

RULES AND REGULATIONS
OF THE
MEDICAL STAFF OF
NORTH SHORE SURGICAL CENTER

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SECTION A
ADMISSION

1. The Facility shall be operated without regard to age, race, color, religion, marital status, sex, national origin, handicap, sexual preference, or sponsor.
2. Unless other arrangements have been approved by the attending medical staff member, patients to have general anesthesia must be accompanied, upon admission and discharge, by a "responsible adult."

Unless other arrangements have been approved by the attending medical staff member, patients having surgery requiring local anesthesia who are premedicated via IV or IM, must be accompanied, upon admission and discharge, by a "responsible adult."

3. It is the responsibility of the admitting medical staff member to obtain written informed consent by the patient, parent or legal guardian, for any procedure to be performed at the Facility.
4. ~~A History and Physical Examination~~ which contains a provisional diagnosis and current medications shall be provided on all patients with the following exceptions:
 - a. Patients admitted for laser surgery who are to receive only topical anesthesia. A Laser Operative Report will be used in place of the History and Physical Examination.
 - b. Patients admitted for minor surgery who are to receive only local anesthesia. A minor surgery assessment will be completed on the minor surgery flow sheet or the nursing flow sheet.

A Medical History and Physical Examination by a physician must be provided in writing for patients of all Oral Surgeons unless the Medical Advisory Committee has recommended and the Board of Representatives approved specific privileges allowing an Oral Surgeon to perform his own History and Physical Examination.

A Medical Clearance may be required from the patient's private physician at the discretion of the surgeon or anesthesia practitioner when such patients have a history of cardiac pathology or other underlying medical conditions that might affect the successful outcome of the planned procedure.

When such History and Physical Examination or Medical Clearance is not available at the time of admission for surgery, the procedure may be cancelled.

5. Laboratory tests may be required for selected patients upon the discretion of the surgeon or anesthesia practitioner.
6. Medical records supplied prior to surgery by the patient's physician will remain on permanent file at the Facility, appropriately supplemented by the results of laboratory and X-ray tests and examinations, and complete reports of the surgical procedure(s) performed.
7. The admitting medical staff member shall have the responsibility for assuring that all relevant medical records are available at the Facility prior to surgery. Such records shall be reviewed, before the patient's arrival for pre-surgical examination, by the Anesthesia Practitioner and Pre-Operative RN. Minimally, the medical records submitted by the attending surgeon shall include a history and a physical examination as required.
8. A consent form for treatment, signed by the patient, parent or guardian, shall be obtained by the time of admission. Such completed form, evidencing informed consent, shall be required prior to pre-operative medication and admission to the operating suite, and shall include a statement that the nature of ambulatory surgery has been explained and understood by the patient, parent or guardian.

9. In regard to patients who are the subject of court appointed guardians, Medical-Legal responsibility will be placed upon the appropriate guardian.

SECTION B

ANESTHESIA

1. Procedures are performed under the following categories of Anesthesia.
 - a. General Anesthesia (includes IV anesthesia)
 - b. Regional Anesthesia
 - c. Monitored Anesthesia Care
 - d. Topical Anesthesia
 - e. Local Anesthesia with and without pre-medication and/or intraoperative medications. Amount of local anesthesia and intraoperative medication shall not exceed toxic levels.
2. The administration of Local, Topical and/or infiltrative anesthesia for local cases shall be the sole responsibility of the surgeon or anesthesia practitioner. Intravenous medication, if given, will require the signature or cosignature of a medical doctor.
3. Anesthesia will not be started until the surgeon is present in the facility.
4. No explosive or flammable agents will be available at the facility. The prevention of certain explosive anesthetic agents from being used in the Operating Room Suite is the responsibility of the Anesthesia Practitioner.

Strict adherence to the recommended safety precautions outlined in the current edition of NFPA Code 56A are in effect at the facility.

SECTION C

DRUGS

1. Drugs will be available only for use in the facility. The Facility will not dispense drugs or fill outpatient prescriptions.
2. Drugs used shall meet the standard of the U.S. Pharmacopea, National Formulary and New and Non-Official Remedies with the exception of drugs for bona fide clinical investigations.
3. All medication administered to patients shall be among those listed in the latest edition of the U.S. Pharmacopea, the National Formulary, the American Hospital Formulary Service or the A.M.A. Drug Evaluations.

