

**TORRANCE MEMORIAL MEDICAL CENTER
DEPARTMENT OF SURGERY
RULES & REGULATIONS
APPROVED 12/31/2019**

TABLE OF CONTENTS

| | | <u>Page</u> |
|-------------|--|-------------|
| ARTICLE I | Responsibilities of the Chief of Surgery | 3 |
| ARTICLE II | Surgery Department | 3 |
| | A. Composition | 3 |
| | B. Responsibilities | 3 |
| | C. Meetings | 3 |
| ARTICLE III | Subcommittees of the Surgery Department | 4 |
| ARTICLE IV | Surgical Privileges | 4 |
| | A. Assignment of Privileges | 4 |
| | B. Proctoring | 5 |
| ARTICLE V | Surgery Department Policies and Procedures | 5 |
| | A. Operating Room Policies and Procedures | 5 |
| | B. Medical Records | 7 |
| | C. General | 8 |
| | D. Emergency Room Call Panels | 9 |
| | E. Burn Center Responsibilities | 9 |
| ARTICLE VI | Criteria for Consultation | 10 |

APPENDICES

| | | |
|--------------|--|----|
| APPENDIX I | Dental Section Rules and Regulations | 11 |
| APPENDIX II | Surgical Procedures Requiring an Assistant | 13 |
| APPENDIX III | Policy for Observers in the Operating Room | 14 |
| APPENDIX IV | Physician-Employed R.N. First Assistants | 14 |
| APPENDIX V | Criteria for Aortic Surgery | 18 |

PRIVILEGE CARDS

Burn and Wound

Cardiovascular Surgery

Dentistry (excludes Pediatric)

Dentistry (Pediatric)

Endovascular Privileges

General Surgery

General Surgery (Pediatric)

Neurosurgery

Oral and Maxillofacial Surgery

Ophthalmology

Orthopedic Surgery

Otolaryngology

Plastic Surgery

Podiatry

Thoracic Surgery

Urology

Vascular Surgery

Allied Health Professional: Nurse Practitioner (NP) – Cardiothoracic Surgery

Allied Health Professional: Nurse Practitioner (NP) – Wound/Ostomy

Allied Health Professional: Physician Assistant – Operating Room

Allied Health Professional: Physician Employed R.N. First Assistant – Operating Room

ARTICLE I – RESPONSIBILITIES OF THE CHIEF OF SURGERY

- A. Provide general supervision over the clinical work of the Surgery Department.
- B. Supervise the Department function in accordance with the rules, regulations, and policies of the Surgery Department.

ARTICLE II – SURGERY DEPARTMENT

A. COMPOSITION:

The Surgery Department shall consist of the Chief of Surgery and all members of the Department of Surgery. The Chief will be nominated and elected as specified by the Bylaws of the Medical Staff. The Chief shall regularly report the activities and progress of the Surgery Department and each subcommittee to the Medical Executive Committee.

B. RESPONSIBILITIES:

The Surgery Department shall ensure quality surgical care for patients of the Torrance Memorial Medical Center by:

1. Meeting regularly to review the Hospital work of staff surgeons.
2. Making policies to ensure quality surgical care.
3. Approving the content of certain educational meetings for the Hospital staff regarding surgical topics.
4. Recommending to the Medical Executive Committee any needed changes in staff surgical privileges.
5. The Surgery Department shall maintain an acceptable standard of medical/surgical care by means of continuing review; education and discussion. It shall recommend surgical policies and procedures to the Medical Executive Committee and to the Chief of Staff.
6. Post-operative surgical care may be relegated to Nurse Practitioner's (NP's) under direct supervision of the surgeon.

C. MEETINGS:

All members of the Department of Surgery may attend Department meetings; however, only Active Staff members may vote on Department business. Quorum requirements are outlined in the Medical Staff Bylaws.

