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.

OR.9.1.2 The name of the surgeon and assistants.

OR.9.1.3 The operation/procedure performed.

OR.9.1.4 Description of the surgery/procedure and findings.

OR.9.1.5 Presence or absence of intra-operative complications.

OR.9.1.6 Surgical specimens removed and sent to histopathology.

OR.9.1.7 Amount of blood loss.

OR.9.2 The operative report is documented before the patient leaves the recovery room to support the continuity of patient care.

OR.9.3 The operative report is signed/authenticated by the surgeon performing the procedure.

Standard Intent:

Operating room should have a policy that control pre, intra, and post procedure documentation. An operative report should be completed before the patient transferred from the room in order to ensure that patient information, surgeon name, samples taken and purpose for it, any complication that occurred during operation are documented elements of substandard OR.9.1.1 through OR.9.1.7). The operative report can be completed by the surgeon or his assistant. If the assistant surgeon is the one who wrote the operative report the principle surgeon (MRP) should review the report and co-sign it in order to ensure that all information included is correct.

OR.10 Tissues removed during surgery are sent for pathologic examination.

OR.10.1 Tissues or specimens removed during surgery have pathological examination unless exempted by a hospital policy.

OR.10.2 Surgical specimens are accurately identified.

OR.10.3 The report of the examination is signed by the pathologist and made part of the medical record.

Standard Intent:

The operative room has a policy that controls all surgical specimen that taken during operation, how to label these specimens and by whom, what type of pathological examination requested, and if a report generated for this examination is should be signed by the authorized pathologist. This specimen must be correctly identified to ensure sending the right specimen for the right patient.

OR.11 Each patient has a post-operative plan of care.

OR.11.1 A post-operative plan of care is written by the responsible surgeon.

OR.11.2 The post-operative plan of care includes:

OR.11.2.1 Post-operative monitoring parameters and its frequency.

OR.11.2.2 Wound care.

OR.11.2.3 Care of drains and catheters.