Parkview Orthopaedic Hospital (POH)
MEDICAL STAFF RULES & REGULATIONS
MEC Approved – 9-14-07, 7/19/2011, 7/16/13, 3/18,14, 04/11/17, 2/12/19, 9/14/2021, 10/8/24.

I. Facilitation of Medical Staff Affairs

Medical Staff Leadership Committee(s) convene for the purpose of maintaining medical staff affairs to safe and quality patient care.

Medical Staff Issues – Physician-to-Physician with or without assistance from hospital staff

Peer Review

1. Qualification for initial and ongoing medical staff membership
2. Qualifications for individual privileges
3. Establishment of privilege criteria (cross specialty being the most challenging)
4. Collegial Intervention when questions about clinical or behavioral performance arise.
5. Establishment of Inquiry Body process when concerns about performance become serious.
6. Chart review / Quality Assurance as needed beyond the efforts of specialty-specific peer review committees
7. Proctoring
8. Addressing medical staff roles in preventing adverse events
9. Ensuring members' rights are protected in all things.

Medical Staff Performance

1. Ensure quality care by identifying opportunities for individual or organizational performance improvement, for example, care criteria, order sets, clinical pathways, etc.
2. Plan processes to resolve unique/ad hoc/cross specialty issues.
3. Manage adherence to established rules, like medical record completion, formulary usage, consultation, equitable unattached call coverage, etc.
4. Ensure "rules" are reasonable, contemporary, and consistently applied to all.
5. Understand medical staff and hospital processes for decision making to assist individual members in voicing their needs.
6. Develop, nominate, and elect future leaders.
7. Plan for and hold effective and efficient meetings.
8. Safely implement new equipment affecting the medical staff
9. Establish guidelines and monitor appropriate use of physician extenders.

Communication

1. Ensure constituency is fairly represented in all matters affecting them at all levels.
2. Ensure constituency has opportunity to share concerns and opinions about any medical staff or hospital matter.
3. Ensure constituency is informed about issues and happenings that affect them.
4. Ensure the right medical staff members are consulted about "operational" issues such as strategic planning, capital purchases, etc.

Operational Issues – Matters in which both medical staff and hospital have interest and must collaborate.

1. How a specific unit (ex: ED, OR, ICU) functions – usually managed by unit medical director.
2. How resources are allocated within a specific unit
3. Block time allocation.
4. Budget and Capital expenditure decisions
5. Surveys and Accreditation activities
6. Benchmarking and establishing of unit performance indicators, ex: OR turnaround time.
7. Consideration of new services
8. Unit prevention of adverse events
9. Strategic planning

Medical Staff committees do not need to be routinely engaged in operational issues; however, medical staff member involvement may be needed and expected from time to time.

A. **Individual Issues**
Should any individual member of the medical staff have an issue of concern, they are encouraged to approach medical staff leadership. The Chief Medical Officer and Medical Staff Services may also be used as an intermediary to ensure communication occurs.

B. **Credentialing and Privileging**
All applicants for appointment or reappointment must continuously meet the qualifications and standards of performance outlined in the Medical Staff Bylaws, Quality Management Plan, specialty-specific privilege forms and other associated policies, rules, and regulations.

The Bylaws describe the minimum eligibility requirements for medical staff membership. Under the oversight of the respective Division and the Credentials Committee, each recognized specialty and subspecialty shall develop and maintain privilege request forms specific to each specialty inclusive of minimum eligibility requirements for basic education, training, certification, and experience. Core privileges by specialty must be defined as well as those.
privileges that are "advanced" or for any other reason require additional evidence of current competency. Examples of such acceptable evidence shall also be defined.

Reappointment assessment of activity during the past two years may include any of these resources or a combination thereof:

1. response to the questions asked on the Application for Reappointment

the absence of any concerns brought to the attention of Medical Staff Executive Committee

2. the response received to an evaluation form sent to the hospital or health care facility
3. where the individual holds active staff status and conducts primary practice.
4. the response received to requested peer evaluations.

Individual review of each applicant for initial appointment and privileges, for additional privileges, and reappointment and renewal of privileges shall occur, and recommendation formed for consideration by the Medical Staff Executive Committee. This same mechanism shall be used to obtain review of Allied Health Practitioners and address matters related to the individual use or performance of Allied Health Practitioners by the Medical Staff.

