LESSON ASSIGNMENT

LESSON 2
Operating Room Personnel, Policies, and Nomenclature

LESSON ASSIGNMENT
Paragraphs 2-1 through 2-35.

LESSON OBJECTIVES
After completing this lesson, you should be able to:

2.1 Select the correct answers to questions regarding surgical nomenclature.
2.2 Identify responsibilities and lines of authority of OR personnel.
2.3 Select the correct answers to questions, which demonstrate a knowledge of legal and ethical responsibilities of OR personnel, including dealing with bereavement.
2.4 Identify the forms and other sources of information needed in the OR.

SUGGESTION
After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.
LESSON 2
OPERATING ROOM PERSONNEL, POLICIES, AND NOMENCLATURE

Section I. SURGICAL NOMENCLATURE

2-1. INTRODUCTION

a. Discussion. The OR specialist should be familiar with surgical nomenclature, the terminology used in the OR. Knowledge of nomenclature enables the specialist to understand the surgery being performed so that he may prepare for it adequately and assist the surgeon efficiently. Word combinations are used frequently to identify different parts of the body, various disease conditions, or specific operative procedures. Terms used to designate certain operative procedures may be derived from either the name of the surgeon who originally developed the technique or from the anatomical area involved. The terms defined in the following paragraphs (2-1 through 2-11) are intended to supplement the OR specialist's knowledge of medical vocabulary. The specialist can further enhance his understanding of the terminology pertaining to surgical procedures by the use of a standard medical dictionary.

b. Objectives of Surgery. Surgery is usually performed in order to accomplish one of three objectives—to alleviate pain, to cure by removing diseased organs, or to repair or reconstruct a part. The surgical procedures themselves may be classified as follows:

(1) Palliative. A surgical procedure that is intended to relieve pain rather than cure the disease.

(2) Curative. A surgical procedure in which the diseased organ is removed.

(3) Plastic. A surgical procedure in which the part is repaired or reconstructed.

(4) Diagnostic. A surgical procedure for the purpose of diagnosing.

2-2. TERMS PERTAINING TO OPERATIVE PROCEDURES

a. Classification of Operations. Surgical operations can be classified according to the type of procedure, as follows:

(1) Incision.

(2) Excision.
b. **Discussion.** The following paragraphs give suffixes as well as complete phrases, words, and synonymous terms descriptive of operative procedures in the above classifications ((1)-(9)). In addition, examples of kinds of operations in each category are given, though these are not all inclusive. However, with this basic information, the specialist can further enhance his understanding of surgical terminology through the use of a standard medical dictionary.

### 2-3. **INCISION PROCEDURES**

a. **Discussion.** **Incision** is a cutting into, a formation of an opening. The suffixes commonly used for operations classified as incisions are:

1. -(o)tomy--to cut into.
2. -(o)stomy--to provide with an opening.
3. -centesis--puncture or perforation.

b. **Otomy Procedures.** Otomy procedures, with examples, include the following:

1. Exploratory operation.
   
   Laparotomy--cutting into the peritoneal cavity for exploratory purposes.

2. Removal of foreign bodies.
   
   (a) Accidental.
   
   Sclerotomy--removal of a foreign body from the eye.
(b) Therapeutic.

Arthrotomy--removal of a surgical nail, pin, screw, and so forth, from a joint.

(c) Pathological.

Nephrolithotomy--removal of kidney stones.

(3) Division of a structure.

Myotomy--cutting or dissection of a muscle; also neurotomy, tenotomy.

(4) Decompression.

Craniotomy--cutting into the skull for relief of pressure on the brain.

c. **Ostomy Procedures.** Ostomy procedures, with examples, include the following:

(1) Surgical creation of an artificial passageway.

Gastrostomy--an artificial passageway through the abdominal wall to the stomach.

(2) Formation of an artificial opening.

Colostomy--formation of an opening in the abdominal wall for exteriorization of the colon.

d. **Centesis Operations.** Centesis operations include the following kinds of procedures, with examples:

(1) Aspiration.

Thoracentesis--puncture of the chest wall for the aspiration of fluid.

(2) Trephination.

Trephine--operation of the cornea; an opening is made into the cornea by inserting a trephine.
2-4. EXCISION PROCEDURES

a. Discussion. Excision is the cutting out of a part. The suffixes used to denote excision are as follows:

(1) --ectomy--to cut out or excise. Excisions are divided into two types--partial or subtotal excision (b, below) and complete or total excisions (c, below).

(2) --exeresis--to strip out. (Examples are discussed in d, below.)

b. Partial or Subtotal Excision.

(1) Resection.

Subtotal gastrectomy--excision of a part of the stomach.

(2) Biopsy.

Biopsy of lymph node--removal of a lymph node from a living person for examination.

(3) Curettage.

Curettage of uterus--the scooping out of retained material.

c. Complete or Total Excision.

(1) Radical excision.

Mastectomy, radical--removal of entire breast and axillary lymph nodes.

Chondrectomy--excision of cartilage.

(2) Obliteration (to efface).

Ligation of varicose veins--the lumen of the vein is closed.

(3) Extirpation (to "root out").

Tonsillectomy.

(4) Enucleation.

Enucleation of eye--removal of an entire eyeball.
(5) Evisceration.

**Evisceration** of eye--removal of contents of an eyeball, leaving the sclera.

(6) Extraction (to draw out).

**Extraction** of lens--cataract.

d. **Other.**

    (1) -exeresis. Removal by pulling out (stripping).
    (2) **Neuroexeresis**--stripping out of a nerve.

2-5. **AMPUTATION PROCEDURES**

a. **Discussion.** Amputation is the cutting off of a part.

b. **Terms Used.** Suffixes are not required to denote procedures used for amputation. The terminology used is as follows:

    (1) Disarticulation of leg--amputation at knee joint.
    (2) Dismemberment of toe--amputation through a metatarsal.
    (3) Amputation of leg--amputation through tibia or fibula.

2-6. **INTRODUCTION PROCEDURES**

a. **Discussion.** Introduction is the placement of a substance into the body.

b. **Terms Used.** Suffixes are not required to indicate operations involving introduction procedures. The following terms are used:

    (1) **Injection**--the forcing of a material such as radiopaque dye, oil, alcohol, air, etc., into a part of the body is classified as an operative procedure.
    (2) **Transfusion**--the introduction of whole blood or its derivatives (plasma, serum albumin) directly into the bloodstream.
    (3) **Implantation**--the placement of a prosthetic device into the orbit following enucleation of an eyeball (for example--a plastic implant). Also, the fixation of a portion of tissue such as skin, nerve, tendon, or bone into a new site in the body. Such portions of tissue are called grafts and operations for the implantation of grafts are classified as plastic procedures (see para 2-8b(1)).
(4) **Insertions**--the introduction of materials such as radium (or other radioactive substance), packs, tampons, drains, and so forth, into the body.

c. **Procedures.**

(1) **Injection.**

(a) **Ventriculography**--x-ray of the head following the removal of cerebral fluid from the ventricles and its replacement by air (or other contrast medium).

(b) **Arteriography, cerebral**--x-ray of the arteries of the brain following injection of a dye (radiopaque material) into the bloodstream.

(c) **Myelography**--x-ray of the spinal cord following injection of a contrast medium into the spinal canal.

(d) **Injection into the nerve**--95 percent alcohol or other substance may be injected into a nerve to relieve pain in the part of the body supplied by the nerve.

(2) **Transfusion.**

(a) **Blood transfusion, indirect**--administration of whole blood that has been withdrawn from a donor into a container, and kept refrigerated until ready for use.

(b) **Plasma transfusion**--the intravenous administration of blood plasma.

(3) **Implantation.**

**Implantation of plastic prosthesis** following enucleation of the eyeball.

(4) **Insertion.**

(a) **Insertion of radioactive substance into the uterus**--done as treatment for malignant tumor.

(b) **Insertion, post-partum, of intrauterine pack**--done to control post-partum hemorrhage.

