

OPERATING - ROOM INTRA-OPERATIVE NURSING RECORD

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|-------|------------|----------|
| DATE: | OR ROOM #: | SURGEON: |
|-------|------------|----------|

ASSISTANTS: _____

PATIENT IDENTIFICATION

PRE-OPERATIVE DIAGNOSIS: _____

POST-OPERATIVE DIAGNOSIS: _____

OPERATIVE PROCEDURE PERFORMED: _____

ANESTHESIOLOGIST: _____

| | | | |
|--------------|--|-----------------------|--|
| CRNA / A.A.: | <input type="checkbox"/> GENERAL <input type="checkbox"/> LMA <input type="checkbox"/> ENDOTRACHEAL <input type="checkbox"/> BLOCKS <input type="checkbox"/> SPINAL <input type="checkbox"/> EPIDURAL <input type="checkbox"/> IV SED <input type="checkbox"/> O ₂ | Anesthesia Machine #: | |
|--------------|--|-----------------------|--|

CASE CLASSIFICATION:

CLEAN CLEAN CONTAMINATED CONTAMINATED INFECTED
 TYPE: SCHEDULED ADD-ON CODE BLUE EMERGENCY

| | | |
|---------|-----|-----|
| COUNTS: | 1ST | 2ND |
|---------|-----|-----|

SPONGE: _____

NEEDLE: _____

INSTRUMENT: _____

1st COUNT SIGNATURE: _____

2nd COUNT SIGNATURE: _____

MEDS ADMINISTERED BY NON-ANESTHESIOLOGIST:

| TIME | MEDS | AMOUNT | ROUTE |
|------|------|--------|-------|
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COMMENTS: _____

CULTURE: YES NO SITE: _____

| | | |
|---|-------------|---------------|
| Antibiotics Given: | Time Given: | MD Signature: |
| <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A | _____ | _____ |

SPECIMEN: YES NO SITE: _____

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|--|--|
| ASSESSMENT | PATIENT IDENTIFICATION: <input type="checkbox"/> ID BAND <input type="checkbox"/> VERBAL |
| | ALLERGIES: <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | NPO: <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | OPERATIVE CONSENT: <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | CHART REVIEW / Pre-Op TESTING AVAILABLE: |
| | H & P: <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | TIME OUT: <input type="checkbox"/> YES |
| | VERIFICATION OPERATIVE CHECKLIST: <input type="checkbox"/> YES |
| | COMMENT: _____ |
| | LEVEL OF CONSCIOUSNESS: |
| <input type="checkbox"/> ALERT <input type="checkbox"/> ORIENTED <input type="checkbox"/> ORIENTED / SEDATED <input type="checkbox"/> LETHARGIC <input type="checkbox"/> CONFUSED <input type="checkbox"/> NON-RESPONSIVE | |

FROZEN SECTION: YES NO SITE: _____

TIME: _____ ADMITTED TO O.R.: _____ INCISION TIME: _____

DELAY CODE: _____

DISCHARGE: _____

TRANSFERRED TO: PACU ICU NURSING UNITS AMBULATORY

SCRUB NURSE: _____

RELIEF / TIME: _____

CIRCULATING NURSE: _____

X-RAY: N/A OBSER- Students:

Portable C-ARM VERS: Reps:

RELIEF / TIME: _____

COMMENTS / LOCAL MONITORING:

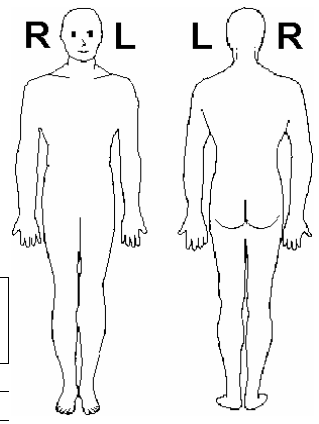
PROSTHESIS / IMPLANTS / GRAFTS

| LOCATION / TYPE | SIZE | LOT / SERIAL NO. | MANUFACTURER | NONE |
|-----------------|------|------------------|--------------|------|
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PART OF THE MEDICAL RECORD

