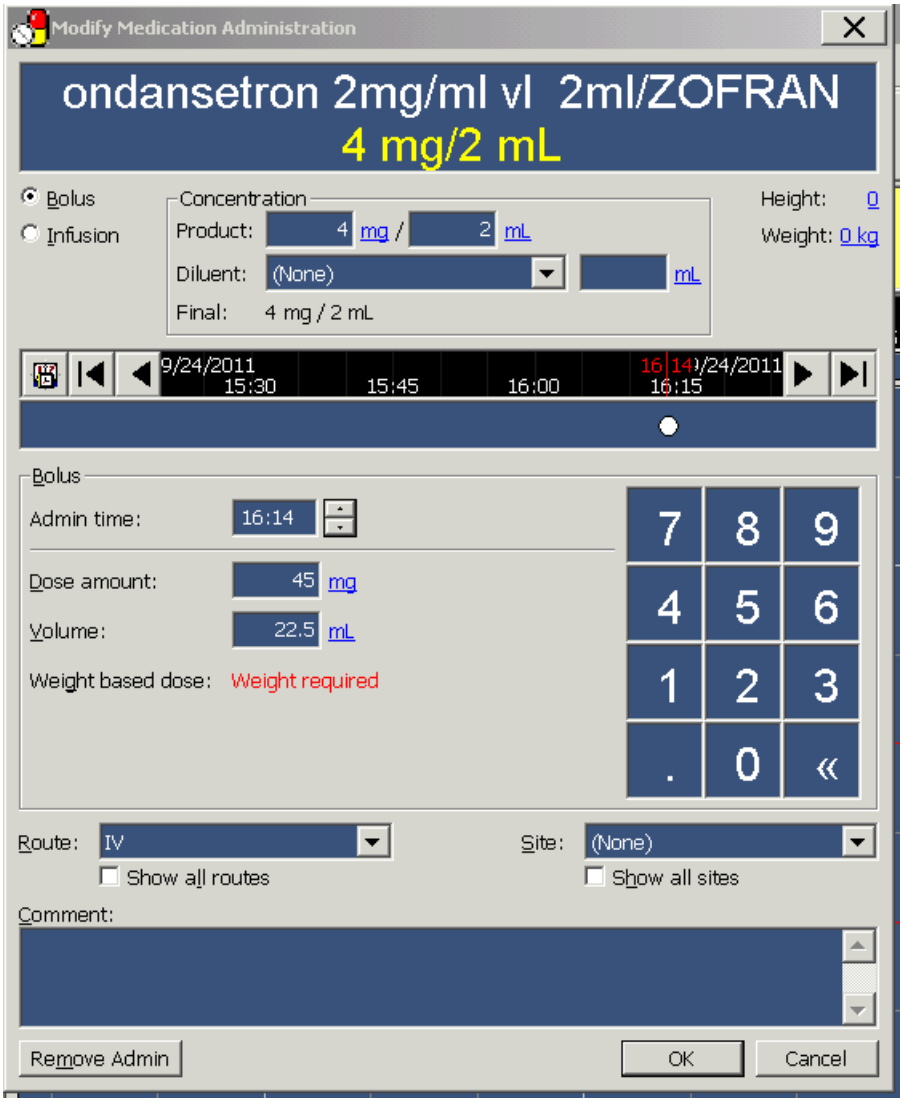
Note: The dialog box is updated to show just the Current tab and the administered medications. This is a very important step in modifying medications. If the Modify Admin option is not selected, there is a high probability that a medication will be added again.

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.



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.

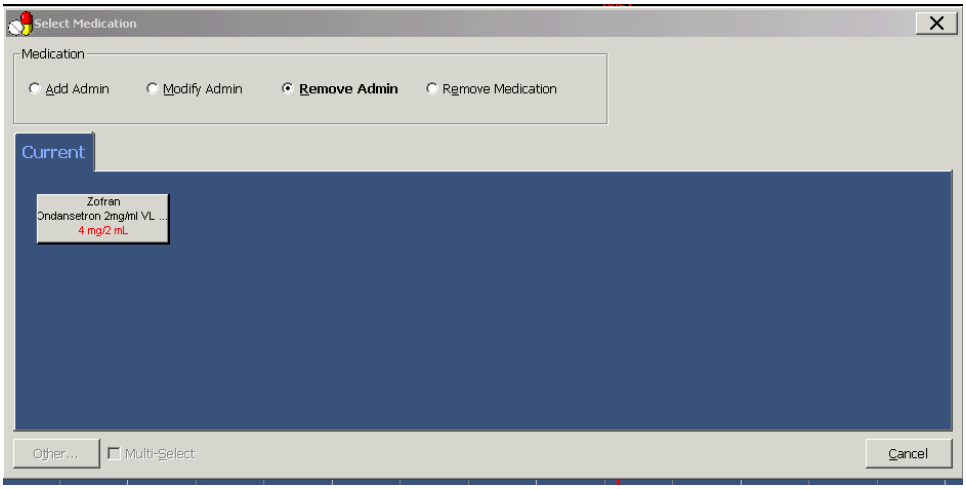
Removing Medications Using the Toolbar

To delete the medications administered, complete the following steps:

1. Click

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.



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.

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.

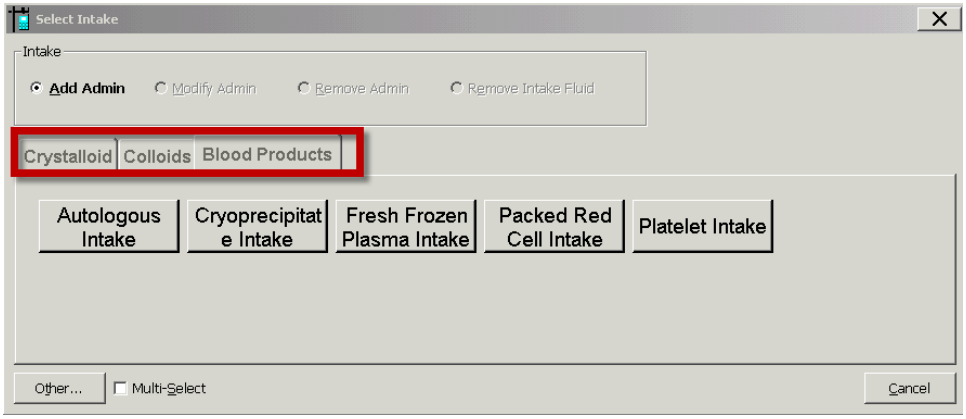
Adding Intakes Not Already on Record

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

1. Click

on the toolbar. The Select Intake dialog box opens.

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



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

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.

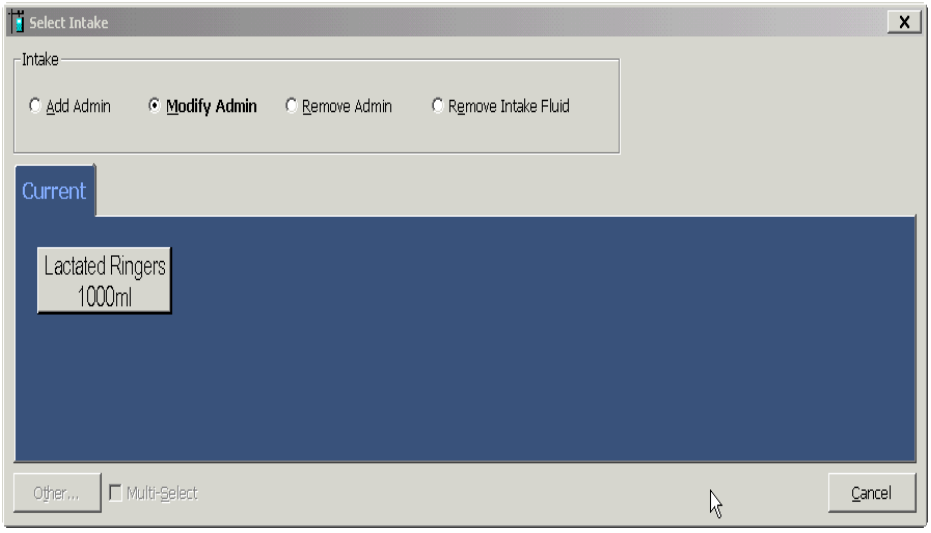
Modifying Intakes

Modifying Intakes Using the Toolbar

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

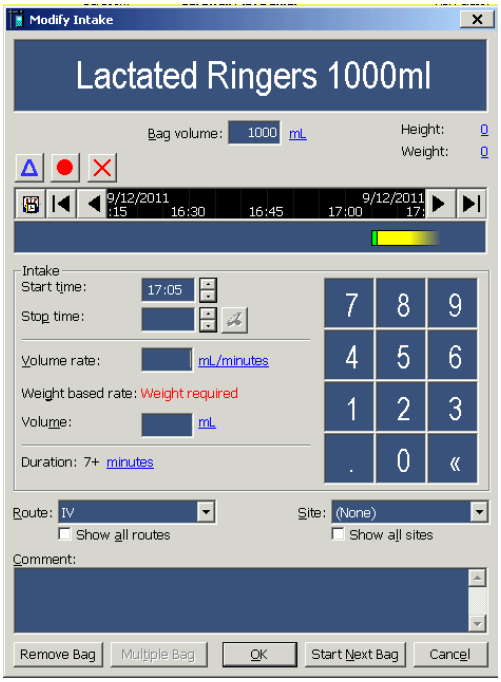
1. Click

on the toolbar. The Select Intake dialog box opens.
2. Select the Modify Admin option.



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.



8. Click . 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.

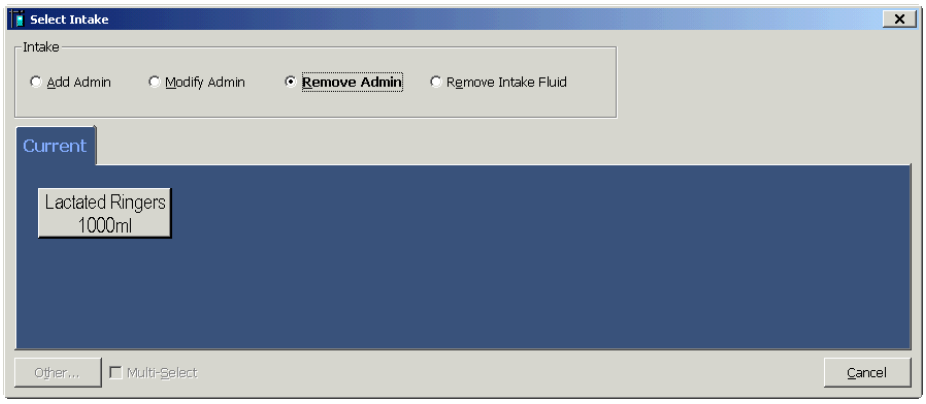
Removing Intakes

Removing Intakes Using the Toolbar

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

1. Click

on the toolbar. The Select Intake dialog box opens.
2. Select the Remove Admin option.

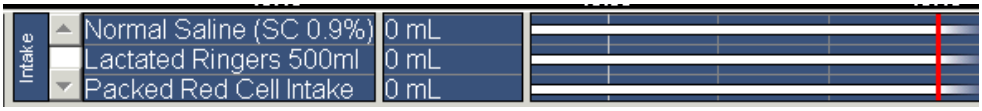


3. Click the medication that needs to have an administration removed, and the corresponding value is removed from the graph.
4. If there are multiple administrations of the same fluid, select the one that needs to be removed, and click OK to remove it from the record.

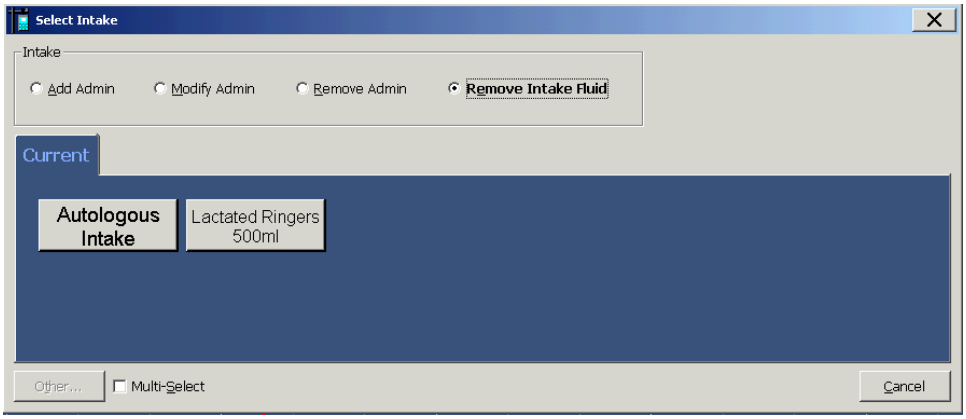
Removing Intakes Using Recorded Fluids

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.



2. Click Remove Intake Fluid to remove the administration.



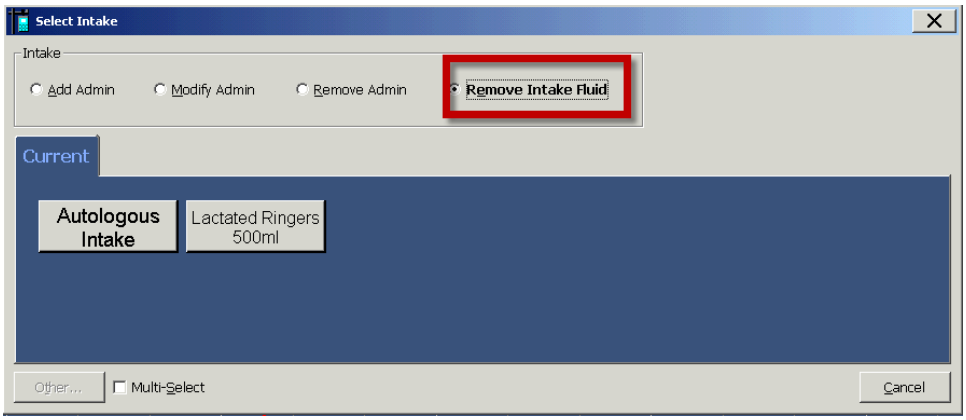
The administration is removed from the record. If there was only one bag hung for that particular fluid, the entire fluid is removed from the record.

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.



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

Adding Outputs

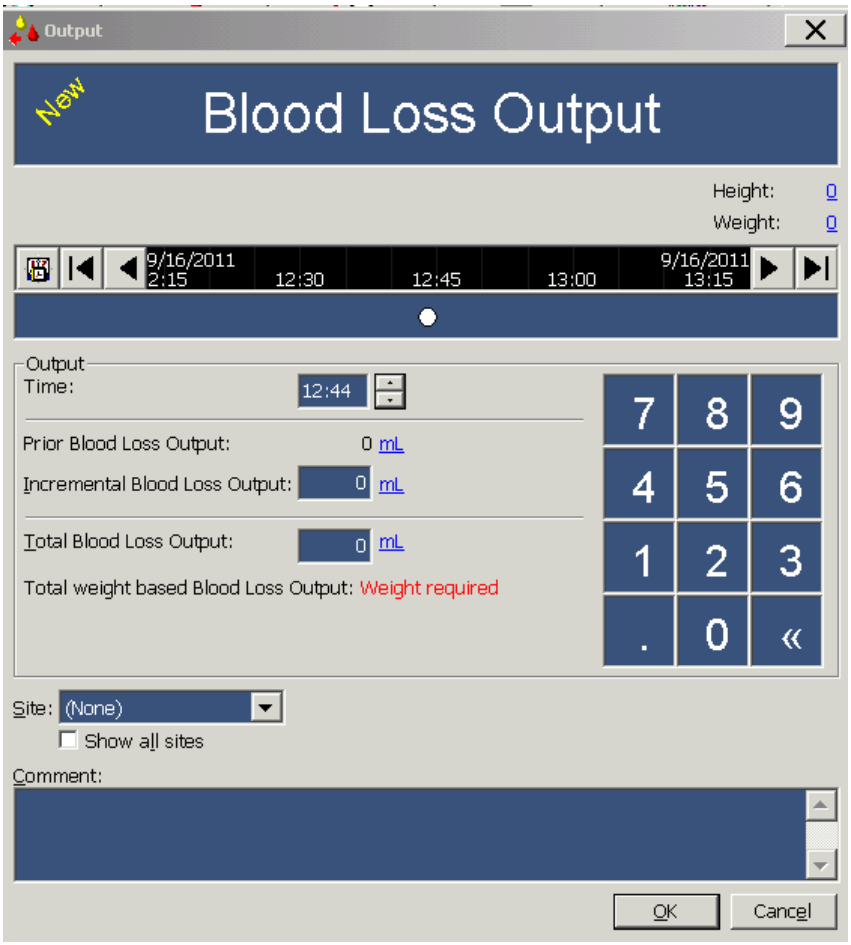
Adding Outputs

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.



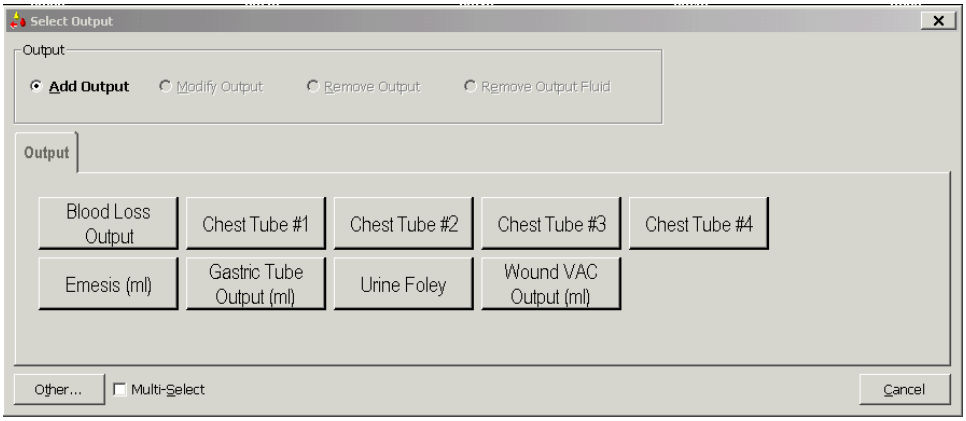
3. Click OK to add the output.

Adding Outputs Not Already on Record

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

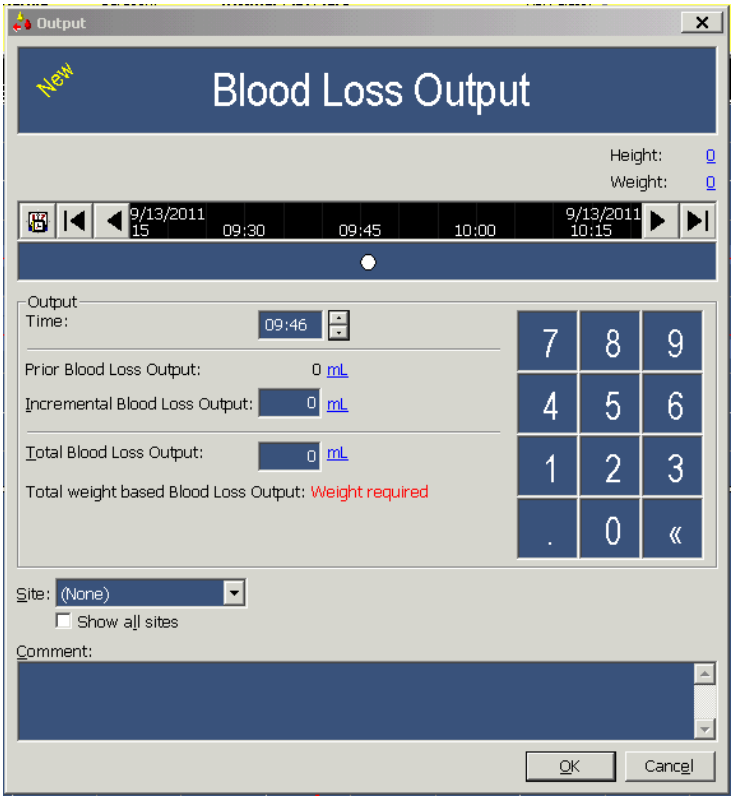
1. Click

on the toolbar. The Select Output dialog box opens.