2-7. **ENDOSCOPY PROCEDURES**

a. **Discussion.** Endoscopy is the inspection of a body cavity or a hollow viscus (organ) by the means of an endoscope.
b. **Suffix.** The suffix denoting endoscopy is *-scopy*. Endoscopic study may be performed on many parts of the body, including those listed in Table 2-1.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anoscopy</td>
<td>the anus.</td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td>the bronchus.</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>the urinary bladder.</td>
</tr>
<tr>
<td>Esophagoscopy</td>
<td>the esophagus.</td>
</tr>
<tr>
<td>Gastroscopy</td>
<td>the stomach.</td>
</tr>
<tr>
<td>Laryngoscopy</td>
<td>the larynx.</td>
</tr>
<tr>
<td>Otoscopy</td>
<td>the ear.</td>
</tr>
<tr>
<td>Proctoscopy</td>
<td>the rectum.</td>
</tr>
<tr>
<td>Rhinoscopy</td>
<td>the nose.</td>
</tr>
<tr>
<td>Thoracoscopy</td>
<td>the chest.</td>
</tr>
<tr>
<td>Tracheoscopy</td>
<td>the trachea.</td>
</tr>
<tr>
<td>Urethroscopy</td>
<td>the urethra.</td>
</tr>
</tbody>
</table>

Table 2-1. Endoscopy procedures.

c. **Combined Procedures.** The surgeon may elect to combine endoscopy with one or more other surgical procedures--for example, he may perform bronchoscopy with removal of a foreign body or cystoscopy with drainage. Operative procedures that may be done in combination with endoscopic procedures are as follows:

1. Biopsy.
2. Dilation.
3. Drainage.
Excision.

Injection.

Irrigation.

Removal.

2-8. REPAIR PROCEDURES

a. Discussion. Repair is the reconstruction, reforming, fixation, or stabilization of a part. The suffixes used for plastic surgery procedures are as follows:

(1) -plasty--the shaping or surgical formation of a body part.

(2) -(o)stomy--to provide with an opening.

(3) -desis--the binding of a body part.

(4) -pexy--the fixation or suspension of a body part.

b. -Plasty.

(1) Graft.

   (a) Skin graft--the implantation of a portion of skin onto a body part.

   (b) Bone graft--the implantation of a piece of bone to replace a removed bone or bony defect.

   (c) Cartilage graft--the implantation of a portion of cartilage into a body part.

(2) Lengthen or shorten--tendon (tenoplasty).

   (a) Advancement--eye muscles.

   (b) Recession--eye muscles.

(3) Attach or reattach

   (a) --nerves (neuroplasty).

   (b) --tendons (tenoplasty).
Reconstruct

(a) --nose (rhinoplasty).
(b) --ear (otoplasty).
(c) --tongue (glossoplasty).
(d) --larynx (laryngoplasty).
(e) --joints (arthroplasty).
(f) --bones (osteoplasty).
(g) --inguinal hernia (hernioplasty).

c. -Ostomy. This suffix indicates a plastic surgery procedure when used to denote the joining together of two parts with the formation of a permanent opening between two spaces that are usually apart from each other. For example, if a portion of intestine is removed, the usual operative procedure is to anastomose the ends (to stitch the two cut ends together). Such a plastic operation is called an enterostomy. The specific parts of the gastrointestinal tract anastomosed are indicated by naming them (see example below). Anastomosis of large blood vessels may be performed also. (Other usage of the suffix -ostomy denotes surgical procedures classified as incisions (see para 2-3a(2),c).

(1) Anastomosis--formation of a communication between stomach and bowel or between any two organs or vessels.

(2) Gastroduodenostomy--anastomosis of the stomach to the duodenum.

(3) Ileocolostomy--anastomosis of the ileum (distal portion of small intestine) to the colon.

d. Desis.

(1) Fusion.

(a) Spondylosyndesis--spinal fusion.

(b) Arthrodesis--fusion of a joint to produce ankylosis (immobility and consolidation of joint).
(2) Stabilization.

Tenodesis—suture of a tendon to a skeletal attachment.

e. Pexy.

(1) Fixation.

(a) Nephropexy—fixation of a movable kidney; performed to correct nephroptosis (downward displacement of the kidney).

(b) Scapulopexy—fixation of the scapula.

(c) Splenopexy—fixation of the spleen.

(d) Colpopexy—fixation of a relaxed vagina to the abdominal wall.

(e) Orchiopexy—fixation into the scrotum of an undescended testicle.

(2) Suspension.

Hysteropexy—suspension of the uterus.

2-9. DESTRUCTION PROCEDURES

a. Discussion. These are surgical procedures that involve a breaking down of tissues.

b. Clasis. Fracture or refracture.

Osteoclasis—refracture of bone.


Neurotripsy—crushing of a nerve.

d. Lysis. Free (from adhesions).

(1) Neurolysis—freeing of a nerve.

(2) Pericardiolyis—freeing of the pericardium.
e. Other Procedures.

(1) Cauterization (destruction of tissue with heat, electricity, or chemical action).

Cauterization of cut blood vessels to seal them off and prevent further bleeding.

(2) Fulguration (destruction of tissue with high-frequency electric sparks).

Destruction of a lesion (such as ulcerated tissue) of the head, neck, trunk, or the extremities by fulguration.

(3) Diathermy (heating of tissue with high-frequency electromagnetic radiation).

Cyclodiathermy—destruction of a portion of the ciliary body of the eye by diathermy; may be performed in the treatment of glaucoma (condition of the eye characterized by increased intraocular pressure).

(4) Debridement (removal of contamination, contaminated tissue, and unhealthy tissue).

Debridement—of a wound of the head, neck, trunk, or limbs.

2-10. SUTURING PROCEDURES

a. Discussion. Suturing operations are those in which tissue is approximated (brought together) and stitched using suture material (such as silk suture, surgical gut suture, wire suture, and so forth).

b. Suffix. The suffix used to denote suturing operations is -rrhaphy. Some examples of rrhaphy procedures are listed in Table 2-2.

2-11. MANIPULATION PROCEDURES

a. Discussion. Manipulative procedures are those in which a condition is corrected by handling and maneuvering the disordered part. Terms used to indicate such procedures are as follows:

(1) Dilatation—the enlargement of a part by the use of an instrument.

(2) Closed reduction—the alignment of a fractured bone without making an incision.
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capsulorrhaphy</td>
<td>-suturing of a joint capsule.</td>
</tr>
<tr>
<td>Myorrhaphy</td>
<td>-suturing of muscle.</td>
</tr>
<tr>
<td>Tenorrhaphy</td>
<td>-suturing of a tendon.</td>
</tr>
<tr>
<td>Fasciorrhaphy</td>
<td>-suturing of a fascia.</td>
</tr>
<tr>
<td>Neurorrhaphy</td>
<td>-suturing of a nerve.</td>
</tr>
<tr>
<td>Blepharorrhaphy</td>
<td>-suturing of an eyelid.</td>
</tr>
<tr>
<td>Glossorrhaphy</td>
<td>-suturing of the tongue.</td>
</tr>
<tr>
<td>Laryngorrhaphy</td>
<td>-suturing of the larynx.</td>
</tr>
<tr>
<td>Cardiorrhaphy</td>
<td>-suturing of the heart.</td>
</tr>
<tr>
<td>Arteriorrhaphy</td>
<td>-suturing of an artery.</td>
</tr>
<tr>
<td>Gastroorrhaphy</td>
<td>-suturing of the stomach.</td>
</tr>
<tr>
<td>Cystorrhaphy</td>
<td>-suturing of the urinary bladder.</td>
</tr>
<tr>
<td>Herniorrhaphy</td>
<td>-repair of a hernia.</td>
</tr>
<tr>
<td>Colporrhaphy</td>
<td>-suturing of the vagina.</td>
</tr>
<tr>
<td>Trachelorrhaphy</td>
<td>-suturing of the uterine cervix.</td>
</tr>
</tbody>
</table>

Table 2-2. Suturing procedures.

(3) **Open reduction**--the alignment of a fractured bone through an incision.

(4) **Application**--the putting of materials on the patient (sometimes this requires the maneuvering of a part, such as in the application of a plaster cast).
b. Procedure.

(1) Dilatation --of esophagus.
--of anal sphincter.
--of urethra.
--of uterine cervix.

(2) Reduction.

(a) Open --open reduction of femur.
--open reduction of dislocated hip joint.

(b) Closed --closed reduction of humerus.
--closed reduction of dislocated ankle joint.

(3) Application--of plaster cast to right forearm.

Section II. THE OPERATING ROOM TEAM

2-12. INTRODUCTION

a. Discussion.

