Gas Chart

User Manual
Table of Contents

INFORMATION MANAGEMENT TREE ......................................................................................................................... 5

SETTING-UP ACCESS ................................................................................................................................................... 5

  VUNETID ........................................................................................................................................................................ 5
  EPASSWORD ................................................................................................................................................................. 5
  RACFID ........................................................................................................................................................................... 5
  RACF PASSWORD ....................................................................................................................................................... 5

LOGGING IN TO GASCHART ........................................................................................................................................ 6

INITIAL CASE LIST SCREEN ..................................................................................................................................... 7

PAST DUE CASES ........................................................................................................................................................... 7

BUTTONS ON THE RIGHT PANEL ............................................................................................................................... 8

  (1) Refresh Screen ....................................................................................................................................................... 8
  (2) Past Due ACR’s ....................................................................................................................................................... 8
  (3) Preop ........................................................................................................................................................................ 8
  (4) Open Case ............................................................................................................................................................. 9
  (5) Open Read-Only ................................................................................................................................................... 9
  (6) Preview ACR .......................................................................................................................................................... 9
  (7) Attending Notes ................................................................................................................................................... 9
  (8) Emergence ............................................................................................................................................................ 9
  (9) Change User ......................................................................................................................................................... 9
  (10) User Manager ................................................................................................................................................... 9
  (11) Exit Gas Chart .................................................................................................................................................. 9

USER MANAGER / CAPTURING YOUR SIGNATURE .................................................................................................... 10

SELECT A CASE .......................................................................................................................................................... 13

  Search by Site ............................................................................................................................................................. 13
  Select Rooms ........................................................................................................................................................... 14
  Status Filters ............................................................................................................................................................ 15

TEMPLATES ..................................................................................................................................................................... 16

  Using a Template ...................................................................................................................................................... 16
  New Template ........................................................................................................................................................... 17
  Edit Someone Else’s Template .................................................................................................................................. 17

CHART IN A CASE .......................................................................................................................................................... 19

RIGHT PANEL .............................................................................................................................................................. 20

Buttons ........................................................................................................................................................................ 20

  (1) Dial Pager ............................................................................................................................................................ 20
  (2) Refresh ................................................................................................................................................................. 20
  (3) Camera Log .......................................................................................................................................................... 20
  (4) Change User ....................................................................................................................................................... 20
  (5) Breaks ................................................................................................................................................................. 21
  (6) Attending Notes .................................................................................................................................................. 21
  (7) Emergence ......................................................................................................................................................... 21
  (8) Postop Orders .................................................................................................................................................... 21
  (9) Check Case ......................................................................................................................................................... 21
  (10) Preview ACR .................................................................................................................................................... 21
  (11) Print Reports ..................................................................................................................................................... 21
  (12) Send to StarChart ........................................................................................................................................... 21
  (13) Exit Case .......................................................................................................................................................... 21

Times ........................................................................................................................................................................... 22

TABLES ........................................................................................................................................................................... 23

  Active ......................................................................................................................................................................... 23
  Complete ................................................................................................................................................................. 23
Incomplete .....................................................................................................................................................................23
Untouched .....................................................................................................................................................................23

VITAL SIGNS TAB ............................................................................................................................................................24
Charting Vitals .................................................................................................................................................................24
  Manually........................................................................................................................................................................24
  Quick Collect.................................................................................................................................................................25
  Auto Collect................................................................................................................................................................26
  Correcting a Vital Sign....................................................................................................................................................27
  Erase a Line of Vitals .....................................................................................................................................................28
  Chart Past Vitals.............................................................................................................................................................29

Vital Parameters ...............................................................................................................................................................31
  Add Vital Parameter........................................................................................................................................................31
  Delete Vital Parameter....................................................................................................................................................33

Respiratory Parameters ......................................................................................................................................................34
  Add Respiratory Parameter..........................................................................................................................................35
  Delete Respiratory Parameter....................................................................................................................................36

Anesthetic Parameters .......................................................................................................................................................38

Gases Parameters ............................................................................................................................................................39

Hemodynamic Parameters ...............................................................................................................................................40

Labs Parameters .............................................................................................................................................................41

Drips ................................................................................................................................................................................42

All Button .......................................................................................................................................................................43

Fluids ................................................................................................................................................................................43
  Add Fluids.......................................................................................................................................................................44
  Document Fluids..........................................................................................................................................................45
  Delete Fluids................................................................................................................................................................46

EBL / UOP Checkboxes ...................................................................................................................................................47
  Minimal EBL..................................................................................................................................................................47
  UOP Not Measured ........................................................................................................................................................48

