

AI-01946 OR RN Jumpstart Onboarding

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I'm a new employee at St Mary's General Hospital as an RN staff in the OR. I'm an RN from the Philippines, 32f and has OR experience but I'm new to the USA system. List 22 things I need to know to jumpstart my adaptation to my new job.

Got it — you're a 32-year-old Filipina RN with OR experience, starting at St. Mary's General Hospital in NJ.

Since you already know the OR's clinical side, I'll focus on bridging your **Philippines experience** with the **U.S. hospital system** — especially policies, communication, workflow, and cultural norms — so you can adapt faster and feel confident sooner.

22 Key Things to Jumpstart Your Adaptation as a New OR RN in the USA

1. OR Workflow & Roles in U.S. Settings

- Understand the **scrub nurse vs. circulating nurse** roles — in many U.S. hospitals, RNs usually circulate while surgical techs scrub.

2. Chain of Command

- Know who to escalate to: Charge Nurse → OR Nurse Manager → Department Director → House Supervisor.
- Direct surgeon confrontation is rare; follow escalation protocols.

3. Time-Out Procedure

- **Joint Commission** requires a formal pause before every case to confirm patient identity, procedure, site, and equipment.

4. Surgical Counts

- **Initial, closing, and final counts** for sponges, sharps, and instruments are strictly documented; two-person verification is mandatory.

5. EMR System

- Master the hospital's **Electronic Medical Record** (Epic, Cerner, Meditech, etc.) — including pre-op checklist, intra-op charting, and post-op notes.

6. Sterile Field Rules

- Expect zero-tolerance for breaks in sterility — even minor contamination means replacing the field.

7. U.S. Documentation Standards

- Chart **real-time**; late entries must be marked as such.
- Document facts only — avoid assumptions.

8. HIPAA

- Never share patient details outside the care team — even in hallways or elevators.

9. OR Scheduling System

- Learn block times, add-on case process, and emergency case prioritization.

10. Equipment & Instrument Familiarity

- Get hands-on with **autoclaves, cautery units, suction systems, surgical tables**, and positioning devices used in the hospital.

11. Medication Handling

- In the U.S., circulating nurses often handle **controlled substances** with witness verification.

- Anesthesiologists control anesthesia drugs, but nurses must document transfers.

12. Infection Control Protocols

- Strict compliance with **AORN standards**: PPE, surgical masks, hand scrubs, and traffic flow rules.

13. Patient Interaction Expectations

- Pre-op: Confirm consents, allergies, site marking, and history.
- U.S. patients may ask more questions — practice short, clear explanations.

14. Cultural Sensitivity

- Patients and staff may have diverse cultural backgrounds — use inclusive language and avoid assumptions.

15. Break & Lunch Protocols

- Breaks are **scheduled and covered**; don't leave the OR unless relieved.

16. Case Turnover Expectations

- Learn the hospital's benchmark time for cleaning, restocking, and setting up between cases.

17. Emergency Codes

- Code Blue (cardiac arrest), Code Red (fire), Code Yellow (disaster), Code Pink (infant abduction), etc. — know your response role.

18. Blood Product Handling

- U.S. transfusion protocols require **two RN verification** before administration.

19. Union or Non-Union Rules

- Some NJ hospitals have nursing unions — know your rights, benefits, and grievance process.

20. Interprofessional Communication

- Use **SBAR** (Situation, Background, Assessment, Recommendation) for surgeon and anesthesia communication.

21. Mandatory Training

- Expect annual competencies: fire safety, infection control, CPR, and possibly ACLS if required.

22. Self-Care & Resilience

- U.S. OR nursing can be intense — build stamina, learn ergonomic positioning, and practice mental decompression after cases.

If you want, I can make you a **“First 90 Days OR RN Survival Plan”** so you can turn these 22 points into a step-by-step adaptation checklist that fits your actual St. Mary’s General Hospital workflow. That would help you move from “just adapting” to “thriving” much faster.

Alright — here’s your **First 90 Days OR RN Survival Plan** tailored for you as a new Filipina OR nurse in the U.S., with your background in mind.

It’s designed so that **each phase builds on the last** — by the end of 3 months, you’ll not only adapt but feel confident and respected in the team.

First 90 Days OR RN Survival Plan – St. Mary’s General Hospital

Phase 1: Days 1–30 — Observation & Learning

Goal: Build foundation, learn the U.S. OR workflow, and establish trust.

1. Shadow & Observe

- Follow experienced RNs for both circulating and (if allowed) scrubbing roles.
- Focus on *flow of cases*, surgeon preferences, and team communication.

2. Learn the EMR

- Schedule 1-on-1 with the superuser/educator for charting in pre-op, intra-op, and post-op.

3. Memorize Emergency Codes

- Code Blue, Red, Yellow, Pink — and your assigned role for each.

4. Master Time-Out & Counts

- Watch the exact words and sequence used by experienced staff.
- Practice verbalizing out loud confidently.

5. Study Hospital Policies

- HIPAA, infection control, sharps safety, medication handling, blood products.

6. Meet Key People

- Charge nurse, nurse manager, anesthesia team, surgical techs, sterile processing staff.

7. Learn Equipment

- Get orientation for cautery units, suction, surgical tables, positioning devices, and autoclaves.

