

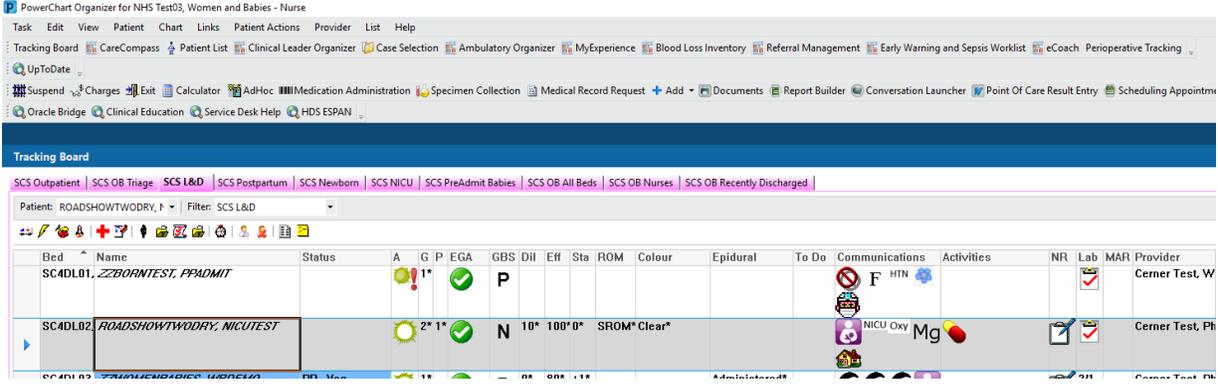
# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

### Steps for WB Operating Room in Millennium

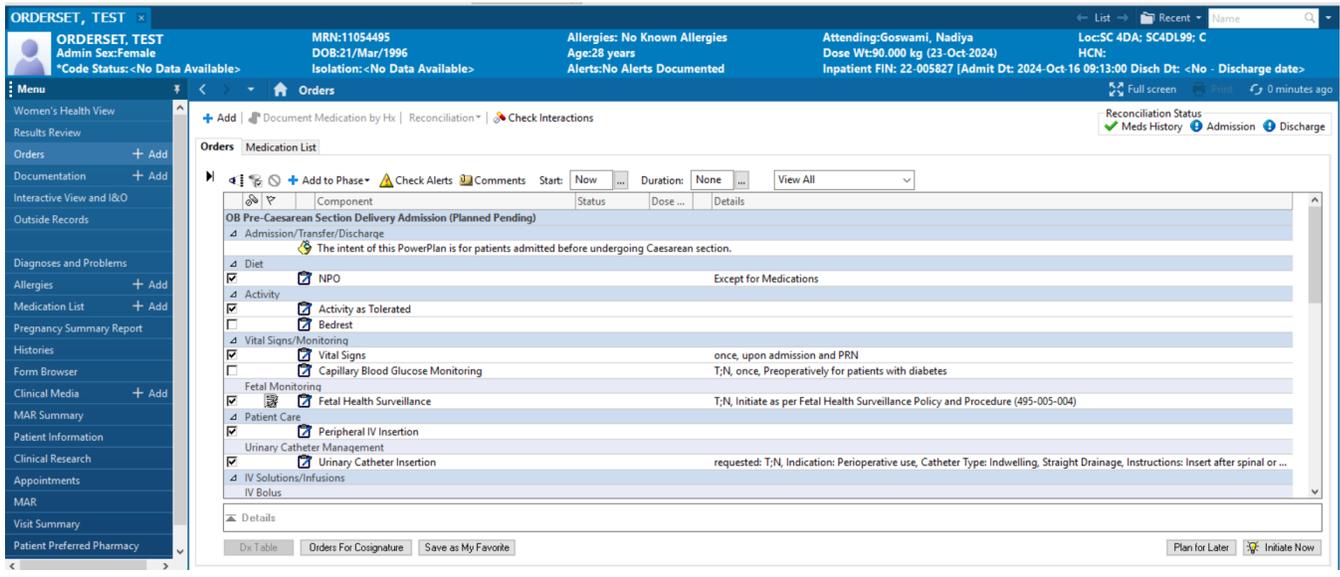
#### Finding your patient in Millennium:

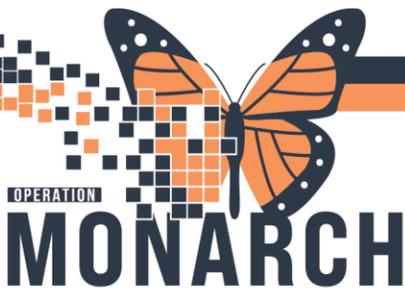
Open Millennium > Find patient on tracking board > Open Powerchart by clicking blue arrow to left of patient



#### Pre Operative Care:

If patient has a Booked C-Section navigate to Orders on the Table of Contents to initiate **planned OB Pre-Caesarian Section Delivery Admission Powerplan** to commence all pre-operative care





# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

For all admitted patient's nurse to complete OB Patient History Powerform located on the Women's Health mPage including the Anesthetic Questionnaire

**Anesthesia Patient Questionnaire**

Does the patient or a family member of the patient have a history of **MALIGNANT HYPERTHERMIA**?

Personal History  
 Family History  
 No History  
 Unknown

**Additional Details**

*\*The unknown columns and fields are to be used only when the patient cannot verify data and the next of kin is unavailable.\**

	Yes	No	Unknown	Comment
*Have you had a problem with an anesthetic in the past? Has any member of your family had a problem?				
*Do you have neck/ jaw or back problems?				
*Do you have dentures/ loose teeth or caps?				
*Have you been told it was difficult to place a breathing tube in your airway (Difficult Intubation)?				
*History of Cigarette/Vape use? If yes, how many a day?				
*Alcohol use? If yes, how many, how often?				
*Have you recently used street drugs? If yes, what kind?				
*Have you recently used any Cannabis products?				
*Have you ever had a heart attack? If yes, when?				
*Do you have angina or chest pains? If yes, how often?				
*Have you ever had heart failure (fluid in the lungs)? If yes, when?				
*Do you have High Blood Pressure?				
*Do you have a Heart Murmur?				
*Do your ankles swell frequently?				
*Do you become Short of Breath with Activity or wake up at night with Shortness of Breath?				
*Have you ever had a Stroke or had Mini Stroke Attacks?				
*Have you undergone any Chemo?				
*Do you have a Pacemaker?				
*Do you bleed or bruise easily?				
*Have you ever had a clot in your legs or lungs?				
*Do you take Blood Thinners? If so, for how long? Date/Time of last dose.				
*Do you have Emphysema Asthma or Bronchitis?				
*Do you have Sleep Apnea?				
*Are you on Oxygen at home?				
*Do you have Diabetes (sugar)?				
*Do you have Thyroid Problems?				
*Do you have Liver Disease or a history of Jaundice or Hepatitis?				

For patients going to the OR navigate to the **ADHOC** folder located in the grey toll bar and select **Pre-Operative Checklist**

**ADHOC**

ZZWOMENBABIES, TESTCINDY

MRN: 11054059  
 Admin Sex: Female  
 \*Code Status: <No Data Available>

Allergies: No Known Allergies  
 Age: 22 years  
 Alerts: No Alerts Documented

Women's Health View

- OB/GYN Inpatient Documenta...
- Admission/Transfer/Discharge
- OB Items

Pre-Operative Checklist

OB Prenatal RSV

Chart Close



# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

Complete all red asterisk \* sections as they are mandatory fields, and the Anesthetic questionnaire will populate from the OB History Powerform once completed

IMPORTANT NOTE: Perioperative checklist lives here and needs completion prior to entering the OR\*\*

Pre Operative Checklist - ZZWOMENBABIES, TESTCINDY

Performed on: 01/Nov/2024 08:45 EDT By: NHS Test03, Women and Babies - Nurse

**General**

**Preferred Communication**

Verbal  
 Sign language  
 Written  
 Interpreter

**Information Given**

Unable to obtain  
 Self  
 Spouse  
 Daughter  
 Family member

Friend  
 Parent  
 Sibling  
 Significant other  
 Son

Legal guardian  
 Other:

**Height Measured**  cm **Weight Measured**  kg **BMI Measured**  **Height Stated**  feet **Weight Stated**  lb

**Ability to Ambulate Prior to Admission**

Independent  
 One person assistance  
 Two person assistance  
 Dependent

**Comments**

**Mobility Devices/Equipment at Home**

Walker  
 Wheelchair  
 Ceiling lift  
 Prosthetics  
 Cane

**Sensory Deficits**

Visual impairment  
 Legally blind  
 Blind, left eye  
 Blind, right eye  
 Hearing deficit, left ear

Hearing deficit, right ear  
 Nonverbal  
 Sensation/Touch deficit  
 Speech deficit  
 Uncorrected visual impairment

Other:

**Home ADL Equipment**

Adapted utensils  
 Bath Board  
 Clamp-on tub rail  
 Commode  
 Dressing stick

Grab bars  
 Handheld shower head  
 Leg lifter  
 Long Handled Bath Brush  
 Long handled reacher

Long handled shoehorn  
 Non slip mat/surface  
 Raised toilet seat  
 Raised toilet seat with arms  
 Shower chair

Shower Stool  
 Sock aid  
 Splint  
 Toilet seat elevator  
 Tub transfer bench

Versa frame

**Living Situation**

In Progress

**NOTE: ALL SURGICAL COUNTS WILL REMAIN ON PAPER AND PLACED IN CHART LIKE CURRENT STATE**

### Opening Perioperative doc:

Navigate to **Perioperative Doc** and a **Case Selection** window will open to Check In patient select **Retrieve** to activate specific case

V2 March 2025

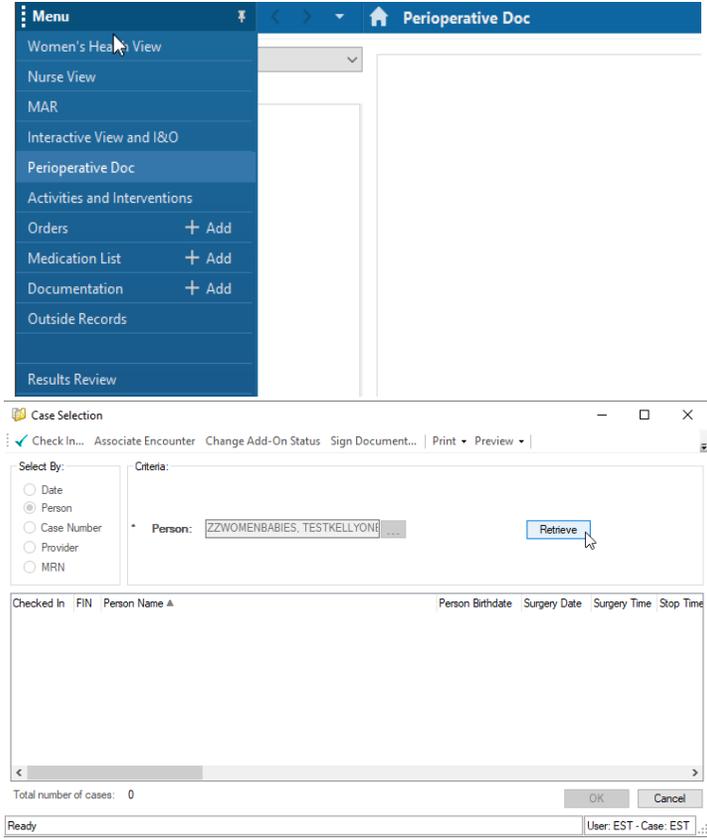
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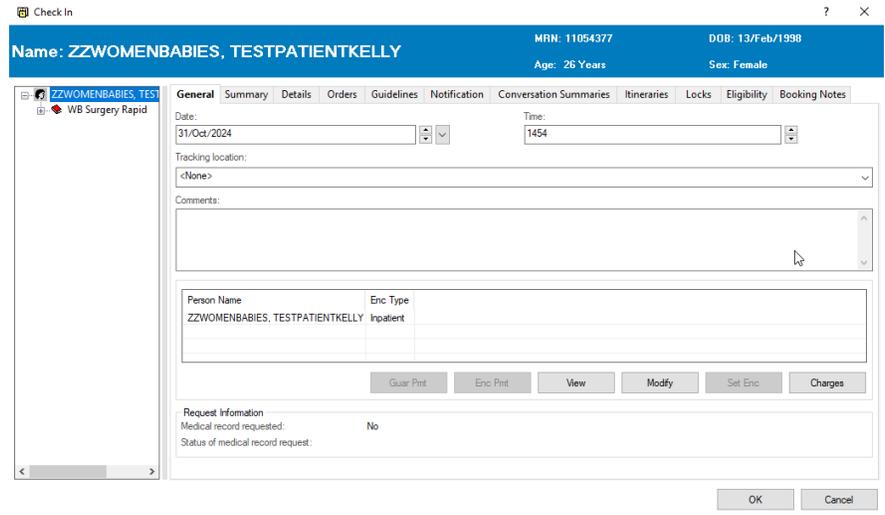


# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

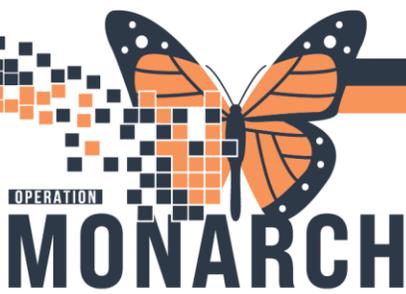


Review Procedure Data and select **OK**



Periop Doc documentation requirements will open starting with Case Times  
V2 March 2025





# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

- Each segment contains mandatory fields, these are marked with small grey boxes beside them. The case cannot be finalized until all mandatory fields have data and you see a green checkmark beside your segment
- Most segments contain a free text option at the bottom to chart as needed
- To account for picklist items and quantities, as well as the preferred method to scan implants

Choosing “next” You can see how many pages each segment has by the page locator at the bottom left

The screenshot shows the 'SC Intraop Record - OR' interface. On the left is a 'Documentation' tree with various categories like 'SSCL: Briefing', 'Skin Assessments', and 'Patient Positioning'. The main area contains several data entry sections:
 

- 'SSCL: Briefing completed' with 'Yes' and 'No' radio buttons.
- 'Patient Has Confirmed' with checkboxes for 'Identity', 'Surgical Site Marked - YES', and 'Surgical Site Marked - NO'.
- 'Labs: Glycemic Control' with 'Lab Results Reviewed' radio buttons and a 'Blood Glucose' input field.
- 'Blood Management' with 'Blood Consent on the Chart' radio buttons and a 'Blood Products available if required (on hand)' section.

 At the bottom right, a yellow box highlights the 'Next' button. A page locator at the bottom left shows '1 2 3'.

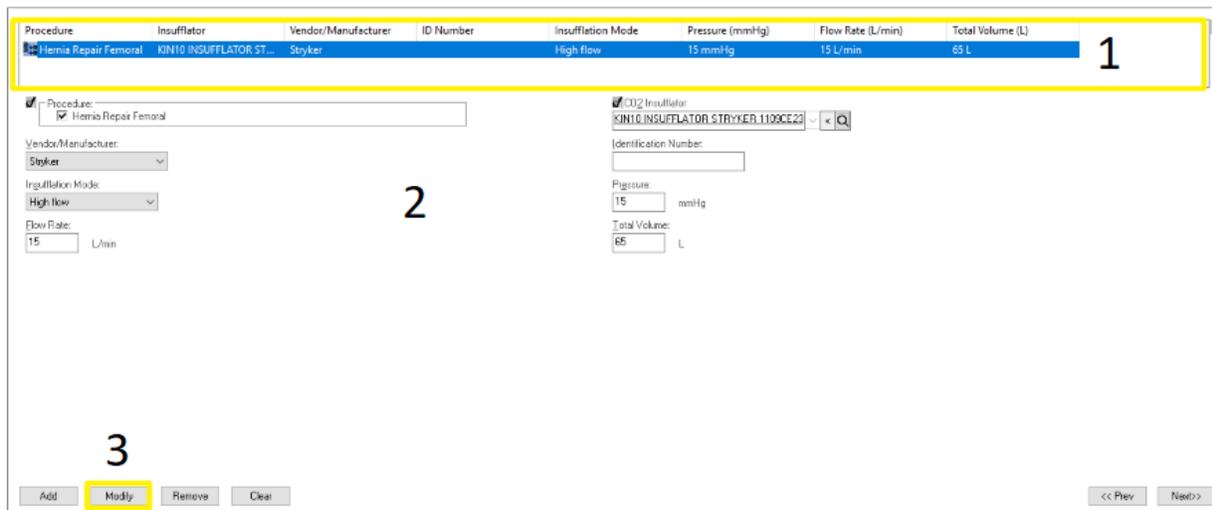
Once you have completed a segment with required/desired data, select “add”

This screenshot shows the 'SC Intraop Segment Group - OR' interface. It features a table for recording 'CO2 Insufflator' data. The table has columns for Procedure, Vendor/Manufacturer, ID Number, Insufflation Mode, Pressure (mmHg), Flow Rate (L/min), and Total Volume (L).
 

Procedure	Insufflator	Vendor/Manufacturer	ID Number	Insufflation Mode	Pressure (mmHg)	Flow Rate (L/min)	Total Volume (L)
<input checked="" type="checkbox"/> Hernia Repair Femoral	<input checked="" type="checkbox"/> CO2 Insufflator	Styker	KENTIG INSUFFLATOR STRYKER 1109CE22	High flow	15 mmHg	15 L/min	65 L

 Below the table, a yellow box highlights the 'Add' button. Other buttons include 'Modify', 'Remove', and 'Clear'. A page locator at the bottom right shows '<< Prev' and 'Next >>'.

If you need to modify the data



Procedure	Insufflator	Vendor/Manufacturer	ID Number	Insufflation Mode	Pressure (mmHg)	Flow Rate (L/min)	Total Volume (L)
Hernia Repair Femoral	KIN10 INSUFFLATOR ST...	Stryker		High flow	15 mmHg	15 L/min	65 L

1

2

3

Add **Modify** Remove Clear << Prev Next >>

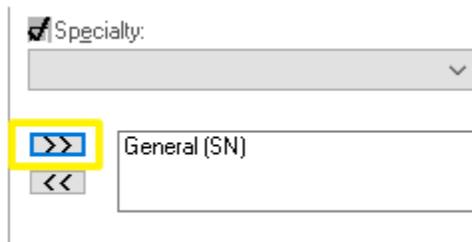
1. Highlight the entry you would like to modify from the workbook.
2. That data will populate in the work space for editing- make desired edits
3. Select "modify"

This concept applies to all segments with a data entry workspace at the top of the screen

This feature is ideal when bringing in data from picklist and missing fields (example: scanned implants, dressing, catheters etc)

**Note: To remove an incorrect entry all together follow the same steps:**

1. Select data from top workbook
2. Data will be retrieved in workspace
3. Select "Remove"



Specialty: [dropdown]

>> General (SN) [text field]

<<

If you see fields like this you will need to choose an item from the drop down list and choose the double arrow to write it to documentation (choose the reverse arrow to retract)



# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

### Segment Details

#### Case Times

In Case Times, Anesthesia times will dither out once the patient “in room time” has been documented

Anesthesia will be responsible for charting their own in/out times

Times are all mandatory fields

The screenshot shows the 'SC Intraop Record - OR' interface. On the left is a 'Documentation' tree with categories like 'General Case Data', 'Surgical Procedures', 'Case Times', 'Delays', 'Case Attendees', 'SSCL: Briefing', 'SSCL: Time Out', 'Skin Assessments', 'Skin Prep', 'Patient Positioning', 'Patient Care Devices', 'Surgical Irrigation', 'Energy', 'CO2 Insufflation', 'Tourniquet', 'Urinary Catheters', 'Hemostasis', 'Medications', 'Cultures and Specimens', 'Cardiac Pacing', and 'L...'. The main area contains several time entry fields:

- Room Prep:** Setup Start Time (1822, 27/Oct/2024) and Room Ready (1822, 27/Oct/2024).
- Patient:** In Room Time (1822, 27/Oct/2024) and Out Room Time.
- Anesthesia:** Start Time and Stop Time.
- Surgeon:** Surgeon In Room and Surgeon Beings.
- Procedure:** Start Time and Stop Time.

#### Delays

If your case experiences delays please pull in the corresponding segment and chart reasons for case delays prior to starting or at the end of the case

The segment will not preload and will need to be manually selected when need be from the yellow folder



# WB OR/PARR TIP SHEET

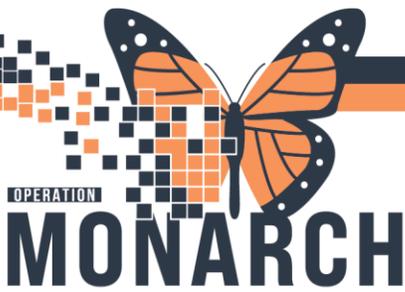
## HOSPITAL INFORMATION SYSTEM (HIS)

### Case Attendees

Surgeon flows in from bookings> highlight surgeon from top workbox and edit time in/outs throughout the case

Note: If someone leaves for break that would be a “time out”. A new entry will be required for **each** occurrence

Note: **a mandatory field is “Case Attendee”** for medical reps or any non-clinical personnel choose **“Other, Authorized Personnel”**



# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

Case Attende	Role	Time In	Time Out	Procedure	Vendor	Non Hospital Prsnl
Fielding, Ryan James	Surgeon - Primary			Hernia Repair Femoral		

<input checked="" type="checkbox"/> Case Attende: Other, Authorized Personnel	<input checked="" type="checkbox"/> Role Performed: Rep. Vendor Company
Time In: 1813	Time Out: [ ] [ ] [ ] [ ]
<input checked="" type="checkbox"/> Procedure: <input checked="" type="checkbox"/> Hernia Repair Femoral	

Non-Hospital Personnel Vendor: Styker	Non-Hospital Personnel (Name, Role): Colin McLone
---	--

Add    Modify    Remove    Clear    << Prev    Next >>

### WB SSCL

The WB SSCL Briefing, Time out and Debrief will need to be filled out in PowerChart

You can use the hardcopy we already have as a worksheet and way to facilitate the Briefing without a computer but all information must be transcribed into PowerChart and the hardcopy be shredded following the case

SC Intraop Record - WB

- Documentation
  - SC Intraop Segment Group - WB
    - Case Times
      - General Case Data
      - Procedures
      - Case Attendees
        - WB SSCL: Briefing**
        - WB SSCL: Time Out**
      - Skin Assessment
      - Skin Prep
      - Patient Positioning
      - Patient Care Devices
      - Energy
      - Urinary Catheters
      - Medications/Hemostatic Agents
      - Cultures and Specimens
      - Dressing/Packing
      - Counts Verification
      - WB SSCL: Debrief**
      - Transport

Room Prep  
Setup Start Time: [ ] [ ] [ ] [ ] Room Ready: [ ] [ ] [ ] [ ]

Patient  
In Room Time: [ ] [ ] [ ] [ ] Out Room Time: [ ] [ ] [ ] [ ]

Anesthesia  
Start Time: [ ] [ ] [ ] [ ] Stop Time: [ ] [ ] [ ] [ ]

Surgeon  
Surgeon In Room: [ ] [ ] [ ] [ ] Surgeon Begins: [ ] [ ] [ ] [ ]

Procedure  
Start Time: [ ] [ ] [ ] [ ] Stop Time: [ ] [ ] [ ] [ ]

V2 March 2025



# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

### Skin Assessment

Skin assessment contains 3 pages, one for pre-procedure documentation and one for post-procedure

You will not get a green checkmark on the segment until the post-assessment is complete

Pre-op Skin Assessment:

The screenshot shows the 'SC Intraop Record - OR' interface. On the left is a 'Documentation' tree with 'Skin Assessments' selected. The main area has a table with columns: Integrity, Abnormality, Surgeon Notified, Location, Type, Staging, Color, Abnorm Comment, and Post Skin Integrity. The 'Preop Skin Assessment' row is highlighted in yellow. Below the table, there are input fields for 'Color', 'Abnormality Comment', 'Skin Integrity' (with radio buttons for 'Intact' and 'Not intact'), 'Surgeon Notified' (radio buttons for 'Yes' and 'No'), and 'Abnormality Location'. There are also 'Add', 'Modify', 'Remove', and 'Clear' buttons at the bottom.

