



Department of Surgery Rules and Regulations

I. Introduction

- 1.1 The Medical Staff Bylaws and General Rules and Regulations of the Medical Staff shall be adhered to by all members of the Department of Surgery.

II. Members

- 2.1 The Department of Surgery shall consist of members of the staff of the CHA Hollywood Presbyterian Medical Center (HPMC) who have been granted surgical, dental, and/or podiatric privileges on the basis of individual training, experience, and capability.
- 2.2 Board Certification requirements for all initial appointments will be in accordance with the Medical Staff Bylaws.

III. Organization

- 3.1 The Department of Surgery shall consist of the following specialties:

- 3.1-1 Colon and Rectal Surgery
- 3.1-2 Dentistry
- 3.1-3 General Surgery
- 3.1-4 Neurological Surgery
- 3.1-5 Ophthalmology
- 3.1-6 Oral and Maxillofacial Surgery
- 3.1-7 Orthopaedic Surgery
- 3.1-8 Otolaryngology
- 3.1-9 Pathology
- 3.1-10 Plastic Surgery
- 3.1-11 Podiatry
- 3.1-12 Thoracic and Cardiac Surgery
- 3.1-13 Urology
- 3.1-14 Vascular Surgery

- 3.2 Laser services shall be under the Department of Surgery supervision.

IV. Department Committee

- 4.1 The Department of Surgery shall consist of all Active members of the Department.

V. Election of the Chair

- 5.1 Active Staff members of the Department, on call by the Chair, shall meet during the month of November for the purpose of electing the Chair. Due notice in writing shall be given to the Active membership of the Department at least ten working days preceding such meeting. The name of the elective Chair shall be presented to the Medical Executive Committee for approval. The Medical Executive Committee, in turn, will submit the name of the elected Chair to the Governing Board for final acceptance and approval.
- 5.2 In case of vacancy and in the event the members of the Department fail to elect a Chair because of lack of quorum or for any other reason, the President of the Medical Staff with approval of the Medical Executive Committee shall appoint the Chair for the full term or balance of a vacated term.
- 5.3 The term of office of the Department Chair will be two years and will not exceed two consecutive terms or until resignation, illness of more than 60 days, or by removal from office by vote of two-thirds majority of Active members of the Department, or by a vote of 75 percent of the Medical Executive Committee.

VI. Selection of Vice Chair

- 6.1 The Department will also have a Vice Chair who has the same qualifications as stated in Article XIII, Section 13.5.1 of the Medical Staff Bylaws and who is appointed by the Chair from among the members of the Department committee with approval of the Medical Executive Committee.

VII. Selection of Chair of Organized Sections

- 7.1 Qualifications and election shall be the same as the Department Chair. The selection must be presented to the Medical Executive Committee for approval. Their term of office will be one year and shall not exceed two consecutive terms.
- 7.2 Should a Section fail to elect its Chair because of lack of a quorum or other reasons or should there be a vacancy, the Chair of the Department with approval of the Department Committee shall appoint the Chair of the Section.

VIII. Departmental Meetings

- 8.1 The members of the Department shall conduct departmental meetings. At least four departmental meetings per year are devoted to the review and analysis of the clinical material from the preceding months. The types and numbers of operations, and morbidity and mortality are analyzed. Special cases having particular teaching value are discussed in detail and their evaluations and summaries are recoded and kept on file together with the attendance record. Other departmental business will be discussed as often as deemed appropriate.
- 8.2 Ongoing monitoring and evaluating of special procedures and related management shall be performed in accordance with the guidelines provided by The Joint Commission, California Medical Association, and the California Department of Health.

IX. Granting of Clinical Privileges

9.1 Initial Appointment Privileging Standards

9.1-1 Category I

- A. Privileges in this category allow the physician to perform or assist in the procedures requested in this category. Privileges in this category allow the physician to admit, diagnose, treat, and consult on patients with diseases or conditions generally considered to be within the scope of the surgical specialty for which he or she is trained. Physicians joining the Medical Staff or members who request additional surgical privileges must be Board Certified or currently eligible in the surgical specialty in which privileges are requested.

