establish specific criteria that known to all operative room staff (substandard OR.6.1.1 through 6.1.8)

OR.7 The hospital has a process to prevent inadvertent retention of instruments or sponges in surgical wounds.

OR.7.1 The hospital develops and implements a policy and procedure to prevent inadvertent retention of instruments or sponges in surgical wounds.

OR.7.2 The count process includes instruments, sharps, sponges, and others as applicable.

OR.7.3 The policy addresses procedures that are exempted from the counting process (e.g., cataract, cystoscopy).

OR.7.4 The count process is standardized.

OR.7.5 The policy addresses the procedure to follow in case of a count discrepancy.

OR.7.6 The count process is documented in the count sheet.

Standard Intent:

Instruments and sponge counting is very important procedure that should be conducting throughout the surgery to ensure that no items are missing or left inside incision. The policy should outline steps of counting and action to be taken in case any item gets missing during the procedure (Substandard OR.7.1 through OR.7.6).

OR.8 The hospital develops and implements a policy for day surgery cases.

OR.8.1 The policy defines the types of surgical procedures that are performed as “day surgery”.

OR.8.2 The policy addresses the categories of patients who are not candidates for day surgery.

OR.8.3 The policy defines a process for patients who have to be admitted to the hospital from the day surgery unit.

OR.8.4 The most responsible physician writes a discharge order.

OR.8.5 Patients are discharged in the company of a responsible adult who assumes responsibility and is capable of taking care of the patient.

OR.8.6 Patient/family education and follow-up care instructions are provided prior to discharge.

Standard Intent:

Day surgery is vital in any hospital as it play role in decreasing bed occupancy rate, however, the day care practice should have policies and procedure that control cases that admitted for day surgery procure, admission and discharge criteria to ensure maximum benefits to patients.

OR.9 An operative report is documented immediately after the surgery/procedure.

OR.9.1 There is always an operative report that includes:

OR.9.1.1 Pre and post-operative diagnosis.