

Virtua Surgical Services: Rules and Regulations

1. The use of the Operating & Procedure Rooms shall be limited to members of the Medical Staff whose privileges include procedures which normally require the use of the these rooms. Surgical procedures may be performed in the Operating Room only in accordance with the privileges delineated in accordance with the Medical Staff Bylaws.
 - 1.1.a The scope and extent of surgical privileges for dentists and podiatrists shall be as specified in the Policy on Appointment, Reappointment and Clinical Privileges.
 - 1.1.b Non-surgical medical staff members such as radiologists and cardiologists who have been granted the appropriate privileges may also schedule procedures in the Operating Room
 - 1.1.c A list of physician's surgical privileges will be available in Cactus for reference by the nursing staff.

2. Minimum Testing requirements for surgery shall be as developed by a system wide collaboration of the anesthesia service providers and approved by the Medical Executive committees.

It is strongly recommended that all preoperative testing be performed at Virtua

It is the responsibility of the operative physician to provide all appropriate preoperative x-ray and laboratory test reports which have been done outside of the Virtua system.

3. All reports/test results should be provided 2 days prior to procedure, but they must be on the chart 24 hours in advance. The procedure is subject to cancellation at the discretion of the Medical Director of the Operating Room/or Charge Anesthesiologist should test results not be available.
4. All patients undergoing surgery must have an **appropriate history and physical** performed and documented on the chart prior to surgery. In a life-threatening emergency, the physician shall make at least a comprehensive note on the patient's chart regarding the patient's condition prior to the induction of anesthesia at the start of surgery.
 - 4.1 In the event that the History and Physical has been performed and dictated, but the document is lost or otherwise fails to reach the chart, the surgeon shall rewrite the History and Physical. The patient will not be transported to the Operating Room Suite until the History and Physical is completed.

- 4.2 If the above process will cause an undue delay in the Operating Room Schedule, the patient may be rescheduled for a time later in the day at the discretion of the Director of Surgical Services or designee.
- 4.3 For inpatient or outpatient surgeries (including patients expected to stay 24 hours or more post-surgery) an H&P must be performed. An H&P will be considered current if it was performed within 30 days prior the hospital admission (or readmission). A day of procedure H&P update is required and must contain either the changes in medical history or physical exam, or a statement indicating that no changes have occurred
- 4.4 The Medical Record of a **post-partum maternity patient**, scheduled for a tubal ligation must contain an update following delivery of the patient's condition and document the physician's discussion with the patient regarding the proposed procedure.
- 4.5 **Laterality** must be written as Left or Right on the History and Physical and OR consent, in cases requiring laterality.
5. No patient may be admitted to the Operating Room suite without a correct, proper, legible identification bracelet.
6. **Consent:** Written, signed, dated, timed, informed surgical consent shall be obtained prior to the operative procedure except in those situations where the patient's life is in jeopardy and suitable signatures can not be obtained due to the condition of the patient. The following shall apply to this surgical consent policy:
 - 6.1 It is the obligation of the attending surgeon to obtain informed consent.
 - 6.2 Policy for witnessing and completing the Virtua consent form are contained in the **Virtua Consent Policy**.
 - 6.3 In all cases wherein the patient is presumed to be mentally competent, every effort should be made to obtain his/her signature or mark after the patient has received the discussion of informed consent about his/her proposed procedure. Only if the patient is obviously temporarily or permanently mentally incompetent or a minor, should a legal guardian or next of kin sign in place of the patient. The fact of incompetence of the patient must be documented on the chart by the physician
 - 6.4 If physical infirmity makes it impossible for a competent patient to sign a consent, verbal consent shall be obtained, witnessed and documented on the Consent Form.

