Surgical Services Rules and Regulations

Main Operating Room

and

Outpatient Surgical Center

St. Mary's Hospital
Athens, GA

Amended and Restated

Revised: 7/1989, 2/1990, 5/1991, 8/1992, 3/1993, 10/1994, 5/1995, 12/1995, 12/1996, 8/1998, 8/1999, 2/2003, 6/2018, 10/2018, 1/2021, 8/2022, 2/2023

Section 1.0 Surgeons

1.1 Surgery may be performed by an Active Staff Member who has been granted privileges in conformance with Bylaws of the Medical Staff.

1.2 The current classification and privileges of each surgeon shall be on file in the Physician Privileges (Privilege Inquiry) module on PC's in designated areas in the Operating Room and Outpatient Surgical Center.

1.3 Temporary surgical privileges may be granted to an applicant whose application for membership and privileges has received favorable recommendation from the Credentials and Medical Executive committees while awaiting final Board approval.

Section 2.0 Assistants to the Surgeon

2.1 Assistants to the surgeon must be credentialed by Medical Staff Affairs.

2.2 Assistants to the Surgeon may be

2.2.1 Any member of the Active Surgical Staff that met the requirements noted in Section 2.1.

2.2.2 Employee of surgeon that met the requirements noted in Section 2.1.

2.3 No one will be allowed to scrub on a procedure unless he is an employee of Surgical Services or meets qualifications specified in Sections 1 and 2.

2.4 Surgeons who do not comply with the Rules and Regulations regarding Assistants will be subject to such action as provided in the Bylaws of the Medical Staff.

2.5 The names of surgical assistants who are employees of Surgeons can be found in the Practitioner Privileges (Privilege Inquiry) module on PC's in designated areas in the Operating Room and the Outpatient Surgical Center.

2.6 Assistants to the surgeon must be Eligible for Rehire with St. Mary's, if applicable

Section 3.0 Administration of all types of Anesthesia Including Moderate Sedation

3.1 Anesthesia may be administered by

3.1.1 An Active Staff Member who has been granted privileges in conformance with Bylaws of the Medical Staff.

3.1.2 An Associate Staff Member who has been granted privileges in conformance with Bylaws of the Medical Staff.

3.1.3 A Certified Registered Nurse Anesthetist (CRNA) or Anesthesia Physician's Assistant (Anesthesia PA) who is an employee of an Anesthesiologist or an Anesthesiology Group who has been granted staff status as a Health Professional Affiliate.

3.1.4 All cases will be reviewed by the Department of Anesthesiology.

3.2 The current classification and privileges of persons administering anesthesia can be found in the Practitioner Privileges (Privileges Inquiry) module on PC's designated in the Operating Room and Outpatient Surgical Center.

3.3 All cases scheduled for the Main OR and OPSC shall be reviewed by the Department of Anesthesiology.

3.4 All Anesthesia personnel must be Eligible for Rehire with St. Mary's, if applicable.

3.5 It is expected that the Anesthesiologist's/designee's arrival time in the Preoperative areas will allow for adequate time to fully prepare the patient for surgery. The patient will be ready to move into the operating room prior to their scheduled start time.

Section 4.0 Consents

4.1 No operations shall be performed, except in an emergency, without the expressed consent of a patient or person legally authorized to consent on behalf of the patient. Without expressed consent, implied consent may be used in an emergency provided no one authorized by Georgia law to consent for the patient is readily available and provided the Operating Surgeon includes a statement stating that a delay would be detrimental to the life or health of the patient.

4.2 Procedures will not be performed in the Operating Room or Outpatient Surgical Center unless there is a signed consent form on the patient's chart prior to surgery, except in emergency situations.

4.2.1 The length of time the consent is valid

4.2.1.1 Thirty days from the date of admission or for the period of time the person is confined to a hospital for that purpose, whichever is greater.

4.2.1.2 Thirty days from the date of the surgical, or diagnostic procedure obtained as a part of the course of treatment for the patient's condition.

4.3 All consents must be duly witnessed, namely

4.3.1 Verbal consents (including telephone consents) must be witnessed by two persons.

4.3.2 Written consents must be witnessed at least by one person. This includes consent forms signed by persons unable to write, i.e., who must make a mark.

4.4 Only those procedures described in the consent may be performed. If the Operating Surgeon decides during the course of surgery that an additional related procedure is absolutely necessary, she/he may perform such procedure and the reasons for same are described in the operative report.

4.5 The names of the Operating Surgeon/s must appear in the consent.

4.6 The following categories define persons authorized to give legal consent

4.6.1 An adult consenting for his/herself.

4.6.2 A parent consenting for his/her minor child.

4.6.3 A married person consenting for his/her spouse.

4.6.4 A minor married person consenting for his/herself.

4.6.5 A guardian consenting for his/her ward.

4.6.6 A person temporarily standing in loco parentis, whether formally serving or not, consenting for the minor under his/her care.

