MEDICAL STAFF RULES & REGULATIONS
SAN ANTONIO REGIONAL HOSPITAL

Approved by the Board of Trustees
April 5, 2022

The following articles included in this issue have been revised since the last edition dated October 1, 2019:

Medical Staff General Rules & Regulations:

- Section H, Radiology Department

Medical Staff Department Rules & Regulations:

- Section E-2, Gastroenterology Division

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I. GENERAL RULES AND REGULATIONS

A. Admission

1. All patients must be admitted and discharged by a Member of the Medical Staff.
2. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In the case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible. Physicians admitting the patient shall be held responsible for giving such information as may be necessary to assure the protection of the patient and others.
3. The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient. A discharge summary is required in all inpatient cases. The final and/or discharge diagnosis shall be recorded on the chart at the time of discharge unless pathological and/or laboratory reports are pending, but no later than fourteen (14) days after discharge (Title 22 requirements). There shall be a clinical summary of the chart of any patient who expires. All information contained in the record is the property of the Hospital. The records shall not be removed from the Hospital unless required by a court order, subpoena or statute. Contents of the discharge summary shall be as follows:
    - Admission Date
    - Discharge Date
    - Admission Information
    - Admission Diagnosis
    - Discharge Diagnosis
    - Brief History of Physical Illness
    - Hospital Course
        - Significant Findings
        - Diagnostic Data
        - Procedures and Treatment Provided
    - Physical Exam
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    - Discharge Medications
        - Home
        - Prescription
    - Discharge Plan/Recommendations
    - Patient Discharge Condition
        - Discharge Disposition
        - Pending Test Results/Studies
4. <u>Contents of an History and Physical</u>
   A complete history and physical examination shall be recorded in all cases within twenty-four (24) hours after admission, except for patients admitted in labor. Patients re-admitted thirty (30) days after discharge must have an interval history and a complete current physical examination.

   For all inpatients, observation patients, and for those outpatients having procedures requiring general, spinal or epidural anesthesia, or IV moderate sedation, the history and physical must include the following documentation as appropriate. The history and physical must be completed by a physician Member of the Medical Staff.
    - Medical History
    - Chief Complaint

- History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status
- Relevant past medical, family and/or social history appropriate to the patient's age
- Review of body systems
- A list of current medications
- Any known allergies including past medication reactions and biological allergies
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- Initial plan; statement of the course of action planned for the patient while in the hospital
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- Physical
    - General to include vital signs
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    - Cardio Pulmonary
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- Diagnostic data
- Impressions or Admitting
    - Diagnosis Specificity
- Admission Qualification

<u>Obstetrical History and Physical</u>
The admission history and physical for all routine obstetrical patients must be completed on the obstetrical admission physical examination form or a complete history and physical must be dictated. All patients undergoing cesarean section or post-partum tubal sterilization procedures must have a complete history and physical examination recorded.

<u>Podiatry and Oral/Maxillofacial History and Physicals</u>
Podiatrists and Oral/Maxillofacial Surgeons may perform a history and physical on all their pre-operative patients provided that cases where the patient is ASAIII (American Society of Anesthesiologists Classification System) or higher, a concomitant consultation from an MD or DO (primary care or specialist) is on the chart prior to surgery.

<u>Radiology History and Physical</u>
The following radiology procedures require a history and physical prior to the procedure:

- Percutaneous nephrostomy
- Percutaneous biliary drainage
- Angioplasty and stent placement
- Vena Cava Filter insertion
- Thrombolytic therapy and de-clotting procedures

- Arterial embolization procedures
- Any procedure which is done with conscious sedation

Outpatients undergoing these procedures will receive a history and physical by the Radiologist with completion of the Outpatient Services History and Physical form. Inpatients can have these procedures done without an additional dictated or written history and physical by the Radiologist, except when there has been a significant change in the patient's condition since admission.

Pediatric patients undergoing these procedures will be admitted to Pediatrics and the history and physical is performed by the attending physician.

5. All hospitalized patients must be seen daily by a physician Member of the Medical staff, who shall document a progress note (preferably electronically in SAM) including date and time for written progress notes in the patient's chart no later than midnight of the day the patient was seen. For surgical patients, the surgeon who operated on the patient (or one with similar privileges) will follow the patient for post-operative care until the patient is surgically stable and the surgeon signs off the case. Progress notes shall include the following:
    - Date and Time
    - SOAP/APSO Note
    - Diagnosis Specificity
    - Progression of Care
    - Level of Care
    - Diagnostic Data
6. Outpatient Observation Stay (OOS) patients will be seen within eighteen (18) hours or less of admission by a physician Member of the Medical Staff.

