



MEDICAL STAFF RULES AND REGULATIONS OF LAKEVIEW SURGERY CENTER, L.C.

I. ADMISSION, DISCHARGE, & TRANSFER RESPONSIBILITIES

1.1 ADMISSION

A patient may be admitted to LSC by a Member of the Medical Staff with appropriate privileges, and shall be the responsibility of that physician until the patient is transferred to another facility, physician or discharged. This physician shall be referred to as the attending physician.

No patient shall be admitted to the LSC until a supporting provisional diagnosis or valid reason for admission has been stated.

1.2 PATIENT TRANSFERS

A patient may be transferred to another facility for hospitalization or for further care if requested by the patient, and if the practitioner who will receive the patient and assume responsibility is determined to be available and concurs in the judgment to transfer the patient.

A patient may be transferred to a hospital or other care facility if its services for the care of the patient are more appropriate for the patient and if the attending Practitioner concurs and feels that the transfer does not involve an unwarranted risk.

A patient may be transferred to another Staff Member, if the other Staff Member is available and concurs to accept responsibility.

The attending physician will be required to write a note regarding the condition of the patient at transfer. The physician note will accompany the patient to the receiving facility or physician.

1.3 PROTECTION FROM HARM

The attending practitioner shall be responsible for providing such information as may be necessary to protect his/her patient from self harm, and to assure the protection of others whenever the patient may be a source of danger for any cause.

1.4 COMPLIANCE WITH QUALITY MANAGEMENT PROGRAM

The attending Practitioner shall comply with the Utilization Review Plan and the Quality Management Program.

1.5 DISCHARGE OF PATIENTS

A patient shall be discharged only on a written order of the attending practitioner, in compliance with the LSC discharge policy. Should a patient leave the LSC against the advice of the attending practitioner a notation of the incident shall be made in the patient's medical record.

1.6 PATIENT DEATH

In the event of a LSC death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a Member of the Medical Staff. Policies with respect to the release of decedent's remains shall conform to state law.

All H&Ps from the primary care physician need to be reviewed by the attending surgeon. Any abnormal findings or special instructions should be addressed **by the attending to the patient** in a timely manner prior to the surgery. This is not a LSC responsibility because LSC does not call patients until 24-48 hours before surgery. Example: If the primary care physician states on the H&P that the patient needs to stop his Coumadin 5 days prior to surgery, the LSC staff won't discover this until 24-48 hours before the scheduled surgery when LSC calls the patient for his/her assessment.

If a patient is readmitted for treatment of the same or related problem within 30 days following discharge from the LSC, the previous history and physical must be updated to reflect any subsequent changes.

When the history and physical examination are not recorded before an operation (or any potentially hazardous diagnostic procedure) the operation or procedure shall be re-scheduled unless the attending practitioner states **in writing** that such delay would be detrimental to the patient and makes a notation on the chart indicating the physical condition of the patient.

Patients over 300 pounds need to be approved by the department of anesthesia on a case-by-case basis. The LSC will contact anesthesia for clearance after completing the patient assessment call.

2.3 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

2.4 OPERATIVE NOTES

Operative reports shall include indications for surgery, a detailed account of the findings at surgery as well as the details of the surgical technique. A comprehensive operative report shall be dictated within 72 hours following surgery and signed by the surgeon and made a part of the patient's current medical record within 30 days. The operating physician, to bridge the time gap until the report is typed, shall place a brief handwritten operative note in the progress record at the time of surgery. Any complications will be documented on the operative note. Any practitioner with un-dictated operative reports 72 hours following the day of the operation(s) shall be automatically suspended for operative privileges until the dictation is completed.

2.5 CONSULTATIVE REPORTS

Consultation reports shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record.

When operative procedures are involved, the consultative note shall, except in emergency situations be recorded prior to the operation.

2.6 DATE AND AUTHENTICATION

All clinical entries in the patient's medical record shall be accurately dated and authenticated. Electronic signatures through clinical computer systems are acceptable as authentication of the report.

2.7 FINAL DIAGNOSIS

Final diagnosis shall be recorded in terms of Standard Nomenclature in full, without the use of symbols or abbreviations, and dated and signed by the responsible Practitioner at the time of discharge of all patients.

2.8 RELEASE OF MEDICAL INFORMATION

Written consent of the patient or authorized representative of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

2.9 REMOVAL OF RECORDS

Records may be removed from the LSC jurisdiction and safekeeping only in accordance with a court order, subpoena, statute, or the patient's written consent. All records are the property of the LSC and shall not otherwise be taken away without permission of the Administrator or his/her designee. In case of readmission of a patient, all previous medical records shall be available for use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the LSC is grounds for suspension of the Practitioner for a period to be determined by the Medical Executive Committee.

