Banner Casa Grande
Medical Center

SURGERY DEPARTMENT
RULES and REGULATIONS

ARTICLE I. ORGANIZATION

Section 1
In accordance with the Bylaws of the Medical Staff of Banner Casa Grande Medical Center, the Department of Surgery is organized as a department of the Medical Staff.

Section 2
The Department of Surgery will be directed by the Surgery Committee.

Section 3
The Chairman of the department will chair the Surgery Committee. The chairman of the department will be elected by the Active Staff members of the department for a two-year term, in accordance with Article 8 of the Medical Staff Bylaws. The chairman shall appoint a Vice-Chairman of the department.

Section 4
The Department of Surgery will report directly to the Medical Executive Committee and include physicians granted privileges in the following:

1. Anesthesia
2. Dentistry
3. General Surgery
4. Hand Surgery
5. Ophthalmology
6. Oral and Maxillofacial Surgery
7. Orthopedic Surgery
8. Otolaryngology
9. Pathology
10. Plastic Surgery
11. Podiatry
12. Urology
13. Gynecology

Section 5
A section of the department may be formed when it is determined by the Department of Surgery Committee that special care, number of patients, or staff members makes it advisable to organize for periodic review of the professional activity of its members.

ARTICLE II. FUNCTIONS, DUTIES AND RESPONSIBILITIES

Section 1

a) The functions of the department are outlined in Section 8.3 of the Medical Staff Bylaws.
b) The Chairman's functions and duties are outlined in Section 8.4-5 of the Medical Staff Bylaws.
c) The qualifications, selection, term of office and removal of the chairman are outlined in Sections 8.4-1 through 8.4-4 of the Medical Staff Bylaws.

Section 2

The Vice-Chairman will be responsible for administration for the department in the absence of the Chairman.

Section 3

The Department of Surgery shall supervise and review all medical practices as listed in Article I. Section 4.a.

ARTICLE III. OR SCHEDULING

Section 1 - OR Scheduling Process

a) Scheduling of elective cases may be done between the hours of 0900 and 1730, Mon-Fri (except holidays) with the Operating Room scheduling secretary.
b) Cases added to the next day's surgical schedule after 1730 must be scheduled with the evening or night administrative Supervisor. The supervisor will complete the OR posting form, place it on the scheduling board in the OR, and alert anesthesia (if they are still in house) that the case has been scheduled. Please advise the supervisor/OR of any equipment or supply needs (i.e. C-arm, etc.). The OR Patient Care Coordinator (or designee) will notify the physician in the morning of the approximate start time available. Cases added to the already published surgery schedule will be done on a "first come, first serve" basis, and will be placed in the first available room.
c) If a surgeon wishes to add a case or change the scheduled order of cases once the OR schedule has posted or is already in progress, it is that surgeon's responsibility to contact the surgeon(s) whose cases will be affected for their approval.
d) Tues. Thurs. Fri. up to three rooms can be scheduled to start at 0800. Wed. up to four rooms can be scheduled to start at 0800. Mon. Wed. after 1500 up to three rooms can continue to operate. From 1900 to 2230 only one room will remain available.
e) Elective cases can be scheduled Monday through Friday beginning 0800 and out of the room by 1900 and on Saturday morning beginning at 0800 and out of the room by 1330.
f) Cases will be scheduled to start at 0800 and then on a "to-follow" basis. Location of a case or the order of cases may be changed to facilitate the flow of the schedule if the surgeon, anesthesiologist and OR PCC (or designee) agrees.
g) The only guaranteed start time for an elective case is 0800. All other cases are done on a "to-follow" basis. Surgeons may request a start time later time in the day (if it is available), however, this is only an approximation based on the progress of the preceding case.
h) Surgeons and assistants not currently in the OR will be notified by the OR PCC (or designee) of an approximate start time for their case once the case immediately preceding is in progress. The surgeon and the assistant will be called again when his/her patient is ready to go into the OR. It is the responsibility of the surgeon (or designee) to contact the OR PCC for all other questions/concerns/issues regarding the case start time.

i) If there is a gap in the schedule due to requested start times other than 0800, cases of an urgent nature may be inserted into the open time, even if it may cause a delay in the unofficial requested (other than 0800) start time.

j) When a scheduled case is cancelled, the next case scheduled in that room will be moved forward if the surgeon and anesthesiologist agree and are available. Other surgeons scheduled in that room will be given an opportunity to move their cases into vacated position in the order of their position on the schedule. The schedule will vacate position in the order of their position on the schedule. The schedule will otherwise proceed as planned.

k) Block posting is released two-five days prior to the block posted date. Surgeons with block days are required to notify the OR scheduling secretary to release these days as soon as they know they will not be utilizing them.

l) Any surgeon wishing to acquire a block of Operating Room time must apply in writing to the Chief of Surgery for a specific day. Members of the Surgical Service will consult with the OR Director regarding availability and then vote on the request.

m) At any time the Surgical Services may review a surgeon's utilization of his/her block day. The day may be rescinded if it is determined that the surgeon is in not consistently utilizing this day fifty percent of the time.