(1) The operating room team consists of all members of the OR staff. As an example, the team includes the OR specialist who usually performs the patient's skin preparation the day before surgery, the specialist who put up the packs that are used for the operation, the specialist (or the AN Officer) who selects the set of instruments, and the specialist who sterilizes the supplies used for the surgery. Other team members who may not necessarily be in an OR during an operation are the Chief of Department of Surgery, the Chief of Anesthesiology and Operative Services, the OR Supervisor, and the noncommissioned officer In charge (NCOIC). The surgical team is the group of people in the immediate area during a surgical procedure. This includes the surgeon and one or more assistants (depending on the complexity of the case), the anesthetist, the nurse or specialist performing the scrub duties, and the nurse or specialist performing circulating duties. All team members work together to accomplish the best possible care of the patient. Every job performed in the OR--no matter how small--contributes to the welfare of the patient, and no job is so important that it alone accounts for the recovery of the patient.
(2) Knowledge of the nature of the duties of OR team members as well as their relationships with each other is essential to the OR specialist because without such knowledge he cannot fully appreciate what is required of him. Figure 2-1 indicates the line of authority for the OR. NOTE: The hospital commander, the chief of professional services, and the chief, department of nursing are not considered members of the OR team.

![Diagram of line of authority for OR personnel in a typical US Army hospital.](image)

Figure 2-1. Line of authority for the OR personnel in a typical US Army hospital.

b. **Professional and Nonprofessional Team Members.**

(1) The professional members of the team include Medical Corps (MC) Officers and Army Nurse Corps (AN) Officers, as well as any civilian medical doctors and nurses assigned (see paragraphs 2-13 through 2-16).

(2) The nonprofessional team members include the NCOIC, the Enlisted specialist, and civilian technicians.
2-13. CHIEF, DEPARTMENT OF SURGERY

The Chief, Department of Surgery (or Chief of Surgery) is a general surgeon of the Medical Corps and is responsible for a broad range of functions, as described below.

a. **Overall Responsibilities.** The Chief of Surgery is responsible for the diagnosis, the medical care and treatment, and the proper disposition of patients assigned or referred to the department of surgery. In addition, he has various other responsibilities, including administrative duties related to the MC Officers assigned to the department of surgery.

b. **Responsibilities Related to Each Surgical Service.** The chief of each surgical service (see figure 2-1) is accountable to the Chief, Department of Surgery, for the performance of patient care and treatment and also for the performance of certain other functions in the management of patient care, such as the appropriate maintenance of records. Within each surgical service are MC Officer personnel who may be classified in one of the following groups:

   (1) Those certified in specialties by accrediting boards.
   
   (2) Those in various stages of training as residents.
   
   (3) Those in an internship program.

2-14. THE SURGEON

The Surgeon is the MC Officer in charge of the treatment given to the patient during the course of an operation. The surgeon may be assisted by other medical officers in addition to AN Officers and OR specialists assigned to the case.

2-15. CHIEF, ANESTHESIOLOGY AND OPERATIVE SERVICES

a. **Discussion.**

   (1) The Chief of Anesthesiology and Operative Services (see figure 2-1) is an MC Officer certified in the specialty of anesthesiology. He is responsible for the administration of all anesthetics except when local anesthesia is given by the surgeon. In addition, he is responsible for the performance of certain other delegated duties.

   (2) The Chief of Surgery delegates numerous duties to the Chief of Anesthesiology such as some of the supervision and schedule planning (OR schedule).
b. Personnel Assigned. The personnel assigned to the Chief of Anesthesiology will depend upon whether or not an installation has an anesthesiology-training program. If it has such a program, the personnel assigned will be resident medical officers in anesthesiology, MC Officer interns who rotate through the department, AN anesthetists, and AN students of anesthesiology.

(1) In those Army-type hospitals not conducting training in anesthesiology, the anesthesiology and operative services may consist of the Chief, Anesthesiology and Operative services, and one or more AN anesthetists.

(2) An OR specialist may be assigned directly to the anesthesiology service where he may assist in positioning and transporting patients and assist the anesthesiologist as directed in handling his equipment. When no specialist is assigned to the anesthesiology service, the OR specialist serving as circulator is responsible for assisting in the performance of these and other tasks as directed by the anesthesiologist or anesthetist. NOTE: An MC Officer who is certified as a specialist in the administration of anesthetics is an anesthesiologist. Other persons who administer anesthetics—such as the AN Officer especially trained in anesthesiology, and the surgeon when he administers a local anesthetic—are appropriately called anesthetists. However, in actual practice in the surgical suite, the person who gives the anesthetic is usually referred to as the anesthetist, even though he may be certified as an anesthesiologist.

2-16. OPERATING ROOM SUPERVISOR

a. Responsibility. The OR Supervisor (see figure 2-1) (an AN Officer) is responsible for all of the nursing functions performed by the OR personnel. He makes out the time schedule and the duty assignment roster for the OR staff nurses, both military and civilian, within the operating suite. He is accountable to the Chief, Department of Nursing, for the nursing care given by AN Officers, enlisted OR specialists, and civilians. He makes out the OR schedule in coordination with the Chief of Surgery and the Chief of Anesthesiology and operative services. He also formulates policy for nursing service personnel working in the OR.

b. Assistants. The professional staff nurses function under the direction and supervision of the OR Supervisor. They perform the functional duties of, and are assistants to, the OR Supervisor. Since the supervisor may not be in the OR or suite at all times, the staff nurses represent the supervisor during surgical procedures and assist in maintaining high standards of patient care.
2-17. NONCOMMISSIONED OFFICER IN CHARGE

a. Discussion. The noncommissioned officer in charge, an enlisted OR specialist, supervises the nonprofessional personnel and maintains the physical environment of the OR. He reports directly to the OR supervisor (see figure 2-1).

b. Duties. Among his varied duties are those related to supervising the work and helping to evaluate the performance of nonprofessional personnel and conferring with the OR supervisor and with instructors (at the hospitals having training programs) when nursing service personnel time schedules (see figure 2-2) and OR schedules (see figure 2-3) are prepared. He assists with the orientation of enlisted personnel.

   (1) In supervising the work, the NCOIC performs duties concerned with the smooth functioning of the surgical suite—example, he ensures that the equipment needed for a case is at hand and that preparation for operations is begun early enough so that the operations will not be delayed.

   (2) The maintenance of the physical environment necessitates such duties as: ordering supplies and equipment, seeing that the surgical suite and furnishings are cleaned properly, and arranging for a periodic inspection and repair of OR equipment.

2-18. OPERATING ROOM SPECIALIST

a. Discussion. The OR specialist is directly responsible to the NCOIC (see figure 2-1) and to the professional personnel with whom he works. The specialist may be assigned duties directly related to the performance of an operation, as the scrub or as the circulator. He may be assigned to the workroom, the instrument room, the anesthesia section, or to any other area within the surgical suite. Specific tasks, which may be revised in accordance with local policy, involved in the performance of these duties are set forth in b and c below.

b. Scrub Duties. Scrub is the term used to designate the member of the surgical team who assists the surgeon by providing sterile instruments, sutures, and supplies within the sterile field. When assigned as the "scrub," the specialist dons conductive shoes, greens (pants and shirt), cap, and mask. He then scrubs his hands and arms in accordance with local policy; he dons sterile gown and gloves (refer to figures 1-30 and 1-31) and helps other members of the "sterile" team to do so. The
### Figure 2-2. Typical nursing services personnel time schedule.