ARTICLE III – SUBCOMMITTEES OF THE SURGERY DEPARTMENT

- A. The Chief of the Surgery Department shall appoint chairmen of the following subcommittees:
1. Bariatric
 2. Burn & Wound
 3. Cardiothoracic
 4. Dental/Oral
 5. General Surgery
 6. Neurosurgery
 7. Ophthalmology
 8. Orthopedic
 9. Hip & Knee Center of Excellence Committee
 10. Otolaryngology
 11. Plastic Surgery
 12. Robotics
 13. Urology
 14. Vascular
- B. These subcommittees will function independently but will report on their activities regularly and shall be responsible to the Surgery Department. The Chief shall appoint liaison representatives to the other Subcommittees, as necessary.

ARTICLE IV – SURGICAL PRIVILEGES

A. ASSIGNMENT OF PRIVILEGES:

Each member of the Surgery Department shall be assigned privileges commensurate with his/her training and ability after review of his/her application by the Surgery Department. All applicants to the Department of Surgery will be reviewed by their respective Subcommittee for privilege delineation.

Each surgeon must fill out a Surgical Privilege Card. When approved by the Surgery Department, it shall be dated and signed by the Chief of the Department. A duplicate copy shall be returned to the surgeon for his records. No changes in privileges shall be made without the most careful consideration.

Temporary privileges may be granted as outlined in the Medical Staff Bylaws and Policies and Procedures.

ARTICLE IV – SURGICAL PRIVILEGES (CONTINUED)

B. PROCTORING:

Proctoring will be conducted as outlined in the Medical Staff Bylaws and Policies and Procedures. The subspecialty committee has the option of requesting various additional cases in order to satisfy the proctoring requirements.

At the discretion of the Chief of Surgery, a Provisional Staff member requiring proctoring may perform a maximum of four (4) emergency cases without a proctor where the surgeon, acting as assistant, would normally qualify to act as a proctor. These cases will not qualify as proctored cases.

Instructions for the Proctor: The proctor is present in the interest of patient care and to review the care of the case for the Medical Staff. It is the proctor's responsibility to exercise contributory and good judgment for the surgical care rendered in the operating theater.

1. Proctor will not be a paid assistant in the case he/she is proctoring.
2. The proctor is expected to review the chart prior to the induction of anesthesia.
3. The proctor is expected to be in the Operating Room from inception of the surgery until he/she is satisfied that the case is proceeding to an appropriate conclusion.
4. The proctor shall complete the proctoring sheet once the procedure has been completed.

ARTICLE V – SURGERY DEPARTMENT POLICIES AND PROCEDURES

A. OPERATING ROOM POLICIES AND PROCEDURES

1. Whenever possible, surgery must be scheduled by the operating surgeon who should furnish the assistant's name, if known, at the time of scheduling. Information concerning x-ray or frozen section contemplated should also be furnished when scheduling surgery.
2. The surgical patient shall be admitted to the Operating Room for surgery only after the patient's chart is complete. The chart will be checked for completeness by the pre-op holding nurse and the circulating nurse. The chart must include a written or typed history and physical examination, laboratory work, and any necessary consultation. Should the patient's chart not be complete, the operation shall be postponed unless the attending surgeon stated in writing on the chart that such a delay would constitute a hazard to the patient.

ARTICLE V – SURGERY DEPARTMENT POLICIES AND PROCEDURES (CONTINUED)

A. OPERATING ROOM POLICIES AND PROCEDURES (CONTINUED)

If the above rule has been complied with, except that the necessary notes have been dictated but are not on the patient's chart at the time the patient is taken to surgery, cysto, emergency room, or for any special procedure, then the surgeon shall make adequate note on the progress sheet with pertinent data regarding history, physical examination, necessary consultation and reason for surgical procedure.

