

SUR Activities

Exercise 1: Add Patients to SUR My List

- Make sure you are on the SUR Tracker.
 - Click on the patient on the tracker who you want to add to your list.
 - That patient's row will turn green.
 - Click the Add to My List button at the bottom of the screen.
 - This patient will now show up in your SUR My List of patients.
- This is a great way to add patients to a list of patients who you may want to follow up on or remember

Exercise 2: Add Additional Case

- Go to LISTS and Click on SUR My List
- Click Edit My List button (bottom of the page)
- You will default into your Current Cases My List, which should be empty.
- Click on the Add Case button
- You can search by Patient, Account Number, User or Case Number.
- Search patient by Name for the patient that your neighbor has.
- Click on patient that comes up
- If the patient has more than one surgical case, you can pick to add one or all of the cases by checking the checkboxes
- Click Add Cases, then Save
- If adding multiple cases, use the checkboxes on the left and then search by name for the next patient.
- Always Add Cases and Save once all cases have been selected

Exercise 3: Add Medical/Surgical History and Special Indicator

- Open the Patient chart by clicking on the chart icon field on the Tracker Board or going to the right of the screen and selecting Open Chart
- Select SUMMARY to the right of the screen
- Under Clinical go to Patient History and Surgical History; Click on the **BLUE** Edit button
- Select the SEARCH tab and type in "Malignant Hyperthermia due to Anesthesia" which now appear at the top under History
- Now Search for "Hx of Cataract Surgery". Under History at the top click on the "Hx of Cataract Surgery" to highlight it green; Change the category from Medical to Surgical by clicking on the category field and selecting from the drop-down menu
- Then select SAVE at the bottom
- Go to Special Indicator and click on the **BLUE** Edit button
- Using the drop-down menu Select Malignant Hyperthermia; Go to NEW and add Falls Risk

- Then select SAVE at the bottom

Exercise 4: Review and Confirm Allergies, Add New and Cancel

Add New Allergy

- Under SUMMARY go to Allergy/AdvReac and Click on the **BLUE** Edit button
- Make sure you are on the NEW tab at the top and select Any Word
 - Type in the search field the name of a new allergy - **Codeine**
- Note the type ahead feature as the system searches for a match
- Once you have selected the allergy at the top of the screen you will see a **RED** Edit button under the Reaction field along with the Type which says Allergy
- Click on the **RED** Edit button and a list of Reactions will appear
- Select the primary reaction as cough
- Follow the steps above to Add a second allergy of **Shellfish** (*****backspace out Codeine**); for the Reaction select palpitations
- Add a secondary reaction to Shellfish by either clicking on the Shellfish allergy or going to the EDIT tab at the top and then selecting Shellfish; In the Comments field type “rash-localized” and SAVE at the bottom
- On the Summary board you will notice under the allergy Shellfish a little comment bubble, which indicates that there is more information to view; by selecting the **BLUE +** sign button you can see those comments

Confirm Allergies

- Click on the **BLUE** Edit button under Allergy/AdvReac (Note: allergies identified from previous admissions will default)
- Place a checkmark beside each allergy (Note details of each allergy will populate in the box below) or you can click on the **BLUE** checkmark to Select ALL at once
- Click CONFIRM from the bottom footer buttons
- SAVE - Note that the date updated to today's date when looking on the Summary Board

Remove Allergies - Wrong Patient

- Click on the **BLUE** Edit button under Allergy/AdvReac
- Place a checkmark beside **Codeine and Shellfish** by clicking beside them individually or you can click on the **BLUE** checkmark to Select ALL at once
- Click REMOVE in the bottom footer buttons
- Enter the reason “Wrong Patient”
- Click OK at the bottom and then SAVE

Exercise 5: Home Medications (select group will be doing BPMH)

Exercise - Home Medications - To review and add additional home medications

- On the SUMMARY Board go to Home Medication and click on the **BLUE** edit button
- Make sure you are on the NEW tab at the top, Under the NAME tab select Any Word and type “Bisoprolol” (once again note the type ahead lookup)
- Click on the **BLUE +** sign under Bisoprolol Fumarate and the **BLUE +** for “10 mg tab” select the drop-down option. You can now EDIT details for this medication.
- For Dose enter 10; Freq select DAILY; Source select PATIENT; Last taken select KNOWN and from the drop-down menu choose Calendar and put today at 0800 (make sure **ALL** * fields are complete); SAVE

