Adding a Patient and a Surgery

Now that you've set up your own file and read the chapters on Data Entry instructions and Customisation, you're ready to start entering your own patients. You will need to refer back to these chapters regularly until you have become familiar with all the functions.

THE PATIENT DEMOGRAPHICS SCREEN

After clicking on **Patients** from the **Home Screen**, you will be led directly into the **Patient Demographics Screen** of the first patient in your database.

> *It is important to understand that each patient only has one entry into the system, regardless of how many surgeries, and what kind of surgeries, they have.*

Mandatory demographic data

The minimum data the program needs on this screen is:

- First and last names
- Gender
- Date of birth
- Also, adding a unique ID is a good idea. This can be the hospital ID, national ID, whatever you want. Sometimes patients get entered twice by mistake, if details are similar, e.g. John Lee DOB 3/4/55, and another John Lee DOB 4/3/55. Checking the ID number will help you to see if it's the same patient with the DOB incorrectly entered.

What you see below is enough data for Socrates to be able to generate useful reports and statistics and track down the name of the individual patient if there is a need. These fields are highlighted with a red asterisk. You will get a warning message if you don't enter the gender, DOB, an ID and first and last names.

The tab at the bottom can record address details which you may or may not want to add. Socrates doesn't generate letters at this stage, so you may not want to include all the address details. There is also a tab for alternative contact details. If you are following a patient for a long period of time its helpful to add a name and contact details for a next of kin or friend.

Email address/notification

This becomes important if you are using the web service for patients to enter their scores on line from their email address. See the chapter on Web Scores.

Adding a New Patient

All **patient data entry** is initiated via the demographic screen. Click on **Add icon** at the top **left** of the screen, and the Last Name window below will appear.

Enter the patient's last name. As a shortcut, you can just enter the first letter or two of the patient's last name, and click the **tick**, and a list of people in the system whose name begin with that letter will pop up. If the patient you want is already entered, highlight the entry and click **Select** or **double-click**. To add a new name, click **New Patient**.

In addition to searching by last name, you can also search by **Patient ID**, which is handy when there a large number of patients with the same name. You don't need to do both. In the example below, the letter was typed in the Last Name field, and all names in the system starting with S will be displayed. You can select the first letter for the option you want, N for new patient, M for modifying the one you have highlighted etc.

Remember, patients may have several surgeries entered from the different modules on different joints and sides, but **only one entry on the demographic screen**. Each surgery on a specific date and side is a separate record, which the program counts as a surgery or treatment.

Note, the patient may not have had an actual surgery; it could be an entry in the **Non-operative Screen**, (such as a steroid injection). Likewise, a patient's details may be entered when they first come for treatment, and they may have an examination and a score, but never get to surgery.

So, while we tend to call it a surgery it's really just a record created for the affected side, which is going to be followed in some way in Socrates.

If a patient has multiple surgeries or treatments, all those details will be displayed on the right-hand side of the **Demographic Screen**. See poor Mr Arkwright below with his one entry and all his surgeries/records listed to the right.

Current Age and Initials

These fields will automatically be generated when you are tabbing through. The patient's age will be calculated when you save the data entered. This field will of course only be correct if the actual date *on your computer* is correct, since the program looks for this date when the data is saved and then calculates the age based on your computer's current date.

Note that the current Patient's Age is different from the Age at Surgery. It may initially be the same, but as the patient gets older, the numbers will obviously be different. The program's statistics are run on the patient's *Age at Surgery*, with X weeks/months/years of follow-up. If the patient is deceased and the record has been altered to reflect this the current age is no longer displayed.

Adding a New Surgery or Treatment

After entering the patient data on the **Demographic Screen**, you can add a new surgery or record for that patient by clicking on the **Add icon** on the **right** side of the screen. We call it a surgery throughout but what you are really doing is creating a record for the treatment/study or surgery that the patient is undergoing for that joint.


The window below will open up. Select the module you want (Hip or Knee General, Hip or Knee Arthroplasty, Shoulder or General Surgery) from the drop down list.

Then select the side you will be operating on -- *this can't be left blank*.

Bilateral Surgeries

The default option in the **Bilateral field** is **"No"**. If you are entering a bilateral procedure, choose from one of the Bilateral options: Staged, Simultaneous, or Previous – Other Side, as below.
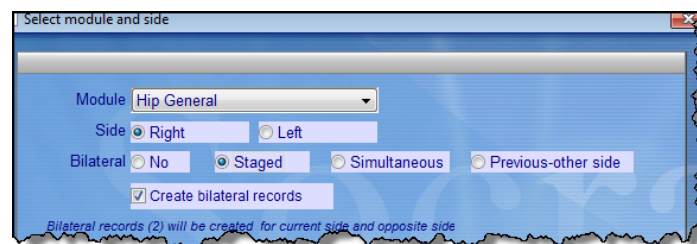
If either "Staged" or "Simultaneous" is chosen, the box "Create bilateral records" will be automatically checked. **Two records will be created**, one for each side. The reason behind this default creation of two separate records is the fact that each of the limbs may have a different outcome (as shown by different scores) during the follow-up period.

If you don't want to create the other surgery record, you can *un-check* the box. If the patient has had a previous same-type surgery on the other side, you can select Previous – Other Side. In this case, a duplicate record will *not* be created, since it already exists or they may not have a record in Socrates for the other side. The surgery may have been done elsewhere and you are not following it but you will be able to search for all surgeries which were bilateral, the other side done previously.

If you selected the check box to create two records, and you go back to the demographics screen on the right side, you will see the two new records. The bilateral flag is also then set on the next screen.

If the other side is done at a later stage you can select these options on the surgery screen as below.

BUT if you want the program to be able to assign scores to the other side you also need to do this on the record for the other side since this was created before the patient had the second surgery thus it wouldn't have been known it was a bilateral. So go back to the other side surgery and select bilateral and you will be able to assign some scores to the opposite side for the next and subsequent reviews - see later in this chapter.