SECTION D

DISCHARGE

1. A descriptive discharge status summary is required by a physician or Anesthesia Practitioner. Patients shall be discharged only on written order of a physician.
2. Surgeons and/or Anesthesia Practitioners must see patients requiring Recovery Room observation at least once before leaving the facility.
3. Discharge from the Facility is based on the patient's ability to leave the facility safely upon meeting the discharge criteria.
4. In the case of a transfer of a patient to a hospital for admission, either a copy of the chart, descriptive narrative of the events leading to the need for hospitalization, or both, must accompany the patient to the hospital.

5. Should the patient leave the facility against the advice of the surgeon or the anesthesia practitioner, the Executive Director and/or Medical Director shall be promptly notified. Notation of the incident shall be made in the patient's medical record.
6. At the time of discharge, the patient and any responsible adult accompanying the patient, shall be provided with complete, written post-op instructions, which have been personally reviewed and explained to the patient. The written post-operative instructions shall be signed by the patient and/or responsible adult accompanying the patient, to signify their acceptance of the instructions given.
7. The surgeon shall be responsible for determining to his/her reasonable satisfaction that adequate resources for provision of post-surgical care are available to the patient.
8. Should circumstances arise during the course of treatment or post-surgical recovery which, in the opinion of the attending medical staff member or the anesthesia staff, indicate the need for hospitalization, immediate notification will be provided to the Medical Director or Nursing Supervisor, who will promptly implement standing procedures for transport and hospital admission of the patient, according to existing arrangements and transfer agreements. The attending medical staff member shall be responsible to arrange hospital admission. The attending medical staff member or the Medical Director shall simultaneously be responsible for notification to the patient's responsible family member or companion of the need for and circumstances relating to the transfer and hospitalization. All transfers will be reported to the QA Committee for study.
9. In the event of death of a patient during a surgical procedure, or during the post-surgical recovery period, proper notification shall be promptly made to the medical examiner's office and/or other appropriate authorities by the Medical Director. The attending medical staff member shall be responsible for notification to the patient's family of the circumstances resulting in death.

SECTION E
MEDICAL RECORDS

1. The admitting medical staff member shall be responsible for the preparation of a complete medical record for each patient.
2. The patient's medical record must contain a medical history, physical examination, documentation of any known allergies, any medication reactions, a list of current medications and dosages, an assessment of mental status and an operative summary with a complete description of the operative procedure, any complications, and the surgeon's signature. Prognosis and infection classification, when appropriate, should be included.
3. All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a Registered Nurse and signed by the attending medical staff member at his/her next visit.

Orders dictated over the telephone shall be signed by the person to whom dictated, with the name of the medical staff member per his or her own name. At the next visit, the attending medical staff member shall sign such orders.

4. The attending medical staff member shall see that the record is complete and signed within thirty (30) days from the date of the procedure. Medical Records remaining incomplete for one month following the patient's discharge may be considered delinquent.

Medical staff members with charts delinquent will be notified by registered letter, return receipt requested, within thirty (30) days of impending suspension. Unless charts are completed within thirty (30) days after receipt of this letter, surgical privileges will be suspended until all delinquent records are completed.

5. All surgical procedures performed shall be fully described by the medical staff member.

6. All tissue removed during the operative procedure shall be sent to the Facility's Pathologist (with the exception of those identified in (a) and (b) below), who shall make such examinations as may be considered necessary to arrive at a pathological diagnosis.
 - a. Non-tissue specimens e.g. orthopaedic hardware, breast implants, ear tubes and foreign bodies are not required to be sent to Pathology. Appropriate notation in the operative report verifying the removal is recommended.
 - b. Tissue specimens such as teeth, bone plates, cataracts, bone and or nasal cartilage from nasal reconstructions, skin and subcutaneous tissue from plastic procedures, veins from AV fistulas, and omental fat from hernia repairs are not required to be submitted. Appropriate notation in the operative report verifying the removal of the tissue is recommended.

The Pathologist shall sign this report, which shall become a part of the permanent medical record.

7. All records shall remain the property of the facility and shall not be taken from the Facility without the express written permission of the Medical Director.