B. Admission to Critical Care (ICU/CCU)

All patients admitted from the Emergency Department should be seen by a physician within two (2) hours of being admitted to any intensive care unit.

C. In-Hospital Orders

1. All orders shall be entered by physicians directly into SAM using computerized physician order entry (CPOE). Verbal orders will be permitted only in rare circumstances such as medical emergencies. Telephone orders will be permitted when physicians are outside of the Hospital, and in emergent situations. Verbal and telephone orders other than for drugs may be accepted by any licensed, registered, or nationally certified health professional provided that the orders received relate to the licensed, certified, or registered area of competence of the individual, such as: Audiologists, Cardiopulmonary/Pulmonary Technologists/Technicians, Dietitians, Laboratory Technologists, Occupational Therapists, Orthopedic Technologists, Physical Therapists, Radiological Technologists, Respiratory Technologists, Respiratory Therapists, and Speech Pathologists. Telephone and verbal orders for administration of medications may be received and recorded by licensed health professionals who are expressly authorized under their practice acts to receive orders to administer drugs. This includes Registered Nurses, Licensed Vocation Nurses, Pharmacists, Physical Therapists (for certain topical drugs), and Respiratory Therapists when the order relates specifically to respiratory therapy. These professionals will enter such orders into SAM immediately upon receiving them. The responsible physician shall authenticate all unsigned telephone/verbal orders within forty-eight (48) hours.

2. All medication orders must be reviewed, renewed, changed, and/or discontinued at least every thirty (30) days. Automatic stop orders prior to thirty (30) days may be established for classes of drugs and/or individual drug entities. These automatic stop orders are determined by a collaborative effort of the Medication Functional Team and the Pharmacy and Therapeutics Committee, with approval of the recommendations by the Medical Executive Committee. A prescriber's medication order for a specific duration of drug therapy supersedes automatic stop orders. Medication orders shall not be discontinued without notifying the physician. If the order expires during the night, the expiration shall be called to the attention of the physician the following morning.
3. Verbal, telephone, faxed and protocol orders will be sent to the physician's Message Center (inbox) for signature. Physicians may designate a proxy to sign their orders (i.e., during vacation or weekend call).
4. Experimental or investigational drugs may be used only by physicians approved by the Institutional Review Board.

D. Surgical Patients

1. When the history and physical examination are not recorded on the chart before the time of the preoperative medication, the operation shall be postponed unless the attending surgeon:
    - Completes the required history and physical, including preoperative diagnosis and operative procedure.
    - The history and physical examination or an interval history and physical examination shall be performed and recorded within twenty-four (24) hours prior to surgery (Title 22) and before the preoperative medication is given.
2. Minimum requirements for preoperative testing on both ambulatory and inpatient surgery patients undergoing general, spinal or epidural anesthesia are as follows:
    - Hemoglobin and Hematocrit or CBC within seven (7) days prior to surgery (females eleven (11) years of age and over, males sixty (60) years of age and over).
    - Serum Potassium within seven (7) days prior to surgery for patients on diuretics.
    - Serum Glucose or Accucheck immediately prior to surgery, and prior to discharge for diabetics.
    - EKG within three (3) months prior to surgery (females fifty (50) years of age and over, males forty-five (45) years of age and over).
    - Additional elective laboratory testing may be ordered at the discretion of the physician and as long as the minimum requirements are met; it need not be restricted to the seventy-two (72) hour time frame.
    - Pre-op chest x-rays are required for those patients who are over sixty (60) years of age and/or have a history of pulmonary disease. This requirement can be omitted for those patients that have had a chest x-ray that is normal for their age in the last six (6) months.
3. Results of these tests should be recorded on the chart before the pre-op medication is given.
4. If the above criteria are not met, the operation shall be postponed unless the surgeon states in writing that such delay would be detrimental to the patient.
5. The only exception to the above is a Category I emergency situation.
6. Prior to any cancer surgery based on a diagnosis from outside of this Hospital, the slides and pathology report will be reviewed at the discretion of the surgeon.
7. For patients less than forty (40) years of age, with American Society of Anesthesiologists – ASA-1, the pre-operative laboratory testing requirements are omitted.
8. These requirements can be waived at the surgeon's discretion for patients having procedures with local anesthesia and/or outpatient surgeries.
9. Upon completion of a surgery or a high risk procedure and before the patient is transferred to the next level of care (i.e. before the patient is transferred out of the PACU), either a full Operative Report or

an Immediate Postop Note is recorded in the Electronic Medical Record system (Cerner). If an Immediate Postop Note is recorded upon completion of a surgery or procedure, an Operative Report shall be recorded by the attending surgeon within twenty-four (24) hours after surgery.