> *NOTE: Separate details for examination and most scores should be entered for each limb, since the outcome and complications may differ between sides. Once one side is completed, return to the Demographics screen, double click to access the opposite side, then enter the data for that side.*

If you have a bilateral case and therefore created two records, it is possible to automatically transfer the generalised scores to the other side. The bilateral check box must be checked for this to happen.

Bilateral Scores – Assigning to opposite side

The VA12 and VA36, EQ5D and Patient Satisfaction score can be assigned to the opposite side for a bilateral surgery to save you entering the same data twice since these outcome scores are related general health and are

not specific to one side or the other. If a bilateral surgery has been checked on both records, the right and left you will see a message asking you if you want to assign these responses to the other side.
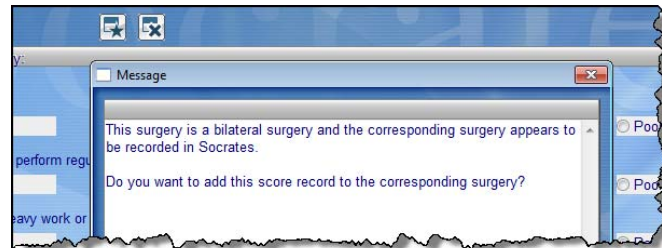
If you select yes the score and the date will be assigned to the record on the other side. If you see the next message it means that the bilate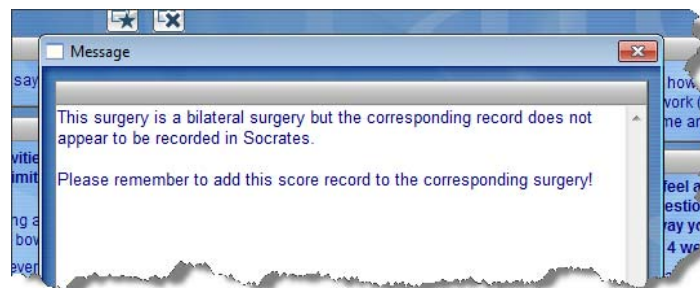ral check box has been checked for this surgery but there is there is either no opposite record in Socrates, or it hasn't been set as bilateral. You would need to go to the record for the other side, and modify the bilateral record in the surgery screen so that in future the scores could be allocated to both sides.

Selecting Follow-Up Protocols

The next decision you have to make when you are adding a new surgery is to select a **Follow-Up Protocol**. This is really just a follow up regime, what scores you want at what time points.   You create these in the **Set-Up Screen** (see the section on protocols in the chapter on Set-Up and Customisation), and you can have as many as you like for each module. In the current "Select module and side" window, however, all you have to do now is choose the Follow-Up Protocol you want from the drop-down menu. Once you have done so, a report can be automatically generated to show who is overdue for their follow-up appointment.

These are very important, if there is no protocol set up it's not possible to sue the web scores service, as well as the reports that's are produced by Socrates which will easily enable you to follow your patients progress if they are grouped into protocols.

If you don't want to assign a follow-up protocol to a surgery, just leave blank line at the top selected.

After you have finished with this window's selections, click on the **tick icon** or press **Enter** to save the data and move to the next screen.

Accessing and Adding to an Existing Patient's Record

Each time the patient returns for a follow-up related to a specific surgery, you will enter the scores and follow-up information into *that surgery's record* until the patient is either completely discharged from follow-up, or has failed and a new surgery record is created for the revision procedure.

To access the surgery, double click on the *existing* entry that corresponds to the date of the surgery or examination from the list in the History window (right side) of the **Demographics Screen**. Enter the new follow-up data by clicking on the score tab inside that surgery record.

Do not use the Add icon on the top right of the **Demographics Screen** to add any follow-ups or other information pertaining to an existing procedure. The **Add icon** will create a NEW surgery or procedure.
In the example below, the patient has three records: a General Procedure on the Right Knee on 12/08/08, a General Procedure on the Right Hip on 02/08/08, and a Right Knee Arthroplasty on 01/03/04. The scores and follow-ups for each of these procedures are entered into the record for the particular surgery currently being followed. To access this record, to make changes, or to add a follow-up score, double click on the entry for the date of the surgery you are following, then enter the scores and follow-up information on the resulting **Surgery Screen**.


Entering follow up scores.

Once you have entered the first score (which is usually a preop) the patient will have their surgery or treatment, and at a later stage they will come back for a follow up score, probably the first of many. So how do you enter the follow up scores? For the remainder of the follow ups for that surgery, locate the surgery on the history screen you are following. The date of surgery usually tells you the right one. Then double click on that entry to access all the scores, and any other follow ups - complications, ROM etc.
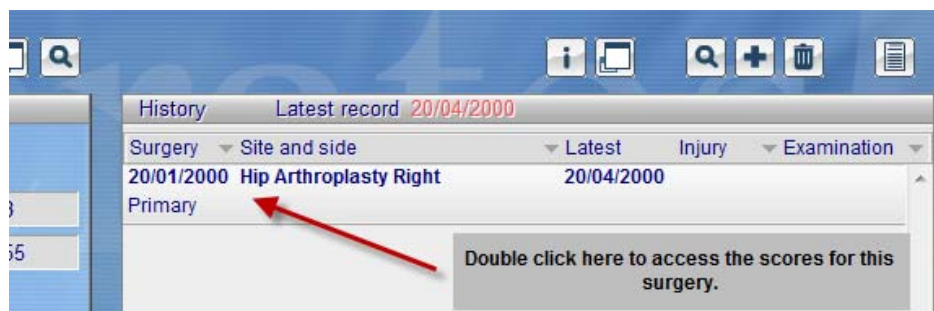
Inside the surgery record the score would show up on the bottom of the history screen, with the number of scores entered in brackets beside the score name. Inside the actual score you will see the two numbers, indicating which score you are looking at (the first number) and the total number of scores.
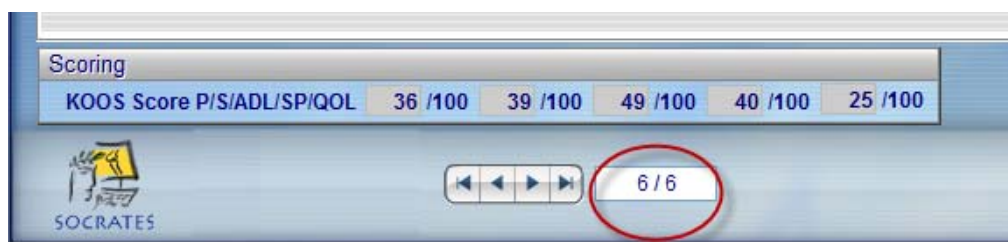
The follow up for the original surgery only ends in 2 ways. If the surgery fails and is revised, then a new surgery is added as a revision and the follow up scores then go into that surgery. Or when the Patient is discharged from follow up and no more scores for that surgery are needed. **EVER…**