<table>
<thead>
<tr>
<th>TITLE</th>
<th>LAST NAME</th>
<th>DUTY</th>
<th>SUN</th>
<th>MON</th>
<th>TUE</th>
<th>WED</th>
<th>THURS</th>
<th>FRI</th>
<th>SAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC</td>
<td>Jones, Donald</td>
<td>ORS</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MAJ</td>
<td>Johnson, Mary</td>
<td>HN</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>00</td>
</tr>
<tr>
<td>CPT</td>
<td>Stevens, Howard</td>
<td>66E</td>
<td>00</td>
<td>1</td>
<td>00</td>
<td>C</td>
<td>00</td>
<td>1</td>
<td>00</td>
</tr>
<tr>
<td>CPT</td>
<td>Jenkins, Lisa</td>
<td>66E</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>C</td>
<td>1</td>
<td>00</td>
</tr>
<tr>
<td>CPT</td>
<td>Young, Ted</td>
<td>66E</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>C</td>
<td>1</td>
<td>00</td>
</tr>
<tr>
<td>SFC</td>
<td>Powell, Robert</td>
<td>NCOIC</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>00</td>
</tr>
<tr>
<td>SFC</td>
<td>Osburn, James</td>
<td>ANCOIC</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>00</td>
</tr>
<tr>
<td>SSG</td>
<td>Everett, Jeff</td>
<td>91D</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>00</td>
</tr>
<tr>
<td>SSG</td>
<td>Ramsey, Albert</td>
<td>91D</td>
<td>00</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>00</td>
</tr>
<tr>
<td>SGT</td>
<td>Baxter, Ralph</td>
<td>91D</td>
<td>C</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>C</td>
<td>0</td>
<td>00</td>
</tr>
<tr>
<td>SGT</td>
<td>James, Rose</td>
<td>91D</td>
<td>00</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>00</td>
</tr>
<tr>
<td>SGT</td>
<td>Parker, Ann</td>
<td>91D</td>
<td>C</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>00</td>
</tr>
<tr>
<td>SPC</td>
<td>Sledge, Joe</td>
<td>91D</td>
<td>00</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>00</td>
</tr>
<tr>
<td>PFC</td>
<td>Smith, John</td>
<td>91D</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>C</td>
<td>0</td>
<td>1</td>
<td>00</td>
</tr>
<tr>
<td>PFC</td>
<td>Townsend, Carl</td>
<td>91D</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>C</td>
<td>0</td>
<td>00</td>
</tr>
<tr>
<td>PV1</td>
<td>Tovar, Janice</td>
<td>91D</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>C</td>
<td>0</td>
<td>00</td>
</tr>
<tr>
<td>GS4</td>
<td>Gray, Cathy</td>
<td>N Aide</td>
<td>00</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>00</td>
</tr>
<tr>
<td>GS4</td>
<td>Durham, David</td>
<td>N Aide</td>
<td>00</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>00</td>
</tr>
</tbody>
</table>

**Instructions:**

- List professional personnel first and then nonprofessional.
- In column under "TITLE" enter title, e.g., Maj., Capt., Lt., Sgt., Pvt., Mr., Mrs., Miss.
- Entries for "DUTY" and for "OFF-DUTY STATUS" will be symbolized as follows:
  - HN: Head Nurse
  - ASST HN: Asst. head nurse
  - LV: Leave
  - GH: General duty
  - CL: Clinical technician
  - HT: Hospital tech
  - WR: Ward orderly

**Dates:** (Inclusive) of period covered: 4 Aug - 10 Aug 19XX

**Signature of Head Nurse:**

Mary Johnson, Maj., AN
Figure 2-3. Operating Room Schedule.

scrub arranges the sterile supplies and assumes responsibility for the sterility of the items for use within the operative field both before and during the surgical procedure. His routine tasks are to:

(1) Check DD Form 1923, OR Schedule.
(2) Perform a surgical scrub.
(3) Put on sterile gown and gloves.
(4) Check internal sterilization indicator controls.
(5) Prepare prep set first.
(6) Separate and arrange sterile basins.
(7) Arrange linen on double-ring stand next to sterile basin.
(8) Drape Mayo stand.
(9) Arrange instruments and sterile supplies on back table and Mayo tray.
(10) Prepare suture material.

(11) Count sponges with circulator (witnessed by registered nurse).

(12) Gown and glove the surgeon.

(13) Assist surgeon with draping.

(14) When ready to begin assisting the surgeon, move Mayo stand into position.

(15) Pass instruments, sponges, supplies, and sutures to surgeon.

(16) Anticipate the surgeon's needs.

(17) Remove loose sponges from operative area as necessary.

(18) Recount sponges with circulator (witnessed by registered nurse).

(19) Assist surgeon with dressing sponges.

(20) Move sterile tables away from operating table.

(21) **Remain sterile** until patient leaves the room.

(22) Prepare instruments and supplies, used and unused, for clean up.

(23) Remove supplies from room and put in proper place.

(24) Assist circulator in preparing for next operation.

c. **Circulating Duties.** The circulator is the member of the surgical team who works outside the sterile field, gives patient care, procedures needed supplies, and assists surgical team members in performing the operation safely and expeditiously. He dons conductive shoes, cap, mask, and greens (pants and shirt). The specialist assigned to circulate assembles and brings into the room all packs, supplies, and equipment needed for the case; he ties the gowns for "sterile" members of the team and sets up nonsterile items of equipment; he also performs other nonsterile duties. His routine tasks are to:

(1) Check DD Form 1923, OR Schedule.

(2) Damp dust all equipment and wet-vacuum floor prior to a surgical procedure.
(3) Check mechanical and electrical equipment.

(4) Arrange furniture in functional order.

(5) Assemble, arrange, and open outer and inner wrappers of sterile supplies. Check package integrity, expiration date, and appearance of the indicating tape.

(6) Assist with gowning of scrub and surgeons.

(7) Pour sterile solutions: water, normal saline, and antibacterial solutions; avoid splashing. Figure 1-22 illustrates commercially prepared and hospital prepared irrigating solutions.

(8) Pass knife blades and suture to scrub.

(9) Pass additional sterile supplies to scrub as needed.

(10) Take sponge count with scrub (must be witnessed by a registered nurse). Record on sponge count board.

(11) Assist anesthetist with moving and positioning patient.

(12) Place the restraining strap properly.

(13) Assist surgeon with prep.

(a) Check with anesthetist before touching patient.

(b) Expose area--avoid unnecessary exposure of the patient.

(c) Place linen protectors to absorb excess moisture.

(d) Focus light.

(e) Removes surgeon's gloves after prep.

(f) Replace kick bucket liner.

(g) Move liner containing soiled prep sponges to outer circle of room.

(h) Do not remove sponges, linen, or trash from room.

(14) Assist anesthetist in securing drapes.
(15) Attach suction tubing to machine.
(16) Remain alert to needs of the scrub.
(17) Assist scrub with arrangement of draped furniture.
(18) Position kick buckets for easy access.
(19) Focus light over operative area.
(20) Prepare specimen for laboratory.
(21) Prepare adhesive strips for dressing.
(22) Verify sponge count with scrub (must also be witnessed by Registered Nurse).
(23) Pass dressing sponges to scrub.
(24) Remove and check drapes for instruments and supplies before discarding into hamper.
(25) Assist in moving patient to litter and secure with straps.
(26) Clean the room and prepare for next case.

d. **Other Duties.** In addition to understanding and performing tasks related to his assignment as the scrub or the circulator for an operation, the OR specialist is required to understand and participate in tasks concerned with preparing the patient for surgery (surgical "prep"), assembling packs for use during surgery, assembling instrument sets, and sterilizing supplies and equipment. The specialist is required to practice personal hygiene measures to prevent the spread of pathogenic organisms; he is also required to demonstrate a high standard of personal ethics, as well as practicing such medical ethics as upholding the patient's right to privacy.

e. **Effective Duties.** In addition to providing effective care of the patient, the OR specialist is responsible for effective performance with regard to the care, preparation, and maintenance of sterile and nonsterile supplies. He is obliged to continue to learn and progress in skill of performing both the simple and more complex procedures. When in doubt, he should not act but seek advice from the proper source.
Section III. ATTRIBUTES NECESSARY IN TEAM MEMBERS

2-19. PERSONAL HYGIENE

Good personal hygiene is of particular importance, since it helps to protect the patient and team members from getting an infection. The OR specialist should shampoo his hair daily because both hair and dandruff harbor bacteria. He should shower at least once a day with antibacterial soap, use a deodorant, and put on clean underwear and socks after each shower. Oral hygiene is also important for the control of both bacteria and offensive odors. The specialist must give special attention to his hands—he should wash and scrub them frequently, and he should keep his nails well trimmed. He should have two pairs of shoes for use in the OR suite and should wear them alternately, allowing one pair to air while wearing the other pair. The specialist should not wear scrub clothes outside of the surgical suite. It should be against regulations for personnel to enter the OR who have infections of the nose or throat, who are known to be carriers of infectious diseases, or who have open sores.

