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.