What not to do…..

This patient had one surgery in 2000. He has since had 3 follow up Hip scores. Instead of double clicking on the 2000 surgery and adding the new follow up scores here the data entry person has created 3 new surgery records each with a score. These scores will not be linked to the original surgery.

Entering Only the Score Totals

Some scores have been changed or updated by their original authors over the years. The questions and answers may be similar but different enough so it's not possible to enter them into Socrates but the score totals may be the same. If you have data from previous versions of some of these tests that have evolved, (the SF12, SF36, Constant, or KSS, for example), Socrates now allows you to enter **total scores** manually after you have calculated them yourself. You will see an instruction in the Total Score section indicating you can *right-click* on the field in order to enter the score manually. Just type in the total number and save.

SF 12 and 36 scores: From the August 2011 update it is no longer possible to enter any responses into the SF 12 and 36 scores. Users who want to use these scores should contact www.qualitymetric.com to obtain a license and the scoring methods, the answers can then be entered into the score totals but there will be no access to the questions. The company who now owns these surveys withdrew their permission for us to include the full scores.
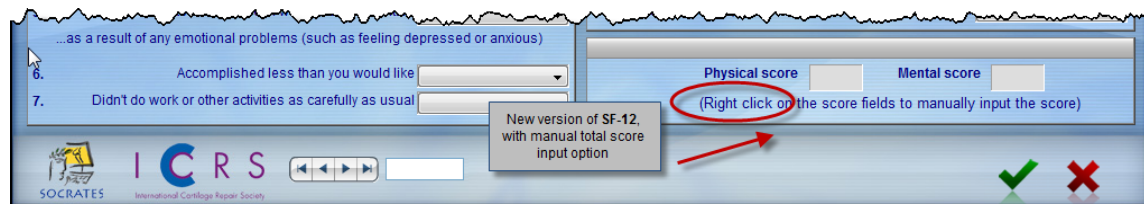

Failed surgery or treatment.

If a surgery or treatment fails these details should be recorded on the Outcome section of the Complications and Outcome screen.

If a surgery has failed and is revised or a new operation needed you would to create a *new* surgery record entry, and the follow-up is then recommenced with this new entry.

The same as if you are following a patient with a non-surgical intervention, say a local anaesthetic which has failed to resolve the problem and the patient then goes on to have surgery. The previous record for non-surgical intervention should be accessed, and the Patient Status changed to "Failed".

The "Revised" or Reoperated box should be checked as "Yes" on the surgeon follow up screen in the surgery status field and details of the date etc. if the surgery required one of these. The program will calculate the weeks from the original surgery if a revision or reoperation date is entered.
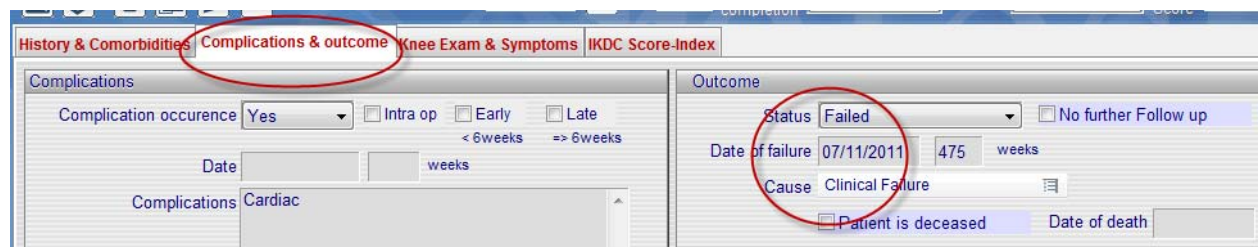
If you record the new surgery as a revision and the program finds an existing surgery in this module for the same side it will prompt you with this message to remind you to go back to the surgeon follow up screen of the original surgery and record that it was revised and details of any complications.
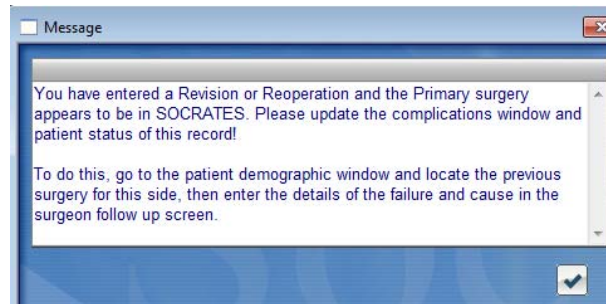
Searching for a Record

Directory Lists

To find a patient record, click on the **Search icon (magnifying glass)** on the far **left** of the **Demographics Screen**. There are *three* search icons on this screen.

The first on the far left is used for searching for any patients in the database - type all or part of the name you are looking for, a list of patients with this name, or the first letters that you typed in will be displayed.

Double-click on the patient you are searching for, or highlight then, use the first letter of the options displayed at the bottom, and the record will open.