3. Surgical Consent should be completed prior to the surgical pre-medication. The surgeon shall also ensure that the procedure has been explained and was understood by the patient and shall make a note to this effect on the patient's hospital chart. In the event of life-threatening emergency, the above stated policy is superseded by the needs of the patient.
4. Only those persons directly involved in the care of the patient shall be allowed in the operating room during surgery. No relatives or friends are to be allowed in the operating room. At the discretion of the Chief of Surgery, observers may be allowed in the operating room on special occasions for education purposes after appropriate consent has been obtained from the patient.
5. Upon approval of the surgeon and the Operating Room Manager, representatives from medical supply companies may be present in the Operating Room to provide support to the surgeon and the Operating Room staff during the placement of medical prosthesis and devices.
6. Surgeons and assistant surgeons are expected to be scrubbed and ready to start the procedure at the scheduled time. The patient will be brought to the operating room when the primary surgeon is present. Infraction of this rule will be reviewed by the Surgery Department. Unwarranted delay may be grounds for cancelling or postponing the surgery at the discretion of the Operating Room Leadership and either the Chief of Surgery or Chief of Anesthesia. For double procedures performed by different primary surgeons, both surgeons will be expected to see the patient in the pre-op, complete all required documentation, and sign the consent and mark the site (when appropriate) prior to the patient being taken back to the operating room. In order to expedite the preoperative process, patients may be brought to the operating room prior to the arrival of the surgeon for the insertion of central lines and/or the insertion of epidural/spinals. However, the surgeon will identify the patient, complete all documentation, and mark the site (when appropriate) in the OR prior to the administration of general anesthesia.

**ARTICLE V – SURGERY DEPARTMENT POLICIES AND PROCEDURES
(CONTINUED)**

A. OPERATING ROOM POLICIES AND PROCEDURES (CONTINUED):

7. All orders, including medication orders, will be cancelled on patients going to surgery and new orders will be written postoperatively.
8. Emergent cases that require immediate surgery will be reported to the lead nurse in the OR if available or House Supervisor. The OR Team will do their best to accommodate ALL emergency cases expeditiously including and not limited to using cardiac and vascular on-call teams. In the event that another surgeon's case is to be bumped, the surgeon performing the emergent case must communicate directly with the surgeon whose case is to be bumped before he/she can bump the case. If there is more than one emergent case that requires immediate surgery and there is only one room available, the lead nurse/House Supervisor will inform the surgeons the he/she must communicate with one another to determine which case will be performed first. Any disputes between surgeons will be resolved by the Chief of Surgery or his designee.
9. All patients undergoing surgery in either the Outpatient Operating Room or the Main Operating Room, independent of the type of anesthesia, shall have an intravenous line in place.
10. For all 0730 cases, surgeon must arrive and identify their patients by 0715. Patients will then be taken to the operating room. Surgeons should meet 65% compliance on-time arrival to the OR each quarter to maintain their ability to book 0730 cases. Failure to maintain compliance initially will generate a letter advising the physician that he or she will be placed on probation for one quarter. If 65% compliance of on-time arrival to the OR is not achieved during the probationary quarter, the physician will forfeit his/her ability to book 0730 cases for one quarter.
11. Advanced practice nurses employed by the medical center may gain hours of experience in the Operating Room at Torrance Memorial to satisfy training program requirements with the approval and oversight of their sponsoring physician(s).

B. MEDICAL RECORDS:

1. Consulting or operating surgeons must examine the patient preoperatively and the results of the examination noted on the chart prior to surgery. Daily progress notes must be written by the operating surgeons or a qualified member of the Medical Staff. An operative noted must be made on the chart upon completion of the surgery. The operative report must be dictated or written within regulatory requirements.