4.6.7 A person eighteen (18) years of age or over consenting for him/herself.

4.6.8 A female, regardless of age or marital status, consenting for herself in connection with pregnancy or childbirth.

4.6.9 An adult, in the absence of parents, consenting for a minor sister or brother.

4.6.10 A grandparent, in the absence of parents, consenting for his/her minor grandchild.

4.6.11 An agent appointed under a Durable Power of Attorney for Health Care.

4.7 The responsibility for obtaining the informed consent rests with the Operating Surgeon.

Section 5.0 Scheduling and Use of Main OR and OPSC

5.1 Elective surgery may be scheduled from 0730 to 1500 Monday through Friday, except for observed holidays. St. Mary's will follow Trinity's PAL policy regarding Holiday observation and department closures. The holiday will be observed on a Friday if the actual holiday is on Saturday; alternatively, the holiday will be observed on a Monday if the actual holiday is on Sunday. Emergency surgery may be performed at any time in the Main OR. Except for emergencies, Surgical Services will be closed on the following observed Holidays:

5.1.1 New Year's Day
5.1.2 Memorial Day
5.1.3 Independence Day
5.1.4 Labor Day
5.1.5 Thanksgiving Day
5.1.6 Christmas Day

5.2 Two members of the Outpatient Surgical Center nursing staff will remain on duty while patients are in the suite Monday through Friday to allow patients to be discharged from the recovery area. In OPSC after 1900/7:00pm, the patient will either be admitted to the hospital for observation, admitted as an inpatient, or discharged from the Outpatient Surgical Center. In Short Stay after 2100/9:00pm, the patient will either be admitted to the hospital for observation, admitted as an inpatient, or discharged from Short Stay.

5.3 The Director of Surgical Services has the authority to limit the number of scheduled procedures based on the availability of Operating Room staff.

5.4 Scheduling of procedures, elective or emergency:

5.4.1 When scheduling a procedure, the following information must be provided:

5.4.1.1 Date
5.4.1.2 Time
5.4.1.3 Surgeon
5.4.1.4 Assisting Surgeon, if applicable
5.4.1.5 Patient Name
5.4.1.6 Procedure including laterality and levels of spine as applicable
5.4.1.7 Length of Procedure/Procedure Time Required
5.4.1.8 Equipment Needed
5.4.1.9 Patient Date of Birth
5.4.1.10 Sex
5.4.1.11 Admission Status: OP/Same Day, Observation, IP
5.4.1.12 Anesthesia Type: General, Epidural, MAC, Spinal
5.4.1.13 Diagnosis
5.4.1.14 Insurance

5.4.2 The Surgeon may request the type of anesthesia.

5.4.3 Surgical procedures are to be scheduled with Operating Room Personnel. Surgical procedures are not to be scheduled with the admission clerk, the switchboard operator or nursing personnel on the units.

5.4.4 If it is necessary to schedule an emergency procedure during the scheduled day, the nature of the emergency should be explained to the Surgeon with scheduled procedures and changes in schedule negotiated with priority given to the emergency procedure.

5.4.5 To schedule an emergency procedure, the Operating Surgeon must do so only through the Operating Room staff or Nursing Supervisor on duty after hours. Surgeon must state the patients name, procedure, and the type of anesthesia desired. They may notify the Anesthesiologist on call or he may request the Operating Room, or Nursing Supervisor, personnel to make the call. Operating Room personnel on call should be notified, giving them the name of the Surgeon, type of anesthesia, patient, and the procedure. Emergency procedures are scheduled with the Operating Room personnel on duty just prior to the time the procedure is to be performed.

5.4.6 If more than one Surgeon wishes to schedule an emergency procedure at the time only one additional "call team" is available, the Surgeons must agree which procedure will take

priority. If additional personnel are needed, the Operating Room personnel or the Nursing Supervisor on duty will endeavor to secure additional personnel after being advised by the Surgeons of the nature and extent of the emergencies.

5.4.7 If a Surgeon finds it necessary to cancel a scheduled procedure, he may substitute a procedure of similar length for that time frame, taking into consideration preoperative testing requirements and clearances. If he does not wish to make a substitution, the Operating Room personnel will contact the Surgeon scheduled to follow the canceled procedure to allow him to start at an earlier time.

5.4.8 A definite time cannot be assigned to any surgeon except for cases scheduled to begin at 0730/7:30am or 0800/8:00am. The Director of Surgical Services will consider a Surgeon's request for a specified time, but this will be subject to demands on the room and staff involved.

5.4.9 The hours for scheduled pre-op visits/phone interviews in Short Stay/Pre-Admission Testing are 0800/8:00am-1600/4:00pm, Monday through Friday, except holidays.