2-20. ETHICAL AND PERSONAL RESPONSIBILITIES

a. Discussion. Ethics can be defined as the study of standards of conduct and moral judgment. It is a system or code of morals of a particular profession. Medical ethics can be guided by the principle—render service to humanity with full respect for dignity of man.

b. Personal. Personal characteristics of honesty, dependability, and integrity are absolutely essential. Each team member is dependent upon and places his confidence in the other team members for the correct performance of duties. The development of a "surgical conscience" is therefore necessary for the OR specialist. The specialist should also possess a desire to learn and to progress from knowledge of simple procedures to more complicated ones. He should be energetic and determined in his efforts to improve his skill in the performance of all his tasks. Skills may be improved through practice, with guidance as necessary by qualified personnel.

c. Medical. The OR specialist has a moral obligation to safeguard the patient against gossip in or outside of the OR. He should not mention a patient's name and the operative procedure performed to personnel not assigned to the surgical suite; and he should discuss such information with other team members only to the extent necessary in the accomplishment of the work. Another medical aspect of both ethical and moral responsibilities concerns events that take place within the surgical suite. Such events should not be discussed outside the OR. The OR specialist should not reveal confidences and trusts or deficiencies observed in the character of the patient.
d. Legal. The work of an OR specialist also entails legal as well as moral responsibilities. When he is unsure of what to do, he should consult the NCOIC, a nurse, or a medical officer.

2-21. MAINTENANCE OF EFFECTIVE RELATIONSHIPS WITH MEMBERS OF THE OPERATING TEAM

Optimum care of the patient is not possible unless effective working relationships are maintained among members of the OR team. The specialist contributes toward the maintenance of such a relationship by knowing his job and performing efficiently, abiding by departmental policies, and displaying a positive attitude toward both his work and his fellow team members.

2-22. LEGAL CONSIDERATIONS

The number of medical malpractice cases has increased substantially in the past few years, both in the civilian and in the military sectors. Liability for medical malpractice in the military is determined under the Federal Tort Claims Act. Under that act, individuals may sue the Federal Government for the negligent acts of Federal employees who are performing within the scope of their duties or employment. The individual military medical care provider is protected from any personal liability by the Gonzales Bill (10 USC 1089) enacted in 1976, which makes the Federal Government solely responsible for the defense and payment of medical malpractice claims. While the individual service member will not have to pay any money judgment for medical malpractice, the service member may be liable for criminal acts such as negligent homicide or involuntary manslaughter.

2-23. LEGAL INTERPRETATION

a. General. The liability of the Federal Government under the Federal Tort Claims Act for medical malpractice is decided by application of the law of the state where the incident occurred. It is true that the law and court decisions vary from state to state, but the trend is to hold all medical care providers to a high standard of care.

NOTE: You are expected to utilize your superior knowledge in performing your duties. You must always carry them out in a manner that meets the high standards of the Army Medical Department (AMEDD).

b. Welfare and Safety of the Patient. All instruction of AMEDD personnel concerning care of the patient emphasizes the welfare and safety of the patient. This is the principle around which nursing care is built. Safe care of the patient results in safety for those responsible for his care.
c. **Malpractice.** Negligence is the failure to exercise due care. Due care is further defined as the action that a reasonable and prudent person would perform under the same or similar circumstances. Due care takes into consideration the training, experience, education, and capabilities of each person. Negligence of professionals, such as medical professionals, is termed malpractice.

d. **Prevention of Lawsuits.** Most mistakes or accidents are preventable. Some are so slight that the patients are never aware of them; others can prove fatal. Even if a patient himself is at fault, those caring for him suffer great remorse. You should be cognizant of many hazards and know the safeguards.

2-24. **POTENTIAL LEGAL INVOLVEMENTS**

a. **Loss of Sponges.** Loss of sponges is a frequent cause of lawsuits. In a few states, the responsibility for accounting for all sponges before closure rests with the surgeon. However, the law in most states is that each member of the surgical team is responsible for his specific duties. Therefore, in a case where the surgeon has performed correctly but a sponge is left in the incision, the circulator or scrub may be held responsible.

b. **Burns.** Burns are another frequent cause of lawsuits. A burn may occur from the use of a hot instrument such as a mouth gag or a heavy retractor. The scrub should have available a basin of cold saline solution for cooling instruments and should cool the instruments when necessary before handing them to the surgeon. A burn may also occur from a light, a thermal blanket, or an electro surgical inactive electrode.

c. **Falling.** Falls are another frequent cause of lawsuits. Observe the usual safeguards for children or disoriented or sedated persons, whether in wheelchairs, in bed, or on the operating table. Use special care when patients are moved from bed to table and back to bed again, as well as those being moved about on litters or wheelchairs.

d. **Patient Identity.** Many serious situations may arise in the hospital as the result of carelessness in checking patient identity. The right medication or treatment for the wrong patient may or may not be serious, but sometimes takes on great proportions. Be sure of the patient's identity.

e. **Unconscious Patients.** Since a great number of patients in the OR receive a general anesthetic and are therefore unconscious, great vigilance is needed. If the patient is injured while unconscious, negligence may be presumed, which may require those caring for the patient to show that due care was followed during the entire period of unconsciousness.
f. **Aseptic Technique.** Each person on the surgical team must take the utmost care to carry out strict asepsis. Dust control, proper cleaning of floors and furniture, and sterilization of instruments and equipment are essential, along with scrub, mask, glove, and gown technique. Any break in asepsis at any point nullifies all the care taken in other ways.

g. **Drugs.** The same strict rules observed on the ward in regard to drugs must be practiced in the OR. The scrub frequently has dangerous drugs such as phenol or cocaine on his table. Special care must be taken to ensure that these are not used improperly. Each drug used is checked by two persons as it is prepared, and the scrub repeats the name of the drug to the surgeon as it is handed to him.

h. **Abandonment.** A patient left alone or a child unguarded may injure himself by an electric shock, burns, drugs, lacerations, falls, or a variety of other things. The sources of such injuries should be removed whenever possible and a patient who might injure himself carefully watched.

i. **Explosions.** Great care must be taken in the OR to prevent explosions.

j. **Tissue Specimens.** The loss of a biopsy specimen could mean the possibility of a second surgical procedure to obtain another. Improperly labeled specimens could mean a mistaken diagnosis, with possible critical involvement for two patients. The loss of a specimen could be vital if diagnosis is not made and proper treatment not given. A report from pathology on a specimen is a permanent record on the patient's chart that a certain piece of tissue or a stone has been removed.

k. **Foreign Bodies.** Care for these according to local policy. They often have legal significance outside the hospital, and frequently are claimed by civilian or military police. A receipt should be required of anyone taking them.

l. **Consent for Operation.** As a rule, witnessed written consent for an operation or procedure is signed by the patient before the surgery or procedure is performed. The patient must understand the details of the agreement fully. If the patient is a minor, unconscious, incompetent, or intoxicated, the nearest of kin or some other authorized person must sign. If a true emergency exists and no one else is available to sign the consent, the Judge Advocate’s Office should be contacted. When this is not possible, the hospital administration may give permission for the procedure or surgery.
m. **Right to Privacy.** This right exists either by law or by custom. Hospital charts and records, X-rays, and photographs are for use by the surgeon and other hospital personnel who are directly concerned with that patient's care. Suits can be, and have been, brought by patients for violation of this right. Unauthorized persons are not permitted to observe operative procedures. Suits have been brought by patients when unauthorized persons, out of curiosity, have been permitted to witness procedures of interest only to professional persons.

n. **Confidential Information.** You have a moral and legal obligation to hold in confidence any information gained from the patient during medical care. However, as there is no medical privilege in the military, you may be required to divulge confidential information upon request by proper authority.

o. **Personal Property.** Generally, the patient comes to the OR without any personal property. However, you should check to make sure that the patient has no eyeglasses, dentures, contact lenses, watches, wigs, or glass eyes that should be removed before surgery. Be sure to follow locally prescribed procedure in handling these articles. Be sure to obtain a receipt for any such articles when they are given to ward personnel for safekeeping. A patient who has hair clipped owns the hair that is removed, and you are responsible for its safekeeping also.

p. **Records.** Inaccurate record can be a source of legal action against the person responsible.

q. **Defective Equipment.** Operating room specialists are responsible for certain equipment checks. Any defect that was noticeable and remained unrepaired has legal connotations in case of an accident. Be sure you can prove that equipment defects were properly reported.

