SurgiNet Anesthesia User Guide

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Getting Started

Logging In

Follow this procedure to log into the system:

1. At the Main Menu window, double-click the Anesthesia button.
2. At the Cerner log-in window, enter your user name in the User Name field.
3. Press TAB to move to the next field and enter your password into the Password field.
4. Click **OK** or press ENTER.

Logging Out

When you have completed your activities, remember to log out of the application you are working on for security purposes. Logging out can be done in one of the following ways:

1. If you are exiting the application temporarily, but planning on returning to that computer shortly, from the task menu, select **Suspend Case**. This returns the screen to the log on window and places the cursor in the password field.

   - OR -

2. From the task menu, select **Exit**.

AppBar Customization

1. Click the **AppBar** button in upper left corner.
2. Click **Customize**.
3. Click the **Options** tab. Verify that the Always on Top, Allow Floating and Large Buttons options are selected.
4. Click the **Buttons** tab, then click the Product column header and scroll until SurgiNet appears.
5. Click the box to left of Anesthesia Record Viewer, then click **OK**..

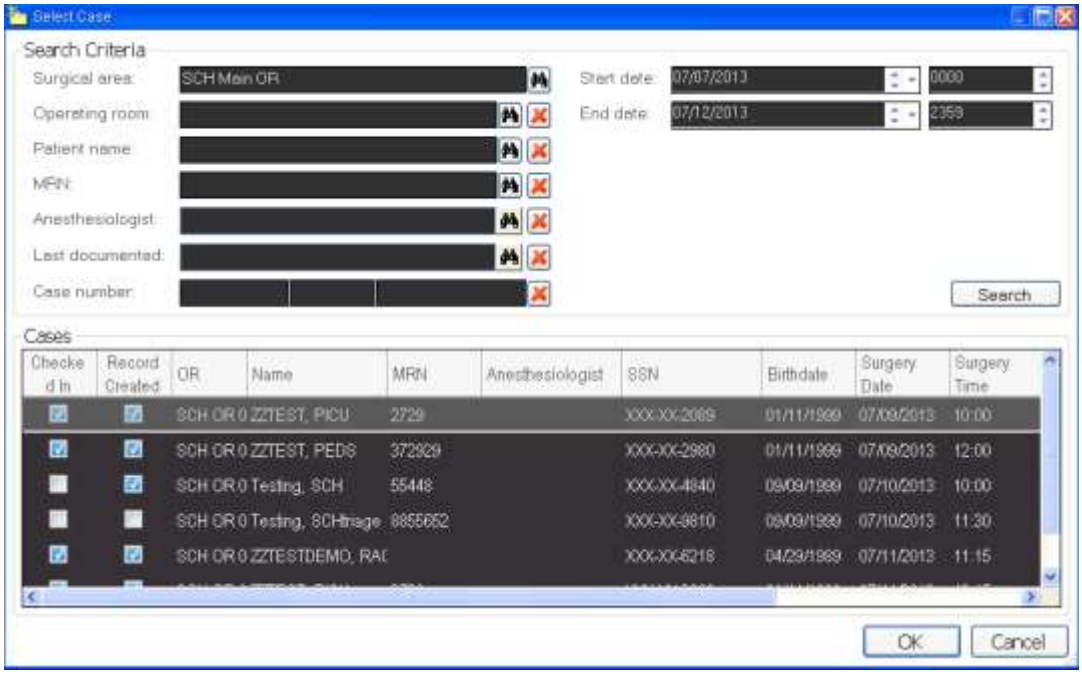
> **Note:**
> When you open an application, its icon and title appear at the bottom of the computer screen. If more than one application is open at a time, click those icons to switch between applications. Continuing to click the AppBar button results in errors and warning messages, with possible system failure.

AppBar Example:

Select a Surgical Case

Upon opening the Anesthesia application, the window that is displayed is called the Case Selection window. The operating room area is entered by default, depending on which room the application is being opened in, and a search is made for the day's cases scheduled for that room.

1. Select the case and click **OK** to open the case.



   a.
   b. If the case cannot be found immediately using the default room, click the **red X** next to it and click **Search** again to find all of the day's cases.
   c. If it still is not found, enter different search criteria such as patient name, case number, or date and try to search again.
2. If multiple document types exist, a Choose Document Type window is displayed. Select the appropriate document type and click **OK**.
3. The system automatically associates appropriate devices based on the location. If there are no default devices, a Choose Devices window opens. Select the appropriate devices depending on the location of the case and click **OK**. After this action, the record opens to the main screen of the application.

Create a Blank Anesthesia Record

If the case has not been schedule and created yet, a blank anesthesia record can still be created. To do this:
Click **Blank Record**.

1. In the Create Blank Record window, click the **binoculars** button on the Created Location field.
2. Drill down into the hierarchy to find the appropriate OR room that the case is occurring in and select that location. Click **OK**.

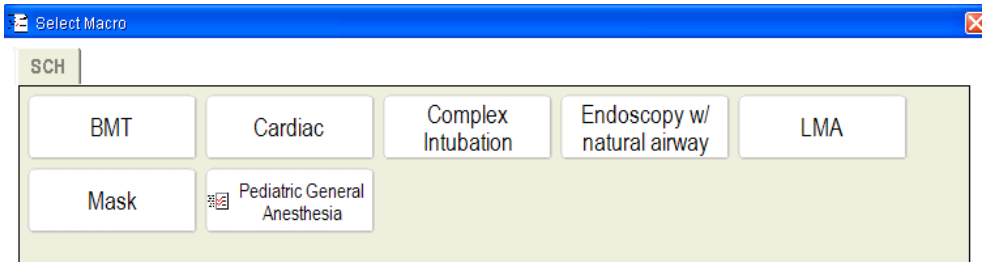
> **Note**
> If the operation room you choose is not associated to the selected surgical area, a warning message is displayed. Click **OK** and choose another location.

3. Select the appropriate Document Type if necessary.
4. Change the Record Description if necessary and click **OK**.

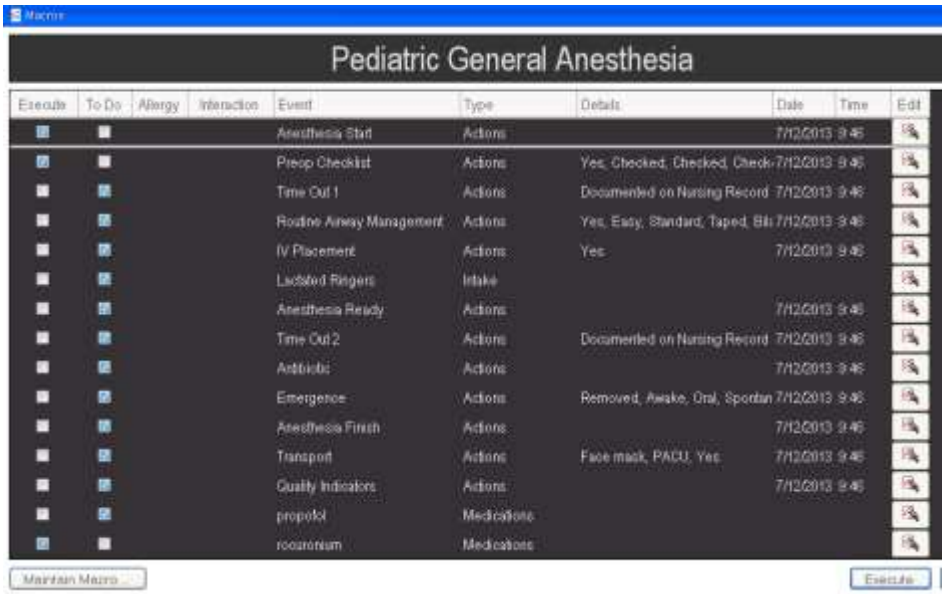
Starting a Macro

After opening the case, a macro can be started to assist in documentation efforts. A macro enters all of the medications, fluids, monitored values, actions, and inventory related to the case with the click of a button. It speeds up the time it takes to get items onto a record, and it is a pretty easy step in the application.