5.4.10 Post-operative outpatients will be transferred to PACU Phases I or II. The patient will be discharged after the patient meets discharge criteria and there is a written order from the surgeon or anesthesiologist.

5.4.11 Outpatient surgical procedures performed when the Short Stay unit is closed may be admitted through the Emergency Department and discharged from an assigned Nursing Unit according to the rules as described in 5.4.10.

5.4.12 Patients admitted the day of surgery will be transferred from the PACU to the assigned nursing units according to the rules described in Section 10.

5.4.13 If the patient is to be an inpatient, or admitted the day of surgery, Bed Control or the Nursing Supervisor (after 1700/5:00pm) must be notified according to the policies of the Admissions Department.

5.4.14 When possible, infectious patients should be scheduled after completion of all other elective procedures for that room/surgeon on that day.

5.4.15 Surgeons and Anesthesiologist shall be in the Operating Room and ready to begin surgery at the time scheduled for their procedures. The Operating Room will not be held longer than 30 minutes after the time scheduled. If a delay is anticipated, the Operating Room personnel will notify the Surgeon and Anesthesiologist as soon as possible so that necessary adjustments may be made in the schedule. Notification of the delay to the Surgeon, Anesthesiologist, or Operating Room personnel will facilitate better patient care and minimize inconvenience.

5.4.16 Surgeons must schedule elective cases in a timely manner to avoid unnecessary costs, such as overnight shipping, incurred to St. Mary's. If surgeons schedule an elective case that incurs unnecessary costs, such as overnight shipping, then the Director of Surgical Services reserves the right to reschedule the case.

Section 6.0 Records

6.1 The patient's chart is to accompany the patient to the Operating Room or Outpatient Surgical Center and the following should be recorded:

6.1.1 An updated History and Physical signed, dated, and timed by the Surgeon. No update needed if H&P completed within 24 hours prior to procedure time. An update is required for H&P's greater than 24 hours and less than 30 days. A new H&P is required if current H&P is over 30 days prior to procedure date. The H&P must include:

6.1.1.1 Any medical disorders
6.1.1.2 Regular medications taken by the patient
6.1.1.3 Any known allergies
6.1.1.4 Diagnosis and planned procedure
6.1.1.5 Findings of physical examination
6.1.1.6 Review of systems

6.1.2 Informed consent properly completed, dated, timed, signed and witnessed.

6.1.3 Pre-operative laboratory testing, chest x-ray or EKG, prior to general or regional anesthesia shall be left to the discretion of the surgeon and/or Anesthesiologist.

6.1.4 Local anesthesia requirements shall be left to the discretion of the surgeon (refer to Section 3.3).

6.1.5 Any abnormal results from pre-operative testing must be reported immediately to the Surgeon and/or Anesthesiologist and notification recorded in the Nurse's Notes. The decision to proceed with the surgery in the presence of abnormal results will be at the discretion of the Surgeon and/or Anesthesiologist.

6.1.6 The pre-operative orders should include the procedure to be performed.

6.2 The pre-anesthetic and post-anesthetic notes shall be the responsibility of the Anesthesiologist.

6.3 The operative report shall be dictated immediately following the surgery and shall contain the description of the findings, the detailed account of technique used, and tissue removed.

6.4 In addition to the operative report, an immediate post-op note dated, timed and signed on the progress record is required prior to the time the patient leaves the surgical suite. This record should include the following.

6.4.1 Brief description of the procedure
6.4.2 Type of Anesthesia
6.4.3 Pre-Procedure Diagnosis
6.4.4 Post-Procedure Diagnosis
6.4.5 Findings
6.4.6 Technical procedure used
6.4.7 Primary surgeon
6.4.8 Assistant(s)
6.4.9 Complications
6.4.10 EBL
6.4.11 Specimens removed

And any other pertinent information. Post-operative orders must be written and signed by the surgeon or Anesthesiologist before the patient leaves the surgical suite. Patients discharged from the Main OR or OPSC must have note on the discharge summary or progress note and signed by the Operating Surgeon.

Section 7.0 Pathology

7.1 Pathology Requirements:

7.1.1 All specimens removed shall be in a labeled containers with a pathology request properly completed.

7.1.2 All tissue removed in a procedure shall be sent to the hospital Pathologist who shall make all necessary examinations to arrive at a diagnosis and shall dictate and sign the report.