Drugs ................................................................................................................................................................................48

Drug Waste.....................................................................................................................................................................51

TOTALS TAB ......................................................................................................................................................................53
  Show Drugs..................................................................................................................................................................53
  Show Fluids..................................................................................................................................................................54
  Fluid Totals..................................................................................................................................................................55

COMMENTS ......................................................................................................................................................................56
  Edit Comments...............................................................................................................................................................58
  Delete Comments........................................................................................................................................................60

Quick Comments ..............................................................................................................................................................62
  Use a Quick Comment..................................................................................................................................................62
  Add Quick Comment...................................................................................................................................................63
  Edit a Quick Comment...............................................................................................................................................65
  Delete Quick Comment..............................................................................................................................................67

ANESTHETIC TAB ............................................................................................................................................................69

AIRWAY TAB .....................................................................................................................................................................71

MONITORS TAB ...............................................................................................................................................................73

CHECKLIST TAB ..............................................................................................................................................................74

CASE INFO .......................................................................................................................................................................76
  Diagnoses ......................................................................................................................................................................76
  Procedure ....................................................................................................................................................................78
  Surgeon.........................................................................................................................................................................80
  Residents, CRNAs and SRNAs ..................................................................................................................................81
  Attending Anesthesiologists ..................................................................................................................................82

EVENTS ................................................................................................................................................................................83
  Add Event.......................................................................................................................................................................83
  Delete Event.................................................................................................................................................................84
  Case Disposition..........................................................................................................................................................84
  No Events Occurred......................................................................................................................................................85

DELAYS ..............................................................................................................................................................................86
  Add Delay.....................................................................................................................................................................86
Delete Delay .................................................................................................................................................................87
No Delays Occurred .....................................................................................................................................................87
OB .....................................................................................................................................................................................88
Fetal Info .......................................................................................................................................................................88
Specific Birth Information ............................................................................................................................................91
Go to C-Section ..................................................................................................................................................................95
SCIP ....................................................................................................................................................................................97
EMERGENCE .................................................................................................................................................................98
ATTENDING NOTES .......................................................................................................................................................99
CHECK CASE ...............................................................................................................................................................105
EXIT CASE .................................................................................................................................................................106
**Information Management Tree**

- **VUNet-ID and Epassword**
  - VPIMS Access
  - Eskind Digital Library
  - Vanderbilt Email
- **RACFID**
  - Clinical Workstation
  - Starchart/Starpanel
  - GasChart
  - VPIMS Website

**Setting-Up Access**

**VUNetID**
- Used for e-mail, VPIMS Web, GasChart
- A VUNetID is created for you through Human Resources when you are hired or through your Security Manager once you are an employee.

**Epassword**
- Used with VUNetID for e-mail, VPIMS Web and GasChart
- Set up by going to www.vanderbilt.edu/epassword once you have a VUNetID

**RACFID**
- Used for CWS machines, Starchart/Starpanel
- Access granted through Human Resources when you are hired or through your Security Manager (they will request it from the SAMS team)

**RACF Password**
- A password will be given to you when the RACFID is given to you. You will have to change it on your first login.
- If you need your password reset, the HelpDesk can do that (3-HELP)
**Logging in to GasChart**

Log into a CWS using your RACF ID. If you can’t get in call 3-HELP for them to reset your password.

Double-click “VPMS GasChart” icon in Departmental Apps (Old Computer Build)

OR

Double-click “VPMS GasChart” icon in Departmental Apps (New XP Computer Build)
A login box will appear. Login with your VUNetID and Epassword.

**Initial Case List Screen**

**Past Due Cases**

When you log into GasChart you might get a screen that looks like the one below with a red box labeled “Past Due Anesthetic Care Reports”. This appears if you have not finished charting on a case, including the Attending Notes.

To finish the case: Click on the case and click the Open Case button

To close the box: Click on the x in the upper right of the red frame
Buttons on the Right Panel

(see picture below)

(1) **Refresh Screen**
- This button can be used to get the current information for this screen from the database. (The screen automatically refreshes as well.)

(2) **Past Due ACR’s**
- This button can be used to see incomplete cases you are associated with (they will also show as incomplete if the Attending hasn’t entered their note)
- Close this window by clicking on the upper right x of the red box.
- For more detail, see section on the previous page.

(3) **Preop**
- This button will pull up an electronic Preop record (if available) for the case
(4) Open Case
- When a case is clicked on in the case list then this button will become active.
- Single-click on this button to open the highlighted case.
- See more information on this button in the “Chart In A Case” section of this document.