In the case of readmission of a patient, all previous records from the past twelve (12) months shall be made available for the use of the attending medical staff member. This shall apply whether the patient was attended by the same or another medical staff member. Previous records will be retrieved from archives as requested by the attending physician or Anesthesia practitioner.

8. Free access to medical records of all patients under their care shall be afforded to members of the Medical Staff, who are in good standing.

Upon written permission of the Medical Director of the Facility, these may be used for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients.

9. Subject to the discretion of the Medical Director of the Facility, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all procedures in which they attended such patients in the Facility.
10. Only those abbreviations listed on the "Abbreviations Approved for Use by the Medical and Nursing Staffs" may be used in the medical record.
11. Identifying errors in the course of documentation within the medical record shall be done in the proper manner. The method shall include: a) single line through the part to be corrected; b) labeled "error"; c) insertion of correct documentation; and d) date, time and initials of person correcting.
12. A complete and legible medical record shall be completed for each patient. The content shall be pertinent and current. The medical records of all patients receiving general anesthesia, monitored anesthesia care, or regional anesthesia shall include the following:
 1. identification data;
 2. chief complaint, present illness and surgical plan;
 3. personal and family history;
 4. physical examination and assessment of mental status;
 5. known allergies;
 6. any medication reaction;
 7. list of current medications and dosages;
 8. practitioners' orders;
 9. pre-surgical test results as required;
 10. consents forms;
 11. pre-operative assessment;
 12. operative report (including the condition of the patient at the conclusion of the procedure);
 13. anesthesia record;
 14. nursing flow sheets;
 15. discharge instructions;
 16. discharge summary and diagnosis;
 17. physician orders;
 18. post-operative nursing assessment and survey;
 19. special reports, such as consultations;
 20. pathology report, when applicable;

13. If the patient has been discharged by transfer from the Facility to another Health Care Facility, a transfer report shall be completed, a copy of which will accompany the patient to the receiving facility, the original to become a part of the medical record at the Facility.
14. The medical record of each patient having only local or no anesthesia shall include the following:
 1. identification data;
 2. brief description of the medical problem, e.g., lesion requiring local surgical intervention;
 3. significant medical history;
 4. physical examination and assessment of mental status;
 5. known allergies;
 6. any medication reactions;
 7. list of current medications and dosages;
 8. practitioner's orders;
 9. presurgical test results as required;
 10. consent forms;
 11. pre-operative assessment;
 12. nursing flow sheets;
 13. brief operative report (including condition of patient at the conclusion of the procedure);
 14. discharge instructions;
 15. discharge summary and diagnosis;
 16. physician orders;
 17. pathology report, when applicable;
15. Consultations: Each consultative report shall show evidence of a review of the patient's record by the consultant, and shall have documented pertinent findings on examination of the patient, the consultant's opinion and recommendations. It shall be signed and made a part of the patient's medical record. Consultations shall be written or dictated. Except in cases of emergencies, consultation notes shall be recorded prior to the performance of the operative procedure.

ADMISSION POLICIES

1. ADMISSION POLICIES

- a. The Facility shall admit patients only for those surgical procedures, including relevant diagnostic and therapeutic procedures, included on the procedure list, as attached, and

made a part of these Rules and Regulations. The Procedure List may be amended from time to time by the Governing Board as recommended by the Medical Advisory Committee.

- b. Patients shall be admitted, treated and attended throughout their stay by members of the Medical Staff of this facility.
- c. No patient shall be admitted to the Facility for general anesthesia until and unless it has been determined that the physical, mental, emotional or other characteristics of the patient make him/her an appropriate candidate for surgical treatment on an ambulatory basis.
- d. Patients will be admitted to the Facility in accordance with the following policies and procedures:
 1. The patient must be recommended as appropriate candidate for ambulatory surgery by a member of the Medical Staff;
 2. The Medical Director and/or Anesthesia Practitioner of the Facility shall have discretionary authority to cancel scheduled surgery on review of any medical records examined which, in their judgment, suggest that the patient may be physically, mentally or emotionally unsuitable for ambulatory surgery, or that the patient's socio/environmental situation is such that the appropriate post-surgical care requirements cannot be adequately met;
 3. On the scheduled day of the surgery, the patient receiving general, regional, or monitored anesthesia care must be personally interviewed by the Anesthesia Practitioner who, following review of the patient's medical records and pre-admission test results, will determine whether or not to authorize preparation of the patient for surgery;
 4. Patients referred to the Facility shall be supplied with necessary instructions, rules, regulations and explanations relating to ambulatory surgical procedures. Such Patient Information materials shall be made available to the offices of the members of the Medical Staff of this facility, so that they may be provided to patients at the time of scheduling;

SECTION F
RECOVERY ROOM

1. The Recovery Room will be under the direction of the Anesthesia Practitioner or his designee.
2. The Facility will not provide accommodations for overnight observation. Any patients requiring prolonged or overnight observation (due to unforeseen complications) must be transferred to a hospital by the admitting doctor.