OPERATING - ROOM INTRA-OPERATIVE NURSING RECORD

| POTENTIAL FOR INJURY | | | |
|---|--|---|--|
| POSITION: <input type="checkbox"/> SUPINE <input type="checkbox"/> PRONE <input type="checkbox"/> LATERAL <input type="checkbox"/> LITHOTOMY <input type="checkbox"/> OTHER (Specify) _____ | | | |
| POSITIONAL AIDE: <input type="checkbox"/> ARMS TUCKED <input type="checkbox"/> PILLOWS <input type="checkbox"/> BEAN BAG <input type="checkbox"/> LEG HOLDER <input type="checkbox"/> WILSON FRAME <input type="checkbox"/> JACKSON TABLE | | | |
| SAFETY STRAP ON? <input type="checkbox"/> YES <input type="checkbox"/> NO L. ARM: Straps - Board less than 90 degrees <input type="checkbox"/> STIRRUPS <input type="checkbox"/> KIDNEY REST R. ARM: Straps - Board less than 90 degrees <input type="checkbox"/> BEACH CHAIR <input type="checkbox"/> FRACTURE TABLE | | | |
| POSITIONED BY: <input type="checkbox"/> ARMS OUT <input type="checkbox"/> AXILLARY | | | |
| POTENTIAL FOR INFECTION | | | |
| ESU: <input type="checkbox"/> YES <input type="checkbox"/> NO MACHINE #: _____ PAD LOT #: _____ SETTINGS: _____ CUT: _____ COAG: _____ | | SKIN CONDITION: * IDENTIFY ON DIAGRAM: 1 <input type="checkbox"/> INTACT 2 <input type="checkbox"/> RASHES 3 <input type="checkbox"/> LACERATIONS 4 <input type="checkbox"/> REDDENED AREAS 5 <input type="checkbox"/> BRUISES 6 <input type="checkbox"/> DECUBITIS 7 <input type="checkbox"/> ABRASIONS | |
| RETURN ELECTRODE LOCATION: APPLIED BY: _____ Post-Op Skin Condition under Pad: _____ | | | |
| BIPOLAR: <input type="checkbox"/> YES <input type="checkbox"/> NO MACHINE #: _____ SETTINGS: _____ | | TED HOSE: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Thigh ___ Right ___ Left <input type="checkbox"/> Knee ___ Right ___ Left | |
| HYPOTHERMIA: <input type="checkbox"/> YES <input type="checkbox"/> NO MACHINE #: _____ SETTINGS: _____ | | SCD: <input type="checkbox"/> YES <input type="checkbox"/> NO MACHINE #: _____ | |
| TOURNIQUETS: #: _____ Time UP: _____ Time DOWN: _____ Setting: _____ | | CLIPPER: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A BY: _____ COMMENTS: _____ | |
| SKIN STATUS: Before PLACEMENT: _____ After: _____ SITE / LOCATION: _____ APPLIED BY: _____ | | | |
| POTENTIAL FOR FLUID IMBALANCE | | | |
| URINARY CATHETER: <input type="checkbox"/> ADMITTED TO O.R. WITH: FOLEY / TEXAS CATH: <input type="checkbox"/> YES <input type="checkbox"/> NO ML's IN DRAINAGE BAG: _____ FOLEY CATH #: _____ INSERTED BY: _____ URINE RETURNED: <input type="checkbox"/> CLEAR <input type="checkbox"/> CLOUDY <input type="checkbox"/> CLOTS <input type="checkbox"/> YELLOW <input type="checkbox"/> DARK AMBER <input type="checkbox"/> PINK <input type="checkbox"/> RED <input type="checkbox"/> OTHER | | | |
| INTAKE: PER ANESTHESIOLOGIST: _____ TOTAL BLOOD PRODUCTS: _____ TOTAL IV FLUIDS: _____ | | SURGICAL PREP SOLUTIONS: <input type="checkbox"/> DYNA-HEX <input type="checkbox"/> PROVIDONE - IODINE GEL <input type="checkbox"/> DURAPREP <input type="checkbox"/> PROVIDONE - SCRUB / SOLUTION | |
| OUTPUT: URINARY DRAINAGE: _____ ESTIMATED BLOOD LOSS: _____ OTHER: _____ | | DRAINS / PACKING: _____ LOCATION: _____ DRESSINGS: _____ | |



STANDARD INTRA-OPERATIVE CARE PLAN

| PATIENT PROBLEM/NURSING DIAGNOSIS (ASSESSMENT) POTENTIAL FOR: | EXPECTED OUTCOMES (PLANNING) | NURSING ORDERS STANDARD OF CARE FOR: | DATE |
|--|---|--|------|
| Infection related to surgical procedure | Patient will be free of infection | Infection: Implemented ON | |
| Retention of A F.B. in the surgical wound | Patient will be free of any F.B. in surgical wound | F.B.'s: Implemented ON | |
| Impaired Tissue Integrity due to electro-surgery | Patient will be free of impaired skin integrity | Skin Integrity: Implemented ON | |
| Injury related to positioning | Patient will be free of any positioning related injury | Positioning: Implemented ON | |
| Anxiety related to surgery | Patient will be able to manage anxiety by discussing feelings | Anxiety: Implemented ON | |
| Adverse reaction to local anesthesia | Patient free of adverse reactions to local anesthesia | Monitoring all V.S. | |
| Alteration in tissue perfusion due to tourniquet | Adequate T.P. | T.P. Plan Management: Implemented ON | |
| Adverse reaction to lasers | Patient free of adverse reactions to lasers | Standard care for lasers | |
| Age specific needs: a. 5-11 yrs old d. >65 yrs old b. 12-18 yrs old c. 19-64 yrs old | Patient communication demonstrates a basic understanding of the Perioperative process | Standard of Care for Age Specific competency implemented | |

EVALUATION: PATIENT OUTCOMES WERE ACHIEVED WITHOUT DIFFICULTY: YES NO NO ADDITIONAL NEEDS IDENTIFIED FOR THIS PATIENT

| SPECIFIC PATIENT NEEDS (NURSING DIAGNOSIS) | EXPECTED OUTCOMES | NURSING ORDERS | |
|--|-------------------|----------------|-------------|
| | | | |
| | | RN: _____ | Date: _____ |

PART OF THE MEDICAL RECORD