There are two kinds of Directory Lists: one for patients and one for surgeries. In this case, you will see a **Patient Directory List**, since you used the **Search icon** on the *left* of the screen.   Note that Patient Lists and Surgery Lists will have different totals, since the patient only appears *once* on the Patient list, but if the patient has had multiple surgeries, each surgery will appear as a *separate entry* on the Surgery list.

This is a patient list, each patient appears once, with their surgeries listed.

Patient		Patient ID	Date of birth	Gender	Surgeries	Last record
ARKWRIGHT	Trevor	479830	06/07/1959	Male	Hip General:1, Hip Arthroplasty:1, Knee General:2, Knee Arthroplasty:2, Shoulde	8y
BAILEY	Martin	90962427	09/12/1930	Male	Hip General:2, Hip Arthroplasty:1, Knee General:1, Elbow & Hand:1, Foot & Ankl	8y
BARTLETT	Christine	4623927	03/02/1947	Female	Hip General:1, Hip Arthroplasty:1, Knee General:1, Foot & Ankle:1, Spine:1, Tota	5y
BOND	Sheila	7865320	03/04/1969	Female	Hip General:2, Knee General:2, Foot & Ankle:1, Spine:1, Total:6	7m
BRACEWELL	Larry	93821528	03/07/1959	Male	Hip General:1, Hip Arthroplasty:2, Knee General:2, Foot & Ankle:1, Total:6	6y
BRINK	Robert	3456	04/05/1950	Male	Knee General:2, Elbow & Hand:1, Total:3	10m
BROWNING	Barry	675342	04/08/1959	Male	Hip General:1, Knee General:2, Foot & Ankle:1, Total:4	5y
CAMPBELL	Beverly	734590	04/07/1977	Female	Knee General:3, Knee Arthroplasty:1, Total:4	4y

This is a surgery list, each surgery appears as a separate entry with their surgeries listed seperately.

If you want to search for a particular type of surgery, choose the **Search icon** on the **right** of the screen. You can use the **Search icon** in the **middle** of the screen if you are looking for a sub-group of patients, e.g. all those under 50. More on the different kinds of Searches in that chapter, later in the User Manual.)

Latest Record

The latest record is displayed in *two* places. The latest record for any of the surgeries a patient may have is in on the top of the list of surgeries. Note that this information is displayed on the **Demographics Screen** as below, as well as on all **Surgical** and **Evaluation Screens**.

The last, or latest, record for the each surgery is on the right of this screen next to the injury date – labelled **Latest.** DOS is day of surgery which means that this is the latest entry for that record.

Creation and modification Dates

In the top right hand corner of all the screens there are details of when the screen was first created, and by which user, and the same for when it was modified.

Patient Number

The total number of patients *in your* system is displayed next to the scroll bars at the bottom of the **Demographics screen**. Note that this is the number of *patients*, not *surgeries*: a patient may have more than one surgery. Therefore, the Patient Directory List may contain 43 entries, but the Surgery Directory List may contain 79 entries.

THE HISTORY SCREEN

After creating a new surgery (or double-clicking on an existing one), you will enter the **History screen**.

General Details

Items on the drop-down menus for Surgeon, Hospital/Clinic, Anaesthetist, etc., are created in the appropriate **Adaptable Fields window**, accessed from the **Set-Up Screen**. (See section on Adaptable Fields in the chapter on Set-Up and Customisation.) All you do here is choose the item you want from the drop-down menu. If its not there hop down to the set Up screen and add it to your list.

Study Name and Study number

These study names are likewise entered via the **Set-Up Screen**. You can return to this screen by clicking the blue **Tools icon** at the bottom of the screen. Study numbers are allocated to each patient by the program, or you can allocate them yourself.

Notes

Note: Any notes that have been entered on the other screens are also displayed on the front screen. Only the history notes can actually be entered into this screen.

On the right of this screen are 3 tabs.

Surgery or procedure details

The first tab captures the date of the surgery or beginning of the treatment to be added. We usually refer to a surgery but Socrates can be used for any procedure, study or non-operative treatment as well. It needs a date to be entered as a baseline so follow up delays can be calculated, i.e. 3 month, 1 year, 5 year follow up after the start of the treatment or study. If no date is entered all follows scores entered up will appear as pre.

Non-surgical treatment (General screens only)

There may be patients being followed who do not require surgical procedures, e.g. ACL injuries, hyaluronic acid studies, etc. In this case, check the **Not for Surgery box** to facilitate separating this group out for searches and statistics. However if you want these patients have a follow up period calculated a commencement date of the study or treatment needs to be entered. If not all your follow ups will all be calculated as preop. We use the term preop but it can be deemed pre, the start of anything, a study, a treatment or a surgery.

The program will prompt you to enter what we have called the "Type" is the surgery a primary, a revision, a reoperation or just a study or a record of clinical findings. The elsewhere means is the revision or reoperation one where the original surgery was done by the operating surgeon or was it done elsewhere.

Diagnosis and Procedure nomenclature

The diagnosis and procedure name can be entered in one of two ways – using a clinically descriptive term and or the codes that you might use – CPT, ICD etc.

In all modules except the Hip and Knee arthroplasty ones there are two windows each for diagnosis and procedure. Why are there two? Codes used for billing might not be descriptive enough for research, nor are they always what's done since they often don't keep up with technology. Plus you might want to use your own descriptive terms for the different surgeries you do. You can add, remove or import your own lists of these at any time. So you have the option of choosing which you want to use, or both. You will need to import your own codes lists, there are too many in the world for us to import them all, and often surgeons only use a small number of the codes in their own practice. It's easy to import them in one list, or just add them in as you go - see the chapter on Set Up.

Patient information

The next captures some information about the history of the patient's weight and height, BMI (calculated by the program) some details of their injury, workers comp, insurance status, litigation pending, how it occurred, the duration of symptoms, and length of stay. The patient height and weight will also be entered into the patient follow up screen automatically as preop eight so if you do want to follow their weight and height over time you can do so by entering the data at the different time point in the patient history screen.