1. Click the **Macros** toolbar button.
2. In the Select Macro dialog box, click the button with the name of the macro.



3. The components of the macro are displayed and can be verified or excluded, depending on the procedure. The user may also edit components from this window prior to executing the macro.



4. Select the appropriate check box to execute the component, place it on the To Do list, or ignore it to not execute that item.
5. If any of the items included in the macro need to be modified prior to executing the macro (for example, adding a dosage to a medication because it is already known at the time of macro execution), click **Edit** to the right of the item. Defaults can be set up to give values to these details, or they can be modified here for addition to the record.
6. Once the contents of the macro are verified, click **Execute** and those contents are recorded. Notice that all of the medications, gases, fluids (Intakes and/or Outputs), monitors, and actions can be seen on the record. Any inventory added via the macro can be seen by opening the inventory dialog.
7. Monitor values begin to show up on the graph as they are collected from the devices.

> **Note**
> The watermark boxes that may appear indicate that nothing was received from the device at that time.

Medications

Adding Medications

There are several different ways to add medications and their dosages to a record. The steps involved vary depending on whether or not the medication is already on the record itself.

Meds already on record

1. Click the name of the medication to insert a dosage at the current time. This opens the Add Medication Administration dialog box. The word New displayed to the left of the medication name indicates that this is a new administration being added to the record.

2. Enter a dose amount and click **OK**. The medication appears on the record.

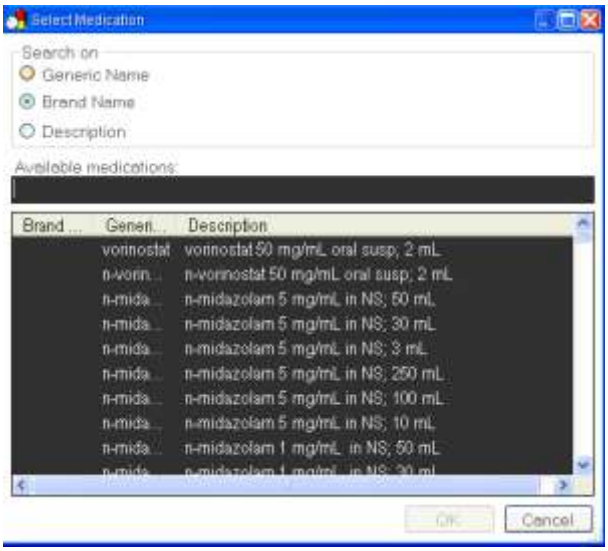
> **Note**
> The other fields on this dialog are optional, but if they are not documented now they must be documented later. Route and site have prepopulated entries but can be changed if necessary.

   a. The height and weight for a patient can also be changed by clicking them in this dialog.
   b. Units can be changed by clicking the units that follow things like height, weight, dose amount, and volume.
   c. Changing the units in the medication concentration also makes the corresponding change in the dose amount, volume, and weight base dose fields.

Meds not Already in Record

1. Click **Medications** from the toolbar at the top of the page. This opens the Select Medication dialog box. The different tabs running across the dialog above the meds are the categories that medications have been configured for your facility.

2. Click the appropriate category, look for the needed medication, and click the button containing the medication name. This action opens the Add Medication Administration dialog box.
3. If you cannot find the medication you are looking for in any of the categories, click **Other** in the lower left hand corner to search the entire formulary.



Adding Medications - Bolus versus Infusion

There are different ways to look at the administrations of medications, depending on whether the med is given as a bolus or as an infusion.

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Bolus	Infusion
1. Allows for volume to be documented as administered in one single minute. 2. If concentration is correct, as well as weight, entering Dose amount or volume causes the rest of the fields to be calculated. 3. Route and Site are not required fields, default to IV and Left Hand, respectively.	1. Allows for volume to be shown as administered over time. 2. If concentration is correct, as well as weight, entering Dosing infusion rate or Pump infusion rate causes all other fields' values to calculate over time. 3. Route and Site are not required fields and default to IV and (None), respectively. 4. The **blue triangle** symbol (delta) in this dialog allows rate changes to be made. Click the **blue delta** and then click in the time frame that the rate needs to be changed in. Enter the correct rate in the appropriate field and a blue separator appears in the bar, indicating a change was made. 5. The **red circle** allows the stop time of the infusion to be entered. Just click the **red circle** and then click in the proper time to indicate the conclusion. 6. The **red X** deletes any rate change indicators that might be present in the bar.

Modifying Medications

Via the Toolbar

1. From the toolbar, click **Medication**. This opens the medication dialog. Click on the **Current** tab. This tab contains all of the medications that have currently been recorded on the anesthesia record.

2. To modify any of the medication administrations, select the Modify Admin option.

3. Notice how the dialog changes to show just the **Current** tab and the administered medications. **This is a very important step in modifying medications. If the Modify Admin option is not selected, there is a high probability that a medication is added again.**

4. Click the medication that needs to be modified and the administration dialog box opens.

5. Change the dose amount to the correct value and click **OK**.

Via the record

1. Find the medication on the record.

2. Click the dosage that needs modification.

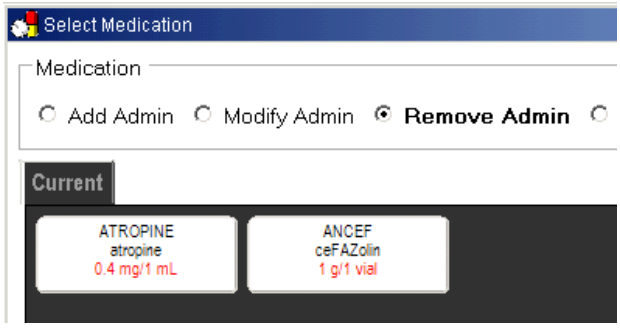
3. This opens the Modify Medication Administration dialog where the changes can be made to the Dose amount, Volume, or times.

