
CentraCare - Willmar Surgery Center
1310 1st Street South
Willmar, Minnesota

# MEDICAL STAFF RULES & REGULATIONS

Approved by Medical Executive Committee: 05/11/23

**CENTRACARE - WILLMAR SURGERY CENTER**

**MEDICAL STAFF RULES & REGULATIONS**

SECTION 1 GENERAL

PREAMBLE
In recognition that the purpose of the Medical Staff of CentraCare - Willmar Surgery Center is to both provide patient care and to evaluate and continually seek means to improve the quality of the care patients receive at CentraCare - Willmar Surgery Center, these Rules and Regulations have been established. These Rules and Regulations are intended to supplement and expand upon the Bylaws of the Medical Staff of CentraCare - Willmar Surgery Center; however, if at any time there should appear to be a contradiction between the Rules and Regulations and the Bylaws, the latter shall have preference. The medical staff is accountable to the governing body.

DEFINITIONS
Terms defined in the CentraCare - Willmar Surgery Center Medical Staff Bylaws shall have the same meaning when used in these Rules and Regulations.

EFFECT
These rules and regulations shall be adopted and remain effective after action by the Medical Staff and Board of Directors as described in Medical Staff Bylaws.

SECTION 2 SPECIFIC REQUIREMENTS FOR ALLIED HEALTH PROFESSIONALS

(A) All written material by an Allied Health Professional, made part of the medical record, must be signed with the last name of the individual and the appropriate letters designating his/her position i.e., P.A., RPA, etc. All materials need to be co-signed by a physician.

(B) All orders, which must have a licensed physician signature, that are recorded by the Allied Health Professionals shall be signed as V.O. (Verbal order) or T.O. (Telephone order). The responsible physician's name must then be followed by the individual's name and appropriate letters designating his/her position.

(C) The Allied Health Professional must always, wherever possible wear a name tag specifying his/her name and position.

SECTION 3 PROTOCOLS FOR MEDICAL STAFF MEMBER IMPAIRMENT AND SUBSTANCE ABUSE

The Process for evaluation and management of concerns regarding potential physician impairment are outlined in the CentraCare Practitioner Health policy, as well as Practitioner Health policy.

Licensed independent practitioners and other professional staff will be educated about recognizing impairment and disruptive behavior patterns, and when and how to report concerning incidents and behaviors.

SECTION 4 PROLONGED ILLNESS

(A) Whenever a member of the CentraCare - Willmar Surgery Center Active Medical Staff is unable to work or work is compromised due to illness or injury for a period of greater than one month and is under medical care, the Medical Executive Committee (MEC) shall evaluate the member's privileges. Recommendations as to requirements including specific dates for review and/or return to previous or modified privileges shall be made to the MEC. The Advisory Committee in turn will make appropriate recommendations for final action.

(B) Any illness or injury, the effects of which result in an absence which lasts six months, shall require the completion of a staff reappointment form before return to full or modified privilege status.

SECTION 5 PATIENT SCHEDULING

(A) WSC shall accept patients for care and treatment, whose diagnosis is appropriate to the services available at WSC, as noted in the Medical Selection & Clearance Criteria policy

(B) Patient scheduling will strive to meet regulatory criteria as noted in the Medical Selection & Clearance Criteria policy.

(C) One member of the Medical Staff (the "Attending Physician") will be responsible for the surgical care and treatment of each patient, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. The Attending Physician will be considered to be a patient's physician of record for the entire period of surgery and post-operative care.

(D) Children 12 years of age or under are classified as pediatric patients, details found in the Pediatric Patient's policy.

SECTION 6 CONSENTS

SPECIFIC CONSENT

If a specific consent form is needed for a procedure, the specific consent form will be completed when deemed necessary by the attending physician or required by Surgery Center policy. This includes sterilization procedures.

INFORMED CONSENT

(A) Informed consent is required for all cases of invasive/surgical procedures requiring anesthesia. WSC uses the Minnesota Alliance for Patient Safety (MAPS) informed consent. Physicians shall discuss the risks and benefits of the procedure, including any risks associated with not performing the procedure, and shall sign the consent form as documentation of the consent. The patient's signature on the consent form indicates understanding of the discussion.

THIS IS IDENTIFIED IN POLICY

SECTION 8 ADMISSIONS AND DISCHARGES

(A) A patient will be medically discharged only on order of the patient's Attending Physician.