The exceptions to this rule, at the discretion of the Surgeon, shall be

7.1.2.1 Normal newborn circumcised tissue

7.1.2.2 Arthroscopic tissue
7.1.2.3 Cataract, trabeculum, and iris fragments
7.1.2.4 Excised teeth
7.1.2.5 Foreign bodies, such as BB pellets
7.1.2.6 Partial phalangectomy tissue
7.1.2.7 Certain tissue removed during plastic surgery procedures, such as abdominoplasty, augmentation mammoplasty, blepharoplasty, brow lift, face lift, otoplasty, liposuction, chin implant, and mastopexy
7.1.2.8 Normal placenta removed during c-sections provided one or more of the following criteria is not present (the attending physician shall instruct Operating Room Personnel as to disposition of c-section placentas):

Prematurity (baby weight below 2500g)	Suspicion of neonatal anemia
Baby small for date	Pre-eclampsia, toxemia
Postmature cases	Maternal diabetes
All babies doing poorly	Suspected single umbilical artery
Any possible intrauterine infections (viral or parasitic diseases during pregnancy)	Any malformation of baby
Any instances of premature rupture of membranes	Stillbirth
Twins	Bleeding (placenta previa, premature separation and vas previa)
Iso-immunization	Tumors of the placenta

7.1.3 All tissues shall remain the property of the hospital. If a patient requests a specimen, the pathology department will be responsible for facilitating.
7.1.4 Foreign bodies, implants, and calculi shall go to the Pathologist for identification or for any other examination requested by the Surgeon, including retrieved surgical implants.
7.1.5 Limbs must be wrapped and placed in a plastic bag properly labeled. Limbs must be sent directly to the Pathology department, accompanied by a properly completed form. If the Pathology department is closed, the Operating Room/Outpatient Surgical Center personnel must notify the Nursing Supervisor on duty for the limb to be placed in the morgue. The pathology request form is placed in the Pathology department box in the Operating Room.
7.2 Specimen Preparation:
7.2.1 All pathology specimens, except for fresh, frozen sections or in special cases as requested by the Surgeon, must be in 10% Formalin Solution.
7.2.2 Aspirated fluids must be sent to the laboratory immediately accompanied by a properly completed request form.
7.2.3 All specimens or swabs for cultures, frozen sections, and bronchial washings must be taken immediately to the laboratory accompanied by a properly completed request form.

Section 8.0 Pre-Operative Routine

8.1 Patients having surgery in the Operating Room must remove all articles of clothing and dress in a hospital gown with a surgical cap to cover hair. Hairpins, jewelry, dentures, removable prostheses, make-up, and nail polish must be removed. Any exceptions must be approved by Anesthesia provider or Surgeon. All personal belongings will be placed in a bag and labeled with the patient's name. Belongings will be given to the accompanying adult, stored in a designated area in the extended recovery unit, or left on the nursing unit in the patient's room.

8.2 Pre-operative shave preps on elective procedures will be done prior to the patient going to the Operating Room by Surgical Services personnel according to the pre-operative orders of the surgeon.

8.3 All pre-operative medication will be administered as ordered by the Anesthesiologist or Surgeon.

Section 9.0 Main OR and OPSC Dress Code

9.1 Surgeons, Surgeons' Assistants, Anesthesiologists, Anesthesia Providers, hospital personnel, and any other approved person must change to the surgical scrubs provided by the hospital, wear appropriate OR shoes or shoe covers, head coverings and masks. All hair should be covered completely, including sideburns, beards, and long hair for women and men. This attire must be worn when entering any area behind the Red Line.

9.2 Caps, masks, and shoe covers must not be worn outside of the surgical suite.

9.3 Masks should be changed between procedures/patients, as supplies last. This also applies to scrubs and caps when contaminated.

9.4 Personal belongings are the responsibility of the owners. Each Surgeon, Anesthesiologist, Anesthesia Provider, and hospital personnel are assigned a locker. It is his/her responsibility to maintain. It is suggested that each person purchase a small lock for their locker.

Section 10.0 Post Anesthesia Care

10.1 Post Anesthesia Care Unit-Inpatient/OR

10.1.1 All patients having general, spinal, or epidural anesthetic are to be admitted to PACU. Patients having other regional anesthesia may be admitted to PACU at the discretion of the Surgeon or the Anesthesiologist.

10.1.2 Any patients requiring isolation will be recovered in the isolation room in PACU. The need for isolation can be determined by the attending physician, Anesthesiologist, or Team Leaders of OR/PACU.

10.1.3 If more than one patient requiring isolation is to be recovered simultaneously: then one must recover in the isolation room and the second patient recovers in the OR until either the isolation room becomes available, or the patient is ready to transfer to the appropriate nursing unit. Usage of the isolation room will be determined by the PACU Team Leader, or designee, in collaboration with the Anesthesiologist in charge.

10.1.3 Patients having a local anesthetic are taken directly back to the nursing unit/short stay unless they require closer observation ordered by the Anesthesiologist or Surgeon.

10.1.4 The nursing personnel in PACU are responsible for assessing patients on admission, at frequent intervals as ordered and on discharge to the next phase of care/nursing unit. The nurses are responsible for documentation of the assessments and nursing interventions.

10.1.5 The Anesthesiologist must assess the patient and sign the order for discharge for the patient to discharge to the next phase of care/nursing unit.

10.1.6 Under all circumstances, it is the responsibility of the PACU nursing personnel to inform the Anesthesiologist and Surgeon of any change in the patient's condition.