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.



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

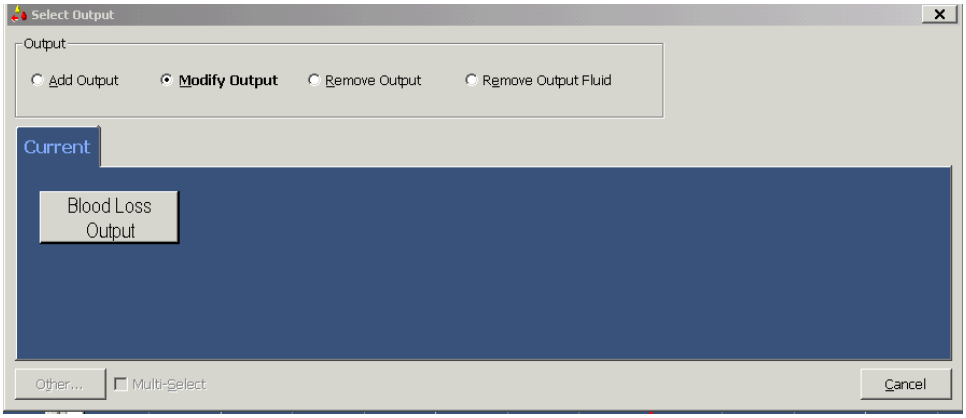
Modifying Outputs

Modifying Outputs Using the Toolbar

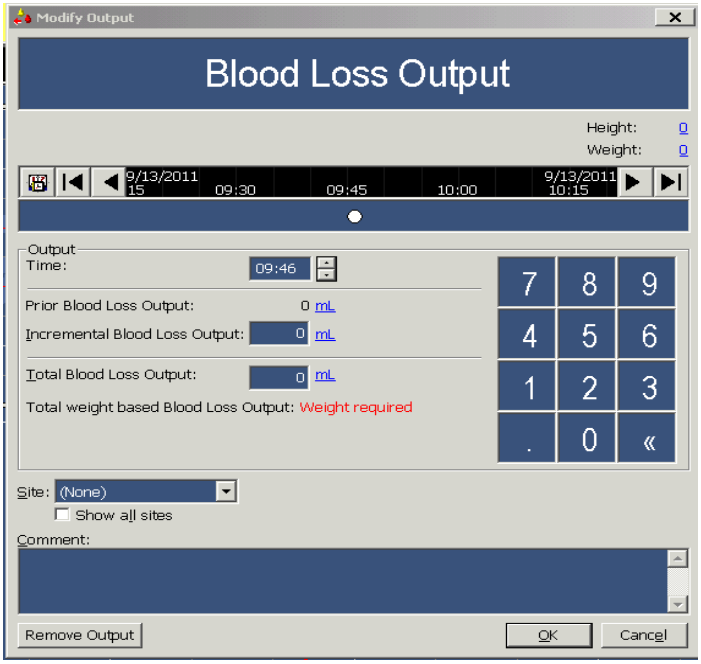
To modify outputs using the Output button on the toolbar, complete the following steps:

1. Click

on the toolbar. The Select Output dialog box opens.
2. Select the Modify Output option.



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



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:

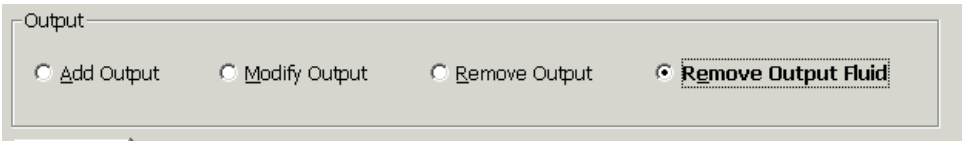
1. If an output has already been documented, click the white dot marking its documentation on the record. The Modify Fluid Output dialog box opens.
2. Modify the volume of the output as needed, and then click OK.

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.

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.

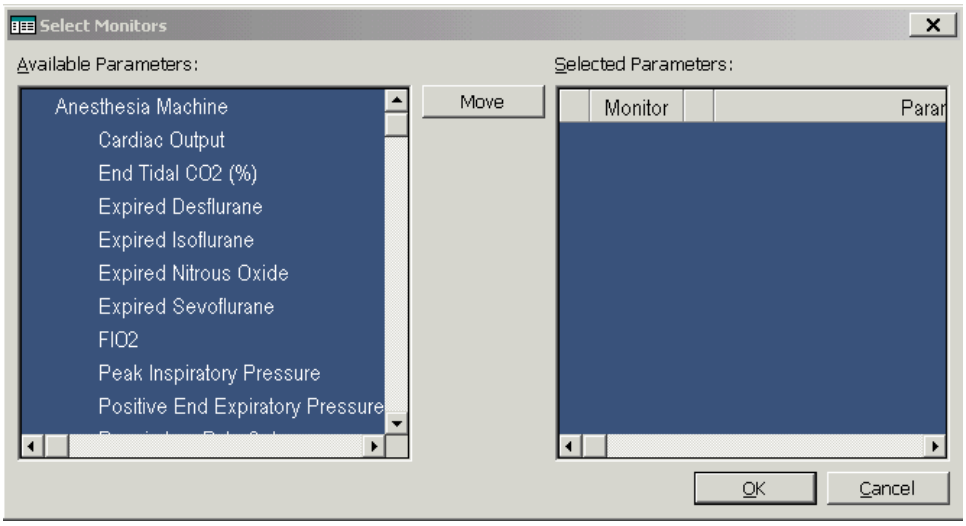
Note: There are standard values that already exist that you can use. Use the steps below in case you need to add or modify a value.

Adding Monitors

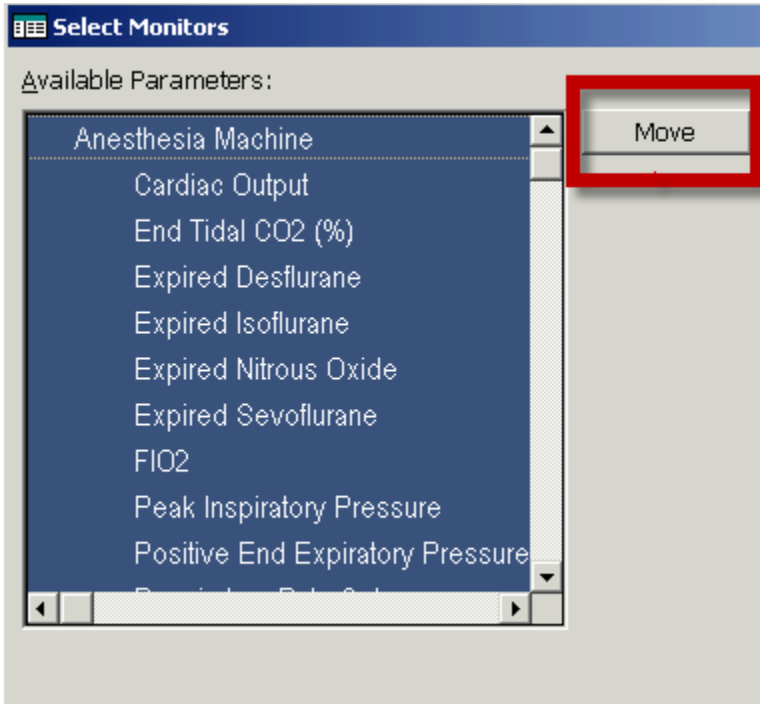
To specify the information to be displayed, complete the following steps:

1. From the Document menu, select Monitors.

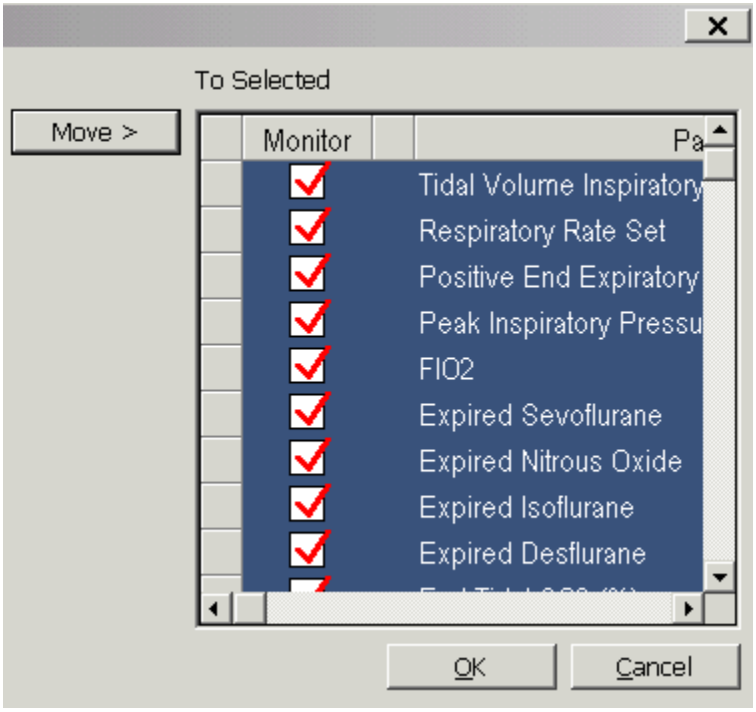
2. The Select Monitors dialog box opens. The list on the left shows the available device parameters to select from. The list on the right side shows those parameters that are currently being monitored.



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.



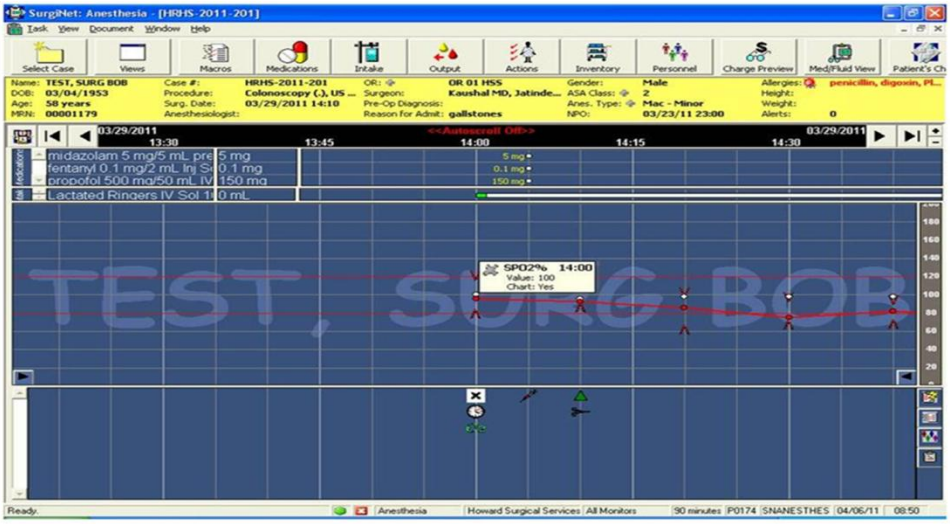
4. Symbols are displayed next to those parameters that have been designated as graphical values. If a parameter does not have a symbol next to it, it is displayed in the Monitors section of the record.
5. Click OK to save your monitors preferences.

Modifying Monitored Values

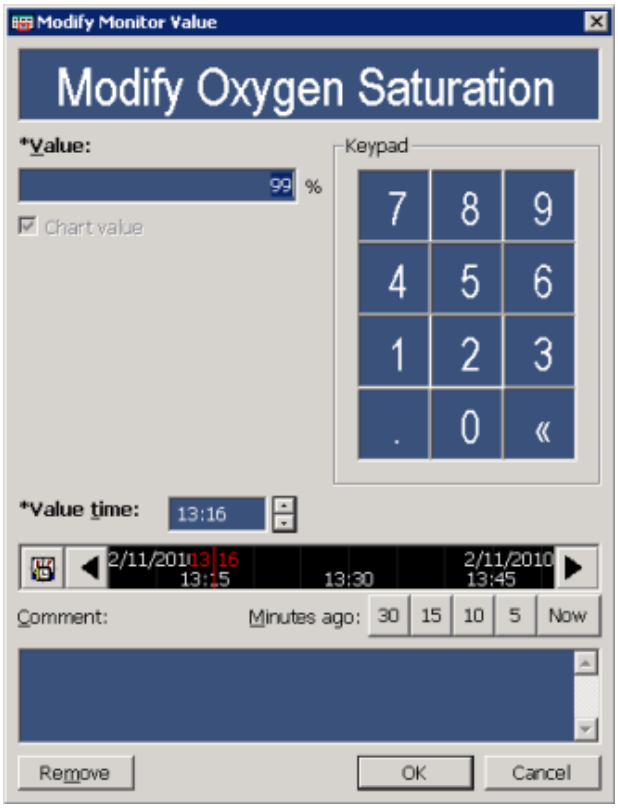
There is always a possibility that the values that populate the electronic record are erroneous or incorrect due to a number of different reasons. Because this interference or artifact is possible, there are ways to adjust the values on the record so that they more accurately represent the patient's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

To modify a monitored value, complete the following steps:

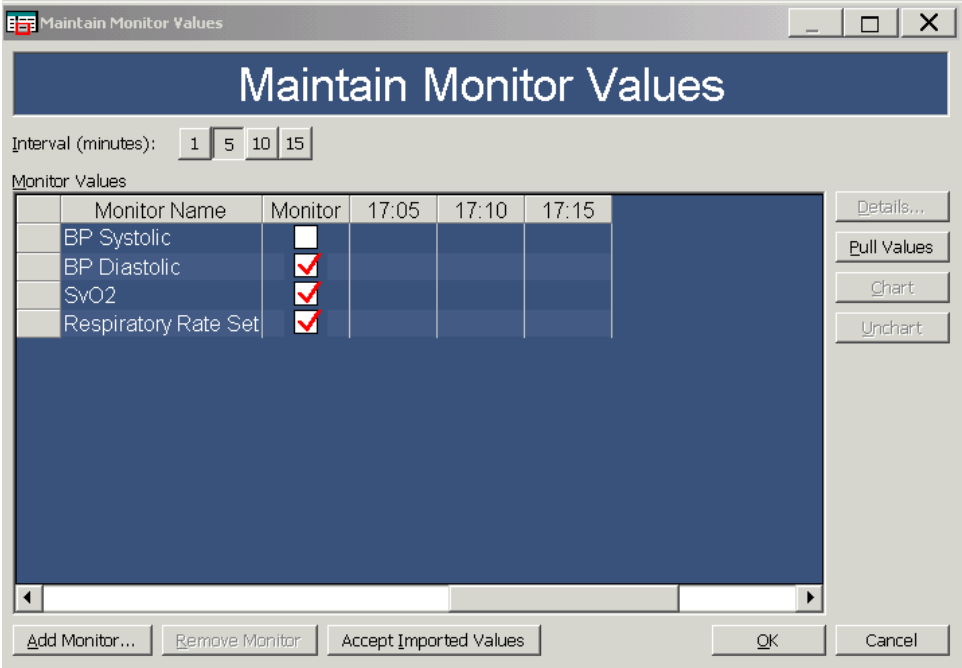
1. In the Monitors section, click any of the values displayed.



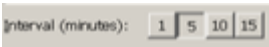
The Modify Monitor Value dialog box opens.



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.



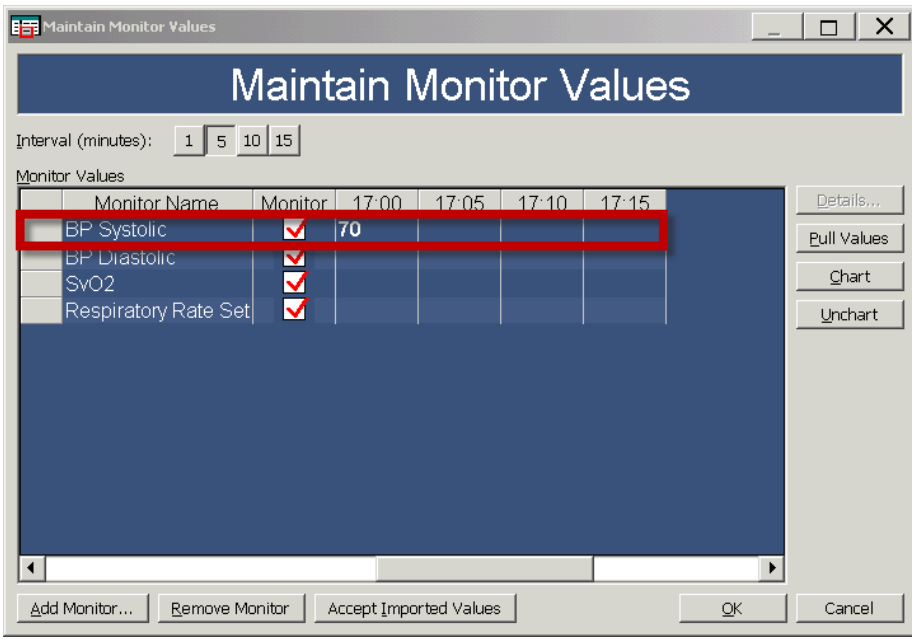
5. Click the value that you want to modify.
6. Make the necessary modifications. You can modify the value interval c clicking the 1, 5, 10, and 25 buttons above the main part of the sheet. This helps narrow or expand the values so that you can locate the values to modify.



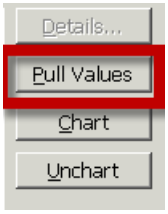
7. Click OK. The record is updated with the correct value.

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.

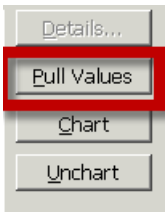


- Pull Values. Click the gray box to the left of any of the monitor names and then click Pull Values to add all of the values that have been collected so far by the device.



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.

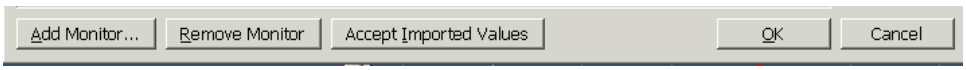


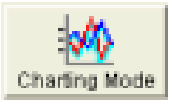
Chart and Unchart

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 

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

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.

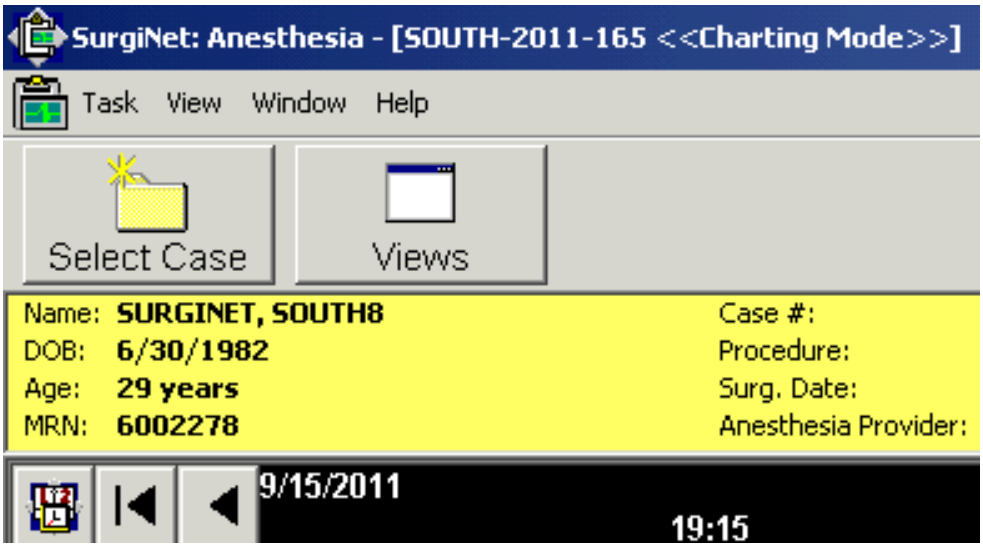
4. When you have finished making your changes in Chart Mode, click Charting Mode on the toolbar again to revert to the normal view.

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.



