Perioperative - Documenting Orthopaedic Operation Reports

Digital Health
CONNECTING BEST CARE

Digital Health
Quick Reference Guide

This Quick Reference Guide will explain how to:

Work a hybrid workflow between the hospital Cerner EMR system and the unit audit Sunray program.

Orthopaedic operation reports for select (and growing) number of procedures are being developed within the Sunray program by exporting the key datapoints entered into the audit system.

Creating a harmonious documentation workflow is essential to improving efficiency and reducing double handling whilst maintaining patient care through accurate and concise documentation.

The QRG was developed to help maintain this workflow prior to a more robust integration between the two systems.

Definitions:

Sunray – A server held web-accessible repository portal used to collect patient data to aid with daily patient care and to allow the ease of ad hoc and regular auditing.

Datapoints – A single piece of patient information routinely collected and recorded as part of clinical documentation. This may be a value, attribute or calculation which is kept in a coded state to allow extraction for documentation or auditing purposes.

How to write Cerner EMR operation reports

1. See the Documenting an Operation Report QRG on how to complete an operation report and an in depth review of the different components.
2. For operation reports that are generated off the Sunray database, we describe the current workflow on integrating this report within the EMR.

Creating a Sunray operation report

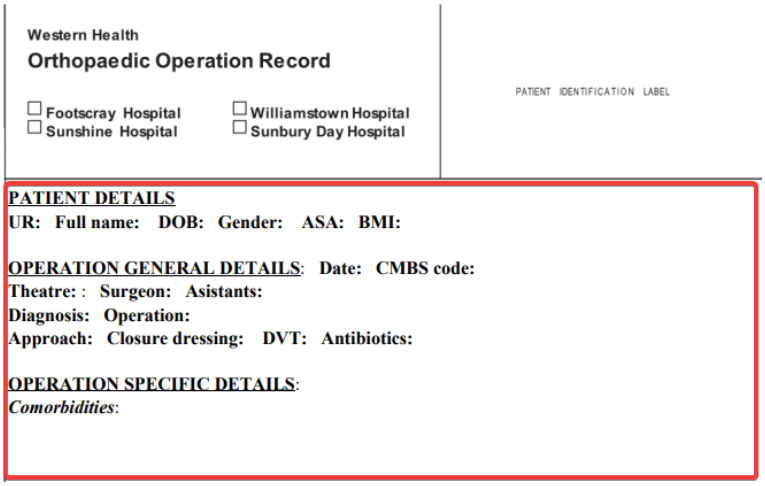
1. Open a new web browser and navigate to the following URL (http://whsortho2.wh.org.au/whorth/).
2. Enter your username and password as per the handover.
3. Click on the Sunray button to make the audit entry for the patient.

4. After completing the audit entry, under Procedures, click on the Operation Record button.

5. After completing the surgery details, click Save (to save) and then click Print.

6. A PDF opens in a new window.

7. Copy the body of the document into your clipboard including the Patient Details and the Operation Specific Details.


Western Health
Orthopaedic Operation Record

☐ Footscray Hospital ☐ Williamstown Hospital
☐ Sunshine Hospital ☐ Sunbury Day Hospital

PATIENT IDENTIFICATION LABEL

PATIENT DETAILS
UR: Full name: DOB: Gender: ASA: BMI:

OPERATION GENERAL DETAILS: Date: CMBS code:
Theatre: : Surgeon: Asistants:
Diagnosis: Operation:
Approach: Closure dressing: DVT: Antibiotics:

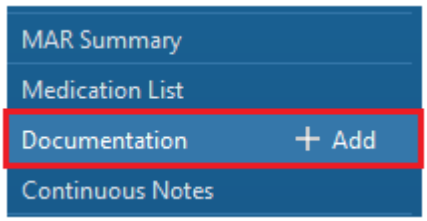
OPERATION SPECIFIC DETAILS:
***Comorbidities*:**