Deleting Medications

Removing Administrations via the Toolbar

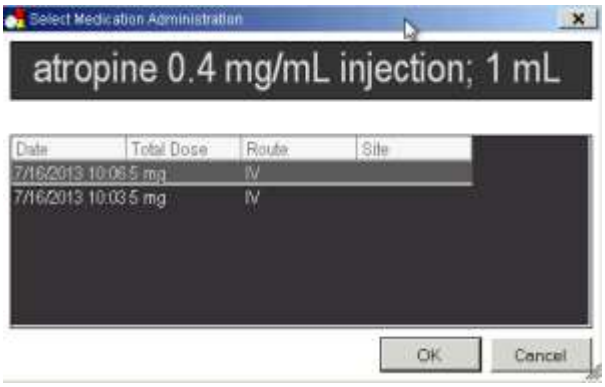
1. From the toolbar, click **Medication**. This opens the medication dialog. The **Current** tab contains all of the medications that have currently been recorded on the anesthesia record.

2. To delete any of the medication administrations, select the Remove Admin option.



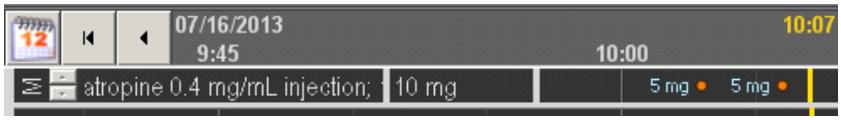
3. Notice how the dialog changes to show just the **Current** tab and the administered medications. **This is a very important step in removing medication administrations. If the Remove Admin option is not selected, there is a high probability that a medication is added again.**

4. Click the medication that needs an administration removed. In the window that opens, select the appropriate administration to remove and select **OK**.



Removing Administrations - Via the Recorded Meds

1. If the medication has already been documented on the record, click the dosage that needs to be removed.

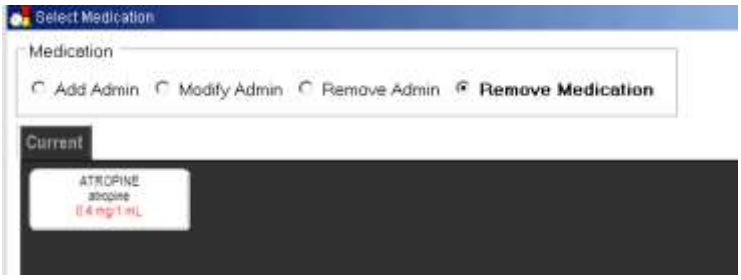


2. Click **Remove Admin** in the lower left hand corner.

3. This removes the corresponding dosage from the record. If it is the only dosage recorded for that medication, it would completely remove the medication from the record.

Removing Medications

1. When clicking **Medications** from the toolbar, there is yet another option of Remove Medication shown. Selecting this option and then clicking a medication removes all administrations of a medication from the record, whether there were multiple dosages given or not.



Intakes and Outputs

Adding Intakes

There are several different ways to add intakes, outputs, and their volumes to a record. The steps involved vary a little bit depending on whether or not the fluid is already on the record itself.

Intakes already on record

1. If a fluid is already on the record – for example, via a macro – click the name of the fluid to start another bag at the current time interval. This opens the Fluid Intake dialog box.

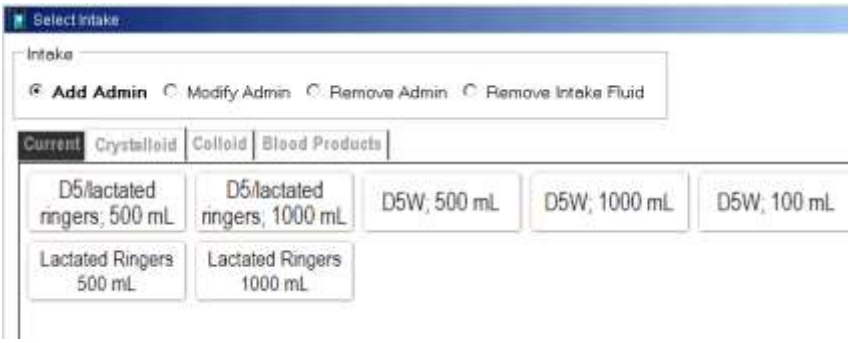
2. Click the **Start Bag** button to get the bag started at the time represented in the time bar.

3. Enter the Volume rate and Weight based rate as appropriate. These fields are not required but help in calculating volume given over time.

4. Route and Site are not required and should default to IV and Left Hand, respectively.

Intakes not already on record

1. Click the **Intake** toolbar button from the top of the screen. This opens the Fluid Selection dialog box.



2. Find the desired fluid by looking through the different tabs above the fluids and then click the button containing that fluid. This opens the Fluid Intake dialog box.

3. Click the **Start Bag** button. Route, site, and the different intake routes do not have to be entered in order to get the bag started. Once a fluid has been running, it is also very easy to start another bag of the same fluid.

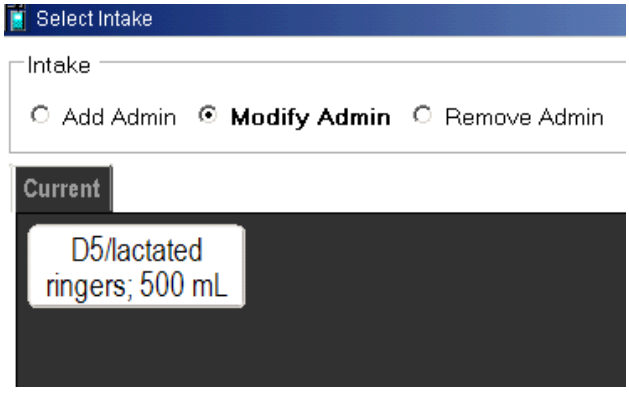
4. To start a new bag of the same fluid, click towards the end of a fluid's bar to open the same Fluid Intake dialog box.

5. Click the **Start Next Bag** button at the bottom of the window to start another bag.

Modifying Intakes via the Toolbar

1. Click the **Intake** toolbar button.

2. Select the Modify Admin option.



3. The category tabs disappear, leaving only the **Current** tab. Click the name of the fluid that needs modification. If there are multiple administrations, select the appropriate one and click **OK**. The Modify Intake window opens:

4. Change the values in any of the fields, such as Volume rate or Weight based rate, if necessary.

5. Change the times by dragging and dropping the green section of the bar to the correct time interval.

6. To change the rate at which the fluid is being administered, click the **blue delta**. Click again within the yellow bar, and then enter the correct fluid rates when the individual sections of the bar are selected.

Via Fluids Already on the Record

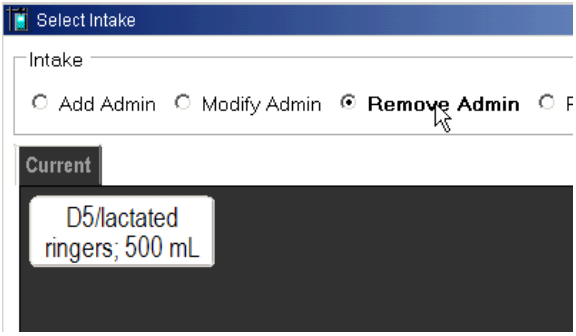
1. If a fluid has already been documented, click the **green starting mark** or anywhere along the red bar to bring up the modify dialog box.

2. The Modify Fluid Intake dialog box opens and changes can be made to any of the fields listed (for example, bag volume, volume rate, weight based rate, and so on).