Post-op Skin Assessment:

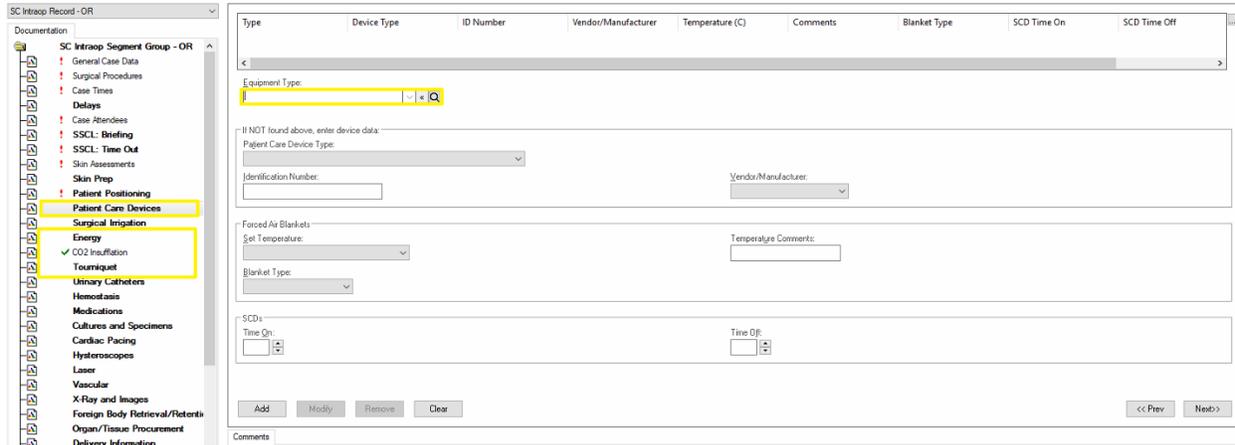
The screenshot shows the 'SC Intraop Record - OR' interface. The 'Postop Skin Assessment' row in the table is highlighted in yellow. The input fields and buttons are the same as in the pre-op assessment, but the 'Skin Integrity' radio buttons are now selected for 'Intact' and 'Not intact'. There are also '<< Prev' and 'Next >>' buttons at the bottom right.

### Charting Equipment

V2 March 2025

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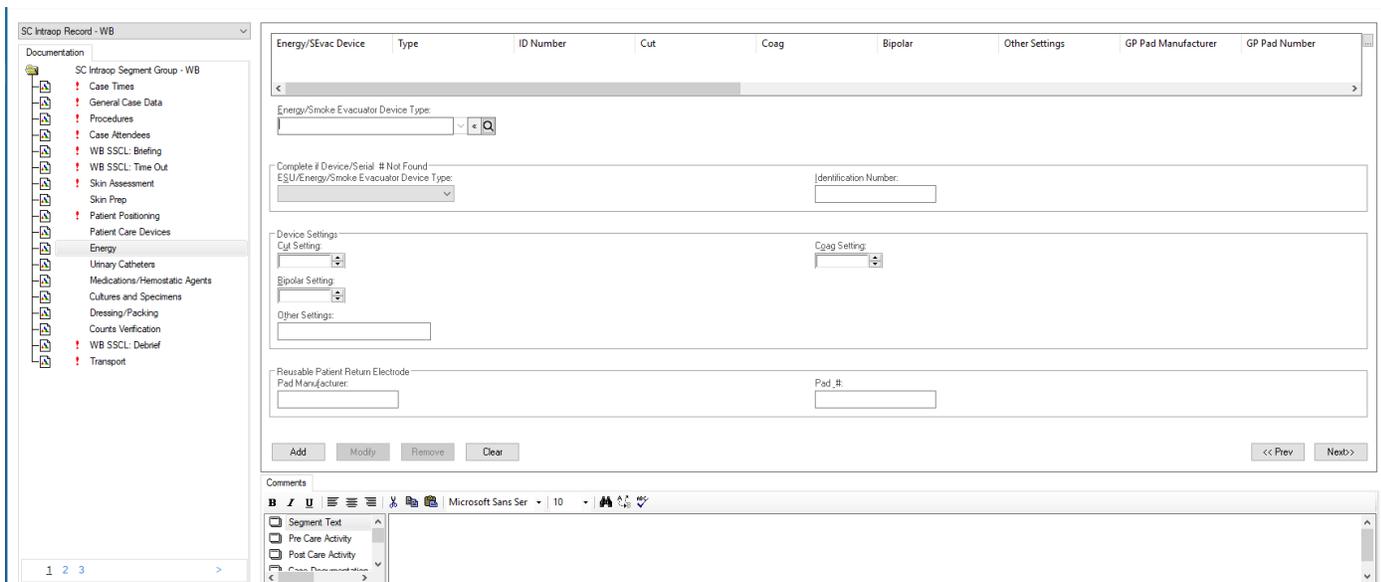


Specific segments will allow you to chart equipment by scanning or codes

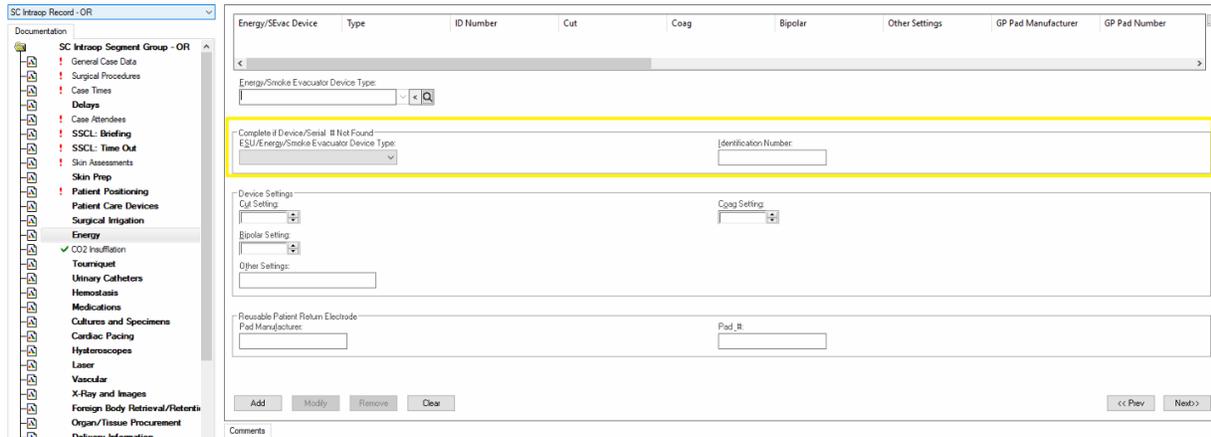
In the highlighted “equipment type” field either:

- Have cursor on field and scan green asset tag> press enter and equipment serial number will generate, fill in the rest of the required fields for that piece of equipment
- Type in equipment code (example: KE11) and press enter> fill in the rest of the required data for that piece of equipment

Here is an example of charting cautery:



If you cannot find a code and the equipment asset tag does not generate serial numbers after pressing “enter” each segment contains a field to free type in equipment



The screenshot shows the 'SC Intraop Record - OR' interface. On the left is a navigation tree with categories like 'General Case Data', 'Surgical Procedures', 'Delays', 'Patient Positioning', etc. The main area contains a table with columns: Energy/Sevac Device, Type, ID Number, Cut, Coag, Bipolar, Other Settings, GP Pad Manufacturer, and GP Pad Number. Below the table, there are several sections: 'Energy/Smoke Evacuator Device Type' with a dropdown and search icon; a yellow-highlighted section 'Complete if Device/Serial # Not Found' with a dropdown and a text input field for 'Identification Number'; 'Device Settings' with dropdowns for 'Cut Setting', 'Coag Setting', and 'Bipolar Setting'; and 'Other Settings' with a text input field. At the bottom, there are buttons for 'Add', 'Modify', 'Remove', 'Clear', and navigation arrows.

### Picklist

Used for Scanning of implants and supplies that were not on Preference Cards, as well as accounting for used items from preference cards and documented as used for case

As a general rule anything in your picklist will document to your perioperative documentation but not vice versa

Example:

- If there are steri-strips on your picklist it will prepopulate in the dressing segment after you have said you have used it
- If you scan your implants in here it will chart to your documentation

For proper case costing we want as much accuracy in our usage as possible

Go to picklist 

Choose



# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

**Batch Use** X

In batch use mode, all open quantities for non-instance tracked items will be defaulted in and you will be able to document against them.

Click 'Go to Pick List' if you would like to skip this step.