(B) Patients who do not meet discharge criteria must be examined by an attending physician or anesthesiologist/CRNA and discharged or admitted by that physician's order.

(C) Patients desiring to leave the Surgery Center against the advice of their attending physician or anesthesiologist/CRNA shall have this status documented in their medical record. These patients shall be requested to sign the "Waiver of Responsibility for Discharge" (Discharge Against Medical Advice) Form. If the patient refuses to sign this form, refusal shall be documented on form and signed by two witnesses. It will also be documented in the nurse's notes.

SECTION 10 QUALITY OF CARE

(A) The Medical Staff and all others involved in the provision of care to patients at WSC will participate in the Quality Improvement/Risk Management Program.

(B) Any question or reason to doubt the care provided to any patient will be brought to the attention of the Medical Director. If a nurse is unable to get a satisfactory resolution to questions, the nurse must notify the Director who in turn may refer the matter to the Medical Director.

SECTION 11 FORMULARY

(A) Drugs used in the treatment of patients shall be only those recognized and approved by the FDA for clinical and/or investigational use.

(B) Drugs for bona fide clinical investigations will be used in full accordance with Statement of Principles Involved in the Use of Investigational Drugs in Surgery Centers and all regulations of the Federal Drug Administration.

(C) Formulary maintenance is the responsibility of the CentraCare- Rice Memorial Hospital Pharmacy.

SECTION 12 DISASTER OCCURRENCE ASSIGNMENTS

(A) A plan shall be prepared, published, and revised as needed, which will organize the Surgery Center and Active Medical Staff for the immediate and efficient handling of injured persons resulting from a local disaster of any type. The plan shall be coordinated with those of other community agencies who would be expected to be involved in response to a local disaster.

(B) Physicians will actively participate in any disaster occurrence or rehearsals in which WSC is involved.

(C) Physicians will be assigned posts and responsibilities by the Director and will cooperate in the activities and directions in accordance with the Disaster Plan adopted by the Medical Executive Committee.

SECTION 13 MEDICAL RECORDS

(A) Medical records shall be kept for every scheduled patient. The medical record shall contain patient identification, history and physical examination, description of significant diagnostic and therapeutic procedures and test results, diagnosis and treatment provided, condition of patient on discharge/transfer; and final disposition, including instructions for follow-up care given to the patient and/or family. Signature of the patient or his/her representative should also be obtained to indicate receipt of instructions.

(B) The physician, oral surgeon, or podiatrist member of the Active or Provisional Medical Staff or a physician, oral surgeon, or podiatrist with appropriate temporary privileges, shall be responsible for the preparation of a complete medical record for each patient to whom he/she provides care.

(C) Symbols and abbreviations are used in the medical record only if they are present on the current approved WSC abbreviation list.

(D) All records are the property of CentraCare and shall not be removed from the premises except by a subpoena, court order, statute, or order of the Governing Body.

(E) In case of patient readmission, all previous records are available within the EMR for the use of the attending physician. This shall apply whether the patient is attended by the same physician or another.

HISTORY AND PHYSICAL EXAMINATION

(A) In surgical/endoscopy cases undergoing general anesthesia, monitored anesthesia care or conscious sedation, a current history and physical must be on the chart prior to surgery. A complete history and physical examination shall be written or dictated within 30 days of the surgery. This report will include the chief complaint, details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral, and social status; relevant past, social, and family histories; an inventory of body systems and a proposed treatment plan. Consultation reports may be used in lieu of a history and physical report if they are complete and comply with the above. The MDA or attending physician will do the H&P or contact the primary provider to get a verbal report of the H&P, if a printed copy is not available at the time of surgery. This will be documented in the chart. The history and physical must, at a minimum, include documentation of:

1. Symptoms/Indications for surgery/procedure;
2. A list of current medications;
3. Any known allergies and/or medication reactions; and
4. Existing comorbid conditions, if any.
5. Heart and lung assessment
6. Pre-op labs and EKG per protocol

ATTENDING PHYSICIAN'S NOTE

A note shall be available from the attending physician, describing the surgery to be performed. The note shall be available 48 hours in advance of the surgery. If the patient is seen within 48 hours of the surgery, the note shall be available prior to surgery. The referring physician may include this information in the History and Physical Examination for endoscopy procedures.