9.1-2 Category II

- A. Privileges in this category allow the physician to assist on cases in this category.

9.1-3 Category III

- A. Privileges in this category allow the dentist or oral surgeon to diagnose, treat, and perform dental and oral surgery procedures delineated in this category on patients with dental and oral surgical conditions. Patients may be admitted by dentists and oral surgeons only with the concurrence of a physician member of the Medical Staff who shall be responsible for the History and Physical management of the patient's medical problems.

9.1-4 Category IV

- A. Privileges in this category allow the podiatrist to diagnose, treat, and perform podiatric surgery procedures delineated in this category on patients with podiatric conditions. Patients may be admitted by podiatrists only with the concurrence of a physician member of the Medical Staff who shall be responsible for the History and Physical management of the patient's medical problems.

9.1-5 Privileges shall be based upon the applicant's training and experience, which may in part be based upon an examination of records of previous cases handled, references, and other relevant information.

9.1-6 Initial applicants must have documented training in the surgery privileges / procedures requested. Formal training is defined as Residency / Fellowship training program or experience in the surgery privilege / procedure that is equivalent to that obtained in a formal program. The Department of Surgery has approved the following minimum standards that need to be met in order to document current competence and therefore receive the specific privilege / procedure. Each applicant is required to provide documentation of specific or subspecialty privilege / procedure activities at HPMC, and/or other hospitals or health care facilities. Failure to provide documentation, if requested, could result in voluntary withdrawals of privileges.

A.

	Training within last three years	Training over three years ago
Procedure	Required Number of procedures performed in formal training	Required number of procedures performed within last two years
Major	24	24
Minor	24	24

9.2 Cardiac Surgery

9.2-1 Initial Applicant

- A. Applicants for cardiac surgical privileges at HPMC will be expected to submit detailed documentation of their surgical training as well as of their recent performance on the surgical team that he or she works with. This is in order that his volume of cases and his surgical results can be adequately analyzed to ensure that the cardiac surgical patient will receive the highest level of care at HPMC.

9.2-2 Reappointment

- B. Anyone maintaining cardiac surgical privileges at HPMC should be Board Certified in the specialty of Thoracic and Cardiac Surgery (or Board Eligible as defined by the American Board of Thoracic Surgery). He or she should be actively engaged in the performance of cardiac surgery, should limit his or her practice to cardiac and thoracic surgery and should be knowledgeable in all aspects of cardiac surgery, including extracorporeal circulation and the postoperative management of the cardiac surgical patient.

- 9.2-3 Reference the Cardiac Surgery privilege section for required number of procedures performed when formal training is within the last three years and required number of procedures performed within the past two years when training is over three years.

9.3 Robotic-Assisted Surgery

9.3-1 Initial Applicant

- A. Applicants for robotic-assisted surgical privileges at HPMC will be expected to submit the required documentation of their surgical training as well as of their recent performance on the surgical team that he or she works with. Applicants with previous documented experience in robotics should include up to 12 cases per year in their specialty. This is in order that his or her volume of cases and his surgical results can be adequately analyzed to ensure that the surgical patient will receive the highest level of care at HPMC.

9.3-2 Reappointment

- B. Anyone maintaining robotic-assisted surgical privileges at HPMC must be Board Certified or Board Eligible in his or her specialty. He or she should be actively engaged in the performance of robotic-assisted surgery.

- 9.3-3 Criteria on training and credentialing requirements for performing robotic surgery will be monitored and enforced by the Robotics Steering Committee, which reports to the Department of Surgery.
- 9.3-4 Reference the Robotic-Assisted Surgery privilege form for requirements on training and renewal of privileges.
- 9.4 Provisional Privileges
 - 9.4-1 Provisional surgical privileges.
 - A. Any new staff member in the Department of Surgery shall be subject to supervision of his or her work by the Chair of the Department or his or her designee. He or she shall be required to be supervised by a qualified staff surgeon.
 - 9.4-2 After the performance of at least six major, diverse surgical procedures acceptable to the Department of Surgery Committee, the surgeon may apply to the Department Committee for release from proctoring.
 - 9.4-3 At that time, his or her proctor reports will be reviewed. At the direction of the Department of Surgery Committee, the Hospital records of the patients treated by the surgeon may be analyzed.
- 9.5 Temporary Privileges
 - 9.5-1 Temporary privileges will only be extended after a Medical Staff application has been completed and submitted as defined in Article VIII, Section 8.7.1 of the Medical Staff Bylaws.

