EAST JEFFERSON GENERAL HOSPITAL
Rules & Regulations for the Perioperative Area

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1.0 PURPOSE:

The purpose of these Rules & Regulations is to establish procedures and guidelines for the Perioperative Area.

2.0 AUTHORITY:

The Surgical Procedures Committee is responsible for the professional medical activities in the Perioperative Area, as well as overseeing the overall function of the Operating Room, as outlined by the Medical Staff Bylaws. This Committee will develop, revise, and review policies and procedures for standards of practice that govern the professional medical activities of Surgery and Anesthesia. The policies are approved by the Chairman of Surgical Procedures and the Sr. Director of Surgery. The Rules & Regulations for the Perioperative Area are approved by the Medical Executive Committee. The Administrative Line Officer of Surgery will be responsible for all administrative aspects of running the Perioperative Area and will be assisted in this task by the Surgical Procedures Committee. The Sr. Director of Surgery is responsible to Administration.

3.0 CHANGES:

Changes in the Rules & Regulations are to be initiated by the Surgical Procedures Committee with recommended approval by a majority of the various surgical departments with final approval by the Medical Executive Committee.

4.0 ADMISSION TO THE PERIOPERATIVE AREA:

4.1 Definition

The Perioperative Area includes operating rooms, PACU, SDS, Holding Area, control desk, physician and staff lounges, and anesthesia offices.

4.2 Inpatients

Patients who are presently in an assigned room, awaiting emergency admission, or arriving the morning of surgery, may be admitted to the Perioperative Area.

4.3 Outpatients

Patients admitted to Same Day Surgery or the Observation Unit may be admitted to the Perioperative Area.

4.4 Pediatric Cases

Infants less than 6 months of age will not be routinely scheduled for surgery. A consultation will occur between the Chair of Surgery and Chief of Anesthesia prior to any surgical procedure scheduled for an infant less than 6 months of age. A pediatrician must evaluate all infants less than 6 months of age prior to a scheduled procedure.

4.5 Criteria for Admission to the Perioperative Area

4.5.1 History and Physical Examination

A relevant history and physical examination must be on the chart for all scheduled patients entering the Perioperative Area. Except in an emergency so certified in writing by the operating surgeon, surgery or any other potentially hazardous procedure shall not be performed until after the pre-operative diagnosis, history, physical examination, and required laboratory tests have been recorded in the chart.

The history and physical examination must be written on all patients no more than 30 days prior to or within 24 hours after registration or inpatient admissions, but prior to surgery or a procedure requiring anesthesia services. *(Refer to Medical Staff Bylaws Section 1.5 (d) (1).*

For a medical history and physical examination that was completed within 30 days prior to registration or

inpatient admissions, an update documenting any changes in the patient's condition is to be completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. *(Refer to Medical Staff Bylaws Section 1.5 (d) (1).*

If the history and physical examination has been dictated, but is not on the chart at the time of surgery, a written note must be entered of the proposed surgery. This note should include the conditions for which surgery is to be performed, the condition of the heart and lungs, allergies known to be present, other pertinent pathology and information relating to the patient. The note should state that the history and physical has been dictated. If not recorded, the surgery shall not be allowed to proceed. *(Refer to Medical Staff Rules & Regulations; Section 8.3.1 History and Physician Examination)*

4.5.2 Consents

A signed and witnessed surgical and anesthesia consent must be on the chart prior to elective admissions to the Perioperative Area. Consents will be completed in accordance with East Jefferson General Hospital's Administrative Policy & Procedure LEG-4: Informed Consents. A signed transfusion consent is required if a patient has been typed and screened or typed and cross-matched.

4.5.3 Emergency Cases

A history and physical and surgical consent may be deferred when a case is certified as an emergency, in writing, by the operating surgeon. Immediately after the emergency surgery has been completed the physician shall make a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure. A complete history and physical must be dictated within 24 hours.

4.5.4 Pre-Operative Preparation

1. Laboratory, X-Ray, and EKGs, are done at the discretion of the surgeon or anesthesiologist. Results must be reported on the patient's chart consistent with the requirements stated below.

2. The patient should be NPO for a period deemed appropriate by the surgeon and anesthesiologist prior to the procedure unless an emergency situation precludes this limit. This should be consistent with the established NPO Guidelines.

