# Table of Contents

- How To Use This Manual ............................................................... 6
- Information Security and Confidentiality ........................................ 6

## Getting Started ................................................................. 7
- Accessing SurgiNet Anesthesia .................................................. 8
- Changing Users Within a Case ................................................. 8
- Suspending a Case .................................................................. 8
- Logging Out .......................................................................... 9

## Using PowerChart ............................................................... 10
- Enter PowerChart from Within SurgiNet Anesthesia .................. 11
- Enter PowerChart from the Desktop ....................................... 11
- Opening the Patient’s Chart .................................................... 12
- Viewing Patient Care Summaries .......................................... 13

## The SurgiNet Anesthesia Environment .................................. 14
- The Surgical Case Environment ............................................. 15
  - Surgical Case Environment – Pre Macro ............................ 15
  - Surgical Case Environment – Post Macro ......................... 17
- Toolbar Buttons .................................................................... 18
- Action Bar Icons ................................................................ 18

## Documenting the Anesthesia Record ..................................... 19
- Selecting a Surgical Case ....................................................... 20
- Device Association ............................................................... 21
- Macros .............................................................................. 21
  - Macro Organization ........................................................... 22
  - Personnel Assignment ........................................................ 22
  - Compliance Attestation ...................................................... 23
  - Sign-Out .......................................................................... 23
  - Finalize Case .................................................................... 23
# Table of Contents

DELETING OUTPUTS .................................................................................................................. 48
  Removing Outputs .................................................................................................................. 48

DEVICES AND MONITORS ........................................................................................................... 49
  ASSOCIATE A DEVICE .............................................................................................................. 50
  ADDING MONITORS .................................................................................................................. 50
  Turn Off a Monitor .................................................................................................................. 51
  Graphical Values ..................................................................................................................... 52
  MODIFYING MONITORED VALUES .......................................................................................... 52
  ADDITIONAL MONITOR VALUE FUNCTIONS ....................................................................... 55
  Details ..................................................................................................................................... 55
  Pull Values .............................................................................................................................. 56
  Chart/Unchart ......................................................................................................................... 56
  Add/Remove Monitors ............................................................................................................ 56

ACTIONS ....................................................................................................................................... 57
  USING ACTION LIST ITEMS ................................................................................................. 58

PERSONNEL ............................................................................................................................... 63
  ADDING PERSONNEL ............................................................................................................... 64
  REMOVING PERSONNEL ........................................................................................................ 65

PRINT PREVIEW .......................................................................................................................... 67
  PRINT PREVIEW ...................................................................................................................... 68

FINALIZE A RECORD .................................................................................................................. 69
  FINALIZE THE CASE .............................................................................................................. 70
  UNFINALIZE THE CASE ......................................................................................................... 72
How To Use This Manual

- If you have questions or problems with Cerner SurgiNet you can contact the Technology Assistance Center (TAC) at 859-7777.
- You will need a Cerner SurgiNet Anesthesia User ID and Password to access SurgiNet. Anesthesia. If you do not have access, use the e-Register form located on KaleidaScope to request access.
- This can be found by typing this address: (http://kaleidoscope/ISTSecurity/forms.aspx) in the Internet Explorer address bar.

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 Joint Commission regulations that dictate how these records are handled.

- When signing on to SurgiNet Anesthesia always use your own User Name and Password, do not share your User Name and Password.
- When you open a chart for the first time, you will be asked to identify your relationship to the patient, for example primary RN, consulting physician, etc.
- The application keeps an audit trail, or record, of who enters each chart and when. SurgiNet Anesthesia records who signed into the chart and who documented each piece of information in the chart.
- Do not leave the computer while still signed on.
- Do not access any charts that do not apply to your current caseload.
This reference guide was designed to supplement the hands-on, instructor led session. Pictures of various screens have been included in order to show general placement. Please note that these are standard screens and may not match exactly to those at your site.
Accessing SurgiNet Anesthesia

Following these steps will not give access to real patient information.
The “live” domain is known as “PROD”.

1. Click the Citrix icon from the lower-right corner of your computer taskbar.
2. Select Applications from the shortcut menu that displays.
3. Then select Cerner-CERT Environment>SurgiNet Anesthesia–CERT.
   - The Cerner Millennium log in window displays.
   - The Domain field is set to Cert.
4. Type the User ID from your Training Card the User Name field.
5. Press the Tab key to advance.
6. Type the Password from your Training Card in the Password field.
7. Press the Enter key or click the OK button.
8. Click the OK button.
   - Cerner SurgiNet Anesthesia is open and the Case Selection area is displayed.