PHYSICIAN ORDERS

(A) All orders for medication must include the name of the drug, dosage, times, frequency and route of administration.

(B) A telephone order will be considered to be in writing if taken and recorded by a registered nurse or other authorized persons, as designated by the Medical Executive Committee, as long as such orders are verified and signed by the Attending Physician.

(C) Administration of Medications: The following individuals shall be considered appropriately licensed to administer medications. They will include RN's, LPN's, Registered Pharmacists, and under certain circumstances, health care assistants in accordance with applicable laws.

(D) Written orders sent with a patient on registration with a physician's signature (i.e., notes on prescription pads, etc.), other than those written on the "Physician Order" sheet, will be saved in the chart until the physician signs the copied orders.

OPERATIVE REPORT

Operative Reports shall include a detailed account of findings at surgery/procedure as well as the details of the surgical/procedure technique, any specimens removed for pathological study, the pre-and postoperative diagnosis, name of the Attending Physician and name of any assistants.

DISCHARGE NOTE

The medical record shall include a dated, timed, and signed post-anesthetic visit made after the patient has left the recovery area, describing significant physical and laboratory findings and events, final diagnosis, patient condition on discharge, the presence or absence of anesthesia related complications, and the specific instructions and arrangements for future care, including physical activity, limitations, medications, diet, and follow-up care.

PATHOLOGY REPORTS

All pathology reports will be signed by the attending physician, who will notify the referring physician.

OVERDUE/INCOMPLETE MEDICAL RECORDS

The Attending Physician will complete all medical records of a patient within 30 days following a patient's discharge. A medical record will not be permanently filed until it is completed by the Attending Physician or is ordered to be filed by the Medical Executive Committee. No Medical Staff Member is permitted to complete a medical record (i.e. sign orders, progress notes, or dictate reports) on a patient unfamiliar to him/her.

Procedure to be followed when medical records are not completed within the specified time period.

(A) The attending with overdue charts at the specified time periods as outlined above will be notified in writing weekly that they have one week to complete their charts. Failure to comply with the medical records requirements shall result in notification in writing to the staff member or privileges holder, followed by automatic suspension of Surgery Center privileges as provided in WSC Medical Staff Bylaws.

(B) The Director will notify the Medical Director and the Chief Executive Officer which doctors are not in compliance with the chart completion requirements.

(C) The Chief Executive Officer or his designee will notify the Surgery Center Director of the name(s) of the attending who have their admitting privileges suspended.

(D) The Medical Director will notify the attending when their privileges have been suspended. A certified letter (with a returned signed receipt) notifying the attending of his/her suspension will also be sent.

(E) The procedure for reinstatement of admitting privileges is outlined in WSC Medical Staff Bylaws.

(F) To assure compliance with these medical records rules, the MEC will, in concert with WSC personnel, develop a systematic plan to evaluate individual compliance.

SECTION 14 RELEASE AND USE OF PATIENT INFORMATION

(A) Access to medical records of patients shall be afforded to Members of the Medical Staff for a bona fide study or research project in accordance with applicable law, provided no personally identifiable patient information is released and provided the consent of such patients is obtained. Subject to the discretion of the Director, former Members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in WSC.

SECTION 15 POLICIES AND PLANS

(A) Policies shall be adopted by majority vote of those recognized as Active Staff members, providing they do not conflict with staff policy or Medical Staff Bylaws, or these Rules and Regulations.

(B) Recognizing the desirability of having defined policies and protocols to assist with the standardization and continuity of care patterns, the following course is strongly encouraged:

1. Formulation of policies and/or protocols which impact multiple medical staff members should, except in extenuating circumstances, be developed by a means which involves at least one affected member who could foreseeable be affected by the policy or protocol.

2. After a draft copy of a proposed policy and/or protocol has been composed, it shall be distributed to each member likely to be impacted, with a specified time given for comment to be returned to the composing body.

3. After comments have been received by the composing body and evaluated for inclusion or exclusion, the finished copy of the policy and/or protocol shall be forwarded to the Advisory Committee, which shall either accept the policy/protocol as written, accept an amended version of the policy/protocol, reject the proposal, or return the policy/protocol to the composing body with instructions for further consideration and/or modification.

SECTION 16 GENERAL RULES REGARDING SURGICAL/PROCEDURAL CARE

(A) Patients admitted for elective surgery shall be directed by the attending/referring physician to have necessary diagnostic examinations, consultations, evaluations, and preparation prior to surgery.