10.2 PACU-OPSC

10.2.1 PACU-OPSC service is available at 0730/7:30am, Monday through Friday, except holidays.

10.2.2 All patients having general, spinal or epidural anesthetic are to be admitted to PACU. Patients having other regional anesthesia may be admitted to PACU at the discretion of the Surgeon or the Anesthesiologist. Any patients requiring isolation will be recovered in the isolation

room in PACU. The need for isolation can be determined by the attending physician, Anesthesiologist, or Team Leaders of OR/PACU.

10.2.3 Patients having a local anesthetic are taken directly to Phase II Recovery/nursing unit unless they require closer observation ordered by the Anesthesiologist or Surgeon.

10.2.4 The nursing personnel in PACU are responsible for assessing patients on admission, at frequent intervals as ordered and on discharge to the next phase of care/nursing unit. The nurses are responsible for documentation of the assessments and nursing interventions.

10.2.5 The Anesthesiologist must assess the patient and sign the order for discharge for the patient to discharge to the next phase of care/nursing unit.

10.2.6 Under all circumstances, it is the responsibility of the PACU nursing personnel to inform the Anesthesiologist and Surgeon of any change in the patient's condition.

Section 11.0 Consultation

11.1 Consultation with another qualified physician may be sought at the discretion of the Surgeon for:

11.1.1 Procedures in which, according to the judgement of the Surgeon, the patient is not a good candidate, the diagnosis is obscure and /or there is some question as to which surgical intervention would be most appropriate.

11.1.2 Inpatients under 35 years of age who are to have a hysterectomy, unless there is a written history on the chart stating the patient has had a previous sterilization or documented pathological evidence of a disease process requiring a hysterectomy.

11.1.3 Vasectomies, not in conflict with the Ethical and Religious Directives for Trinity Health. Vasectomies performed for medical reasons need not have a consultation. However, the medical reasons should be documented in the history and operative report.

Section 12.0 X-Ray Responsibilities in Main OR and OPSC

12.1 All x-ray equipment, including the C-Arms used in surgery, must be operated by x-ray personnel or with x-ray personnel in attendance.

12.2 X-ray personnel performing services in surgery must follow regulations as to surgical attire.

12.3 The x-ray machines are to be cleaned before and after each procedure by the x-ray personnel.

12.4 The processing room is the responsibility of the x-ray personnel.

12.5 X-ray personnel will be notified by the Operating Room personnel as to the time they are needed.

12.6 The x-ray department should always afford adequate coverage to prevent delay for surgical patients.

12.7 All films taken in surgery should be returned to the x-ray department.

12.8 Surgical Services will schedule periodic in-services of aseptic technique for x-ray personnel performing services in surgery.

Section 13.0 Visitors

<u>Main OR-OPSC OR</u>

13.1 Private duty nurse, relative and friends of patients, unless they are Physicians or Licensed Nurses, may not accompany the patient to surgery. In the case of Physicians or Licensed Nurses, they may accompany the patient only with the mutual agreement of the Surgeon, Anesthesiologist, Director of Surgical Services, and the prior written consent of the patient.

13.2 No other people will be allowed to observe surgery other than the customary people involved with the surgery; with the exception of ancillary, educational, and supporting staff as is deemed appropriate by the OR Manager or Director.

Short Stay/Pre-Op

13.3 Visitors must be dressed appropriately, must wear a shirt and shoes.

13.4 Visitors should maintain a quiet environment and avoid unnecessary noise. Disruptive behavior and unsafe practices are not acceptable; these situations, while usually rare will be addressed directly and promptly.

13.5 Visitors may be asked to leave the room during tests, treatments or when a physician, anesthesiologist or nurse needs to see the patient.

13.6 For the protection of our patients, St. Mary's Healthcare System asks that any child under 12 years of age or people with colds, sore throats, or a contagious disease should not visit patients or patient care areas.

13.7 For the safety of all, children must be accompanied by an adult and must always be directly supervised. The patient cannot be considered the designee supervising the child. Responsibility for the child's behavior and safety rests with the parent and/or parent's designee.

13.8 Visitors including children accompanied by an employee or physician who are not designated patient visitors, must comply with the visitor guidelines and remain in areas designated as public.

13.9 St. Mary's Healthcare System prohibits discrimination against or visitors, patients and staff based on age, race, ethnicity, religion, culture, language, disability, socio-economic status, sex, sexual orientation or gender identity and expression.

Section 14.0 Laser Surgery

14.1 Surgical Services must keep a current list of Medical Staff members with laser privileges.

14.2 Nursing Staff Policies

14.2.1 Nursing personnel assigned to laser procedures must have attended an in-service program on operation, care and maintenance of machine from manufacturer's representative.