ARTICLE V – SURGERY DEPARTMENT POLICIES AND PROCEDURES (CONTINUED)

B. MEDICAL RECORDS (CONTINUED):

2. All consultants who operate must provide a written consultation on the chart prior to surgery. In the event this consultation has been dictated but is not on the chart, an appropriate written note on the Progress Sheet stating that the consultation has been dictated, and all pertinent findings and indication for surgery shall be written on the Progress Sheet prior to surgery. It is required that the operating room surgeon shall keep proper follow-up notes on the patient even if the referring physician is also doing this.
3. When warranted, the surgical chart should indicate when sutures, drains, and so forth, were removed. If such items are not removed during the course of the patient's hospitalization, the clinical resume should indicate when this procedure will be done.
4. When dictating separate operative reports on different aspects of the same procedure, surgeons must cross-reference one operative report to the other.

C. GENERAL:

1. Surgeons are permitted to perform only those operations, which are approved on their current privilege card.
2. Surgical and anesthesia deaths shall be reviewed by the Surgery Department, and anesthesia deaths shall also be reviewed in the Anesthesia Committee. Written reports signed by the Chief of the respective departments shall be submitted to the Medical Staff PI Committee upon the completion of this review.
3. Pediatric and adult general surgical privileges shall be evaluated separately.
4. In case of biopsy to rule out malignancy where definitive surgery is to follow immediately, a surgeon with privileges necessary to do definitive surgery shall evaluate the patient preoperatively and be present in the operating room at the time the biopsy is taken.
5. All physician utilizing fluoroscopy equipment in the O.R. shall obtain the appropriate state certification.

The above policies and procedures are intended to supplement those of the Medical Staff Bylaws, and Rules and Regulations. Any of the above which are in conflict with the Medical Staff Bylaws or Rules and Regulations shall not apply.

ARTICLE V – SURGERY DEPARTMENT POLICIES AND PROCEDURES (CONTINUED)

D. EMERGENCY ROOM CALL PANELS:

Upon the recommendation of the Chief of Surgery, the Surgery Department may develop and implement an emergency room call panel for any surgical subspecialty as outlined in the Medical Staff Bylaws and Rules and Regulations.

Upon reaching the age of 60, a surgeon may request an exemption from the Call Panel as outlined in the Medical Staff Rules and Regulations.

E. BURN CENTER RESPONSIBILITIES:

1. The surgeon assigned to take Burn Center Call will be available for evaluation of outpatients and the admission of acute care burn or wound related patients. The surgeon will evaluate the appropriateness of admission utilizing the American Burn Association standards and the Burn Center Admission Criteria. The surgeon will evaluate the stability of patients for transport and designate the type of transportation required.

Admission will be coordinated with the nursing staff to determine bed and staffing availability. Patients meeting those standards and criteria, including patients covered by third party payer contracts with the hospital shall not be refused admission, nor shall the staff surgeon refuse to accept such patients, for financial or other non-medical reasons.

2. The staff surgeon so assigned must respond to the Burn Center within 15 minutes. The on-call staff surgeon will be responsible for obtaining a Burn Center surgeon to take his/her place and to notify the Burn Center of the same if he/she is unavailable or cannot take his/her assigned call.
3. The surgeon may access the Emergency Department surgical and non-surgical specialties for consultation.
4. If the surgeon assigned to the burn Center call rotation does not meet the responsibilities identified above in 1, 2, and 3, he/she is subject to corrective action pursuant to the Medical Staff Bylaws.
5. Since availability on short notice is essential, the place or residence, as well as the office location must be reasonably close to TMMC.

ARTICLE VI – CRITERIA FOR CONSULTATION

Consultation may be sought under the following circumstances:

- A. The patient's condition warrants specialist consultation, (e.g., Cardiology, Neurology and Pulmonary).
- B. With another surgeon where assistance in the patient's management is warranted.

APPENDIX I – DENTAL SECTION RULES AND REGULATIONS

ARTICLE I – CHIEF OF DENTAL

The Chief of Dental shall:

- A. Provide general supervision over the clinical work of the Dental Department.
- B. Supervise the Dental Section function in accordance with the rules, regulations, and policies of the Surgery Department.