8. Cultural Awareness

- Notice how U.S. patients ask questions and how staff answer — adapt to concise, plain-English explanations.

Phase 2: Days 31–60 — Practice & Contribution

Goal: Start circulating cases independently with supervision.

1. Circulate Simple Cases

- Begin with low-complexity procedures (e.g., hernia repair, cataract, minor ortho).

2. Refine Turnover Speed

- Learn cleaning/restocking flow to meet hospital benchmarks.
- 3. Engage in SBAR Communication**
 - Use SBAR to speak with anesthesia and surgeons — builds credibility.
 - 4. Assist in Emergency Cases**
 - Join rapid turnovers or urgent add-ons to see high-pressure workflow.
 - 5. Know Surgeon Preferences**
 - Keep a small notebook of each surgeon's quirks, preferred instruments, and pet peeves.
 - 6. Blood & Med Handling**
 - Practice proper double-verification for blood products and controlled substances.
 - 7. Seek Feedback**
 - Ask your preceptor/charge nurse weekly: "One thing I can improve?"
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Phase 3: Days 61–90 — Independence & Integration

Goal: Function as a competent, trusted OR RN in the U.S. system.

- 1. Independently Circulate**
 - Manage medium to complex cases without direct supervision.
- 2. Handle Documentation Alone**
 - Chart efficiently and accurately in real time.
- 3. Train in Specialized Areas**
 - If available, rotate through CVOR, neuro, ortho, or robotics to broaden skills.
- 4. Emergency Role Competence**
 - Be ready for rapid OR prep for trauma or stat C-section.
- 5. Build Relationships**

- Develop trust with anesthesia, surgeons, and techs — teamwork improves efficiency.

6. Contribute to Problem-Solving

- Suggest small workflow improvements once you understand the system.

7. Plan for Year 1

- Discuss with your manager about cross-training, certifications (CNOR), or leadership opportunities.

Success Tips for All Phases

- **Be humble but proactive** — ask when unsure, but volunteer when confident.
- **Document everything** — U.S. system values clear, factual, time-stamped notes.
- **Learn from surgical techs** — in the U.S., they're highly skilled and can be a great resource.
- **Pace yourself** — OR nursing is physically and mentally taxing; maintain hydration, good shoes, and mental breaks.

If you like, I can also make you a **pocket-sized laminated "U.S. OR Cheat Sheet"** with **codes, time-out script, SBAR template, count sequence, and med verification steps** so you can carry it in your scrub pocket in your first weeks.

That way you'll never be caught off-guard even in your early shifts.

Perfect — here's your **Pocket-Sized OR RN Cheat Sheet** you can print small, laminate, and keep in your scrub pocket.

I've kept it **short, direct, and U.S.-specific** so you can glance at it mid-shift without drawing attention.

POCKET OR RN CHEAT SHEET – U.S. SYSTEM (St. Mary's General Hospital)

1. Emergency Codes

- **Code Blue** – Cardiac Arrest / Medical Emergency
 - **Code Red** – Fire
 - **Code Pink** – Infant Abduction
 - **Code Yellow** – Disaster (Internal/External)
 - **Code Gray** – Security / Aggressive Person
 - **Code Silver** – Active Shooter
 - **Code Orange** – Hazardous Spill
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2. Surgical Time-Out (Joint Commission)

Say out loud before incision:

1. **Patient Name & DOB**
 2. **Procedure**
 3. **Site / Laterality** (mark visible)
 4. **Allergies**
 5. **Antibiotics given?**
 6. **Imaging available?**
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3. Surgical Counts

- **When?**
 1. Before incision
 2. At cavity closure
 3. Skin closure/end of case
 - **Items:** Sponges, sharps, instruments
 - **Rule:** Two-person verification (RN + scrub)
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4. SBAR Communication

S – Situation: Why you're calling/reporting

B – Background: Relevant history, allergies, labs

A – Assessment: What’s happening now

R – Recommendation: What you need

Example:

“S: Dr. Smith, patient’s BP is dropping.

B: Healthy 45 y/o, in laparoscopic chole, no history of hypotension.

A: BP now 70/40, HR 120.

R: Request immediate evaluation.”

5. HIPAA Quick Reminders

- Discuss patient info **only** with those involved in care.
 - No sharing in halls, elevators, or social media.
 - Dispose of papers in **confidential bin**.
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6. Blood Product Verification

- **Two RNs** must verify:
 1. Patient name/DOB
 2. MRN
 3. Blood type & unit #
 4. Expiration date
 - **Sign in EMR before starting transfusion**
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7. Infection Control

- Surgical mask: **Before entering OR**
 - No jewelry/watches above elbows
 - Hand scrub: Fingertips to elbows, 2–5 min
 - Sterile field: **If in doubt, throw it out**
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8. Turnover Benchmarks

- Remove trash/linen
 - Clean & disinfect surfaces
 - Restock supplies
 - Set up for next case
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9. Quick Equipment Reminders

- **Bovie:** Check pad placement before activation
 - **Suction:** Test prior to incision
 - **Positioning:** Confirm pressure points padded
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10. U.S. OR Culture Tips

- Be early for case setup
 - Call people by title + last name (Dr. Smith) until told otherwise
 - Speak up for patient safety — *you're protected by law*
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If you want, I can make this into a **print-ready PDF** that's already formatted for **wallet size** so you can print, cut, and laminate — like a nurse's "survival card" for your first weeks.