**2-25. THE OPERATING ROOM SPECIALIST AND BEREAVEMENT**

Another consideration that must be taken into account is the OR specialist's handling of bereavement. Any person who works in a hospital may be called upon to deal with a bereaved person. The dynamics of bereavement and grief are essentially the same whether the loss is of a person, a limb, or simply of the powers that make one able to maintain his normal routine. While these are the same in their dynamics, there is obviously a variation in the depth of the experience. Whatever the depth of loss, the OR specialist may find himself frequently in a position of helping people cope with grief in a constructive way.
2-26. DYNAMICS OF GRIEF

If one is to integrate a loss, he must come to terms with his objective loss and with the threat that loss poses for his life and well being. He must also contend successfully with the fear and anger which results. There are both positive and negative aspects of every relationship so that in bereavement, both positive and negative feelings will be present. The "unacceptable" feelings of anger toward a person who has been valued, loved, and now lost may make the expression of grief a very difficult task, complicating it with guilt. Also, a person may be afraid of any deep feelings. Although grief is trying, it is a healing phenomenon. It is our way of being separated from someone or something with which our life is intimately entwined. It involves the process of withdrawing ties and establishing new ones. All the rituals surrounding death and burial are designed to help us do this important work of mourning.

2-27. HELPING THE BEREAVED

a. One central question concerns the expression of feelings. Most people can express some of their feelings, but still deny and repress others. Some will recoil from any strong feelings. After the initial period of shock, these feelings will have to be expressed or the person's well being may be gravely compromised.

b. Frequently, it may be important to consider whether the person feels adequate to face life and go on, whether he feels valuable or worthless, or whether he is optimistic or pessimistic about the future. If he feels that things will work out and that he is a person of value who is adequate in dealing with life, he is more likely to be able to abandon himself to grief and do the work of mourning without panic. It is also important for him to see that his pain has purpose and is useful in some way.

c. The bereaved person should bear the responsibility for making decisions and choices, although he may need considerable support. Making decisions about funeral arrangements helps the bereaved to face the fact of death.

2-28. MEDICAL PERSONNEL AND HOSPITAL AS SCAPEGOATS

a. There are certain cases where the bereaved may justifiably blame the doctors or the hospital and its staff for the loss of a patient. On the other hand, there are a great many cases in which the doctors and hospital personnel have done all that was reasonably possible to save a patient, yet are vehemently blamed for his death. A malpractice suit may even result. This can be a baffling experience unless the dynamics underlying this response are understood.
b. As mentioned above, relationships are never all positive or all negative. Given the ambivalence of relationships and our natural tendency to deny negative aspects of relationship, death of a loved and valued person brings about a critical situation. Anger because the person has left through death is added to the unresolved anger in the relationship, and at the same time expression of this anger becomes unacceptable. In their deep need to express this kind of anger, people often transfer it to the doctor and hospital.

Section IV. POLICIES AND INFORMATION ON FILE

2-29. INTRODUCTION

Several sources of information are kept within the surgical suite and are available to the specialist. These sources or references, discussed in the paragraphs to follow, make up the local policy for the suite. The specialist should, therefore, know where these references are kept and refer to them as often as necessary.

2-30. PROCEDURE MANUAL

The procedure manual sets forth step-by-step instructions for the performance of tasks within the surgical suite. Also, the administrative policies for the suite are often included in the procedure manual. The specialist may refer to the procedure manual at any time to check the local policy for the performance of assigned tasks.

2-31. INSTRUMENT CARD FILE

a. Discussion. Instrument cards contain information as to the "basic" instruments and other items used for the various kinds of operations (such as appendectomy, cholecystectomy, tonsillectomy, and so forth). The selection of instruments for a given operation is made in accordance with information on the appropriate card in this file.

b. Basic Instruments. The instruments with which an operation may be performed are classified as the basic instruments (or basic set) for that operation. Therefore, each card in this file has recorded on it the name of the operation, the names of the instruments needed, the sizes (for instruments available in different sizes), and the number of each kind of instrument to be included.

c. Other Items. Items not considered instruments (such as drains, safety pins, and so forth) but needed to perform the operation are also listed on the instrument card.
2-32. SURGEON'S PREFERENCE CARDS (SUTURE CARDS)

The surgeon's preference cards contain information as to the types of sutures, needles, and stitches required for a procedure. A card is on file for each surgeon for each kind of operation that he performs. The surgeon's glove size may also be included on the card as well as the surgeon's preference for an instrument not included in the basic set.

Section V. SELECTED FORMS USED IN THE OPERATING ROOM

2-33. INTRODUCTION

The forms selected for discussion are those that provide basic information to the specialist concerning his work in the OR suite. The specialist checks the OR Schedule to identify the operations to which he is assigned. The specialist may obtain detailed information for the performance of his assigned tasks by referring to the procedure manual. The assignment roster may be prepared for the entire week, but the specialist should check it at least twice daily because a change in assignments may have been entered.

2-34. NURSING SERVICE PERSONNEL TIME SCHEDULE

a. Discussion. DA Form 3872, Nursing Service Personnel Time Schedule (see figure 2-2) is used to list the days on duty and off duty for all OR personnel. The NCOIC assists in the preparation of the time schedule for the OR specialists. The schedule is posted for one week at a time and is usually prepared several weeks in advance.

b. Need for a Time Schedule. The use of a time schedule enables the personnel responsible to plan for the adequate coverage of the suite at all times and enables personnel assigned to make plans ahead of time. If the hospital has a "call system" for coverage after normal duty hours, the time schedule should indicate the personnel who are "on call" for the week.

c. Coverage After Normal Duty Hours. All surgical suites must plan for adequate coverage in the event that emergency surgery must be performed after normal duty hours. In large OR suites, or in a hospital where a great deal of emergency work is done, coverage is provided by scheduling personnel on shifts around the clock. In surgical suites not using shifts, personnel should be placed "on call" to provide coverage for emergency operations. Some installations assign call personnel as well as having shifts. Persons on call must be highly skilled in all kinds of surgery since the types of emergency operations cannot be predetermined. The specialist taking call must be available within a very short time and must inform the person responsible for calling him of his whereabouts at all times. Local policy will indicate whether personnel taking call are to sleep in a room in the hospital or in quarters. The shifts and call duty are rotated frequently so that a person does not work the same shift all the time or take excessive call.
d. **Planning for the Time Schedule.** The time schedule is planned and prepared in order to provide an opportunity for the specialist to have learning experiences. This is accomplished by scheduling a person who needs further training to be on duty with a person having the appropriate training and experience. Such considerations make the planning and the preparation of the time schedule a difficult task.

e. **Operating Room Specialist's Requests Concerning Time Off.** The OR specialist should write his routine requests for specific days off duty, for passes, and for leaves, and he should give such requests to the NCOIC before the time schedule is prepared. The specialist should not ask to have his time changed after the schedule has been prepared unless he has a true emergency. He should make all requests concerning his time to the NCOIC.

2-35. THE OPERATING ROOM SCHEDULE

a. **Discussion.** DD Form 1923, ORSchedule (see figure 2-3) is used for one day's surgery. It contains the basic information needed by the scrub and the circulator in the planning and organization of their work for that day. In order to be able to use the information on the schedule, the specialist must know what each brief entry means in terms of his tasks as the scrub or the circulator. While studying the interpretation of the various entries on the schedule, refer to figure 2-3. **NOTE:** The OR schedule is distributed to all units concerned. In addition to the surgical suite, these include the surgical nursing units, the recovery room, the anesthesiology and operative service, the Chief, Department of Surgery, the commanding officer, the Chief, Department of Nursing, the Laboratory, the Department of Radiology, and the Chaplain.

b. **Room Number.** (See figure 2-3). The individual ORs are assigned to the various surgical services by the OR Supervisor in coordination with the Chief Anesthesiologist and Chiefs of Surgical Services. For example, the general surgical service may use room one on Mondays, Wednesdays, and Fridays and the urology service may use the same room on Tuesdays and Thursdays. Such an arrangement enables greater efficiency and economy in the use of the equipment required by a particular service and also lets the scrub and the circulator know ahead of time what equipment will be needed in a room on a given day of the week.

