HENDRICKS REGIONAL HEALTH
SURGERY SERVICE RULES AND REGULATIONS

I. **Delineation of Privileges**

All surgeons will have delineation of privileges completed on appointment to the Medical Staff and every two years at reappointment. A copy of privilege delineation is on file and available for review in the scheduling area. The Chief of Surgery will be notified immediately by the OR Director/designee if a physician exceeds their privileges. Requests for additional privileges must be requested through the Medical Staff credentialing process.

II. Requirements for Elective Surgery

A. **History and Physical**

A history and physical is required on all patients undergoing procedures. The history must include history of present illness, allergies, medications, medical diseases, and major surgeries. The physical must include examination of the heart and lungs as well as the affected area.

The history and physical requirement stated above applies to all inpatient and outpatient procedures, including those performed utilizing IV (procedural) sedation.

The history and physical must be completed and on the patient's medical record prior to surgery or procedure. The history and physical must be completed by a licensed physician and/or a licensed osteopathic physician for patients receiving treatment by a podiatrist. Only members of the Hendricks Regional Health medical staff may provide the preoperative H&P. The physician may delegate all or part of the physical examination and medical history to other practitioners, but the physician shall sign for and assume full responsibility for these activities.

Exception: Oral surgeons, who have been granted privileges may complete a history and physical on those patients considered to be ASA I, II, III. For patients with ASA designations of IV and V, the oral surgeon must request consultation with an appropriate physician with the history and physical to be completed by a licensed physician and/or licensed osteopathic physician.

When such history and physical examination are not recorded and in the patient's chart before the time for an operation, the operation shall be delayed by the Operating Room Director/designee or Director of Anesthesia unless the attending surgeon states in writing that such delay would constitute a hazard to the patient. The history and physical may be completed not more than thirty (30) days prior to surgery. However, an updating entry must be made in the progress notes documenting systems stability or change and any other pertinent information the day of surgery.

B. **Pre Operative Diagnostics**

Pre operative diagnostic procedures (lab, X-ray, EKG, etc.) are individualized according to physician orders and patient condition. Certain applicable screening criteria may apply.

C. **Requirements for Same Day Surgery**:

1. History and physical as described in II.A.
2. Order sheets.
3. Lab and X-ray studies, if appropriate.
4. Operative report
5. Anesthesia notes
6. Post Anesthesia Care
7. Nurses notes.
8. Discharge status.

9. Discharge instructions.
    a. Completion of the post-procedure/surgical discharge instruction form is required for all outpatient surgery. If the physician has pre-printed discharge instructions for a certain procedure, this may be indicated on the discharge instruction form and a copy of the pre-printed instructions attached to the back of the form as well as a copy placed in the medical record for documentation.

D. **Requirements for Pediatric Surgery**

Pediatric patients who may require subspecialty surgical intervention unavailable at our hospital should be transferred to an appropriate facility.

III. **Scheduling Elective Surgical Procedures**

A. Scheduling of elective procedures will be done Monday-Friday (except holidays) from 7:30 A.M. until 4:20 P.M. The surgeon/office staff scheduling a surgical procedure needs to supply specific information.

Information required:
1. Patient's name
2. Date of Birth
3. Age
4. Cell Phone, Home Phone, Work Phone numbers
5. Social Security Number
6. Physician Name
7. Complete Procedure including (R) or (L) when applicable
8. Length of procedure time
9. Type of anesthesia
10. Type of admission or room number if inpatient~~)~~
11. Latex sensitivity
12. Insurance information
13. Blood Bank Request

B. Requests for special positioning and or equipment and supplies must be made at this time.

Example: C-arm, flexible sigmoidoscope, intraocular lens, etc.

C. The surgeon/office staff will request a specific date and time for the procedure to be scheduled.

If the first choice is unavailable, the surgeon/office staff will request an alternate date & time.

D. No scheduling will be done by the House Supervisor.

IV. **Scheduling an Emergency Surgical Procedure**

Monday through Friday During Scheduled Procedures

A. Surgical procedures deemed to be of an emergency nature will be done as soon as an operating room, anesthesia staff and nursing staff are available.

A Surgical Emergency is defined as a critical clinical situation that requires immediate operative intervention due to direct threat to life or limb. That is, the longer the delay in performance of the procedure, the higher the likelihood of a dire outcome. <u>Surgical Emergency</u> cases are given priority above all other cases.

If elective procedures occupy all operating room suites and staff, the first operating room to become available will be used. This will necessitate "**bumping**" subsequent cases in that operating room.