It would fit perfectly in your scrub top pocket without folding.

Expand on pre-op checklist, intra-op charting, and post-op notes. Tell more about

Got it — I'll expand on **pre-op checklist, intra-op charting, and post-op notes** in the context of U.S. OR nursing, especially for someone with your Philippines OR background moving into St. Mary's General Hospital's system.

Think of these as **your three main charting pillars** for each case — if you're solid in all three, you'll meet both clinical and legal documentation standards.

1. Pre-Op Checklist (Before Patient Enters OR)

Purpose: Ensure patient safety, readiness for surgery, and compliance with hospital and regulatory requirements.

Where: In the EMR under *Pre-Operative* section (often dropdown fields + narrative notes).

Core Items to Document

1. Patient Identification

- Full name, date of birth, medical record number (MRN) — verified against ID band and verbal confirmation.

2. Procedure Verification

- Exact name of procedure as per consent — match with OR schedule and surgeon's order.

3. Consent Form

- Signed, dated, witnessed, correct procedure, and surgeon's name.

4. Allergies

- Drug, latex, food, iodine — include reaction type (rash, anaphylaxis, etc.).

5. Site Marking

- Done by surgeon, visible after skin prep, initialed if required by policy.

6. NPO Status

- Last oral intake of food and fluids documented.

7. Pre-Op Medications

- Antibiotics, sedatives, anticoagulant status, insulin, etc.

8. Baseline Vitals

- BP, HR, SpO₂, temp, pain score.

9. IV Access

- Size, location, patency, fluids infusing.

10. Special Equipment Needs

- Implants, scopes, surgical robots, positioning devices ready.

11. Personal Items

- Jewelry removed, dentures/contacts stored, prosthetics documented.

12. Pre-Op Labs/Imaging

- Available in EMR and reviewed.
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2. Intra-Op Charting (During Surgery)

Purpose: Create a real-time legal and clinical record of events, safety measures, and patient status in the OR.

Where: Intraoperative record in EMR — continuous updates.

Key Sections

1. Case Start Time & Team

- Record surgeon, anesthesia provider, scrub tech, circulator(s).

2. Patient Positioning

- Position type, padding used, safety straps applied, pressure points checked.

3. Skin Prep

- Solution used, site prepped, prep time, no pooling.

4. Counts

- Initial, closing, and final counts — with name of scrub verifying.

5. Time-Out

- Start and completion time, all members present, checklist items confirmed.

6. Implants

- Lot numbers, serial numbers, manufacturer, size.

7. Medications

- Dose, route, time given, by whom — especially irrigation meds, local anesthesia, contrast agents.

8. Specimens

- Label type (frozen, permanent), description, sent to pathology.

9. Safety Devices

- Bovie pad location, sequential compression devices, warming blankets.

10. Vitals

- Documented at intervals or per anesthesia record interface.

11. Events

- Complications, delays, changes in plan, critical communications.

12. Case End Time

- Time dressing applied, drapes removed, patient transferred to PACU.

3. Post-Op Notes (After Patient Leaves OR)

Purpose: Provide a handoff-ready summary for PACU staff and complete the OR's legal record.

Where: Postoperative or "Nurse's Notes" section in EMR.

Essential Elements

1. Patient Transfer

- Mode (bed, stretcher), accompanied by, to PACU or ICU.

2. Condition at Transfer

- Awake/drowsy, airway status, pain level, vital signs.

3. Dressings & Drains

- Location, type, drainage color/amount.

4. Lines & Tubes

- IV access status, Foley catheter output, drains secured.

5. Specimens

- Confirm all specimens sent and documented.

6. Implants

- Verification of documentation in intra-op record.

7. Blood Products

- If given, confirm documentation and any reaction notes.

8. Equipment Returned

- Loaner trays, special instruments accounted for.

9. Family Updates

- Whether surgeon spoke to family (note time if applicable).

10. Handoff to PACU Nurse

- Use SBAR format for report, note in EMR that handoff given.

U.S. Difference You'll Notice vs. Philippines

- Documentation is **much more detailed** and EMR-driven — you'll spend more time typing during cases.
- Regulatory compliance (Joint Commission, AORN) is built into the charting — missing even a small checkbox can flag your record.
- Times are **exact to the minute** — most systems track time stamps automatically when you save.

If you want, I can make you a **flowchart-style "OR RN Documentation Map"** that visually shows **what to do and chart** in the **Pre-Op → Intra-Op → Post-Op** sequence so you can follow it in real time without second-guessing. That would fit right next to your pocket cheat sheet.

Explain more the US OR clinical side.

Alright — let's deep dive into the **U.S. OR clinical side** so you can blend your Philippines OR skills with the U.S. style of perioperative nursing.

I'll break this down into **roles, standards, workflow, expectations, and clinical nuances** that make the U.S. operating room system different from what you may be used to.

1. Perioperative Nursing Roles in the U.S.

In most U.S. hospitals, RNs focus on **circulating** and occasionally assisting, while **scrubbing** is often done by surgical technologists (certified STs).

However, RNs are legally accountable for **the patient's overall care** while in the OR.

Circulating Nurse (RN)

- Maintains a **sterile, safe environment**.
- Coordinates with anesthesia, surgeons, and scrub techs.
- Documents everything in real time.
- Anticipates needs — retrieves extra instruments, meds, or equipment.
- Protects patient privacy and advocates for their safety.