2.10 RECORDS FOR STUDY AND RESEARCH

Medical records of all patients shall be available to Members of the Medical Staff for bonafide study and research upon approval of the Medical Executive Committee consistent with preserving the confidentiality of personal and medical information concerning the patient. Subject to the discretion of the Administrator, former members of the LSC shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the LSC. Any study or research documents for presentation must be submitted for prior review and approval to the LSC Governing Board.

2.11 INCOMPLETE MEDICAL RECORD PROCEDURE

Physicians are notified of all incomplete records at twenty-one days (21). Charts that remain incomplete become delinquent thirty days (30) after the date treatment was provided whereupon automatic suspension of operative privileges will be invoked. Vacations and illness will be considered exceptions to the above policy. If LSC is notified, the age of the record will be adjusted for the amount of time the physician was unavailable.

II. GENERAL CONDUCT OF CARE

3.1 CONSENT FORM

A general consent form, signed by or on behalf of each patient admitted to the LSC, must be obtained at the time of admission. It shall be the attending practitioner's obligation to obtain proper consent before a patient is treated in the LSC. The admitting nurse will notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the attending practitioner's obligation to obtain proper consent before the patient is treated. A specific consent form that informs the patient of the risks inherent in any special treatment or surgical procedure shall be obtained. Should a second operation be required during the patient's stay in the LSC, a second consent form shall be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they shall all be described and consented to on the same form.

3.2 TREATMENT ORDERS

All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to a duly authorized licensed registered nurse and reviewed and signed by the responsible practitioner. All orders dictated over the telephone shall be signed by the appropriately authorized person who took the dictation and will include the name of the practitioner giving the orders. The responsible practitioner shall authenticate such orders and failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action.

A Practitioner's orders must be written clearly, legibly and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse. The use of "renew," "repeat," or "continue orders," is not acceptable.

All drugs and medications administered to patients shall be those listed in the latest edition of LSC Formulary.

A sample specimen of all pathological tissue removed during surgery shall be sent to the LSC's contracted pathologist who shall make such examination, as he/she may consider necessary to arrive at a pathological diagnosis. Identification, including pertinent information relative to the case, shall accompany the specimen. The Pathologist's report shall be made a part of the patient's medical record.

* **Exemptions from the above rule are limited to:**

1. Benign bone; skin; muscle; fat; or tissue that is not customarily sent to pathology for evaluation.

Examples of which include:

- a. Toenails
- b. Teeth
- c. Scar tissue / Redundant tissue
- d. Nasal Septal Cartilage
- e. Tonsils and adenoids at surgeon's discretion
- f. Vas deferens tissue at the surgeon's discretion following vasectomy.

2. Appliances or hardware

IV. CONSULTATIONS

4.1 THE RIGHT TO REQUEST A CONSULT

The right to added professional opinion is not only that of the attending Practitioner, but is the patient's privilege. It is the duty of the Medical Staff, through its Medical Executive Committee to insure that a practitioner seeks consultation when indicated.

If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of the Executive / Clinical Director or Medical Director. If warranted, the Executive/ Clinical Director or Medical Director may bring the matter to the attention of the practitioner involved.

4.2 QUALIFIED CONSULTANTS

The attending Practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He/she shall contact the Consultant and brief him/her on the problem involved and shall provide written authorization to permit another attending Practitioner to attend or examine his/her patient, except in an emergency.

Any qualified Practitioner with clinical privileges in the LSC may be called for consultation within his/her area of expertise.

The consultant must be qualified to give an opinion in the service in which it is sought. This should require evidence of special training and experience in this service. The consultant's findings and opinion shall be recorded, signed and become a part of the medical record.

V. SCHEDULING OF SURGICAL CASES

5.1 HOW TO SCHEDULE

The LSC surgeon or their staff will schedule patients with the LSC scheduling personnel.

LSC surgeons will be assigned surgical time blocks by the LSC scheduler and the LSC Clinical Director.

Patients requiring chest x-rays, blood tests not available at LSC, or pre-anesthetic medical evaluation by a family physician, internist, pediatrician or cardiologist will have arrangements made prior to the date of surgery by the LSC surgeon's office. These reports should be returned (faxed) to the surgeon's office and LSC. so the abnormal findings or special instructions need to be addressed by the attending physician to the patient in a timely manner. LSC personnel will coordinate retrieval of this information so that it is available to the anesthesiologist and surgeon on the day of surgery.

5.2 SCHEDULING TIMES

Surgery start time (anesthesia start) is 7:00am on all regular/scheduled days. Anesthesia induction and patient preparation will be initiated accordingly. **Surgeries must be completed by 5:00 – 5:30 pm. or at the discretion on the Medical Director and the Clinical Director.**

VI. PRACTITONER CONCERNS OR GRIEVANCES

LSC Medical Staff Members should contact the LSC Medical Director, LSC Administrator, LSC Clinical Director or Medical Executive Committee Designee for resolution.