Resolving scheduling conflicts: When there are add on cases, it is generally not appropriate for the Patient Care Manager/designee to be the mediator when cases must be bumped. It is imperative that surgeons discuss the need to bump directly with their colleagues since this is in the best interest of patients and OR efficiency. The OR Patient Care Manager/designee may assist the surgeon in locating the other surgeon, but discussion must occur between surgeons.

Emergency Cases are given priority for the next available OR suite and other cases would be moved to follow completion of that case. Surgeons would be notified by the OR Patient Care Manager/designee that an emergency case had been given priority and that all other cases would follow.

B. The surgeon will schedule the procedure with the Patient Care Manager/designee, giving the Information required:

Patient's name & age; surgical procedure appropriate information, (including (L) or (R) when applicable); type of anesthesia desired; location of patient; positioning; special equipment needs; assistant needed.

C. Every effort will be made to accommodate URGENT cases in the most efficient manner possible.

Surgical urgency is defined as a serious clinical situation that requires "next available" time in the operating room due to significant *potential* threat to life or limb. That is, the procedure should take precedence over elective cases in stable patients, but would not take precedence over surgical emergency cases.

Urgent Cases take priority over **elective** procedures. An urgent case would be placed in the next available OR suite. Surgeons would be notified that an urgent case has been given priority over elective cases with stable patients and other cases scheduled for that suite would follow.

D Emergency and urgent patients may be handled as inpatient, outpatient or as an emergency room patient.

E. When there **are two emergency cases** needing to be done at the same time, the surgeons involved in the cases **via direct doctor-to-doctor communication** would decide which case carried the most risk if delayed and then decide which case would go first. The same process would apply to two urgent cases needing to be done at the same time.

Exception: In cases when a surgeon is actively attending to a critical patient, he/she may ask the House Supervisor or OR Patient Manager/designee to make contact with the other surgeon.

Following discussion between surgeons if a consensus cannot be reached, the Chief of Surgery or designee would decide which case would be given priority.

Evenings-Nights-Weekends-Holidays

A. Patient will be evaluated by the surgeon and the surgeon is to notify the House Supervisor of the impending case

Information required: patient's name & age; surgical procedure (including (L) and (R) when applicable); type of anesthesia desired; location of the patient; positioning; special equipment needs; assistant needed.

B. Two OR nursing personnel are scheduled on call.

If surgeon deems third person is required, every effort will be made to meet the request.

C. OR nursing staff on 1st and 2nd call are required to be within 45minutes of the hospital to provide emergency surgical services.

V. Definition of Hazardous Case

Hazardous surgical cases that require a scrubbed **physician first assistant** include cases in which the primary surgeon anticipates:

a. Significant or difficult to control blood loss,
b. Prolonged anesthesia time,
c. High risk of intra-operative complications,
d. Procedures requiring considerable judgmental or technical skills,
e. Anticipated fatigue factors affecting surgeon or surgical team performance,
f. Procedures requiring more than one operating team

Hazardous surgical cases that require a qualified, scrubbed, **non-physician first assistant** include the following:

a. Cases that do not fit the criteria above for requiring a physician first assistant, and
b. Patients ASA class IV or V undergoing major open abdominal or thoracic procedures.

Surgical cases that do not meet any of the above criteria do not require a scrubbed first assistant.

VI. OR Start Time

The first case of the day is to have the patient in the OR Room as scheduled. The surgeon must notify the operating room of any delay in arrival time.

VII. Block Time Scheduling

A. The goal of block scheduling is to provide surgeons fair and adequate access to the operating rooms and to assure the efficient use of the operating room staff, anesthesia, and ancillary services. In general:

1. Blocks apply to elective procedures only.

2. Blocks may be assigned to individual physicians or groups of physicians.

3. No more than 75% of total surgical services available operating time may be assigned as blocks – thus allowing FCFS access and scheduling for urgent/emergent procedures.

B. Requesting Block Time

1. Procedure to obtain new OR block time is listed below:
   a. Request block time with the surgical committee.
   b. Block time will be given if available.
   c. Procedure if only morning block time is wanted and none is available.
      i. Determine what MD has the lowest block utilization that is less than 70%
      ii. That MD will give up 50% of his block time to the requesting MD

2. Procedure to obtain more OR block time is listed below:
   a. Request block time with the surgical committee.
      i. Block time will be given if available.

   b. Procedure if only morning block time is wanted and none is available.
      i. Determine what MD has the lowest block utilization that is less than 70%
      ii.. That MD will give up 50% of his block time to the requesting MD.

   c. Procedure to obtain new or more OR block time when no physician's utilization is less than 70% is listed below:
      i. Use an afternoon block time that is already available.
      ii. Petition the hospital and anesthesia to open up a new room and subsequently a new block time.