(5) Open Read-Only
- When a case is selected you can single-click on this button to open the case in Read-Only mode (not editable and you will not be signed into the case)

(6) Preview ACR
- Click this button to view a print preview of the ACR report for the case highlighted.
- Click the x at the top of the document to get back to the main page screen.

(7) Attending Notes
- Click this button to go directly to the Attending Notes section for the case that is highlighted.
- See Attending Notes section of this document for more information.

(8) Emergence
- Click this button to go to the emergence section of the case that is highlighted.
- You can only open the Emergence section to chart once the Out Of Room time is filled in for the case.
- See the Emergence section of this document for more information.

(9) Change User
- This button may be used to log off and bring the login screen back up for someone else to log in.

(10) User Manager
- This button may be used to change or view your personal settings
- See the User Manager section of this document for more information.

(11) Exit Gas Chart
- This button is used to exit GasChart (it will not just close the ACR window)
User Manager / Capturing Your Signature

On the first screen after login, click on the User Manager button to change your personal settings.

Your name will be listed with all of your settings. You can change your pager number here as well as collect your signature.

To change your signature, click on the Change Signature button.
A new box will open. Sign on the line with a stylus and a touch screen or with your mouse (if there is no touch screen available).

Then click Save Signature button.

Then make sure to click in the box to put a checkmark next to the agreement.
If you have made changes click the Save button… then click the Exit button.
Select a Case

Search by Site

The center box lists all the cases particular to the filters you have selected.

To select the site for which you would like to see the cases, click on the site to highlight it black. If there is a site you don’t want to see (and it is highlighted) click on it to deselect it. (More than one site can be viewed at the same time)

To see the cases for all sites click the “All” button.

To see no sites, or to clear your selections, click the ‘None” button.
Select Rooms

To select rooms to view within the site that is selected, click on the rooms that appear in the room list (for only the sites selected) that you would like to see.

To see the cases for all sites click the “All” button.

To see no sites, or to clear your selections, click the “None” button.

To see only the sites associated with your name, click the “My Rooms” button.
Status Filters

The status filters limit the cases in the display window to only the cases that are of the type of status selected. By default, all of the filters are selected so you see all cases, regardless of status.

- To unselect a status, click on the status, and the highlighting around the button will disappear.
- To select an unselected status, click on the status, and highlighting will appear around the button.
Templates

Using a Template

A case template may be created and used to start the documentation of a new case.

- Search for templates by user (you can use other users’ templates).
- Select the template before you open a case.

Once a template is selected, click on the case you would like to open to highlight it. Then click the “Open Case” button. A new window will appear, verifying what template was selected to open the case.

Once a case is open with a template, the template cannot be taken off of the case. But, even the templated fields can be changed while charting in the case.
**New Template**

You can make a new template under your name. Click on the 'New' button in the Case Templates section to open a blank template to create and save.

**Edit Someone Else’s Template**

To edit a template it must be listed under your name.

Find the template you would like and highlight it. Then click the “Copy” button.

[Image of the GasChart interface showing the 'New' and 'Copy' buttons]

It will pull up a box to change the name of the template. (The new name will be used as the name of the template under your username).

[Image of a new template dialog box with the name 'Copy of GETA' and owner 'Webb, Amy']

It will then open the template for you to make changes on.
Click “Exit Template” and the template will be saved with your changes and appear under your name in the list of templates.
**Chart in a Case**

Once you highlight a case and click “Start Case” it will open a box with the template information on it. Then it will open a box with the patient information on it.

If this is correct click “OK”.

If it is not the correct case, click “Cancel” or the case will have a Past Due ACR on that case.
Right Panel

Buttons

(1) Dial Pager
   • This button is used to send a text page to another person.

(2) Refresh
   • This button is used to gather information into your case in between automatic system refresh times. (Ex: Gather time information entered by the circulator in Patient Tracker in between system refresh times.)

(3) Camera Log
   • This button will be active when someone is looking at the room through the Vigilance camera.
   • To find out who is looking into the room, click on the button to show the user name.

(4) Change User
   • This button may be used to log off and bring the login screen back up for someone else to log in. You should never chart under another user’s login. Always have the previous person log out and log in yourself.
(5) **Breaks**
- This button is used to document any breaks and allows users giving breaks to enter their name and times without logging in officially.

(6) **Attending Notes**
- This button is used by the Attending. They enter their documentation into this section.

(7) **Emergence**
- Click this button to go to the emergence section of the case.
- You can only open the Emergence section for documentation after the Out Of Room time is entered.
- See the Emergence section of this document for more information.

(8) **Postop Orders**
- This button pulls up a form to document postop orders.