- 6.5 In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from the child's parents, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record.
 - 6.6 No alterations, additions, or changes are to be made on the Surgical/Procedure consent form. Any intended alterations necessitate a new consent form.
 - 6.7 The name of the operating physician/surgeon must be on the Consent Form.
- 7 The anesthesiologist will obtain informed consent from the patient for the anesthesia portion of a procedure. It is the anesthesiologist's responsibility to obtain the appropriate signatures on the appropriate consent form.
 8. When an anesthesiologist decides that an elective case should be canceled it is his/her responsibility to discuss the case with the attending physician/surgeon prior to the patient being informed of the cancellation.
 9. It is the responsibility of the surgeon to initiate call for anesthesia and operating room nursing personnel when "after-hours" surgery is contemplated.
 10. Surgeons should be in the Operating Room and ready to commence surgery ten (10) minutes before the time scheduled. This means that the surgeon should be changed into scrub clothes, the pre-operative paperwork and labs completed, the operative consent signed and witnessed, and the appropriate verifications. Markings for Correct Site Surgery (as detailed in the Virtua Correct Site Surgery Policy) are to be performed, when appropriate, by the operative surgeon prior to the scheduled procedure.
 - 10.1 If a surgeon is unable to be present at the scheduled operating time, the surgeon should so notify the Operating Room no later than thirty (30) minutes prior to that scheduled time. When possible, attempts will be made to reschedule the case at a time mutually acceptable to the surgeon and the Operating Room. In the absence of such notification, the Operating Room shall be held no longer than fifteen (15) minutes past the scheduled time. Such a delayed case shall be rescheduled or cancelled at the prerogative of the Director of Surgical Services or designee. The surgeon will be notified by the Medical Director of the operating room of the cancellation/rescheduling. Surgeons who do not comply will be subject to sanctions as approved by the appropriate medical staff committee. Should a case be delayed by the Operating Room, the surgeon will be notified thirty (30) minutes prior.

- 10.2. Surgeon lateness is defined as the surgeon arrival in the OR suite at the scheduled case time, or after.
11. When cases are scheduled, it is the responsibility of the surgeon to inform the operating room of special services or preparation needed for the patient. The surgeon must also notify the Surgical Services scheduling staff as to whether or not an x-ray technician and/or qualified surgical assistant is required for his/her surgery. It is the physician's responsibility to procure or notify the need for a qualified assistant. Surgeons at Virtua must have a qualified surgical assistant as noted in the OR policy entitled "Operating Room Procedures Requiring Assistants". Surgeons requiring private, non-physician technical assistants in the operating room must have these assistants approved consistent with the hospital policy for non-medical staff credentialing.
12. Immediately following each surgical procedure, the surgeon will write a post-operative note to include:
- a. Name of surgeon/assistants
 - b. Procedure name
 - c. Post-op diagnosis
 - d. Specimens removed
 - e. Findings
 - f. Blood loss
13. No unnecessary or unauthorized personnel are permitted in the Operating Room Suite. Family members, including those who are physicians, of patients being operated on should not be present in the actual operating room during the surgical procedure, except for obstetrical cases. Certain personnel may be permitted in the Operating Room Suite as follows:
- 13.1 Physician employed staff provided that they have been credentialed in accordance with the credentialing Policy of the Medical Affairs Office
- 13.2 Physicians, dentists or podiatrists in training. If the training program has a formal affiliation with Virtua, then duties will be in accordance with the Virtua Policies on Graduate Medical Education. If the training program does not have a formal affiliation with Virtua, prior approval must be sought from the responsible/respective Medical Director of Operations and the Graduate Med Ed office.
- 13.3 Surgical Assistants if appropriately credentialed.

- 13.4 The surgeon of record will be responsible for the acts of and adherence to all hospital and medical staff policies and procedures by his/her approved assistants or requested observers.
14. The Medical Staff shall maintain a list of those operative procedures requiring a physician as a first assistant. The physician first assistant must be a member of the Medical Staff and must hold unrestricted surgical privileges in a surgical specialty.
15. During Surgical and other procedures performed in the Surgical Services and Interventional Radiology areas where the performing physician is physically involved in performing the procedure and unable to complete the Order Entry Process the following protocol will be implemented:

Nursing staff involved in the care of the patient will obtain order information from the physician verbally as x-rays are needed or specimens are obtained from the patient.

The nursing staff member will enter the order for x-rays needs or for Tissue Pathology, Non-Gyn Pathology, Tissue Pathology Frozen Section, Microbiology and other miscellaneous laboratory testing on matter removed from the patient during surgical and other procedures, directly into Soarian.