Length of Stay and Discharged details

The window at the bottom right of the screen allows you to record the patient's length of stay, either in multiples of days, or as a day-only option. This is where you note where the patient was discharged to, should you wish to record this information. This information is usually taken from the patient's notes at the first post-op visit.

Some of the detail in this screen is generic to all modules, and some is more specific to the module, such as the type of previous surgery. See the chapters on each module for more details.

> *Note that the first time you enter this screen you will in data entry mode;*
>
> *but if you are revisiting this screen, you need to use the Modify icon.*

SURGERY DETAILS SCREENS

If you want to collect more details than just the name of the procedure and diagnosis the Surgery Details

Screens are accessed via the Surgery Details icon (Surgeon's face) on the top right side of the History screen.

Once into the **Surgery Details Screens**, you will see tabs specific to each module, outlining the major types or divisions of that type of surgery. There are varying levels of detail on each of the modules, some are till under development. . For more detail, see the specific chapter on each module later in this User Manual.

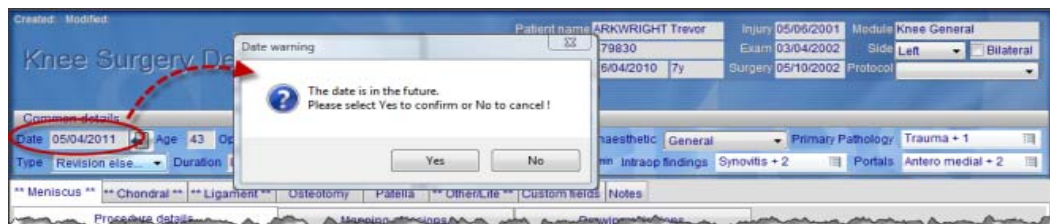## Common Details for all Surgery Screens

All **Surgery Screen** have common details at the top.
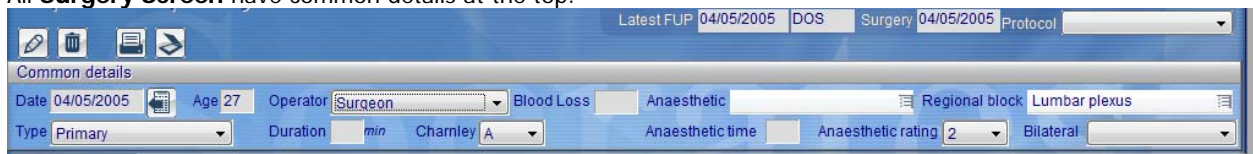
These differ slightly between modules, but mainly relate to the general details for the surgery and the anaesthetic. None are mandatory, except for the Date of Surgery (or Treatment) and the Type of Surgery (primary, revision or reoperation). The Date enables calculation of the patient's age at time of surgery, and the delays for the scores, which are calculated from this date of surgery.

Note that for Socrates' purposes, the patient remains this same age (Age at Surgery) for the duration of follow-up, but with X years of follow-up added. Thus, the patient might be 50 years old at time of surgery; in 10 years time, her age *at surgery* would still be 50, but now with 10-year follow-up.

When entering a surgery date that is in the future, you will be asked to confirm that you haven't made an error.

Surgery Type

Another important field in the Common Details section of the **Surgery Screens** is that of **Type of Surgery** – whether it is a Primary, Revision, Reoperation, or just an Arthroscopic Review .
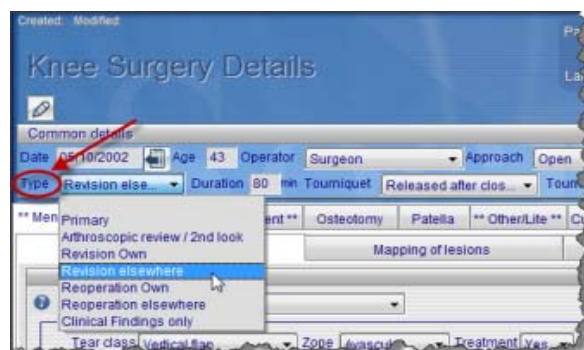
The Revision and Reoperation options have a couple of further opportunities for specificity: you can document whether the original surgery was your own or someone else's, and in the General modules, by way of a drop-down menu, you can document the **Cause of Revision**. his will only be available to enter if the revision tabs have been selected.