(9) **Check Case**
- This button is used to check for information missing from a case before it can be closed. It will make sure all mandatory fields are populated, and a pop up box will inform the user which mandatory items have not been completed.

(10) **Preview ACR**
- This button is used to view the chart copy of the ACR.

(11) **Print Reports**
- This button is used to print out the ACR to PACU.

(12) **Send to StarChart**
- This button allows the anesthesiologist attendings to send the completed record to StarChart.

(13) **Exit Case**
- This button may be used to leave a case but you do not leave GasChart entirely. It also does not “close” a chart.
**Times**

Enter the Anes Start time to begin charting vitals. Click the “Anes Start” button to enter the current date and time. Or, click in the white box to change the time. (You cannot chart future times).

Anes Start and Anes Finish needs to be entered by the anesthesia provider. The other times will come over from Patient Tracker.
Tabs

Active
The active tab (the one that is currently being viewed) has a dark blue color above the tab name. (Ex: Vital Signs tab in picture below)

Complete
If the tab has been clicked into and all of the mandatory fields for that page are filled in then the color above the tab name is green. (Ex: Totals, Comments and Airway tabs in picture below)

Incomplete
If the tab has been clicked into and all of the mandatory fields for that page are NOT filled in then the color above the tab name is red. (Ex: Anesthetic tab in picture below)

Untouched
If a tab has not been clicked into yet then a dark grey color will appear above the tab name. (Ex: Monitors, Checklist, Case Info, Events, Delays, OB and SCIP tabs in picture below)
Vital Signs Tab

Charting Vitals

Manually

Click on the symbol on the left panel that you would like to chart.

Then click on the grid where you would like to chart that sign.

Then you can click another symbol and click on the chart to chart it and repeat as necessary.
**Quick Collect**

Click the white box to place a checkmark next to the vitals you would like to chart.

Click on the “Collect” button under the checkboxes on the left panel as shown above. Then, click on the grid to chart the vital sign listed at the top. It will take you through all of the vital signs you have checked on the left panel.
**Auto Collect**

Click the white box to place a checkmark next to the vitals you would like to chart. Then click the checkbox next to “Collect vitals every 5 minutes.”

A box will pop up with the vitals listed. (If the boxes have no vitals or if the vitals look wrong, check to make sure the patient is listed in GasChart as being in the correct room. If that is correct, call the HelpDesk.)

- Click “Accept” to have the vitals charted on the grid.
- Click “Defer” to not chart the vitals but for the vitals to be temporarily held. The computer will only hold the vitals for a limited time.
- Click “Reject” to discard this set of vitals.
Correcting a Vital Sign

To correct one vital, click on the vital symbol you would like to correct from the left panel (as in the Manual Chart Vitals Section of this document).

Then click on the grid where you want the vital sign to appear and the other symbol on that time line will be moved to the new location where you clicked.
**Erase a Line of Vitals**

Click on the “Clear Line” button.

Then hover over the line of vitals you want to delete until a yellow line highlights that line of vitals.
Then click once to remove the vitals on that line.

**Chart Past Vitals**

To get past vitals that you have not charted, click on the 'Get Past Vitals' button.
A box will come up with all of the past vitals. You can Defer, Reject or Accept each set of vitals. The count of the vital reading you are on is at the top of the window with the date and time.
**Vital Parameters**

To enter a value for the vitals on the bottom grid, click in the empty box. Either type in the value or use the pop-up box to enter the value.

**Add Vital Parameter**

To add a vital to chart, click on the “Add Param” button.
A new box will pop up. Click on the next to what you want to add to shift it over to the left box. Then click the “Accept” button.

The selected item will appear in the lower grid so the user can enter information.
Delete Vital Parameter

To delete a vital from the chart, click on the “Add Param” button.

A new box will pop up. Click on the × next to what you want to delete to shift it over to the right box.

You can only delete Parameters if you have not entered values for that parameter. Then click the “Accept” button.
The change will appear in the lower grid.

**Respiratory Parameters**

Click on the “Resp” button to enter values for the Respiratory Parameters. The parameters for respiratory are listed on the left of the bottom grid (Mode, RR, TV and PIP).

Either add a value by typing it or use the pop-up box.
Add Respiratory Parameter

To add a respiratory parameter, click on the “Add Param” button.

A new box will pop up. Click on the button next to what you want to add to shift it over to the left box. Then click the “Accept” button.
The selected item will appear in the bottom grid so the user can enter information.

**Delete Respiratory Parameter**

To delete a respiratory parameter from the chart, click on the “Add Param” button.
A new box will pop up. Click on the ✗ next to what you want to delete to shift it over to the right box. You can only delete parameters if you have not entered values for that parameter.