ARTICLE II – DENTAL DEPARTMENT

The Dental Section shall function as a Subcommittee of the Surgery Department. The Dental Section shall consist of a Chairman (Chief of Dental) and all members of the Dental Section. The Dental Chief will be appointed by the Chief of Surgery. The Dental Chief shall regularly report the activities and progress of the Dental Section to the Surgery Department.

The Dental Section shall maintain an acceptable standard of dental/medical/surgical care by means of continuing review, education and discussion. It shall recommend dental/surgical rules and regulations and policies and procedures to the Surgery Department.

All members of the Dental Section may attend Section meetings.

ARTICLE III – SURGICAL PRIVILEGES

A. ASSIGNMENT OF PRIVILEGES

Each member of the Dental Section of the Department of Surgery shall be assigned privileges commensurate with his/her training and ability after review of his/her application by the Surgery Department and Dental Section. All applicants must be licensed by the State of California to practice Dentistry, and Specialists must be either qualified to sit for the exam or Board Certified in the specialty for which they are requesting privileges.

Each dentist must fill out a Dental Privilege Card which shall be kept on file. When approved by the Surgery Department, the privilege card shall be dated and signed by the Chief of the Dental Section and the Chief of the Department of Surgery. A duplicate or copy will be returned to the dentist for his records. No change in privileges shall be made without the most careful consideration.

APPENDIX I – DENTAL SECTION RULES AND REGULATIONS (CONTINUED)

ARTICLE III – SURGICAL PRIVILEGES (CONTINUED)

A. ASSIGNMENT OF PRIVILEGES (CONTINUED):

Temporary privileges may be granted by the Chief of Surgery to a new dentist in accordance with the procedure as outlined in the Medical Staff Bylaws. When the Board of Trustees, acting on recommendation of the Executive Committee, approved the dentist's applications, he/she will be granted provisional members to the staff.

B. PROCTORING:

As outlined in the Medical Staff Bylaws and Rules and Regulations

ARTICLE IV – DENTAL SECTION POLICIES AND PROCEDURES

- A. All specimens, with the exceptions as outlined in the Rules and Regulations of the Medical Staff Bylaws, shall be sent to the hospital pathologist, who shall make examinations as he may consider necessary to arrive at a pathologist diagnosis.
- B. All major surgical cases wherein an assistant is customarily present at surgery must have an assistant. Open reduction of mandibular fractures, maxillary fractures and mid-face fractures performed shall require a surgical assistant.

APPENDIX II – SURGICAL PROCEDURES REQUIRING AN ASSISTANT

ABDOMINAL

Lap Roux-en-Y Gastric Bypass
Open Roux-en-Y Gastric Bypass
Lap revisional surgery
Open sleeve gastrectomy
All open bariatric cases where the patient's BMI is greater than or equal to 35

CARDIAC (X2)

All surgeries except insertion of pacemakers and IABP

HEAD AND NECK

The use of an assistant surgeon will be at the sole discretion of the surgeon.

ORAL SURGERY

Cleft lip and/or palate
Craniofacial deformities of the jaws (congenital, development and acquired orthognathic procedures)
Maxillofacial fractures and soft tissue trauma of an extensive nature.
Temporomandibular joint surgery (open arthroscopy)

PLASTIC SURGERY

Free flaps
Replantation

ROBOTIC SURGERY

All robotic procedures require an assistant. **Robotic assisted inguinal hernia procedures may be performed without an assistant provided that the surgeon has performed 20 robotic assisted cases or greater.*

THORACIC SURGERY

Diaphragmatic hernia
Esophagectomy (X2)
Pulmonary resection
Thoracoabdominal surgery
Thoracoplasty
Thoracotomy (except pleural biopsy)
Vascular

APPENDIX III – POLICY FOR OBSERVERS IN THE OPERATING ROOM

The policy regarding observers in the Operating Room is as follows:

1. People directly involved with the care of the patient shall be allowed in the Operating Room. Others who meet the following criteria may also be present in the Operating Room.
 - a. Clergymen may be permitted to enter the Operating Room to administer rites related to the patient's faith upon request of the patient or family and with permission of the surgeon.
 - b. Visiting physicians and medical students are permitted in the Operating Room for specific surgeries at the request of the surgeon and with the permission of the Chief of Surgery.
 - c. Manufacturers' technical representatives are permitted in the Operating Room upon the request of the operating surgeon and with the approval of the Operating Room Manager.
2. Relatives and friends of patients will not be allowed in the Operating Room.

