Perioperative – Documenting Endoscopy Procedures

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Quick Reference Guide

This Quick Reference Guide will explain how to:

Complete in-theatre nursing documentation for Endoscopy procedures

Definitions:

Provation – Endoscopy system used for scheduling and documenting procedures with images from scopes

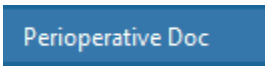
SurgiNet Anaesthesia – Cerner application for documenting the Anaesthesia Record

Segment – Page of specific data in the Perioperative Doc

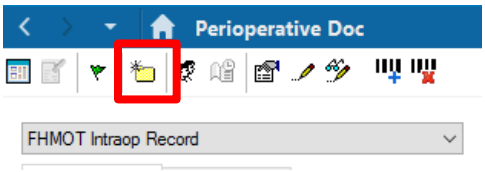
Endoscopy documentation in the EMR and Provation

Nursing and Anaesthesia documentation is completed in Cerner. Nurses enter the case times and endoscopy details into the Perioperative Document using PowerChart, and Anaesthetists document the Anaesthesia Record in SurgiNet Anaesthesia. The Proceduralist will continue to complete the procedure note using Provation.

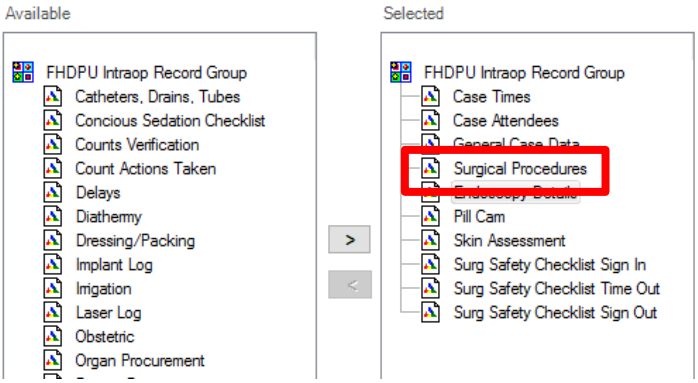
1. Using the TOC, Launch the Perioperative Doc from the patient's chart, selecting the Intraop Record.



2. If the Endoscopy Details segment is not included in the Intraop Record be default, select Add Segment from the Periop Doc taskbar.



3. Highlight the required segments from the Available items, and click the chevron (>) to move them to the Selected list, and click OK.



4. Complete the nursing document as normal, documenting all mandatory fields and finalizing with the green flag when the procedure is complete.