14.2.2 Surgical Services must keep a current list of nursing personnel meeting the requirements as described in 14.2.1.

14.2.3 During laser procedures with the surgeon-controlled foot pedals, only 1 RN Circulator is required.

14.2.4 During laser procedures without the capacity for surgeon-controlled foot pedals, there must always be a Circulating Nurse and a Laser Operator present. The Laser Operator is to remain with the Laser machine while the Circulator performs other duties.

14.3 Laser Safety Policies must always be followed with no exceptions.

Section 15.0 Tissue Bank

15.1 The tissue bank is in the OR Sterile core storage room and only authorized personnel have access.

15.2 The temperature of the bank is continuously monitored with an escalating notification alarm system.

15.3 Bone/Tissue from the Bank will not be released for use in any other facility/institution.

Section 16.0 Concurrent and Overlapping Surgeries

16.1 Surgical procedures in the operating room should be scheduled to provide for adequate time in between procedures that are to be performed by the same primary surgeon to ensure that the

critical portions of each operation, for which a single surgeon is responsible, do not occur at the same time.

16.2 Every patient in the operating room will have at least one primary attending surgeon clearly designated in the patient's medical record.

16.3 The primary attending surgeon will inform the operating room team, either in person or by phone, as to the surgical plan and his/her availability or the availability for another attending surgeon for the entirety of the case.

16.4 The primary attending surgeon is personally responsible for the patient's welfare throughout the operation. In general, the patient's primary attending surgeon should be in the operating suite or should be immediately available for the total case time.

16.5 A primary attending surgeon's involvement in concurrent surgeries on two different patients in two different rooms should not be performed, except for emergency situations in patient care.

16.6 Unanticipated circumstances may arise during procedures that require the surgeon to leave the operating room before completion of the critical portion of the operation. In this situation, a backup attending surgeon must be identified and available to come to the operating room promptly.

16.7 When the primary attending surgeon is not present or immediately available another attending surgeon should be assigned to be immediately available.

Section 17.0 Surgical Scheduling Definitions

17.1 **Definitions of Case Classification**: Accurate and objective definitions of case type must be used to ensure that the elective schedule is protected, and scheduled times are maintained. The following classifications will be utilized.

Critical: Unstable patient with life threatening conditions requiring immediate attention that takes precedence over all other cases. Critical cases will be performed in the first available room during regular hours (or may bump prescheduled cases). The Leaders in the OR will notify the surgeon being bumped. Examples may include unstable multiple trauma, penetrating trauma, unstable bleeds, ruptured AAA.

Emergent: Life or limb threatening conditions requiring surgery within 4 hours, but which may lead to severe complications if surgery is not performed within 12 hours. Patients designated as emergent take priority over urgent or non-urgent inpatients. Emergent cases during weekdays scheduled surgery hours must be worked into available time in the schedule or done in the evening. These cases will be done on a first come first served basis and will take priority over elective, non-urgent, inpatient "add-ons". Any emergent case which has not been accommodated within 4 hours is reclassified as critical. When a surgeon schedules an "emergent" case but is unavailable until a specified time, the priority of that case will be determined by his time of availability, not the time the case was requested. Examples may include vascular occlusion, perforated viscous, dislocated fracture, open fracture, etc.

Urgent: Patients who require surgical intervention within 48 hours. Such cases are to be worked into the existing schedule, performed during evening hours, or reclassified. Designation as urgent must be agreed upon by the attending Surgeon, Anesthesiologist, OR Team Leader/OR Manager. Examples may include renal patients requiring vascular access for dialysis, Emergency Department (ED) patients who require surgical intervention, etc.

Non-Urgent: The patient is under no immediate medical threat, but the procedure is needed as a principle component of current medical care. Time is not a factor in the outcome of the patient. Delay in treatment may result in "denied days" resulting in loss of hospital reimbursement. These

cases are done in accordance with the demands of the scheduled patients and emergent and urgent procedures. Inpatient procedures which may result in a denied day will take scheduling priority over other non-urgent, inpatient elective, "add-ons". Examples may include fractured hips, etc.
Elective: A procedure which has been scheduled through the Surgical Schedulers by 1500/3:00pm prior to day of surgery.
Add-On: A procedure posted after 1500/3:00pm the day before surgery.

17.2 **Definitions of Surgical Posting:**

Medical Necessity Documentation: Required documentation necessary to post procedures as listed in Section 5.1.4.
Procedure Time/ Scheduled Time: The time the patient is to be in the OR. This time will refer to the time when the following events should occur simultaneously:

- Patient is in the OR.
- The Surgeon is present and ready to begin surgery.
- The Anesthesiologist/anesthetist is ready to administer anesthesia.
- The Operating Room Team is ready to begin surgery.