3. Pre-Operative Evaluations
   a. It is recommended that all patients scheduled for elective surgery complete the pre-admission process and chart documentation 5 business days prior to the day of surgery. All scheduled patients must complete the pre-admission process and chart documentation by 12 noon the day prior to surgery. Surgical cases may be removed from the surgery schedule when preoperative evaluation and chart documentation is incomplete.
   b. Pre-operative evaluations of all patients scheduled for elective surgery, using other than local anesthesia, will be completed and verified by the Department of Anesthesiology.
   c. If a patient who lives outside the metropolitan area is unable to complete the anesthesia interview in person, the interview may be conducted over the telephone or on the day of surgery. Arrangements for this interview will be made by the hospital so that the burden of contacting anesthesia will not be borne by the patients. The means of doing this will be outlined in the Policies and Procedures Manual for the operating suite.
   d. For elective surgery refer to the Pre-operative Evaluation Policy.

4. Chart Documents
   a. All chart documents must be received by Chart Management by 12 noon the day prior to surgery. Complete chart documentation requires:

> Test Results > History & Physical > Orders > Consents > Pre-operative Interviews

b. The pre-op Surgical Evaluation Center Supervisor, or designee, will notify all surgeons when complete preoperative evaluation and chart documentation is not consistent with these rules.
c. Abnormal results will be called to the surgeon and the anesthesiologist based on the Abnormal Lab Reporting Policy within 24hrs and by 12 noon prior to the day of surgery. The operating physician may determine the need to postpone elective surgery. The anesthesiologist may delay the elective surgery after discussion with and obtaining consent from the operating physician.
d. Incomplete chart documents may be reviewed monthly by the Surgical Procedures Committee for possible further action.

5. In general, patients will not be brought or sent to the Perioperative Area until the area in which the patient is being held is advised that the Perioperative Area is ready to accept the patient. This may vary in times of an emergency.

4.5.5 Discharge from Perioperative Area

Unless a patient is going to the Post Anesthesia Care Unit or Intensive Care Unit, a specific surgical and/or anesthesia release is required before the patient may be released from the Perioperative Area.

5.0 ANESTHESIA:

5.1 PRIVILEGES

5.1.1 Anesthesiologist Credentials

All anesthesiologists must be credentialed in accordance with the Medical Staff Bylaws and have completed an approved Anesthesia Residency Program.

5.1.2 CRNA Credentials

All CRNAs must be credentialed through the Hospital's Allied Health credentialing process and practice under the supervision of an anesthesiologist.

5.2 ANESTHESIA CARE

Anesthesia care will begin at pre-operative evaluation and follow the patient through the immediate post-operative recovery period. This care will be consistent with comprehensive performance standards approved by the Hospital, the Department of Anesthesia, the Surgical Procedures Committee and the Medical Executive Committee.

5.3 ANESTHESIA INDUCTION

Anesthesia will not be administered to a patient unless the operating surgeon is immediately available in the Perioperative Area. Exceptions may be made at the discretion of the anesthesiologist, in consultation with the operating surgeon.

6.0 OPERATING ROOM PRIVILEGES:

No surgeon may schedule or be the primary surgeon for any surgical procedure unless they have completed an approved surgical residency training program and have been credentialed in accordance with Articles III & IV of the Medical Staff Bylaws. Podiatrists may schedule surgical procedures if the division's criteria are met, documenting completion of a one-year post graduate training program and have been credentialed in accordance with Articles III & IV of the Medical Staff Bylaws.

Other physicians may utilize the OR facilities, as appropriate, for procedures if they have completed an approved residency training program and have been credentialed in accordance with Articles III & IV of the Medical Staff Bylaws.

6.1 ASSISTANCE

The need for assistance will be determined by the operating surgeon.

6.2 SURGICAL ASSISTANT CLASSIFICATIONS:

1. Physicians
2. Residents, Interns, and Medical Students
3. Registered Nurses, RN First Assistants
4. Physician Assistants
5. Surgical Technicians
6. Licensed Practical Nurses

The operating surgeon must remain in the Perioperative Area (refer to 4.1 definition) until the procedure is complete, unless his/her assistant is a physician. Placement of suture by non-MD, non-DPM, and non-DDS surgical assistants is limited to skin closure.

6.2.1 Allied Health Professionals

All Allied Health Professionals must be credentialed as appropriate and according to the Allied Health Credentialing Policy and Medical Staff Bylaws and Rules and Regulations.

6.3 OTHER PERSONNEL

6.3.1 Specialized Personnel

Personnel with specialized training (vendor representatives or personnel with specialized knowledge of surgical equipment or instruments) may enter the Perioperative Area, at the special request of the operating surgeon, for demonstration purposes only. This will be approved, on a case-by-case basis, by the Sr. Director of Surgery prior to the scheduled procedure. Non-medical personnel may not assist on any surgical procedure. Refer to the Traffic Control Policy.

6.3.2 Visiting Physicians

Visiting physicians may assist in surgery. They must be credentialed as provided in Medical Staff Bylaws. The Sr. Director will be informed of their approval prior to the procedure.