Scrub Role

- Primarily surgical technologists.
 - RN may scrub in smaller hospitals or specialized teams.
 - Handles instruments, maintains sterile field, anticipates surgeon needs.
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2. U.S. OR Standards You'll Follow

Most policies are influenced by:

- **AORN** (Association of periOperative Registered Nurses)
- **The Joint Commission** (TJC)
- **Centers for Medicare & Medicaid Services (CMS)**
- **OSHA** (Occupational Safety and Health Administration)

Core Principles:

- **Sterility is absolute** — even borderline contamination means starting over.
 - **Time-out** is non-negotiable.
 - **Counts** are done *and documented* every time without shortcuts.
 - **Patient identification** is a two-identifier process.
 - **HIPAA** — no patient talk outside the OR.
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3. Typical U.S. OR Case Workflow

A. Pre-Case Prep

- Review EMR for allergies, labs, imaging.
- Gather case cart and additional instruments.
- Check all equipment (Bovie, suction, lights).
- Verify implants and supplies.

B. Patient Arrival

- Receive patient from pre-op nurse.
- Verify ID, consent, site marking, allergies.
- Position patient with padding and safety straps.
- Apply monitoring equipment (by anesthesia).

C. Surgical Time-Out

- Entire team pauses — confirm patient, procedure, site, allergies, antibiotics.

D. Intra-Operative

- Maintain sterile field integrity.
- Anticipate surgeon and anesthesia needs.
- Handle specimens correctly (label, log, send to pathology).
- Document everything in EMR in real time.

E. Closing Phase

- Perform counts — sponges, sharps, instruments — and document.
- Assist with dressings, drains, and securing lines/tubes.
- Prep patient for transfer to PACU.

F. Patient Transfer

- Move patient safely, give SBAR handoff to PACU RN.
 - Ensure charting is complete before leaving the case.
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4. Clinical Nuances in U.S. OR Nursing

- **Communication is assertive but respectful** — everyone is expected to speak up if they notice a safety concern, even to the surgeon.
 - **Surgeon preference cards** — each surgeon's instruments and setup are standardized and stored in the EMR or supply system.
 - **Specialty Teams** — larger hospitals have dedicated neuro, ortho, CVOR, trauma teams. You may rotate or specialize.
 - **Implant Tracking** — FDA requires detailed recording of lot numbers, serial numbers, and manufacturer.
 - **Specimen Chain of Custody** — mislabeling can trigger a major incident report; double-check labels with the scrub.
 - **PPE Compliance** — masks are worn at all times in the OR; eye protection is common policy.
 - **Pressure Injury Prevention** — positioning and padding are heavily emphasized due to legal risks.
 - **Equipment Checks** — defibrillators, cautery, and suction are tested before each case — not just assumed functional.
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5. Differences You'll Notice Compared to the Philippines

Philippines OR	U.S. OR
RNs often scrub & circulate interchangeably	RNs mostly circulate, scrub techs handle sterile side
More paper charting	EMR charting with built-in checklists
Surgeon authority is rarely questioned	Nurses are empowered (and expected) to challenge for patient safety
Less emphasis on implant tracking	Strict implant and specimen traceability
Count procedures vary by facility	Standardized, mandatory counts every case
Family updates sometimes by nurse	Usually surgeon's responsibility

 **Pro Tip for You:**

In the U.S., **your main value as an OR RN** is *patient advocacy + system coordination*. The scrub tech handles instruments, the surgeon operates, anesthesia manages sedation — but **you are the safety net** who ensures no detail is missed.

If you want, I can make you a **"U.S. OR Clinical Playbook"** — a condensed, one-page reference that combines this workflow, standards, and safety checks into a quick visual you can keep in your locker or use during orientation. That way, you'll have both your **pocket cheat sheet** for immediate reminders and a **playbook** for the big picture.

Tell more on US documentation at my workplace as an OR RN.

Got it — let's zoom in on **U.S. OR documentation**, specifically what you'll likely handle at St. Mary's General Hospital as an **OR RN**.

The documentation style in the U.S. is very **structured, legal-focused, and EMR-based**, and it follows the "if it's not documented, it didn't happen" rule.

1. Documentation Systems in U.S. ORs

- **EMR Charting:** Most U.S. hospitals use systems like **Epic, Cerner, Meditech, or SurgiNet**.

You'll document directly into a perioperative module — no loose paper except for rare downtime.

- **Real-Time Entry:** You are expected to chart during the case, not just after.
 - **Pre-Set Fields:** There are mandatory drop-downs, checkboxes, and free-text notes.
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2. Major Documentation Categories

You'll see three main sections:

A. Pre-Op Documentation

- **Patient identifiers** (two required: name, DOB, MRN).
 - **Consent verification** (correct procedure, site, surgeon).
 - **NPO status** confirmed.
 - **Allergies & reactions** documented.
 - **Baseline vitals.**
 - **Pre-op medications** given and their times.
 - **Site marking** confirmation.
 - **Skin integrity check** (existing bruises, rashes).
 - **Pregnancy test results** if applicable.
 - **Safety checklist completion** (per hospital policy).
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B. Intra-Op Documentation

- **Case start time & end time.**
- **All team members present** with times in/out.
- **Positioning details** — type of position, padding, safety straps, armboards.
- **Skin prep** — antiseptic used, prep area, performed by.
- **Counts** — initial, closing, final counts, who participated, all counts correct/incorrect.

