Operating Room Downtime Form

HM2460

Date: ______________________ OR: ______________________ Room #: ______________________

Healthcare information may be disclosed to: Name: ______________________ Phone number: ______________________

Procedure(s): ____

____

Case Classification: ☐ Elective ☐ Emergent ☐ Urgent ☐ Partially Cosmetic ☐ Unplanned return to surgery – Same Day ☐ Planned return to surgery – Same Day

Wound Class: ☐ Clean ☐ Clean Contaminated ☐ Contaminated ☐ Dirty/Infected ☐ N/A

Case Cancelled: ☐ In Pre-Op ☐ In OR Pre-Anesthesia ☐ In OR Post-Anesthesia ☐ In OR Pre-Anesthesia, perfusion pump primed **Reason for Cancellation:** ____

Staff Name:	Role:	Time In:	Time Out:	Time In:	Time Out:
	Primary Surgeon				
	Resident/Fellow				
	Assistant/PA/LSA				
	Circulator				
	Scrub				
	Perfusionist				

Event	Time	Date
In Room		
Case Start		
Case Finish		
Out of Room		
Procedural Care Complete		

Delay Type	Delay Reason	Length	Comments

Anesthesia Time Out			
Patient identified:	☐ Yes ☐ N/A	Anticipation of difficult airway:	☐ Yes ☐ N/A
Procedure confirmed:	☐ Yes ☐ N/A	Special airway equipment:	☐ Yes ☐ N/A
Blood products available:	☐ Yes ☐ N/A	Normothermia maintenance:	☐ Yes ☐ N/A
Type of anesthesia:	☐ Yes ☐ N/A	SCD's applied and on:	☐ Yes ☐ N/A
Suction checked:	☐ Yes ☐ N/A	Special monitoring equipment addressed: ☐ Yes ☐ N/A	
Performed date/time:			
Surgeon:			
Anesthesia Staff:			
Staff:			
Other:			

HOUSTON Methodist® LEADING MEDICINE

Intraoperative Record

Form # HM2460 (10/2020) - Version 5
Surgery Dept

Pre-Procedure Time Out	
Patient identified: ☐ Yes ☐ N/A	Pre-procedure confirmed: ☐ Yes ☐ N/A
Procedure confirmed: ☐ Yes ☐ N/A	Performed date/time:
Surgeon:	
Anesthesia Staff:	
Staff:	
Other:	

Fire Risk Safety Assessment	
Procedure site:	☐ Above xiphoid ☐ Below xiphoid
Open oxygen source:	☐ Face mask ☐ Nasal cannula ☐ None
Ignition source:	☐ Cautery ☐ Fiberoptic light source ☐ Laser ☐ None
Prepping agent:	☐ Alcohol-based ☐ Other volatile chemical ☐ Non-volatile chemical ☐ None
Other contributors:	☐ Defibrillator ☐ Drills ☐ Saws ☐ Burrs ☐ None
Performed date/time:	
Surgeon:	
Anesthesia Staff:	
Staff:	
Other:	

Pre-Incision Time Out			
Acknowledge team members & roles:	☐ Yes ☐ N/A	Site confirmed and marking visible:	☐ Yes ☐ N/A
Patient confirmed:	☐ Yes ☐ N/A	Equipment and implants needs confirmed:	☐ Yes ☐ N/A
Procedure confirmed:	☐ Yes ☐ N/A	Anticipated length of procedure with post procedure plan/disposition confirmed:	☐ Yes ☐ N/A
Prep completed with allotted time lapse:	☐ Yes ☐ N/A	Anticipated blood loss, availability of blood:	☐ Yes ☐ N/A
Patient allergies:	☐ Yes ☐ N/A	Availability of images:	☐ Yes ☐ N/A
Antibiotics:	☐ Yes ☐ N/A	Patient and procedural safety precautions:	☐ Yes ☐ N/A
Beta-blockers:	☐ Yes ☐ N/A	All clear acknowledgement:	☐ Yes ☐ N/A
Performed date/time:			
Surgeon:			
Anesthesia Staff:			
Staff:			
Other:			

Debrief			
Name of procedure & wound class:	☐ Yes ☐ N/A	Physician responsible for post-op orders:	
Specimen verification:	☐ Yes ☐ N/A	Process or equipment problems to report:	☐ Yes ☐ N/A
Counts verification:	☐ Yes ☐ N/A	Specific concerns for recovery:	☐ Yes ☐ N/A
Performed date/time:			
Surgeon:			
Anesthesia Staff:			
Staff:			
Other:			

Patient Verification:

ID band applied? ☐ Yes ☐ No

Patient ID verified: ☐ Verbal ☐ Armband ☐ Patient unable to verbalize ☐ Peds- Parent ID ☐ Emergency ID band

Pre-op Verification:

H&P verified within 30 days? ☐ Yes ☐ No

H&P updated on day of surgery or within 24 hours for inpatients? ☐ Yes ☐ No

Consents Confirmed: ☐ Operative ☐ Informed ☐ Anesthesia ☐ Blood Products ☐ Photographs ☐ Observers ☐ Students ☐ Electroconvulsive Therapy ☐ Not applicable ☐ Other: ______________________

Pregnancy Test: ☐ Positive ☐ Negative ☐N/A

Antibiotic Ordered: ☐ Yes ☐ No ☐ N/A

Items Removed: ☐ Glasses/Contacts ☐ Piercings ☐ Dentures ☐ Hearing Aids ☐ N/A ☐ Other: ____________

Procedure Verification:

Correct patient? ☐ Yes ☐ No

Correct site? ☐ Yes ☐ No

Site marked? ☐ Yes ☐ No ☐ N/A

Special equipment or implants? ☐ Yes ☐ No ☐ N/A

Correct procedure? ☐ Yes ☐ No

Correct laterality? ☐ Yes ☐ No ☐ N/A

Correct position? ☐ Yes ☐ No

Chart Verification:

NPO: ☐ Yes ☐ No

Pre-op test results: ☐ In chart ☐ Not in chart

Type and screen? ☐ Yes ☐ No ☐ N/A Blood products available? ☐ Yes ☐ No ☐ N/A ☐ Refused

Allergies: ☐ Yes ______________________________ ☐ N/A

Patient Belongings at Bedside:

Patient belongings at bedside: ______________________________

Belongings sent to: ☐ Safe ☐ Family Member ☐ Stayed with patient during procedure

Has the patient completed an advance directive document such as a LIVING WILL (sometimes called DIRECTIVE TO PHYSICIANS), MEDICAL POWER OF ATTORNEY, or OUT OF HOSPITAL DNR order?

☐ Patient does not have an advanced directive ☐ Unable to determine ☐ Patient has a LIVING WILL or DIRECTIVE TO PHYSICIANS ☐ Patient has MEDICAL POWER OF ATTORNEY ☐ Patient has OUT OF HOSPITAL DNR document ☐ Patient has a PSYCHIATRIC ADVANCE DIRECTIVE

Counts: ☐ No counts needed ☐ RFID Confirmation #: ______________________

Count	Sponge Correct?	Needles/Sharps Correct?	Instruments Correct?	Counted by	Verified by	Time/ Date Performed
Initial	☐Yes ☐ No ☐ N/A	☐Yes ☐ No ☐ N/A	☐Yes ☐ No ☐ N/A			
Closing	☐Yes ☐ No ☐ D/C	☐Yes ☐ No ☐ D/C	☐Yes ☐ No ☐ D/C			
Final	☐Yes ☐ No ☐ D/C	☐Yes ☐ No ☐ D/C	☐Yes ☐ No ☐ D/C			
Safety	☐Yes ☐ No ☐ D/C	☐Yes ☐ No ☐ D/C	☐Yes ☐ No ☐ D/C			
Other	☐Yes ☐ No ☐ D/C	☐Yes ☐ No ☐ D/C	☐Yes ☐ No ☐ D/C			

Physician notified of incorrect count? ☐ Yes ☐ No Room searched? ☐ Yes ☐ No

X-ray taken? ☐ Yes ☐ No X-ray results? ☐ Positive ☐ Negative X-ray read by: ______________

Comments: ______________________________

Pre-Op Skin Condition:

Grounding: ☐ Warm, Dry, Intact ☐ Other: ____________________

Operative: ☐ Warm, Dry, Intact ☐ Other: ____________________

Overall: ☐ Warm, Dry, Intact ☐ Other: ____________________

Comments: ____________________

Site Prep:

Prep Site, laterality, and comments: ____________________

Hair removal: ☐ Clipped ☐ Clipped in Pre-op ☐ Depilatory ☐ Patient performed own hair removal ☐ None ☐ Other __

Scrub Solution: ____________________

Paint Solution: ____________________

Alcohol prep used? ☐ Yes ☐ No

Was skin prep dry before draping? ☐ Yes ☐ No

Time prep applied: __________ Time prep complete: ________ Time determined dry: ______________

Time drapes applied: ________

Positioning/Protective Devices:

Safety devices applied? ☐ Yes ☐ No Positioned by: ____________________

SCDs applied and turned on? ☐ Yes ☐ No ☐ Contraindicated

Position/Protective Devices: ____________________

OR LDAs:

Foley: ☐ Present on admission ☐ Inserted in OR

Placement date & time: ____________________

Reason for insertion: ☐ Urinary retention ☐ Bladder obstruction ☐ Patient immobile ☐ Physician Order ☐ Other: ____________________

Inserted/Placed by: ____________________

Catheter type: ☐ Coude ☐ Double-lumen ☐ Latex ☐ Non-latex ☐ Straight-tip ☐ Temperature probe ☐ Other: ____________________

Tube size (Fr): ______________ Catheter Balloon Size: ______________ Urine returned: ☐ Yes ☐ No