X. Participation in the ER On Call Panel

- 10.1 Surgeons interested in joining the Surgical ER On Call Panel must fulfill the following general requirements:
 - 10.1-1 Must meet all Medical Staff requirements for on call.
 - A. Completed proctoring (unless waived by the Medical Executive Committee [MEC] for extenuating circumstances).
 - B. Active or Courtesy staff status (unless waived by the Medical Executive Committee [MEC] for extenuating circumstances).
 - C. Able to respond on site within 30 minutes.
 - D. Maintains active back up for emergency situations.
 - 10.1-2 Must be able to perform and be credentialed for all reasonably expected ER patient specialty-specific procedures. In particular:
 - A. Vascular Call

- i. Arterial lacerations
 - ii. Evaluation and stabilization of
 - 1. Abdominal aneurisms
 - 2. Peripheral vascular disease
 - iii. Placing of endovascular grafts
 - iv. AV shunt grafts
 - vi. AV fistula construction
- B. Orthopaedic Call
- i. All long bone fractures
 - ii. Evaluation and stabilization of complex fractures of
 - 1. Hand
 - 2. Pelvis
 - 3. Spine
 - iii. Repair of tendon laceration

10.1-3 Surgeons on the ER Call Panel must ensure reliable back-up by a physician with comparable clinical privileges whenever a surgeon is on call but may not be available. Surgeons on the ER Call Panel are allowed to be on call for two different specialties at the same time within the same facility.

XI. Summary Suspension of Surgical Privileges

- 11.1 If a member shows evidence of incompetence, or his or her actions and/or physical / mental condition may endanger the expected outcome or life of the patient, his or her privileges shall be suspended immediately by the Chair of the Department or his or her alternate in conjunction with Administration until an investigative hearing is held by the Department of Surgery Committee. The findings will be forwarded to the Medical Executive Committee for action.

XII. New Procedures and Appliances

- 12.1 Any person who plans to perform a new major surgical procedure should explain the procedure to the Department of Surgery Committee and obtain approval prior to conducting the new procedure(s). Department of Surgery will recommend criteria for privileging to the Medical Executive Committee.
- 12.2 Prior to application of new surgical appliances, it must be approved by the Department of Surgery Committee.

- 12.3 Experimental and investigational procedures must be approved by the Research Oversight Committee and the Department of Surgery Committee prior to their performance.

XIII. Proctoring

- 13.1 The Department of Surgery has established a proctoring program to ensure the highest quality of surgical care. Physicians to be proctored shall include the following:
- 13.1-1 New physicians on the Medical Staff in the Department of Surgery. In the case of pediatric surgery subspecialists who apply for membership in the Department, they will be asked to present documentation of their proficiency in their field from another hospital and the Chair or his or her designee will monitor their performance.
 - 13.1-2 Physicians on the Medical Staff applying for additional surgical privileges as deemed appropriate by the Department Chair.
 - 13.1-3 Any staff physician performing surgery that according to the Department of Surgery Committee needs to be proctored for just cause.
 - 13.1-4 A minimum of two proctors are required. Proctoring by an associate will not be accepted.
 - 13.1-5 Reciprocal Proctoring:
 - A. Three (3) satisfactory proctored surgeries at another hospital may be utilized to fulfill a portion of the six (6) required proctored cases at HPMC. A summary of the outside proctored cases is acceptable.
 - 13.1-6 Proctoring for robotic-assisted surgery is as follows:
 - A. Basic Robotic-Assisted Surgery
 - i. A minimum of the first three basic cases proctored by an approved proctor (refer to the Robotic-Assisted Surgery Credentialing and Privileging Policy).
 - ii. A minimum of the first five non-proctored cases retrospectively reviewed.
 - B. Advanced Robotic-Assisted Surgery
 - i. Completion of all proctoring and all case reviews for basic robotic-assisted surgery privileges.
 - ii. Approval from the Robotics Steering Committee. Additional proctoring or case reviews as deemed appropriate by the Robotics Steering Committee.
 - C. Surgical Bedside Assist
 - i. MD/DO or PA with current privileges to assist in open or laparoscopic surgery will require a minimum of the first two cases proctored (proctoring not required for surgeons with robotic-assisted surgery privileges).