Actions

Using the Action List

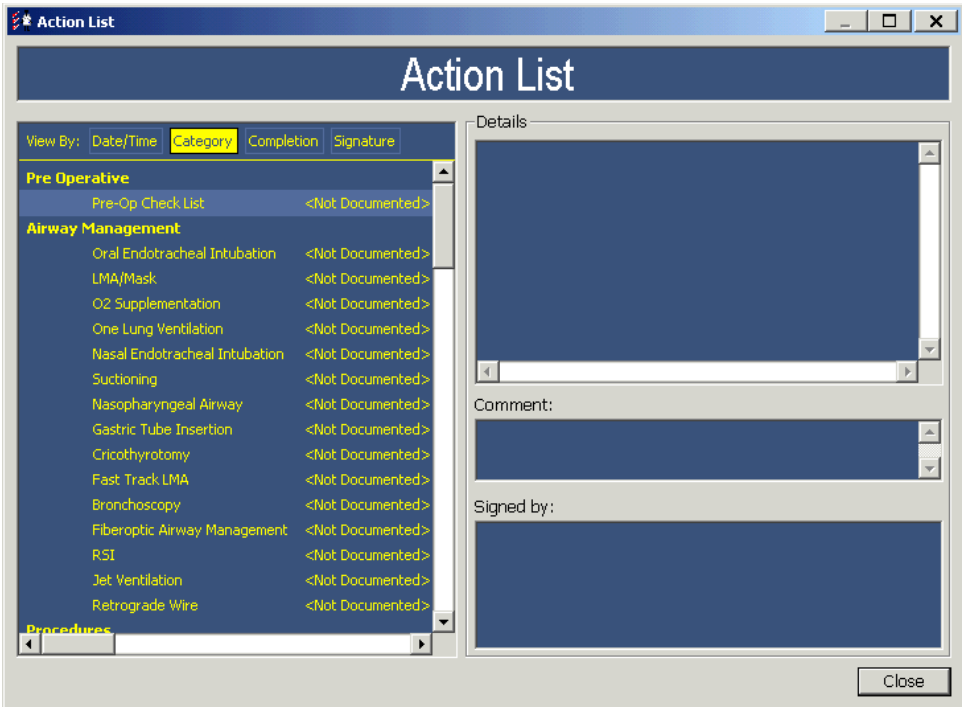
Note: This section is for informational purposes only. If you use an action, it currently will not display in the case or documentation.

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.

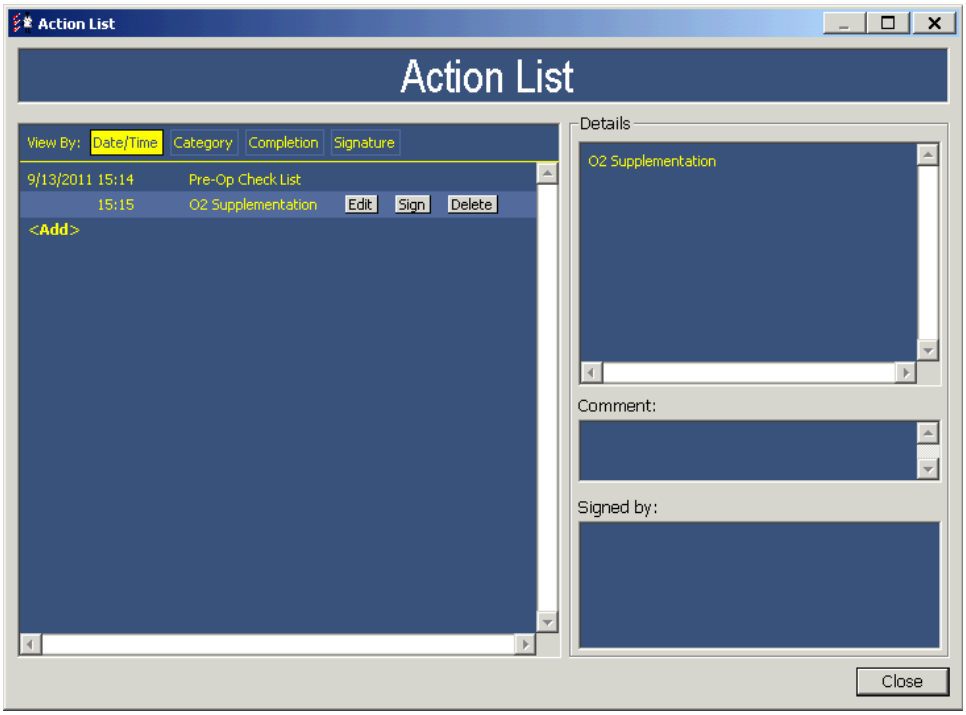
There are actions that have details built behind them (such as add IV regional block), and there are also actions that do not have any details (such as add anesthesia start time).

1. Click

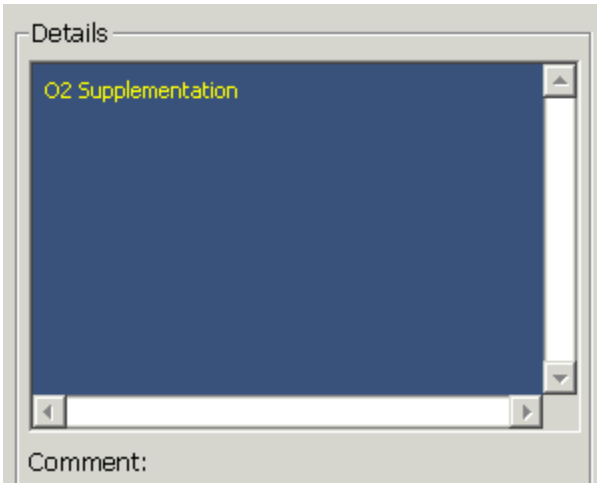
on the toolbar. A list of actions is displayed. Several methods exist to view the actions that have been documented.



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.



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.



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

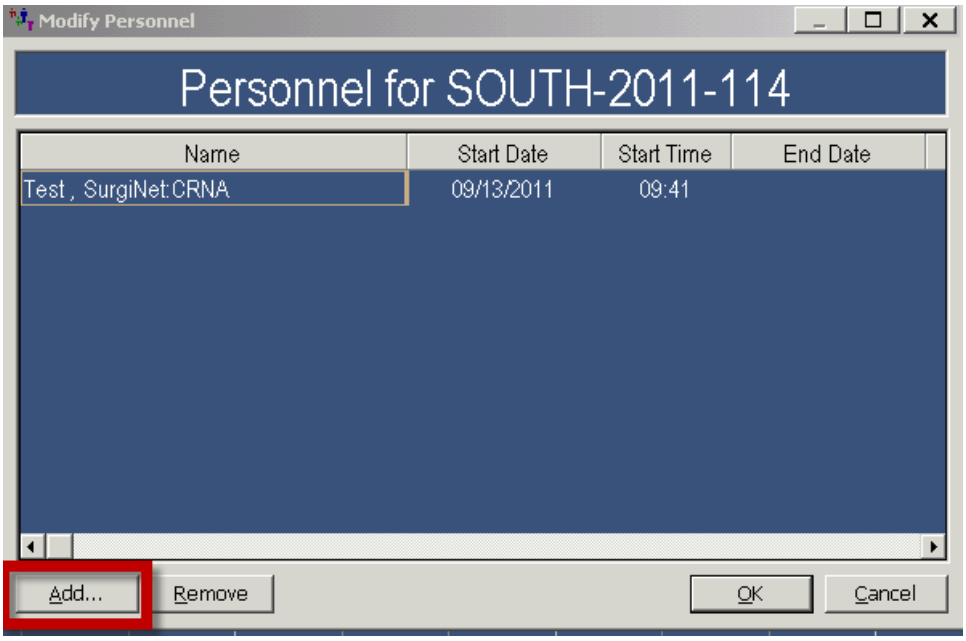
Personnel can be added to the record to show how many providers have been involved in a particular case and the times they were involved. Personnel can be seen on the record in the Action Bar area, or it can be viewed in a separate dialog box by selecting the Personnel toolbar button.

Adding Personnel

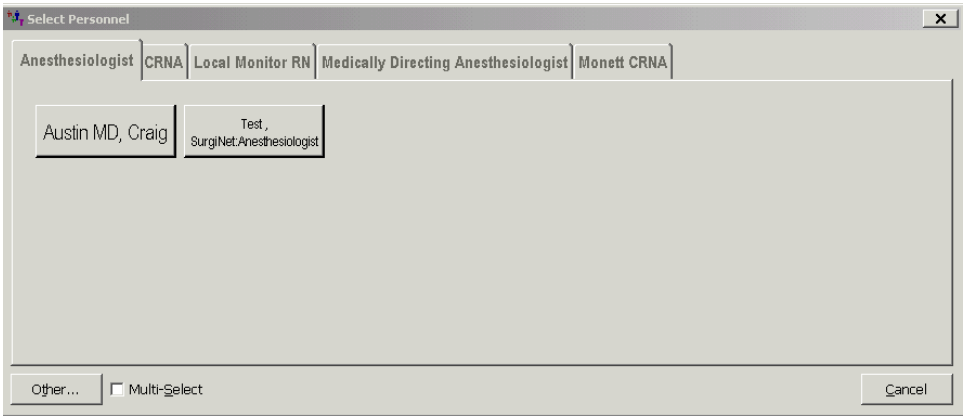
In *SurgiNet* Anesthesia you are able to add or remove personnel. To add personnel, complete the following steps:

1. Click

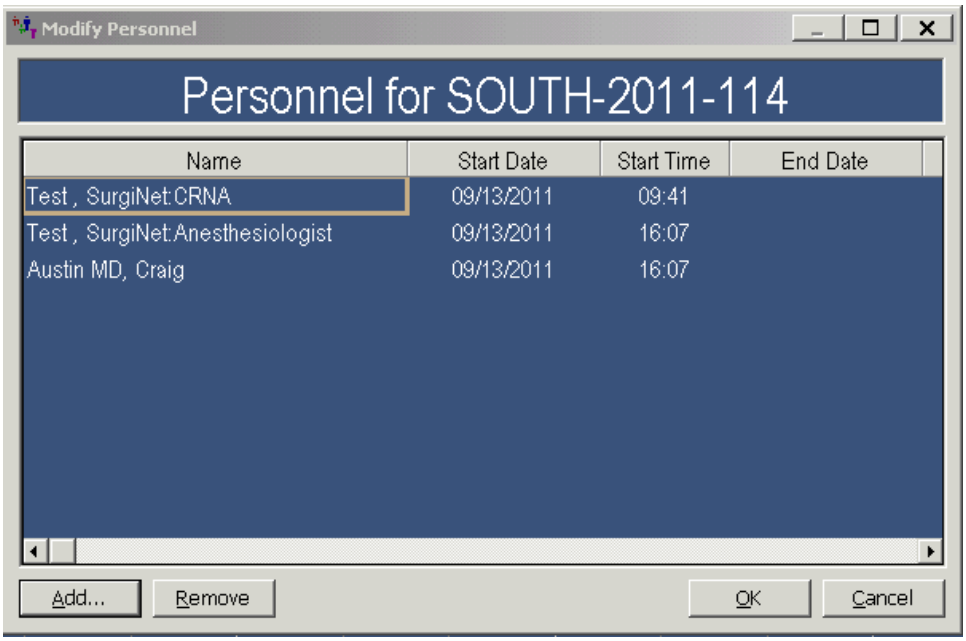
on the toolbar. The Modify Personnel window opens.
2. Click Add to open the Select Personnel dialog box.



3. Locate the provider.



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



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

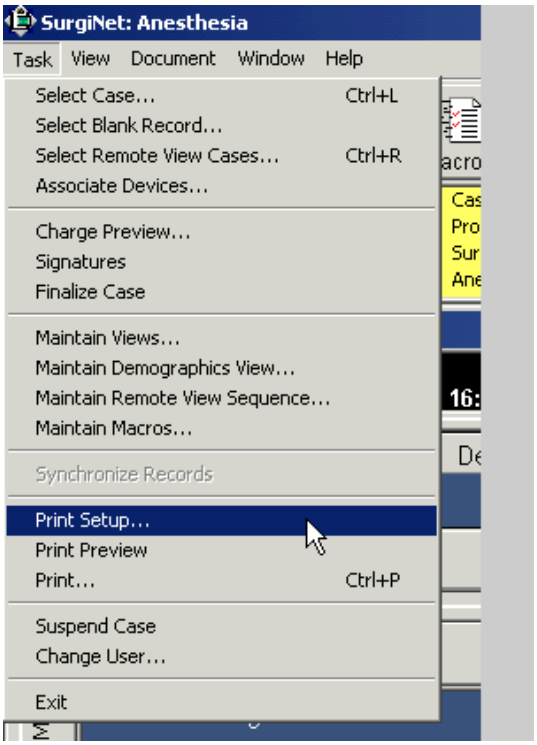
Note: To remove personnel, select the personnel that you want to delete and click Remove.

Printing Records

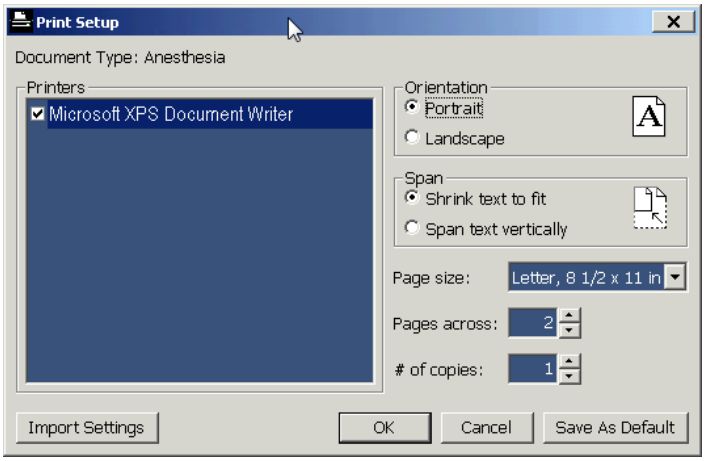
Print Setup

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:

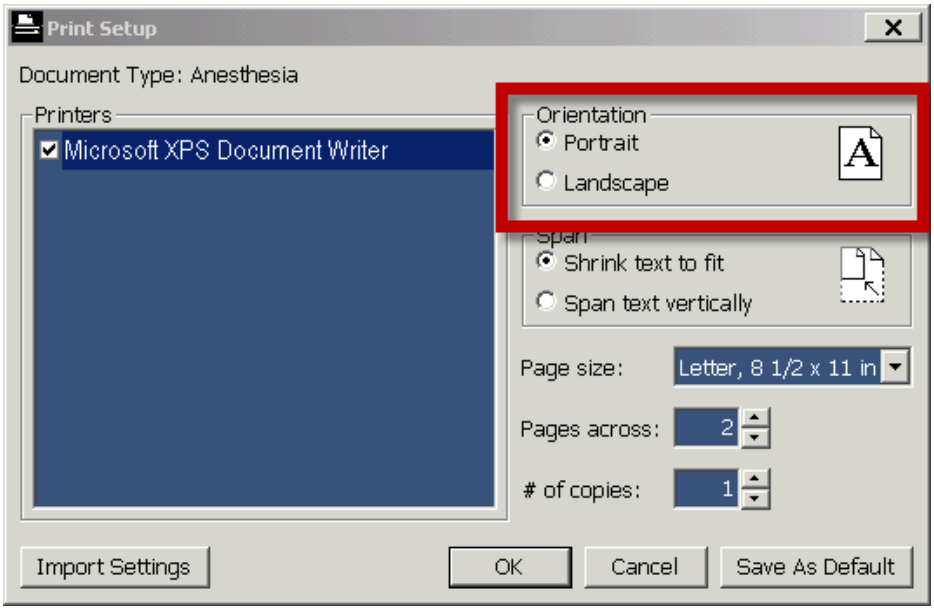
1. Select Print Setup from the Task menu to display the Print Setup dialog box, in which you can specify print parameters.



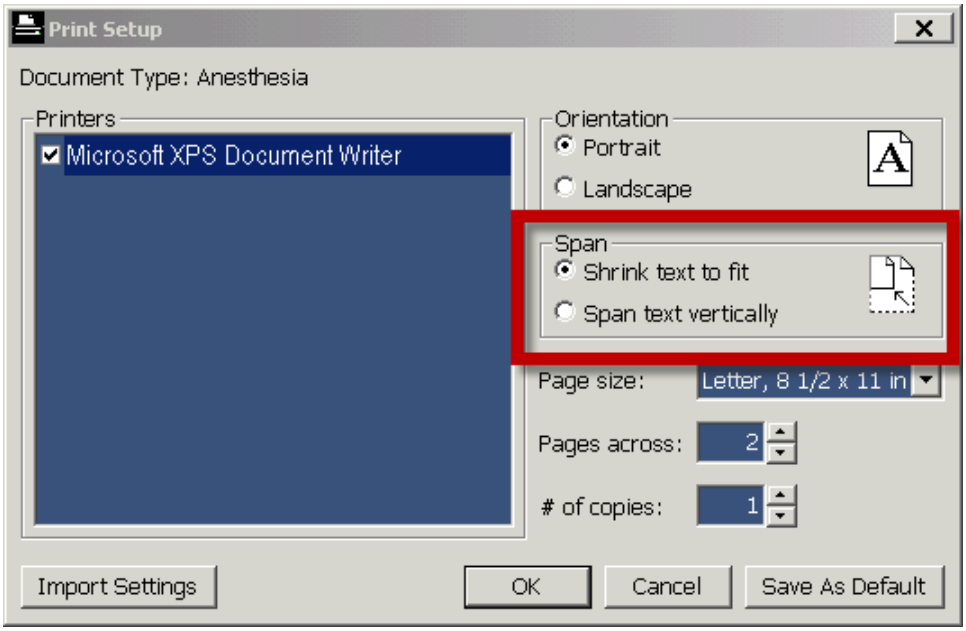
2. To specify the printer to print the record to, select the printer from the Printers list.



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

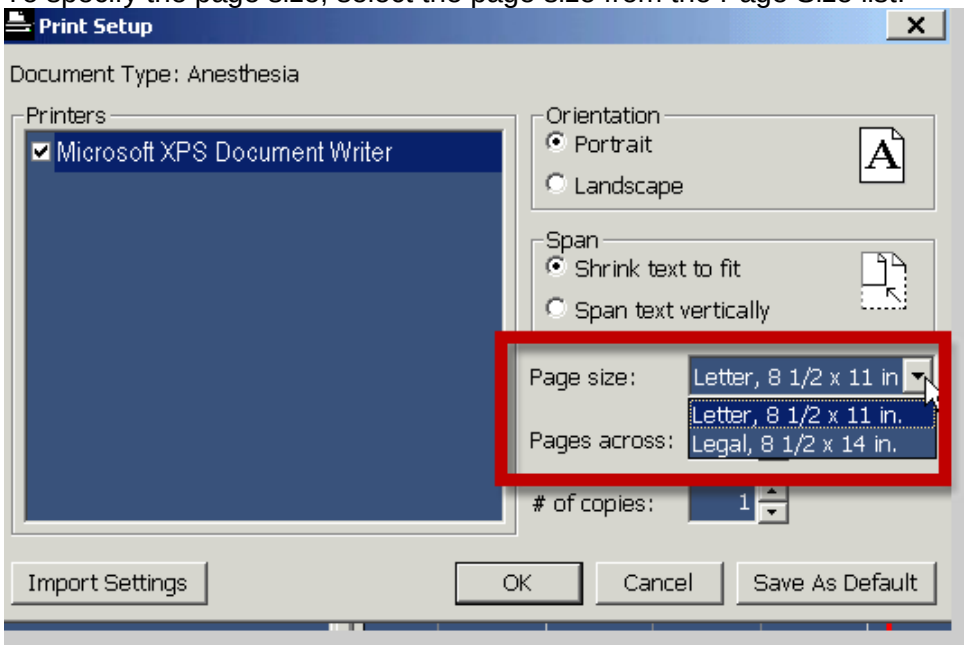


4. To indicate the span and text layout of the printed record, select the Shrink Text to Fit or Span Text Vertically option.