n) A surgeon with a block day must utilize his/her block time before scheduling a case on any other day of the week; unless he/she has released his/her block time for that week. Chief of Surgery must approve any exceptions to this rule. Filled block posting is 8–10 hours of operating room time scheduled (dependent on the number of cases scheduled including turnover time), with the last case to be completed/patient in the PACU by 1900.

o) An emergency case is defined as one that must be performed as soon as possible because of the serious potential threat to life/limb/fetus.

p) Emergency cases added into the elective schedule during the day must be brought to the attention of the OR PCC (or designee) as soon as possible. It is not sufficient to write the case on the schedule board or to schedule the case with anesthesia provider only.

q) Emergency cases that need to interrupt the elective OR schedule will be done at the earliest possible time that an OR crew and room are available.

r) It is the responsibility of the surgeon who is interrupting the elective OR schedule to contact the surgeon whose case is being bumped, as well as to notify anesthesia of the type of case that needs to be performed.

s) If a surgeon wishes to add an emergent case prior to the normal start of the elective schedule (i.e. a case with a 0600 start time that will delay an entire room of scheduled cases) he/she must contact the Chief of Surgery for approval. The OR PCC (or designee) (or the administrative supervisor in their absence) will notify the other surgeons in that room whose cases have been bumped.

t) Any questions or concerns regarding a request by a surgeon to bump, or a case that has previously been bumped, need to be directed to the surgeon(s) involved and the Chief of Surgery.

u) All urgent / emergent cases that result in a surgeon's needing to "bump" another's case(s) will be brought to the attention of the Chief of Surgery for review by the OR Patient Care Coordinator.

Section 2 - OR General Standards

a) For 0800 cases, the patient is to be brought into the operating room at 0745. The anesthesia provider is expected to be present in the OR no later than 0745. Anesthesia will not be administered until the attending surgeon is present in the OR suite. The surgeon will be in scrubs and in the OR by 0745. The assistant, when required, must be present in the OR when the case is started.
b) First cases will be rescheduled to end of the day, start time switched if feasible, or canceled for the day if the surgeon doesn't arrive by 0815, if such an action isn't life threatening to the patient.
c) The Chief of Surgery will be notified of any violations of the OR Standards by surgeons or anesthesiologist. Monitoring of issues will be done on a quarterly basis.
d) A letter will be sent the first time that the physician is late during a single quarter. After the second occurrence the matter will be forwarded to surgery service for review. If late start events exceed two times in a quarter, the surgeon will lose the privilege to schedule 0800 cases for the reminder of that quarter and the entire next quarter. All block time will be released for the reminder of that quarter and the entire next quarter. At the end of the full quarter, the surgeon may re-apply for block time.
e) If a surgeon is unable to start his/her next scheduled case within thirty minutes after the OR and patient(s) are ready, another surgeon may be offered the opportunity to do a case, even if this will delay the previously scheduled case. The time slot will first be offered to other surgeons to move one of their scheduled cases up, or to another surgeon looking for time but not yet scheduled.
f) During a long case, the surgeon may leave the OR for no longer than fifteen minutes, providing that another physician remains in the OR suite.
g) The need for a qualified physician to assist on any case will be left at the discretion of the attending surgeon.
h) When scheduling a case with an assistant, the name of the assistant must be given to the OR scheduler within twenty-four hours of the scheduled case and appear on the operating room schedule.
i) If an additional scrub technician is required for a case, this must be scheduled with the patient care coordinator (or designated charge nurse) when the case is scheduled.
j) Physician disagreements that cannot be mutually resolved shall be brought to the Chief of Surgery for a decision. In the absence of the Chief of Surgery, the Vice-Chief of Surgery will be contacted for assistance. If both are not available, the VPMA and/or Chief of Anesthesia will be consulted.
k) No patient will be placed in an operating room without the following present: valid H&P on the chart. Only exception is a life and death emergency or loss of limb. For emergency cases in lieu of a type written or hand written H&P on the chart, a note by the attending surgeon on the progress note saying (1) H&P dictated w/ RC#, (2) Admission note about diagnoses, and (3) Statement indicating no complications.
l) Correct identification band on the patient.
m) The hospital policy only requires a valid H&P and identification band on the patient. It is the responsibility of the surgeon, in conjunction with the anesthesia service, to determine what basic tests, lab work, etc. are required preoperatively.
n) Day Surgery staff will notify the surgeon's office by 1100 the day before surgery if all of the required preoperative documents are not on the chart (i.e. H&P, EKG, labs, preauthorization, etc.)
o) A courtesy call should be made to the surgeon with elective patients scheduled seventy two hours prior to surgery with charts not complete by 1600 the day before surgery may be removed

from the surgical schedule if the necessary documents cannot be produced by 1800.

p) For scheduled inpatients, anesthesiologists will review the completed charts for inpatients the day before the cases are scheduled.

q) Outpatient charts will be reviewed 3-4 days prior to the scheduled procedures with further evaluations scheduled pre-operatively, if needed.

