Perioperative - Documenting an Operation Report - Summary

Digital Health
CONNECTING BEST CARE

**Digital Health
Quick Reference Guide**

This Quick Reference Guide will explain how to:

Document an Operation Report in the EMR, by outlining the key steps.

For a more detailed description, please see the 'Perioperative - Documenting an Operation Report' QRG.

## Documenting an Operation Report

1. Click on *Documentation* in the Table of Contents, the drop-down arrow next to +*Add* and then *PowerNote*.
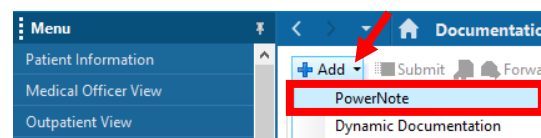
2. Select the *Catalog* tab and then the *Surgery* or *Obstetric* catalogue (depending on your role) in the drop-down. Click on *Operation Report* then *OK*.
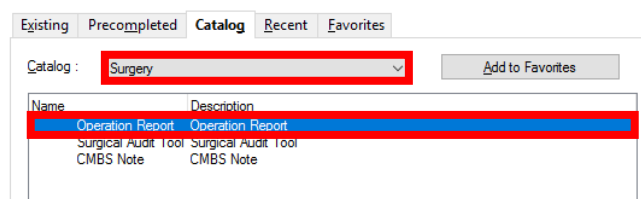
3. Select the **Case Number** for the operation and click *OK*. The Case Number should then automatically populate into the Operation Report.
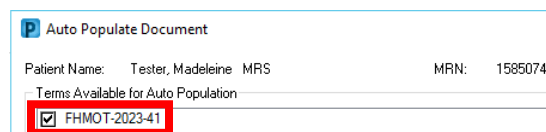
4. To record the **Consultant, Operator(s)** and **Assistant(s),** click on *Add Staff Member* in each field, and search for the staff member(s) using the '*last name, first name'* format. Select from *Scrubbed*, *In Theatre* or *Available* to record the consultant's presence during the case.

5. To add the **Operative Diagnosis**, click on *Add Operative Diagnosis*, then ➕ Add and either <u>search</u> for a diagnosis or use the <u>folders</u> of common diagnoses or saved favourites. Highlight the diagnosis and select *Include* to add it to the Operation Report.

6. To add the **Procedure Performed**, click on *Add to Procedure History*, then ➕ Add and either <u>search</u> for a procedure or use the <u>folders</u> of common procedures or saved favourites. Ensure search terminology is set to *SNOMED CT*. Add multiple procedures if required. Highlight the procedure(s) and select *Include* to add them to the Operation Report.

💡 **Handy Hint**

Can't find your preferred procedure description? Check if *SNOMED CT* and *Contains* is selected in the search. If you still can't find a suitable procedure, select the closest term and update the *Display As* field.

> **Important**
>
> **CMBS codes are required for all procedures for billing purposes**

7. To add a **CMBS Procedure**, first enter the quantity/multiple of your first CMBS code by clicking on *Quantity===*, selecting the appropriate number, then clicking *OK*. Then click on *Add CMBS Code*, ➕ Add and either search for a procedure or use the folder of saved favourites. Ensure search terminology is set to *Medicare Benefits Schedule (AU)*. Highlight the procedure and select *Include* to add it to the Operation Report.

8. Another CMBS Procedure field will have appeared below the original. Use this to document any additional CMBS codes if required.

9. To document the **Findings**, **Details of Procedure** and **OT Medications Administered** click on ===, enter your text and click *OK*.

> **Important**
>
> **For any OT Medications Administered, please ensure you record the medication name, strength, dose, route and time administered, e.g., Marcain 0.5% 5mL injected into wound at 0900.**
> This is the only place where these medications are recorded in the EMR and it is therefore critical that they are correctly recorded for patient care and safety.

10. To document **Specimens Sent to Pathology**, select *Yes* or *No*, and add a comment, if required, by clicking on *Comment*.

11. To document a post operative plan, use the Post Operative Checklist and/or Post Operative Plan sections. To document in the **Post Operative Checklist**, select from the predefined answers and add a comment, if required, by clicking on *Comment*. To document in the **Post Operative Plan**, click on ===, enter your text, and click *OK*.

12. To insert **Images**, click on *Add Image* and select either *Drawing Box* or *MultiMedia Manager*.
    - *Drawing Box* – draw operative images on the computer with or without an anatomical image
    - *MultiMedia Manager* – include images from the patient's file (e.g., a photo of an operative drawing completed on the AD253.3 Operative Drawings form)

13. Review your note and then finalise by clicking on *Sign/Submit*.