



**LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
HARBOR-UCLA MEDICAL CENTER**

SUBJECT: OPERATIVE REPORTS

POLICY NO. 609

CATEGORY: Health Information Management	EFFECTIVE DATE: 1/79
POLICY CONTACT: Beverley Petrie, MD	UPDATE/REVISION DATE:
REVIEWED BY COMMITTEE(S): Medical Executive Committee	

PURPOSE:

To establish the timeliness and content requirements for written or electronically recorded operative notes and dictated operative reports.

POLICY:

Harbor-UCLA Medical Center shall ensure that immediately after completion of an operative procedure, an operative note must be written or electronically recorded in the medical record progress notes. The note must contain sufficient information to clearly identify the reason for the operation, the procedure performed, the members of the operating team, any complications, and the condition of the patient at the conclusion of the procedure.

A detailed operative report should be entered into the electronic medical record or dictated by the operating surgeon immediately after surgery and must always be entered or dictated within 24 hours after the completion of the surgery. A dictated operative report will contain the same essential elements as a written or electronically recorded operative note, as well as a detailed description of the operative findings and the technical conduct of the operative procedure.

The transcribed dictated operative report must be edited, corrected, and electronically signed by the dictating operating surgeon, and reviewed and electronically signed by the attending surgeon within 24 hours of it being available for review. The attending surgeon must be a member of the Professional Staff Association (PSA) and must have operating privileges appropriate to the surgery performed.

PROCEDURE:

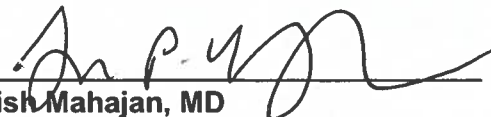
The required elements are listed in tabular form and are as follows:

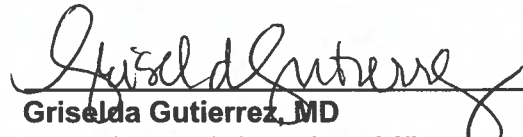
I. WRITTEN OR ELECTRONICALLY RECORDED OPERATIVE NOTE

The written or electronically recorded operative note must contain the following elements:

REVISED: 9/89, 11/91, 11/95, 1/99, 11/01, 9/07, 2/12, 8/14, 1/18, 5/22

REVIEWED: 9/86, 11/95, 1/99, 11/01, 9/04, 2/12, 8/14, 1/18, 5/22

APPROVED BY: 
Anish Mahajan, MD
 Chief Executive Officer
 Chief Medical Officer


Griselda Gutierrez, MD
 Associate Chief Medical Officer


Jason Black, MBA, DNP, RN
 Chief Nursing Officer



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1. Preoperative diagnosis
2. Postoperative diagnosis
3. Name of operative procedure(s)
4. Attending surgeon(s)
5. Operating surgeon, if different from the attending
6. Assistant surgeon(s)
7. Type(s) of anesthesia used
8. Operative findings
9. Estimated blood loss
10. Complications, if any
11. Condition of the patient at the conclusion of the procedure

II. DICTATED OPERATIVE REPORT

The dictated operative report requires proper identification of surgeons and patients and shall contain detailed information related to the procedure.

If more than one procedure is performed at a particular surgery, the detailed note may be dictated in more than one part, each report pertaining to the procedure performed and indicating the sequence in which the procedures were performed.

After accessing the dictation system according to the Medical Center's established procedures, the dictating member of the surgical team must dictate a report containing the following elements:

(Identification)

- A. Dictating Surgeon's full name, with correct spelling
- B. Dictating Surgeon's service
- C. Patient's full name with correct spelling
- D. Patient's medical record number
- E. Date of operation
- F. Date and time of dictation

(Operative Content)

- A. Preoperative diagnosis
- B. Postoperative diagnosis
- C. Name of operative procedure(s)
- D. Attending Surgeon's full name, with correct spelling
- E. Attending Surgeon's department or division
- F. Operating Surgeon's full name, with correct spelling
- G. Operating Surgeon's department or division
- H. Name(s) of Assistant Surgeon(s)
- I. Type(s) of anesthesia used
- J. Description of the operative procedure(s) and findings, including:
 1. Technical conduct of the operation
 2. Findings associated with the procedure
 3. Complications, if any
 4. Estimated blood loss
 5. Fluids administered



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6. Review of sponge and needle counts
7. Packs and/or drains used
8. Objects implanted
9. Specimens removed
- K. Condition and disposition of the patient at the conclusion of the procedure.

Reviewed and approved by:
Medical Executive Committee 05/2022

A handwritten signature in cursive script that reads "Beverley A. Petrie".

Beverley A. Petrie, M.D.
President, Professional Staff Association