ARTICLE V

SURGICAL CARE

5.1 Scheduling Surgery

(a) The operating surgeon must be named to schedule a surgical case and is responsible for the complete surgical care of the patient. Posted case start time is defined as the time the patient enters the Operating Room. The surgeon shall be present in the surgical suite at the case start time. The surgery and anesthesia personnel shall, through coordinated efforts, have patients in the Operating Room at the scheduled posted start times. When it becomes evident that a case will not start at the scheduled time, every attempt shall be made to notify the surgeon at least thirty (30) minutes in advance.

(b) All surgical cases shall begin at the scheduled time to minimize delay of successive cases and avoid case postponement. Case postponement may occur when it becomes obvious that a late surgeon cannot complete the case on time. Lateness shall be defined as fifteen (15) minutes or more beyond the scheduled time. Case postponement may occur even if the surgeon calls to notify the Operating Room he will be late. The act of calling shall not ensure the time and availability of an operating room when the surgeon arrives in the Operating Room. When the surgeon is late fifteen (15) minutes or more for the first case of the day, more than three (3) times during a one (1) month period, the Operating Room Committee Chair shall be notified, resulting in an automatic inability to schedule cases as first cases of the day for a three (3) month period. Copy of notification will also be sent to the Medical Staff Office and surgeon for enclosure in the surgeon's peer review file.

(c) The specifics, of the procedure must be designated on the schedule, with the patient's name, age and procedure. Unrelated elective procedures may not be added to a case after it is posted if other cases are already posted to follow. The case must be done as originally posted or scheduled. Cases requiring frozen sections should be posted as such at the time the case is scheduled.

(d) Priority of surgical scheduling of cases - refer to the Perioperative Services Scheduling Policy and Procedure.

5.2 Surgical Records

(a) Except in emergencies, the following data shall be recorded in the medical record prior to surgery or in the case of lab results, telephone summary of tests recorded when no report has been received. Verification of the identity of the patient, medical history, including medication and sensitivities, physical examination to include the body part to be operated including the capacity of the patient to

withstand anesthesia; provisional diagnosis; laboratory, x-ray, and EKG results; any consultation reports; Hospital Informed consent for surgery form; and anesthesia evaluation and plan approved by the anesthesiologist.

(b) For emergency surgical cases, the following data shall be recorded in the medical record prior to surgery.

(1) Verification of the identity of the patient.

(2) Admitting progress note stating the pertinent patient complaints, physical exam results, preoperative diagnosis, and the necessity for immediate surgery.

(3) A complete history and physical is required within twenty-four (24) hours after the surgery. Refer to Article VI, Medical Records for history and physical minimum requirements.

(c) All operations and high risk procedures that use moderate or deep sedation or anesthesia shall be dictated or written by the operating surgeon immediately after the operation/procedure and filed in the medical record as soon as possible after surgery. When there is a transcription and/or filing delay, a comprehensive operative/procedure progress note shall be entered in the medical record immediately after surgery. The operative/procedure report and the post operative/procedure progress note shall contain:

(1) the pre-operative diagnosis;

(2) post-operative diagnosis;

(3) name of the operation (using standard nomenclature);

(4) detailed description of the operation;

(5) technique used;

(6) the name(s) of the primary surgeon and all assistants; and

(7) findings;

(8) specimens removed; and

(9) estimated blood loss.

(d) Procedures that do not include the use of moderate or deep sedation or anesthesia

requires a written note immediately post procedure that includes the following:

(1) date and time;

(2) name of procedure;

(3) findings;

(4) name of physician.

5.3 Anesthesia Rules and Records

(a) A pre-anesthetic evaluation by a qualified anesthesia provider shall be recorded within forty-eight (48) hours prior to surgery to include the ASA status. The qualified anesthesia practitioner must identify the patient and record verification of the patient's identity in the patient's medical record. If the evaluation is done by a certified registered nurse anesthetist (C.R.N.A.), it must be authenticated by a Physician prior to surgery either by co-signature or verbal order.

(b) A record shall be maintained of all events taking place during the induction and maintenance of and emergence from anesthesia, including the dosage and duration of all anesthetic agents, drugs, intravenous fluids, and blood or blood fractions.

5.4 Post Anesthesia

(a) Post-operative orders must be written by the surgeon or a designated qualified person upon arrival in the Post Anesthesia area. Release of a patient from a designated post- anesthesia care area shall be based upon discharge criteria approved by the Anesthesia Section. Evidence of the patient's readiness for discharge from Post Anesthesia care and details of the discharge should be recorded in the patient's medical record. A post anesthesia follow up report must be written within 48 hours after surgery.