Batch Use
Go to Pick List

Select the top left box to pre-check all supplies on your preference card (edit if need be)

Select use on the bottom right

Note: This is the window we scan implants into

Item Description	Item Number	Class	Open	Hold	Filled	Used	Wasted	Returned
****NEEDING RESOURCE NURSE VALIDATION****	SN99997		0	0	0	0	0	0
1 BASIN SET	INST0009	Packs, Bundles and Drapes	1	0	0	0	0	0
5 MM 30 DEGREE LAPAROSCOPE	INST0031	Instruments	1	0	0	0	0	0
BLADE SCALPEL POLYMER CT NO.11 73-0411	036721	Supplies	1	0	0	0	0	0
COVER LIGHT HANDLE FLX GREEN DYNJLHS2	008102	Supplies	1	0	0	0	0	0
CYSTO BASIN LARGE	INST0279	Packs, Bundles and Drapes	1	0	0	0	0	0
DRAPPE 3/4 SHEET 53IN X 77IN DYNJP2414	021743	Packs, Bundles and Drapes	1	0	0	0	0	0
GLOVE SURG PF TRIUMPH LT 8.0 MDS108080LT	032627	Supplies	2	0	0	0	0	0
GOWN SURG XL SIRUS NON REINF DYNJP2002S	033762	Packs, Bundles and Drapes	1	0	0	0	0	0
GREEN TOWEL [ 4]	INST0528	Packs, Bundles and Drapes	1	0	0	0	0	0
HASSON BULLDOG GRASPER	INST0548	Instruments	1	0	0	0	0	0
KIT FOG REDUCTION/ELIMINATION NONFB100	020737	Supplies	1	0	0	0	0	0
LAPAROSCOPIC CLIP APPLIER - GREENMEDLG	INST1222	Instruments	1	0	0	0	0	0
LIGHT CORD	INST1255	Instruments	1	0	0	0	0	0
MICROLINE LAPAROSCOPIC SET	INST1343	Instruments	1	0	0	0	0	0
PACK LAPAROSCOPIC CHOLE DYNJ39905A	042940	Packs, Bundles and Drapes	1	0	0	0	0	0
REGULAR VERRES NEEDLE	INST1500	Instruments	1	0	0	0	0	0
SLEEVE UNIVERSAL OPTVIEW 5MM 2CBSLT	055276	Supplies	2	0	0	0	0	0
SPONGE PREP 2%CHG 70%ALCOHOL 100 27	038784	Supplies	1	0	0	0	0	0
STRIP CLOSURE SKIN 1/2IN X 4IN R1547	NO... 000224	Bandages, Dressings and T...	1	0	0	0	0	0
SUTURE MONOCRYL PLUS 4-0 P-3 MCP494G	033044	Sutures	1	0	0	0	0	0
SUTURE PASSER	INST1721	Instruments	1	0	0	0	0	0

If you go to batch use you will have to individually select the number of used items for each supply (not recommended) but here you can see what segment your supplies are set to flow into



# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

### Batch Use

In batch use mode, all open quantities for non-instance tracked items will be defaulted in and you will be able to document against them.

Click 'Go to Pick List' if you would like to skip this step.

Batch Use

Go to Pick List

Batch Use

In batch use mode, all open quantities for non-instance tracked items are defaulted in.

#### Non-Instance Tracked Items

Description	Item Number	Available	Quantity	Procedure	Segment	Edit	Remove
SLEEVE UNIVERSAL OPTVIEW 5MM 2CB5LT	055276	0	- 0 +	Cholecystectomy Laparoscopic	No Segment		
SPONGE PREP 2%CHG 70%ALCOHOL 100.27	038784	0	- 0 +	Cholecystectomy Laparoscopic	No Segment		
STRIP CLOSURE SKIN 1/2IN X 4IN R1547 NON250412	000224	0	- 0 +	Cholecystectomy Laparoscopic	WS Dressing/Packing - OR		
SUTURE MONOCRYL PLUS 4-0 P-3 MCP494G	033044	0	- 0 +	Cholecystectomy Laparoscopic	No Segment		
SUTURE PASSER	INST1771	0	- 0 +	Cholecystectomy Laparoscopic	No Segment		
SUTURE VICRYL PLUS 0 UR-6 VCP603H	033007	0	- 0 +	Cholecystectomy Laparoscopic	No Segment		
TIP CAUTERY L WIRE 5MM DISP 0600	025221	0	- 0 +	Cholecystectomy Laparoscopic	No Segment		

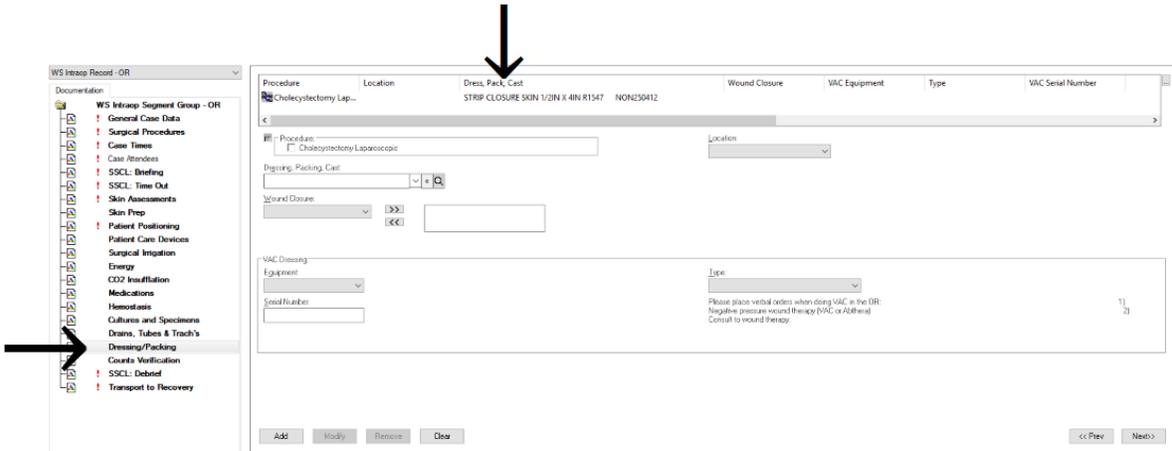
Save Cancel

Here is our used picklist item flowing into the “dressing/packing” segment



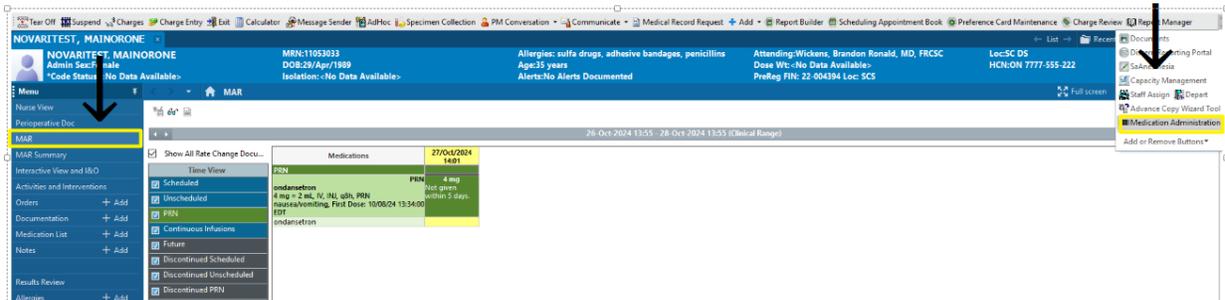
# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

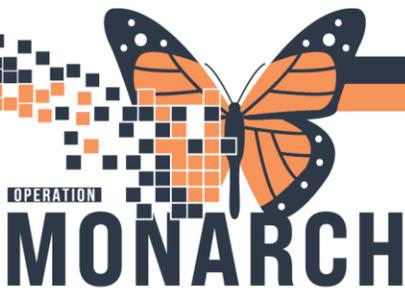


### Medications

**ALL medications given by a nurse** needs to be charted within the MAW/MAR so there's clear visibility between care providers when a medication has been give and an order has been fulfilled (preventing double doses etc)

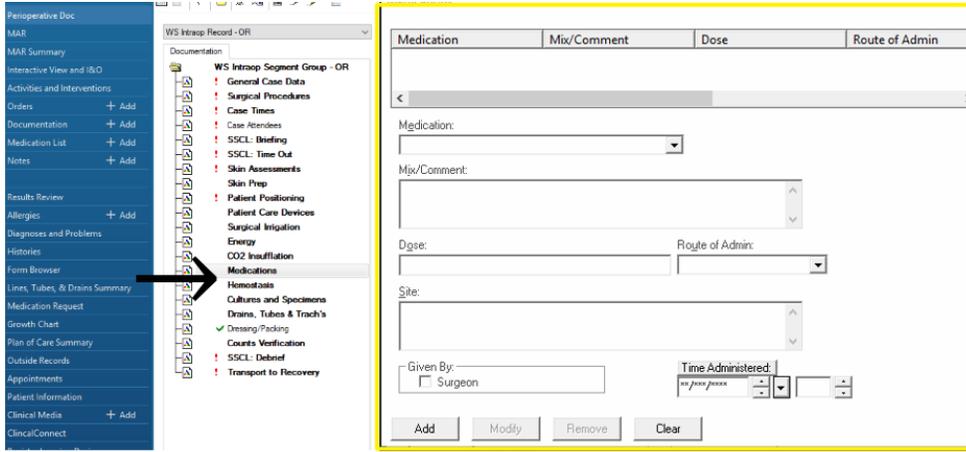


**All medications given by a surgeon within the sterile field** can be charted within our perioperative documentation



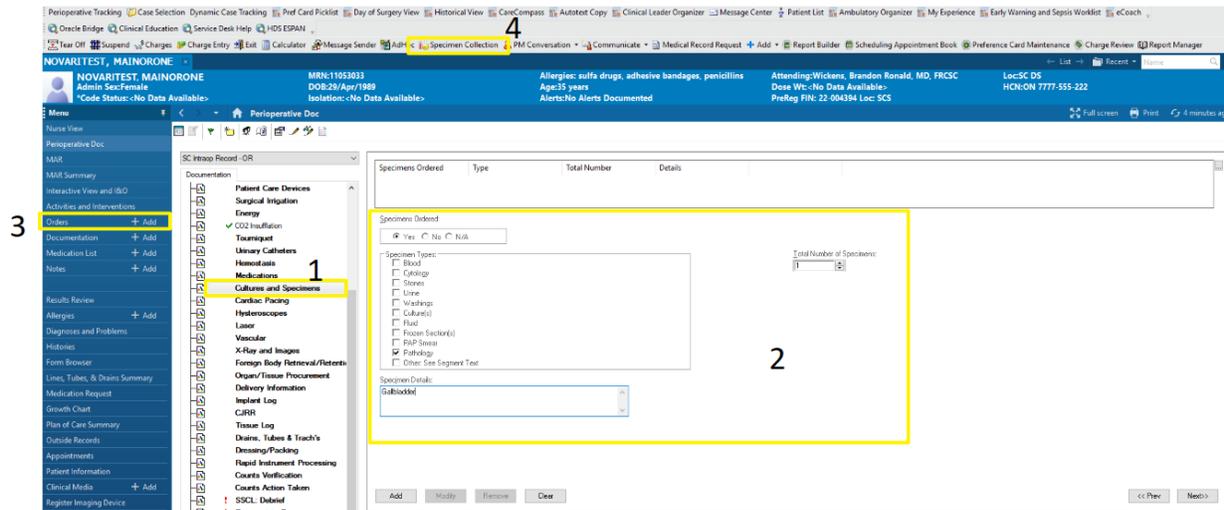
# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)



### Specimens

A surgeon likely will not leave a specimen in a planned state to initiate, as it would be hard to predict  
 We will need to document specimens collected as well as place this order as we receive specimens



1. Pull in segment "cultures and specimens" if it is not listed from the segments folder
2. Fill in collected specimen into OR documentation



# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

3. As specimens are collected, you will need to input this pathology order and it'll be sent to the Dr's message center for co-sign
4. Print the labels and scan they have been collected

Note: for more details on placing specimen orders and printing labels see separate tip sheet

### Blood Administration

Blood for the fridge (or boxed for NFS/WS) is an order that nursing can place **“Red Cells for Hold”**

Once the blood has been given the Dr or nurse (depending on urgency of the case) will need to place an actual order for blood (that is married to the transfuse order) with the corresponding number of units used

All other units can be sent back to blood bank

The screenshot displays the HIS interface for a medication order. The left sidebar contains navigation options like 'Nurse View', 'Perioperative Doc', 'M&T', 'M&T Summary', 'Interactive View and I&O', 'Activities and Interventions', 'Orders', 'Documentation', 'Medication List', 'Notes', 'Results Review', 'Allergies', 'Diagnoses and Problems', 'Histories', 'Form Browser', 'Lines, Tubes, & Drains Summary', 'Medication Request', 'Growth Chart', 'Plan of Care Summary', 'Outside Records', 'Appointments', 'Patient Information', 'Clinical Media', 'Register Imaging Device', 'Patient Preferred Pharmacy', and 'Clinical Connect'. The main content area shows 'Orders for Signature' with a table listing an order for 'Red Cells for Hold (OR/W&B)' on 2024-04-28 09:11. Below the table, the 'Details for Red Cells for Hold (OR/W&B)' form is visible, including fields for 'Blood Priority', 'Total Quantity Units' (set to 2), and 'Reason for Ordering' (set to 'SCS OR for Fridge'). A dropdown menu for 'Reason for Ordering' shows options: 'SCS OR for Fridge', 'SCS OR for Fridge', 'NFS/WS OR Unstable Pt boxed', and 'WB&Babies Boxed'. The bottom of the screen has buttons for 'Missing Required Details', 'Orders For Consumption', 'Orders For Nurse Review', and 'Sign'.