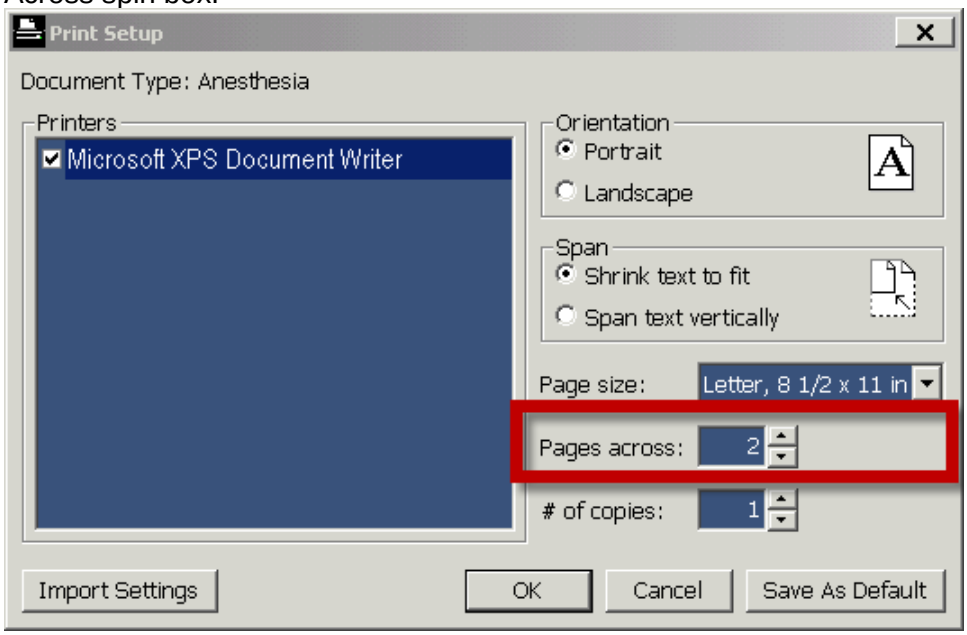


Note: Selecting the Shrink Text to Fit option specifies the entire printed anesthesia record to print on the designated page size. Selecting the Span Text Vertically option specifies the printed anesthesia record to print on multiple pages if the text does not fit on a single page.

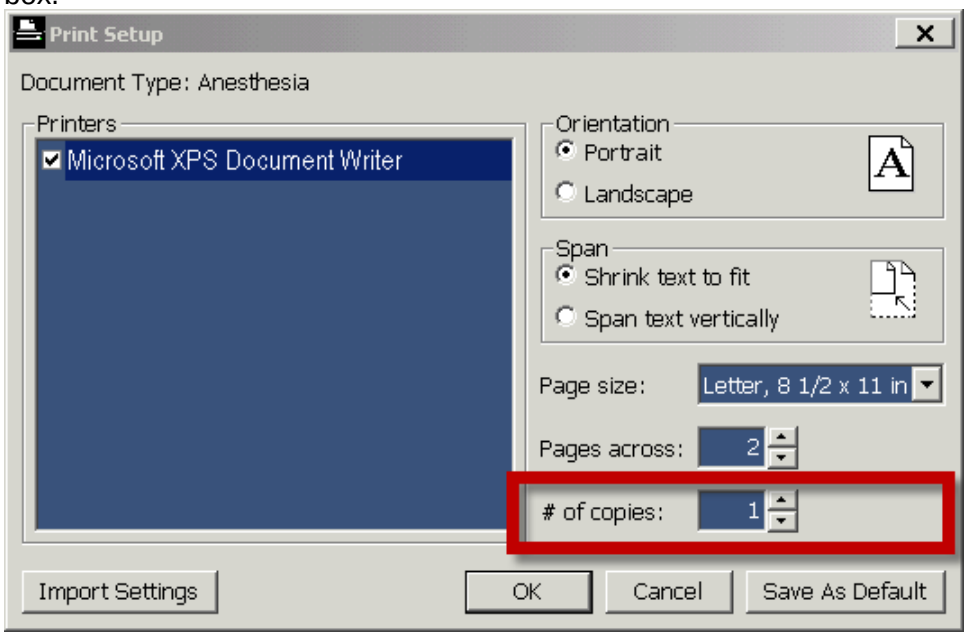
5. To specify the page size, select the page size from the Page Size list.



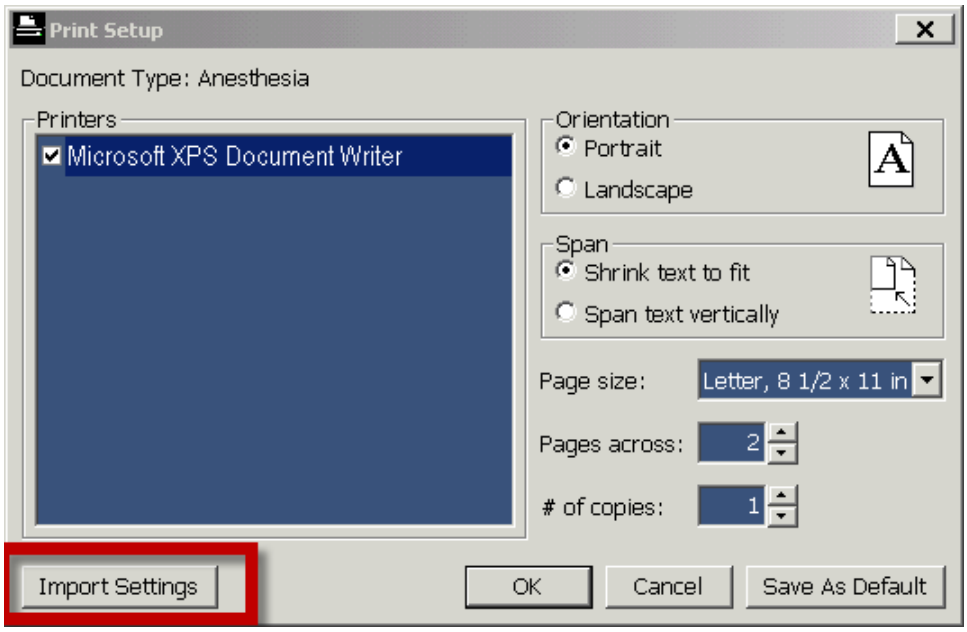
6. To specify the number of pages to print the record to, enter the number of pages in the Pages Across spin box.



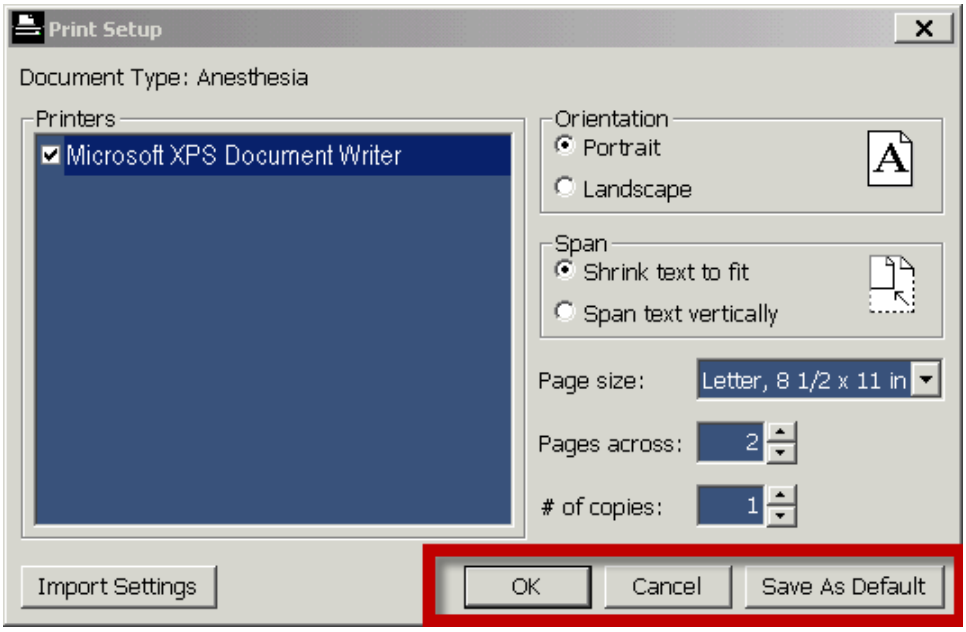
7. To indicate the number of copies to be created, enter the number of copies in the # of Copies spin box.



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.



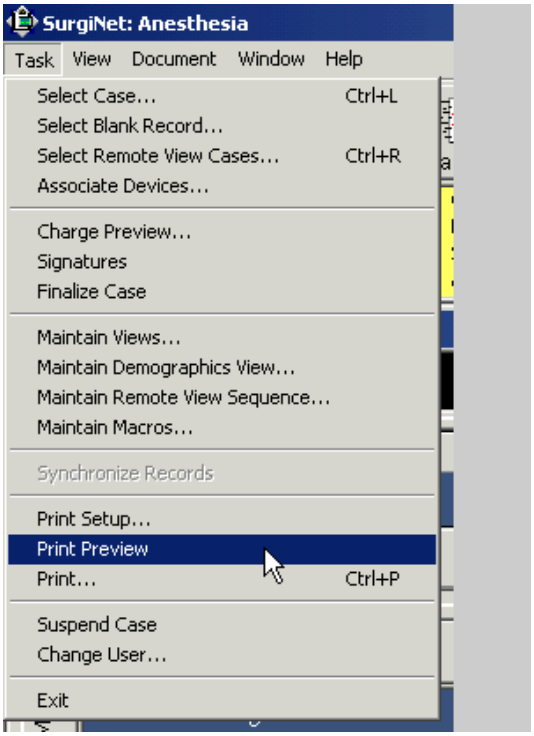
9. After you have made the appropriate specifications in the Print Setup dialog box, click OK to close the dialog box and save your settings, click Cancel to close the dialog box without saving your settings, or click Save as Default to make your settings the default next time you want to print an anesthesia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



Print Preview

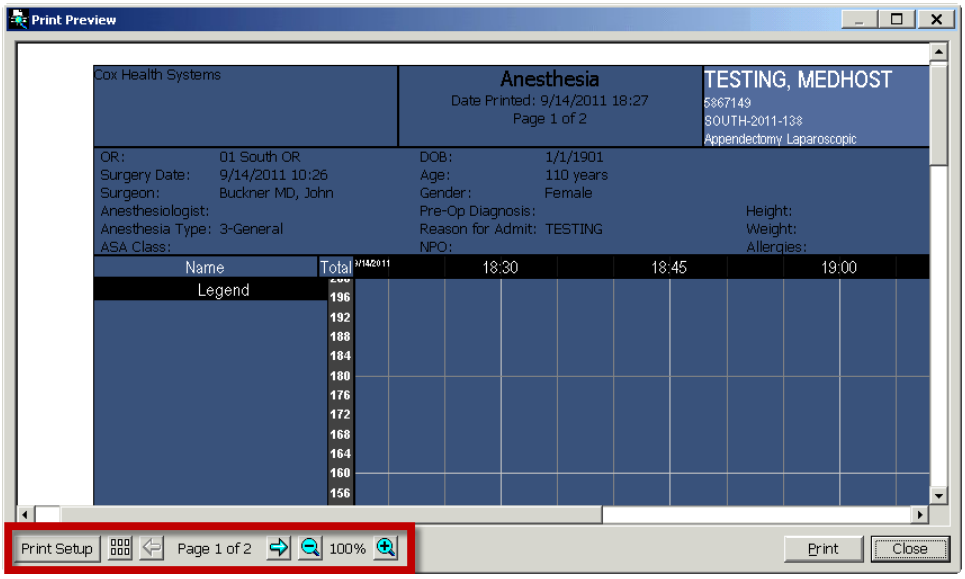
To preview the record prior to printing it, complete the following steps:

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



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

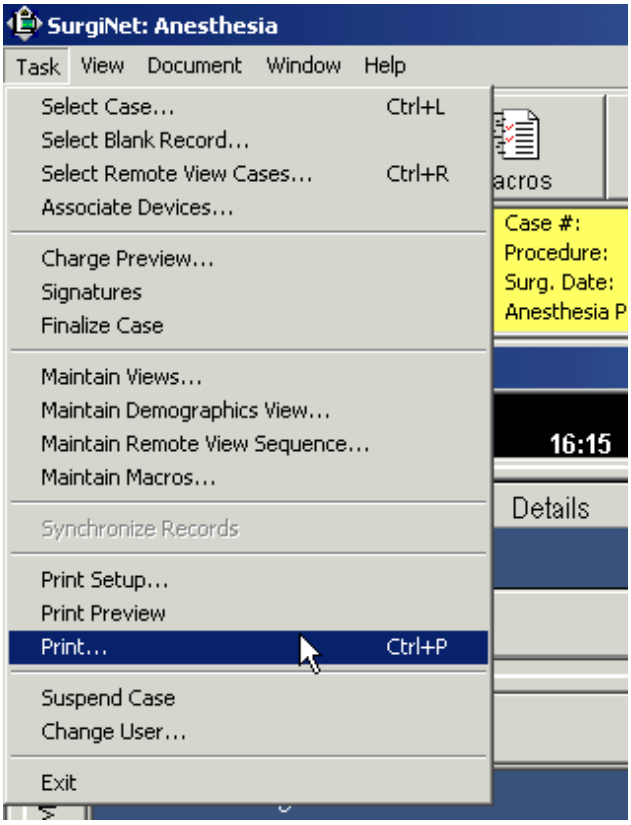
2. Click Print Setup to make modifications to the page format, or click Print to send the record to the printer. Click Close to close the Print Preview window without sending the record to the printer.



Printing a Record

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

1. From the Task menu, select Print.



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

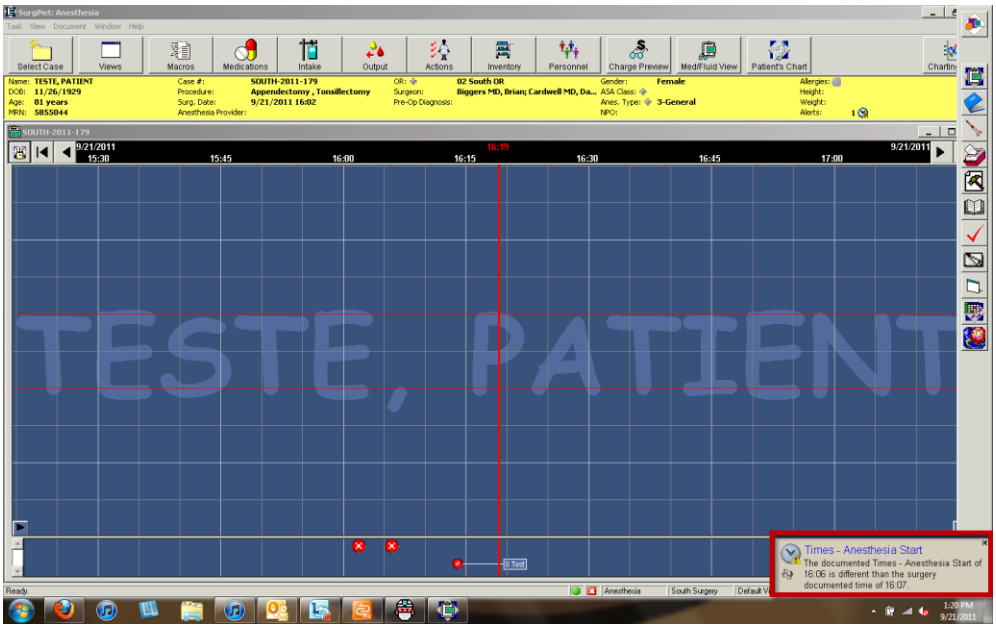
2. Modify any print settings as needed, such as specifying the printer to which the record should be sent.
3. Click OK to send the record to the printer.
4. If the printing data exceeds one page, the system will print the following message: **Refer to electronic record for complete data in the Actions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

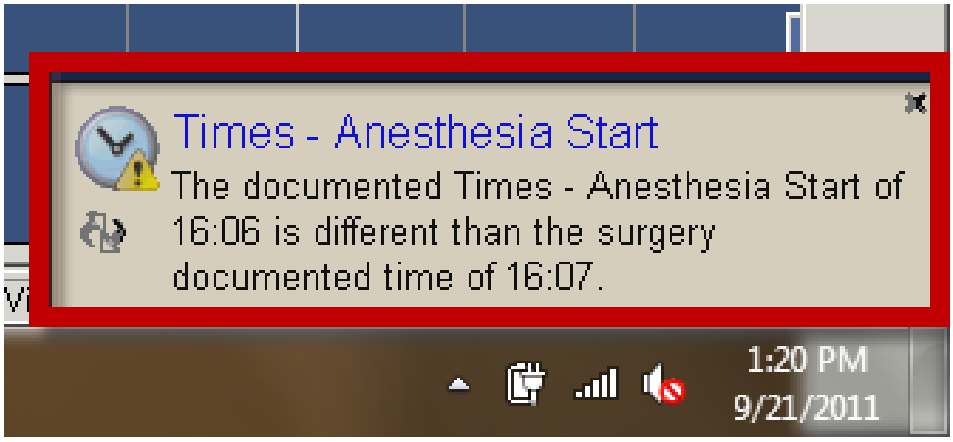
Alerts

Viewing and Managing Alerts

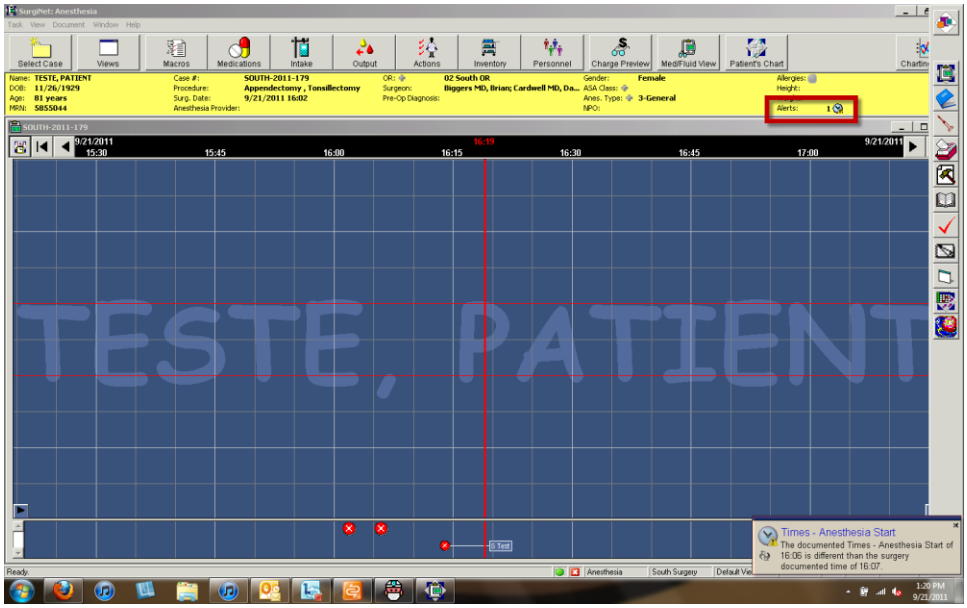
Alerts display only if information regarding the anesthesia record and the anesthesia documentation do not correlate. The discrepancy then fires an alert that is displayed in two locations on the anesthesia record.

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


TESTE, PATIENT
Times - Anesthesia Start
The documented Times - Anesthesia Start of 16:06 is different than the surgery documented time of 16:07.