Then click the “Accept” button.

The change will appear in the lower grid.
**Anesthetic Parameters**

Click on the "Anes" button on the lower right. This will display the anesthetic for which you can chart information.

Enter values by clicking in the box.

You can either type in values using your keyboard or if a window pops up, use it to enter values.

To add an anesthetic parameter or delete one that you already added, click on the “Add Param” button. (To see step-by-step instructions see the Add and Delete Vital or Respiratory Parameters sections in this manual.)
**Gases Parameters**

Click on the “Gases” button on the lower right. This will display the gases for which you can chart information.

Enter values by clicking in the box.

You can either enter values using your keyboard, or if a window pops up, use it to enter values.

To add a gases parameter or delete one that you already added, click on the “Add Param” button. (To see step-by-step instructions see the Add and Delete Vital or Respiratory Parameters sections in this manual.)
Hemodynamic Parameters

Click on the “Hemo” button on the lower right. This will display the parameters for which you can chart information.

Enter values by clicking in the box.

You can either enter values using your keyboard or if a window pops up, use it to enter values.

To add a hemodynamic parameter or delete one that you already added, click on the “Add Param” button. (To see step-by-step instructions see the Add and Delete Vital or Respiratory Parameters sections in this manual.)
**Labs Parameters**

Click on the “Labs” button on the lower right. This will display the parameters for which you can chart information.

Enter values by clicking in the box.

You can either enter values using your keyboard, or if a window pops up, use it to enter values.

To add a labs parameter or delete one that you already added, click on the “Add Param” button. (To see step-by-step instructions see the Add and Delete Vital or Respiratory Parameters sections in this manual.)
Drips

Continuous infusions may be documented by clicking on “Drips” on the lower right.

To enter information on a drip, you first have to add the drip by clicking on the “Add Drip Button”. Then follow the same process as adding parameters. (For step-by-step instructions, see the Add and Delete Vital or Respiratory Parameters sections in this manual.)
**All Button**

To see only the fields in which you have documented, click on the “All” button. This will display the parameters that you are using from all 8 parameter boxes (Vitals, Resp, Anes, Gases, Hemo, Labs and Drips).

**Fluids**

The yellow section at the bottom of the lower grid is for fluids. When a case is started, there are no fluids listed. In order to document, fluids you have to add them.
Add Fluids

To add a fluid, click on the “Add” button in the yellow section of the lower grid.

A new window will pop up.

To add a Fluid In, click the button next to the fluid name to push it over to the upper left box.

To add a Fluid Out, click on the button next to the fluid name to push it over to the box on the lower left.

Then click the “Accept” button.
Then the fluids selected will appear in yellow on the list.

Document Fluids
To enter a value for a fluid click in the box next to the fluid name. A new window will pop up. Use the numbers in the new window to enter a value and click “OK”. (A fluid can only be documented after it is added. See section on previous page on how to add a fluid.)
**Delete Fluids**

To delete a fluid, click on the “Delete” button in the yellow section of the lower grid. Only 1 fluid can be deleted at a time. Also, you can only delete the fluids on which no documentation has occurred.

A new window will pop up. Click on the name of the fluid you want to delete then click the “OK” button.
Then the fluid selected will disappear from the yellow list.

**EBL / UOP Checkboxes**

**Minimal EBL**

If minimal blood loss was incurred, click the box next to "Minimal EBL" to put a checkmark in the box.
**UOP Not Measured**

If urine output was not measured, click the box next to “UOP Not Measured” to put a checkmark in the box.

**Drugs**

To edit what drugs are in the chart click on the top blue bar.
A new window will pop up. Click on the [ ] next to the drug you want to add.

A new window will pop up to enter the dose for the drug that was selected. Then click the “OK” button.
The drug will appear in the bottom window with the dose you entered. Click on the boxes to the right to document the correct route,

When finished, click the “Accept” button. There will be a marker in the blue section at the top for the newly entered drug. (The number reflects how many different drugs were entered by the user at that time.)

To edit the dose of a drug, click on the number icon in the top blue bar. Then click on the name of the drug in the bottom box that you would like to edit the dose for. Type in the new value, or if you want to delete the drug just type in “0” for the dose.
To see more information about the drug entered, you can click on the to expand the drug section.

**Drug Waste**

Vials opened from the anesthesia cart and not used are recorded as waste. The entire vial amount should be recorded as wasted.

To enter a wasted drug click on the icon.
Click on the next to the name of the drug that you want to add. A window will pop up to enter the dose.

Enter the dose and click “OK”. The drug with the dose will be listed in the bottom window. Click “Accept”.