13.2 Method – Applicant

13.2-1 Upon approval of an applicant’s request for surgical privileges, a list of proctors will be made available to the applicant by the Medical Staff Office. It will be incumbent upon the applicant to obtain a proctor for each case admitted to the Medical Center. The name of the proctor who has agreed must be submitted prior to booking except in emergency situations.

13.2-2 New staff members will not be proctored by a physician who practices in the same medical office or group.

13.3 Method – Proctor

13.3-1 Proctor must have the same privileges as the physician being proctored.

13.3-2 Proctor must be physically present in the Operating Room before the patient is taken to the Operating Room.

13.3-3 Proctors will evaluate preoperative care, including indications for surgery, postoperative care until discharge, and be present at any surgery performed. At his or her discretion, the proctor shall serve as an assistant surgeon.

13.3-4 An evaluation form will be completed by the proctor for each case and submitted to the Medical Staff Office.

13.4 Evaluation Form

13.4-1 A proctor Evaluation Form shall be supplied to the proctor by the Surgical Staff for each individual case. This form will include data pertinent to medical and surgical management of each case and shall include a recommendation from the proctor on the status of the individual being proctored. This form will be considered a confidential document and, as such, is not subject to discovery.

XVI. Consultants

14.1 A “qualified” consultant for another surgeon shall be a surgeon on the staff of HPMC who has full surgical privileges in the same specialty.

XV. Consultations

15.1 Consultation is encouraged for all surgical patients where there is an unusual risk, an obscure diagnosis or when there is a question about the choice of the therapeutic approach.

XVI. Assistant Surgeon

16.1 The necessity for an assistant surgeon for a procedure will be determined by the surgeon. However, cardiovascular operative procedures that require extracorporeal bypass must comply with Title 22 requirements.

16.2 A minimum of three surgeons shall constitute a surgical team for the performance of all cardiovascular operative procedures which require extracorporeal bypass. At least one surgeon must meet the

requirements outlined in Title 22. This physician shall be certified or eligible for Certification by the American Board of Thoracic Surgery or the American Board of Surgery with training and experience in cardiovascular surgery.

16.3 Physicians requesting surgical assist privileges must provide the following:

16.3-1 Liability insurance that covers surgical assist.

16.3-2 Competency / documentation of surgical assist experience.

16.3-3 If proof of competency cannot be provided, at least three cases must be proctored.

16.4 All assistant surgeons participating in a surgical procedure should not leave the operating room prior to reaching the subcutaneous tissue plane.

16.5 Non-surgeons must evidence competency by functioning as an assistant surgeon during the preceding two years.

XVII. Consent to Operate

17.1 Every competent adult person has the fundamental right of self-determination over his or her person and property. Those individuals who are unable to exercise this right, such as minors and incompetent adults, nonetheless that the right to be represented by another who will protect their interests and preserve their basic rights.

17.2 Depending on the type of procedure involved, it is the physician's duty to secure the patient's Informed Consent, i.e. inform the patient of the nature of the treatment, its risk, possible complications, expected benefits or effects, the alternatives and their risks, expected benefits or and the consequences of refusing the treatment.

17.3 Consents for surgical procedures and/or treatments witnessed by the proper HPMC personnel shall be signed by the patient prior to the patient undergoing surgical intervention and before administration of any preoperative medication.

17.4 Consents must name the surgeon and/or associates of the surgeons performing the procedure. When separate surgical procedures are performed by different surgeons on the same patient, separate consents must be obtained for the procedure.