Changing Users within a Case

If it becomes necessary to change users within a case, the following steps should be used:

1. Click the Change button on the toolbar or, from the Menu bar click Task and select Change User.
2. The new users follows steps 1-8 above to sign on to SurgiNet Anesthesia.

Suspending a Case

It may be necessary to suspend a case. Note that by using the following steps, the computer being used will lock out all other users.

1. Click the Suspend button on the toolbar.
   - The workstation is now locked.
2. To Resume the case at the workstation where you suspended the application, click the application on the Status bar located at the bottom of the screen.
   - Note that your User Id is already in the User Id field.
3. Enter your password to resume your case.
Logging Out

When you have completed your SurgiNet Anesthesia case documentation you need to log out of the SurgiNet Anesthesia application.

1. On the Menu bar click **Task** and select **Exit**, or you can click the “X” located in the upper right corner.
   - You will be logged out of the application.
USING POWERCHART

This unit will introduce you to PowerChart. This section provides an overview of the steps to access and exit PowerChart from SurgiNet Anesthesia or from the Desktop.

Topics in this Unit:
- PowerChart from SurgiNet Anesthesia
- PowerChart from the Desktop
- Exit PowerChart
- Opening the Patient Chart
- Viewing Patient Care Summaries
Enter PowerChart from within SurgiNet Anesthesia

Click **Chart** on the Menu bar and select the **appropriate component** of the patient chart you wish to view from the options that display.

1. Once in the patient chart, use the **Menu** to select **components** of the patient chart you wish to view.
2. Click **Chart** on the Menu bar and select **Close Charts** to close the patient chart, or click the **X** to the right of the patient name above the patient demographic.

Enter PowerChart from the Desktop

1. **Click** the Citrix icon from the lower-right corner of your computer taskbar.
2. **Select** **Applications** from the shortcut menu that displays.
3. **Then select** Cerner-CERT Environment>PowerChart--CERT.
   - The Cerner Millennium log in window displays.
   - The **Domain** field is set to **CERT**.
4. Type the **User ID** from your Training Card in the User Name field.
5. Press the **Tab** key to advance.
6. Type the **Password** from your Training Card in the Password field.
7. Press the **Enter** key or click the **OK** button.
Opening the Patient’s Chart

1. Click the Patient List button on the Organizer toolbar.
2. Using your Training card, locate your patient and the correct patient list.
3. Double-click the patient name to open the chart.
   - If this is the first time you are working with this patient’s chart you will need to claim a relationship.
   - The Patient Care Summary displays.
4. Stop and watch the instructor.

Organizer

- PAL
- Patient List
- Multi-Patient Task List
- Apache
- Staff Assignment
- Quality Measures

Links

- Lab Label Reprint
- Charges
- Up to Date (Clinical Database)
- Bridge
- Issue Collector

Action Toolbar

- Depart
- Patient Education

Demographic Banner Bar

- Addition of Weight
- Addition of Advance Directives (new functionality)
Viewing Patient Care Summaries

Note:

- The menu on the left is known as the menu, the TOC or the Table of Contents menu. Clicking on a chart component from this menu will display that section of the chart in the Workspace on the right.
- The patient chart opens to the Patient Care Summary.
- The Patient Care Summary component is new functionality.
- The Patient Care Summary is visit-specific and will only populate after documentation.
- The reason for visit is populated from registration.

1. Click the Push Pin to the right of Menu to collapse the menu on the left.

<table>
<thead>
<tr>
<th>Menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Summary</td>
</tr>
<tr>
<td>Chart Summary Screen</td>
</tr>
<tr>
<td>Allergies</td>
</tr>
<tr>
<td>Add</td>
</tr>
<tr>
<td>Medication List</td>
</tr>
</tbody>
</table>

2. Hover over the Menu button on the left side of the screen to expand the menu.

<table>
<thead>
<tr>
<th>Menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Summary</td>
</tr>
<tr>
<td>Critical Labs [1 Day]</td>
</tr>
<tr>
<td>Lab</td>
</tr>
</tbody>
</table>

3. Click the Push Pin to lock the menu in place again.

4. Click the Chart Summary component from the menu.

Note:

- The Chart Summary component is current functionality, and is a read-only screen.
- Chart Summary is visit-specific and will only populate after documentation.
This unit will introduce you to the SurgiNet Anesthesia environment. You will be provided an overview of the Surgical Case screen and introduced to the SurgiNet Anesthesia menus, toolbars, buttons and icons that you will use to complete tasks within the application associated with the administration of Anesthesia during a surgical procedure.
The Surgical Case Environment

SURGICAL CASE ENVIRONMENT – PRE MACRO

Once you have selected a Surgical Case the main SurgiNet Anesthesia case screen displays.