Deleting Intakes

Removing Intakes - Via the Toolbar

1. Click the **Intake** toolbar button.
2. Select the Remove Admin option.



3. Click the medication that needs to have an administration removed, and the corresponding value is removed from the graph.

4. If there are multiple administrations of the same fluid, select the one that needs to be removed, click **OK**, and it is removed from the record.

Removing Intakes via Recorded Fluids

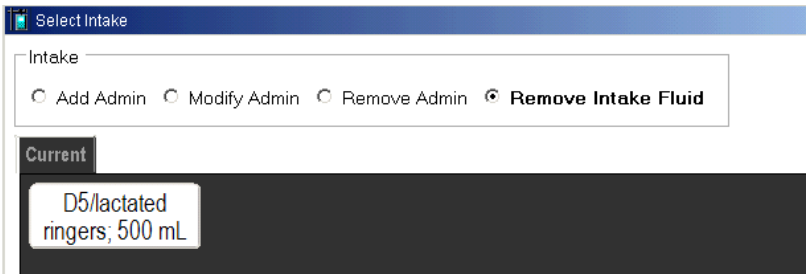
1. If a fluid has already been documented, click anywhere along the red bar to bring up the dialog box.

2. Click the **Remove Bag** button in the lower left hand corner to remove the administration.

3. The administration is removed from the record, and if there was only one bag hung for that particular fluid, the entire fluid is removed from the record.

Removing Intakes

1. Click the **Intake** toolbar button.
2. Select the Remove Intake Fluid option.



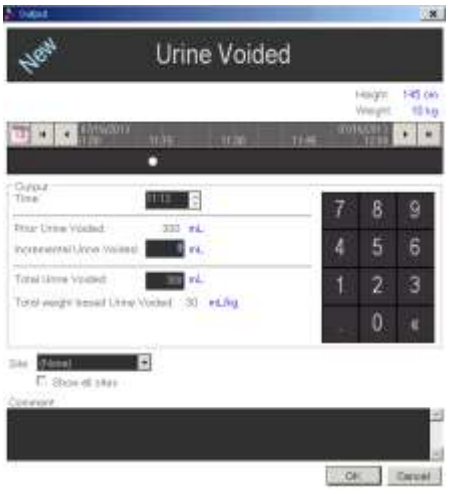
3. Click the fluid that needs to be removed from the **Current** tab and that fluid is removed from the record.

Adding Outputs

The addition of outputs occurs very similarly to that of intakes, there are just much fewer fields available (for example, rates, duration, and so on).

Outputs Already on Record

1. If an output is already on the record, perhaps via a macro, click the name of the output to enter another value at the current time interval. This opens the Fluid Output dialog. The new output volume needs to be entered and the time verified, and that output is seen on the graph.



2. Site is not required and should default to (None).

Outputs Not Already on Record

1. Click the **Output** toolbar button. This opens the Select Output dialog box.

2. Click the output that needs to be documented and the Fluid Output dialog opens. Enter the output amount.

3. Click **OK** and that volume is entered onto the record at the time indicated.

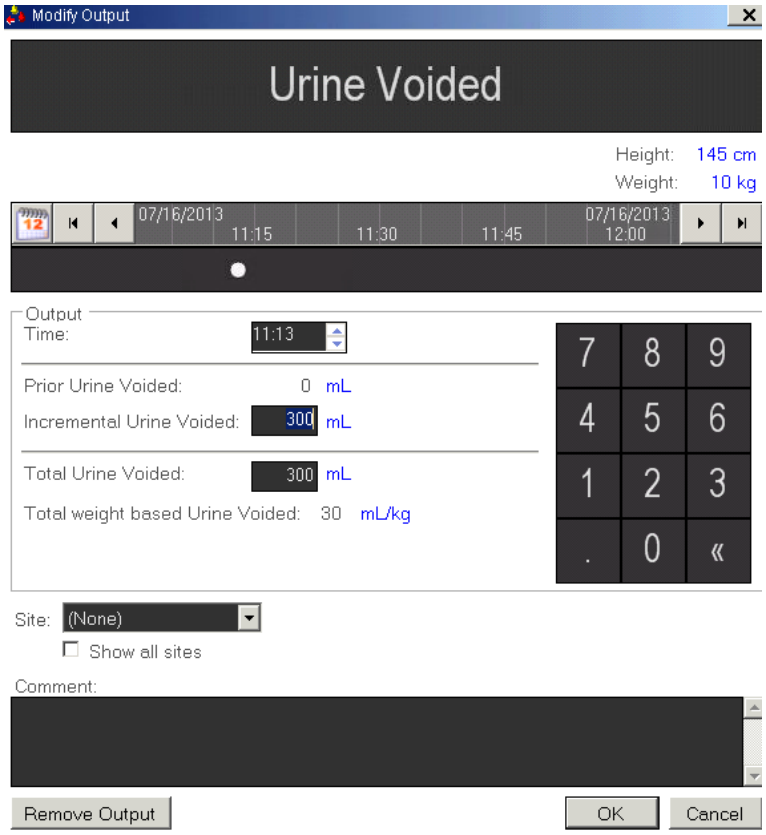
Modifying Outputs via the Toolbar

1. Click the **Output** toolbar button.

2. Select the Modify Output option.

3. The category tabs disappear, leaving only the **Current** tab. Click the name of the output that needs modification to bring up the next window.

4. Change the volume value in the output field, click **OK**, and that change is represented on the record.



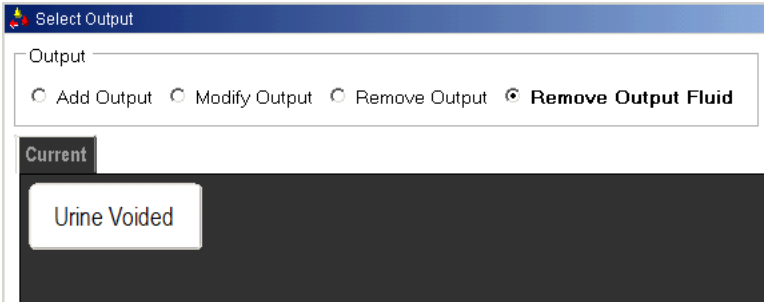
Modifying via Outputs Already on the Record

1. If an output has already been documented, click the **red dot** marking its documentation on the record. The Modify Fluid Output dialog box opens and changes can be made to the volume of the output before clicking **OK**.