APPENDIX IV – PHYSICIAN EMPLOYED R.N. FIRST ASSISTANTS

The RN First Assistant renders direct patient care as part of the perioperative role by assisting the surgeon in the surgical treatment of the patient. The responsibility of functioning as first assistant must be based on documented knowledge and skills acquired after specialized preparation, formal instruction and supervised practice.

The following criteria have been developed for Physician-Employed R.N. First Assistant (RNFA).

- | | |
|--------------------|---|
| Education/Training | <ol style="list-style-type: none">a. Current California R.N. Licenseb. Employee of surgeon in good standing of TMMC Medical Staffc. 3 years verifiable experience as R.N. in O.R.d. Current professional liability insurance on the amounts of \$1-\$3 millione. Must be certified through Competency & Credentialing Institute (CCI) as Certified Nurse Operating Room (CNOR) and a Certified Registered Nurse First Assistant (CRNFA)f. Successful completion of an Association of Perioperative Registered Nurse (AORN) approved didactic, structured course for RNFA'sg. Validation of an ongoing basis of clinical skills by a surgeon employer. |
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APPENDIX IV – PHYSICIAN EMPLOYED R.N. FIRST ASSISTANTS (CONTINUED)

The RNFA practices under the direct supervision of the surgeon during the surgical intervention.

The RNFA must perform only as the first assistant and not concurrently as scrub nurse.

Only in extreme emergencies should an RNFA be expected to assist on procedures that present an unusual hazard to life.

The RNFA must adhere to the policies of Torrance Memorial Medical Center and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California and scope of perioperative nursing practice as defined by the AORN.

The RNFA may perform the following technical functions:

1. Assist with the positioning, prepping and draping of the patient or perform these independently, if so directed by the surgeon.
2. Provide retraction by:
 - a. Closely observing the operative field at all times
 - b. Demonstrating stamina for sustained retraction
 - c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue
 - d. Managing all instruments in the operative field to prevent obstruction of the surgeon's view
 - e. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.
3. Provide hemostasis by:
 - a. Applying electrocautery tip to clamps or vessels in a safe and knowledgeable manner as directed by the surgeon
 - b. Sponging and utilizing pressure as necessary
 - c. Utilizing suctioning techniques
 - d. Applying clamps on superficial vessel and the tying or electrocoagulation of them as directed by the surgeon
 - e. Placing suture ligatures in the muscle, subcutaneous, and skin layers
 - f. Placing hemoclips on bleeds as directed by the surgeon

APPENDIX IV – PHYSICIAN EMPLOYED R.N. FIRST ASSISTANTS (CONTINUED)

4. Perform knot tying by:
 - a. Having knowledge of basic techniques
 - b. Tying knots firmly to avoid slipping
 - c. Avoiding undue friction to prevent fraying of suture
 - d. Carrying knot down to the tissue with the tip of the index finger and laying stands flat
 - e. Approximating tissue rather than pulling tightly to prevent tissue necrosis
5. Provide closure of layers by:
 - a. Correctly approximating the layers under the director of the surgeon
 - b. Demonstrating a knowledge of different types of closure
 - c. Correctly approximating skin edges when utilizing skin staples
6. Assist the surgeon at the completion of the surgical procedure by:
 - a. Affixing and stabilizing all drains
 - b. Cleaning the wound and applying the dressing
 - c. Assisting with the application of casts or plaster splints