Removal date & time: ____________________

Removal reason: ☐ Drain/catheter damaged ☐ Removed by provider ☐ Drainage ☐ Occluded ☐ Per order ☐ Per protocol ☐ Per patient/family request ☐ Accidental ☐ Not present on admission ☐ Other ____________________

Drain/Tube: ☐ Present on admission ☐ Inserted in OR

Placement date & time: ____________________

Inserted/Placed by: ____________________

Tube Number: ______________ Orientation/Location: ____________________

Tube type: ☐ Pigtail ☐ Flat ☐ Round ☐ Other: ______________ Reservoir type: ☐ Accordion ☐ Bulb

Size (Fr): _____________ Drain reservoir size (mL): ________________

Chest Tube: ☐ Present on admission ☐ Inserted in OR

Placement date & time: ____________________

Inserted/Placed by: ____________________

Tube Number: __________ Orientation/Location: ____________________

Size (Fr): __________

Chest tube drainage system: ☐ Gravity/nonsuction water seal drainage ☐ Indwelling pleural catheter ☐ One-way valve system (Heimlich) ☐ Suction ☐ Other: __________

Tourniquet:

Applied by: __________ Tracking Number: __________ Padding applied? ☐ Yes ☐ No

Time inflated: __________ Time deflated: __________ Pulses present? ☐ Yes ☐ No

Site/laterality: ____________________

Equipment	Tracking Number	Comments (setting, location, Lot number, etc.)

Medication	Given by:	Dose:	Route:

Implant Name:	Lot Number:	Reference Number:	Serial Number:	Size:	Expiration:	Tissue? *If yes see below	Site/Laterality	In/Out/ Wasted
						☐ Yes ☐ No		
						☐ Yes ☐ No		
						☐ Yes ☐ No		
						☐ Yes ☐ No		
						☐ Yes ☐ No		
						☐ Yes ☐ No		

***Tissue Implants:** Package intact/temperature in range? ☐ Yes ☐ No

Received by: __________ Prepared by: __________

Preparation method: ☐ Reconstitution ☐ Rinsing ☐ Sterilization ☐ No reconstitution

Tissue type: ☐ Skin ☐ Bone ☐ Other __________

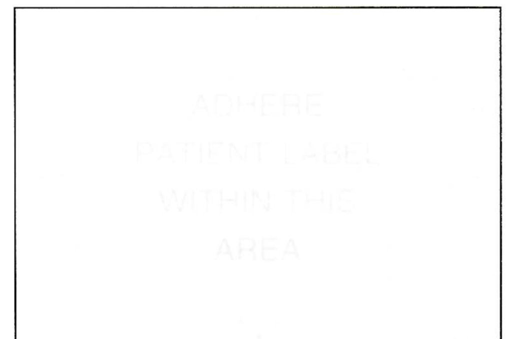
Preparation start: __________ Preparation end: __________

Solution: __________ Lot #: __________ Expiration date: __________

Comments: ____________________

____

____



Billable Supply:	Reference Number:	Lot Number:	Quantity Used:	Quantity Wasted:

Specimen Description:	Type of Specimen:	Test(s):	Time/Date Collected:

Site Completion:

Incision site completely closed? ☐ Yes ☐ No ☐ N/A

Dressing/Site/Laterality: ______________________________

____

____

Post-Op Skin Condition:

Grounding: ☐ Warm,Dry, Intact ☐ Other: ______________________________

Operative: ☐ Warm,Dry, Intact ☐ Other: ______________________________

Overall: ☐ Warm,Dry, Intact ☐ Other: ______________________________

Comments: ______________________________

Transport:

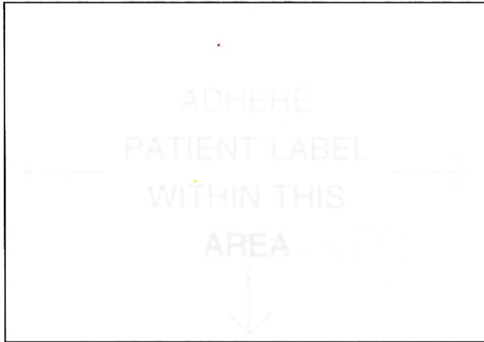
Transferred to: ☐ Nursing Unit ☐ ICU ☐ IMU ☐ PACU ☐ Home ☐ Other ______________________________

Comments: ______________________________

____

____

Hand Off Given By:	Hand Off Given To:	Date:	Time:



Specimen Attestation: All specimens collected, documented, verified with surgeon, and sent to appropriate location.

☐ Yes ☐ N/A

Print Name: ____________________ Signature: ____________________

Date/Time: ____________________

Chart Verification:

Print Name: ____________________ **Signature:** ____________________

Date/Time: ____________________

Nursing Notes

ADHERE PATIENT LABEL WITHIN THIS AREA

Nursing Notes

Print Name: ______________________ Signature: ______________________

Date/Time: ______________________

ADHERE PATIENT LABEL WITHIN THIS AREA

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