1. Click the arrow to expand the application work menu as shown below.

2. Click the arrow again to collapse the menu.
The **Menu Bar** contains the window elements used to accomplish a task.

The **Surginet Anesthesia Toolbar** contains the application elements used to accomplish a task.

The **Patient Demographic Banner** displays information pertinent to the selected case.

The **Anesthesia Record Timeline** displays various case times.

**Macro** component area which displays the To Do and Completed components from the Macro.

**Administration Documentation** area which is essentially the same as the SurgiNet Anesthesia toolbar.

**Anesthesia Administration Graphing Area.**

**Action Bar** item documentation area.

The application **Status Bar** displays the status of the application, such as Ready as well as the date, time and the user id of the person logged on to the application.
**SURGICAL CASE ENVIRONMENT – POST MACRO**

Anesthesia Administration **Graphing Area**.

**Action Bar** item documentation area.

**Macro** documentation area.
Toolbar Buttons

- **Select Case**
  Opens the Select Case window so you can select the case to be displayed.

- **View**
  Opens the Select View Item dialog box so you can select the view to be applied to the record.

- **Macro**
  Opens the Select Macro dialog box so you can specify the macros to be executed.

- **Medications**
  Opens the Select Medications dialog box so you can specify the medications to be displayed. You can also add, modify or remove administrations from this dialog box.

- **Intake**
  Opens the Select Intake dialog box so you can specify the intake fluids to be displayed. You can also add, modify or remove administrations from this dialog box.

- **Output**
  Opens the Select Output dialog box so you can specify the output fluids to be displayed. You can also add, modify or remove administrations from this dialog box.

- **Actions**
  Opens the Select Action dialog box so you can specify the actions to be displayed. You can also add, modify or remove administrations from this dialog box.

- **Inventory**
  Opens the Inventory dialog box so you can specify the inventory to be displayed. You can add or remove inventory in this dialog box.

- **Personnel**
  Opens the Personnel dialog box so you can specify the personnel to be displayed. You can also add or remove personnel in this dialog box.

- **Charge Preview**
  Opens the Charge Preview dialog box so you can view or modify charges.

- **Medication/Fluid View**
  Opens the Medication/Fluid View dialog box so you can view all medication and fluid information recorded for the case.

- **Patient’s Chart**
  Opens the patient’s chart in PowerChart.

- **Chart Mode**
  Changes the view to Chart Mode so you can quickly indicate which values are to be charted or uncharted.

Action Bar Icons

- **Action Bar Actions**
- **Action Bar Macros**
- **Action Bar Personnel**
- **Action Bar Results**

  - Inactive Action Bar icons appear gray in the Action Bar area. To activate an icon double-click the Action Bar icon.
This unit will show you how to select and document a surgical case using a Macro.

The Case Selection screen by default will display the operating room number for the room that the application was opened in allowing you to search the day’s cases scheduled for that room.

**Topics in this Unit:**
- Patient Selection
- Device Association
- Macros
- Personnel Assignment
- Compliance
- Signing-Out
- Finalizing a Case
Selecting a Surgical Case

Note:
- Patients can be found based on the case location (OR, L&D, Anesthesia).
- Patients scheduled for today’s date will be listed for the selected location.
- All patients ready for Anesthesia documentation should already be checked-in.
- Verify the patient name, birth date, case number, surgeon and procedure.
- No financial number is available for the Case Selection screen.
- Check with the Circulating or assisting RN for any discrepancies before initiating Anesthesia documentation.

1. Highlight the case and click the OK button to open the case.

- If the case cannot be found using the default room Click the red X next to the operating room number and click Search again to find all cases scheduled for the day.
- If the case is still not found using all rooms use different search criteria such as patient name, case number, or date and search again.

Once the case has been located:

2. Click the case to highlight it and click the OK button.
   - The system will automatically associate appropriate devices based on the location.

3. If there are no default devices select the appropriate device(s) from the Choose Devices dialog box and click the OK button.
The record will now open to the main screen of the application.

**Device Association**

- Devices include Anesthesia machines and patient monitors.
- Devices in the OR (and C-Section suite) will be automatically assigned to the Anesthesia record.
- Refer to the Device section for additional details on assigning Devices.

**Macros**

- Macros are a compilation of items (reminders, actions, medications, monitors, intakes, outputs, etc.) that are documented in the Anesthesia record.
- Macros are organized by category. (Refer to the illustration below).
**Note:**
- Anesthesia Provider start/stop times are included for professional billing reports.