- Now repeat the above steps to enter in the home medication of Tylenol 500 mg Q4h Prn for breakthrough pain. Last taken Unknown. Source Patient. (Hint: select Tylenol Extra Strength)
- Save

Exercise 6: Adding SOC

- Click on PREOPERATIVE on the right and go to the CARE PLAN tab and the top of the page which will take you to a blank page. This is a One Time Record, located in the “Do” section of the EMR
- Click the Add button at the bottom of the page
- Click on the Standard of Care tab at the top of the page
- Select the “SOC Day Surgery - Adult”
- Click Save

Exercise 7: Add Intervention

- Under the Pre-Op Phase and under the CARE PLAN tab
- Go to ADD and the bottom of the screen and using either the NAME or ANY WORD tab start to type “Urinary” and select the “Urinary Catheter (Insert/Maintain) option; SAVE
- Ensure this populates the WORKLIST by checking under the WORKLIST tab at the top

Exercise 8: Resolve Clock

- Go to the WORKLIST tab at the top to see the clocks
- Click on the clock for the Height/Weight intervention
- Click the “NOT DONE” button at the bottom of the page
- Select the reason “patient asleep” for not documenting from the drop-down window that appears
- Note the **RED X** beside the clock
- Click the REFRESH button at the bottom of the page
- The clock should have been removed

Exercise 9: Documentation of Assessments

- Document the Pre-Op checklist intervention; IV: Peripheral Assessment; and Vital Signs
- Go to the NOW column and put a checkmark in each of the above interventions
- Select DOCUMENT from the bottom footers
- You can now go through each intervention to document; Once done SAVE and EXIT to go back to the worklist

Exercise 10: Back time, Edit and Undo Documentation

- Under the Vital Signs Intervention click in the NOW column

- Click DOCUMENT from the footers below
- Note the green box on the top right-hand side of the assessment which includes the date, current time and your initials
- Use the “top carrot” (arrow) to produce the drop-down box
- Change the time in the box to the time the assessment occurred (0900)
- Click OK
- Note the time now says 0900 in the top right-hand corner
- Proceed to document vital signs – for now just put a Temp of 36.5 Tympanic; Save and Exit
- If reviewing documentation history, it will show when the assessment was documented and when the assessment occurred
- Realise you made a mistake, and the patient was febrile at that time
- On the Worklist Click on the LAST DONE time cell under the Vital Signs
- Note all documented instances of this intervention are now listed for you to see under the HISTORY tab
- Select the Documentation you wish to EDIT by clicking on the word “document” in the Activity Type column; then click the EDIT button at the bottom of the page
- The Documentation to change will be highlighted green at the top; change the Temp to 39, hit Enter; Save and Exit; Back to return to the Worklist
- It’s a bad day and now you realise you documented on the wrong patient and need to Undo the documentation.
- On the Worklist Click on the LAST DONE time cell under the Vital Signs; Select the documentation you wish to Undo
- Click on the Undo/Save button at the bottom of the page
- Answer YES you want to undo the documentation
- Select Incorrect Patient as the reason for UNDO, then hit BACK to return to the worklist

Exercise 11: Setting Note Preference and Write Note

- On the Worklist go to the WRITE NOTE tab at the top; You will then have to pick a discipline to chart under and select Preoperative Note; This will change depending on what phase/area you are in. To make it faster next time, you can select Manage Favorites at the bottom and select all areas that pertain to you.
- The format for notes is **SOAPE**
- To write a note you need to select a foci – go to the TEXT footer button at the bottom; Select F. Vital Signs; now you can document a note on the patient being febrile and that the surgeon was notified. Select OK; Enter your PIN (this will not be required for Go Live)
- Go to the NOTES on the right in the see portion of the EMR, to ensure that the note is there

Exercise 12: Enter Intraoperative Case Details, Actual Procedure, Staff and Position