Blood in the OR will most often be given by Anesthesia with your assistance

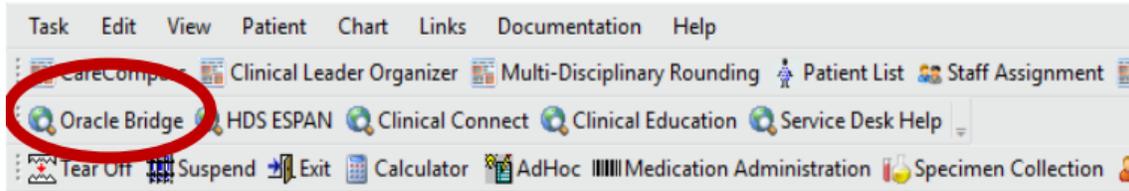
**\*Scanning\*** is you best option when giving blood!!

Since we are always monitoring vital signs through SA anesthesia and they flow into i-view we do not need to record vital signs in Bridge

V2 March 2025

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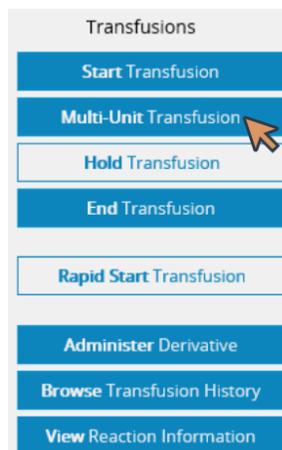




After opening Bridge scan you patient's armband

Patient ID

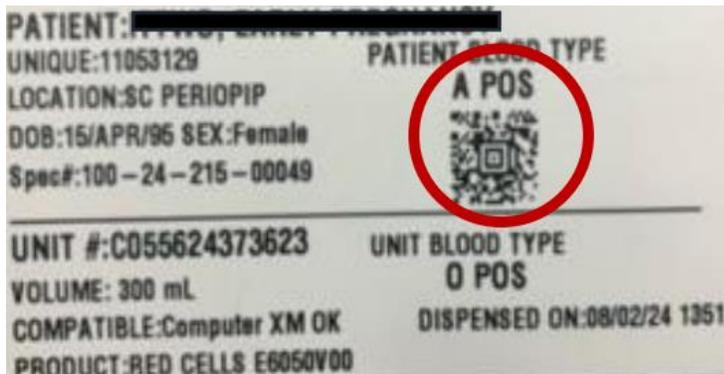
Select Multi-unit transfusion: The only workflow that allows you to bypass vital recording is in **multi-unit transfusion** blood administration (in this option you can also give **one** unit of blood)



Follow the prompts, taking note that only fields with an \* are required

\*MRN (Scan Barcode on Product Label)

Recipient tags are scanned first on cross-matched blood and look like this:



You do not need to hand type in all numbers- please scan in the letter “U” shape



1. Unit number
2. Blood product
3. Expiration date
4. Donor blood type

Please see blood transfusion tip sheets for further details



# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

### iView and the OR

All documentation that needs to be visible for anyone involved in the patients circle of care **NEEDS** to be charted in **iView**

Periop documentation only creates a signed note - and the information is only visible for those who read that note

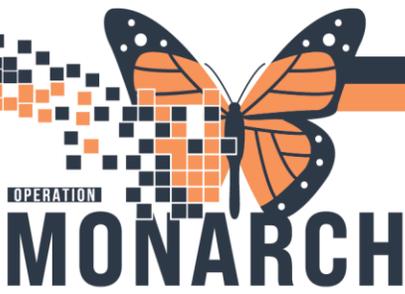
#### Items we need to chart in iView:

- IV starts
- Nursing assessments you want to chart (example: Respiratory, breath sound assessment)
- Codes
- TOC

#### IV Start:

The screenshot displays the iView software interface. On the left is a navigation pane with categories like 'Nurse View', 'MAR', 'Perioperative Doc', and 'Results Review'. The main area shows a list of medical orders, with 'OB Lines - Devices' selected and expanded. A dropdown menu is open, showing 'Peripheral IV Site' options: Ankle, Antecubital Fossa, Basilic vein, Brachial cephalic, Brachial vein, Cephalic vein, Digit, Foot, and Forearm. The 'Peripheral IV Site' dropdown is currently set to 'Peripheral'. The interface also shows a date of 31/Oct/2024 and a time of 16:14.

#### Nursing assessments:



# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

Women's Health View

Nurse View

MAR

**Interactive View and I&O**

Perioperative Doc

Activities and Interventions

Orders + Add

Medication List + Add

Documentation + Add

Outside Records

Results Review

Appointments

Allergies + Add

Diagnoses and Problems

Form Browser

Histories

MAR Summary

Lines/Tubes/Drains Summary

Clinical Media + Add

Patient Information

Pregnancy Summary Report

- OB Triage
- Antepartum
- Labour and Delivery
- Newborn Delivery Data
- OB PARR
- OB Postpartum
- OB Special Assessment
- OB Systems Assessment**
- Vital Signs
- Pain Assessment
- Comfort Measures
- Integumentary
- Mental Status/Cognition
- Neurological
- Respiratory
- Breath Sounds Assessment
- Cardiovascular
- Pulses
- Edema Assessment
- Gastrointestinal
- Glucose Capillary Blood Point of Care
- Genitourinary
- Bladder Scan/Postvoid Residual
- Urinary Catheter
- Braden Assessment
- Morse Fall Scale
- Post Fall Evaluation
- Critical Event

Last 24 H

Find Item

Critical  High  Low  Abnormal  Unauth  Flag

Result	Comments	Flag	Date	Performed By
			31/Oct/2024	
			16:15	
<b>Pain Assessment</b>				
Pain Present				
Self Report Pain				
Unable to Self Report Pain				
Pain Negatively Impacts				
Opioid Adverse Effects				
Pain Site 1				
Pain Site 2				
Pain Site 3				
<b>Integumentary</b>				
Skin Colour				
Skin Temperature				

### Codes/Critical Events:

Women's Health View

Nurse View

MAR

**Interactive View and I&O**

Perioperative Doc

Activities and Interventions

Orders + Add

Medication List + Add

Documentation + Add

Outside Records

Results Review

Appointments

Allergies + Add

Diagnoses and Problems

Form Browser

Histories

MAR Summary

Lines/Tubes/Drains Summary

Clinical Media + Add

Patient Information

Pregnancy Summary Report

Newborn Discharge Information

- OB Triage
- Antepartum
- Labour and Delivery
- Newborn Delivery Data
- OB PARR
- OB Postpartum
- OB Special Assessment
- OB Systems Assessment**
- Vital Signs
- Pain Assessment
- Comfort Measures
- Integumentary
- Mental Status/Cognition
- Neurological
- Respiratory
- Breath Sounds Assessment
- Cardiovascular
- Pulses
- Edema Assessment
- Gastrointestinal
- Glucose Capillary Blood Point of Care
- Genitourinary
- Bladder Scan/Postvoid Residual
- Urinary Catheter
- Braden Assessment
- Morse Fall Scale
- Post Fall Evaluation
- Critical Event**

Last 24 Hour

Find Item

Critical  High  Low  Abnormal  Unauth  Flag

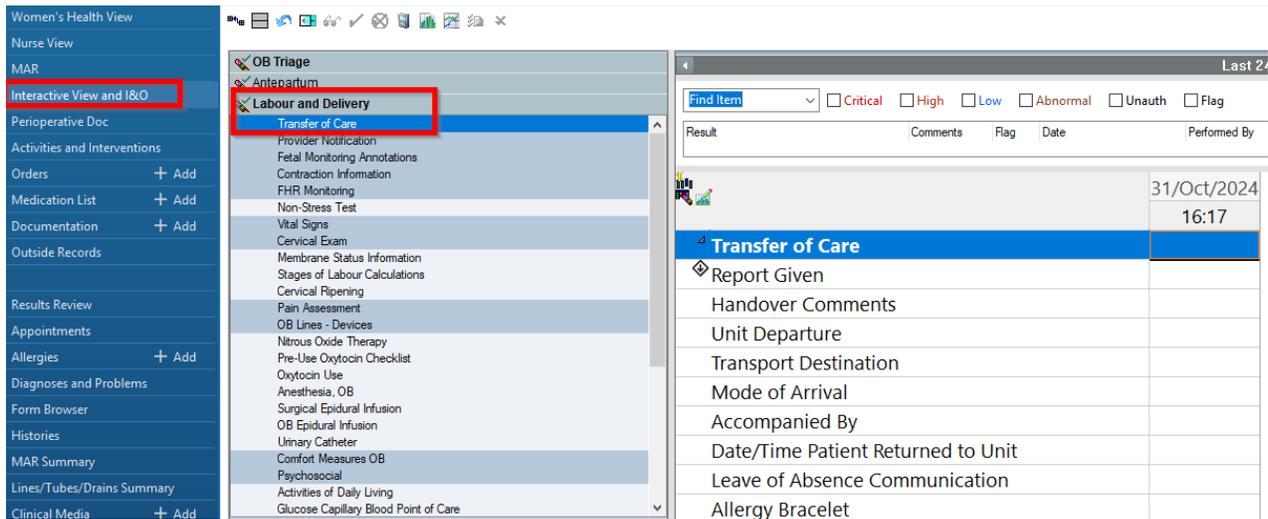
Result	Comments	Flag	Date	Performed By
			31/Oct/2024	
			16:16	
<b>Critical Event</b>				
Type of Critical Event				
Start Time				
End Time				
Outcome				

V2 March 2025

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TOC:



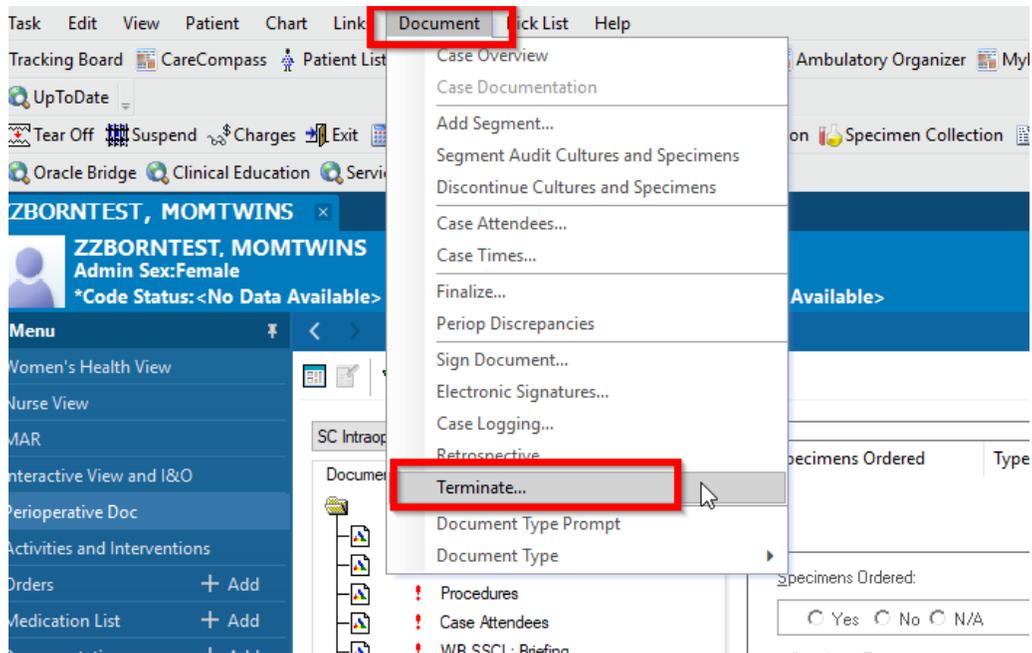
The screenshot shows the HIS interface with the following elements:

- Left Navigation Panel:** Includes 'Women's Health View', 'Nurse View', 'MAR', 'Interactive View and I&O' (highlighted with a red box), 'Perioperative Doc', 'Activities and Interventions', 'Orders', 'Medication List', 'Documentation', 'Outside Records', 'Results Review', 'Appointments', 'Allergies', 'Diagnoses and Problems', 'Form Browser', 'Histories', 'MAR Summary', 'Lines/Tubes/Drains Summary', and 'Clinical Media'.
- Central Content Area:** Shows a tree view with 'OB Triage', 'Antepartum', and 'Labour and Delivery' (highlighted with a red box). Under 'Labour and Delivery', 'Transfer of Care' is selected and highlighted with a red box.
- Right Panel:** Displays a table with columns for 'Result', 'Comments', 'Flag', 'Date', and 'Performed By'. The table contains one entry:
 

Result	Comments	Flag	Date	Performed By
Transfer of Care			31/Oct/2024 16:17	

### Case Termination

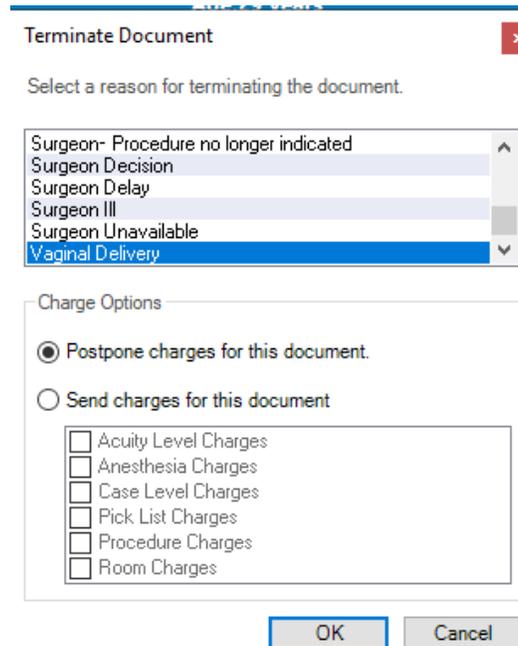
1. If a case is brought into the OR and then terminated e.g called c-section by OB but patient delivers in room, navigate to the grey tool bar and click on Document and select Terminate



The screenshot shows the HIS interface with the following elements:

- Top Menu Bar:** Includes 'Task', 'Edit', 'View', 'Patient', 'Chart', 'Link', 'Document' (highlighted with a red box), 'Check List', and 'Help'.
- Document Menu:** A dropdown menu is open, listing various options. 'Terminate...' is highlighted with a red box and a mouse cursor is pointing at it.
- Background Content:** Shows a patient record for 'ZZBORNTTEST, MOMTWINS' with 'Admin Sex:Female' and '\*Code Status:<No Data Available>'. The left navigation panel is also visible.

2. Terminate Document window will open select reason for termination e.g. vaginal delivery and then **OK**



Terminate Document

Select a reason for terminating the document.

- Surgeon- Procedure no longer indicated
- Surgeon Decision
- Surgeon Delay
- Surgeon Ill
- Surgeon Unavailable
- Vaginal Delivery

Charge Options

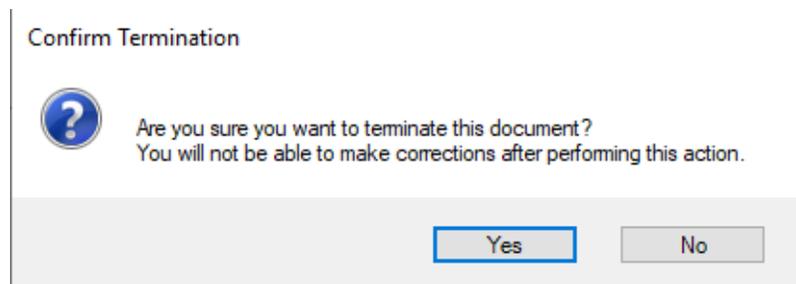
Postpone charges for this document.

Send charges for this document

- Acuity Level Charges
- Anesthesia Charges
- Case Level Charges
- Pick List Charges
- Procedure Charges
- Room Charges

OK Cancel

3. Confirm Termination and select **Yes**



Confirm Termination

Are you sure you want to terminate this document?  
You will not be able to make corrections after performing this action.

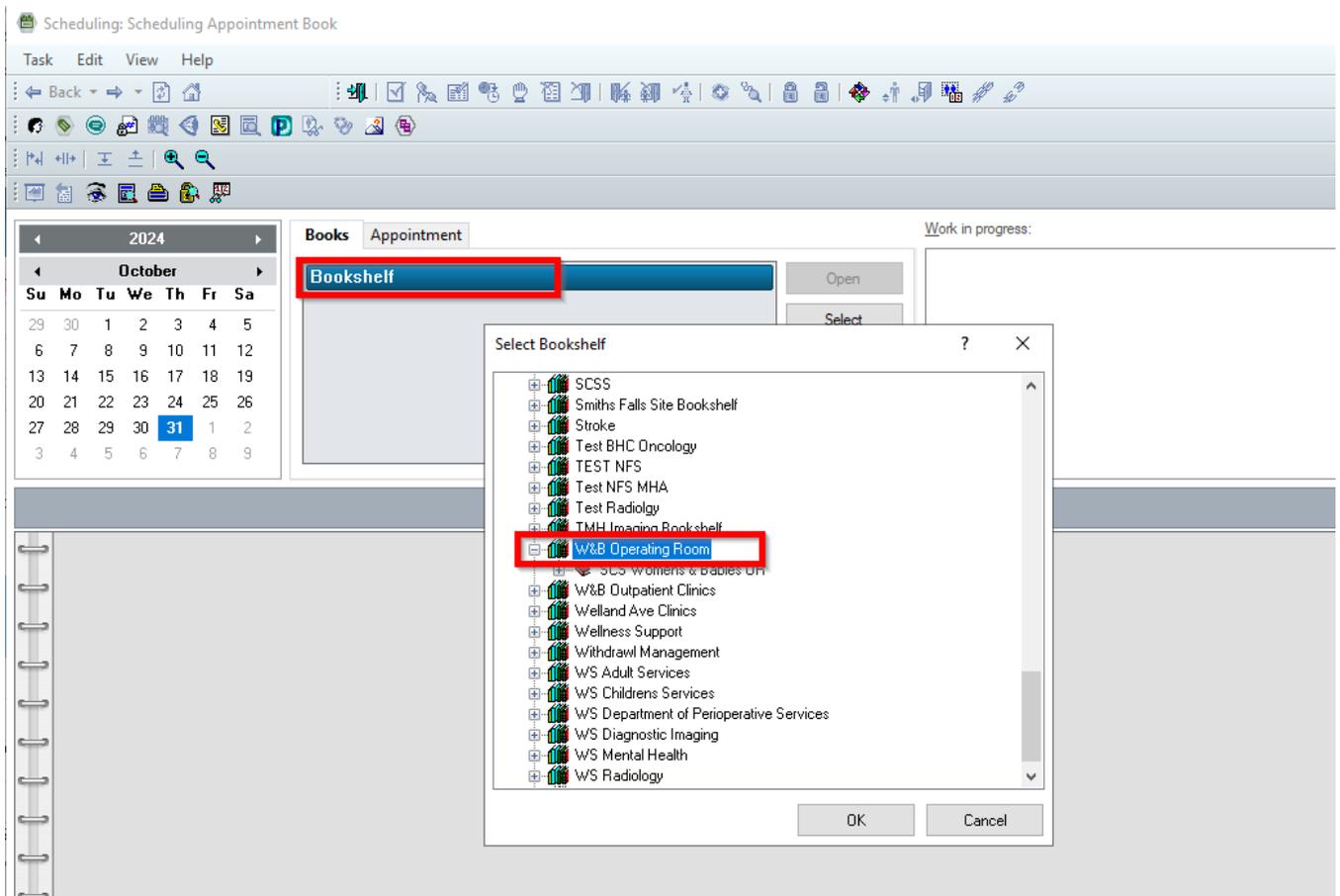
Yes No

### Modify Bookings

Occasionally cases will need modification:

- When a new surgeon takes over call
- When a procedure name may need to be added or changed
- Patient ate for booked CS and OR time is changed to later in the day

1. Go into SchapptBook
2. Click on Bookshelf and choose your site + “SCS WB Operating room”



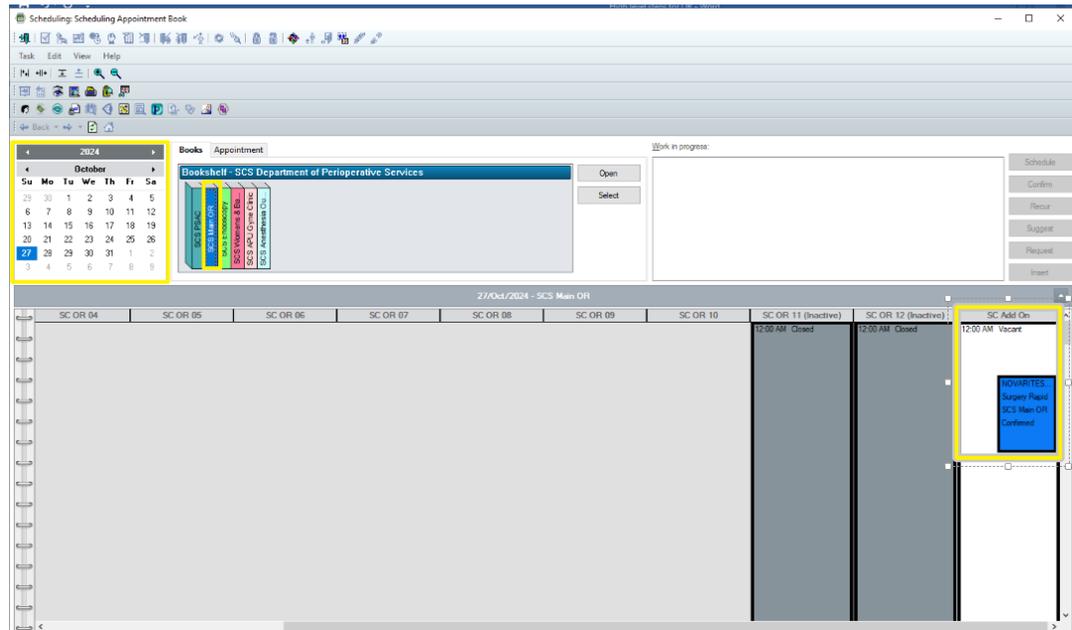
The screenshot shows the 'Scheduling: Scheduling Appointment Book' window. The 'Books' tab is active, and the 'Bookshelf' button is highlighted with a red box. A 'Select Bookshelf' dialog box is open, displaying a list of bookshelves. The 'W&B Operating Room' option is highlighted with a red box in the list. The list includes various departments such as SCSS, Smiths Falls Site Bookshelf, Stroke, Test BHC Oncology, TEST NFS, Test NFS MHA, Test Radiology, TMH Imaging Bookshelf, W&B Operating Room, SCS Womens & Babies Unit, W&B Outpatient Clinics, Welland Ave Clinics, Wellness Support, Withdrawal Management, WS Adult Services, WS Childrens Services, WS Department of Perioperative Services, WS Diagnostic Imaging, WS Mental Health, and WS Radiology.