To add another drug click on the and repeat the steps above.
Totals Tab

Click on the “Totals” tab at the top of the screen to document and view the total values.

Show Drugs

By default the “Show Drugs” button is chosen. These are pulled from the “Vitals” tab. You can also click on a specific drug to view time and route.
**Show Fluids**

Click on the “Show Fluids” button. These values are pulled from the “Vitals” tab.

Click on a fluid to see the details listed in the Administration Details window.
**Fluid Totals**

Click on the “Fluid Totals” button. These values are pulled from the “Vitals” tab.

Click on a fluid to see the details listed in the Administration Details window.
Comments

Click on the “Comments” tab at the top.

Click in the “Add Comment” button.
A new window will pop up to enter the comment. Use the keyboard to enter your comments in the white space. Then click ‘OK’.

The comment will then appear in the field. Comments appear in the order that they are entered.
Edit Comments

You can only edit comments that you have written. To edit a comment, click on the “Edit Comment” button.

A new window will pop up with all of your comments listed for you to edit. Click on the edit button ( ) next to the comment you would like to change.
A window will pop up with the comment for you to edit. Edit the comment and click “OK”.

Varify that the changed you typed are showing in the comment. Click “Done” at the bottom of the window.

The comment will appear edited in the comments window.
Delete Comments

You can only delete comments that you have written. To delete a comment, click on the “Edit Comment” button.

A new window will pop up with all of your comments listed for you to edit. Click on the delete button next to the comment you would like to delete.
A window will pop up asking if you would really like to delete the comment. Click “Yes”.

Varify that the comment you deleted is no longer showing. Click “Done” at the bottom of the window.

The comment will appear edited in the comments window.
Quick Comments

Use a Quick Comment

To use a quick comment that you have created, click in the white space to get the comment box. Then, click the arrow next to the list of quick comments and choose the one you want to use. Then click “OK” for the comment.

The comment will then be placed in the document.
Add Quick Comment

When the comment box popup appears, click in the white box. Then click “Edit Quick Comments”.

A new window will open. To add a new comment, scroll till you see an empty comment field and type your comment into that one.
When you start typing in the empty comment, a new section will appear below, in case you want to enter another quick comment below it. When done entering the new comment, click the “Done” button.

The comment you added will now appear in the list of quick comments available for you to use.
**Edit a Quick Comment**

When the comment box popup appears, click in the white box. Then click “Edit Quick Comments”.

A new window will open. To edit a comment, scroll till you see the comment you want to edit. Then make the changes to that one using your keyboard.
Then click the “Done” button and your changes will be saved.

The edited comment will appear in the dropdown list under Quick Comments.
Delete Quick Comment

When the comment box popup appears, click in the white box. Then click “Edit Quick Comments”.

Then click in the bar next to the comment you want to delete to highlight it.

Then click the “Delete” button.
A new window will open to ask if you really want to delete the comment. Click “Yes.”

The comment is removed. Then click “Done” button.

The comment will also be removed from the Quick Comments list.
Anesthetic Tab

Click on the top “Anesthetic” tab to document anesthetic settings.

The mandatory fields are in red. Also, on the bottom of the window it lists which mandatory fields are incomplete.
You can select a box by clicking in the box. It will place a checkmark in the box. If it is a standard GA then you can just click the “Std GA” button and the standard choices will be filled out.
Airway Tab

Click on the Airway tab to view and edit airway information.

Fill in the information by checking the white box. Once you click any of the intubation options, the mandatory airway confirmation choices will appear in red.
If the airway is Standard General Endotracheal Anesthesia you can click on the “Standard GETA” button to fill in the standard information.

Once you complete the mandatory fields, the red letters go away (no more mandatory information on this page).
Monitors Tab

Click on the Monitors tab to view and edit the monitor information.

This screen allows documentation of any invasive or noninvasive monitors, IV access and special equipment.

If you choose NIBP then you must use the drop down box to enter the location.
To enter standard information with 1 click, you can click on the “Std. GA” button, “Std. Reg/MAC” button, or the “Std. LMA” button.

**Checklist Tab**

Click on the Checklist tab to view and edit the checklist information. The purpose of this screen is to document the essential and supplemental equipment checks.
You may click on the ‘Essential Check’ button…

Or you may click the ‘Supplemental Check’ button…

You can also add comments in the bottom white comments box at the bottom of the screen.
Case Info

Click on the ‘Case Info’ tab to open the case information.

Diagnoses

Diagnoses are pulled from Patient Tracker information. If you need to change or add this information, click on the ‘Edit Diagnoses’ button.
A new window will pop up. Click on the fields in the boxes to narrow your search. When you find the diagnosis then double-click on it. It will then appear in the list of diagnoses in the lower right box.