- To be able to move to the Intraoperative Phase, on the Preoperative Tab at the bottom fill in the fields Completed By and Completed Date/Time; SAVE
- Select Intraoperative on the right
- Become comfortable with the **N** button as it will bring in many details
- Actual procedure will populate using **N** but it can be changed
- Enter any staff and position. If you note someone in the staff look-up that is not present please let the trainer know

Exercise 13: Document Skin Prep and Invasive Procedures

- Under the Intraoperative Tab
- Go to Skin Prep; Under New Prep Site; Select Site One from drop-down; Click on “Chlorohexidine 2% w Alcohol 70%” and also “Sterile Water”
- After clicking on Sterile Water Write a comment: Testing and hit Enter (comment appears at the bottom of the screen and is highlighted green); You will now see a little **C** in a yellow bubble for your comment
- Go to Invasive Procedures; From the drop down menu click on Foley Catheter – 2 way and OK
- Go to Equipment and hit the **N**; equipment appears from Preference Cards

Exercise 14: Document Equipment, Items, Implant/Explant, Irrigation

- Check to see if Medical Equipment has pulled in from Preference Cards
- Add one additional piece of equipment from the drop-down menu on right and click OK
- Write a comment
- Use preference cards to pull in any ITEMS and add an IMPLANT
- Add one IRRIGATION SOLUTION

Exercise 15: Document Medication Additive, Output, Pathology and Cytology

- Document the MEDICATION ADDITIVES if this is used at your Facility
- Document under OUTPUT 500 mL of estimated blood loss
- Document PATHOLOGY specimen from Lower Abdomen, enter dates and times in all fields so that the cold ischemic time calculates
- Enter one CYTOLOGY specimen

Exercise 16: Place Order and Enter X ray for Incorrect Count

- Go to ORDER MANAGEMENT to Enter an order for Amylase (using the mini order screen)
- Under the Category Tab, Select Chemistry and find Amylase; Click Next at the bottom
- You will now be prompted to select the Provider (Surgeon Name) and the Source (eg. Telephone); hit OK
- Click on the **BLUE** Edit button; Change the Specimen to Pre-Collection label and the Freq to STAT; hit OK
- Select SUBMIT and you will have to enter in your PIN

- Next go to COUNTS; put no for Counts Correct; Select YES to Request an Abdominal Xray, then click on QUICK SAVE on the bottom; Click on the order for the Xray; hit OK; Select the Provider and Source; hit OK
- Go to the **RED** Edit button and put in Relevant Clinical Information, Now for time; SUBMIT and enter your PIN
- Fill in the Completed By and the Completed Date/Time fields to finish the Intraoperative Phase

Exercise 17: Creating a Chart for Emergency Case

Launch into the SUR Scheduler Desktop or from Tracker

- If on the TRACKER Board, Click CREATE CHART on right hand menu
- This brings you to a “find patient” screen.
- Type in the patient’s name to find him or her in the system. Make sure you select the correct patient and the correct account.

NOTE - Your patient may have several accounts in the system. It is very important that the correct account is selected.

- Pull in the Surgeon
- Pull in the Procedure
- Choose primary or secondary
- Pull in the laterality (SIDE)
- Choose the Operating Room
- Choose the Date/Time
- Choose the Case Type
- Only the fields with asterisks are required *
- You do not have to enter in the Assistant, Anesthesiologist or Anesthesia Type (but you can if you know it)
- Click Save
- You will have to Add the Patient to My List to be able to document on them

Now that you have created a case, you can start your documentation for this case, print a pick list, and print a preference card.

Exercise 18: Preference Cards

- **Go into the Print Preference Card routine and become familiar with the different options**
- Found in the Main Menu; Clinical; Surgical Services; Preference Cards/Picklists

e 19: Temporary Location

- Go to the MAIN MENU; Clinical; Patient Care; and Temporary Location
- Type the Last name, First name of the patient
- Operating room will automatically default to location field
- ****This is the only inpatient location currently**
- Identify return date and time

- Click Save



Note: Temporary location now displays on patient header below patient name (T)

- To Remove, Repeat the above Steps but delete the Temp Location that was entered in the field and SAVE; when you go back to the Tracker the (T) will have disappeared

Need to do Orders Management, eMAR/BMV and TAR

Discharge Plan- Not built out yet for SUR, it will be similar to other modules