Deleting Outputs

Removing Outputs

1. Click the **Output** toolbar button.
2. Select the Remove Output Fluid option.

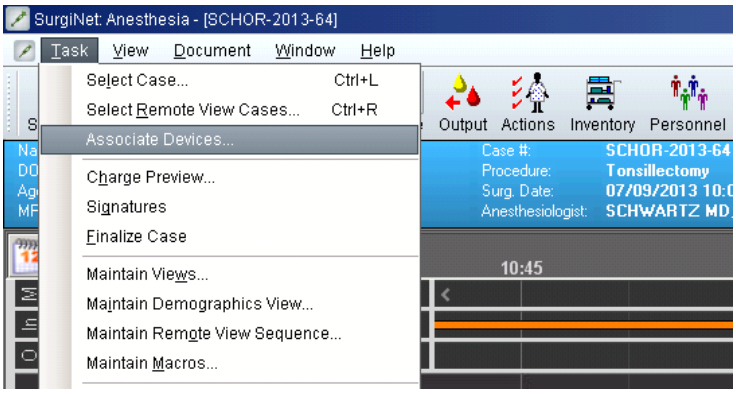


3. Click the output that needs to be removed from the **Current** tab and that output is removed from the record.

Associate Devices

1. You can associate additional devices during a case. To select a device for the case in progress, complete the following steps:

2. From the Task menu, select **Associate Devices**.



3. From the Select Device dialog box, select from the available devices. Click **OK**.

Monitored Values

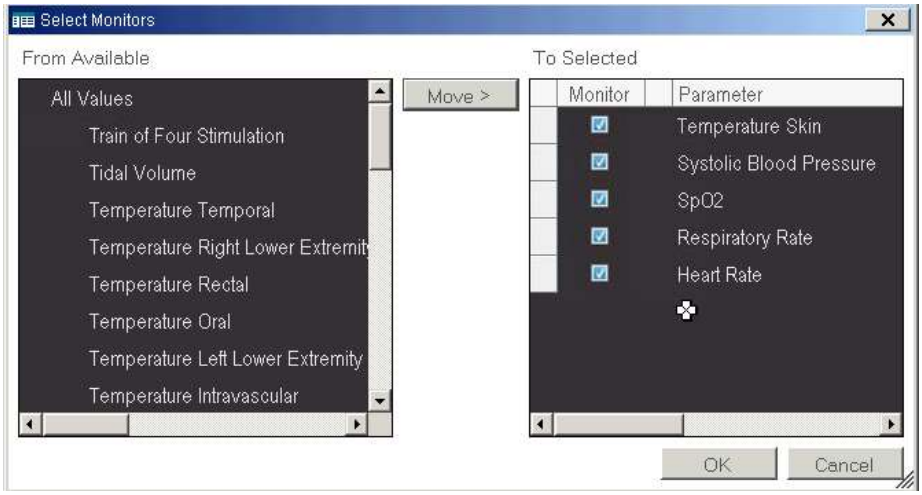
The bedside medical devices play a large role in the documentation of an anesthetic record, so the values that these devices are monitoring are very important to the application. Most of the monitored values that need to be recorded during the case are probably started via a macro at the beginning of the case. However, there is always the possibility that a monitor and its values might need to be added to the record.

Adding Monitors

1. From the menu bar, select **Document > Monitors**. This opens the Select Monitors dialog box.

2. The list on the left shows the available device parameters to select from. The list on the right side shows those parameters that are currently being monitored.

3. Select values in the Available Parameters list and then click the **Move** button to move them to the Selected Parameters list. This can also be done in the reverse direction if you want to take monitored values off of the record.



4. Select and deselect the **blue checks marks** as needed to turn monitors on and off. If there are values that do not need to be displayed during a portion of the case, select the box containing the blue check mark to remove the check mark and turn the monitor off. For example, this might be needed during the bypass portion of a cardiac procedure.

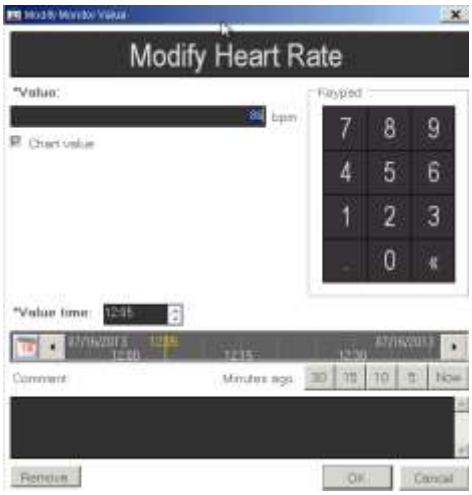
5. Symbols are next to those parameters that have been designated as graphical values. If a parameter does not have a symbol next to it, it appears in the Monitors section of the record.

Modifying Monitored Values

1. There is always a possibility that the values that populate the electronic record are erroneous or incorrect due to a number of different reasons. Because this interference or artifact is possible, there are ways to adjust the values on the record so that they more accurately represent the patient's vitals.

2. In the Monitors section, click any of the values displayed. The Modify Monitor Value dialog box opens.

3. Enter the correct value to replace the current value.



4. Click **OK** and that value takes its place on the record.

5. If one of the graphical values (for example, blood pressure, heart rate, or similar) needs to be adjusted, from the menu bar, select **Document > Value**.

6. The Maintain Monitor Values dialog is displayed. This allows users to modify all of the monitored values that have been recorded for the case.

7. Click the value that needs to be modified and make the change by entering the correct value. The value interval can be changed by clicking the **1**, **5**, **10**, or **25** buttons above the main part of the sheet. This can help narrow down or expand the values so that the ones needing changes can be located.

8. Click **OK** and the correct value is displayed in the record. Other functions can be carried out using this dialog, if necessary:

    a. Details - Click any of the values and then click the **Details** button on the left and you can see the main dialog for that specific value where the value and time can be changed or a comment can be added for that value.
    b. Pull Values - Click the gray box to the left of any of the monitor names and then click **Pull Values** to add all of the values that have been collected so far by the device. An example of when this might be used: A temperature probe was attached early in the case but the Temperature monitor was not selected for the record. While it might not be displayed on the record, the application is still collecting all values that are tied to this parameter. So when the user realizes this, he or she needs to add Temperature, pulling the values displays all of them on the graph.
    c. Chart/Unchart - This allows the user to select multiple cells on this screen and then select whether or not they should be included in the permanent record.
    d. Add/Remove Monitors - These buttons allow the user to add monitors to the record without having to exit this screen and return to the menu and dialogs mentioned above in the Monitors section.

Actions

1. Actions make up a majority of the anesthesia record outside of medications and fluids. Actions might include things like Times, Positions, Airway Management, Procedures, Notes, and Billing Modifiers.

2. There are actions that have details configured behind them (for example, Add IV Regional Block), and there are also actions that do not have any details (for example, Add Anesthesia Stop Time).

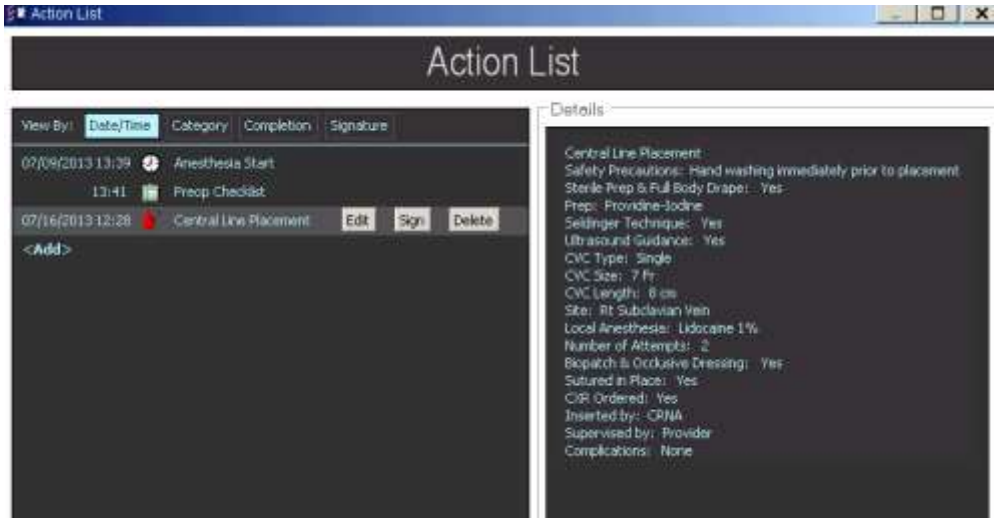
Using the Action List

1. Click the **Actions** toolbar button. A list of Actions appears. There are numerous ways to view the actions that have been documented.