Then click on the ‘Done’ button. The diagnosis chosen will appear in the Diagnoses box.
To delete a diagnosis, just double click on the name of the diagnosis you would like to delete in the lower right box.

**Procedure**

Procedure is pulled from Patient Tracker information. If you need to change or add this information, click on the ‘Edit Procedure’ button.
A new window will pop up. Click on the fields in the boxes to narrow your search. When you find the desired procedure, double-click it. Then it will appear in the list of procedures in the lower right box.

Then click on the ‘Done’ button.

The procedure chosen will appear in the Procedure box.
To delete a procedure, double click on the name of the diagnoses you would like to delete in the lower right box.

**Surgeon**

Surgeon and attending anesthesiologist name should be entered. Click on the arrow next to the empty white box and select the surgeon you would like to enter into the case.
Residents, CRNAs and SRNAs

Modification of sign in/out times for anesthesia provider is performed here. Click the ‘Sign’ button to enter your name and signature when you are logged into the case. It will also document your time in the case. To enter time out, just click on the white box to the right of where your time in is listed.

To edit times, click in the box of the time you would like to edit and change the time.
**Attending Anesthesiologists**

You may view the attending notes using this box. The notes are not editable here. If an attending is working alone on a case, check the box next to Solo.
Events

Add Event

This tab is used to document events which occurred during the case, as well as the case disposition. These events are used for internal audit only; the information does not appear on the ACR.

Click on the name in the Event Category window to populate the events list.

Then double-click on the event you would like to add. It will appear in the bottom box of events.
**Delete Event**

To delete the event, click on the \(\times\) next to the event listed in the bottom box. Then click ‘Yes’ to delete the event.

**Case Disposition**

Click on the ‘Case Disposition’ button to report case cancellation or death.
A new window will pop up. Click in the dispositions that apply and click ‘Done’.

**No Events Occurred**

If no events occurred, then check the white box next to No Events Occurred.
Delays

Add Delay

Used to report intraoperative delays. This information does not appear in ACR; it is used to identify system inertia. This field is required if case is started after the scheduled time.

Click on the Delays tab to enter information.

Click on one of the items in the Delay Category to display a list of the available Delays.

Then double-click on the Delay you would like to add. It will appear in the bottom box of Delays.
**Delete Delay**

To delete the delay, click on the ☐ next to the delay listed in the bottom box. Then click ‘Yes’ to delete the delay.

**No Delays Occurred**

If no delays occurred, check the white box next to No Delays Occurred.
OB

Click on the OB tab to record information about a birth.

Fetal Info

The Fetal Info portion of the page is for one-time documentation of the general OB information. This will only be documented once per case (i.e. once despite twins, triplets, etc).

The first section is for general OB comments and other fetal information:
Enter Gestational Age (in weeks) in the appropriate box. If appropriate, check the box by Uterine Incision Required. Enter a Uterine Incision Time by clicking the white box.

Use the pop-up box to enter the date and time.

Enter a time in the keypad (or click NOW for current time) and click OK.
This will enter the time into the Uterine Incision Time field and also automatically check the Uterine Incision Time checkbox (see below).

If a Uterine Incision Time is documented, and the user unchecks Uterine Incision Required, the following warning will appear.

Clicking Yes will uncheck Uterine Incision Required and will erase the Uterine Incision Time. Clicking NO will cancel out of the operation and return the user to the OB screen, leaving the data as is.
Specific Birth Information

The “Specific Birth information” section is for documentation on the individual infant birth(s). In the case of multiple births, additional records can be added by clicking on the ‘Add New Delivery’ button. To add new infant information, click on Add New Delivery.

This will create a blank infant record as shown, which can then be documented as outlined below.

Document the Infant Name (or temporary name) in the first box. This can be the infants name (if known), or some identifying label to help identify the infant, especially in the case of multiple deliveries. For this example we will just use “TEST BABY A.” (NOTE: INFANT NAME is a mandatory field.)

Click on “APGAR Score” to add the APGAR Score (Scores at 1 and 5 minutes).
Clicking in either the “1 MIN” or “5 MIN” box will launch the following keypad to facilitate score entry.

Clicking on a value from 0 to 10 will select that value and close the window. If the value is already present, it will show as selected. Clicking CANCEL will leave the current value and return to the OB form, while clicking DELETE will erase the current value.

Values of 3 or less will alert the user with the following prompt.

Follow the same steps outlined above to document the 5 minute Apgar score. (NOTE: Apgar score is not a mandatory field, but is available for documentation.)