SECTION G
SCHEDULING

1. Except in the case of an emergency, all treatment provided at the Facility shall be on an elective and pre-scheduled basis.
2. The admitting medical staff member shall be held responsible for giving information, as may be necessary, to secure the protection of other patients from those who are a source of danger from any cause whatsoever.
3. Patients for surgical procedures shall be admitted not later than one (1) hour before the scheduled operation, or within the pre-arranged time frame in order to allow adequate time for pre-operative preparation.
4. Patients Criteria for Scheduling.
 - a. Patients who are candidates for outpatient surgery must meet the following criteria:
 1. The patient must be in good health (A.S.A. Class I) or with mild systemic disease which is under control and does not require special management (A.S.A. Class II). A.S.A. Class III patients must have recent tests

considered significant to document control, and their reports must accompany the patients at the time of admission; e.g., medical clearance from their private physician.

2. The patient and/or person signing the consent for surgery must agree with the concept of outpatient surgery/ anesthesia and must exhibit the ability to use judgment and follow instruction.
 3. The patient's physical and emotional environment must be conducive to a successful outcome.
- b. Patients not acceptable for admission to the Facility are as follows:
1. Infection: Patients having infections or communicable diseases which require isolation and additional professional help in surgical or recovery room services. These patients shall be referred to the hospital for care.

Surgery will be cancelled automatically if patient shows any evidence of respiratory disease or infection.
 2. Infants with significant oro-facial anomalies.
 3. Children under age three (3) months must have prior approval of the Anesthesia Practitioner.
5. Criteria for Scheduling Procedures: Procedures are recommended by the Medical Staff and approved by the Board of Representatives.

SECTION H
STAFF PRIVILEGES

1. Patients may be treated only by physicians, surgeons, or other professionals who have submitted proper credentials and have been duly appointed to the Medical Staff by the Board of Representatives.
2. Applicants for Medical Staff privileges may be granted temporary privileges for a period of thirty to ninety days upon written approval by the Chairman of the Medical Advisory Committee and the Executive Director.
3. Case privileges may be granted to the following individuals:
 - a. Current Medical Staff members who are applying for new or additional surgical privileges; and
 - b. Prospective Medical Staff members.

Case privileges may be granted for a period of one to five days for non-medical staff members and a period of thirty to ninety days for Medical Staff members. Prior approval by the Chairman of the Medical Advisory Committee and the Executive Director is required for each case procedure to be performed at the Facility.

SECTION I
STAFF REQUIREMENTS

1. Anesthesia Practitioners will be available in the facility in time to evaluate patients receiving anesthesia care adequately before surgery.

2. Medical staff members shall be in the operating room and ready to commence the operative procedure at the time scheduled, and in no case will the operating room be held longer than fifteen (15) minutes after the time scheduled.
3. All members of the Medical Staff must abide by the policies of North Shore Surgical Center.
4. All Medical and Allied Health Professional Staff will comply with the Facility's Exposure Control Plan for compliance with the Occupational Safety and Health Administration (OSHA) Standard on Occupational Exposure to Bloodborne Pathogens as modified from time to time.

SECTION J
AMENDMENTS

These Rules and Regulations may be amended at any meeting of the Medical Advisory Committee by a two-thirds (2/3) vote of those present and shall become effective when approved by a majority vote of the Board of Representatives.

Submitted by: James A. Henry Date: 8-18-92
Executive Director

Recommended for Approval: William B. Reber, M.D. Date: 8-19-92
Chairman, Medical Advisory Committee

Approved: [Signature] Date: 8/21/92
Chairman, Board of Representatives

Renewed: MAC/BR Date: 8/92

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_____ Date: _____

_____ Date: _____