c. **Time.** (See figure 2-3). The time entered means that the incision is to be made at that hour. The patient should have been previously anesthetized, positioned, prepared, and draped. Therefore, the scrub and the circulator should perform their tasks in the preparation of the room sufficiently ahead of time in order not to delay the case. To follow means "TF" when used in this column and indicates that the room is to be prepared as quickly as possible upon completion of the preceding operation. The time required for this preparation is about 20 minutes. (A patient whose surgery is
scheduled "TF" is given the preoperative hypodermic "on call.") That is, OR personnel will notify the ward nurse to give the hypodermic about 1/2 hour before the completion of the operation preceding the "TF" operation).

d. **Patient's Grade.** (See figure 2-3). The patient's grade is inserted following his name if he is a member of the Army; the abbreviation "ret" is added for retired personnel. The term "C-D" indicates civilian dependent. The inclusion of age is important to personnel in both the OR suite and the anesthesiology service. Children are scheduled before adults to avoid excessive dehydration in the children. In addition, the instruments required for the operation will likely be different when the patient is a child than when the same operation is to be performed on an adult. As an example, a hernioplasty on a child requires fewer and smaller hemostatic forceps and scissors than does this surgery on an adult.

e. **Register Number.** (See figure 2-3). The register number is used to help identify the patient. The circulator must see that it is entered on the pathology forms so that the specimen from a patient is properly identified (if two patients have identical names, the register number may be the only accurate means of identification). In Army hospitals, the social security account number is used (in addition to the register number) to identify the patient and his clinical records.

f. **Nursing Unit.** (See figure 2-3). The column headed "NURSING UNIT" indicates the location of the patient prior to surgery as well as the nursing unit to which he will be sent upon completion of his surgery. Patients who have been given general or spinal anesthesia are sent to the recovery room. Those who have been given local or regional block anesthesia are usually returned to their original-nursing units.

g. **Operation.** (See figure 2-3). The circulator and the scrub must know the location of the operative area and the site of the incision. These are often (though not always) obvious to the specialist if he knows the definition of the operation (see paragraphs 2-1 through 2-11). For an operation that might be performed using one of several sites for the incision, the incision site should be specified immediately following the name of the operation. Once the specialist is assigned to select the instruments for the case, he obtains the instrument card (see paragraph 2-31) for that operation and assembles the items recorded on the card. The inexperienced OR specialist may need to use references for an understanding of some operations, especially those named after individuals.

(1) Normally, Dorland's Illustrated Medical Dictionary is available in every OR suite. This volume includes a brief description of operations named for the surgeon who originated or modified the procedure. These are examples: Albee's operation--for ankylosis of the hip, consisting of cutting off the upper surface of the head of the femur, and so forth; Bergenhem's operation--surgical implantation of the ureter into the rectum.
(2) Other more detailed references may also be available. Some books
describe the operative procedure, the operative area, the site and kind of incision, the
position, and the draping. One that includes these descriptions (and is established as
an Army field manual) is Alexander's Care of Patient in Surgery. This book also lists
instruments and sutures necessary for operative procedures; however, these lists are
not always applicable to all hospital ORs. NOTE: Many terms pertaining to
an operation are abbreviated. As an example, in the listing, (see figure 2-3), of the
radical neck dissection. "STSG. DSRT. THIGH" indicates that the patient will have a
split thickness skin graft and his right thigh will be used as the donor site. If the
specialist assigned to scrub or circulate for an operation is uncertain of the meaning of
any abbreviation of the schedule, he should ask the NCOIC or an AN Officer. Operative
procedures performed on a bilateral structure should always indicate the side of the
procedure. T and A (see figure 2-3) stands for tonsillectomy and adenoidectomy.
C-section is the abbreviation for cesarean section.

h. Surgeons. (See figure 2-3). The name listed first denotes the surgeon in
charge of the operation. The names that follow are other MC Officers assigned in the
order of first assistant, second assistant, and so forth.

(1) The circulator. The number of surgeons listed indicates to the circulator
the number of gowns necessary. The circulator also finds out the glove sizes for the
MC Officers listed.

(2) The scrub. Before scrubbing up, the scrub obtains the surgeon's
preference card (see paragraph 2-32) for the surgeon in charge of the operation. He
follows the information on the card with regard to preparation of sutures and any special
equipment listed. The scrub also determines what his position at the table should be in
relation to this group--to the right or left of the surgeon and at which side of the
operating table. In making this decision, the scrub considers a number of factors,
including the following--the location of the operative area and any special needs
imposed due to either the location or the nature of the surgery; the working habits and
preference of the surgeon; the number of members of the sterile team and their tasks;
and whether or not any members of the sterile team are left-handed. The scrub then
sets up the Mayo stand, the back table, and the basin (ring) stand for his use in
accordance with his position at the OR table. Note the grouping of the sterile tables in
figure 1-30A, B, C, and D.

i. Nursing Staff. (See figure 2-3). The OR specialist and other OR
personnel assigned to work on the cases are listed in the column headed "Nursing
Staff." "Scrub" and "circulate" may be abbreviated "S" and "C." Duties of the scrub and
the circulator include those set forth in paragraph 2-18. Whenever two team members
are assigned to scrub, the first listed is the senior (or the more skilled) team member
and the other serves as the assistant.
j. **Anesthetist.** (See figure 2-3). If the patient is to be given local infiltration anesthesia, the surgeon's name is repeated in this column, or the word "surgeon" may be entered. For anesthesia administered by a member of the anesthesiology service, the name of the anesthetist assigned for the operation (either MC or AN Officer) is entered. The circulator should put a revolving stool in place for the anesthetist (see paragraph 1-17a and figure 1-15). If the surgeon is scheduled to administer the anesthetic agent, the circulator should see that a source of oxygen is available in the room. (The gas anesthesia apparatus provides this source of oxygen unless piped-in oxygen is available.)

k. **Anesthetic.** (See figure 2-3). The information entered in this column indicates whether a local or a general anesthetic will be given, the method of administration, and often the anesthetic agent to be used. The word "endo" (an abbreviation for endotracheal) is usually added if the anesthetist is going to intubate the patient (insert a tube which provides an artificial airway into the patient's trachea by way of his nose or mouth). Additional time (15 or 20 minutes) is required for anesthetizing when a patient is to be intubated.

   (1) The listing of the type of anesthetic may be of assistance in the selection of instruments. For example, an operation scheduled as "excision of keloid, right forearm" gives no information about the size of the surgical wound. If it is scheduled for local anesthesia rather than general, the specialist can safely assume that the incision will be small, to be closed without skin grafting.

   (2) The letter "T" followed by a number of ml (1000, 1500 ml, and so forth) indicates that whole blood has been ordered from the laboratory and is available in the amount listed, and the patient has been typed and cross matched in anticipation of his need for a transfusion during the operative procedure.

l. **Summary.**

   (1) Practice and experience will increase the student's knowledge greatly. Both the scrub and the circulator can obtain much information from the references available in the OR suite. These references include the procedure manual, instrument card file, surgeon's reference cards, the various DA Forms (especially the OR Schedule), standing operating procedures or policy file, and available dictionaries.

   (2) The references listed serve to give assistance and direction to all members of the surgical team. The OR specialist enhances his value to other members of the surgical team and provides more effective care of the patient when he is able to interpret and apply the information available.
EXERCISES, LESSON 2

INSTRUCTIONS. Answer the following exercises marking the lettered response that best answers the question or best completes the incomplete statement, or by writing the answer in the space provided.

After you have completed all of these exercises, turn to "Solutions to Exercises," at the end of the lesson and check your answers. For each exercise answered incorrectly, reread the material referenced with the solution.

1. For which one of the following reasons is a palliative surgical procedure done?
   a. Remove a diseased organ.
   b. Repair a body part.
   c. Cure a disease.
   d. Relieve pain.

2. A suffix used to denote an operation classified as an incision is which of the following?
   a. centesis.
   b. exeresis.
   c. scopy.
   d. desis.

3. A patient is scheduled to have a colpopexy performed. What is the operative procedure to be done?
   a. Suspension of the colon.
   b. Suturing of the scrotum.
   c. Incision into the bladder.
   d. Fixation of the vagina.
4. Which of the following actions would be helpful to a bereaved person?
   b. Helping him to feel like a valuable person.
   c. Giving him a sedative so that he does not have to deal with his feelings.
   d. Helping him to see that his grief serves no purpose.