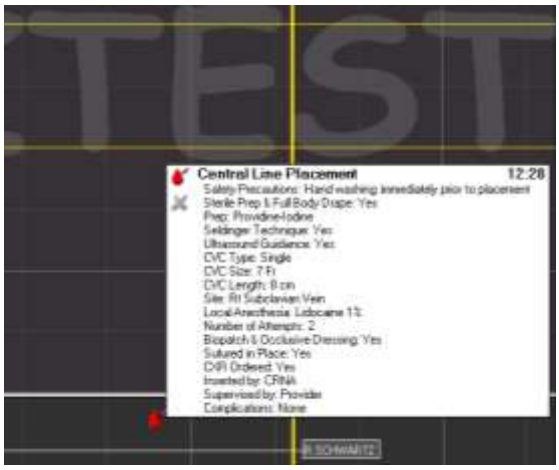
2. When looking at the actions with the view set to Date/Time, it displays all of the actions that have been documented on the record in the order of the time associated to the documentation.

3. Clicking the **Edit** button allows that action to be edited as necessary. Clicking **Delete** causes that action to be removed from the record and this list of actions.

4. If an action has details documented with it, those details are displayed in the right hand pane of the dialog and make viewing what has been documented a lot easier.



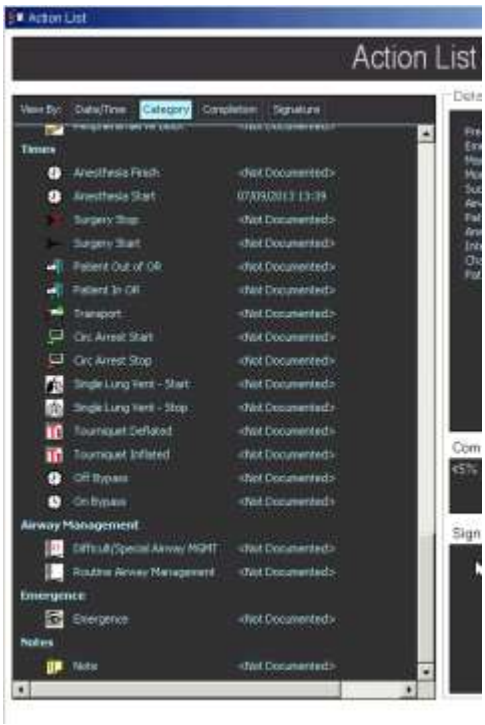
5. The actions displayed in the Action Bar at the bottom of the screen and are represented as symbols. If the action does not have a symbol associated to it, the red circle with a white X is displayed.



6. To add an action to the record while the view is set to display by Date/Time, click **<Add>** at the bottom of the list to select the row, then click the **Document** button. The Select Action dialog box opens.

7. The first tab shows what has currently been recorded. The other tabs can be clicked to find the desired action, and then that action box can be clicked to add it to the record.

8. The Action List can also be viewed by clicking the **Category** button. This shows all of the available action categories and the actions that have been documented beneath them. It also indicates if and when they have been documented with the date and time listed in the column on the right.



If an action needs to be added to the record (like one of the ones listed as Not Documented), simply select that action and then click the **Document** button that appears. Edit the action in the dialog box that appears and it is added to the record. If fields have been made mandatory on an action, then that action appears in the list with a red asterisk by it. When viewing the actions by Completion, those actions that have required fields not yet documented are separated from the rest of the completed actions. Click **Edit** and complete the required fields and that action falls into the Complete category of actions.

Inventory

Adding inventory to a record is very important for tracking purposes as well as for billing. Inventory can be added as part of a macro or it can be added independently. Inventory is a little different from meds, fluids, monitored values, and actions because none of it can be seen on the main screen of the application. The **Inventory** toolbar button must always be clicked to view what has been documented.

1. Click the **Inventory** toolbar button.
2. Click **Add Item** in the lower left hand corner.
3. Search for the necessary inventory item by clicking through the different inventory category tabs.
4. Click the inventory item to get it added to the record.
5. Adjust the Used, Wasted, and Returned counts by using the counters, if necessary. It defaults to show that one has been used.
6. Items can also be removed from this screen by selecting an item and clicking on the **Remove Item** button that is next to the **Add Item** button.

Personnel

Personnel can be added to the record to show how many providers have been involved in a particular case and the times they were involved. Personnel are displayed on the record in the Action Bar area, or they can also be viewed in a separate dialog box by clicking the **Personnel** toolbar button.

Adding Personnel

1. Click the **Personnel** toolbar button.
2. Click **Add** in the lower left hand corner. Find the desired provider in the Select Personnel dialog. Click the provider when found to add him or her to the list.
3. The dates and times can be adjusted in this dialog to get the times correct. Just click the time, make sure that the cursor is under the part that needs to be changed, and then click the **up/down arrows** to adjust.
4. To remove personnel, select the provider and click **Remove**.

Orders/Results Review

Orders and results on the patient's electronic medical record can display in the Anesthesia record. These orders and results are limited to a time range and to orders and results relevant to anesthesia based on client configuration. Results can also be added to the Anesthesia record if desired.

Viewing Existing Orders/Results

When the Anesthesia provider opens the patient's chart, they can review all the anesthesia related orders and results on the patient's chart within the time frame specified in the configuration by positioning their pointer over the Orders/Results icon on the demographics bar and then clicking **View Result**.

Notification of New Orders

When a new order is placed on the patient's record, a notification appears momentarily at the bottom of the screen and the icon in the demographics bar flashes. Clicking the pop-up notification or positioning your pointer over the icon on the demographics bar and then clicking the link opens the Orders & Results window to allow review of the new order.

Notification of New Results

When a new result is placed on the patient's record, a notification appears momentarily at the bottom of the screen and the icon in the demographics bar flashes. Clicking the pop-up notification or positioning your pointer over the icon on the demographics bar and then clicking the link opens the Orders & Results window to allow review of the new result.

Documenting a Result on the Anesthesia Record

To include a result from the Orders & Results window on the Anesthesia record, click the **green plus** symbol next to the result.
The result is now displayed in the actions window at the bottom of the record at the time the result was verified. To remove a result from the Anesthesia record, click the **Red X** symbol next to the result in the Orders & Results window.

Printing

Printing the record can be done at any time during the documentation of the case. In fact, the Print Preview option is a very useful tool in getting a look at everything that has been documented on a case so far.