To add the birth weight of the infant, click on Birth Weight to add birth weight. Birth weight is in lbs.
Clicking on Birth Weight will launch the following popup:

Enter the Infant’s birth weight, or click CANCEL to return to the previous value. Birth weight can also be manually typed into the field by tabbing into the field. (NOTE: Birth weight is an optional field and is not required to close the case.)

Click on Time of Delivery to launch the time keypad popup and then enter the time of delivery of the infant.
Click on Time of Placental Delivery to enter the time the placenta was delivered.

<table>
<thead>
<tr>
<th>Infant Name (or Temp Name)</th>
<th>APGAR Score</th>
<th>Birth Weight (lbs)</th>
<th>Time Of Delivery</th>
<th>Time Of Placental Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby A</td>
<td>9</td>
<td>8.1</td>
<td>11/10/2004 9:04 AM</td>
<td></td>
</tr>
</tbody>
</table>

Once all data has been entered, the entry will resemble the following.

<table>
<thead>
<tr>
<th>Infant Name (or Temp Name)</th>
<th>APGAR Score</th>
<th>Birth Weight (lbs)</th>
<th>Time Of Delivery</th>
<th>Time Of Placental Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby A</td>
<td>9</td>
<td>8.1</td>
<td>11/10/2004 9:04 AM</td>
<td></td>
</tr>
</tbody>
</table>

(NOTE: Time Of Delivery and Time of Placental Deliver are all required fields.)

In the event of multiple births (twins, triplets, etc), additional entries can be added by clicking on the Add New Delivery Button. Follow the same steps at outlined above for each additional delivery.

To delete an entry, just click on the red ✗ next to the entry. Clicking on the red ✗ (delete entry) will bring up a confirmation prompt:

**Delete Delivery?**

Are you sure you want to delete Infant: Baby B (Delivery #2) from the case?

[Yes] [No]

*Note: To summarize, the OB tab itself is non-mandatory if everything is blank. However, once any data has been entered on the OB tab, the form must be completed in order to lock/print or complete the case. The requirements for completion are:

There must be at least one Infant record present.

Infant record must include Name (or Temp Name), Time Of Delivery, and Time of Placental Delivery. If Uterine Incision Required is checked, then a Uterine Incision Time must be present.

The remaining items are optional, but it is recommended to complete these for documentation purposes and possible future use.*
**Go to C-Section**

'Go to C-Section' button schedules a new case for the current patient with new case numbers for the impending Cesarean case. When this button is clicked a new window pops up where the user must input case data.

(NOTE-This tab is used if the patient’s Labor and Delivery was already scheduled and underway, but then turned into a Cesarean Section.)
The user must input all fields on the Create Cesarean Case form. This information (along with the generated case numbers) is the only non-reused fields from the L&D Case. When the case is created, the Anesthesia finish time for L&D case is automatically entered and the case then gets locked and printed. If there are missing items in the case, the case will not lock and print. The case will then remain open until the missing items are entered or the case can be exited.
Click on the SCIP tab to document SCIP information.

Answer the question by clicking in the appropriate box. If more information is required it will display an additional question to answer below the question you just answered.
Emergence

You cannot document Emergence information until the Out of Room time is entered.
When you have entered an Out of Room time then click on the Emergence button.

Fill in the fields on this page by clicking in the boxes that are appropriate.
Attending Notes
This section is to enter notes by the attendings.
Click on the Attending Notes Button to open the section.

The signature and start time of the person signed into the case will appear in the next available attending box.
Click on the white End Time box to enter your end time.

Enter a note into the Attending Intraop Note Field by clicking in the box. A new window will pop up for you to enter your note.

Click OK.
The note now will appear in the note field.

If there is someone taking over the case for you, choose their name from the "Case To Be Taken Over By:" dropdown.
Click on a button to select the Assigned Case Level.

Click on the radio button to designate if case level was appropriate or not.
Click on the appropriate ASA score button.

Once the bar at the top turns green, all mandatory fields have been filled out and you can exit the attending notes page.
Click on the ‘Exit Attending Notes’ button to exit this section.

The attending note now appears in the Case Info tab in the attending notes section.
Check Case

At the end of a case, click the ‘Check Case’ button to see if you missed documenting on any mandatory fields.

If all mandatory fields are filled in, then you will get a case complete message. Click OK. If not, then a box with all of the fields that you missed will be listed.

Click OK and fix the necessary fields in the chart. You can click the “Check Case” button as many times as you need to.
Exit Case

When you get the “Case is complete” message from Check Case, you can exit the case using the “Exit Case” button.

You will be brought back to the main page of cases.