Case Time: Calculated as the time from Patient in Room until Patient Out of Room.
Surgeon Time: Calculated as the time from incision to close.
Turnover Time: Time calculated from prior Patient Out of Room to succeeding Patient In Room for consecutive cases during regularly scheduled hours.
Block Time: Hours of OR time reserved for a given service or surgeon. Within a defined start and cutoff period. During this period only the given service/surgeon may schedule.
Open Time: Hours of OR time not reserved for any service/surgeon. Any service/surgeon may schedule according to the rules established by the given institution.

Section 18.0 Surgical Schedule and Posting

18.1 Surgery Hours of Operation

Main OR

Nine (9) ORs	Mon-Fri	0700-1530
Four (4) ORs	Mon-Fri	1530-1730
Two (2) ORs	Mon-Fri	1730-1900

OPSC OR

Four (4) ORs	Mon-Fri	0700-1530

*Note: The OPSC is staffed between the hours of 0700-1530. It is the expectation that the last case must be recovered and ready to discharge by 1700. If this criteria is unattainable, such cases will be moved to the Main OR and completed as rooms and time allows.

Surgical case scheduling occurs through the Surgical Schedulers during "normal business hours" Mon-Fri 0700-1530. Outside of these hours, surgical case scheduling responsibility falls to the OR staff or the Nursing Supervisor, in that order.

18.2 Schedule Coordination

18.2.1 The OR Team Leader in consultation with Anesthesia, is responsible for execution of the daily OR schedule.

18.2.2 Order of elective cases may change from the printed schedule based on surgery classification of elective, critical, emergent, or urgent, equipment conflicts, patient considerations, and delays which would negatively impact the day's schedule.

18.2.3 Case "on time" relates to only the first case and will be based on a 5-minute window extending after the scheduled start time.

18.2.4 All members of the surgical team are accountable to achieving wheels in scheduled start time.

18.2.5 Documentation of physician arrival to the preoperative period and documentation of delay reason will occur in the preoperative area.

18.2.6 Physician specific tardiness occurrences of 10% of the overall number of 1st case starts will be considered excessive and directed to the Surgery Tripod Governance Committee for further follow up.

18.2.7 Surgeons that exceed their blocks by more than 10% of their blocked time will be considered excessive and directed to the Surgery Tripod Governance Committee for further follow up.

18.2.8 The Operating Room Team Leader is responsible for notifying the surgeon and providing an estimate time if a delay is anticipated. Likewise, a surgeon whose arrival will be delayed should contact the Scheduling Desk or OR Team Leader so the appropriate schedule adjustments can be made.

18.3 Dual Room Scheduling and/or Flip Room

18.3.1 Dual Rooms/Flip Rooms may be utilized at the discretion of the OR Team Leader in consultation with anesthesia, facilitating the completion of the daily surgery schedule. Availability will depend on:

- Sufficient OR staff and anesthesia support
- Room availability
- Equipment availability
- Efficiency of surgeon

18.3.2 If less than 4 case are posted in a surgeon's/services reserved/blocked flip room, consideration to pull flip room if needed to facilitate surgery schedule needs may be initiated by OR Team Leader or Anesthesia.

18.4 Guidelines for Bumping:

18.4.1 Any bump, with the exception of critical cases, requires Surgeon-to-Surgeon communication.

18.4.2 Bumping will take place into the same service line when possible.

18.4.3 Utilize unused room when another surgeon is allotted and/or blocked in two (20 rooms. Every effort must be made to facilitate the flow of the scheduled cases for the bumped surgeon.

18.4.4 If disputes arise, decisions will be made by the Surgical Services Director in collaboration with the Chief of Surgery and Chief of Anesthesiology.

18.4.5 If the bumped surgeon chooses not to re-schedule into his next assigned and open block, bumped cases will become first on the "add on" list as prioritized by acuity.

18.5 Delayed Procedures

18.5.1 As soon as it appears that the surgeon cannot meet the scheduled time, they should notify the OR Team Leader so the preparation of the patient can be modified accordingly.

18.5.2 If the delay will cause substantial delay of further scheduled surgeries, the surgery will be postponed until subsequent case (accounting for staff and equipment availability are completed. The postponed case is to be done, however, at the earliest available time suitable for the surgeon, the involved personnel and patient.

18.5.3 When it is identified that the schedule is running more than forty-five (45) minutes late, and other adjustments cannot be made for cases to follow, the surgeons who are scheduled to follow will be notified by the OR/OPSC Team Leader with estimated case start times.

18.5.4 If the surgeon is not present in the Surgery Prep area or has not contacted the OR/OPSC Team Leader or OR Manager thirty (15) minutes prior to the scheduled surgery time the surgeon will be contacted by the OR/OPSC Team Leader to discuss arrival time or to determine alternative options.

18.5.5 Exceptions to these regulations may be changed by the Surgical Services Director.

18.5.6 All means to accommodate the surgeon and the patient will be attempted to prevent rescheduling.

18.5.7 Elective and non-critical cases will not be scheduled to be performed during the off-hours. Critical cases scheduled during off-hours are to be performed within 30 minutes from the time the surgeons call to post the case.