NOTE: Once a physician obtains block time he or she will have one year to build his practice. During that year he or she is safe from losing his block. After one year if his utilization is low someone can take half his block.

C. Release of Block times will be 2 weeks.

D. OR Efficiency Metrics

OR Efficiency Metrics will be monitored and reported as follows:

1. Block utilization
2. First start delays
3. Approved start delays
4. Anesthesia delay
5. Equipment delays
6. Nursing delays
7. Rep delay
8. OB delivery
9. Other case delays
10 Cancellations date of surgery

Action plans for improvement will be developed for any metric exceeding benchmarks

E. Evaluation of Block Time Utilization

utilization percentage will be determined by operating minutes within a four-hour blocks divided by 240 minutes (four hours) x 100, where operating minutes is the time from the start of the physician's first case till the end of the physician's last case.

Example 1: Surgeon 1 Block from 7:30 till 11:30
First case: In time 07:22 Out time 08:35
Second case In time 09:02 Out time 10:06
Last case In time 10:34 Out time 11:12
Utilization time = 230 minutes / 240 minutes x 100% = 95.8%

Example 2: Surgeon 2 Block from 8:00 till 12:00
First case: In time 09:15 Out time 10:05

Last time In time 10:40 Out time 13:00

Utilization time = 165 minutes / 240 minutes x 100% = 68.8%

Physician 2 would not get credit for the late start unless it was secondary to an approved reason.

1. Notification of planned absences, such as vacation time, must be given 30 days in advance to avoid unutilized block times counted.

2. First cases must be scheduled by 0730.

3. To improve OR efficiency on DOS, cases may be moved to alternative OR's without affecting block utilization analysis.

4. Utilization percentages will be reported monthly, both as most recent month and trend.

5. Any block percentage utilization less than 70% can be reviewed for modification of assigned time.

6. Utilization reporting reflects only actual OR utilization and does not consider cancelled procedures.

7. Requests for new or additional block times shall be made to the committee for consideration/action.

VIII. Surgical Consultation

Surgical consultations will be classified as urgent under the guidelines provided in section 3.6-1 of the Medical Staff Rules and Regulations.

Requests for urgent surgical consultations require physician-to-physician contact in order to communicate pertinent patient information. This process ensures the consultant is fully informed of the reason for the consult and will be able to provide requested services for the patient.

IX. Credentialing of Surgical Assistants

Surgical Assistants who are not employees of Hendricks Regional Health must be credentialed

as Allied Health Professionals as specified in the Medical Staff Credentialing Manual.

X. Observers in the Operating Room

Generally, observers, students, visiting physicians, salespersons, etc. are not allowed in the operating suite. Observers may be allowed in the operating suite for observation only, with consent of both the surgeon and anesthesiologist in charge of the case. Relatives may be allowed with consent of the surgeon in consultation with the patient.

Medical visitors, i.e. student nurses, physical therapy, etc. desiring clinical observation privileges must obtain permission of the surgeon, OR Director/Patient Care Manager/designee before observing in any operating room. Per request of surgeon, sales representatives are considered technical advisors and may be present in the OR suite.

Appropriate infection control criteria, “hold harmless statements”, and standard precautions educational packet will be provided to each individual requesting permission to observe procedures in the operating room. Composition of the packet will be in accordance with Medical Staff, Infection Control and Operating Room Procedures. The Sponsor will be responsible for obtaining the packet from the OR Director /Patient Care Manager/designee or Medical Staff Office and assuring that the observer acquires signatures and supporting documentation in a timely manner.

If the observer is a minor, the Consent to Allow a Minor To View Surgical Procedures form must be completed by the parent/legal guardian, signature obtained and witnessed prior to the student observer presenting to the OR.

All required documentation must be on file in the medical staff office or presented to the OR Patient Care Manager /designee no later than 30 minutes prior to the scheduled procedure. Observers will not be permitted in the OR without required documentation.

XI. Tissue - Foreign Body Handling

A. Implantable Devices

1. Implantable devices will be purchased sterile, when available, from the vendor.
2. Implantable devices not in original manufacturer's sterile packaging, which are otherwise amenable to sterilization will be sterilized in the Central Sterile Department.

   Each sterilized load of implantable devices will contain an Attest culture. Sterilized items will be shelved for 3 hours pending negative Attest sterilizer culture report. If item must be used prior to the 3 hour culture report, the surgeon, operating room and Infection Control Officer will be informed.
3. **Emergency** – Orthopedic Implants may be sterilized using the 10 minute 270 degree sterilization process in the operating room.

   Sterilization process will include a one-hour rapid readout biological indicator, a chemical indicator strip and the rigid closed container system.