Times - Anesthesia Start
The documented Times - Anesthesia Start of 16:06 is different than the surgery documented time of 16:07.
1:20 PM
9/21/2011

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

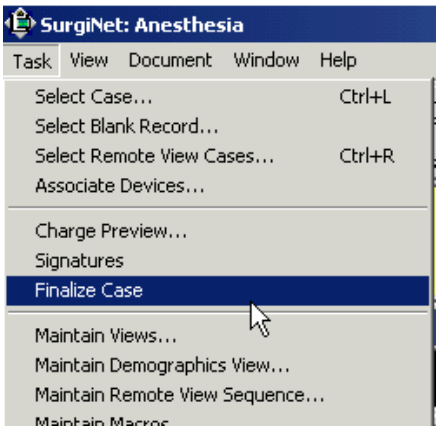


Finalize a Record

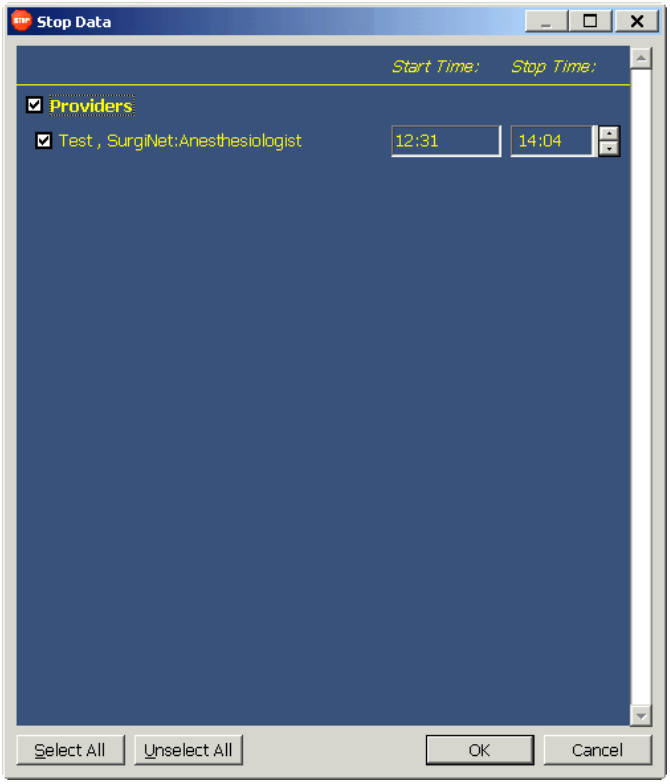
Finalizing the Case

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

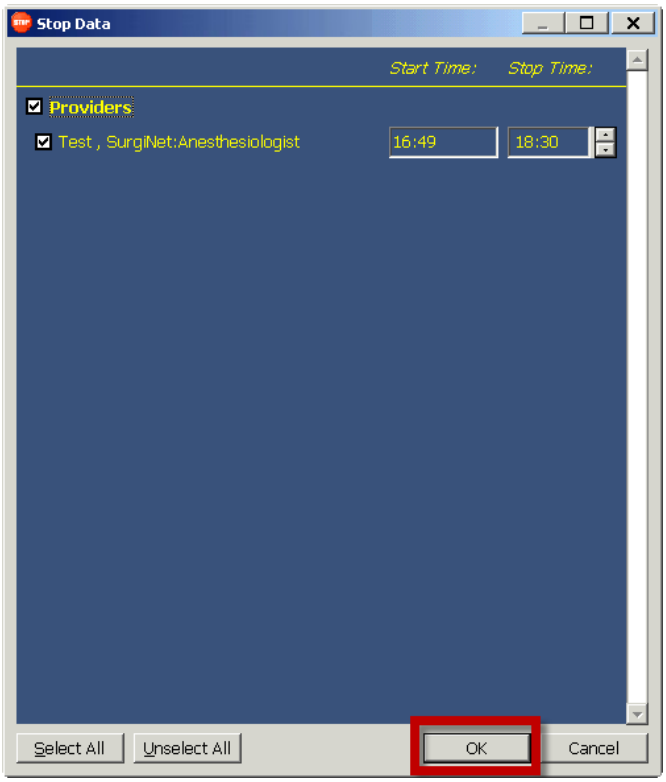
1. After your documentation is complete, select Finalize Case from the Task menu to open the Finalize window.



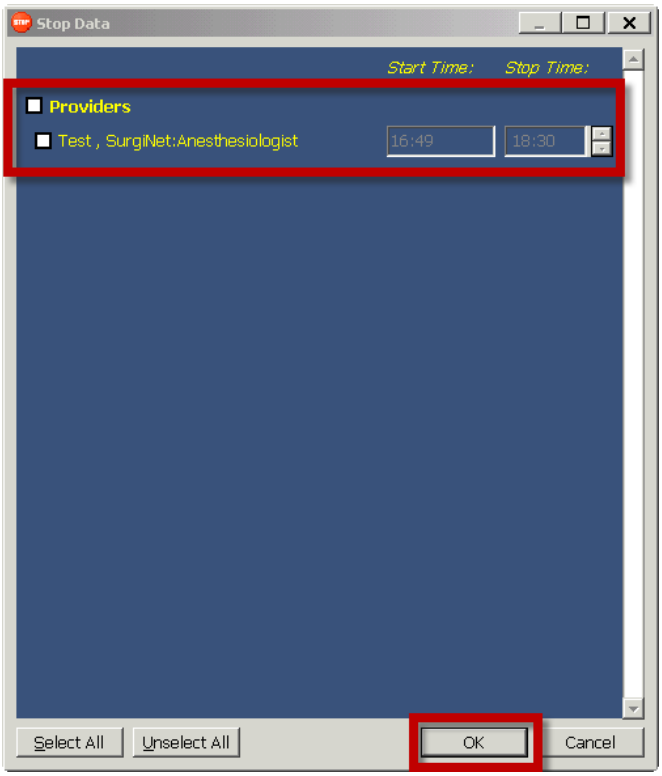
2. If any current tasks or administrations are being conducted on the anesthesia record that finalizing the record will interrupt, the Stop Data dialog box is displayed.



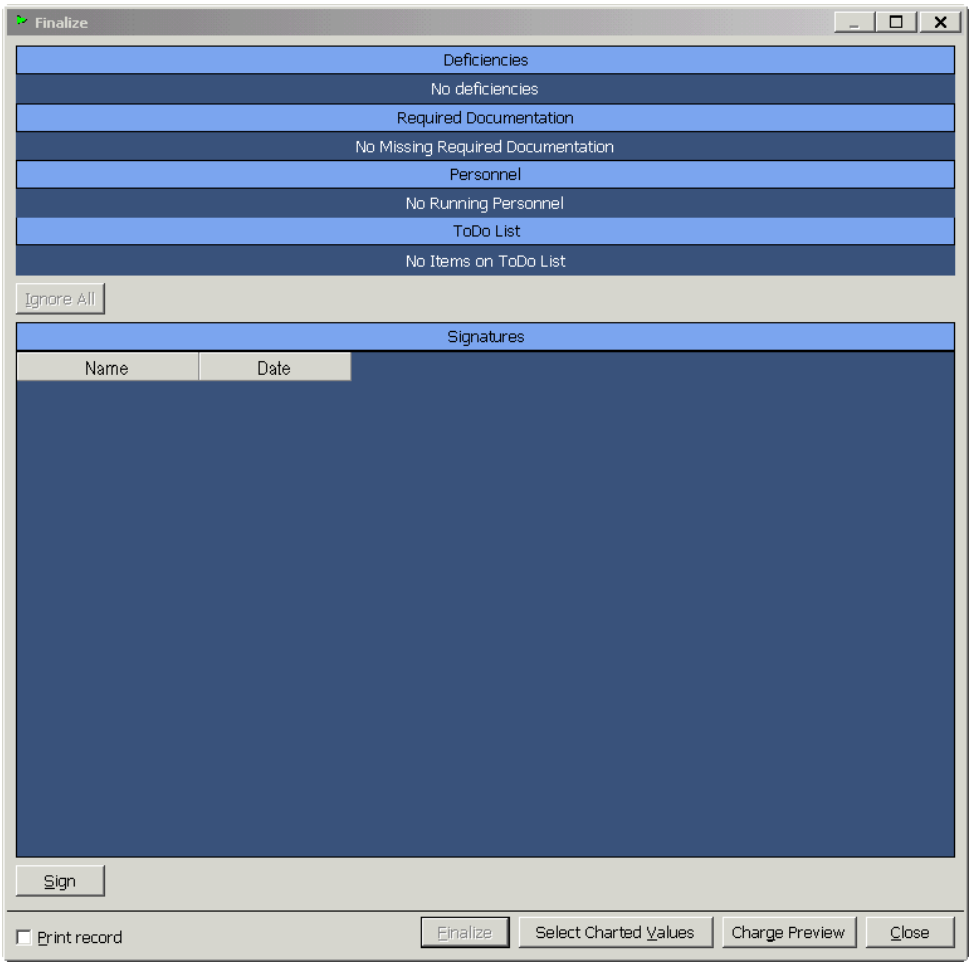
3. To stop the task and proceed, select the check box adjacent to the task, complete any required fields, and click OK.



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

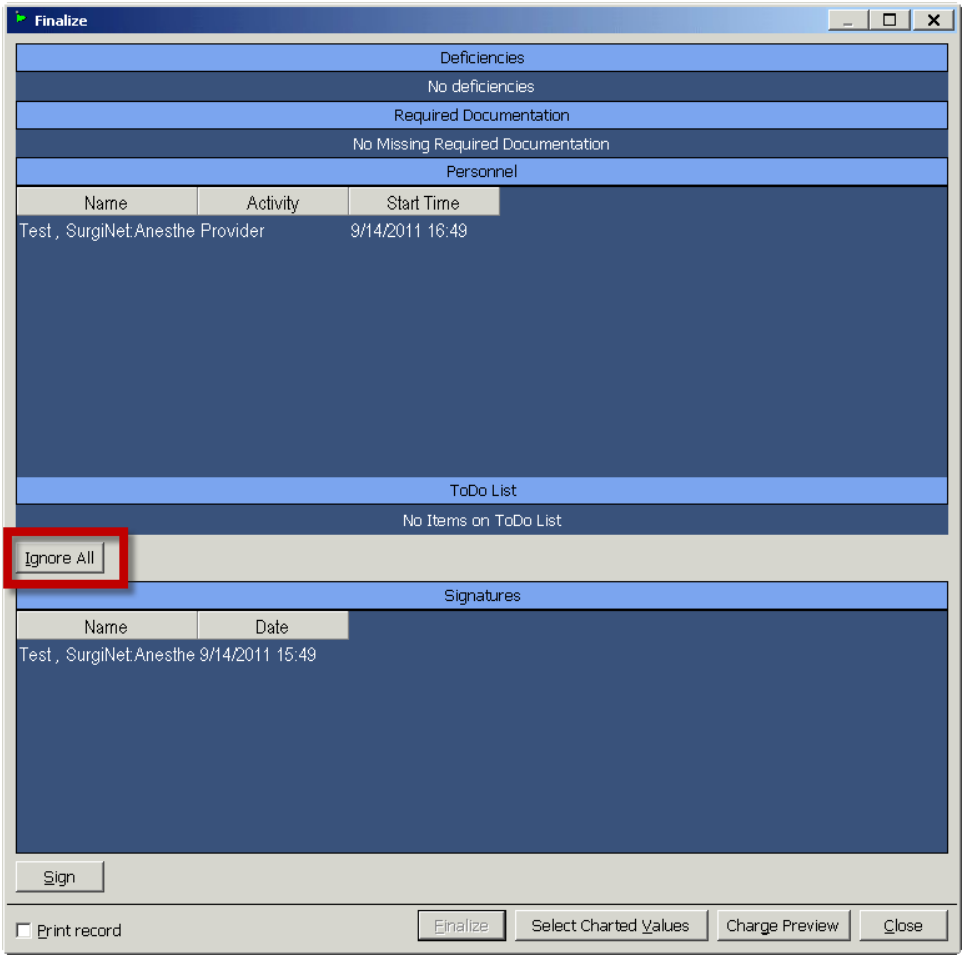


5. To add values directly from this dialog box, click Edit in the Type row and add the values as appropriate.
6. In the Finalize dialog box, review any documentation deficits in the Deficiencies list and duplicate actions that may be restricted to being documented only once, if any exist. The Finalize 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.



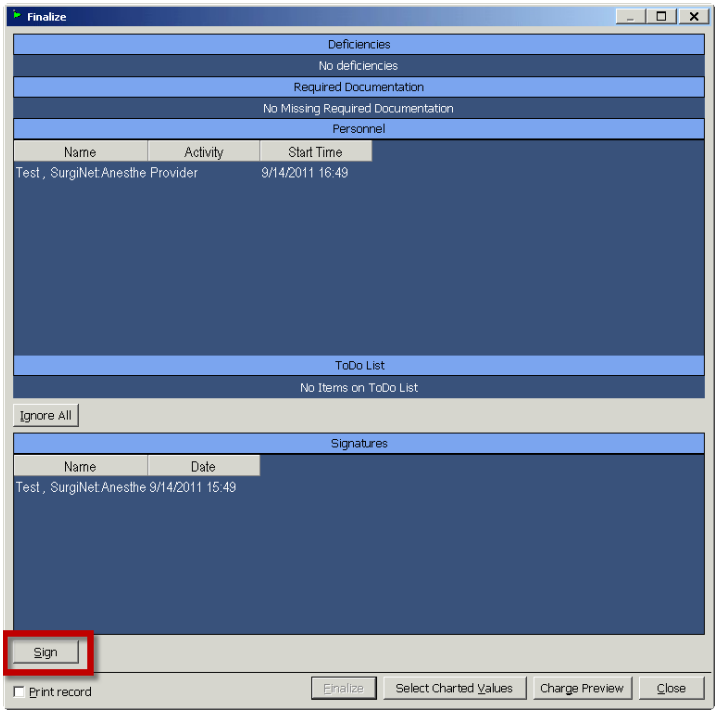
Note: If there are any fluids that need stop times or actions that have required fields on them, they will be seen in the Deficiencies section. Click Edit to edit the fluid or action. Once the deficiency is accounted for, that item is removed from the Finalize dialog box.

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.



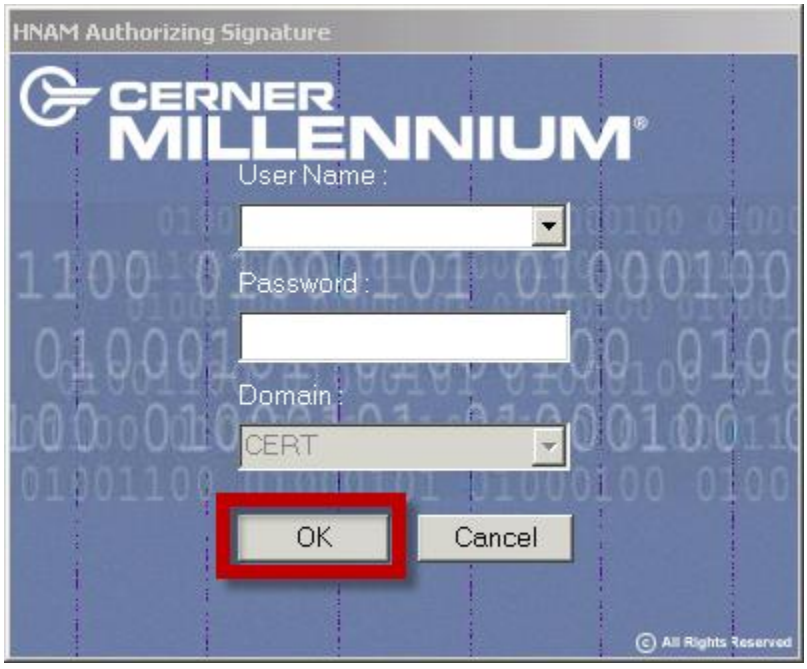
8. In the Finalize dialog box, review all required documentation. Required documentation is predefined in SADBBuild.exe.
9. Review the personnel or documented providers that are not assigned to a stop time.
10. In the Finalize dialog box, review your to-do list.

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

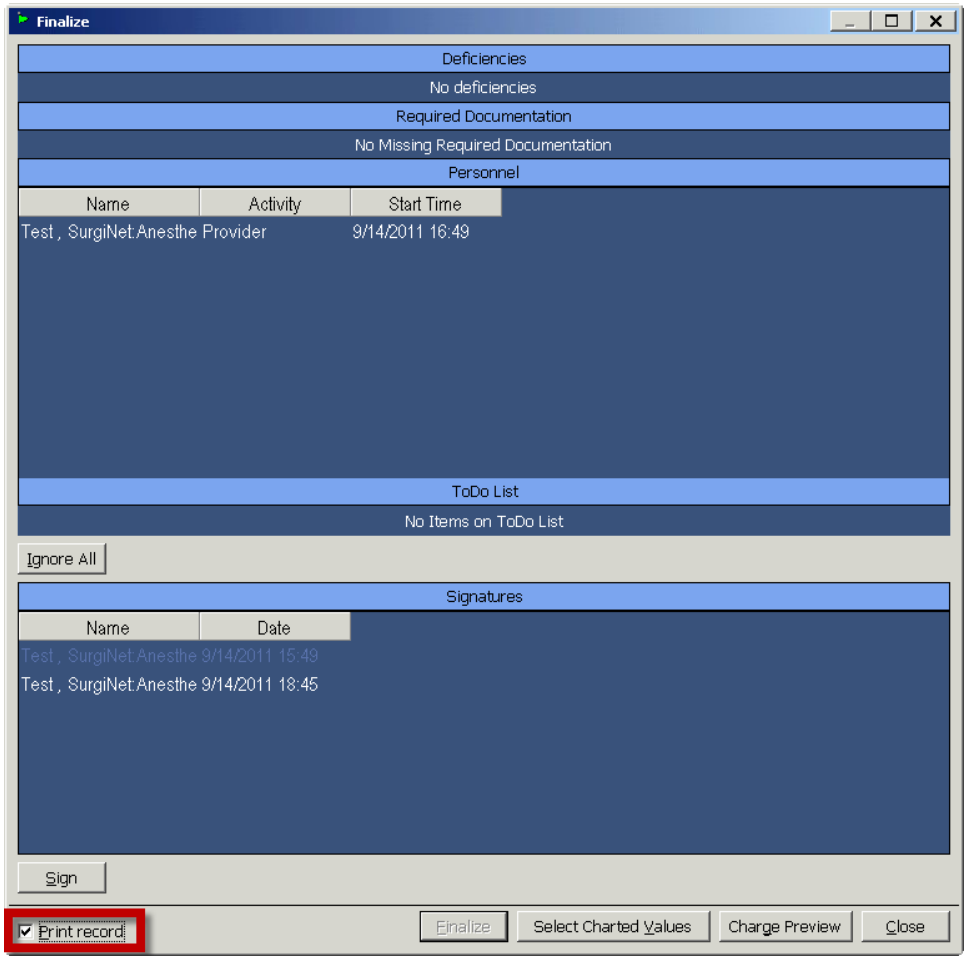


The HNAM Authorizing Signature dialog box is displayed.

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

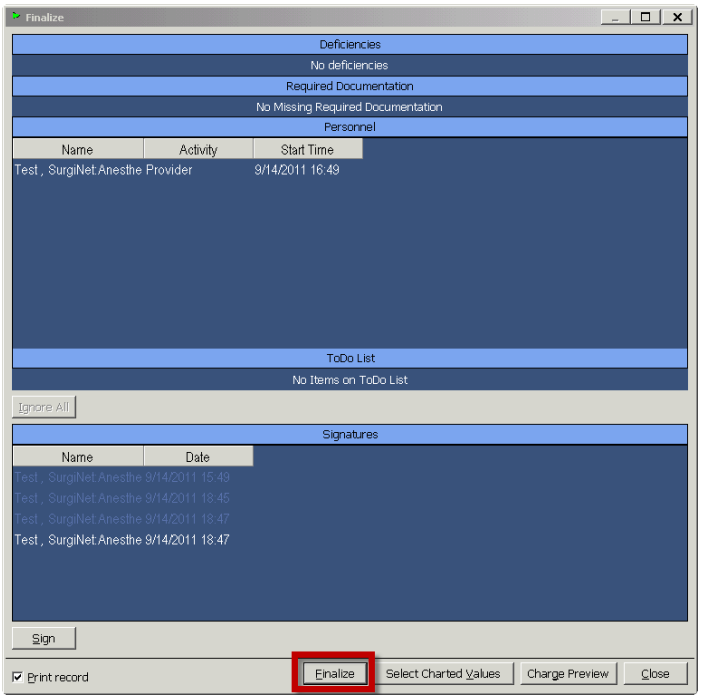


13. Select the Print record option to print the record when it is finalized.



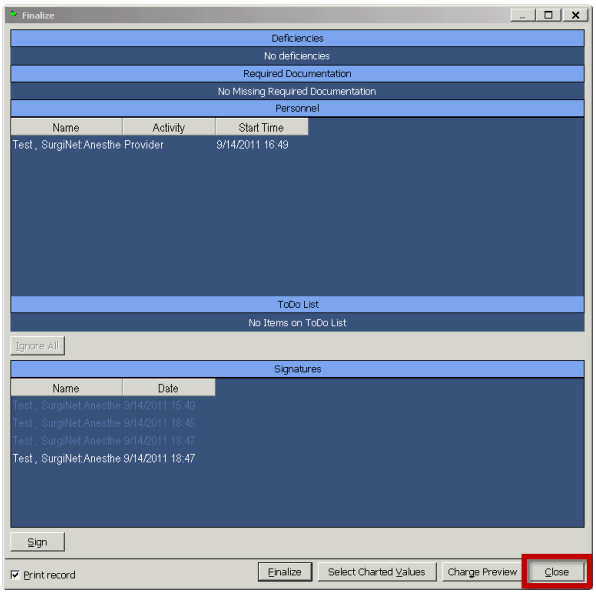
Note: The record will also be put into a read-only phase so that nothing can be modified on the record. If changes do need to be made to the record, select Unfinalize Case from the Task menu. This refreshes the application and record so that they no longer are in a read-only status.