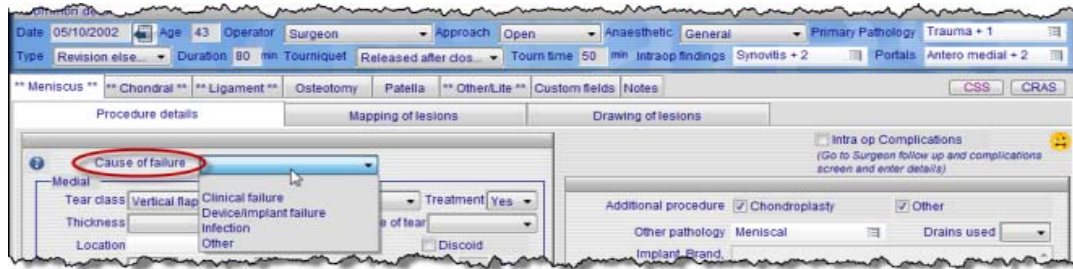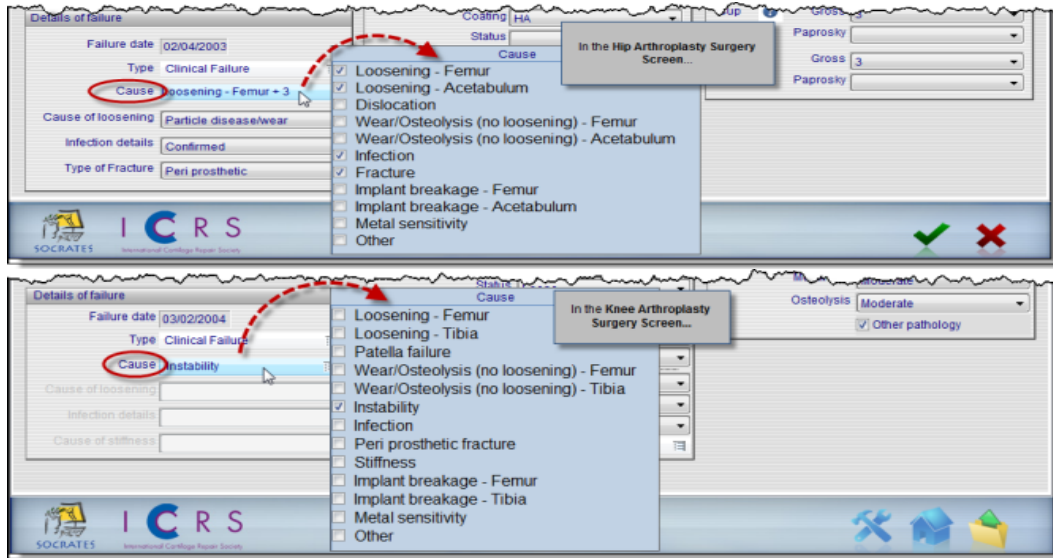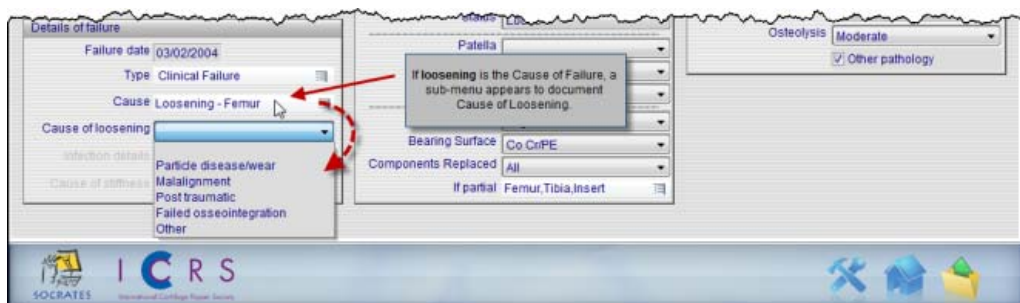The Arthroplasty modules have multiple fields about the **Cause of Revision**. More than one cause can be selected.

You will also find **sub-menus** for some of the Causes or Failure. For example, if **Loosening** is selected as the Cause of Failure, a second drop-down menu appears, allowing you to document the cause of that loosening.

Adaptable Fields on the Surgical Screens

In the General Modules, you will find several small windows that allow you to access lists of Adaptable Fields. Examples include the Surgery/Procedure Name, the Diagnoses, Complications, and Surgery Keywords.   All of these lists can be added to, modified, or deleted, either by changing one or two items, or adding or deleting an entire list. In Modify mode, click the window space to view the available lists.

To add or delete items to the entire list, go to the **Set-Up Screen** by clicking on the **Tools icon**.   Remember, you can also import whole lists from other sources, either as numeric lists, or combinations of text and numbers, such as ICD10 and DRG codes. See the chapter on Set-Up and Customisation for more details.
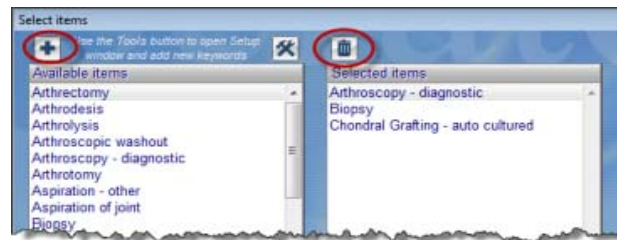
Surgery/Procedure Name

Since the procedure is recorded with its clinical description back on the main **Surgery Screens**, (as ACL, HTO, medial meniscectomy, for example), you may choose to leave this window blank, as you may find it repetitious. However, it is useful for searching and auditing purposes to assign a name to each procedure in this field. You will be prompted to do this if you leave the screen without adding anything to this window.

Diagnosis

Choose from the default list, modify items on it, or add your own. Remember, you could import a list of codes here, such as the ICD10s or DRGs from your own country. You will be prompted to do this if you leave the screen without adding anything to this window.

Keywords

Record anything notable here that may not have already been assigned a field or window, but you think may be necessary to recall at a later date.

Intra-operative Complications

There is a checkbox on each **Surgical Screen** to indicate that an intra-operative complication occurred. If this box is checked when you save and exit the screen, you will be automatically returned to the Complication screen on the **Surgeon Examination Follow-Up and Complication tab** from the previous screen. You can then record the details of the complication. See later in this chapter for more detail on recording complications.
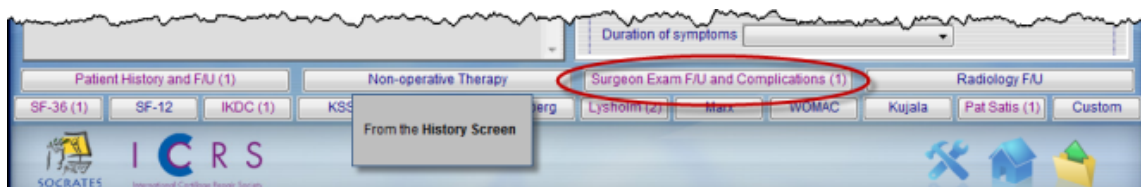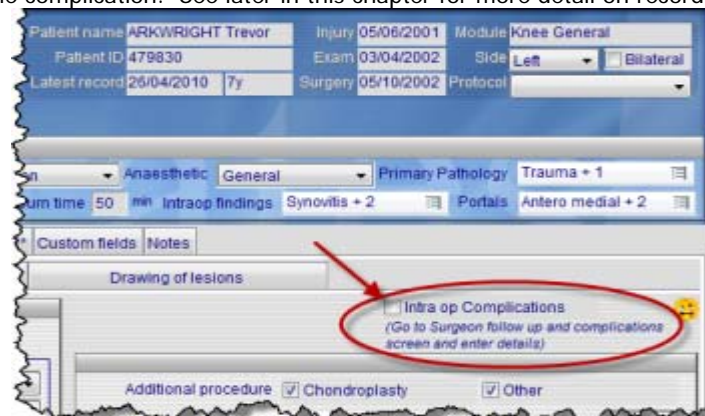
Surgery Notes