- Choose W&B Operating Room

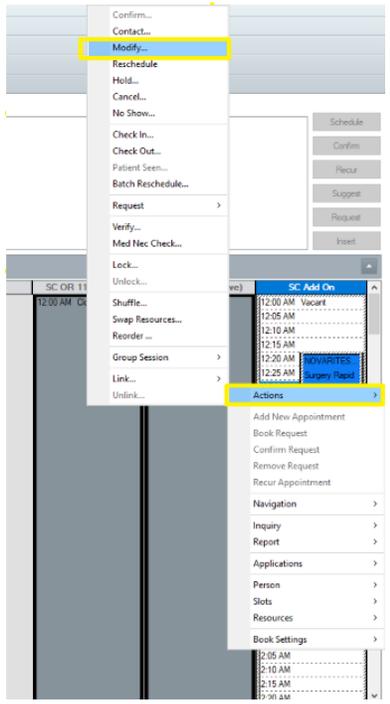


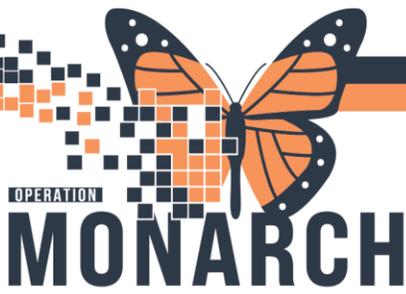
# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)



- Right click on booking> Actions> Modify





# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

- In the "orders" tab update your new surgeon's name

Modify

Name: NOVARITEST, MAINORONE MRN: 11053033 DOB: 29/Apr/1989  
Age: 35 Years Sex: Female

NOVARITEST, MAINORONE

Cholecystectomy Laparoscopic  
Hernia Repair Inguinal Laparoscopy

Optional Search Existing Orders Privileges AOS Required

\*Primary Surgeon: Sawala, Donald Alan

Surgical Assist:

Surgical Area:

Referral Date:

\*Requested Start: 27/Oct/2024 0020

Priority: Emergency B

\*Patient Type: Admit Day Of

Preop Diagnosis:

OK Cancel

- You can also add, remove and modify procedures in this window after an initial booking

Modify

Name: ZZBORNTTEST, MOMTWINS MRN: 11054557 DOB: 01/Oct/1995  
Age: 29 Years Sex: Female

ZZBORNTTEST, MOMTWINS

CAESAREAN SECTION

Optional Search Existing Orders Privileges AOS Required Nom

Caesarean Section  
Double Setup  
Ovarian Cystectomy  
Retained Placenta  
Tubal Ligation  
Vaginal Laceration (3rd Degree) Repair  
Vaginal Laceration (4th Degree) Repair  
Vaginal Laceration Repair

\*Primary Surgeon: NHS Test03, Physician - Women's Health

Surgical Assist:

Surgical Area:

Referral Date:

\*Requested Start: 31/Oct/2024 1600

Priority: Elective

\*Patient Type:

OK Cancel

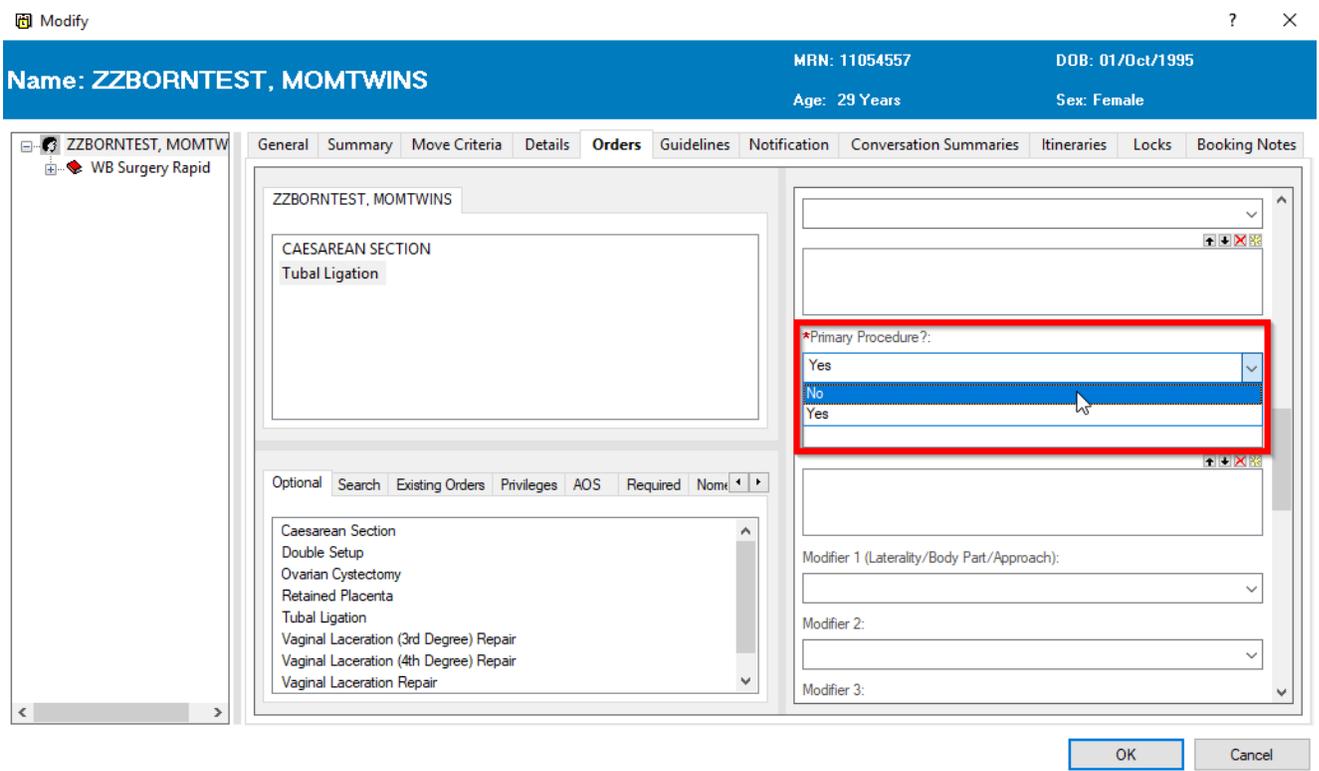
V2 March 2025

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### Adding multiple procedures:

- Booking more than one procedure is possible during bookings
- It takes place in the second screen in Schappt Book
- After choosing the primary procedure, continuing choosing more by double clicking to add as many as required
- **Note:** ensure only the primary procedure is noted and all others are marked as “no”
- Once procedures added review fields in the right box and select **OK**



Modify ? X

**Name: ZZBORNTTEST, MOMTWINS** MRN: 11054557    DOB: 01/Oct/1995

Age: 29 Years    Sex: Female

ZZBORNTTEST, MOMTWINS  
WB Surgery Rapid

General Summary Move Criteria Details **Orders** Guidelines Notification Conversation Summaries Itineraries Locks Booking Notes

ZZBORNTTEST, MOMTWINS

CAESAREAN SECTION  
Tubal Ligation

Optional Search Existing Orders Privileges AOS Required Noml

Caesarean Section  
Double Setup  
Ovarian Cystectomy  
Retained Placenta  
Tubal Ligation  
Vaginal Laceration (3rd Degree) Repair  
Vaginal Laceration (4th Degree) Repair  
Vaginal Laceration Repair

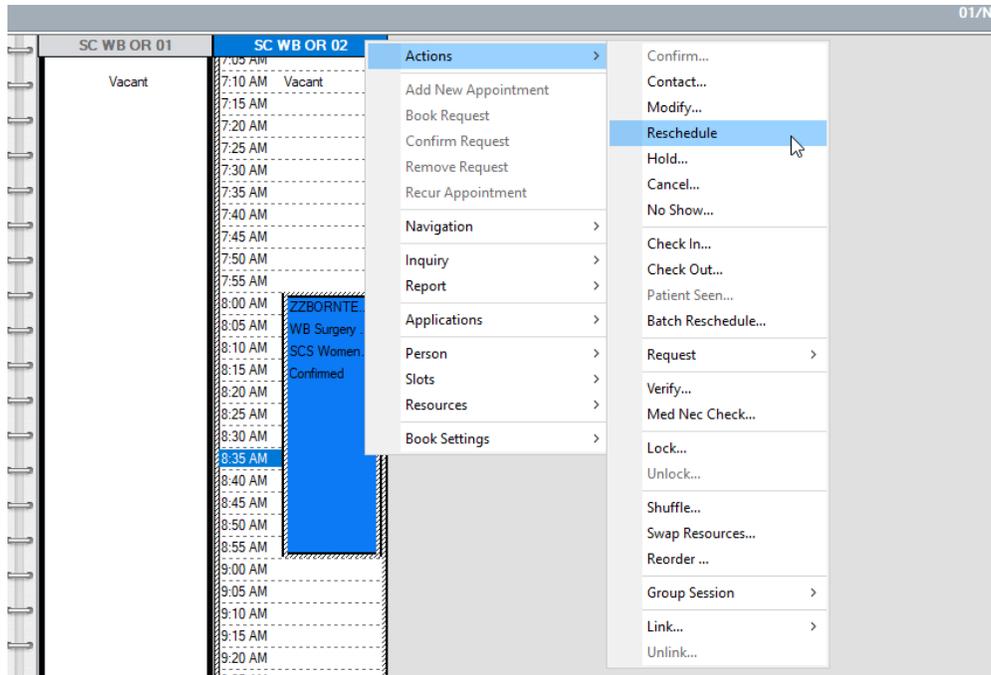
\*Primary Procedure?:  
Yes  
**No**  
Yes

Modifier 1 (Laterality/Body Part/Approach):  
Modifier 2:  
Modifier 3:

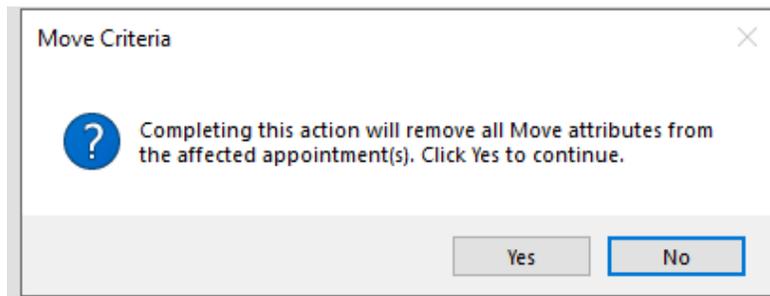
OK Cancel

### Modifying Date + Time of procedure

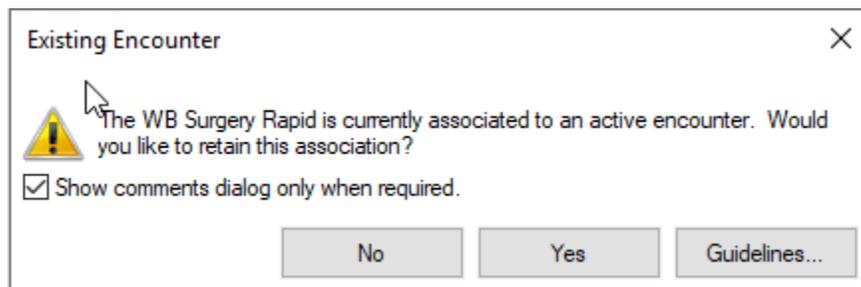
- To reschedule procedure for later in the day right click the **Appointment**, navigate to **Actions** and select **Reschedule**



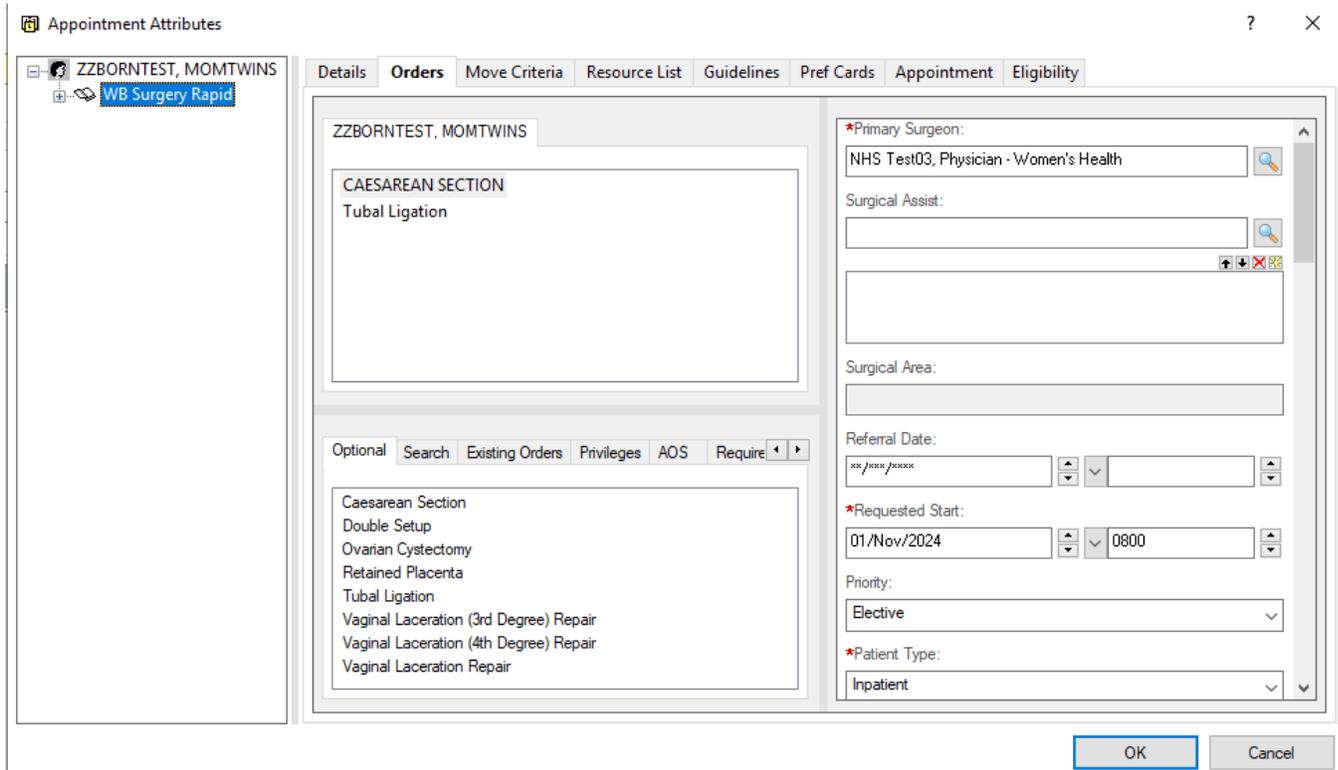
- Once procedure is rescheduled a pop up for confirm will appear and select **Yes**



- Another confirmation window will open regarding encounters select **Yes**



- Please verify any changes to Orders and Procedure and select **OK**



Appointment Attributes

ZZBORNTST, MOMTWINS

WB Surgery Rapid

Details Orders Move Criteria Resource List Guidelines Pref Cards Appointment Eligibility

ZZBORNTST, MOMTWINS

CAESAREAN SECTION  
Tubal Ligation

Optional Search Existing Orders Privileges AOS Require

Caesarean Section  
Double Setup  
Ovarian Cystectomy  
Retained Placenta  
Tubal Ligation  
Vaginal Laceration (3rd Degree) Repair  
Vaginal Laceration (4th Degree) Repair  
Vaginal Laceration Repair

\*Primary Surgeon:  
NHS Test03, Physician - Women's Health

Surgical Assist:

Surgical Area:

Referral Date:  
no time passed

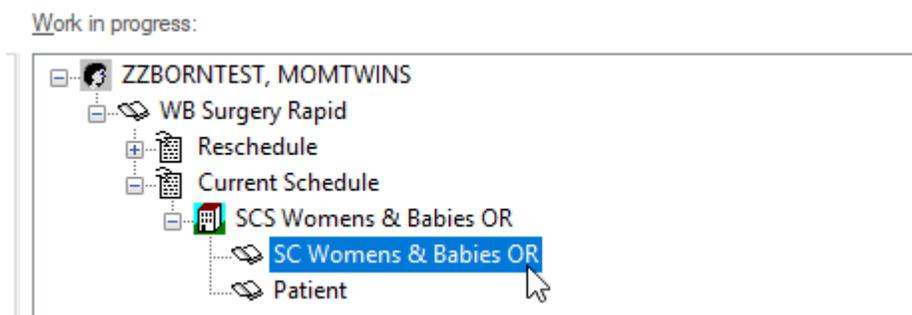
\*Requested Start:  
01/Nov/2024 0800

Priority:  
Elective

\*Patient Type:  
Inpatient

OK Cancel

- The appointment will then move to the **Work in progress** box where you will click on the **SCS Women's & Babies OR** and drag into the new time on the scheduling grid



Work in progress:

ZZBORNTST, MOMTWINS

WB Surgery Rapid

Reschedule

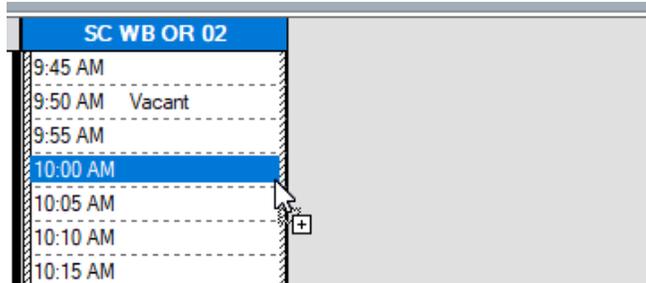
Current Schedule

SCS Womens & Babies OR

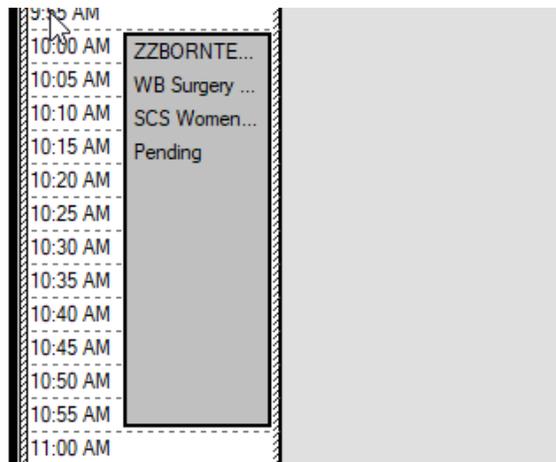
SC Womens & Babies OR

Patient

- Click and Drag Appointment



- Once appointment is dropped into the new time select Confirm



- Once **Confirm** is selected a Confirmation window will open, review all data and select **OK**



# WB OR/PARR TIP SHEET

## HOSPITAL INFORMATION SYSTEM (HIS)

- After appointment is rescheduled a **Reschedule** window will open to prompt a reason for rescheduling to be added and select **OK** once inputted confirmation completed

### PARR

- Once OR procedure completed, and patient is transferred to WB PARR
- Disassociate from FetaLink if not done already
- Transfer patient in Cerner once moved to WB PARR (select the rocketship icon in grey tool bar and refer to Bed Transfer Tip Sheet)

V2 March 2025

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**Tracking Board**

SCS Outpatient | SCS OB Triage | **SCS L&D** | SCS Postpartum | SCS Newborn | SCS NICU | SCS OB All Beds | SCS PreAdmit Babies | SCS OB

Patient: ZZWOMENBABIES, WBC | Filter: SCS L&D

Bed	Status	A	G	P	EGA	GBS
SC4D			1*		✓	P
SC4DL02, <i>ROADSHOWTWODRY, NICUTEST</i>		2*	1*		✓	N
SC4DL03, <i>ZZWOMENBABIES, WBDemo</i>	PP - Vag	1*			✓	P

- Associate patient to cardio resp monitor in PARR (refer to BMDI Tip sheet)
  - I.E scan patient and scan monitor
- Navigate to iView and select OB PARR section and document accordingly for your recovery phase

**Menu**

- Women's Health View
- Nurse View
- MAR
- Interactive View and I&O**
- Penoperative Doc
- Activities and Interventions
- Orders + Add
- Medication List + Add
- Documentation + Add
- Outside Records
- Results Review
- Appointments
- Allergies + Add
- Diagnoses and Problems
- Form Browser
- Histories
- MAR Summary
- Lines/Tubes/Drains Summary
- Clinical Media + Add

**Interactive View and I&O**

- OB Triage
- Antepartum
- Labour and Delivery
- Newborn Delivery Data
- OB PARR**
- Transfer of Care
  - Provider Notification
  - Vital Signs
  - Aldrete I Assessment
  - Postpartum
  - Warming/Cooling
  - Obstetrical Bleeding
  - Pain Assessment
  - Pain Evaluation
  - Pain Sedation Assessment
  - OB Lines - Devices
  - Urinary Catheter
  - Spinal Assessment
  - Anesthesia, OB
  - Surgical Epidural Infusion
  - Palliative PCA
  - Comfort Measures OB
  - Psychosocial
  - Activities of Daily Living
  - Postpartum Patient Education
  - Blood Product Transfusion
  - Critical Event

**OB PARR**

Find Item  Critical  High  Low  Abnormal  Unauth  Flag

Result	Comments	Flag	Date	Performed By
			01/Nov/2024	
			11:40	
<b>Transfer of Care</b>				
Report Given				
Handover Comments				
Unit Departure				
Transport Destination				
Mode of Arrival				
Accompanied By				
Date/Time Patient Returned to Unit				
Leave of Absence Communication				
Allergy Bracelet				