17.5 Consents are prepared on the Nursing Unit prior to the surgical procedure based upon the order by the surgeon.

17.6 Consents for operation on a minor patient must be signed by a parent or a guardian. Consent for a mentally incompetent adult must be signed by the patient's conservator. However, if a patient's conservator is not available to speak with, or the patient does not have a conservator, this must be documented in the Physician's Progress Note if it potentially life-saving, life-essential, and will save life and limb (this would exclude elective procedures). Refer to General Rule 5.1-3 for further information.

17.7 Additional consents are needed for:

17.7-1 Non-medical observers

- A. This consent must be obtained prior to the procedure and before any preoperative medication is administered.

17.7-2 Move and/or video of a procedure.

17.8 Consent by telephone is acceptable

17.8-1 When a written consent cannot be obtained from the patient.

17.8-2 Patient representative must be informed to the same extent as the patient would have been informed.

17.8-3 Two hospital personnel should listen in to the physician's informed consent to verify that appropriate information was provided to the patient's representative.

17.8-4 Physician must answer patient's representative questions regarding the recommended surgery / procedure / risks, benefits, etc.

17.8-5 Follow-up by requesting a fax, telegram, or letter ASAP from the patient's representative.

17.9 All consent forms become part of the patient's medical record.

17.10 A written informed consent form will be obtained for any of the following diagnostic procedures, and any procedures that the physician feels that an informed consent is warranted (generally any invasive procedure):

17.10-1 All procedures performed in the Operating Room.

17.10-2 All diagnostic procedures that require anesthesia.

17.10-3 All procedures performed in the GI Lab.

17.10-4 All biopsies, including bone marrow and liver biopsies for diagnostic / laboratory purposes.

17.10-5 Insertion of pacemaker and cardioversion.

17.10-6 Medications:

- A. Any investigational drug.
- B. Rho (d) immune Globulin.

17.10-7 Laser procedures.

17.10-8 Pain management procedures.

XVIII. Emergency Consent Procedures

- 18.1 Treatment of a patient under emergency conditions without consent is authorized under the Doctrine of Implied Consent.
- 18.2 The attending surgeon shall designate that an emergency exists. There is no legal requirement that the physician seek consultation. Consequently, it is a matter of discretion for the treating physician to determine if consultation is advisable in confirming the existence of the emergency. Medical determination that an emergency exists should be carefully charted by the physician.

XIX. Operative and Other Invasive Procedures

- 19.1 An appropriate clinical assessment is determined by the attending physician in cases of emergent operative and other invasive procedures in conditions which are life threatening or cause irreversible harm to the patient. These conditions supersede all admissions or clinical confirmation requirements for surgery and surgical intervention will occur immediately.
- 19.2 An appropriate clinical assessment for a non-emergency operative or other invasive procedure shall include but not be limited to a History and Physical (H&P) examination recorded on the chart, or if dictated and not available on admission, the physician must write a short form H&P.
 - 19.2-1 If the H&P is greater than 234 hours old, then an interval note must be documented prior to surgery.
 - 19.2-2 Preoperative lab test should be based on the needs of the patient and the planned procedure as determined by the physicians involved in the procedure.
- 19.3 The provisional diagnosis shall be recorded by the surgeon prior to the operation. If the admission H&P is performed by another physician, the operating surgeon will record his or her consultation prior to surgery.
- 19.4 In all operative and other invasive procedures, a proper and legally signed informed consent(s) shall be attached to the patient's chart prior to surgery and an assessment of the need to administer blood or blood components shall be addressed.
- 19.5 For breast surgical procedures, the Breast Surgical Consent form should be used, showing that all alternatives, methods of treatment, possible results, and complications were thoroughly explained by the physician.
- 19.6 Hysterectomy – informed consent.

XX. Reports

- 20.1 The reports of operations must be dictated immediately following the procedure.
- 20.2 Documentation of a H&P for the patient must be on the patient's chart prior to the patient being taken to the Operating Room, unless the case is an emergency. No patient is to have surgery without "comprehensive" pre-surgical notes, including assessment of the patient's cardiac and respiratory systems, notation of patient allergies, current prescriptive needs, and information about reasons for surgery.