- **Meds & solutions** given on the sterile field — name, dose, route, time.
- **Implants** — full details: type, size, lot #, serial #, manufacturer, expiration date.
- **Specimens** — type, source, labeling, destination (pathology, frozen section).
- **Time-out** — documented with all team members confirming.
- **Equipment** — electrosurgical unit (ESU) settings, tourniquet time, warming devices, laser use.
- **Adverse events or delays** — with detailed description.

C. Post-Op Documentation

- **Patient condition at closure** — stable, vital signs, skin status.
- **Dressings applied** — type, location, condition.
- **Drains/tubes placed** — type, size, location, securement method.
- **Counts final verification** — and whether all were correct.
- **Patient destination** — PACU, ICU, direct admit, morgue.
- **Handoff details** — SBAR format, names of receiving staff.
- **Family updates** — whether surgeon met family and any nurse interactions.

3. U.S. Documentation Style Differences You'll Notice

Philippines	U.S. OR
Often narrative or checklist on paper	Structured EMR with mandatory fields
May be filled after case	Real-time or near real-time entry
Surgeon name only sometimes recorded	Every team member's role/time in & out recorded
Counts may be brief in notes	Counts are explicitly detailed & timed
Implant details minimal	Full traceability for regulatory compliance

4. What Your Educators Will Watch For

- **Completeness** — every mandatory field filled.
 - **Accuracy** — no contradictions (e.g., time-out documented before patient entered).
 - **Timeliness** — not documenting hours later unless in downtime mode.
 - **Specificity** — “Left knee, lateral incision, 2-0 Vicryl” instead of “Sutures placed.”
 - **Legibility** in free-text fields — correct spelling, no slang.
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5. Quick Documentation Tips for You

- Learn **your hospital’s EMR shortcuts** early — keyboard tabs, templates, and smart phrases.
 - Keep **implant stickers** until after you’ve scanned or recorded them.
 - Always **double-check specimen labels** with the scrub before they leave the room.
 - For time-critical events (code, bleed), **chart basic facts in real time**, add narrative later.
 - If unsure — **ask how they want it documented** rather than guess.
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If you want, I can make you a **U.S. OR RN Documentation Guide for St. Mary’s** that breaks down *exact* EMR screen flows, common terms, and example charting entries so you can be fluent during your first solo cases.

This would be like a **“documentation language translator”** from your Philippine style to the U.S. OR style.

Give an OR documentation example start to finish

Alright — here’s a **full U.S.-style OR documentation example** from **pre-op → intra-op → post-op**, so you can see how it would look in practice at St. Mary’s in EMR format.

I’ll model it as if you’re charting in a perioperative EMR module like Epic or Cerner.

OR Documentation Example

Procedure: Laparoscopic Cholecystectomy

Date: 08/08/2025

Patient: Jane Doe, MRN 1234567, DOB 02/14/1978

Surgeon: Dr. John Smith

Anesthesiologist: Dr. Anna Lee

Primary RN: [Your Name]

Scrub Tech: Maria Perez

1. Pre-Op Documentation

Field	Entry
Patient Identifiers	Verified using full name and DOB against wristband and EMR.
Consent Verification	Consent signed for "Laparoscopic Cholecystectomy." Procedure, site, and surgeon verified.
Allergies	Penicillin – hives. Latex – rash.
NPO Status	NPO since 2300 on 08/07/2025.
Baseline Vitals	BP 126/78, HR 82, RR 16, Temp 36.8°C, SpO ₂ 98% RA.
Site Marking	RUQ marked by surgeon, initials visible.
Skin Integrity	Skin intact, no lesions noted on abdomen.
Pregnancy Test	Negative (urine, 08/08/2025 at 0705).
Pre-Op Medications	Cefazolin 2g IV given at 0720.
Safety Checklist	Pre-op checklist completed in EMR.

2. Intra-Op Documentation

Field	Entry
Patient In-Room Time	07:30
Anesthesia Start Time	07:35

Field	Entry
Patient Position	Supine with arms extended on padded armboards, safety strap applied, padding under heels, head in neutral alignment.
Skin Prep	Chlorhexidine gluconate 2% with alcohol, abdomen prepped, performed by scrub tech under sterile technique.
Counts – Initial	Sponges × 10, sharps × 10, instruments × baseline count, verified with scrub tech Maria Perez – correct.
Time-Out	07:38 – All team members present, patient ID, procedure, site, and allergies confirmed.
Incision Time	07:40
Medications on Field	Bupivacaine 0.25% 10 mL infiltrated into incision sites by surgeon at closure (08:10).
Implants	None used.
Specimens	Gallbladder – labeled with patient name, MRN, “Gallbladder,” sent to pathology at 08:15, verified by RN and scrub.
Counts – Closing	08:12 – Sponges, sharps, instruments correct × 2 count verifications.
Adverse Events	None.
Patient Out-of-Room Time	08:20
Anesthesia End Time	08:22

3. Post-Op Documentation

Field	Entry
Patient Condition	Awake, stable vitals, moving all extremities.
Dressings	3 × small occlusive dressings over port sites, clean/dry/intact.
Drains/Tubes	None placed.
Final Counts	Correct – verified with scrub tech.
Destination	Transferred to PACU via stretcher, side rails up, with anesthesia provider and RN escort.