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.



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

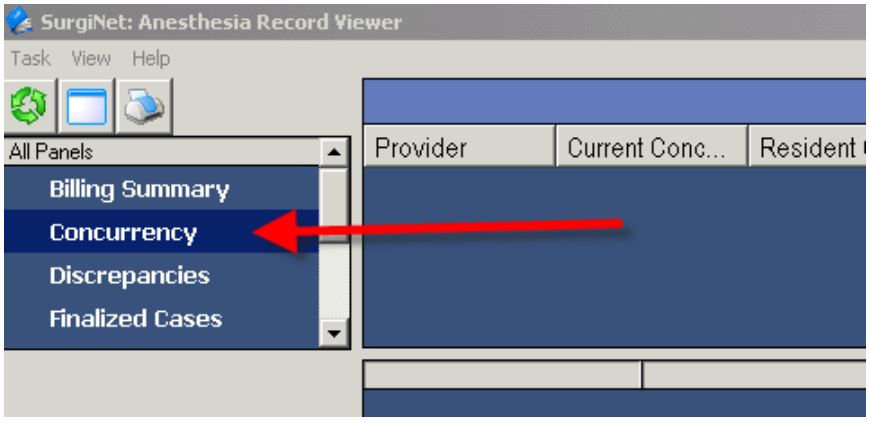
Viewing Concurrency

Viewing Concurrency for Multiple Providers

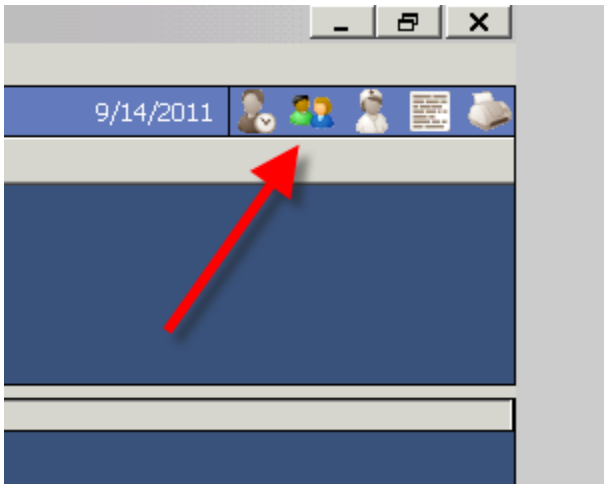
Your *SurgiNet* Anesthesia system allows you to define the ratio limits of providers to cases to comply with federal, state, local and facility-specific regulations and standards of care. These limits are set in *SurgiNet* Anesthesia Database Build Tool. *SurgiNet* Anesthesia Record Viewer allows you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



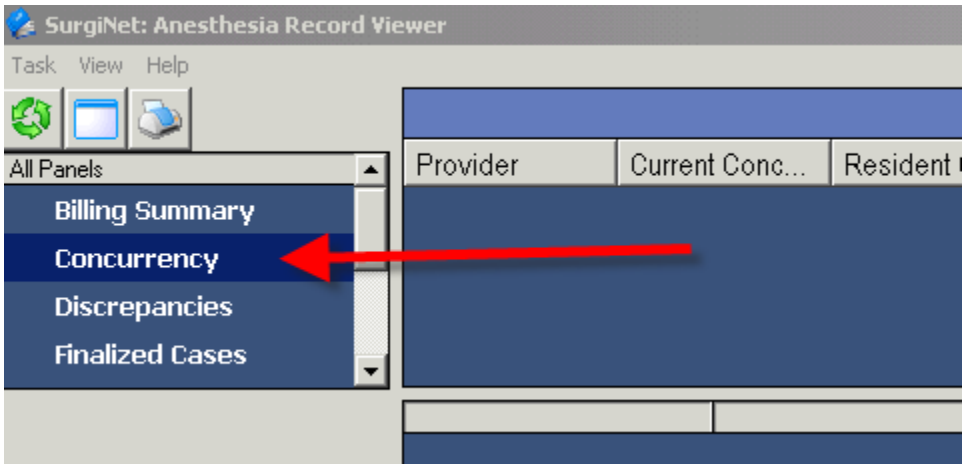
3. Select the provider from the providers list. All cases that provider currently is supervising are displayed in the records list. To view the case details, click the plus sign and double-click the case to view that record's details.
4. To end the provider's attendance of a case, right-click the record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

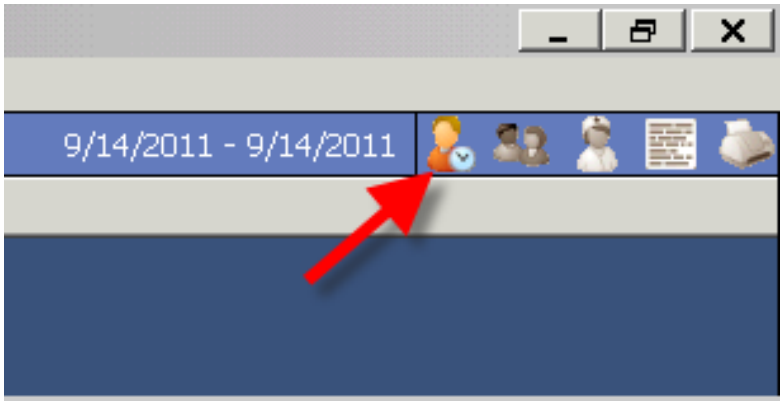
Your *SurgiNet* Anesthesia system allows you to define the ratio limits of providers to cases to comply with federal, state, local and facility-specific regulations and standards of care. These limits are set in *SurgiNet* Anesthesia Database Build Tool. *SurgiNet* Anesthesia Record Viewer allows you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

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

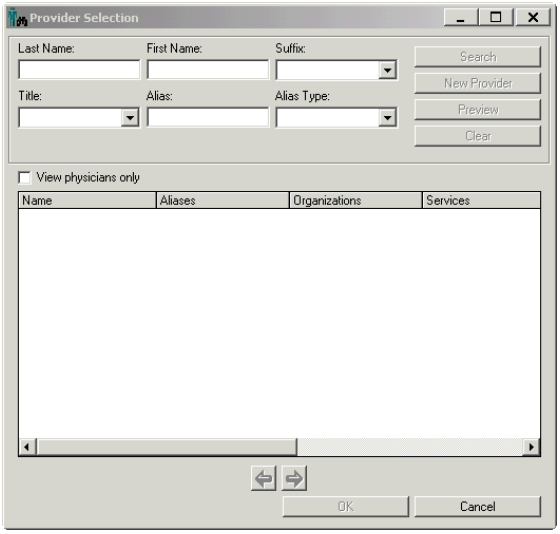
1. From the All Panels list, select Concurrency.



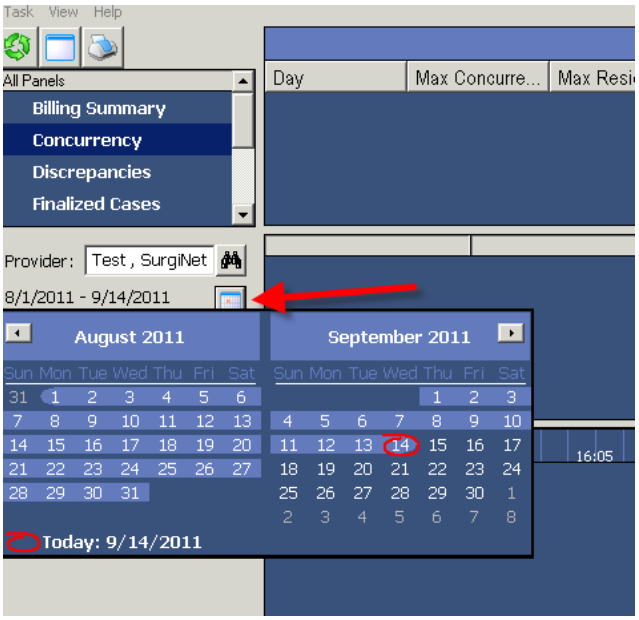
2. Click the Provider with Timeframe icon.



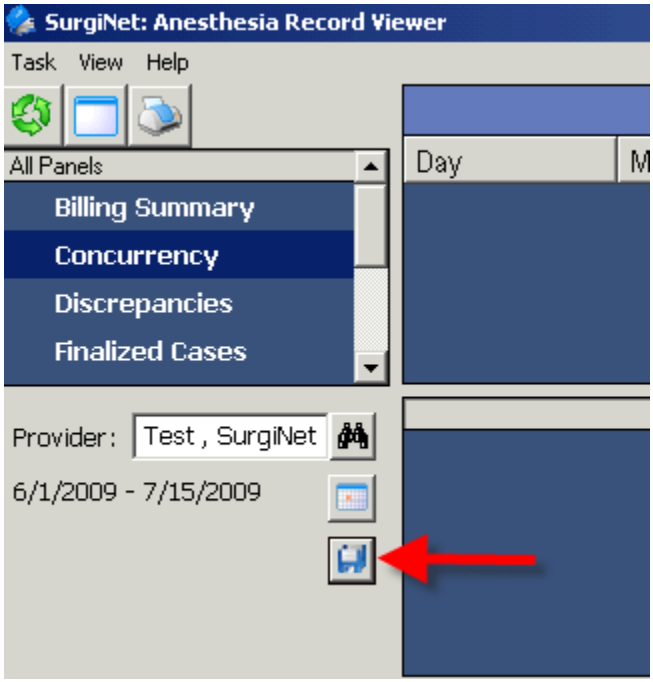
3. Enter the provider name in the Provider box, or search for the provider by clicking to open the Provider Selection dialog box. Enter the name of the provider and click Search. Select the provider and click OK to return to the *SurgiNet* Anesthesia Record Viewer window.



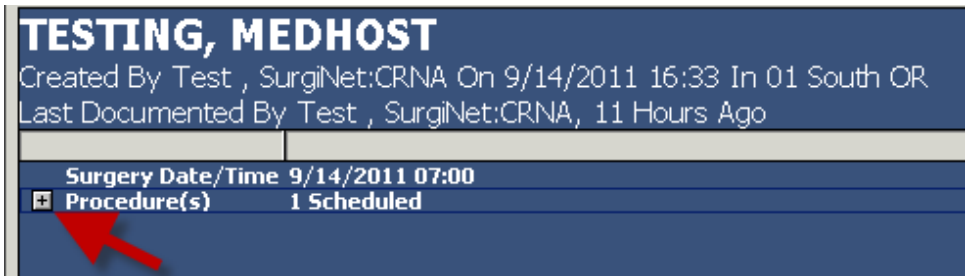
4. Click Select Date to open the calendar and select a date range. Click the beginning date of the range, press SHIFT, and click the end date of the range. Press ENTER.



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.



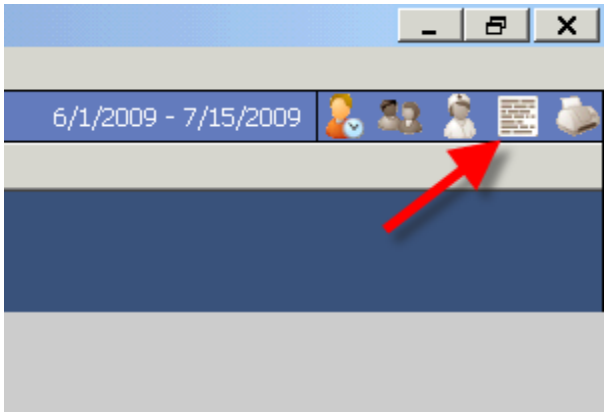
6. Select the provider from the providers list. All cases that provider currently is supervising are displayed in the records list. To view the case details, click the plus sign and double-click the case to view that record's details.



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.

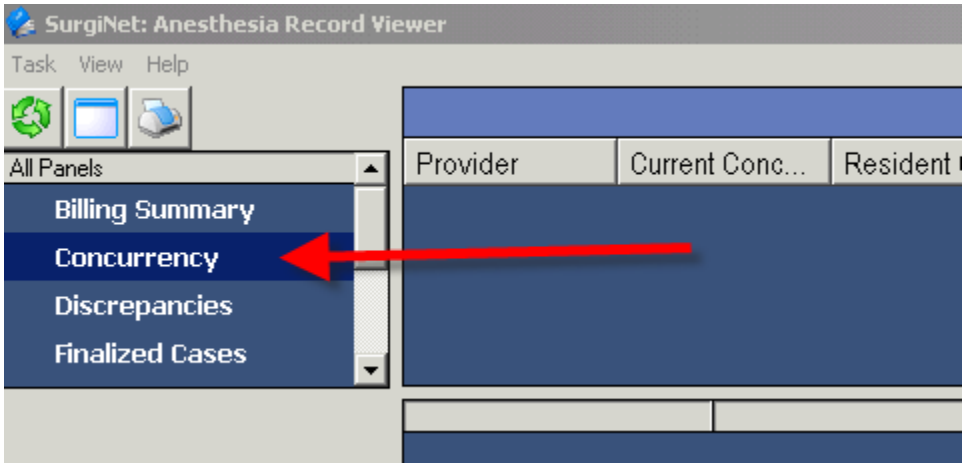


Viewing Concurrency on a Specified Date

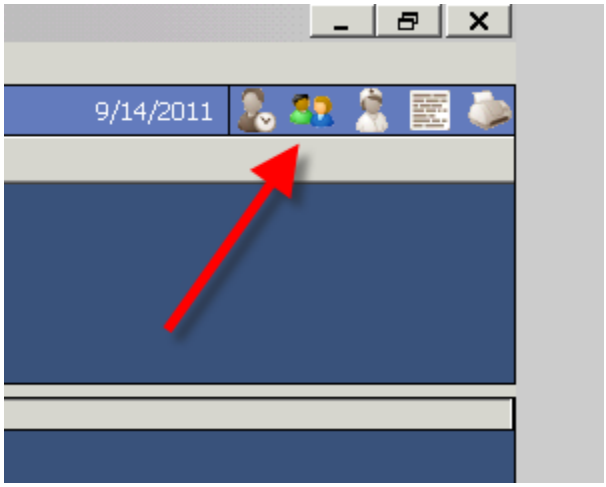
Your *SurgiNet* Anesthesia system allows you to define the ratio limits of providers to cases to comply with federal, state, local and facility-specific regulations and standards of care. These limits are set in *SurgiNet* Anesthesia Database Build Tool. SurgiNet Anesthesia Record Viewer allows you to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

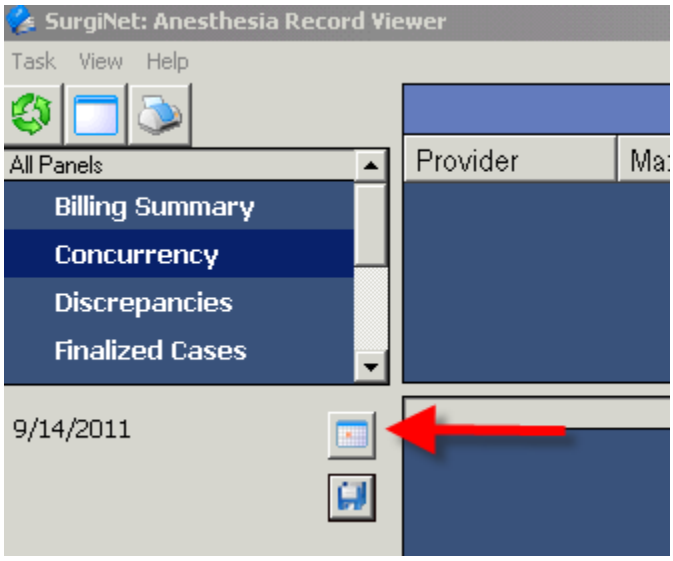
1. From the All Panels list, select Concurrency.



2. Click the All Providers icon.



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

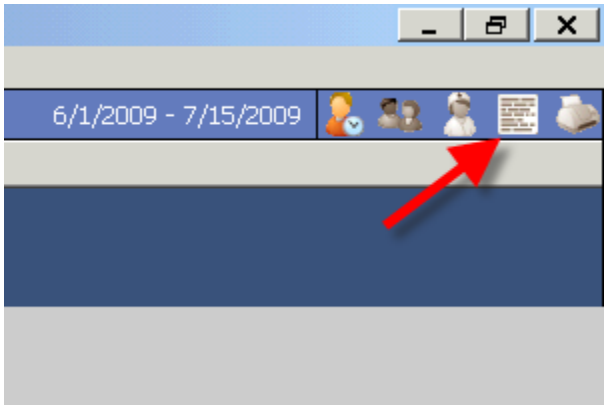


   All providers that were supervising cases on the selected date are displayed in the providers list. The provider's maximum concurrency and maximum resident concurrency are displayed in the providers list.

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.



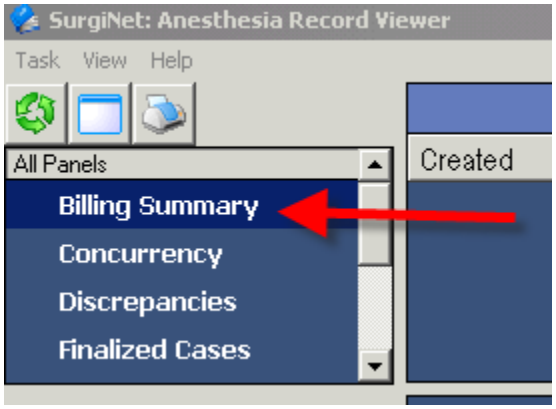
Viewing Billing Summaries

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.

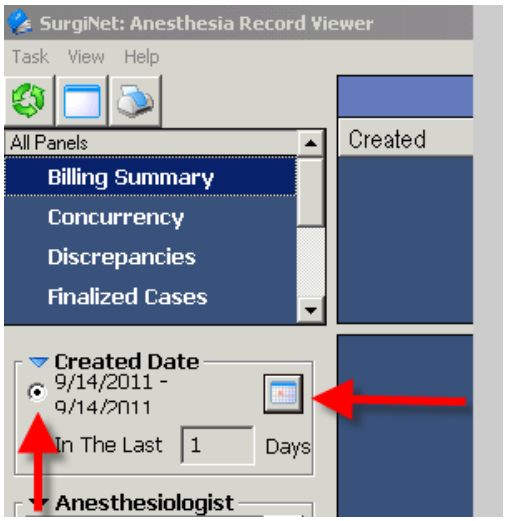
Billing Summary Panel

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

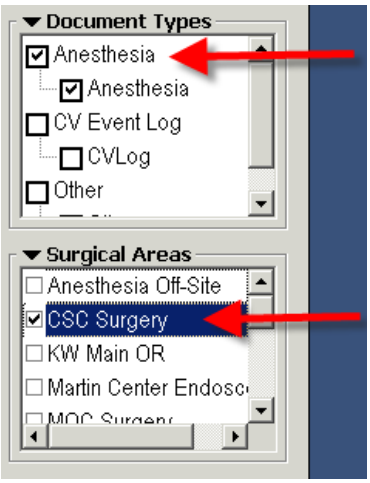
1. From the All Panels list, select Billing Summary.



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.