C. **Collegial Intervention and Peer Review**
Reference Medical Staff Bylaws and related policies

II. RULES AFFECTING ALL MEDICAL STAFF

A. EMTALA Compliance - As POH does not have an on-premises Emergency Department, no obligation exists under EMTALA with respect to individuals who come to POH as an initial point of entry into the medical system seeking a medical screening examination or treatment for an emergency medical condition. POH recognizes and respects its responsibility to accept, within the capacity and capability of the hospital, appropriate transfers from requesting hospitals without regard to the presence or absence of an on-premises Emergency Department. In compliance with CMS requirements, POH has allopathic and osteopathic physicians on duty or on call at all times. These physician resources are continuously available to make appropriate determinations regarding transfer requests.

B. **Consultations -** Practitioners requesting consultation should be responsible for directly calling the consultant requested. Physician-to-Physician communication is always preferred. When a written order is issued, this information shall be transmitted by Nursing at the time the order is noted.

Written Order Requirements: The written order must include the name of the practitioner or group to be consulted, the reason for the consultation, and the timeframe in which the consultation should occur**.** If the written order is incomplete, nursing staff shall transmit the information available. The consulting practitioner is responsible for contacting the referring practitioner for clarification.

Transmission of Written Orders: Nursing staff shall be responsible for directly contacting the office of the designated practitioner or group to relay the request for consultation, if the order is issued during office hours. After office hours, nursing staff will contact the practitioner on call for the designated practitioner or group through the answering service.
The transmission of the written order shall be noted in the patient record.

Responsiveness to Consult Request: The Medical Staff Bylaws require timely consultation (II.3.G) which shall be defined as within 24 hours, unless otherwise defined in Rules and Regulations and related policies.

An in-person physician response to a consultation request is the normal expectation. In the event a physician consultant (or another physician from the physician's group) is not personally seeing the patient in response to the consultation request, mutual understanding must exist between the requesting physician and the physician consultant on how the service will be provided.

C. **Process for Changing Physicians for Hospitalized Patients**

The Medical Staff recognizes that circumstances may occur where patients or physicians may no longer wish to continue the patient - physician relationship. When these difficult circumstances occur, it is critical to manage them as professionally as possible to prevent any erosion of relationship between the patient, physician, and/or nursing staff or loss of confidence in the other care providers associated with the case. The following procedure must be followed in order to ensure continuance of appropriate patient care and the medical staff member's compliance with the responsibility to assure such care. Under no circumstances should a staff nurse be placed in an intermediary role between the patient and the physician(s).

1. The patient or physician must state that they no longer wish to continue the relationship.
2. The decision must be documented in the medical record.
3. Physician or nurse notifies house supervisor of the situation and the precipitating circumstances.
4. In turn, the house supervisor notifies the Chief Medical Officer for assistance in securing physician coverage for the patient.
5. The patient must be asked if they have a request for a specific physician to assume their care.
6. The CMO will contact appropriate alternative physician(s), taking into account the desires of the patient, until a new physician has indicated their willingness to assume care. As appropriate, the CMO may contact the Hospitalist on duty for assistance. When transfer of care is accepted by the new physician, this acceptance is documented on the chart. Ideally, the exiting physician provides report to the accepting physician.
7. The original physician may be contacted for orders of an urgent nature until an accepting physician has documented his or her acceptance on the chart.

It is not appropriate to force patients to change physicians against their will. If the physician is uncomfortable with the relationship, the patient shall be given 30 days' notice of the physician's intent to no longer provide care. During this time the physician will continue to provide appropriate care, unless or until another physician assumes care. This would apply to cases in which the patient is not willing to consent to treatment plans outlined by the physician but does not wish to change physicians.

D. Patient Visit by Advanced Allied Health Practitioners in Place of Physician Daily Visit

In accordance with Medical Staff Bylaws and Policy, the physician may request an Advanced Practice Provider (APP) who has been granted privileges as an Advanced Practice Provider at Parkview Hospital to visit hospitalized patients of the Sponsoring physician in place of the physician. Advanced Practice Providers at Parkview Ortho Hospital is defined as an APP credentialed at Parkview Hospital in one of the following categories: Advanced Practice Nurses (NP) Physician Assistant-Certified (PA-C).