Note: The system may not print all documented actions if printed actions exceed one page. If the printing data exceeds one page, the system shall print the message, **Refer to electronic record for complete data**, in the Actions

Printing

1. From the menu bar, select **Task > Print**.
2. The Print dialog opens and a printer must be designated. Select the appropriate printers.
3. Click **OK** and the document is printed using the designated printer. More than one printer can be selected, if appropriate.

Print Preview

The Print Preview feature allows users to see what a printout of the record looks like at any time during a case. Using Print Preview does not mean that the record is printed, so viewing it can be very beneficial.

1. From the menu bar, select **Task > Print Preview**. This opens the Print Preview window and there are numerous controls in the lower left hand corner. Zooming in and out, setting up the print variables, and moving between pages of the printout are all possibilities with this dialog.
2. Click the **View Thumbnails** button ( ) to bring up a thumbnail view of each page in the record.

Finalize a Record

Records need to be finalized at the end of a surgical procedure in order to get the data written to the patient's record. It also gives the anesthesia provider an opportunity to print the record and complete the details of any medications, fluids, or actions.

Finalizing the Case

1. From the menu bar, select **Task > Finalize Case**. This opens the Finalize dialog box that displays the deficiencies and signatures on the record. If there are any fluids that need stop times, actions that have required fields on them, or personnel signatures that are required, they are seen in the Deficiencies section.
2. Click the **Edit** button to complete the necessary action to remove the deficiency. Once the deficiency is accounted for, that item disappears from the finalize dialog.
3. Select the Ignore check box to ignore the deficiency and allow finalization to continue.
4. When all deficiencies are taken care of, users can sign the record. Click the **Sign** button. The Cerner splash screen opens.
5. Enter the user name and password for the provider signing the record and click **OK** to show the updated finalize dialog box.
6. Select the Print record check box if you want to open up the print dialog as you finalize, and then click the **Finalize** button to close the dialog box. The record is displayed and the word Finalized is displayed with the case number at the top of the screen. The record is also put into a read-only phase so that nothing can be modified on the record.
7. If changes do need to be made to the record, from the task menu, select **Unfinalize Case**. This takes the application and record out of the read-only status.

Supervisor Signature

Release Considerations

The Supervisor Signature Required setting is available beginning with the 2010.01 Release Update. When the Supervisor Signature Required setting is enabled, the system requires that at least one documented Supervisor sign the record prior to finalization. The supervisor signature status button located at the bottom of the screen defaults to Requires Supervision when the case is opened. The supervisor signature status can be toggled from Requires Supervision to No Supervision Required by clicking the button.

Note

In order switch the supervisor signature status, the user must be granted task 802820 (GRANT Unsupervised Records).
The supervisor signature status can also be toggled from within the Task menu. A check mark next to Requires Supervision indicates that a supervisor signature is needed for the case. Removing the check mark next to Requires Supervision indicates that a Supervisor Signature is not needed for the case. When the check mark is removed in the Task Menu, the Supervisor Signature Status button is updated to No Supervision Required.

Supervisor Signature Deficiencies

The Anesthesia Record is deficient at the time of finalization if a Supervisor Signature is required and a documented supervisor has not yet signed.

Note

If a user has task 802820 (GRANT Unsupervised Records) granted and also has task 802814 (GRANT Ignore Deficiencies) or 802805 (GRANT Ignore All Deficiencies) granted, it is possible for the Supervisor Signature deficiency to be ignored and the record can be finalized without a supervisor signature. If a user task 802814 (GRANT Ignore Deficiencies) or 802805 (GRANT Ignore All Deficiencies) granted, but DOES NOT have task 802820(GRANT Unsupervised Records) granted, the record cannot be finalized without a supervisor signature. If a user has task 802820 (GRANT Unsupervised Records) granted but DOES NOT have task 802814 (GRANT Ignore Deficiencies) or 802805 (GRANT Ignore All Deficiencies) granted, the supervisor signature deficiency cannot be ignored, but the user is able to switch the Supervision Required status.

Signatures Not Documented on Record

If a user not documented on the record signs the Anesthesia Record, a Not Documented on Record message will appear. The following message appears after the user enters valid credentials: **You are currently not documented on the record you are trying to sign. Would you like to continue with signing this record?**
Clicking **Yes** completes the signature process and allows the record to be signed by a non-documented user. Clicking **No** stops the signature process.

Run RecordViewer Reports

Release Considerations

Available with the the 2010.02 Release Update, filters display only the areas the active user has access to.
RecordViewer provides several reports which are useful for managing the anesthesia department and ensuring that documentation has been completed.

Viewing Concurrency

SurgiNet Anesthesia allows you to define the ratio limits of providers to cases to comply with federal, state, local and facility-specific regulations and standards of care. SurgiNet Anesthesia Record Viewer allows you to view these concurrency reports.
To view providers currently supervising cases and how many cases they are supervising, complete the following steps:

1. Click **Concurrency** in the All Panels list. If you want, select a Provider in the providers list. All cases that provider currently is supervising are displayed in the records list. To view case details, select a case and double-click it to view that record's details.
2. To end the provider's attendance of a case, right-click the record in the providers list and select **Open for Documentation** to open SurgiNet Anesthesia. You also can open the record in read-only or remote view in SurgiNet Anesthesia from the context menu.
3. Select the case in the records list to select that case's timeline in the timeline box. Arrows displayed in the timeline indicate the case is ongoing. The color of the timeline indicates concurrency alerts. Green indicates the provider is more than one case away from the maximum

concurrency limit, yellow indicates the provider is one case away from the maximum concurrency limit, and red indicates a provider at the maximum concurrency limit. You can scroll through the timeline displayed.

4. To print the report, click the **Print Concurrency** button. To print the concurrency summary report, click the **Concurrency Report** button.

Viewing Billing Summaries

You can view and print a Billing Summary report for a selected case. This report pulls information from various sources in Cerner Millennium and provides you the ability to collect billing information required to complete the CMS-1500 form.

Billing Summary Panel

To view the billing summary for a case, complete the following steps:

1. Click **Billing Summary** in the All Panels list.
2. Select the case creation date or date range to filter the list for cases created on that date or within the specified date range.
3. Select the Anesthesiologist, Document Type, and Surgical Area to filter anesthesia records in the Billing Summary records list
4. Select the record in the Billing Summary records list you want to view. The Anesthesia Billing Summary reports displays below the Billing Summary record list.
5. To view the billing summary for the selected case, click the **Billing/Summary Record** button in the lower right corner of the application.
6. To print the billing summary for a single record, click the **printer** button.

Finalized Cases Panel

You can also view a Billing Summary report and the Anesthesia Record from the Finalized Cases panel in the SurgiNet Anesthesia Record Viewer.

1. Click **Finalized Cases Panel** in the All Panels list.
2. Select the case finalized date or date range to filter the list for cases finalized on that date or within the number of days range.
3. Select the Document Type, and Surgical Area to filter anesthesia records in the Finalized Cases records list.
4. Select the record in the Finalized Cases record list you want view.
5. To view the billing summary for the selected case, click the **Billing/Summary Record** button in the lower right corner of the application.
6. To print the billing summary or anesthesia record, click the **printer** button.