We have included the ability for you to record surgical notes on a tab in the **Surgical Screens** called **Notes**. The information you add here is available to be accessed through the standard search function. The Notes you write through this tabbed field are specific to the surgery that was performed on that particular date. There is no spell-check function included; however, you can easily copy and paste Word documents into this area.

Notes are generally best used to enter additional information that might be of interest for you to read *as a reminder* at a later follow-up appointment. An example might be more information about a complication, including the treatment and its outcome: "DVT diagnosed by ultrasound. No symptoms. Clexane BD x 10 days. Discharged on aspirin."

As mentioned above, Socrates can search for words or phrases in the Notes area, but if you want to record something that you *know* you might want to search for later, it is probably a better idea to use either a Keyword or a Custom Field to record it. When writing notes quickly, it is easy to misspell words, or use similar, *but different*, terminology, thereby making searches difficult or impossible.

In the example above, the word "aspirin" was misspelled. If, at a later date, you searched the Notes section for all patients who were prescribed "aspirin," you wouldn't find this entry. We recommend that you consider the possibility of future searches, and create Keywords for entries such as these. (There's no reason you couldn't do both!)

Entries in these Notes sections can be imported into a document for generating Operation Reports. See the later chapter on Report Templates & Word Processing.

EXAMINATION, FOLLOW-UP AND COMPLICATIONS SCREEN

These screens are accessed through a **tab** at the bottom of the **History screens**, above the Scores and Evaluations. We'll explore some of the features of the **Follow-Up and Complications** elements of this tab, but we refer you to the individual modules for more detailed explanations about the **Examination screens**.

The Complications Screen

This screen is accessed by clicking on the Complications and Outcome Status tab on the Surgeon Exam, Follow-Up and Complications Screen. This screen is the same for all modules, it's just the list of complications that differ.

Status and Failure Details

This left half of the screen records the ongoing status and outcome of the surgery. It records details of any failure, the date (calculated in weeks since surgery), and whether a revision or reoperation was needed.   In general, a **Revision** is when the surgery has failed, and the surgery has to be largely redone – hardware replaced or a new surgery performed – to fix the problem. A **Reoperation** may be the removal of screws or plates, or the resection of a delaminated graft, for example. Here, the original operation is still regarded as successful. When a new surgery is added, the **Patient Status** will automatically be assigned as **Ongoing** until one of the other fields is checked.

If a patient has died this can either be entered on this screen, on the front demographic screen and all the surgeries will be altered to reflect this.

Enter the details here and the surgery records will also be updated

NOTE: It is important to keep this field up-to-date, as when you are searching for score results or other groupings, you won't want to mistakenly include surgeries that have failed, patients who have died, or patients who have been lost to follow-up. If you do want this data, you'll want to purposely search for it using these groups as sub-sets.

Complications

Accurate tracking of complications is an important part of any follow-up care, so some effort should be made to record any such events carefully. It is always a good idea to record even more details in the **Notes tab** on this screen, since you may need to recall this information years after the actual occurrence. Details about **Complications** are captured on the right side of the **Surgeon Exam, Follow-Up and Complications screen**.

> *NOTE: It's possible to record a lot of data on this screen; not all of may be necessary. Just a Yes or No, to the presence of a complication, and what it was may be enough. The program will prompt you to enter the name of the complication if you select Yes and don't enter what it was. Additionally, if there is a revision, it will also prompt you to enter the complication that prompted the revision.*

Occurrence

Record as **"Yes"** or **"No"**.

Date of Complication

This date is recorded separately from the Date of Follow-Up, as the complication may have occurred at a different time. For example, a patient could return to you for his 6-month follow-up, but may have had a DVT at 3-months post-op that was treated elsewhere. If you enter a date here, Socrates calculates the time from surgery to complication for you.

Complication Name(s)

Double-clicking in this window brings up the available list of complications. Remember, these can be added, modified, or deleted through the **Set-Up Screen - Adaptable Fields** option, accessed by the **Tools icon**.

Location

Choose **"Local"** or **"General"**, based on whether the complication was directly related to the surgery, such as a graft delamination after an ACL procedure (Local), or if it was not specific to the surgery site, but directly caused by the surgery, such as a DVT, PE, or GI bleed (General). It is possible that the patient had complications that were both General and Local, for example a graft delamination *and* a PE.

Cause of Complication

Was the complication caused (or *could* it have been caused*)* by a co-morbidity? Was it caused by the product or device or procedure used?

Hospitalisation

Record if the patient had to be admitted, or stayed longer than would have been expected for her original surgery, because of the complication. How many days?

Outcome

Was the complication resolved? Did it result in ongoing sequelae? Death?

Adverse Event

This field refers to a decision made by you, or as defined by the study, that the complication should be considered an Adverse Event or a Serious Adverse Event. This is a judgment, and no set rules apply. In some cases, you may be involved in a study that gives you a list of what is considered an AE or SAE.