4. The implantable device will not be used until the one hour rapid readout results are known in emergent situations if possible.
5. Right and left implantable parts (devices) will be labeled and color coded prior to placing on the sterile cart before the cart is taken to the OR.
6. Circulators, scrubs, and vendors must perform verification of the implantable device according to AORN standards – verification must include verbalization of the product, size, laterality, and expiration date.
7. Hospital Personnel will be responsible for passing the implantable to the operating team.
8. The surgeon will verify with the scrubbed surgical team prior to introducing the implantable onto the surgical field.

B. All tissues surgical specimens are to be sent for pathological examination according to the Policy for Defining Specimens for Pathology Examination – see attached.

XII. Dress Code in Surgery Department

Street clothes may be worn only in the immediate front office area up to posted sign entering the clean outer corridor. See posted signage. To enter inner core or clean outer corridor, scrub attire/jumpsuit and cap will be required. To enter the operating rooms, scrub attire, mask and cap are required. Perianesthesia associates must have on scrub attire. Visitors and ancillary staff will be allowed to enter Perianesthesia in street clothes.

XIII. Personal Conduct in the Operative Suite

The proper function of the OR requires teamwork and the optimal functioning of all involved in patient care. If a caregiver with a vital role in patient care is distracted by non-medical interests; his/her performance in the OR may be affected. As advocates for the patient, the surgeon, anesthesiologist and other allied health professionals must take personal responsibility to ensure that the OR environment is conducive to the safe conduct of anesthesia and the performance of surgery. The use of laptop computers, PDA's, and other electronic devices for non-medical activity is prohibited. Music may be permitted with the consent of the surgical team. Eating and drinking in the OR violates the hospital-wide infection control policy and **is not permitted**.

XIV. Operative Documentation

At the conclusion of an operation the surgeon will immediately document on the OR Record of Operation the wound class, preoperative diagnosis, post operative diagnosis and operation/findings. Packing/drains, casts and estimated blood loss are also documented when applicable. A complete detailed account of every operation (minor or major) must be completed by the surgeon within 24 hours of the procedure as outlined in the Medical Staff Rules and Regulations.

XV. Itinerant Surgery Policy

A surgeon will not perform elective surgery at a distance from his usual location without personal determination of the diagnosis, and the adequacy of preoperative preparation. He will personally render the postoperative care unless it is delegated to another physician as well qualified to continue this essential aspect of total surgical care. Itinerant surgery may be necessary occasionally for emergent reasons, but habitual or frequent operations under these circumstances will not be condoned.

Surgery Committee Approved: 02/06/2023
MEC Approved: 02/13/2023

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POLICY FOR DEFINING SPECIMENS
FOR PATHOLOGY EXAMINATION

Principle: A list of specimens approved by the medical staff and filed with the Indiana State Department of Health for gross examination only, at the discretion of the pathologist.

Policy: I. All specimens must be sent for pathology examination, with the following exceptions optional:

A. Orthopedic appliances
B. Foreskins of newborn infants
C. Placentas from normal vaginal delivery
D. Tissue removed during obstetric scar revision
E. Cataracts
F. Specimens rendered unrecognizable/undiagnosble by virtue of maceration in removal (e.g., meniscus shavings, phaecoemulsifications)
G. Joints removed by routine total joint procedures for osteoarthritis. Specimens may be sent for pathological evaluation at the discretion of the surgeon.
H. Plastic Surgery Implants
I. Cosmetic Surgery

II. The following specimens may be taken by the surgeon to show to the patient if disposition is documented on #19 pathology requisition:

A. Orthopedic appliances
B. Urinary stone
C. Foreign bodies

III. The following specimens are approved for gross examination only, at the discretion of the pathologist:

A. Bone from hammer toes and bunions
B. Foreskins on newborns (older children and men may be a micro)
C. Foreign bodies
D. Gingiva
E. Hernia sacs with lipomata
F. IUD with no endometrium
G. Ligaments
H. Meniscus
I. Nails (fingernails/toenails)
J Nose cartilage
K. Prosthesis
L. Stones (urological stones are sent for analysis)
M. Teeth
N. Tonsils and adenoids under 18 years of age
O. Traumatic amputation of limbs (digits, hand, etc.)
P. Tubes from ears
Q. Vaginal mucosa (perineum, cystocele, rectocele from vaginal repair).

All tissue removed are required to be sent for pathological diagnosis.

IV. The pathologist, following usual and customary professional standards subjects all specimens not otherwise exempted to examination.

Approved by Surgery Committee: 02/06/2023
Approved by Ancillary P&T Committee: 02/08/2023