Batch Printing

You can batch print billing summaries. To do this, complete the following steps:

1. Click the **Batch Print Summary/Records** button. The Batch Print box displays.
2. Select if you want to print Billing Summaries or Anesthesia Records or both, by clicking the appropriate box.
3. Filter the batch of records you want to print by Date, Anesthesiologist, Document Types, Surgical Areas, or whether to include Discrepant Records.
4. Click **Print**.

Viewing Discrepancies

You can view discrepant information between the anesthesia record and the surgery record for a patient in SurgiNet Anesthesia Record Viewer. The report is displayed in spreadsheet format with an indicator displayed for discrepant information. It is imperative these discrepancies are resolved or validated for

continuity of care between anesthesia and surgery. You can resolve the documentation discrepancies by opening SurgiNet Anesthesia directly from the report.
To review discrepancies, complete the following steps:

1. Click **Discrepancies** in the All Panels list.
2. Click **Select Date** to open the calendar and select a date range. Click the beginning date of the range, press SHIFT, and click the end date of the range.
3. Press ENTER. Click **Save** to save your changes and add them to the report. You also can enter a value in the number of days box, select that option, and click **Save** to add the discrepancies to the report. All anesthesia records that have a discrepancy with the surgery record are displayed in the Discrepancies list.
4. Select the record from the Discrepancies list and the discrepancies are displayed in spreadsheet format in the results list. To expand the lists, click the **plus** (+) button to view the details in that list. Any discrepant information is highlighted in red and indicated by an exclamation point (!). The Case Times list contains times that are on both the anesthesia record and the surgery record. The Single Case Times list contains times that are only on either the anesthesia record or surgery record.
5. To resolve the discrepant information in the record, right-click the record in the Discrepancies list and select **Open for Documentation** to open SurgiNet Anesthesia. You also can open the record in read-only or remote view in SurgiNet Anesthesia from the context menu.
6. To view a preview of the printed report, click the **Print Preview** button. The discrepancies are shaded. To print the report, click **Print** in the Discrepancy Report dialog box.
7. To refresh the discrepancy report with the most recent information, click **Refresh All** on the toolbar.

Viewing Finalized Cases

You can view all finalized cases in SurgiNet Anesthesia Record Viewer that meet the filter criteria that you select. To monitor finalized cases, complete thefollowing steps:

1. Click **Finalized Cases** in the All Panels list.
2. To view all finalized cases in the system, select the Not Filtered option and click **Save** to add the cases to the report.
3. To view finalized cases over a date range, enter a value in the number of days box, select that option, and click **Save** to add the cases to the report. All finalized cases that match the filter criteria are displayed in the Finalized Cases list.
4. Select the case from the Finalized Cases list and the case details are displayed in spreadsheet format. To expand the list, click the **plus** (+) button to view the details in that list.
5. To view more information on the finalized case, right-click the case in the Finalized Cases list and select **Open for Documentation** to open SurgiNet Anesthesia. You also can open the record in read-only or remote view in SurgiNet Anesthesia from the context menu.
6. To print the report, click the **Print Finalized Cases** button.

Viewing Open Cases

You can view all open cases in SurgiNet Anesthesia Record Viewer that match the filter criteria you select. To view open cases, complete the following steps:

1. Click **Open Cases** in the All Panels list.
2. To view all open cases in the system, select the Not Filtered option and click **Save** to add the cases to the report.
3. To view open cases over a date range, enter a value in the number of last days box, or in the number of older days box, select that option, and click
4. **Save** to add the cases to the report.
5. To view open cases created in a specific OR, click the **Select Operating Room** button on the Created In field to open the Select Operating Room dialog box. Select the OR and click **OK** to add the cases to the Created In list. Click **Save** to add the cases to the report.

6. To view cases opened by specific providers, click the **binoculars** button to open the Provider Selection dialog and search for a specific provider. Enter the name of the provider and click **Search**. Select the provider and click **OK**. Click the **green plus** (+) button to add the provider to the Opened By list.
7. Click **Save** to add the cases to the report.
8. Select the case from the Open Cases list and the case details are displayed in spreadsheet format. To expand the lists, click the **plus** (+) button to view the details in that list.
9. To view more information on the open case, right-click the case in the Open Cases list and select **Open for Documentation** to open SurgiNet Anesthesia. You also can open the record in read-only or remote view in SurgiNet Anesthesia from the context menu.
10. To print the report, click the **Print Open Cases** button.

Viewing Unassociated Records

You can view all blank records that have not been associated to a surgical case in SurgiNet Anesthesia Record Viewer using various filtering methods or in a comprehensive list. To view open cases, complete the following steps:

1. Click **Unassociated Records** in the All Panels list.
2. To view all unassociated records in the system, select the Not Filtered option and click **Save** to add the records to the report.
3. To view unassociated records created in a specific OR, click the **green plus** (+) button on the Created In filter to open the Select Operating Room dialog box. Select the OR and click **OK**. Click **Save** to add the records to the Created In list.
4. To view unassociated records over a date range, enter a value in the number of last days box, or in the number of older days box, select that option, and click **Save** to add the records to the report.
5. To view cases opened by specific providers, click the **binoculars** button to open the Provider Selection dialog and search for a specific provider. Enter the name of the provider and click **Search**. Select the provider and click **OK**. Click the **green plus** (+) button to add the provider to the Opened By list.
6. Click **Save** to add the cases to the report.
7. Select the record from the Unassociated Records list and the record details are displayed in spreadsheet format. To expand the lists, click the **plus** (+) to view the details in that list.
8. To view more information on the record, right-click the record in the Unassociated Records list and select **Open for Documentation** to open SurgiNet Anesthesia. You also can open the record in read-only or remote view in SurgiNet Anesthesia from the context menu.
9. To print the report, click the **Print Unassociated Records** button.

Viewing Unfinalized Cases

You can view all unfinalized cases in SurgiNet Anesthesia Record Viewer using various filtering methods or in a comprehensive list. To monitor unfinalized cases, complete the following steps:

1. Click **Unfinalized Cases** in the All Panels list.
2. To view unfinalized cases created in a specific OR, click the **green plus** (+) button in the Created In field to open the Select Operating Room dialog box.
3. Select the OR and click **OK**. Click **Save** to add the cases to the Created In list. Click **Save** to add the cases to the report.
4. To view all unfinalized cases in the system, select the Not Filtered option and click **Save** to add the cases to the report.
5. To view unfinalized cases over a date range, enter a value in the number of last days box, or in the number of older days box, select that option, and click **Save** to add the cases to the report. You also can select a start and end date in the Surgery Date/Time Between group box or select the Use Today option to use the current date as the start or end date.
6. To view cases opened by specific providers, click the **binoculars** button to open the Provider Selection dialog and search for a specific provider. Enter the name of the provider and click

Search. Select the provider and click **OK**. Click the **green plus** (+) button to add the provider to the Opened By list.

7. Click **Save** to add the cases to the report.
8. Select the case from the Unfinalized Cases list and the case details are displayed in spreadsheet format. To expand the lists, click the **plus** (+) button to view the details in that list.
9. To view more information on the record, right-click the record in the Unfinalized Cases list and select **Open for Documentation** to open SurgiNet Anesthesia. You also can open the record in read-only or remote view in SurgiNet Anesthesia from the context menu.
10. To print the report, click the **Print Unfinalized Cases** button.