18.6 Block Scheduling

18.6.1 Block allocations will be determined by the Surgical Tripod committee, in collaboration with Senior Leadership.

18.6.2 The Surgical Tripod Committee is charged with the following responsibilities:

- Recommendations related to allocation of block time
- Monitoring, reporting, and evaluating block utilization quarterly with recommendations for changes as needed.
- Implementing sanctions as described in the Surgical Services Scheduling Policy.
- Recommending and approving a grid of additional available Block Times for use by Senior Leadership in pursuing additional surgical volumes.

18.6.3 The targeted amount of time blocked in the surgery schedule will not exceed 80% of room availability.

18.6.4 Surgeons can request block time by forwarding a written request to the Manager and/or Director of Surgical Services who will then facilitate the review by the Surgical Tripod Committee. The Committee shall determine assignment and make approvals after evaluation of the following criteria:

- Six months of data collection supporting the request.
- Consideration of the request in relation to the Strategic Plan for the hospital, along with capital and human resource needs to support the request.

18.6.5 To qualify and/or maintain block allocation a surgeon or group must meet the following guidelines:

- Demonstration of high volume OR use and/or consistent quarterly block utilization of 80%.
- Practice according to the Surgical Services Scheduling Policy and promote cooperation and collaboration with all professionals.
- Maintenance of at least 80% block utilization as measured on a quarterly basis. Block utilization is defined as the block time used divided by the total block time allocated. Utilization will include all time used in an assigned block as measured from the time the first patient enters the OR until the last patient leaves the OR, including room turnover time.

18.6.6 Surgeons with allotted block time are required to schedule their first case of the day at the beginning of their block time.

18.6.7 Surgeons with allotted block time may not book in Open Time until their block time has been filled.

18.6.8 If Block Utilization falls below 80% in a given quarter, the physician/specialty group will be notified by mail and in person and placed on probation for the following quarter. I f the utilization does not increase to 80% in the following quarter, the Surgical Tripod Committee shall review and adjust/eliminate/reduce the block allocation. Holidays are excluded from Block Utilization percentages.

18.6.8 It is expected that all elective cases are to be completed within the surgeon's block time. Any block exceedance is subject to review by the Surgical Tripod Committee, refer to 18.2.7.

18.6.10 The surgeon/group may release block time at any time, however, if more than 20% of block time is release in any given quarter, the surgeon/group will be notified and may be placed on probation for the following quarter. It is the responsibility of the surgeon/group to ensure adequate utilization is met. Block time released within the guidelines will not be considered against utilization statistics unless it is in excess of 20% of allocated time.

18.6.11 A minimum of 2 weeks' (10 business days) notice must be received to avoid penalty for unused block time. Surgeons are requested to notify Surgery Scheduling in writing (fax/email), or by phone, of the released dates of allocated block.

18.6.12 Blocks will automatically be released at 0100 daily, Monday-Friday, excluding holidays. If time within the surgical block is not utilized by the released time, the unused block will be reclassified as Open Time and released for use on a "first come, first serve" basis.

Block time will automatically release as specified per service-line:

Service Line	Business Days Prior to Block	Service Line	Business Days Prior to Block
ENT	4	Orthopedics	2
General	5	Plastics	4
GYN	5	Podiatry	5
Hand	2	Robotics	5
Neurosurgery	2	Urology	3
Ophthalmology	7	Vascular	2

Section 19.0 Anesthesia Staffing Assignments

Approved 8/12/22
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19.1 All efforts will be made to facilitate the completion of scheduled cases and accommodate preferred scheduled times. This includes but is not limited to working with OR staff to rearrange flip rooms, working with ancillary departments to rearrange schedule and make recommendations to resolve scheduling conflicts and facilitate the completion of the schedule.

- 1st Tier:
  - Main OR
  - OB (Always an anesthetist assigned)
  - Neuro Interventional (No standby personnel. If not scheduled, will take flip room anesthetist. If flip room anesthetist is not available, will take from lower Tier assignment.)
- 2nd Tier:
  - OPSC
- 3rd Tier:
  - Bronchoscopy (Prioritized because greater urgency and acuity patient than Tier 4)
- 4th Tier: (Prioritized A>B)
  - A: ENDO Surgeon (Facilitate OR Schedule)
  - B: ENDO Gastroenterologist
- 5th Tier:
  - Cath Lab
- 6th Tier:
  - IR (Not Neuro-Interventional)
- 7th Tier:
  - All other

19.2 With the exceptions of emergent, critical, and urgent cases, as well as other unexpected superseding scenarios, it is expected that the Anesthesiologist's/designee's arrival time in the Preoperative areas will allow for adequate time to fully prepare the patient for surgery. The patient will be ready to move into the operating room prior to their scheduled start time.