All tissues removed at operation shall be sent to the hospital pathology department which shall make such examination as considered necessary to arrive at a tissue diagnosis. An authenticated report shall be made part of the patient's medical record. The following are exempted from this rule:

- 15.1 Cartilage from rhinoplasty and septoplasty
- 15.2 Cataracts
- 15.3 Fat from liposuction
- 15.4 Foreign bodies
- 15.5 Foreskin from circumcision of newborns
- 15.6 Normal placenta
- 15.7 Orthopedic appliances, screws, or plates
- 15.8 Previous surgical scars
- 15.9 Redundant skin from facelifts and abdominoplasties

medical record

- 15.11 Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements
- 15.12 Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary.
- 15.13 Salivary stones
- 15.14 Healthy bone
- 15.15 Removed devices (catheters, infusion ports, etc)

16. **Operating Room Scheduling:**

- 16.1 The Nurse Director of the Operating Room, in collaboration with the Anesthesiologist Charge Physician or designee shall be in complete charge of the daily Operating Room schedule.
- 16.2 Block time, is defined as OR time allocated to one physician or group of physicians who have exclusive rights to that time. Block time is allocated by the Administrative Director of Surgical Services based on customer requests/time availability.

Block time utilization will be evaluated quarterly to ensure full utilization of the time. Minimum utilization of block time is 65%. Utilization less than 65% can result in loss of time, days or both. Specific higher utilization may be required for use of designated rooms or equipment" (ie. Robot.)

- 16.2.1 New practitioners will be given 6 months before utilization will be reviewed.
- 16.4 Urgent/Emergent cases may be scheduled at any time, but will be done at a time suggested by the Nurse Director of the Operating Room or designee as to fit into the prearranged Operating Room schedule.

16.2.2 Patients upon whom an “emergency operation”, as determined by the Surgeon, is indicated, shall be operated upon AS SOON AS the patient can be prepared. If more than one emergency should arise at consultation with the Medical director of the operating room.

16.3 If an emergency requires “bumping” a scheduled procedure, it is the responsibility of the operating surgeon to notify the surgeon who’s case is being delayed. In the event of disagreement, priority shall be determined by the Chairman of the Department of Surgery.

17. Virtua Health: OR cases requiring assistants

General/Vascular/Thoracic/Colorectal Surgery

Whipple procedure

Total pancreatectomy

Major hepatic resection (lobectomy)

Open aortic surgery

Pulmonary embolectomy

Spine Surgery: All cases require assistants except:

Microdiscectomy

Kyphoplasty/Vertebroplasty

Posterior lumbar I & D without removal or revision of instrumentation or revision decompression

Neurosurgery:

Craniotomy for posterior fossa tumors

Trans-sphenoidal surgery

Otolaryngology and Head and Neck Surgery:

Extensive composite cancer resection of the head and neck

Extensive reconstructive maxillofacial surgery

Oral and Maxillofacial surgery:

Surgical correction of major maxillofacial deformities

Plastic and Reconstructive Surgery:

Composite resection of mandible and maxilla combined with neck dissection

Surgical correction of major maxillofacial deformities

Urologic Surgery:

Laparoscopic or open radical nephrectomy

Laparoscopic or open radical cystectomy with urinary diversion

Radical prostatectomy

Gynecologic Surgery:

Any and all hysterectomies

Any and all myomectomies, excluding hysteroscopic myomectomy

Radical vulvectomy

18. SURGICAL SERVICE “DEFINITION OF TERMS”

Case Status Definitions

<i>Scheduled/Elective Case:</i>	Any case scheduled before the schedule closes. M-F
<i>Emergency Case:</i>	Cases in which loss of life, limb or bodily function may occur if not done expediently.
<i>Urgent Case:</i>	Cases that should be done within 24 hours
<i>Scheduled Time:</i>	Case scheduled time as posted in the computer.
<i>Room Set-Up:</i>	The time “set-up” for the case begins. The time the patient enters the operating room.
<i>Patient in the Room:</i>	
<i>Anesthesia Start Time:</i>	The time the patient enters the operating room.
<i>Incision Time:</i>	The time of surgical incision.
<i>Procedure Stop Time:</i>	When the dressing has been placed on the incision.
<i>Patient Out of the Room:</i>	The time the patient exits the operating room.

Turnover Time:

The time from the patient leaving the operating room to the “anesthesia start time” for the next procedure (which is the same time that the next “patient enters the room”).

Recovery Definitions

Recovery Room In:

Arrival time to the PACU.

Anesthesia End:

The time anesthesia turns the patient over to another caregiver in the PACU