5. After the doctor and hospital personnel have obviously done all that is possible to help Mr. Jones, he dies. His spouse is very angry with the doctor and threatens to sue. For what reason do you think Mrs. Jones is reacting in this manner?
   a. She is dealing well with her feelings toward her husband.
   b. She had neither positive nor negative feelings toward her husband.
   c. She and her husband had unresolved anger in their relationship.
   d. She feels in control of the situation.

6. What information is found on an instrument card in addition to the instruments needed for an operation?
   a. Sutures needed.
   b. Number of sterile gowns needed.
   c. Number of straight tools needed.
   d. Items such as sterile drains needed.
7. When the specialist desires a specific time off duty and no emergency exists, he should do which of the following?

a. Ask for the time off after the schedule is prepared.

b. Ask for the time off when the schedule is prepared, but before it is posted.

c. Write the request before the schedule is prepared.

d. Write the request when the schedule is prepared, but before it is posted.

FOR EXERCISES 8 AND 9. Use the following situation:

SITUATION: Your assignment for the day is to scrub for surgery.

8. Which of the following is the most appropriate source for learning detailed information concerning the performance of your assigned tasks as an OR specialist?

a. Noncommissioned officer in charge.

b. Operating room supervisor.

c. Nursing Service Assignment Roster.

d. Standing operation procedures.

e. Operating Room Schedule.

9. Which of the following sources should be used to identify the operations to which you are assigned?

a. Operating Room Schedule.

b. Nursing Service Assignment Roster.

c. Standing operation procedures.

d. Noncommissioned officer in charge.

e. Operating room supervisor.
SPECIAL INSTRUCTIONS FOR EXERCISES 10 -- 25. These exercises are based on the facsimile of the OR Schedule found below.

<table>
<thead>
<tr>
<th>OPERATING ROOM SCHEDULE</th>
<th>HOSPITAL</th>
<th>DATE</th>
<th>30 MAY 19XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE &amp; ROOM</td>
<td>PATIENT'S NAME</td>
<td>STATUS AGE</td>
<td>RELIGION</td>
</tr>
<tr>
<td>RM I 0730</td>
<td>JACKSON, CLARK A.</td>
<td>MSG 42 yrs</td>
<td></td>
</tr>
<tr>
<td>TF</td>
<td>BLAKELY, ROBERT</td>
<td>CO 19 90 yrs</td>
<td></td>
</tr>
<tr>
<td>RM II 0800</td>
<td>ASBUT, JAMES</td>
<td>C.D. 8 yrs</td>
<td></td>
</tr>
<tr>
<td>TF</td>
<td>WHITE, MARY</td>
<td>C.D. 20 yrs</td>
<td></td>
</tr>
<tr>
<td>RM IV 0800</td>
<td>FORD, DEAN F.</td>
<td>MAJ 38 yrs</td>
<td></td>
</tr>
</tbody>
</table>

Operating room schedule for exercises 10-25.

SPECIAL INSTRUCTIONS FOR EXERCISES 10–20. Ten through 20 are based on the first operation listed.

10. "Rm 1" pertains to the:
   a. Patient's room number.
   b. Room to which the patient will be taken upon completion of surgery.
   c. Operating room in which surgery will be done.
   d. Induction room in which the patient will be anesthetized.

11. The specialist assigned to bring MSG Jackson to the surgical suite must obtain him from which place?
   a. Recovery room.
   b. Room one.
   c. Emergency ward.
   d. Nursing unit 16A.
12. What action should occur at 0730 hours?
   a. Someone should go to the ward and bring the patient to the OR.
   b. The scrub and the circulator should begin setting up the OR.
   c. The anesthetist should begin the induction of anesthesia.
   d. The surgeon should make the incision.

13. In accordance with the listing of the surgeons for MSG Jackson, the scrub must obtain whose suture card?
   a. Only Dr. Croft's.
   b. Only Dr. Ferman's.
   c. Only Dr. Dudley's
   d. All of the above surgeons.

14. With the knowledge that the patient will have a right nephropexy. Which of the following does the specialist have the information to determine?
   a. Sutures required.
   b. Operative area.
   c. Number of sterile gowns and gloves required.
   d. Time the induction of anesthesia will begin.

15. What operative procedure do the surgeons plan to perform upon MSG Jackson's right kidney?
   a. Incision.
   b. Excision.
   c. Fixation.
   d. Fusion.
16. The abbreviation "Endo" indicates that:

a. The patient will be examined with an endotracheal tube.

b. An endotracheal tube will be kept immediately available for emergency use.

c. An endotracheal tube will be placed in the patient's trachea through his mouth or nose.

d. An endotracheal tube will be placed in the patient's trachea through an incision in his throat.

17. Which of the following actions is appropriate for the circulator in assisting a member of anesthesiology service, MAJ Dodd?

a. Set up the anesthetist's table.

b. Set up the gas anesthesia apparatus.

c. Place a revolving stool at the head of the operating table.

d. Set up cautery equipment.

18. Who makes the decision as to the scrub's appropriate position at the operating table?

a. Dr. Croft.

b. Dr. Ferman.

c. SFC Clark.

d. SFC Good.
19. What does the "(S)" after SFC Good's name mean?
   a. He will supply the sutures needed for the case.
   b. He will pour the required solutions.
   c. He will stay in the room to help as needed.
   d. He will serve as the senior scrub.

20. What does "T.1000 ml" indicate?
   a. A tourniquet will be placed on the patient after he has lost 1000 ml of blood.
   b. A tube (endotracheal) will be placed into the patient while the last 1000 ml of anesthetic is being given.
   c. The patient will be given whole blood at 1000 hours.
   d. The patient has been typed and cross-matched for 1000 ml of whole blood.

SPECIAL INSTRUCTIONS FOR EXERCISE 21. Exercise 21 is based on the second operation listed.

21. Since "TF" is entered on the operating room schedule, when should the scrub and the circulator prepare the operating room?
   a. Twenty minutes after completion of the preceding case.
   b. Immediately upon completion of the preceding case.
   c. Twenty minutes before completion of the preceding case.
   d. When setting up for the first case.
SPECIAL INSTRUCTIONS FOR EXERCISE 22. Exercise 22 is based on the fifth operation listed.

22. "Herniorrhaphy" means that a hernia will be surgically:
   a. Drained.
   b. Removed.
   c. Repaired.
   d. Injected.

SPECIAL INSTRUCTIONS FOR EXERCISE 23. Exercise 23 is based on the fourth operation listed.

23. Which of the following is a duty of the circulator with regard to the patient's anesthetic?
   a. Notify the anesthesiology service that the patient is to have local anesthesia.
   b. See that a source of oxygen is available in the room.
   c. Remind the surgeon to obtain a source of oxygen and place it in the room.
   d. Set up the sterile table for the injection of the anesthetic.

SPECIAL INSTRUCTIONS FOR EXERCISES 24 AND 25. Exercises 24 and 25 are based on the last operation listed.

24. A hernioplasty is what kind of a surgical procedure?
   a. Introduction.
   b. Fixation.
   c. Repair.
   d. Crushing.
25. According to the anesthetic, the patient is scheduled to receive. Where should he be taken upon completion of surgery?

a. Ward 42B.

b. Recovery room.

c. Ward 16A.

d. Room IV.

Operating room schedule for exercises 10-25.

Check Your Answers on Next Page
SOLUTIONS TO EXERCISES, LESSON 2

1. d (para 2-b(1))
2. a (para 2-3a(3), d(1))
3. d (para 2-8e(1))
4. b (para 2-27b)
5. c (para 2-28b)
6. d (para 2-31c)
7. c (para 2-34e)
8. d (para 2-30)
9. a (para 2-33)
10. c (para 2-35b)
11. d (para 2-35f)
12. d (para 2-35c)
13. a (paras 2-35h, 2-35h(2))
14. b (paras 2-35g, 2-8e(1))
15. c (paras 2-8a(4), 2-8e(1))
16. c (para 2-35k)
17. c (para 2-35j)
18. d (para 2-35h(2), i)
19. d (para 2-35i)
20. d (para 2-35k(2))
21. b (para 2-35c)
22. c (para 2-10b)
23. b (para 2-35j)
24. c (paras 2-8a(1), b(4))
25. b (para 2-35f)

Return to Table of Contents