- 20.3 If a complete physical examination has been performed within 30 days prior to admission, such as in the office of a physician staff member, or when appropriate, the office of a qualified oral and maxillofacial surgeon staff member, a durable, legible copy of this report may be used in the patient's Hospital medical record, provided there have been no changes subsequent to the original examination or the changes have been recorded at the time of admission, and an addendum physical assessment completed within 24 hours of admission.

XXI. Scheduling

- 21.1 The Scheduling Office is open from 8:00 AM to 4:30 PM Monday through Friday.
- 21.2 Elective Cases
- 21.2-1 Elective cases may be scheduled during regular business hours.
- 21.2-2 First Outpatient case can be scheduled at 7:30 AM; last Outpatient case can be scheduled at 2:00 PM.
- 21.2-3 First Inpatient case can be scheduled at 7:30 AM; last Inpatient case can be scheduled at 5:00 PM.
- 21.2-4 Requests for add-on elective cases received after normal business hours will have to be verified the next morning with the charge nurse. You will receive a phone call to inform you of the status and possible time for your add-on case by the charge nurse in the morning.
- 21.2-5 Weekday elective cases which require ancillary department support should be scheduled so that such medical consultations are completed by 5:00 PM.
- 21.2-6 Pediatric elective cases will not be scheduled after 12:00 PM.
- 21.3 Scheduling Add-On Cases
- 21.3-1 Loss of life or limb emergencies are considered **emergent**. In emergent circumstances, the patient will be taken into the next available operating room and bump scheduled cases.
- 21.3-2 Urgent add-on cases will be added on the board. The surgeon can request a time but this is a request, not a guarantee. If the requested time is available and assigned to the case and surgeon is not on time, it will be added to the bottom of the add-on list again. In urgent situations, scheduled cases will not be bumped (unless a surgeon-to-surgeon agreement is made).
- 21.3-3 If there is any disagreement on classification of emergent vs. urgent, the Department of Surgery Chair will get involved in decision-making, along with the OR charge nurse.
- 21.4 Scheduling Cases on Weekends, Evenings, and Holidays
- 21.4-1 The Operating Room is only available for emergent cases on weekends, evenings, and holidays. Requests to schedule cases outside of normal business hours for the convenience of the surgeon cannot be accommodated.
- 21.5 7:30 AM Cases

21.5-1 If the physician is more than 20 minutes late for the scheduled procedure in the Operating Room and/or GI Lab, the scheduled procedure may be moved to the end of the day or cancelled for the day, on the basis of availability of surgery department personnel and anesthesia personnel.

21.5-2 The Surgery Department will monitor and report to the Department of Surgery Committee for follow-up.

21.5-3 Definition of 7:30 AM Case:

- A. Surgeon arrival on-time 7:20 AM (arrival in ASC). Surgeon must complete surgical mark before bringing the patient to the Operating Room.
- B. Anesthesia on-time 7:00 AM (arrival in ASC).
- C. Reasonable delays, when communicated by the surgeon, will be accommodated based on the OR schedule.

21.6 Bumping

21.6-1 Any case that is delayed 20 minutes due to a late physician will be moved to the first available time in the line-up that does not conflict with a regularly-scheduled case. When an elective surgery is scheduled at the time any emergency surgery is booked, nursing personnel will not be responsible for the decision to “bump” the elective surgery. When a surgeon decides a procedure is an emergency that cannot wait for available room the crew without inconveniencing other surgeons, it will be the surgeon with the emergency cases that is to contact the surgeon to be “bumped.” If the surgeons cannot agree on which surgery has precedence, the Chair of the Department of Surgery or the President of the Medical Staff will be contacted to make the decision. The surgery staff will make every effort to accommodate the “bumped” surgery by reassigning the case to the first available room. The decision to “bump” one case and replace it with another case must be communicated physician-to-physician. It will not be delegated to nursing personnel.

21.7 Scheduling Procedure, Monday through Friday until 4:30 PM

21.7-1 When scheduling procedures, the following information shall be provided to the Scheduling Office:

- A. Patient’s name.
- B. Procedure.
- C. Diagnosis.
- D. Age.
- E. Date and time desired.
- F. Approximate length of procedure and treatment.

- G. Surgeon and admitting physician.
- H. Surgeon's assistant.
- I. Type of anesthesia (general, local, etc.).
- J. Special equipment necessary (if any).
- K. If blood is to be ordered, and if so, how much.