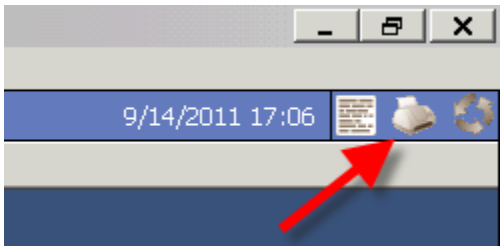
3. Select the anesthesiologist, document type, and surgical area to filter anesthesia records in the Billing Summary records list.



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 . Click the Billing Summary Report icon in the lower right corner.

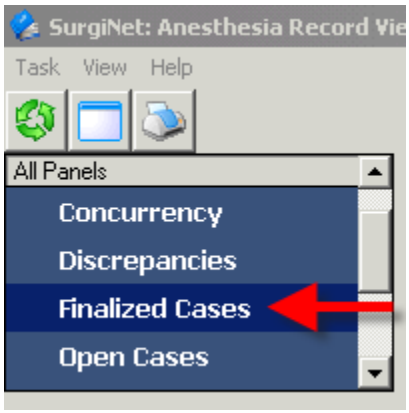
6. To print the billing summary for a single record, click the printer icon.



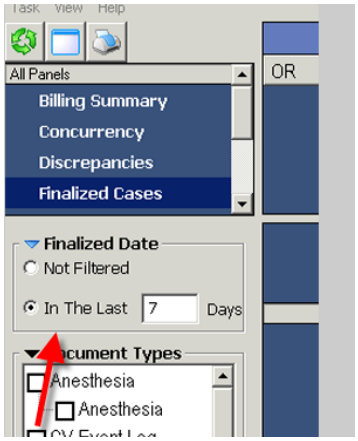
Finalized Cases Panel

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

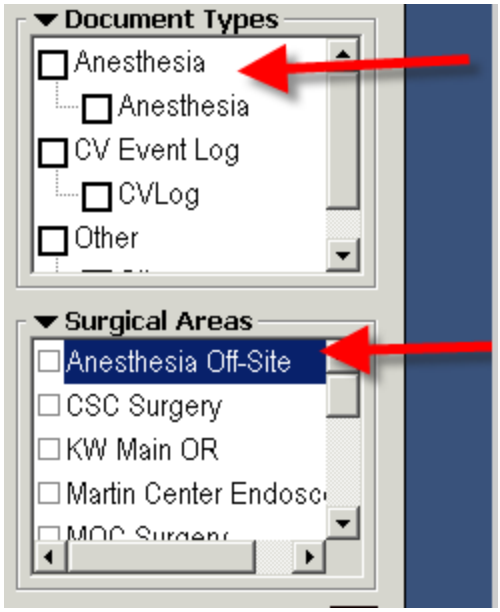
1. From the All Panels list, select Finalized Cases.



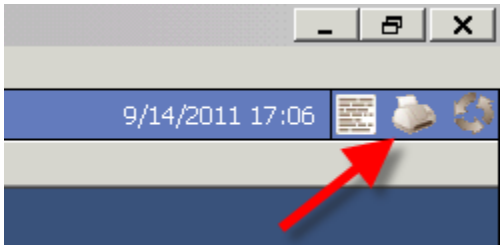
2. Select the case finalized date or date range to filter the list for cases finalized on that date or within the number of days range.



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



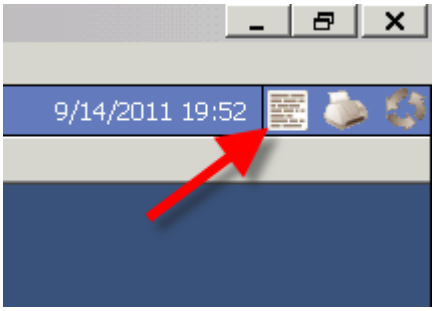
4. Select the record from the Finalized Cases record list you want view.
5. To view the billing summary for the selected case, click the Billing/Summary Record icon . Click the Billing Summary Report icon in the lower right corner.
6. To view the anesthesia record for the selected case, click the anesthesia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



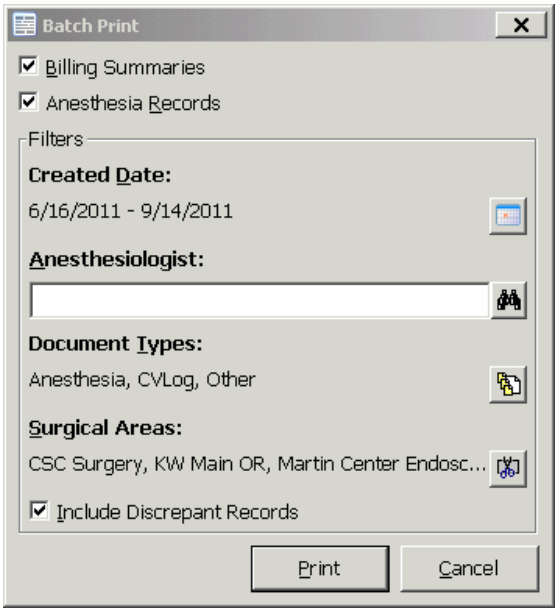
Batch Printing

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

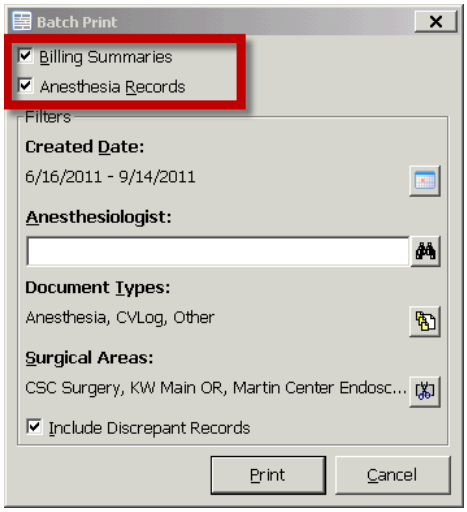
1. Click the Batch Print Summary and Records icon.



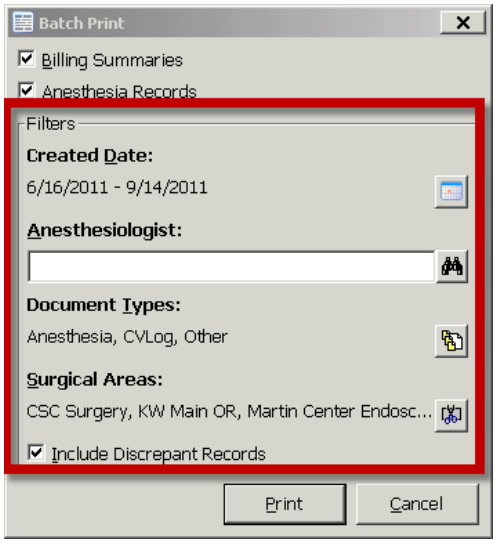
The Batch Print dialog box opens.



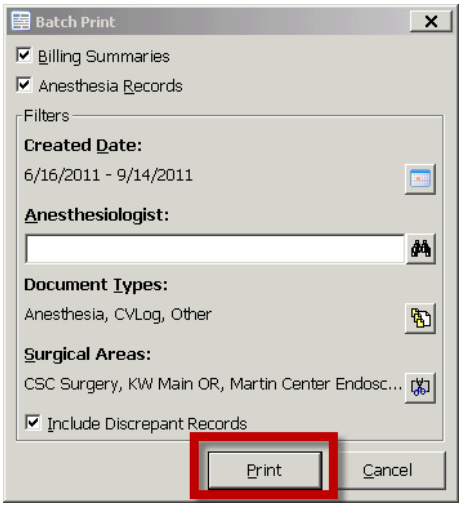
2. Select the appropriate check box to designate whether you want to print billing summaries, anesthesia records or both.



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



4. Click Print.



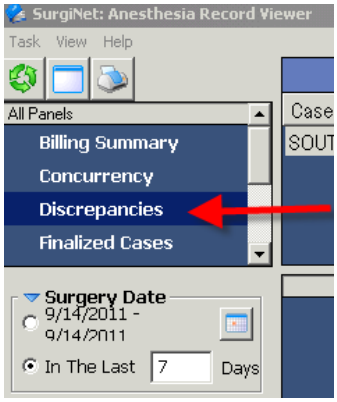
Viewing Discrepancies

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.

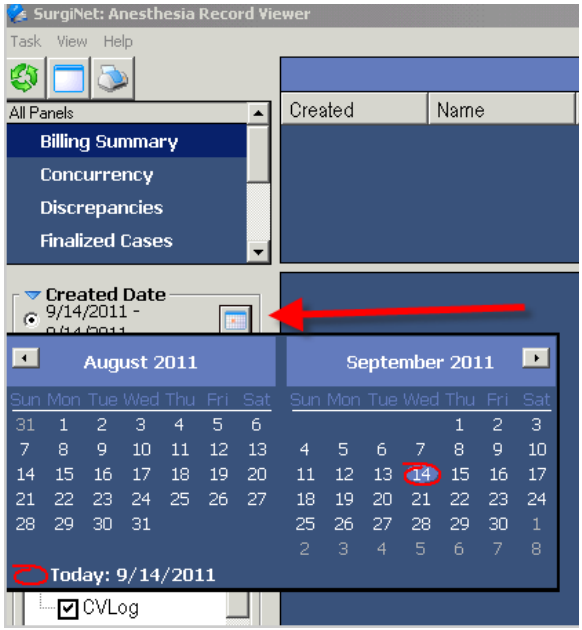
You can resolve the documentation discrepancies by opening *SurgiNet* Anesthesia directly from the report. While working with discrepancies, you also can filter the anesthesia records by document type, surgical area, or both.

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

1. From the All Panels list, select Discrepancies.

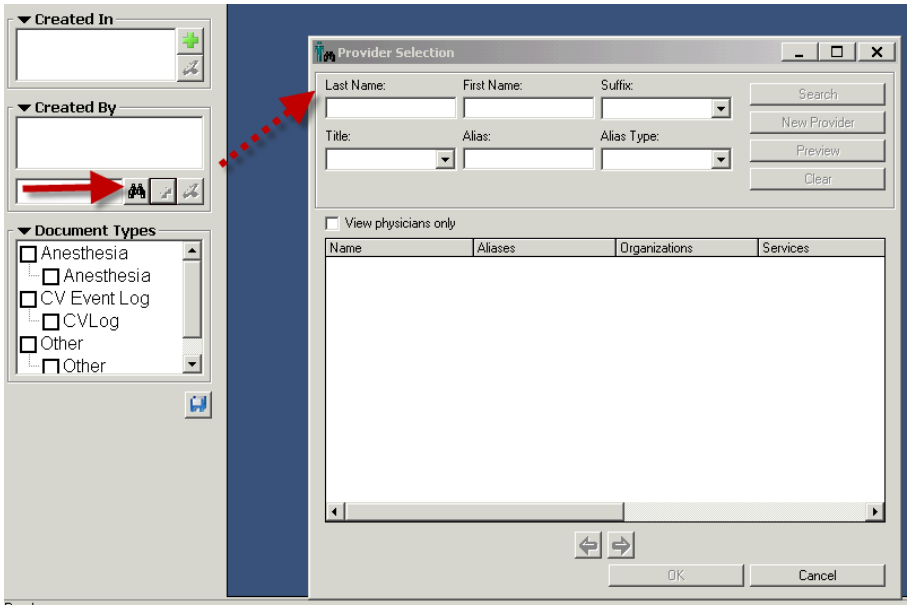


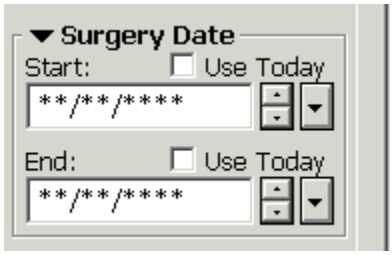
2. Click Select Date to open the calendar and select a date range. Click the beginning date of the range, press SHIFT, and click the end date of the range. Press ENTER.



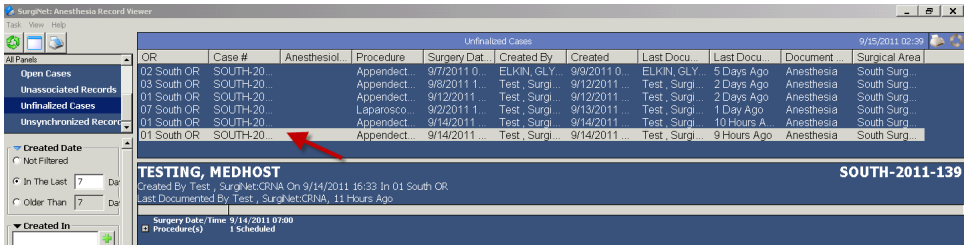
3. Click Save to save your modifications and add them to the report. You also can enter a value in the Number of Days box, select that option, and click Save to add the discrepancies to the report.

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.



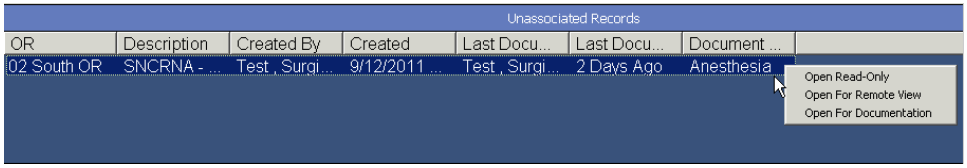


4. Select the record from the Discrepancies list. The discrepancies are displayed in spreadsheet format in the results list.



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.

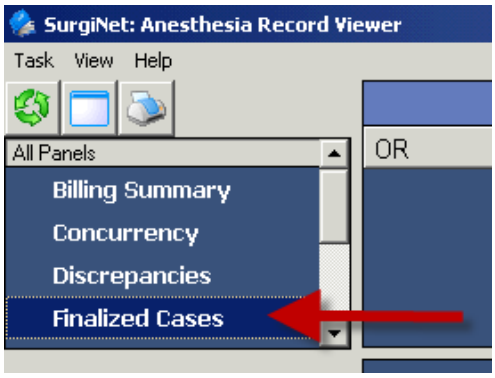
7. To refresh the discrepancy report with the most recent information, click Refresh All on the toolbar.

Viewing Finalized Cases

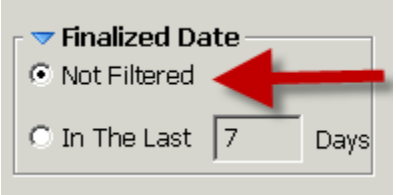
You can view all finalized cases in *SurgiNet* Anesthesia Record Viewer over a specified date range or in a comprehensive list. You also can filter finalized cases by document type, surgical area, or both.

To monitor finalized cases, complete the following steps:

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

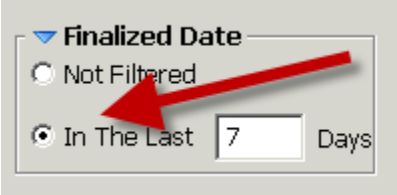


2. To view all finalized cases in the system, select the Not Filtered option

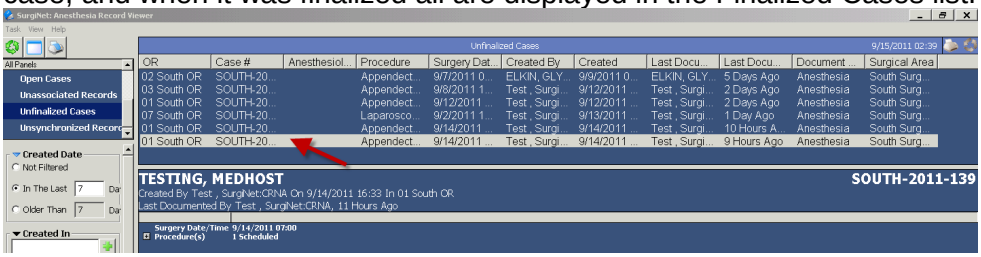


3. Click Save to add the cases to the report.

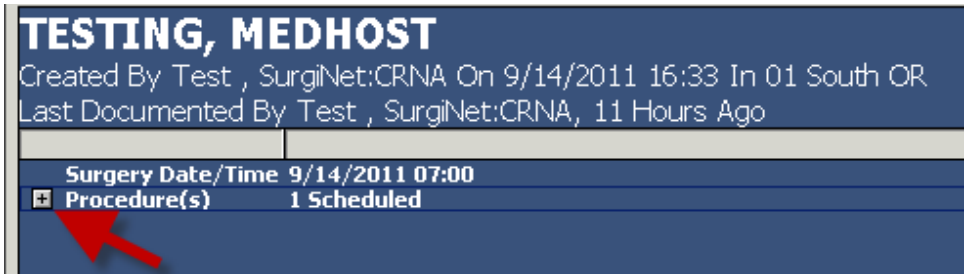
4. To view finalized cases over a date range, enter a value in the number of days box, select that option, and click Save to add the cases to the report.



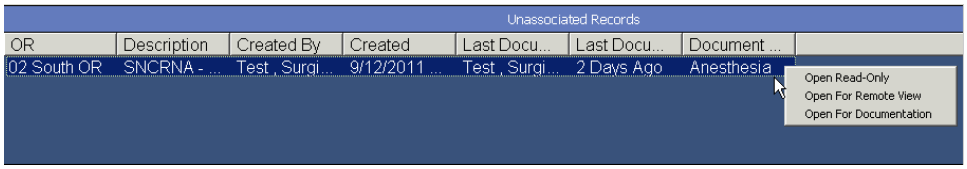
All finalized cases are displayed in the Finalized Cases list. The OR, case number, anesthesiologist, procedure, surgery date/time, who created the case, created date, who signed the case, and when it was finalized all are displayed in the Finalized Cases list.



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.



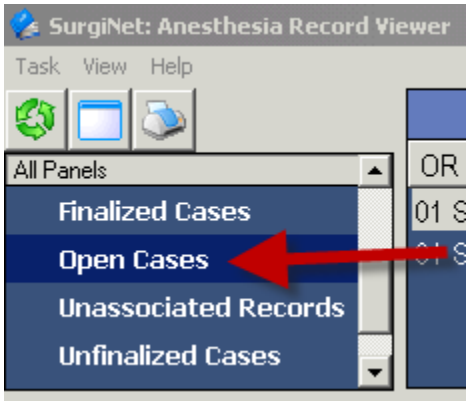
7. To print the report, click the Print Finalized Cases icon.

Viewing Open Cases

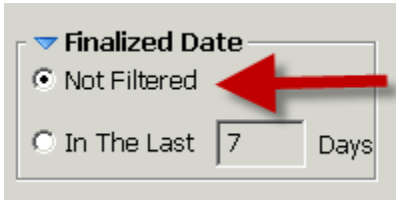
You can view all open cases in *SurgiNet* Anesthesia Record Viewer using various filtering methods or in a comprehensive list. You also can filter the list of open cases by document type, surgical area, or both.

To view open cases, complete the following steps:

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

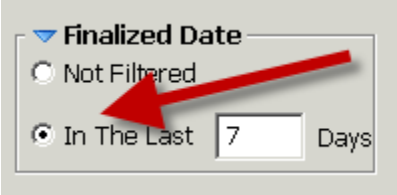


2. To view all open cases in the system, select the Not Filtered option.



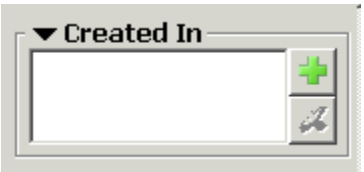
3. Click Save to add the cases to the report.