**Macro Organization**

- Items are sequenced in the order they would typically be performed.
- Items are defaulted to either execute immediately or to go onto a “to-do” list for documentation in the case at a later time.
- Items are defaulted as appropriate to the macro (i.e., medication route, action components).
- Separate macro tabs have been established for non-IV bolus medications (continuous drips, infusions) (Refer to the Medication Macro tabs illustration below).

![Medication Macro tabs illustration](image)

- Certain items have been included on every macro. They include:
  - Anesthesia provider start time
  - Reminder to assign ASA class
  - Reminder to confirm anesthesia type
  - Reminder to add Attending (for supervisory compliance)
  - Compliance attestation
  - Sign-out
  - Anesthesia provider stop time
  - Reminder to finalize the case

**Personnel Assignment**

- Attending, resident and CRNA staff are listed.
- Assignment of a supervising attending is required for residents and CRNAs – concurrency reports are generated by the SNA.
- See the Personnel section for details on adding/modifying personnel.
**COMPLIANCE ATTESTATION**
- Documentation of the presence of an attending according to A.S.A. standards.

**SIGN-OUT**
- Documentation of transfer to post-operative/post procedure staff.

**FINALIZE CASE**
- Complete the intra-operative/intra-procedural anesthesia record.
- Closes the record and makes it available for viewing within the EMR.

**ANESTHESIA DELIVERY LOCATIONS**
- Operating Rooms (including GI and Urology)
  - Anesthesia machines, patient monitors and workstations are defined by location (i.e. devices and workstations “know” where they are located and will automatically default to that location).
- Labor and Delivery
  - L&D Epidural
    - Patient monitors will not be automatically associated with the anesthesia record.
    - Monitor values may be added to the anesthesia record manually.
  - C-Sections
    - Anesthesia machines, patient monitors and workstations defined by location as for OR
- Anesthesia out of the OR
  - Patient monitors will not be automatically associated with the anesthesia record.

**CREATING A BLANK ANESTHESIA RECORD**
- Use this option for unscheduled cases requiring anesthesia documentation.
  - Identify the case as follows:
  - Document anesthesia record according to standard procedure.

**PROCEDURE DOCUMENTATION**
- Provider documentation remains on paper for Phase 1.
  - Epidural blood patch
  - Pain management out of the OR
  - Post-anesthesia documentation
START A MACRO

1. Click the **Macros** button on the toolbar.

2. On the Select Macro dialog box click the appropriate surgical area **Macro** tab to view the available Macros.

3. Click the appropriate **Macro** button to run the macro.
   - The components of the macro will display and can be verified and/or excluded depending on the procedure.

4. Click the appropriate **checkbox** to execute the component or place it on the **To Do** list.
   - Leave blank if you want to ignore and not execute an item.
5. Click the Edit icon to the right of the item to modify the item prior to executing the macro. (e.g. adding a dosage to a medication because it is already known at the time of macro execution).

- Defaults can be set up to give values to these details, or they can be modified here for addition to the record.

6. Once the components of the macro have been verified click the **Execute** button to record the values.

- After the macro has been executed all medications, gases, fluids (Intakes and/or Outputs), monitors, and actions can be seen on the record.
- Monitor values will begin to show on the graph as they are collected from the devices.
- Watermark boxes may appear indicating nothing was received from the device at the time the macro was executed.
This unit will show you how to add, modify and delete medications for the surgical case. You will also learn how the medication administration is displayed on the patient record.

**Topics in this Unit:**
- Adding Medications
- Modifying Medications
- Deleting Medications
Adding Medications

There are several different ways to add medications and related dosages to a record. The steps involved will vary depending on whether or not the medication is already on the record.

**MEDICATIONS ALREADY ON RECORD**

1. Click the **medication name** to record a dosage at the current time.
   - This will display the **Add Medication Administration** dialog box.
   - The word **New** displays to the left of the medication name indicating that this is a **new administration** being added to the record.

2. Enter the **medication dose** and **volume** then click the **OK** button.
The height and weight for a patient can be changed by clicking on them in this dialog box.

Units can be changed by clicking on the blue unit hyperlink to the right of height, weight, dose amount, and volume.

Changing the units in the medication concentration will also make the corresponding change in the dose amount, volume, and weight base dose fields.

The new medication will now display on the record.

Note: The other fields on this dialog box are optional. If they are not documented now they will need to be documented later. Route and site have numerous options in their drop-down lists and will default to IV Push and (None).

Medications NOT Already ON Record

1. Click the Medications button on the toolbar.
The Select Medication dialog box displays.

The tabs in the dialog above the medications are the medication categories.

If you are unable to locate a medication in any of the categories, click the Other button located in the lower left hand corner of the dialog box to search the entire formulary.