NOTE: The above specifications are general guidelines and do not reflect all the duties in all the specialty areas. Therefore, these specifications should not preclude the performance of other duties which, in the judgment of the surgeon, can be successfully accomplished by the RNFA. However, the RNFA must know his/her limitations and may refuse to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

7. Cases for which RNFA may be utilized by:
Orthopedic Surgery
 - a. Open reduction and internal fixation
 - b. Microsurgery with double-armed scope
 - c. Acetabular and pelvic fractures
 - d. Total hip and knee replacements
 - e. Shoulder arthrotomy
 - f. Repair of anterior cruciate ligament
 - g. Arthroscopy

APPENDIX IV – PHYSICIAN EMPLOYED R.N. FIRST ASSISTANTS (CONTINUED)

7. Cases for which RNFA may be utilized by (Continued):

Ophthalmology Surgery

“Surgeons Discretion” assuming RNFA has had formal training. Ophthalmology assistants with the preparation and administration of eye medications and obtaining implant devices or tissue for use during the perioperative period, as directed by the surgeon

- a. Prepare preoperative local injections
- b. Prepare irrigation solutions for intraoperative use
- c. Instill eye drops and ointments
- d. Inject medically subconjunctivally, as directed by surgeon
- e. Provide patient implant devices or tissue (i.e., IOL, scleral buckle, done cornea) to surgical site

Urology

“Surgeons Discretion” assuming RNFA has had formal training

Cardiovascular Surgery

“Surgeons Discretion” assuming RNFA has had formal training

Neurosurgery

- a. RNFA’s are not allowed to assist in craniotomies
- b. RNFA’s are allowed to assist in spinal surgical procedures at the discretion of the operating neurosurgeon assuming RNFA has had formal training.

General Surgery

- a. Hernia
- b. Breast surgery
- c. Dehiscence of wounds

Otolaryngology

“Surgeons Discretion” assuming RNFA has had formal training

Plastic Surgery

“Surgeons Discretion” assuming RNFA has had formal training

8. Membership:

RNFA’s will be processed for membership on the Allied Health Professional Staff and must adhere to the Medical Staff Bylaws and Rules and Regulations in relation to the Allied Health Professional Staff.

APPENDIX IV – PHYSICIAN EMPLOYED R.N. FIRST ASSISTANTS (CONTINUED)

9. Proctoring:

Proctoring for RNFA's will not be required. Continual evaluation to validate skills will be performed by the surgeon employer.

APPENDIX V – CRITERIA FOR AORTIC SURGERY

1. Genetic (isolated asymptomatic ascending aneurysm) – BAV, TAD, MFS, LDS, EDS, FTAAS, Turner Syndrome
Height and gender adjusted 4.5cm (smaller 4.2 in LDS) if low risk and well informed consent. Measurement done using Svenson number or chart adjusted for body surface area (Yale criteria)
2. Non-Genetic (isolated asymptomatic ascending aneurysm)
Height and gender adjusted 5cm with low operative mortality and well informed consent
3. Concomitant Surgery AVR (in presence of ascending aortic aneurysm)
Height and gender adjusted 4.5cm in non-genetic asymptomatic trileaflet AOC

OR

Height and gender adjusted 4cm or larger in BAV, BAV family, MFS, FTAAD, only with low operative risk and informed consent

4. Description pathology, TEE, CT, MRI, Intra-op
5. Svensons Criteria greater than 10 Aorta for aortic intervention in bicuspid aortic valve patients
6. Yale Criteria nomogram for thoracic aortic aneurysm surgical intervention

FOR GENERIC OR BICUSPID CASES – MUST MEET SVENSON CRITERIA > 10 IN BICUSPID VALVES

FOR ALL THORACIC AORTIC ANEURYSM CASES – MUST MEET YALE CRITERIA (ELEFTERIADES, JA)