Surgical Advisory Committee

I. Composition

Members shall include the Chairman of the Department of Surgery, an anesthesiologist, and other members as are deemed necessary to represent the various surgical specialties, which make use of the operating room. The various surgical sub-specialties will receive representation on the committee. The director of Surgical Services, nurse managers, and Surgical Technology Program manager shall be ex officio members of the committee.

The surgical division of the medical staff shall be so organized as to exercise adequate supervision and definite control over the surgery performed in the hospital. The Chairman of the Department of Surgery shall be responsible for the department.

II. Duties

1. The committee shall act as an advisory committee to the Department of Surgery and to the hospital administration on matters concerning operation of the surgical suite.

2. It shall make a constant review of the practices and procedures in the surgical suite.

III. Meetings

The committee will meet quarterly and report to the Department of Surgery.

IV. Rules and Regulations

1. Except in an emergency, all operations shall have the following requirements:

1. A history and physical examination must be documented and authenticated in the medical record prior to the operative procedure. The Short Stay form may be utilized for patients who are scheduled for outpatient surgical procedures.
2. Pre-Admission Testing is recommended for all outpatients and postop admissions.

3. Preop testing is completed as indicated by the anesthesiologist or physician performing the procedure and on the chart prior to surgery.

4. Informed consent must be documented and on the chart prior to surgery. The physician must document that he has discussed risks, benefits, and alternatives to the procedure with the patient.

5. The operative permit should be on the chart and filled out to the physician's specifications.

6. A pre-anesthesia assessment will be completed by an anesthesiologist for all patients undergoing general, MAC, or regional anesthesia. The patient will be reassessed immediately prior to induction of anesthesia.

7. A pre-anesthesia assessment will be completed by the surgeon or physician responsible for administering IV conscious sedation for those patients receiving IV conscious sedation.

2. A complete description of findings and technique of the operation shall be written and dictated by the surgeon following the operation in accordance with Medical Records Rules and Regulations.

3. All tissues shall be sent to the clinical laboratory to be examined and reported upon by a pathologist. Fresh tissue and all specimens designated by the physician shall be sent to the laboratory immediately. Formalin fixed specimens shall be sent to the laboratory as soon as possible.

The following specimens are exempt:

1. Readily identifiable foreign objects and teeth;
2. Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;
3. Cataracts;
4. Orthopedic hardware;
5. Normal appearing placentas from uncomplicated deliveries;
6. Traumatically injured amputated members where exam for medical or legal reasons is not deemed necessary;
7. Foreskins, normal appearing;
8. Portions of bone removed only to enhance operative exposure;
9. Normal appearing skin and fat from cosmetic surgery.

4. Hours of operation are 7:30 a.m. to 11:00 p.m. Monday through Friday, and 7:30 a.m. to 3:00 p.m. on Saturday.
5. All elective cases should be scheduled with Centralized Scheduling between the hours of 8:00 a.m. and 6:00 p.m. After 6:00 p.m. cases may be tentatively scheduled with the second shift clerk or charge nurse. Cases may be tentatively scheduled with the house supervisor when operating room personnel is not on duty. Urgent and emergency cases are scheduled with the nurse manager or charge nurse.

6. The schedule of operative cases shall begin at 7:30 a.m. each day. On the first Wednesday of each month cases will start at 8:30 a.m.

1. All cases after the first 7:30 a.m. cases will be listed with estimated starting times given based on historical data obtained from SIS computer system.

2. Start time is defined as the time the patient is taken back to the operating room; the patient will not be taken to the operating room until the surgeon is present in the OR suite.

3. Cases may begin prior to the scheduled time of surgery when the patient and team members are ready.

4. It is the responsibility of the nurse manager or charge nurse and the Chief of Anesthesia to be continually involved in the shifting of cases already scheduled from room to room to keep all cases as close as possible to the anticipated, estimated time.

5. To ensure the smooth flow of patients through the OR on a daily basis, the nursing staff will strive to turn rooms around as quickly as possible, with a goal of sixteen (16) minutes on the average.

6. On Saturdays, elective cases no longer than two hours may be scheduled on a first-come, first-served basis, subject to bumping by emergency cases.

7. Emergencies may be done outside the regular operating hours. Cases are to be scheduled using the following classifications:

1. Scheduled cases - Routine scheduled in advance.
2. Urgent - Cases must be done within 24 hours.
3. Emergency - Case must be done within one hour.