7.0 SCHEDULING

7.1 ELECTIVE SURGERY

All elective procedures are scheduled with Surgical Scheduling from 7:30 a.m. to 5 p.m., Monday through Friday. Procedures may be scheduled via the fax machine, email, or recorder. After hours, weekends, and holidays the telephone recorder is available for scheduling. The process for scheduling an elective surgery is governed by Medical Staff Policy & Procedure. Procedures done in other areas of the hospital, except OB, which require general or spinal anesthesia, special equipment, and surgical staff are scheduled with Surgical Scheduling in a similar manner.

7.12 WEEKEND SCHEDULING

Only emergent or urgent cases can be scheduled on Saturdays and Sundays except for identified Saturdays when elective cases are performed. Saturday elective cases are identified as ASA I and ASA II. No pediatric elective cases will be performed. Saturday scheduling is available two working days in advance for urgent inpatient (already bedded) surgical procedures.

7.3 ADD-ON / EMERGENCY PROCEDURES

On weekdays all add-on or emergency procedure bookings are directed to the Surgical Department. Emergency surgery may be performed at any time, 24 hours per day. During weekends or holidays,

emergency bookings are directed through the Administrative Representative on duty for the hospital. Refer to the Scheduling of Elective Surgery Policy for this procedure.

7.4 SURGERY START TIME

For clarity, of understanding and for consistency with National data, the surgery start time is defined as "patient induction". This definition will be used for reporting of time elements related to the surgical process.

8.0 ARRIVAL DAY OF SURGERY

8.1 PATIENT

Patients should be instructed by the surgeon to arrive no later than two hours prior to the scheduled surgical time. Failure to comply may result in case postponement to a later time.

8.2 SURGEON

8.2.1 For *first cases*:

1. The surgeon must be in the Perioperative area so that induction occurs no later than scheduled start time or be considered late.
2. If the surgeon is unavoidably delayed and the delay is anticipated to exceed 20 minutes, the room may be opened to another surgeon.
3. Unavoidable delays due to exceptional circumstances may be overridden by the Department Chair or Division Chief.

8.2.2 For *to follow cases*:

1. The surgeon must be in the Perioperative area at the scheduled start time or be considered late. The scheduled start time is the time mutually agreed to by the surgeon and the Surgery Department the day before surgery or the day of surgery if the case is booked after 5 p.m. of the day before.
2. If the surgeon is unavoidably delayed and the delay is anticipated to exceed 20 minutes, the room may be reassigned to a waiting surgeon.
3. If the surgeon is delayed because of the room or personnel not being available, he/she is to be notified as soon as this becomes apparent. If such a delay occurs without notification, the surgeon is to report the incidence as per Section 10.1.
4. Delays due to anesthesia will be dealt with according to the compliance policies established in the Rules and Regulations governing the conduct of the Anesthesia Department.

9.0 AFTERNOON COVERAGE

9.1 The operating room will run the necessary amount of rooms in the afternoon to accommodate the elective cases booked on the final surgery schedule.

10.0 URGENT CASES

10.1 An urgent or add-on case will be defined as a case that was booked after the final surgery schedule has been posted.

10.2 An urgent case will be scheduled at a time to be determined by the surgeon and the operating room director or their designee. The Sr. Director of Surgery will make every effort to ensure the urgent case is started within 4 hours of the requested time.

11.0 CASE DELAYS

11.1 When a scheduled case is delayed at the request of a surgeon every effort will be made to accommodate a

new mutually beneficial start time.

11.2 A case delayed by a surgeon will not be allowed to interfere with the start time of another scheduled case.

12.0 SURGICAL VOLUME MANAGEMENT

12.1 A Surgery Volume Committee will convene at the request of the Sr. Director of Surgery in anticipation of a consistent pattern of change in surgical volume.

12.2 The Surgery Volume Committee will consist of the Chairman of the Surgical Procedures Committee or their designee, the Vice President of Surgical Services, the Operating Room Sr. Director, and the Chief of Anesthesia.

12.3 The Surgery Volume Committee will be charged with creating and implementing a solution that manages the change in surgical volume to meet the needs of the Medical Staff.

13.0 MISCELLANEOUS

13.1 HOSPITAL TEAM MEMBERS

Perioperative Area RNs and CSTs may be utilized to assist in surgery as personnel availability permits, and if appropriately credentialed. Perioperative Area RNs and CSTs may function as private surgical assistants when off-duty, if appropriately credentialed.

13.2 PATHOLOGY

A pathologist will be available for frozen sections. He/She will communicate by written report to the operating surgeon, or if necessary, come directly to the Operating Room. All specimens will be examined by a pathologist as outlined by the Medical Staff Rules & Regulations.