Click a category to search for a medication. When a medication is located, click the button containing the medication name. The Add Medication Administration dialog box will display.

Adding Medications – Bolus v. Infusion

There are different ways to look at the administrations of medications, depending on whether the medication is administered as bolus or as infusion.
**Bolus**

- Allows for volume to be documented as administered in one single minute.
- If concentration is correct, as well as weight, entering **Dose amount** or **Volume** will cause the rest of the fields to be calculated.
- Route and Site are not required fields and will default to *IV Push* and *(None)* respectively.

**Infusion**

- Allows for volume to be shown as administered over time.
- If concentration is correct, as well as weight, entering **Dosing infusion rate** or **Pump infusion rate** will cause all other field values to calculate over time.
- Route and Site are not required fields and will default to *IV Push* and *(None)* respectively.
- The blue triangle symbol (a.k.a. delta) in this dialog allows rate changes to be made. Click the blue delta and then click in the time frame that the rate needs to be changed in. Enter the correct rate in the appropriate field and a blue separator will appear in the bar, indicating a change was made.
- The red circle allows the stop time of the infusion to be entered. Click the red circle and then click at the proper time to indicate the conclusion.
- The red X will delete any rate change indicators that might be present in the bar.
Modifying Medications

**Via the Toolbar**

1. Click the **Medications** toolbar button.

   ![Medications Toolbar](image)

   - The Select Medication dialog box displays.

   ![Select Medication Dialog](image)

   - NOTE: the first tab is the Current tab which contains all of the medications that have been currently recorded on the anesthesia record.

2. To modify a medication administration click the **Modify Admin** radio button.

   ![Modify Admin](image)

   - The dialog box changes to show *only* the Current tab and the medications currently being administered.

   - This is a very important step in modifying medications. If the **Modify Admin** radio button is not selected there is a high probability that a medication will be added again.
3. Click the medication that needs to be modified and the Modify Medication Administration dialog box will display.

4. Change the dose amount to the correct value and click the OK button.

**VIA THE RECORD**

1. Locate the medication that needs to be modified on the record.

2. Click the dosage that needs modification.
   - The Modify Medication Administration dialog box will display where changes can be made to the dose amount, volume, or times.
Deleting Medications

Removing Administrations Via the Toolbar

1. Click the Medication toolbar button.

   - The Medication dialog box will display. The Current tab contains all of the medications that have been recorded on the anesthesia record.

2. To delete a medication administration, click the Remove Admin radio button to select it.

   - The dialog box changes to show the Current tab and the administered medications.
- **Important Note**: If the Remove Admin radio button is not selected the medication might be added again.

3. Click the medication that needs an administration removed to select it.

4. Click the OK button.

   ![Select Medication Administration](image)

- If a medication has only one administration the Select Medication Administration dialog box will not appear. The medication will be removed from the record entirely after clicking on the name of the medication.

5. Click the administration of the medication that needs to be removed to select it.

   ![Select Medication Administration](image)

6. Click the OK button and that instance of the med will be removed from the record.

**REMOVING ADMINISTRATIONS VIA THE RECORDED MEDICATIONS**

1. If the medication has already been documented on the record, click the dosage that needs to be removed.

   ![Recorded Medication](image)
2. Click the **Remove Admin** button in the lower left hand corner.

- This will remove the corresponding dosage from the record.
- If it is the only dosage recorded for that medication it will remove the medication from the record.

**REMOVING MEDICATIONS**

1. Click the **Medications** toolbar button.

2. To delete a medication entirely click the **Remove Admin** radio button.

3. Click the Medication to select and remove all administrations of a medication from the record.
INTAKES AND OUTPUTS

This unit will explain how to document intake and output volumes. You will learn how to start, add, modify and delete fluids as well as how to monitor them on the patient record.

Topics in this Unit:
- Adding Intakes
- Modifying Intakes
- Deleting Intakes
- Adding Outputs
- Modifying Outputs
- Deleting Outputs
Adding Intakes

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

**INTAKES ALREADY ON RECORD**

1. If a fluid is already on the record, click the fluid name to start another bag at the current time interval.

   ![Fluid Intake dialog box](image)

   - The Fluid Intake dialog box displays.

2. Click the **Start Bag** button to record the **start time** represented in the time bar.

3. Enter the **Volume rate** and **Weight based rate** as appropriate.
   - The Volume rate and Weight based rate fields are not required but will help in calculating volume given over time.
   - The Route and Site fields are not required and default to IV Push and (None).
INTAKES NOT ALREADY ON RECORD

1. Click the **Intake** toolbar button

   - The **Select Intake** dialog box displays.