Notes
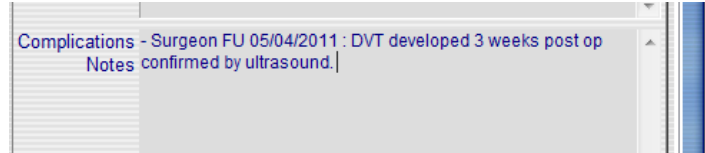
The window under the **Notes tab** will automatically insert the date that you write the Note, and will indicate that the notes written are from the Surgeon's Follow-Up. The notes you write here will be stored on this screen, but will also be combined with notes from the main **History Screen**.
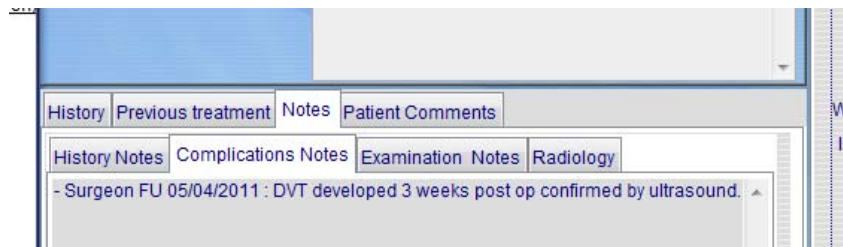
PATIENT HISTORY AND FOLLOW-UP SCREEN (GENERAL MODULES ONLY)

This screen tracks patient's work, functional and sport history over the period of follow-up, until discharge from follow-up for *this* surgery. The **Patient History and Follow-Up tab** is located above the scores and evaluations at the bottom of the **History screen**.
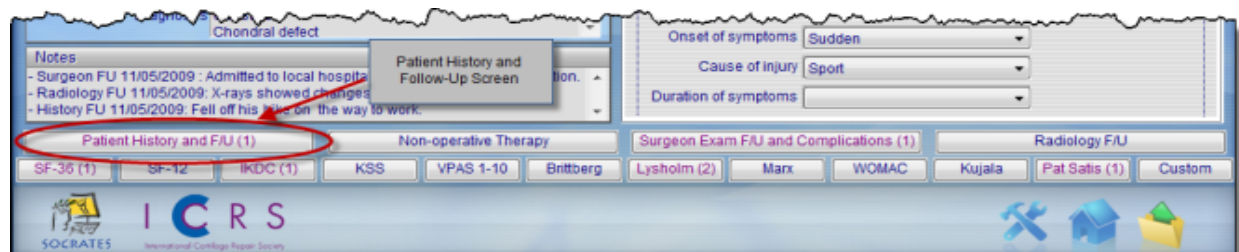
Questions relating to the patient's work, sporting and general function are recorded **pre-operatively** and **at subsequent visits**. Some of the questions are only relevant post-operatively, return to work and sports questions, for example. The **Main Sports window** can be added, modified or deleted through the **Adaptable Fields option** (**Tools icon** to **Set-Up Screen** to **Adaptable Fields**.)

NOTE: This form can be scanned in to the program. Click on the scan icon and you will see the option of the pre- and post-op forms. The pre-op form includes the patient history (Date of Injury, Worker's Comp, Cause of Injury, etc.) that was found on the main History screen. There is a separate form for pre-op and post-op scores. See Data Entry chapter – Scan Forms section.

POST-OP AND REHAB SCREEN

This screen is found after clicking on the **Rehab icon** at the top right of the **History screen**. It allows you to collect information relating to any post-operative therapy and/or rehabilitation therapy, often an important component of the outcome of the surgery.

The left side of the screen allows you to record **General Post-Op** and **Rehab** information:

- **DVT Prophylaxis**: five fixed options to choose from

- **Anticoagulation**: five fixed options to choose from

- **Rehabilitation Protocol**: six options, labelled A, B, C, D, E, and F. Since there is no consensus to a standardised rehab protocol, and they may differ among individual studies and procedures, this format allows you to decide on your own protocols, and assign them each a letter. For example, Protocol A = 6 wks NWB, 6 wks toe touching, 4 wks CPM 8hrs/day; Protocol B = 3 wks NWB, 3 wks toe touching, 2 wks CPM 4hrs/day.
  (Note that the ICRS has established a rehabilitation team to provide some standardised rehab protocols and guidelines. These will be added to Socrates when they are completed.)

- **Compliance with Rehab**: four fixed options to choose from

- **Viscosupplementation Protocol**: five options, labelled A, B, C, D, and E. As with Rehab protocols, there is no standardised agreement on visco-supplementation. You can assign your own protocols to the letters, and could even decide to trial different products. For example Protocol A = Slipperyjoint Brand; Protocol B = Longlast Brand; Protocol C = Beetlejuice Brand.

- **Antibiotics**: three options: Yes, No, and Unknown. Details of the actual drug can be entered in the Notes section (at the bottom of this screen), as a Keyword, or in the Custom Fields, if you feel the details are important to record.

- **Anti-inflammatories**: three options: Yes, No, and Unknown. Details can be recorded as with Antibiotics above.

- **Neutraceuticals**: three options: Yes, No, and Unknown. Details can be recorded as with Antibiotics above.

The right side of the screen allows you to record information about **Pain Management**:

- **Pain Management Protocols**: Since these protocols differ among procedures and institutions, there are four options here, labelled A, B, C, and D, and you can allocate each letter to a protocol of your own design. You may, for example, be trialling different products, and can use this field to track the outcomes: A = PCA plus 5mgs Morphine PRN; B = 5 mgs Morphine q4h; C = Endone 2 tabs q6h.

- **Post-op Analgesia**: eight options in a checkbox list

- **Pain Pump**: Yes or No

- **Route of Administration**: three options in a checkbox list

- **Location Used**: three options (geographic, not anatomic locations)

- **Delivery Method**: three options to choose from

The bottom part of the screen allows you to record notes on the **Medications** used during the Post-Op and Rehab period. As indicated in the Antibiotics bullet above, it is convenient to document medication details here, but if you choose, you can also add this sort of information as a Keyword or in a Custom Field, to make it easier to do more streamlined searching later.

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