1. Request for substitute visit in place of the physician daily visit may not be appropriate in all circumstances, and such requests must include guidelines for medical practice to be considered. Other requests for substitute visit will be reviewed by Officers as they are identified, for consideration of approval to request these privileges.
2. The attending/sponsoring physician must visit the patient at a minimum of every other day and is responsible for the initial visit and admitting History and Physical examination.
3. This privilege must be requested by both the sponsoring physician and the APP by completing the applicable section of the APP privilege form.
4. The attending/sponsoring physician must attest to the competency of the applicant to visit the patient within their scope of practice and privileges.
5. All requests are subject to review by the applicable specialty representative for appropriateness and suitability to the specialty and patient need. Upon recommendation by the specialty representative, the request is to be forwarded for review by the Credentials Committee and Medical Staff Executive Committee and approval by the Board of Directors.

E. EPIC Training

Purpose is to advance proficiency in navigating the electronic medical record in the EPIC system, the Parkview Hospital Medical Staff has established the following training requirements:

1. To be issued a user name and password and have the ability to practice as a member of the Medical Staff at Parkview Hospital (including its locations at any of the following: Parkview Hospital Randallia, Parkview Regional Medical Center and Parkview Behavioral Health), a minimum of ten (10) hours of classroom training in inpatient EPIC training is required prior to initial EPIC implementation date.
2. To the extent that it is determined that a Medical Staff member needs to devote additional time to navigating the electronic medical record for either the inpatient EPIC training or the physician office EPIC training, then the Medical Staff member shall devote such additional time to education as is required for the Medical Staff member to demonstrate proficiency and to ensure competent operation within the EPIC system.

III. SPECIALTY-SPECIFIC INFORMATION

A. Anesthesia:

The Clinical Advisor for Anesthesia Services shall have overall administrative responsibility for the services. provided and the quality of anesthesia care rendered by the anesthesia providers anywhere in the Hospital. He/she shall be responsible for the development of policies relative to the functioning of the anesthesia providers in the various units. He/she shall report to the various Medical Staff Committees including the Quality Resource Management Committee and the Medical Executive Committee.

Responsibilities of each Anesthesiologist:

1. Anesthesiologists, or CRNAs under the supervision of an anesthesiologist as described in the CRNA privilege form, should routinely:

- Make pre-anesthetic evaluations and write a pre-anesthetic summary that shall include examination of patients to determine the degree of surgical risk, type of anesthesia to be administered, known drug allergies, and an evaluation of the patient's physical status, labs, and pre-operative sedation.
- Utilize pre-anesthesia orders on their surgical patients, unless otherwise ordered by the anesthesiologist. The pre-anesthesia orders will be placed on all surgical charts, initiated as a protocol as authorized by Anesthesia, and completed by Nursing. The pre-anesthesia orders will be signed by the individual within 48 hours.
- Advise and consult with attending physicians regarding the patients' general condition and risk involved.
- Utilize monitoring equipment as per ASA standards, administer anesthetic in a manner prescribed by general medical standards, and help positioning of patient as surgical procedures mandate.
- Observe anesthetized patient for adverse reactions and initiate remedial measures.
- Maintain record of anesthetic administered, record condition of patient prior to and throughout peri-operative period, order immediate post-anesthetic medications, record condition of patient in the Recovery Room.
- Be physically present for the entire peri-anesthetic period except in the most unusual circumstances, for surgical procedures where anesthesiology services are utilized.
- Remain in the PACU in attendance of the patient until the patient is ready for transfer to the care of the recovery room nurses and shall give a verbal report to the nurse. When the admitting or attending physician or surgeon is not immediately available, the anesthesiologist/CRNA team will undertake the care of the patient (in the interim) until the attending (primary) physician can be notified and can assume the care of his/her patient.
- Manage and treat anesthesia-related complications of which they are aware, or which are reported to them. All other complications are the responsibility of the attending physician.
- Be consulted by PACU nurses before analgesic or sedative drugs are administered to patients recovering from anesthesia.