8. Switch to Cerner EMR (Powerchart).

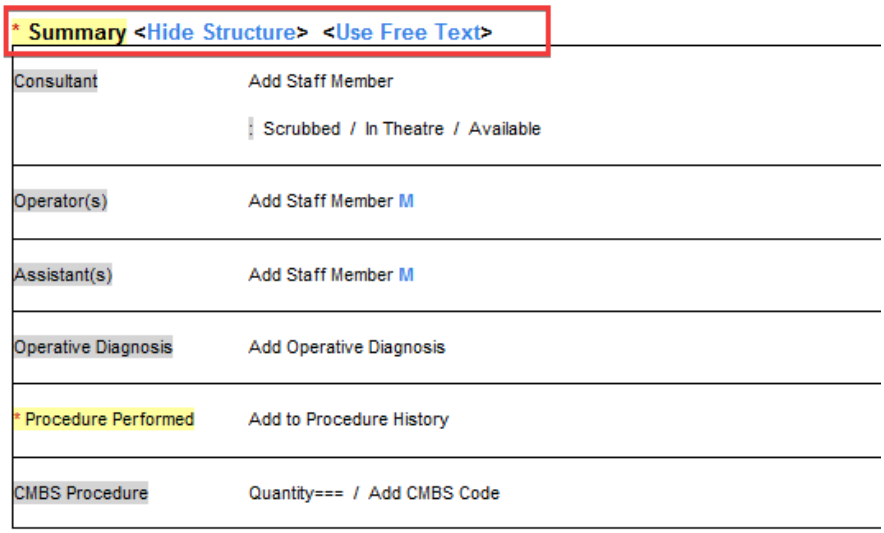
Integration into EMR

1. Open up EMR (Powerchart) and navigate to Documentation in the Table of Contents.

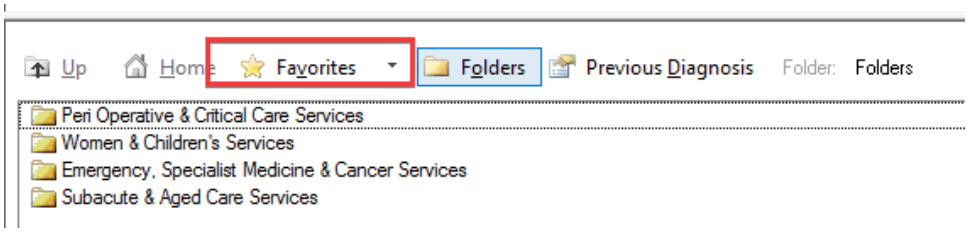
2. Open an Operation Report as per the Documenting an Operation Report QRG.



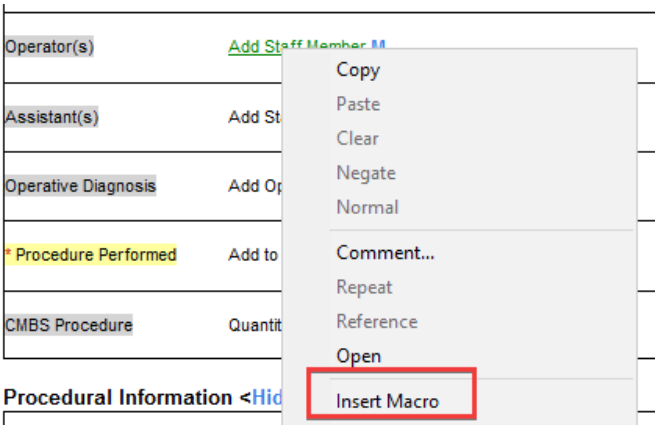
3. Complete the Summary section of the operation report – this helps with communication and record keeping of the patient's operation (including communication to the patient's LMO).



   a. We suggest you create a favourites folder of the common procedures you document.



4. Completing the Operator(s), Assistant(s) and Consultant allows you to easily audit these fields later.
    a. We suggest you use Macros to create lists of common operators / assistants for you to easily reference and insert.



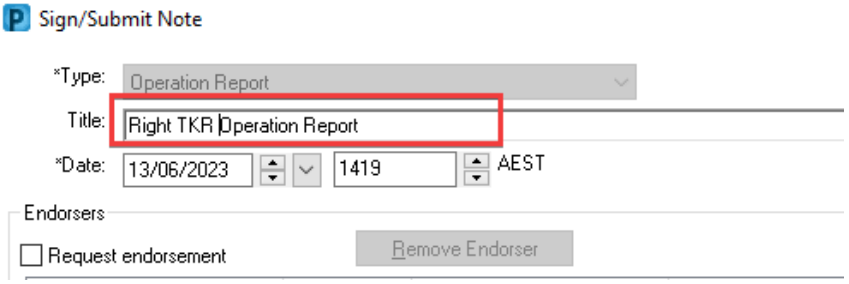
5. Complete CMBS code.

Important

CMBS codes are required for all procedures for billing purposes

6. For Procedural Information, click on <Use Free Text> and then paste the text from earlier into this section. Reformat as required.

7. Complete the remainder of the sections within the operation note as necessary and then click Sign/Submit.
8. Rename the note to reflect the operation and then sign the report.



9. **Note** - you will be able to streamline a number of these steps by using Precompleted Notes and Macros. More details can be found in the PowerNote Templates - Precompleted Notes and Macros QRG.