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

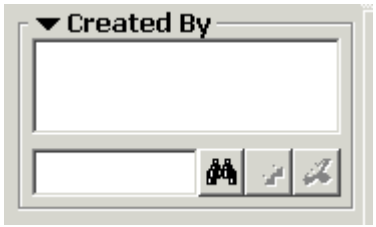


5. Click Save to add the cases to the report.

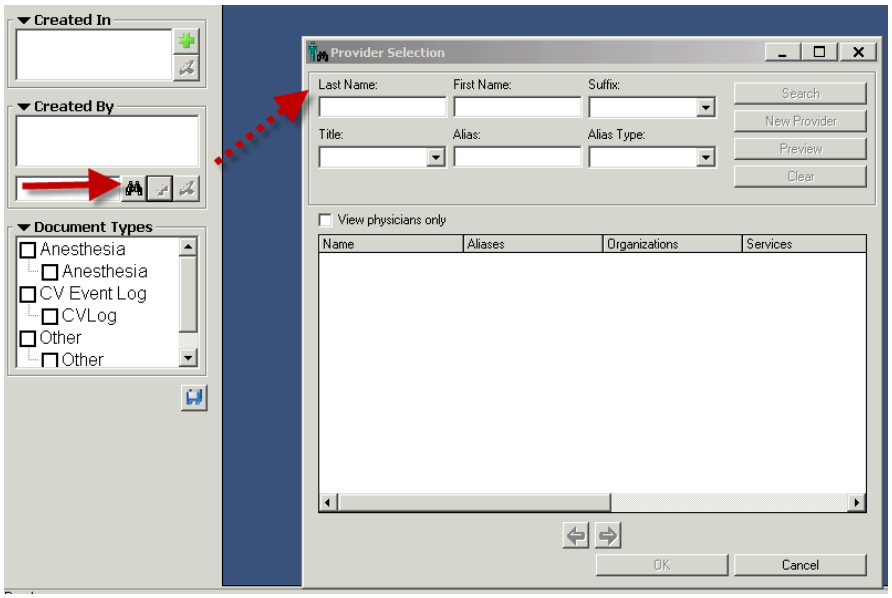
6. To view open cases created in a specific OR, click to open the Select Operating Room dialog box. Select the OR and click OK to add the cases to the Created In list. Click Save to add the cases to the report.



7. 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.

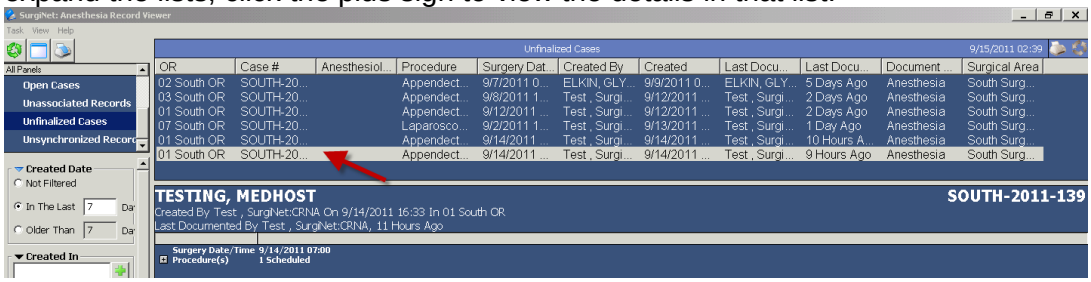


Enter the name of the provider and click Search.

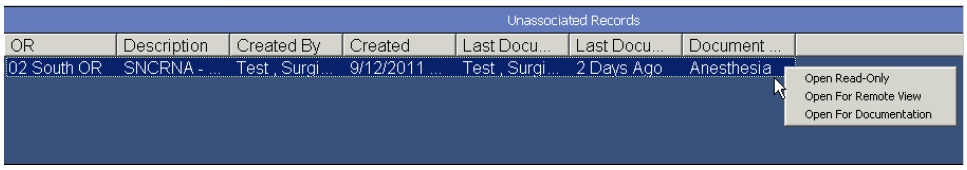


8. Select the provider and click OK to return to the *SurgiNet* Anesthesia Record Viewer window. Click to add the provider to the Opened By list. Click Save to add the cases to the report.

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.



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.



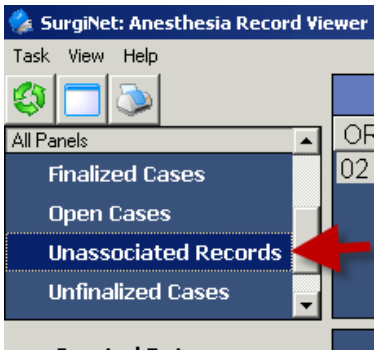
11. To print the report, click Print Open Cases on the toolbar.

Viewing Unassociated Cases

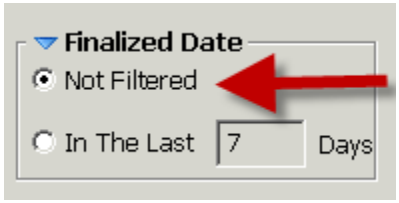
You can view all blank records that have not been associated to a surgical case in *SurgiNet* Anesthesia Record Viewer using various filtering methods or in a comprehensive list. Unassociated records can be filtered by Document Type.

To view open cases, complete the following steps:

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

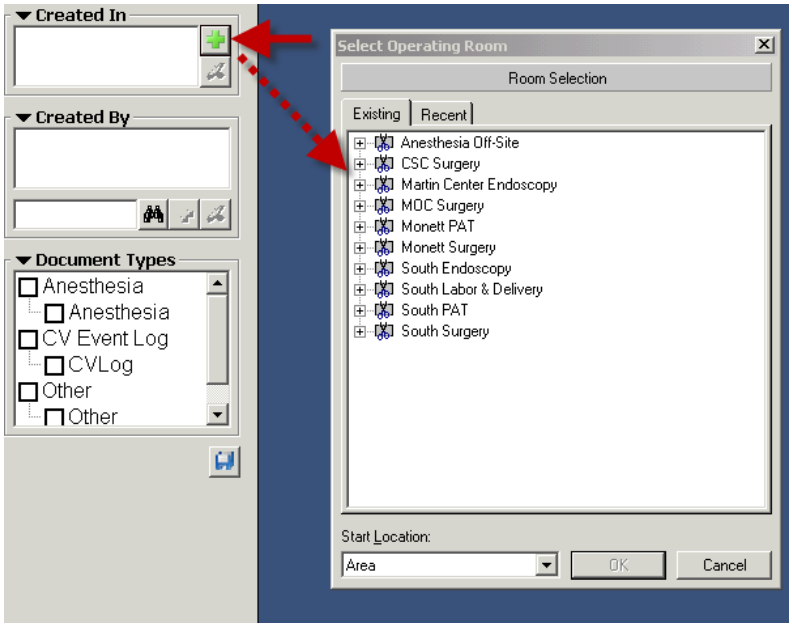


2. To view all unassociated records in the system, select the Not Filtered option.



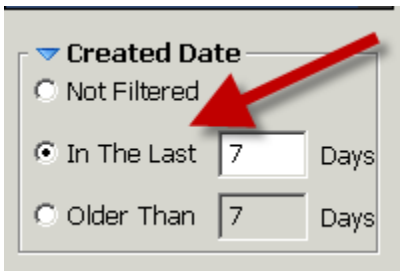
3. Click Save to add the records to the report.

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

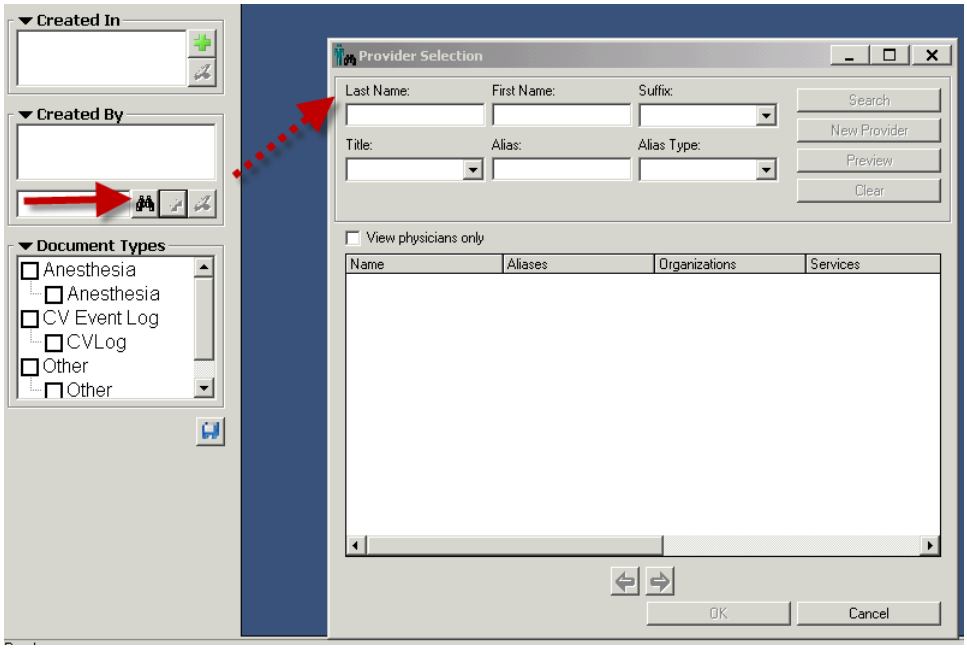


5. Select the OR and click OK. Click Save to add the records to the Created In list. Click Save to add the cases to the report.

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.

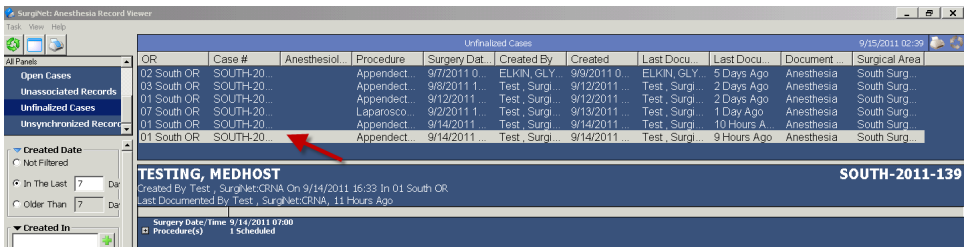


7. To view records opened by specific providers, enter the provider name in the Provider box, or search for the provider by clicking to open the Provider Selection dialog box.

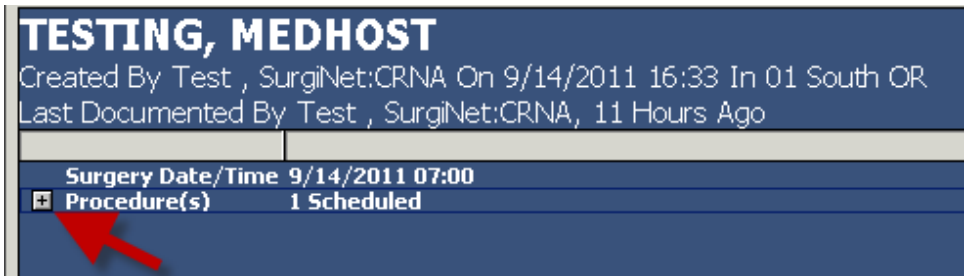


8. Enter the name of the provider and click Search.
9. Select the provider and click OK to return to the SurgiNet Anesthesia Record Viewer window.
10. Click to add the provider to the Created By list.
11. Click Save to add the records to the report.

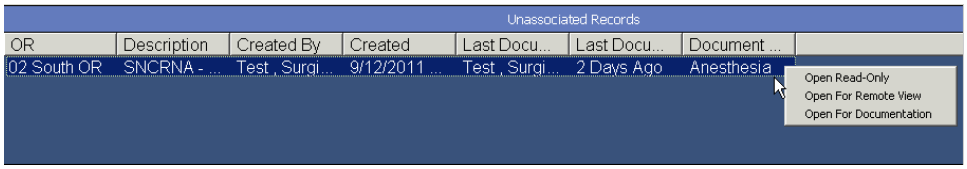
12. Select the record from the Unassociated Records list and the record details are displayed in spreadsheet format.



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



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.



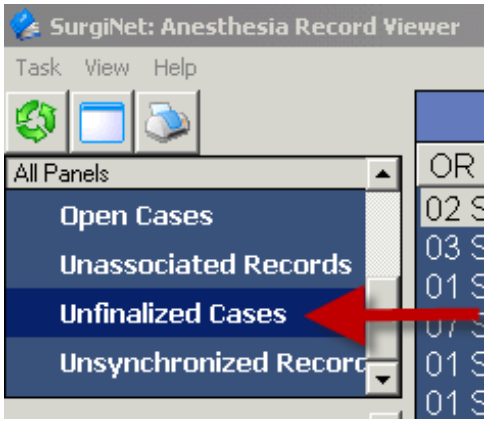
15. To print the report, click Print Unassociated Records on the toolbar.

Viewing Unfinalized Cases

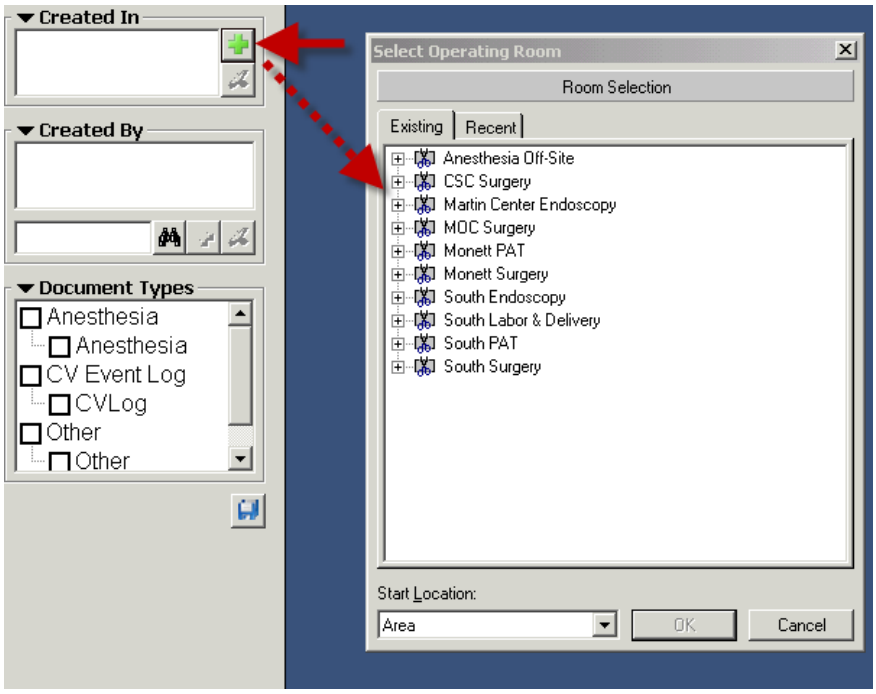
You can view all unfinalized cases in *SurgiNet* Anesthesia Record Viewer using various filtering methods or in a comprehensive list. You also can filter unfinalized cases by document type, surgical area, or both.

To monitor unfinalized cases, complete the following steps:

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

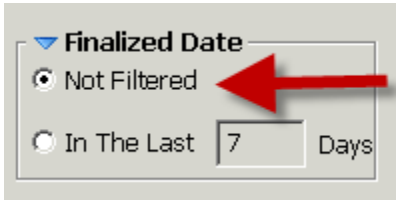


2. To view unfinalized cases created in a specific OR, click to open the Select Operating Room dialog box.

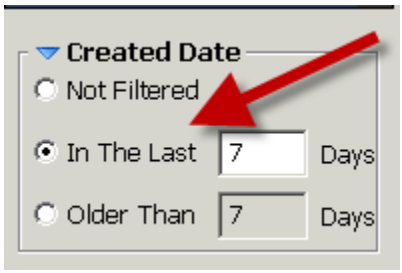


3. Select the OR and click OK.
4. Click Save to add the cases to the Created In list.
5. Click Save to add the cases to the report.

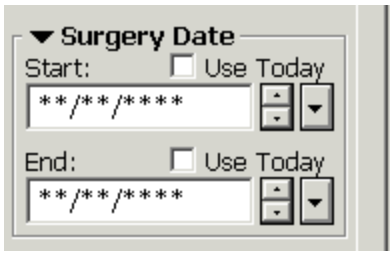
6. To view all unfinalized cases in the system, select the Not Filtered option and click Save to add the cases to the report.



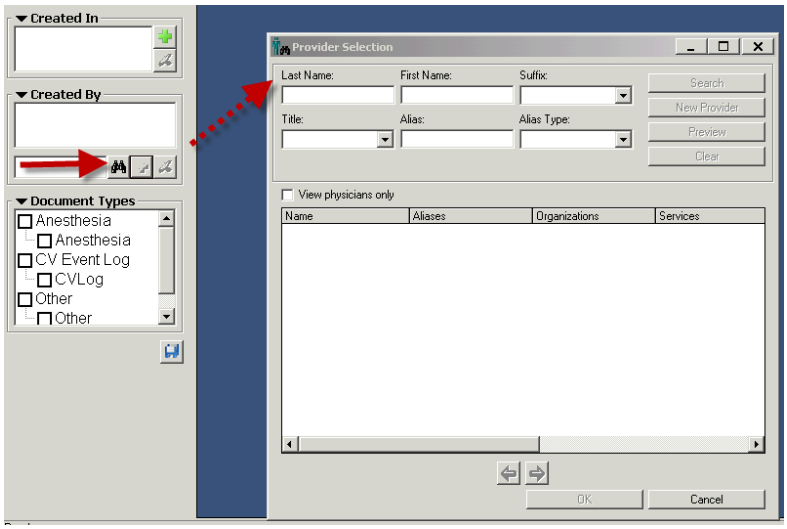
7. To view unfinalized cases over a date range, enter a value in the number of last days box, or in the number of older days box, select that option, and click Save to add the cases to the report.



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.

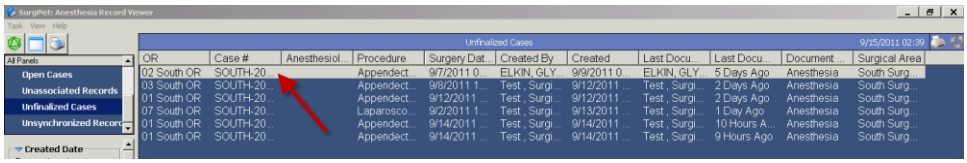


8. To view cases opened by specific providers, enter the provider name in the Provider box, or search for the provider by clicking to open the Provider Selection dialog box.

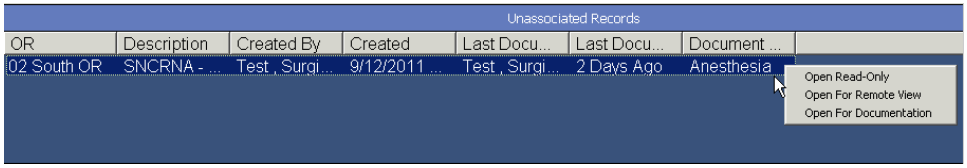


Enter the name of the provider and click Search. Select the provider and click OK to return to the SurgiNet Anesthesia Record Viewer window. Click to add the provider to the Created By list. Click Save to add the cases to the report.

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.



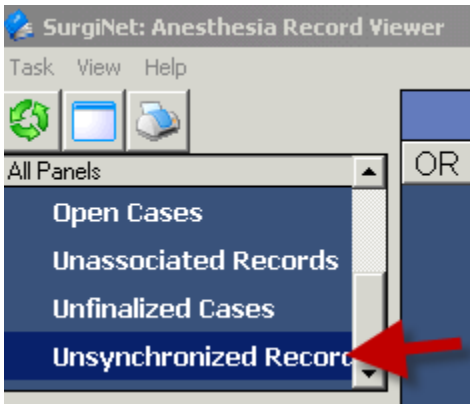
11. To print the report, click the Print Unfinalized Cases icon.

Viewing Unsynchronized Records

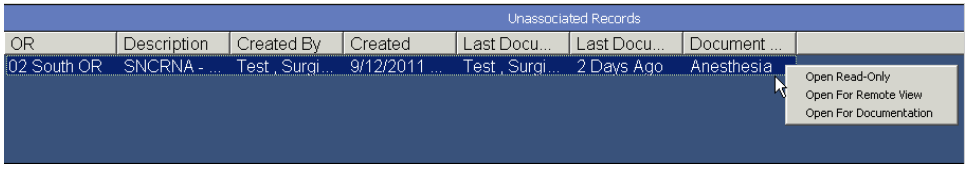
You can view all unsynchronized records that were documented in disconnected mode and have not been synchronized in *SurgiNet* Anesthesia Record Viewer.

To view unsynchronized cases, complete the following steps:

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



2. To view more information on the record and synchronize the record with the respective room, right-click 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 (https://wiki.ucern.com/pages/releaseview.action?pageId=712649). 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).