2. Locate the desired fluid using the tabs above the fluid names and click the **fluid name** button to select it.

   - The **Fluid Intake** dialog box displays.
4. Click the **Start Bag** button.
   - The route, site and intake values do not have to be filled out in order start the bag.
   - Once a fluid has been running, you can start another bag of the same fluid.

5. Click the **fluid bar** towards the end of the bar.

6. Click the **Start Next Bag** button.

### Modifying Intakes

**VIA THE TOOLBAR**

1. Click the **Intake** toolbar button.

   - The Select Intake dialog box bog displays.
2. Click the **Modify Admin** radio button to select it.
   - The current tab displays.

![Modify Admin screenshot]

3. Click the **name of the fluid** that needs modification.
4. If there are multiple administrations select the **appropriate administration** and click the **OK** button.

![Select Intake Administration screenshot]

5. Click the **blue delta** icon to modify the time.
   - The mouse pointer displays as a blue delta icon.
6. Click the **Administration bar** at the time interval where you want to stop the current fluid rates.
   - The time interval is marked on the administration bar with a blue block.
   - The time can be adjusted by clicking on the blue block and dragging it to the desired time.
Intakes and Outputs

The administration display bar for the current fluid rate is located to the left of the blue block and by clicking on the bar you can see fluid rate start and stop time as well as the volume rates.

Notice that the administration display bar to the left is yellow to indicate you are looking at the current administration info.

The administration display bar for the new fluid rate is located to the right of the blue block. Note that there is no Stop time and the Volume rate value is blank.

Notice that the administration display bar to the right is yellow indicating you are looking at the new administration info.

10. Click the Administration display bar to the right of the blue block.

11. Enter the fluid rates to change the rate at which the fluid is administered.

**Via Fluids Already On Record**

1. If a fluid has been documented, click anywhere on the administration display bar to access the Modify Fluid Intake dialog box.
The Modify Intake dialog displays where changes can be made to any of the fields.

![Modify Intake dialog](image)

3. Click the blue delta icon to modify the time.
   - The mouse pointer displays as a blue delta icon.

4. Click the Administration bar at the time interval where you want to stop the current fluid rates.
   - The time interval is marked on the administration bar with a blue block.
   - The time can be adjusted by clicking on the blue block and dragging it to the desired time.

5. Click the Administration display bar to the right of the blue block.
6. Enter the fluid rates to change the rate at which the fluid is administered.

### Deleting Intakes

**Removing Intakes Via the Toolbar**

1. Click the Intake toolbar button.
2. Click the **Remove Admin** radio button to select it.

![Remove Admin Radio Button](image1)

3. Click the **medication** that needs to have an administration removed and the corresponding value will be removed from the graph.

![Select Fluid Administration](image2)

4. If there are multiple administrations of the same fluid click the **fluid that needs to be removed** to highlight it.

5. Click the **OK** button and the administration will be removed from the record.

**Removing Intakes Via Recorded Fluids**

1. If a fluid has already been documented click anywhere along the administration display bar to access the Modify Fluid Intake dialog box.

![Modify Fluid Intake Dialog Box](image3)
2. Click the **Remove Bag** button located in the lower left hand corner of the Modify Intake dialog box to remove the administration from the record.

![Modify Intake dialog box]

- If there was only one bag recorded for that particular fluid the entire fluid is removed from the record.

**REMOVING INTAKES**

1. Click the **Intake** toolbar button.

2. Click the **Remove Intake Fluid** radio button to select it.
3. Click the **fluid name** that needs to be removed from the Current tab.
   - The fluid will be removed from the record and you are returned to the patient documentation screen.

### Adding Outputs

The process of adding outputs is similar to adding Intakes.

**OUTPUTS ALREADY ON RECORD**

1. If an output is already on the record click the **name of the output** to enter the new value.
   - The Fluid Output dialog box displays.
   - The time can be adjusted by clicking on the white dot below the time display bar.

2. Enter the new **Output Volume** and the new amount will be seen on the graph.
   - Note: The new value is the total cumulative output.
   - Site is not required and should default to (None).

**OUTPUTS NOT ALREADY ON RECORD**

1. Click the **Output** toolbar button.
2. Click the **Output** that needs to be documented to access the Fluid Output Dialog box.

3. Enter the **appropriate output amount** and click the **OK** button.
   - The values entered will display on the surgical record at the time recorded.

### Modifying Outputs

**VIA THE TOOLBAR**

1. **Click the Output toolbar button.**

   - The Select Output dialog box displays.