Field	Entry
Handoff	SBAR given to PACU RN, Jane Miller – including procedure, anesthesia type, estimated blood loss, fluids given, pain score, dressings, and specimens sent.
Family Updates	Surgeon spoke to patient's spouse in family waiting area at 08:40.

✔ Key Notes on Style:

- **Time-stamping** is crucial — U.S. OR documentation is time-sensitive for legal and billing purposes.
- Always **name who verified counts** and who received the patient.
- Be specific — “occlusive dressing” is better than “dressing,” “supine with arms extended” is better than “supine.”
- Avoid vague terms like “okay” or “good condition” — describe facts (vitals stable, skin warm and dry).

If you want, I can turn this into a **filled-out EMR mock-up** that visually looks like the U.S. charting screens you'll see at St. Mary's. That way, you'll know exactly where and how to enter it in real life.

List top books about US RN OR Training Manual

If you're looking for top resources to support your growth as a U.S. OR RN, here are some highly recommended training manuals and textbooks that professionals commonly rely on:

Recommended OR RN Training Manuals & Textbooks

1. "Alexander's Care of the Patient in Surgery" (17th edition)

- Often hailed as the *"Bible of OR nursing"*, this comprehensive book is widely used for orientation and CNOR preparation.

“Alexander's Care of the Patient in Surgery is pretty much regarded as the Bible of OR nursing.” (Reddit)

- Covers detailed perioperative workflow, roles, aseptic technique, and patient care across the surgical continuum.

2. **"Berry & Kohn's Operating Room Technique" (14th edition)**

- A practical, easy-to-read manual, especially great for scrub and circulate roles—very popular for new OR nurses.

"Berry & Kohn's Operating Room Technique" is praised as "a good resource." (Reddit)

3. **"AORN Guidelines for Perioperative Practice"**

- The definitive evidence-based standards from the Association of PeriOperative Registered Nurses, often referred to as the OR nursing standard "Bible."

It's the AORN guidelines that are considered essential and updated regularly. (Reddit, Henry Ford Library Guides)

4. **"Fast Facts for the Operating Room Nurse" (3rd Edition) — Theresa Criscitelli, EdD, RN, CNOR**

- A concise, portable orientation guide with easily accessible, evidence-based information—great for quick referencing on the job. ([SpringerConnect](#))

5. **"Perioperative Nursing: Principles and Practice" — Susan S. Fairchild**

- A structured text covering pre-op, intra-op, and post-op responsibilities with a nursing-process focus. Supports learning foundational and advanced perioperative practice.

6. **Instrumentation & Prep References**

- **"Surgical Instrumentation: An Interactive Approach"** (4th edition) and **"Instrumentation for the Operating Room"** (9th edition) are valuable for mastering instrument names and tray assembly. (learninginstitute.nshealth.ca)

- Helpful additions, especially when learning surgeon preferences or prepping for procedures.

Peer Recommendations & Community Insight

- One OR nurse emphasized how **Alexander's** and **Pocket Guide to the OR** helped her anticipate instruments and understanding surgical flow. ([Reddit](#))
- Another user shared:

"The Holy Trinity: Alexander's Care of the Patient in Surgery, Berry & Kohn's Operating Room Technique, and AORN's Guidelines for Perioperative Practice." (Reddit)

Product Suggestion (for local training courses)

While not a book, this local course aims to build your OR foundation:

- **Principles in Nursing Operating Room and Aseptic Techniques** — structured as a formal course for OR nurse skills development. Priced at approximately ₱800.00.

Summary Table

Title	Why It's Useful
Alexander's Care of the Patient in Surgery	In-depth, OR-focused; ideal for thorough orientation
Berry & Kohn's Operating Room Technique	Practical and approachable guide for daily OR tasks
AORN Guidelines	Official standard-setting reference for perioperative care
Fast Facts for the OR Nurse	Compact, evidence-based quick reference
Perioperative Nursing: Principles & Practice	Theoretical foundation and detailed workflow insight
Instrumentation Texts	Critical for mastering instrument familiarity

Title	Why It's Useful
Local Training Course	Structured, skill-based learning tailored to Philippines

Let me know if you'd like help figuring out which book to tackle first, or if you want resources catered to CNOR prep or specialty OR areas like CVOR or robotics.

List common Epic Software Shortcuts or help

Here's a **quick-reference list** of common **Epic EMR shortcuts** and workflow tips that OR RNs in the U.S. often use.

Since Epic is highly customized per hospital, these may vary slightly at St. Mary's, but they're a solid starting point:

Epic Keyboard Shortcuts (Universal Defaults)

Shortcut	Function
F1	Help (opens Epic's in-app help for the current screen)
Ctrl + 1	Jump to Patient Lookup/Search
Ctrl + 2	Jump to In Basket
Ctrl + N	New Chart / New Note
Ctrl + Alt + C	Close all open charts
F2	Moves to the next field to fill out (in a form)
Ctrl + D	Open patient's Storyboard / Demographics
Ctrl + Shift + F	Opens the Patient List
Ctrl + Alt + S	Save (instead of clicking the Save button)
F9	Sign and Close Note (if all required fields are filled)
Shift + F9	Sign Only (keep chart open)
Alt + =	Jump to Orders tab
Alt + M	Jump to MAR (Medication Administration Record)
Ctrl + Alt + P	Print current screen or report

OR-Specific Epic Tips

1. Pre-Op Documentation

- **Use “Periop Navigator”** – opens the workflow from Pre-op Checklist → Intra-op Charting → Post-op.
- **Pre-op Safety Checklist** often has drop-downs for site/side verification, NPO status, allergies, consents, and skin prep confirmation.