r) All surgeons operating in the hospital must have a listing of surgical privileges on file in Medical Staff Services and the Operating Room. The OR will not schedule procedure not listed on the surgeon's privilege form. The surgeon must apply through the normal process for additional privileges.

s) Visitors will be permitted in the operating room with the consent of the patient, operating room director or surgeon, patient care coordinator, and anesthesia provider (excluding professional representatives requested by the surgeon or needed for the case).

t) The routine medical staff credentialing process must credential all allied health professionals such as physician's assistants or private scrub nurses. These individuals must be sponsored by a surgeon on the active staff who will assume their liability under his/her policy and document this through Medical Staff Services. Otherwise, they must provide a copy of their own liability policy to be kept on file in Medical Staff Services.

u) The operating room director and/or patient care coordinator has the authority to:
   - Enforce all the previously mentioned standards of operation of the OR and PACU.
   - Move cases to another room to expedite the schedule.
   - Deny a surgeon scheduling time for a procedure not on the surgeon's list of approved privileges unless previously approved by the Chief of Surgery.
   - Close an operating room because of insufficient personnel coverage with the notification of the Chief of Surgery and Chief of Anesthesiology.

ARTICE IV. MISCELLANEOUS PROVISIONS

Section 1 – Meetings

a) Information regarding meetings is outlined in Section 10.1 through 10.4 of the Medical Staff Bylaws.

b) All members of the department are members of the committee. If circumstances warrant, the Chairman may appoint members to form the committee with the approval of the MEC and, in this case, a reasonable attempt will be made to assure representation from all surgical sub-specialties actively practicing in the hospital.

c) The presence of two voting Medical Staff members shall constitute a quorum for the transaction of department and committee business.

Section 2 – Attending Staff Responsibilities

Information regarding Admitting and Discharge, Orders, Consultations and Surgical cases including documentation requirements are outlined in the Medical Staff Rules and Regulations.

Section 3 – ER Call

Department of Surgery physicians shall serve on the on-call roster for charity, unassigned and emergency patients as determined by the applicable department, the Medical Executive Committee and the CEO.

Section 4 – Non-Physician Practitioners

Privileges may be granted to non-physician practitioners. This will be in accordance with the Bylaws and Allied Health Professional Rules and Regulations.

Section 5 – Committee Assignment
Members of the department are expected to fulfill obligations created by membership on this and other staff committees.

Section 6 – Appointment Procedure

a) Membership – Physicians applying for department membership and privileges will apply in accordance with the Medical Staff Bylaws and Credentialing Manual.
b) Focused Professional Practice Evaluation (FPPE)
    1. Refer to Banner Health Policies and Procedures.
        a. Three to six months after a practitioner's initial appointment or initial granting of privileges, the Medical Staff Office will obtain a list of the practitioner's activity in the hospital. An evaluation form will be generated for three (3) randomly selected cases which will be reviewed and/or assigned for review by Department Chairman as needed. Results of the review will be reported to the Surgery Department Chairman for review and action.
        b. The reviewer's report is confidential and for use of the Department only. The report, however, may be released to other hospitals if requested in writing, by the reviewed physician for privileges at other hospitals.
        c. Active staff members of the Department of Surgery are eligible to serve as reviewers for the retrospective review process.
        d. The reviewer shall give a candid opinion on the report to the Department Chairman. The reviewer shall immediately notify the Department Chairman should any questions arise concerning a physician's competency or management of a particular case.
        e. Following review of the completed review forms, additional cases may be required if deemed necessary by the Department Chairman.
        f. For those practitioners with minimal activity during the initial FPPE period (practitioners who only provide occasional coverage at the hospital) during the initial period 100% of his/her cases may be reviewed and/or peer references attesting to the provider's competency, at the time of reappointment, may be accepted as FPPE.
c) Ongoing Professional Practice Evaluation (OPPE).
d) Practitioner-specific data will be collected and evaluated for OPPE in the areas of six general competencies: Medical/Clinical Knowledge, Patient Care, Practice-Based Learning & Improvement, Interpersonal/Communication Skills, Professionalism, and Systems-Based Practice. Specific indicators within these general competencies may include but not be limited to: complication and mortality rates, quality of medical record documentation, adherence to regulatory and/or Banner system initiatives, performance trends and Peer Review Information, as available.
e) Special Procedures – Concurrent Supervision or Retrospective Review of a set number of cases may be required by the Department of Surgery. Active members of the Department of Surgery with unsupervised privileges for the procedure(s) are eligible to serve as supervisors/reviewers.
f) Reviewer's Responsibilities
    1. The reviewer shall give a candid opinion on the report to the Department Chairman.
    2. The reviewer shall immediately notify the Department Chairman should any questions arise concerning a physician's competency or management of a particular case.
g) Surgery Assisting Privileges – Medical Staff members who have surgical assisting privileges only will not be allowed to perform any surgical procedures and will limit their participation in surgical procedures as assistants only. Other limitations are delineated in the Medical Staff Bylaws.
h) Operating Room Observers – Any physician or surgeons with a valid license may observe operations or procedures upon approval by the Director or Surgical Services. The charge nurse shall be notified and consent shall be obtained from the patient.