(b) At least one professional registered nurse shall be on duty in the Post Anesthesia area whenever the room is occupied. Additional personnel shall be provided to meet the needs of each patient.

5.5 Dental Patients

A patient admitted for dental surgery is the dual responsibility of the attending dentist and physician. (See section on Admissions in these Rules and Regulations for additional responsibilities.) A qualified oral or maxillofacial surgeon who has been specifically

privileged in history and physicals under the delineation of privileges listing may perform a medical history and physical examination on an otherwise healthy patient.

(a) Dentist's responsibilities shall include:

(1) a detailed history justifying Hospital admission;

(2) a detailed description of the examination of the oral cavity and preoperative diagnosis;

(3) a complete operative report, describing the findings and technique used. In cases of teeth extraction, the dentist shall clearly state the identity by name and number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the pathologists for examination;

(4) progress notes pertinent to the oral condition;

(5) clinical summary; and

(6) discharge order unless otherwise noted by the dentist or surgeon.

(b) Physician's responsibilities shall include:

(1) medical history pertinent to the patient's general health;

(2) a physical examination to determine the patient's condition prior to anesthesia and surgery; and

(3) supervision of the patient's general health status while hospitalized.

5.6 Podiatric Patients

A patient admitted for podiatric surgery is the dual responsibility of the attending podiatrist and physician. (See section on Admissions in these Rules and Regulations for additional responsibilities.)

(a) Podiatrist's responsibilities shall include:

(1) a detailed history justifying Hospital admission;

(2) a detailed description of the examination of the foot and preoperative diagnosis;

(3) a complete operative report, describing the findings and technique used. All tissue shall be sent to the pathologists for examination;

(4) pertinent progress notes;

(5) clinical summary; and

(6) discharge order unless otherwise noted by the podiatrist or surgeon.

(b) Physician responsibilities shall include:

(1) medical history pertinent to the patient's general health;

(2) a physical examination to determine the patient's condition prior to anesthesia and surgery; and

(3) supervision of the patient's general health status while hospitalized.

5.7 Operating Room Records

(a) A roster of physicians, dentists and podiatrists, with a listing of the delineation of surgical privileges of each, shall be maintained in the Medical Staff Office and available to the Operating Room Supervisor or designee.

(b) An Operating Room record shall be maintained on a current basis. The Operating Room record shall contain at a minimum the date of the operation, the name and number of the patient, the names of surgeons and surgical assistants, the names of anesthetists, the type of anesthesia, the pre- and post-operative diagnosis, the type of surgical procedure, and the presence or absence of complications in surgery. Any other information maintained in the Operating Room record shall be directed and approved by the Operating Room Committee.

5.8 Operating Room Attire

Anyone entering the Operating Room suite shall wear a scrub suit, a cap which completely covers the hair, and a mask which completely covers the nose and the mouth. All Practitioners and surgical and anesthesia personnel shall observe departmental policies and procedures relating to infection control and eye protection.

5.9 Pathology Report

Specimens removed during a surgical procedure shall be properly labeled and sent to the Laboratory for examination by the pathologist according to current Joint Commission Standards. The pathologist shall determine the extent of examination necessary for

diagnosis. The specimen must be accompanied by pertinent clinical information, including its source and the pre-operative and post-operative surgical diagnoses, if known. The pathologist shall sign his report, which becomes a part of the patient's medical record.

All specimens including tissues, foreign bodies, implants and hardware, removed during surgery shall be properly labeled and sent to the Department of Pathology. The operating surgeon, however, may designate specific specimens which are not to be sent to the Department of Pathology and such designation shall be in writing, signed by the surgeon and included in the patient's record.

5.10 Radiology Services

From time to time, the use of Radiology Services in the Operating Room will be necessary. It will be the surgeon's responsibility to see that all radiation safety protocols will be adhered to as outlined by the Radiation Safety Committee, and part of the Radiology Section in the Department of Surgery. Any surgeon utilizing fluoroscopy or radionucleide scanning devices needs to be credentialed for that procedure. When Radiology Services are used, it will be the surgeon's responsibility that if an interpretation of an intra-operative or post-operative radiograph requires a radiologist's interpretation, that he communicate with the radiologist covering the Operating Room for that day.

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