2. Intra-Op Charting

- **Timers:** Epic has a “surgical timer” or “procedure log” for incision time, counts, specimen send-off, and closure.
- **Quick Texts (SmartPhrases):**
 - `.allergiesverified` — Inserts “Allergies reviewed and verified with patient/family.”
 - `.timeoutcompleted` — Inserts standardized surgical time-out documentation.
- **Flowsheets:** Many ORs use “Intraoperative Record” flowsheets to document position, counts, devices, irrigation, implants, and anesthesia info.

3. Post-Op Notes

- **SmartLinks** can pull patient data directly into your note:
 - `@NAME@` — patient name
 - `@AGE@` — patient age
 - `@ALLERGIES@` — allergies list
- Many hospitals have a **Post-Anesthesia Care Transfer Note** template — check if St. Mary’s has a locked format you must follow.

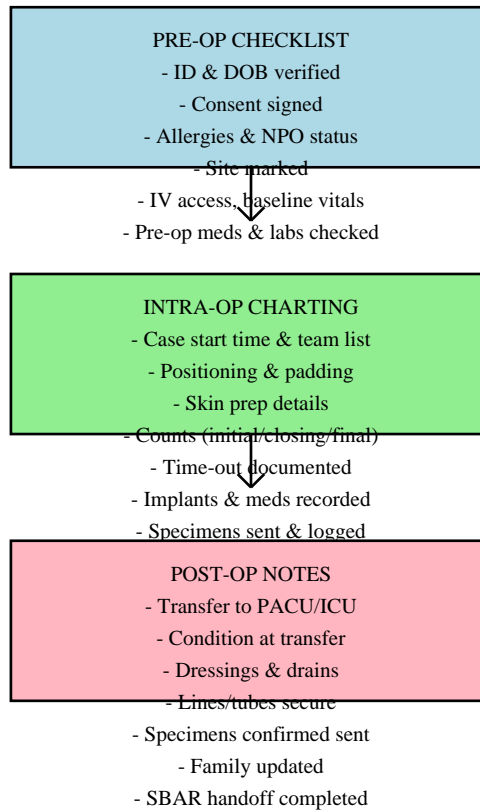
Pro Tips for Faster Epic Use

- **Favorites Toolbar** – pin most-used orders (e.g., antibiotic redose, warming blanket, specimen label).
- **Search with “dot commands”** – typing `.` in a note field can bring up SmartPhrases; type part of the word to filter.

- **Use “Recently Viewed”** – patient icon drop-down shows last accessed charts.
 - **Ctrl + Space** – auto-complete in data entry fields.
 - **In Basket Filters** – set up “OR Only” or “My Patients Today” filters to avoid overload.
-

If you want, I can **make a pocket-sized OR RN Epic Shortcuts card** that you can laminate and keep in your badge holder, so you have the key shortcuts + SmartPhrases with you in the OR. That way you won't have to rely on memory while adapting.

OR RN Documentation Map – Pre-Op → Intra-Op → Post-Op



OR RN Epic Shortcuts & SmartPhrases – Pocket Card

Shortcut	Function
F1	Epic Help
Ctrl + 1	Patient Lookup
Ctrl + 2	In Basket
Ctrl + N	New Chart/Note
Ctrl + Alt + C	Close All Charts
F2	Next Field in Form
Ctrl + D	Patient Storyboard
Ctrl + Shift + F	Patient List
Ctrl + Alt + S	Save
F9	Sign & Close Note
Shift + F9	Sign Only
Alt + =	Orders Tab
Alt + M	MAR (Med Admin Record)
Ctrl + Alt + P	Print Screen

Common SmartPhrases (dot commands)

.allergiesverified	Inserts: 'Allergies reviewed and verified with patient/family.'
.timeoutcompleted	Inserts standard surgical time-out text.
.preopchecklistdone	Confirms pre-op safety checklist completed.
.handofftopacu	Standard PACU transfer note format.

POCKET OR RN CHEAT SHEET – U.S. SYSTEM (St. Mary's Gen

1. EMERGENCY CODES:

Blue – Cardiac Arrest | Red – Fire | Pink – Infant Abduction

Yellow – Disaster | Gray – Security | Silver – Active Shooter | Orange – HazMat

2. SURGICAL TIME-OUT:

1. Name & DOB 2. Procedure 3. Site/Laterality 4. Allergies

5. Antibiotics given? 6. Imaging available?

3. SURGICAL COUNTS: Before incision, cavity closure, skin closure.

Items: Sponges, sharps, instruments. Two-person verification.

4. SBAR: Situation, Background, Assessment, Recommendation.

Example: S: BP drop, B: Healthy 45 y/o, A: BP 70/40 HR 120, R: Immediate eval.