2. Click the **Modify Output** radio button to select it.

3. The **Current** tab displays with the current output names.
4. Click the name of the output that needs modification.

5. Enter the volume value in the output field and click the OK button.
   - The change is reflected on the record.

**VIA OUTPUTS ALREADY ON RECORD**

1. For outputs already being documented, click the white dot marking its documentation on the record.

   ![Modify Fluid Output dialog box](image)

   - The Modify Fluid Output dialog box displays.

3. If necessary, adjust the time using the white dot located below the time interval bar.

4. Enter the new output volume value and click the OK button.
Deleting Outputs

**REMOVING OUTPUTS**

1. Click the **Output** toolbar button.

   ![Select Output dialog box](image)

   - The Select Output dialog box displays.

2. Click the **Remove Output Fluid** radio button to select it.

3. Click the **output name** that needs to be removed from the Current tab and that output will be removed from the record.
DEVICES AND MONITORS

This unit will show you how to associate additional devices used during a surgical case.

The bedside medical devices play a large role in the documentation of an anesthetic record. The values that these devices are monitoring are very important.

Most of the monitored values that need to be recorded during the case will usually 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.

Topics in this Unit:
- Associate A Device
- Adding Monitors
- Modifying Monitored Values
- Additional Monitor Value Functions
Associate A Device

You can choose to associate additional devices during a case that is in progress.

1. Click Task on the SurgiNet Anesthesia menu bar and select Associate Devices.
   - The Select Device Dialog box displays.

2. Select the appropriate device from the available devices listed, or click the Other button.

3. When the appropriate device has been located and associated click the OK button.

Adding Monitors


2. Click to select Monitors from the drop-down menu that displays.
The Select Monitors dialog box displays.

- The left side of the dialog box displays the available device parameters to select from.
- The right side shows those parameters currently being monitored with a red check mark.

3. Click the appropriate Monitor in the available parameters list to select it.
4. Click the Move button with the right facing arrow to add the Monitor to the selected parameters list.
   - To remove a Monitored value, click the value to select it and click the move button with the left facing arrow to remove the value from the record.

**TURN OFF A MONITOR**

For values that do not need to be displayed during portions of a case you can turn the monitoring off.
1. Click the **Red check mark** next to the value being monitored that you want to turn off.
   - The Red check mark is removed and the value is no longer displayed.

2. Click the **empty check box** next to the value you want to monitor to insert a red check mark and display the value

**Graphical Values**

Symbols appear next to those parameters that are designated as graphical values.

Parameters without a symbol next to it appear in the Monitors section of the record.

**Modifying Monitored Values**

1. To Modify a Monitor click the **value** you want to modify displayed in the Monitor section of the case.

   - The Modify Monitor Value dialog box displays.
2. Enter the **correct value** in the value field and click the **OK** button.
   
   - The corrected value now displays on the patient record.

3. To modify a graphical values click **Document** on the menu bar and select **Value**.
   
   - The Maintain Monitor Values screen will display where you can modify all of the monitored values that have been recorded for the case.
4. To adjust the value interval click the 1, 5, 10, or 25 interval buttons located at the top of the Maintain Monitor Values screen.
   - This will narrow down or expand the visibility of values to assist in locating a value.

5. Click the value that needs to be modified and enter the correct value.
6. Click the OK button and the correct value will display on the record.
Additional Monitor Value Functions

**DETAILS**

1. Click any of the **Monitor values** and click the **Details** button on the right.

- The modify monitor value dialog for that specific value will display where the value and time can be changed or comments can be added.
PULL VALUES
The application is collecting values that are tied to a parameter even if a monitor was not selected for the record. To add the parameter value pulling the values and display them on the graph:

1. Click the gray box to the left of any monitor name and then click Pull Values.
   - This will add all of the values that have been collected so far by the device and display them on the graph.

CHART/UNCHART
1. Highlight multiple cells on the screen and then select chart or unchart to include or exclude from the permanent record.

ADD/REMOVE MONITORS
1. Click the Add Monitor button to add monitors to the record without having to exit this screen.
Actions make up a majority of the anesthesia record outside of medications and fluids. Actions include Times, Positions, Airway Management, Procedures, Notes, and Billing Modifiers.

Some actions have details built behind them (i.e. Add IV Regional Block). There are also actions that do not have any details (i.e. Add Anesthesia Start Time).
Using Action List Items

1. Click the Actions toolbar button.

- The Action List dialog box displays allowing you to view documented actions by Date/Time, Category, Completion status and Signature status.

2. To edit an action, click the appropriate action to select it and then click the Edit button.

- An Action Details Modify dialog box will display where changes to the documentation can be made.

3. Click the OK button to record your changes.

4. To delete an action, click the appropriate action to select it and then click the Delete button.

- An Action Delete confirmation box will display requiring you to click a Yes or No button to confirm the action.