2. All inpatients to whom anesthesia care have been administered from the PACU may be discharged by nursing to the floors, using the criteria established by Anesthesia or upon order of the anesthesiologist/CRNA, or surgeon. Outpatients may be discharged using these same criteria. Endotracheal tubes may be removed by Recovery Room nursing staff when Anesthesia criteria are met or when so ordered by the anesthesiologist or CRNA.

3. A mutual understanding should exist between the primary surgeon and anesthesiologist/CRNA regarding appropriate timing of patient induction. This understanding may be implied based on standard practice or may be specific to a given case as related through operating personnel. If uncertainty exists, it is essential that the surgeon and anesthesiologist/CRNA interact directly.

B. Diagnostic Imaging/Radiology

Diagnostic Imaging services shall be available to meet the needs of patients referred by the Medical Staff. Radiologists shall be available for consultation and interpretation in person or telecommunication 24 hours per day, 7 days per week and shall respond promptly to requests for emergency services. All requests for imaging services shall contain adequate medical reason for the procedure ordered. All imaging procedures shall have a written interpretation and shall be produced in a prompt and orderly fashion by a physician**.**

Requests for multiple imaging services shall be scheduled by the Radiologist in the appropriate sequence to assure proper patient care without unnecessary delay.

Requests for invasive procedures (i.e. angiography, biopsy, drainage) shall be accompanied by appropriate consultation between referring physician and performing physician. Reports of consultations and interpretation of procedures shall be included in the patient's medical records. Documentation of appropriate laboratory values and/or medications shall be available prior to the performance of the imaging procedure. Consent forms shall be completed for indicated procedures.

The parental administration of iodinated contrast or radionuclide in the Department shall require:

A. Approval of a Radiologist and the presence of a supervising physician in the hospital.
B. Completion of consent forms when indicated.

C. Emergency

At all times a privileged and licensed physician will be immediately available to respond to cardiopulmonary arrests, other emergent circumstances, and either the physician and/or orthopaedist on call shall assess requests for transfer from other hospitals requiring the services available within the capacity and capability of the hospital. *Please refer to Section I. A - EMTALA*

D. Pathology

Pathology is under the direction of the Pathologist-Director. As such, he/she is responsible for the department's operation, including quality control, test result accuracy and professional standards of the personnel. He/she is responsible for the maintenance of standards established by the College of American Pathologists, Joint Commission, and State Board of Health.

The Pathology Department will bring forth recommendations on a regular basis regarding Transfusion practice and policy, Criteria for Autopsy, and Gross Tissue Exemption list for review and recommendation of the Medical Executive Committee. ***Please refer to Addenda accompanying these rules and regulations.***

The laboratory encourages preadmission testing. All patients are encouraged to report to a laboratory at least 24 hours prior to admission.

Since autopsies are the basis for quality assurance, physicians are encouraged to obtain and attend autopsies. *If physicians have special requests, please either document on the Autopsy Request form or contact the Pathologist.*

Therapeutic drug monitoring is encouraged. All stat requests should be justified. Unnecessary stat tests are to be discouraged.

Physicians are encouraged to consult directly with the pathologists if an abnormal test result is questioned.

1. **SPECIMEN HANDLING:** *Refer to Addendum A: Tissue Exempt List & Gross Only List*

All specimens sent to the laboratory should be properly labeled individually and accompanied by a requisition form. Information required for a proper label consists of patient name, hospital number, room number and attending physician's name. Improperly labeled specimens will not be accepted. The names of consult-physicians who need a report should appear on the requisition form. In doing this, the patient's safety will not be jeopardized in any way.

The Parkview Health laboratory, per contract, will perform all tests requested. If certain tests are not available, the pathologist will determine the reference laboratory using the list approved by MEC. Requests for special handling or special tests should be addressed to the pathologist. ("Split sample" tests are considered in the latter category and after consultation with the pathologist should be sent to the laboratory for "splitting.")

The surgical request slip accompanying the tissue specimen should be completely filled out, especially the information regarding previous surgery, preoperative diagnosis and findings.