5. HIPAA: Share info ONLY with care team, no halls/elevators/social media.

6. BLOOD PRODUCTS: 2 RN verify – Name/DOB, MRN, Blood type & unit #, Exp date

EMR-Style Reference Log – OR RN Training Manuals & Resources

Resource Name	Summary & Purpose	Notes/Status
Alexander's Care of the Patient in Surgery (17th ed.)	Comprehensive perioperative reference covering patient care, procedures, and aseptic technique.	Reproducible, fast reference.
Berry & Kohn's Operating Room Technical Manual	Practical manual on scrub and circulate duties, surgical set-up, and OR reference.	Good for daily reference; accessible.
AORN Guidelines for Perioperative Practice	Official evidence-based standards for all perioperative practice.	Manually used for policy.
Fast Facts for the Operating Room Nurse	Portable, concise guide for quick reference in the OR.	Keep in pocket or locker; ideal.
Perioperative Nursing: Principles and Practice	Structured text emphasizing the nursing process from pre-op to post-op.	Get your foundation.
Surgical Instrumentation: An Interactive Approach	Interactive guide for instruments, trays, and usage by specialty.	Use to improve instrument recognition.
Instrumentation for the Operating Room	Comprehensive reference for instrument names, purposes, and handling.	Helpful when learning surgeon.
Principles in Nursing OR & Aseptic Techniques	Formal foundational course to strengthen OR foundations & aseptic techniques.	Optional for refresher or new.

U.S. OR Clinical Playbook – RN Quick Reference

1. Perioperative Roles

Circulating RN	Coordinates patient care, maintains sterile field integrity, documents events, ensures safety comp
Scrub Role	Handled mainly by Surgical Technologists. RN may scrub in small teams.
Anesthesia Provider	Manages sedation, airway, pain control, and patient monitoring.
Surgeon	Performs procedure, directs operative plan, communicates with team.

2. Standard OR Case Workflow

- Pre-Case: Review EMR, gather supplies, check equipment.
- Patient Arrival: Verify ID, consent, allergies, site marking.
- Time-Out: All team members confirm patient, procedure, site.
- Intra-Op: Maintain sterility, anticipate needs, document events.
- Closing: Perform counts, secure dressings/drains, document.
- Transfer: Move patient safely, complete SBAR to PACU.

3. Key Standards

- Follow AORN guidelines for safety and sterility.
- Use two identifiers for patient verification.
- Perform surgical counts before, during, and after procedure.
- Document time-outs, positioning, meds, implants, specimens.
- Maintain HIPAA compliance at all times.
- Report and address any break in sterile technique immediately.

4. Safety Focus

Patient ID	Use full name & DOB, match ID band and chart.
Sterile Field	No breaches; re-prep if contamination suspected.
Positioning	Pad bony prominences, avoid nerve injury.
Counts	Sponges, sharps, instruments—always with a second person.
Specimens	Double-label with patient name, MRN, description.
Implants	Document lot, serial number, manufacturer.

U.S. OR RN Documentation Guide – St. Mary’s General Hospital

1. Pre-Op Documentation (Before Patient Enters OR)

Patient ID Verification	Use two identifiers (Name, DOB) and match to wristband & EMR.
Consent Verification	Confirm correct procedure, site, surgeon, and that consent is signed.
Allergies	List allergens and reactions, highlight in EMR.
NPO Status	Confirm last intake and chart per protocol.
Baseline Vitals	Record from pre-op or take on arrival.
Site Marking	Surgeon initials visible; verify before prep.
Skin Integrity	Note rashes, wounds, tattoos, scars.
Pregnancy Status	Document urine/blood test result if applicable.
Pre-op Medications	Chart antibiotic start time and any pre-meds given.
Safety Checklist	Complete hospital’s pre-op checklist in EMR.

2. Intra-Op Documentation (During Case)

Case Times	Record patient in-room, incision, closure, out-of-room times.
Team Members	List all names/roles; track in/out times.
Positioning	Note position type, arm/leg supports, padding.
Skin Prep	Document antiseptic, area prepped, person who performed.
Counts	Chart initial, additional, final counts & who participated.
Meds/Solutions	Document name, strength, route, time administered.
Implants	Type, size, lot #, serial #, manufacturer, expiration date.
Specimens	Description, source, labeling, destination, confirmation.
Time-Out	Chart completed with all team members present.
Equipment Use	Document ESU settings, tourniquet time, warming devices, laser use.
Events/Delays	Note complications, conversions, or unplanned events.

3. Post-Op Documentation (After Case)

Patient Condition	Stable/unstable; chart vitals and skin assessment.
Dressings	Type, size, location, condition (dry, intact, bloody).
Drains/Tubes	Type, size, location, securement method.

Final Counts	All correct or note discrepancies and resolution.
Destination	PACU, ICU, direct admit, or morgue; transport method.
Handoff	SBAR to receiving RN; name of person receiving.
Family Updates	Note if surgeon spoke to family; any nurse updates given.

4. Charting Tips for St. Mary's OR RNs

- Chart in real time whenever possible.
- Use hospital-approved abbreviations only.
- Save implant stickers until recorded in EMR.
- Double-check specimen labels with scrub before sending.
- If you document a delay or complication, include times and actions taken.
- Never leave mandatory EMR fields blank.
- For downtime, use paper chart then transcribe into EMR as soon as restored.