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3-6-2020

Dictation Templates for Surgical Learning and Improved Operative Reporting

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Barnes, K Lauren. "Dictation Templates for Surgical Learning and Improved Operative Reporting." (2020). https://digitalrepository.unm.edu/hsc_qips/33

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INTRODUCTION

- Precise operative reporting is important to patient care, accuracy in billing, and trainee education
- Operative reports are primarily a method of conveying information, but are prone to inaccurate transcription, incomplete information, and delayed completion
- These factors hamper the quality of the medical record, billing, and teaching
- Prior studies have demonstrated that dictation templates decrease rates of inaccuracies, insufficient documentation, and delayed completion of reports

STUDY OBJECTIVE

- Determine common surgical procedures in Urogynecology
- Identify universal template and dictation phrases to improve understanding and readability
- Compile “Dictation Manual” for Urogynecology Division
- Distribute information to division and residents for use in dot-phrases

METHODS

- 12 month review of all Urogynecologic surgeries completed
- 23 common procedures identified
- Standardized blank template created
- Detailed dictation of each procedure completed
- Attending affirmation included to avoid deficiencies in billing
- An index of procedural add-ons created to add additional procedures as needed
- Dictation manual distributed to entire division and on-service resident physicians

RESULTS

SAMPLE DICTATION

8. Retropubic Midurethral Sling

DATE OF PROCEDURE: _

PREOPERATIVE DIAGNOSIS:
1. _ urinary incontinence

POSTOPERATIVE DIAGNOSIS:
1. _ urinary incontinence

PROCEDURE PERFORMED:
1. Exam under anesthesia
2. Retropubic midurethral sling placement
3. Cystoscopy

ATTENDING SURGEON:
_

ASSISTANTS:
_

OPERATIVE FINDINGS:
360-degree survey of the bladder was performed revealing no trocar in the bladder, mesh or injuries.

ANESTHESIA:
_

ESTIMATED BLOOD LOSS:
_ mL

URINE OUTPUT:
_ mL

INTRAVENOUS FLUIDS:
_ mL

TIMEOUT:
Timeout procedure was performed at the beginning of the operation, debriefed at the end of the operation and all present were in agreement.

COUNTS:
Sponge and needle counts were accurate

SPECIMENS:
None

IMPLANTS:
Boston Scientific Advantage Fit _ Caldera Desara Blue Lot # _

MEDICATIONS:
Ancef, _

COMPLICATIONS:
None

DRAINS/PACKING:
Foley catheter to gravity

INDICATIONS FOR PROCEDURE:
Patient is a _ year-old with _ urinary incontinence who has failed conservative management. Decision was made to proceed with mesh midurethral sling. Specific risks of mesh were discussed and included that the mesh is permanent, difficult to remove if needed and may cause pain, erode into the vagina or surrounding structures or cause recurrent UTIs. After our discussion, the patient agreed to proceed with surgery.

PROCEDURE IN DETAIL:
The patient was taken to the operating room and general anesthesia was induced without difficulty. She was prepped and draped in the usual sterile fashion in high dorsal lithotomy position in the Allen stirrups. Care was taken to ensure she was appropriately positioned and that her joints were not hyperflexed or overextended. Perioperative antibiotics were given and pneumatic compression boots were placed and activated. A surgical time-out was performed with the entire operative staff per protocol.

A Foley catheter was inserted and the bladder was drained. With the assistance of the Foley bulb, the urethrovesical junction was identified. Allis clamps were placed to frame the mid urethra. A dilute solution of vasopressin was injected between the 2 Allis clamps and along the vaginal fornices with a total of _ mL used. A scalpel was used to incise between these 2 Allis clamps. Metzenbaum scissors were then used to create tunnels separating the overlying vaginal epithelium from the underlying vesicovaginal septum. Tracing towards the retropubic space on both sides, taking care to not violate the epithelium. The exit sites for the trocars were marked suprapubically 2 cm lateral to the midline bilaterally behind the pubic bone. 10 mL of local anesthesia was then injected on each side. The bladder was confirmed to be drained. Starting on the patient's right side, the trocar was placed through the vaginal incision, aiming toward the ipsilateral shoulder, passed behind the pubic bone through the retropubic space and exited out the previously marked suprapubic incision. Then the left sided trocar was placed through the vaginal tunnel, passing behind the pubic bone aiming toward the ipsilateral shoulder.

The Foley catheter was removed and a 70 degree cystoscope was inserted. A careful 360-degree survey of the bladder was performed after distention, revealing no trocar in the bladder, mesh or injuries. Normal appearing bladder mucosa, urethra was noted and no trabeculations, cellulites, diverticula, stones or masses were appreciated. There was bilateral ureteral efflux. The cystoscope was removed, carefully checking the urethra. The Foley catheter was reinserted and the bladder was drained. A Heaney clamp was placed behind the mesh and the mesh was positioned, taking care to ensure that it was lying flat at the mid urethra in a tension-free fashion and removing the plastic sheaths. At this point the mesh sling was trimmed below the suprapubic incisions. These were closed with 4-0 Monocryl. The vaginal incision and mesh were inspected and noted to have good hemostasis. The vaginal incision was then reapproximated with 2-0 Vicryl in a continuous fashion. Excellent hemostasis was assured.

The patient returned to the dorsal supine position and awakened from general anesthesia. She tolerated the procedure well and was taken to the PACU in stable condition. Sponge, lap and needle counts were correct x2 and wandung was negative. The attending physician, Dr. _ was present and scrubbed for the entire procedure.

SUMMARY

- Errors in transcription and incomplete dictations commonly affect operative reports at UNM
- Standard, structured dictation templates can improve accuracy in reporting, billing and conveying knowledge to trainees
- Templates are easily copied into PowerChart and can be customized to a surgeon's usual practice
- The Urogynecology dictation manual is now available for use

CONCLUSION

- Standardization of universal components of operative reports may improve:
 - Compliance with billing
 - Accuracy of reporting
 - Provider efficiency
 - Time to completion of dictated reports
 - Trainee learning experience

REFERENCES

- Gillman LM, Vergis A, Park J, et al. Structured operative reporting: a randomized trial using dictation templates to improve operative reporting. *Am J Surg.* 2010;199(6):846-850
- Hoffer DN, Finelli A, Chow R, et al. Structured electronic operative reporting: comparison with dictation in kidney cancer surgery. *Int J Med Inform.* 2012;81(3):182-191
- Jennings JM, McNabb DC, Meservey AJ, et al. Use of a computerized arthroplasty registry to generate operative reports decreases transcription errors. *Int J Med Inform.* 2017;101:23-27
- Novitsky YW, Sing RF, Kercher KW, et al. Prospective, blinded evaluation of accuracy of operative reports dictated by surgical residents. *Am Surg.* 2005;71(8):627-631; discussion 631-632

ACKNOWLEDGEMENTS

I would like to thank Dr. Gena Dunivan, Dr. Peter Jeppson, Dr. Cara Ninivaggio, and Dr. Yuko Komesu for allowing me to use their excellent operative reports to form a basis for this dictation manual