21.7-2 Other admitting information such as

- A. Date of admission.
- B. Insurance information (should be faxed and made available to scheduling department).
- C. Telephone number (day and evening).
- D. Transportation for patient, if outpatient.

21.8 Scheduling Procedure – After Hours

21.8-1 Call the nursing supervisor to schedule cases after the surgery department is closed. Surgery supervisor / charge nurse will confirm the requested time the morning of the surgery for weekday added on case.

XXII. Ambulatory Surgery

22.1 All elective outpatient surgery cases must finish surgery by 4:30 PM. The Ambulatory Surgery Center closes at 7:00 PM weekdays, and is closed all day Saturday, Sundays, and holidays.

XXIII. Scrub Attire

23.1 All persons entering the semi-restricted and restricted area of the Surgical Suite must wear appropriate scrub attire. Appropriate scrub attire is scrub top, pants, shoe covers, and head covering. All possible head and facial hair, including sideburns and neckline, should be covered while in the semi-restricted and restricted areas of the Surgical Suite. In the restricted areas, i.e. areas where the surgical procedures are carried out, persons must wear a mask covering the nose and mouth.

23.2 Masks are to be changed after every procedure and should not be dangling around the neck.

23.3 Scrub attire should not be worn outside the semi-restricted or restricted area of the Surgical Suite. If one must leave the area, a cover gown must be worn over the scrub attire.

23.4 Gloves

23.4-1 Latex-free gloves are available.

23.5 Goggles or Face Shields

23.5-1 Goggles and/or face shields are available for use during surgery.

XXIV. Observers in the Surgical Suite

- 24.1 No observers in the Surgical Suite are allowed except members of health care. Permission to observe must be given by the patient, surgeon, and surgery supervisor. Surgeon must obtain Observer Consent per California Consent Manual.
- 24.2 A representative from a particular manufacturing firm may be present in the Operating Room at the request of the individual physician, but may not actively participate in the operative procedure. All manufacturing representatives must provide a negative TB test within six months and are required to complete Departmental orientation prior to entering the Operating Room / Surgical Suite.

XXV. Infractions

- 25.1 The surgical supervisor is responsible for reporting any infractions of the Department Rules and Regulations to the Chair of the Department. Infractions shall be investigated by the Chair and appropriate recommendations made to the Medical Executive Committee.

XXVI. Surgical Site Infection Guidelines

- 26.1 Eight category 1A recommendations (summarized):
 - 26.1-1 Administer appropriate prophylactic antibiotics before all Cesarean sections.
 - 26.1-2 In clean and clean/contaminated procedures, do not administer antibiotics after the surgical incision is closed in the OR, even in the presence of a drain.
 - 26.1-3 Implement perioperative glycemic control (blood glucose levels <200 mg/dL) in patient with and without diabetes.
 - 26.1-4 Maintain perioperative normothermia and adequate volume replacement.
 - 26.1-5 For patients with normal pulmonary function undergoing anesthesia with endotracheal intubation, administer increased FiO₂ during surgery and after extubation in immediate postoperative period.
 - 26.1-6 Perform skin preparation in the Operating Room with an alcohol-based agent unless contraindicated.
 - 26.1-7 Do not give antibiotics after incision is closed in the Operating Room; applies to prosthetic joint patients receiving corticosteroids or other immune suppressive therapy, ~~and~~.
 - 26.1-8 Do not give antibiotics after incision is closed in the Operating Room; applies to prosthetic joint patients even in the presence of a drain.
- 26.2 Four category 1B recommendations:
 - 26.2-1 Administer preoperative antibiotics only when indicated based on clinical guidelines.

- 26.2-2 Do not apply topical antimicrobial agents (ointments, solutions, or powders) to the surgical incision for surgical site infection (SSI) prevention.
- 26.2-3 Advise patients to shower or bathe (full body) with soap (antimicrobial or nonantimicrobial) or an antiseptic agent on at least the night before the operative day.
- 26.2-4 Do not withhold transfusion of blood products from surgical patients as a means to prevent SSI.