13.3 INSTRUMENTS, SHARPS, SPONGE COUNT

The attending surgeon may request an instrument count on any procedure. An instrument count will be automatically performed in all cases in which the likelihood exists that an instrument could be retained. Refer to Incorrect Count Policy for this procedure.

13.4 ATTIRE

All individuals entering the operating room will dress in clean East Jefferson scrub clothes with caps and masks. Protective shoe coverings, are optional. Hospital scrub clothes should not be worn outside the hospital environment. All caps, masks and shoe covers must be removed when leaving the Perioperative Area. All damaged or soiled articles must be changed immediately.

13.5 TRAFFIC PATTERNS

Operating Room traffic is dictated by the Traffic Control Policy. The Sr. Director of Surgery will enforce this policy.

13.6 UNUSUAL EVENT REPORTING

Any unusual or unexpected incidents occurring during an operative procedure shall be reported to the Sr. Director of Surgery. This includes, but is not limited to, any serious break of sterile technique occurring during a procedure, equipment breakdown or failure, and instruments or material lost during an operative procedure.

Surgeons who frequently call the OR desk to advise of late arrival may be reported to the Surgical Procedures Committee for review and possible action. The Sr. Director will involve the Surgical Procedures Chairman,

when assistance is required, in dealing with Medical Staff.

13.7 VIOLATIONS

Any violation of these rules is to be reported to the Chairman of the Surgical Procedures Committee. The Chairman of the Surgical Procedures Committee may act alone or present the matter to the entire committee, depending upon the seriousness of the violation. If indicated, the Surgical Procedures Committee may present the matter to the Medical Executive Committee for action.

14.0 GRIEVANCES

14.1 A surgeon who has a complaint regarding OR function or management may bring it to the Surgical Procedures Committee chairman or call the complaint to the Medical Director . Such complaints will be reported to the MEC if necessary

14.2 Complaints of a significant nature may be taken directly to Hospital Administration by the Surgical Procedures Committee Chairman.

15.0 PERIOPERATIVE AREA EVALUATION

15.1 The Surgical Procedures Committee Chairman and the Sr. Director of Surgery will review the overall function of Surgical Services annually.

16.0 SEQUELAE

16.1 LATE ARRIVALS

Late arrivals will be monitored on a quarterly basis. Surgeons or anesthesiologists who are late three times in a quarter will be warned by letter. Surgeons who are late four times in a quarter, for first starts, will forfeit the ability to schedule an elective first case for 30 days following notification of the fourth offense. Within a 12 month rolling period, the 2nd suspension for late arrival is for 60 days and the 3rd suspension is for 90 days. For the anesthesiologist, the Surgical Procedures Committee Chairman will send a letter to the Chairman of Anesthesia for appropriate action.

16.2 EMERGENCY SURGERIES

Any emergency that has been questioned as potentially inappropriate by the Sr. Director of Surgery will be reviewed by the Surgical Procedures Committee. If the committee determines that the procedure was not emergent, a letter will be sent to the surgeon and his/her department chairman.

17.0 DEPARTMENT REGULATIONS

Departments may establish and recommend department-specific rules, regulations, and policies. Such shall not be in conflict with, or less restrictive than the Rules & Regulations and Policies & Procedures of the Perioperative Area, and Medical Staff Bylaws. Department-specific rules and policies shall be approved by the Surgical Procedures Committee, Medical Executive Committee, and Administration.

Department of Gynecology:

1. When possible, high-risk procedures should be done in the Perioperative Area.

2. For patients in the child-bearing age group in whom a gynecologic procedure is advised which will

result in sterilization, consent must be properly signed and executed before the patient is pre-medicated. Consultation is not required.

3. If an obstetrical and gynecological procedure to accomplish sterilization is recommended by the operating surgeon for medical indications while the patient is under anesthesia, and a consent has not been obtained, the recorded opinion of a knowledgeable consultant will be obtained. Every effort will be made to secure consent from next of kin.

4. Pregnancy testing will be routine on women of childbearing age, with an intact uterus, undergoing gynecologic procedures. Patients undergoing obstetric procedures (i.e. cesarean section, D&C for a miscarriage, cerclage, etc.) do not require pregnancy testing.

5. Therapeutic abortions will only be performed at East Jefferson General Hospital in accordance with Louisiana law.

APPROVED:

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Chair, Department of Surgery ***Date***
Chair, Surgical Procedures Committee

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Chair, Medical Executive Committee ***Date***

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President & Chief Executive Officer ***Date***

Revised: ***10/83, 12/85, 8/86, 7/87, 4/88, 4/92, 4/93, 7/93, 7/96, 7/01, 8/03, 6/04, 5/05, 4/07, 6/07, 9/09, 4/12, 5/16, 7/16, 9/16, 1/17***