All tissues, foreign bodies, calculi, etc., removed at operation shall be sent to the hospital pathologist, who shall make such examination as he/she may consider necessary to arrive at a pathologic diagnosis, and record same on the patient record. The surgeon shall have the discretion to recommend that "no microscopic examination be performed" noted on the specimen. In the clinical lab we acknowledge that the physician may request not to have the written consultation or interpretation associated with the test. If the physician so wishes, the written consultation or interpretation will be forgone.

E. Podiatry

The scope and extent of surgical procedures performed by podiatrists shall be specifically delineated and granted in the same manner as all other surgical privileges. All podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician member of the Medical Staff shall be responsible for the admission of any patient under the care of a podiatrist. A physician member of the Medical Staff may be responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization.

F. Psychiatry

POH has provisions for the acceptance of Psychiatrists on its medical staff.

Procedure Statement:

1. Any patient, who in the opinion of the evaluating physician, is actively dangerous to himself or others, will be transferred to a psychiatric facility as soon as possible.

2. Admission for psychiatric illness, alcoholism or chemical dependency is treated at the facility only until his/her medical condition, within the scope of services of POH, has been stabilized.

3. It is the responsibility of the attending physician to evaluate the patient and refer him/her to the facility/service which will meet his/her immediate needs.

4. If a patient presents primary or secondary mental illness or chemical dependency during hospitalization, a psychiatric or chemical dependency evaluation is recommended.

5. When the physical condition improves and psychiatric treatment is necessary, admission to a psychiatric facility/service should be initiated.

G. Surgery

No one shall be permitted to observe or work in the operating rooms beyond the retracting doors unless properly garbed with cap, mask, gown or special shirt and trousers, and operative shoes or shoes with shoe covers, most of which are provided by the hospital. Guests are to be authorized via Medical Staff Services *(Reference: Guests of Medical Staff Policy)*.

In all cases of major operation, it shall be the decision of the surgeon as to whether a physician assistant should be used. No operative procedure shall be done in this hospital which does not conform with the general staff rules.
A physician declaring a life- or limb-threatening emergency will be given priority for assignment of an operating room and anesthesia.

Scheduled operations that are not started on time without good reason may be canceled by the operating room supervisor, if in his/her opinion the delay would seriously interfere with completion of the remaining cases for the day. In cases where there is unavoidable delay in meeting a scheduled operation, the individual responsible for that delay is also responsible for notifying all parties involved.

All elective surgery patients requiring moderate sedation, major block (epidural, spinal or arm, etc.) or general anesthesia, shall show on the record the routine lab work in the current protocol unless otherwise ordered by the physician.

ADDENDUM A

TISSUE EXEMPT & GROSS ONLY LISTS

Tissue Exempt List

All tissues, foreign bodies, calculi, etc., removed during an operation shall be sent to the hospital pathologist, who will make such examination as he/she considers necessary to arrive at a pathologic diagnosis, and record same on the patient record. The follow are exemptions, but may be sent to the Pathologist at the discretion of the surgeon:

- Tissue from hand and foot surgery (including ganglion cysts, synovial cysts, and bone fragments from LRTI's).
- Orthopedic hardware and appliances
- Toenails and fingernails
- Finely fragmented bone or meniscus
- Femoral heads removed for degenerative joint disease, except for fracture
- Bone submitted to the bone bank
- All bone or soft tissue removed as part of any corrective or reconstructive procedures (ex: total joints, spinal surgery, soft tissue repair – open or arthroscopic)

ADDENDUM C

CRITERIA FOR AUTOPSY

INTRODUCTION: These criteria include but are not limited to the following:

1. Unanticipated death
2. Death occurring while the patient is being treated under a new therapeutic trial regimen
3. Intraoperative or intraprocedural death
4. Death occurring within 48 hours after surgery or an invasive diagnostic procedure
5. Death where the cause is sufficiently obscure to delay completion of the death certificate
6. Deaths with genetic implications

RESULT REPORTING:

A provisional autopsy report will be signed out within 72 hours from the time the autopsy procedure is completed. A routine Final autopsy report will be out in 30 days. A non-routine final autopsy report will be out in 60 days. Final reports sent out with any found errors are documented, corrected and an amended report is sent out to areas, which received the initial report.

When ordering an autopsy, clinicians are urged to provide as much information as possible on the areas in which they wish the pathologist to focus his/her exam.