5. Click the Yes button to delete the Action from the record.

6. To Sign an Action, click the appropriate action to select and highlight it and then click the Sign button.

- An Authorizing Signature dialog box will display where you will need to enter your User Name and Password and click the OK button to electronically sign the action.
- Details that are documented for Actions are visible in the Details pane on the right side of the Action List dialog box.

- Actions display in the Action Bar at the bottom of the surgical case screen and are represented with symbols. Actions that do not have a symbol associated with them appear as a red circle with a white X in the center.

7. If an Action needs to be added to the record while the view is set to display by Date/Time, click the `<Add>` link at the bottom of the list to highlight the row, then click the Document button.
- The Select Action dialog box will appear.

- The Current tab shows what has currently been recorded.

- The other tabs can be clicked on to locate the desired action and when located that action box can be clicked to add it to the record.

8. An Action List can also be viewed by clicking on the Category button.
• This will display all of the available action categories with the actions documented beneath them.
• The date and time documented will display in the column at right.

9. To add an action to the record, click the action to select it, then click the gray Document button.

![Screen shot of action list]

• The Action Details dialog box displays.

![Screen shot of action details]

10. Edit the time if necessary and click the OK button to add the action to the record.
• Mandatory fields of an action appear in the list with a red asterisk after the action name.
An Action List can be viewed by Completion.

- Actions that have undocumented required fields are listed as Incomplete Actions.

9. Click the **Edit** button to complete the required fields and click the **OK** button.

- The action will now appear in the Complete list of actions.
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 they can be viewed in a separate dialog box by clicking on the Personnel toolbar button.
Adding Personnel

1. Click the Personnel toolbar button.

2. Click the Add button in the lower left hand corner.

- The Select Personnel dialog box displays.
3. Click the **provider name** to select it and add them to the list and the Modify Personnel dialog box appears.

4. Modify the **Date** and **Time** values by double-clicking into the field and using the up/down arrows to adjust the forward or backward.

![Modify Personnel Dialog Box](image)

### Removing Personnel

1. To remove personnel from a case click the **Personnel** toolbar button.

![Select Case Tool](image)

2. When the Modify Personnel dialog box displays, Click the **name of the person** to remove to select it and click the **Remove** button.

![Remove Button](image)
The dialog box now displays with the person removed from the case.
Print Preview can be a useful tool providing you a snapshot of everything that has been documented on a case so far.

Topics in this Unit:
Print Preview
Print Preview

The Print Preview feature allows you to see what a printout of the record will look like at any time during a case. Using Print Preview doesn't mean that the record will be printed, but can be useful in providing you a snapshot of the record.

1. Click Task in the menu bar and select Print Preview.

- The Print Preview screen dialog box displays with numerous controls in the lower left hand corner.
- Use the Print Setup Dialog box to Zoom in and out, set up the print variables and move between pages of the print preview screens.
Finalize a Record

**FINALIZE A RECORD**

*Topics in this Unit:*
Finalize the Case

Records will need to be finalized at the end of a surgical procedure to permanently record the case data to the patient’s record.

It will also give the anesthesia provider an opportunity to print preview the record, or complete the details of any medications, fluids, or actions.
Finalize the Case

1. Click Task on the menu bar.

2. Click Finalize Case to select it from the drop down menu.

- The Finalize dialog box will display the deficiencies and signatures for the record.
Any fluids that need stop times or actions that have incomplete required fields will display in the Deficiencies section located at the top of this dialog box.

3. Click the Edit icon to edit the fluid or action and the fluid/action dialog will display.
   - After a deficient item has been completed it will disappear from the finalize dialog.

4. Click the Ignore checkbox to ignore the deficiency and allow finalization to continue.
   - All deficiencies should be appropriately managed prior to finalizing the case.
   - Return to the record to complete deficiencies prior to finalizing the case.

5. Click the Sign button in the Finalize dialog box and the Cerner Authorizing Signature splash screen displays.
6. Enter your **User Name** and **Password** to sign the record and click the **OK** button to display the updated finalize dialog.

7. Click the **Print record checkbox** to open up the print dialog box as you finalize, and click the **Finalize** button.

   - Anesthesia records will be viewable within the MR and will NOT be routinely printed.
   - Records can be printed using the Print option.
   - You are returned to the main screen of the record which displays as Finalized with the case number at the top of the screen.

   - Once finalized, the record becomes read-only.

**Unfinalize the Case**

1. Click **Task** on the menu bar then click to select **Unfinalize Case**.

   - The read only status has been removed and the record can now be modified.
   - Remember to Finalize the case after all modifications have been completed.