**Oral Surgery Assistant Responsibilities**

# **Chart Review**

* Chart review 2 business days before
* From chart review
  + History and exam reviewed for:
    - Chief complaint
    - History of present illness
    - Past medical history
    - Past surgical history
    - Current medications
    - Allergies
    - Alcohol, drug, tobacco use
    - Oral evaluation
    - Radiographic information
    - Diagnosis
    - Counseling note
    - Orders (listed as plan in EMR)
  + Imaging
  + Financial agreement
  + Referral
  + Consent in coordination with plan
  + Prosthesis
  + Supplies/equipment/instrumentation/materials
  + Implants
  + For X Nav case, verification through Team Viewer and Digital Specialist for case planning being complete
* If anything is missing, send to:
  + Front office
    - Financial agreement
    - Missing intake interview items from H&E
    - Consent
  + Doctor
    - No orders
    - Discrepancy between orders and referral
  + Digital Specialist
    - Incomplete plan in DTX

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# **START OF SURGICAL DAY**

## **Before Surgery:**

**Assistants** (as assigned by Tx column or Op)-Before day starts, or night before

* Room prep
* Tray prep

**Lead Assistant or RN**

* Approve room/tray prep
* Med draws

**Huddle**

* Clarification of assistant assignment to surgery

**Patient Arrival**

* Awareness of patient arrival (Instant message, headset/verbal communication, signaling system)
* Assistant go to Operating Room (OR), start board, mark light
* Get Patient from front office
* Take patient to the OR

## **During Surgery:**

**In Operating Room**

* Start time out
  + Start op report
  + Mark the white board
  + Verify surgery description
  + NPO status
  + Verify undress level and on-person items (jewelry and piercings and contact lenses)
* Hook the patient up to the monitors
* Obtain pre op vitals and enter into EMR
* Start IV
* Person running the table:
  + Raise table
  + Start oxygen
  + Tape IV tubing
  + GO GET (DON’T CALL) the doctor
* On OP report
  + In room time
  + Start IV time
  + Start anesthesia time
  + Start procedure
  + Throat pack in
  + Enter medications as administered
  + Enter vitals as they are taken
* As procedure ends:
  + Throat pack out
  + End procedure
  + Stop anesthesia
  + Transfer information from op report to anesthesia record
* Bed from recovery brought to OR
* Patient unhooked from monitors
* Patient transferred to PACU bed

## **After Surgery:**

* Flip room:
  + Dispose of sharps
  + Clear instruments off table and bring to sterilization
  + Wipe down and sterilize the room
* Patient is in recovery
* Discharge charting (pre-built phrases in op report are clicked into the op report)
* Note PACU charting in two places:
  + In the operative data section, note patient’s vitals in PACU, pain level at entry and discharge, PACU score, site of IV, assessing IV site, patient on room air or needs oxygen and oxygen saturation
  + In discharge data section, note six pre-built phrase choices to describe patient status
* When patient is ready for discharge, change oral dressings and discontinue IV
* Retrieve patient take-home bag
* Once patient discharged, strip and clean bed
* Clean monitors
* Bed remade

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# **PERSON OF THE DAY**

In order to effectively manage the back-office flow process, it is important to have a “**PERSON OF THE DAY**” who can ensure the following:

* Chart review two days ahead of time
* Run the day’s huddle
* Get all prescriptions entered and signed by the doctor
* Monitor patient flow for running on time per the schedule
* Arrive early if needed
* Stay late if needed
* Work through lunch if needed
* Cope with needed lunches or breaks (ensure coverage)