(B) CentraCare - Willmar Surgery Center will develop preoperative lab, X-ray, EKG requirements for anesthesia based on current literature.

(C) A physician's pre-anesthesia note, with date and time, shall be documented in the medical record of all patients scheduled for surgery that specifically includes information relative to the choice of anesthesia for the anticipated procedure. Whenever a Certified Nurse Anesthetist generates the pre-anesthesia note it must be countersigned by a physician.

(D) All vital tissues removed during the operation/procedure shall be sent to the CentraCare - Rice Memorial Hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis.

1. The Medical Staff, in consultation with the pathologist, decides the exceptions to sending specimens removed during a surgical procedure to the laboratory. Exceptions are made only when the quality of care has not been compromised by the exception, when another suitable means of verification of the removal has been routinely used, and when there is an authenticated operative or other official report that documents the removal. The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include, but need not be limited to, the following:

    a. Specimens that by their nature or condition do not permit productive examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;
    b. Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;
    c. Foreign bodies (eg, bullets) that, for legal reasons, are given directly in the chain of custody to law enforcement representatives;
    d. Specimens known to rarely, if ever, show pathologic change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant;
    e. Teeth, provided the anatomic name or anatomic number of each tooth, or fragment or each tooth, is recorded in the medical record.
    f. Skin with surgical scars, toenails and fingernails, redundant skin from plastic surgery procedures, varicose veins, hernia sacs, drain tubes from ears, strabismus muscle resections, staples, fat from abdominal panniculectomy, cartilage, vaginal mucosa, intrauterine devices, nasal cartilage and bone, tonsils and adenoids (under 18 years of age).

(E) Any patient who has received other than local anesthesia shall meet discharge criteria and be accompanied home by a designated person. Patients who do not meet discharge criteria must be examined by a physician and discharged or admitted by that doctor's order. This examination shall be performed by a physician or by a qualified oral surgeon, dentist, podiatrist.

(F) WSC complies with national standards of care by removing nose, lip and tongue jewelry preoperatively.

(G) Any instructions for follow-up care shall be given to the patient and/or responsible family member and documentation thereof place in the Surgery Center record.

(H) CentraCare - Willmar Surgery Center will develop preoperative requirements for NPO with regard to solids and liquids based on current literature.

(I) The anesthesiologist or CRNA (or Attending Physician if no anesthesiologist or CRNA will be involved in care) will make a pre-operative check of the physical condition of the patient and review records and

reports of diagnostic studies. The pre-procedure evaluation will be recorded on the chart form. The anesthesiologist or CRNA will complete a post-anesthetic follow-up of the patient after recovery from anesthesia and will record all observations in the patient's medical record. Post-anesthetic notes will be completed within three (3) days, will include an appraisal of the patient and will be dated and timed.

(J) The Attending Physician is responsible for the accurate scheduling of a patient to include assistant surgeons or other assistants as may be indicated, to assure the availability of special equipment and to ensure that a pathologist will be notified and is available if a frozen section is anticipated. Where possible, he/she should state the expected time or length of the operative procedure.

(K) Immediately prior to beginning a procedure, the operating team verifies the patient's identification, intended procedure, correct surgical site and that all equipment routinely necessary for performing the scheduled the schedule procedure, along with any implantable devices to be used, are immediately available in the operating room. The operating surgeon is personally responsible for ensuring that all aspects of this verification have been satisfactorily completed immediately prior to beginning the procedure.

## SECTION 17 ABORTIONS

No therapeutic abortions may be performed at WSC.

## SECTION 18 *LOCUM TENENS* CONSIDERATIONS

(A) Request for a physician, oral surgeon, or podiatrist to serve in a *locum tenens* capacity must be initiated by a request from within the department in which the physician, oral surgeon, or podiatrist will be practicing.

(B) Temporary short-term practice privileges must have a specified length of time which may not exceed (6) six consecutive calendar months.

(C) Status will be temporary with rights of Active Staff. Are not eligible to vote or hold office.

(D) May admit patients either as their primary responsibility or in conjunction with another Active Staff member if admitting privileges are granted.

(E) May participate in transactions of medical staff if it involves a subject or patient in which he/she is involved.

(F) A yearly maximum of 180 working days.

Adopted 2004; Revised 6/2021,