5.5. Rules for Operating Room

A. Except for life-threatening or limb-threatening emergencies, surgical procedures shall be performed only with the documentation of informed consent of the patient and/or his/her legal representative.

B. The history and physical examination shall be completed prior to any surgery or procedure requiring anesthesia as set forth in Section 5.2(d) of the General Rules. The responsible practitioner shall document in the medical record the pre-operative diagnosis, and state the intended operation prior to the beginning of the procedure.

C. If the patient is admitted from the operating room, the pre-operative history and physical may serve as the history and physical for the admission. This document will remain in the paper chart until discharged when it is scanned into the electronic record.

D. When a completed history and physical is not available from the attending surgeon or other practitioner, the anesthesiologist may perform the history and physical in addition to the pre-anesthesia evaluation and shall complete the Anesthesia History and Assessment form accordingly**.** Regardless of who completes the history and physical examination, the attending surgeon must still examine the patient and document that the need for surgery is still present.

E. Surgical procedures shall be performed only by a practitioner, with surgical privileges. When surgical procedures involve residents, the practitioner will be present for critical portions of the procedure.

F. A resident at the appropriate level of training, as defined by the program director, may begin a surgical procedure in an emergent circumstance when delaying the start of the operation until the attending surgeon is present, could result in the loss of life or limb or the permanent impairment of a bodily system under the following circumstances:

1. If the attending surgeon determines that the case is emergent and is not immediately available. The attending surgeon will directly inform the charge RN that the resident may begin the procedure and of the expected arrival time of an attending surgeon.

2. If the attending surgeon cannot be contacted, the attending anesthesiologist may determine that the case is emergent and that the resident may begin the procedure. Each department/section will determine the level of training required for residents to start emergency cases and the residents will be responsible for knowing their limitation based on their level of training. The attending anesthesiologist will directly inform the charge RN that the resident may begin the procedure.

G. Surgeons must be in the operating room and ready to commence surgery prior to the time scheduled in accordance with the operating room policies and procedures and in no case will the operating room be held longer than fifteen (15) minutes after the time scheduled. It will be the responsibility of the operating room to notify the surgeon if the actual starting time of the proposed case will be delayed more than fifteen minutes (15).

H. Patients having symmetrical site surgery will have the correct surgical site identified and marked prior to any incision being made in accordance with applicable Hospital and operating room policies and procedures.

I. A surgical timeout will occur prior to the surgical incision or start of procedure in accordance with applicable Hospital and operating room policies and procedures.

J. All previous orders written for a patient are not effective while the patient is in the operating room but may be resumed postoperatively. The resident, allied health professional, or attending physician are responsible for reviewing and resuming suspended orders postoperatively.

K. Anesthesia personnel shall maintain a complete anesthesia record as described in the policies and procedures of the Department of Anesthesiology & Pain Medicine.

L. All tissue specimens removed during a surgical procedure will be sent to the Hospital pathologist except those specimens that may be exempt from this requirement under the policies of the operating room. The Hospital pathologist will make such examinations as he/she may consider necessary to arrive at a pathological diagnosis.

In consultation with the surgical pathologist on duty, the surgeon and the pathologist may agree that certain specimens do not require pathologic examinations. A listing of specimens automatically exempted from examination shall be mutually agreed upon and every three years (3) reviewed and updated by the Section Chief of Anatomic Pathology and the Surgeon-in-Chief. The pathologist shall sign his/her report on examined specimens.

When specimens are removed for special laboratory procedures other than histopathology, the studies and their results will be recorded with the Department of Pathology & Laboratory Medicine. The Hospital pathologist shall be notified prior to removal of the specimens when the study includes gross anatomic evaluation of a portion of the specimen. The practitioner primarily responsible for the patient's care will determine the priorities for use of the specimen removed.

M. Operative reports are to be dictated and recorded in the medical record immediately after surgery and contain the preoperative diagnosis, a description of the operative findings, the technical procedures, the specimen(s) removed (if any), the postoperative diagnosis, estimated blood loss, any complications and the name of the primary surgeon and any assistants. In the case of cardiothoracic surgery when estimated blood loss cannot be accurately estimated, “N/A” may be entered for estimated blood loss.

N. An operative note is required for any surgical procedure performed on a patient.

O. Operative notes may be dictated through Medquist or entered directly into Epic using the procedure note type. Those notes dictated through Medquist must be authenticated within the Streamline Health.

P. The Surgeon-in-Chief shall immediately suspend the surgical scheduling of any surgeon who has not dictated or otherwise not submitted operative notes or attending staff notes outstanding over three (3) days. The suspension will be in effect until the operative notes or attending staff notes are completed. In the event that an emergency surgical case arises during the period that the surgeon's scheduling is suspended, the suspension will be waived for the care of that particular emergency case.

Q. When a surgeon wishes to use an operating room previously scheduled by another staff member, it shall be the responsibility of that surgeon to personally contact the staff member who originally scheduled the room and secure permission for this change. Exceptions will be made only in cases of life-threatening or limb-threatening emergencies.

R. Operative procedures shall be scheduled in conformance with the delineation of privileges granted the individual surgeon.

S. Scheduling policies, rules and changes thereof for the operating room shall be reviewed and approved by the Perioperative Council. All approved rules and regulations of the operating room shall be available in the operating room supervisor's office.

T. All operative procedures performed in the operating room will be under the supervision of the Surgeon-in-Chief.

Medical Staff Office/ka

- **Action of the Bylaws Committee: Approved 10/9/14**
- **Action of the Medical Executive Committee: Approved 10/21/14**
- **Notification of provision to the General Staff:**
- **Action of the Board of Directors:**