The physician scheduling the emergency procedure shall be responsible for determining the classification of emergency and shall relate this to the operating room staff when scheduling the case.

If a conflict in scheduling should arise, the physician shall be responsible for determining which procedure is to be done first.

8. The patient is to be transported to the holding room in the surgical suite thirty to sixty minutes prior to the scheduled time of surgery. Therefore, in all cases which
are scheduled for 7:30 a.m., the patient should be in the operating room suite at that time. The anesthesiologist shall start the anesthetic at this time, if the operating surgeon and assistant are in the operating room suite. The surgeon and assistant are expected to be in the operating room suite at 7:20 a.m. or ten (10) minutes prior to the time the patient is taken into the operating room.

9. The surgeon should be present in OR ten (10) minutes before the anticipated start time. If the surgeon/assistant is not present in OR ten (10) minutes before the anticipated start time, he/she is to be notified by the front desk. Any surgeon or assistant who is one-half (2) hour late may have to postpone his or their case until the end of the schedule or at such a time that the case can be rescheduled. This thirty (30) minutes time starts ten (10) minutes prior to the scheduled time. Postponement or bumping of cases is at the discretion of the Nurse Manager of OR/Scheduling and the Anesthesia Department. Such discretion to be exercised when in his/her judgment lateness will affect subsequent cases.

1. Surgeons who are consistently late for scheduled cases will be monitored and addressed. If the surgeon continues to be late, he/she will not be allowed to schedule any 7:30 a.m. cases for the next six (6) months.

   **Note:** It is recommended that the surgeons and assistants check in at the scheduling desk before going to the doctor's lounge.

2. Every effort should be made by the OR staff and/or physicians to communicate to each other if a delay in a case is anticipated. The Nurse Manager of OR/Scheduling will work with Anesthesia and physicians to move cases so that any delay to patients and/or physicians is kept at a minimum.

10. Allied Health Professionals, privately employed, shall apply for privileges in the same manner as staff physicians.

11. Any emergency threatening the life or limb of a patient may be performed immediately or as rooms and personnel are available.

12. The Anesthesia Department shall be responsible for the case and discharge of those patients to whom they have administered anesthesia and admitted to the Post Anesthesia Care Unit (PACU).

   Physicians admitting patients to the PACU shall be responsible for the care and discharge of their patients.

13. For purposes of publication, written consent must be obtained from the patient when taking photographs of any procedures for the purpose of education and/or research. Authorization from the patient is not necessary when taking pictures of endoscopy procedures.
14. Visitors or anyone not directly associated with the care of the patient in OR must obtain permission from the surgeon, nurse manager of OR/Scheduling, and anesthesiologist to be allowed in the operating room while an operation is in progress. Family members are not permitted in the OR suite.

15. No person except those wearing proper attire shall be allowed in the operating room. Appropriate PPE shall be worn by all persons in situations where there is potential for exposure to blood borne pathogens.

16. Universal precautions must be implemented on all cases. Precautions for patients with airborne diseases, multiple resistant organisms, or immunosuppression are to be handled according to Operating Room Guidelines.

17. Enforcement of the rules shall be the responsibility of the Department of Surgery management staff. Any Disciplinary action recommended by the OR Committee shall be referred to the Department of Surgery.

V. Ambulatory Surgery

18. It is recommended that all patients be pre-admission tested prior to surgery. All patients scheduled for ambulatory surgery under general anesthesia should be requested by the to arrive at the hospital at least one to two (1 - 2) hours prior to the time the procedure is scheduled to allow necessary laboratory work and anesthesia preparation prior to surgery.

19. Preop testing is completed as indicated by the anesthesiologist or physician performing the procedure and on the chart prior to surgery.

20. A history and physical must be completed on all patients having a surgical procedure under local or general anesthesia. This includes all patients for ambulatory postoperative and/or observation beds. The history and physical may be completed on the Short Stay form.

21. Informed consent should be documented on the chart prior to surgery. The physician must document that he has discusses risks, benefits, and alternatives to the procedure with the patient.

22. CMOPS hours of operation are Monday through Friday, 7:30 a.m. to 5:00 p.m. On the first Wednesday of each month cases will start at 8:30 a.m.