Contents of the Immediate Postop Note shall be as follows:

- Date and time of Surgery
- Surgeon name
- Preoperative Diagnosis
- Postoperative Diagnosis
- Anesthesia
- Name of Operation/Procedure
- Estimated blood loss
- Specimen(s) removed
- Surgical packing
- Findings

Contents of the operative report shall be as follows:

- Date and time of Surgery
- Surgeon name
- Surgical Assistant (if applicable)
- Preoperative Diagnosis
- Postoperative Diagnosis
- Preoperative Condition
- Postoperative Condition
- Anesthesia
- Anesthesiologist
- Name of Operation/Procedure
- Procedure/Technique Description
- Description of Surgical Site Infection, if present
- Estimated blood loss
- Specimen(s) removed
- Surgical packing
- Findings
- Complications
- Level of Care

10. A post-anesthesia evaluation must be completed and documented by anesthesia no later than 48-hours after surgery or a procedure requiring anesthesia services.
11. All tissue removed during surgical procedures, endoscopic procedures and obstetrical procedures shall be sent to the pathology laboratory for examination. Exceptions for San Antonio Regional Hospital have been granted by the Department of Health Services for the following: intrauterine device, first ribs, prepuce of newborn.
12. The Medical Staff has defined procedures requiring Informed Consent as follows:
    - All procedures performed in the Operating Room, Heart Catheterization Lab, Endoscopic Lab, invasive procedures done in Radiology, and Labor and Delivery Operating Room Suite.

- All procedures requiring the use of anesthesia; i.e., moderate (conscious) sedation or deep sedation.
- Transfusions of blood or blood products.

E. Patients with Infectious Diseases

In all patients with contagious disease, proper isolation techniques must be used. These diseases include: chickenpox, rubella (German measles), rubeola (measles), mumps, whooping cough, possible active tuberculosis, typhoid, infectious hepatitis, meningococcal infections, meningitis, encephalitis, poliomyelitis, herpes zoster, AIDS, and staphylococcal aureus coagulase positive infections.

F. Consultations

1. The patient's physician is responsible for securing prompt consultations when indicated for medical and behavioral medicine needs. It is the responsibility of the physician (including a specialist who wishes to obtain a consultation from the primary care physician) who is requesting consultation, to select the appropriate consultant and to contact the consultant personally. Physicians should inform the consultant of the reason why consultation is needed and the level of urgency. The request for consultation from any physician and need for consultation must be documented in the patient's medical record.
2. A surgical consultation is required prior to surgery, except in emergencies, when the surgeon is not the attending physician.
3. Consultations shall be performed within twenty-four (24) hours of the request, or sooner, as appropriate to the patient's condition. Consultation notes shall include the following:
    - Consultation Date
    - Referring Physician
    - Reason for Consult
    - History Present Illness
    - Review of System
    - Past History
    - Social History
    - Family History
    - Diagnostic Data
    - Recommendation
    - Diagnosis Specificity
    - Medications
    - Physical Exam
    - Assessment and Plan

G. Discharge of Patients

Patients shall be discharged only on order of the attending physician.

When a patient leaves the Hospital against the advice of the attending physician, or refuses treatment recommended by the attending physician, the patient shall be requested to sign a statement releasing the physician and the Hospital from any responsibility. An explanatory note shall be made on the chart and that notation witnessed by a third party.

H. Autopsies

Autopsy is recommended in the following circumstances:

- Unanticipated death.
- Death occurring within forty-eight (48) hours of surgery or invasive diagnostic procedure.
- Death incident related to pregnancy or within seven (7) days of pregnancy.
- Deaths where the cause is sufficiently obscure to delay completion of the death certificate.
- Deaths, which qualify as a Coroner's case, but jurisdiction is not accepted by the Coroner.

The physician will secure consent from the family or surrogate to perform an autopsy and document in the medical record. When an autopsy is refused by the next of kin documentation in the patient chart is recommended. The Pathologist will notify the attending physician when an autopsy is to be performed.

I. Chain of Command

In situations involving concerns with the management of a patient, a lack of timely response to the emergency department or other patient care areas, or other situations requiring the assistance of a Medical Staff officer, the following sequence of command shall be followed:

- Division Chairman, if applicable
- Chairman of Department
- Vice Chairman of Department
- President of the Medical Staff
- President-Elect
- Immediate Past President
- President of the Hospital or designee

J. Practitioner Back-up Coverage

All staff members who are granted clinical privileges are required to provide and regularly update names of one or more designated back-up practitioners who have comparable clinical privileges and are willing to provide back-up in case a practitioner cannot be reached by any department of the Hospital. Exceptions to this requirement include Surgical Assistants, Allied Health Professionals and contracted in-house groups (i.e., Anesthesia, Pathology, Radiology and Emergency Medicine). This list of back-up practitioners will be made available to all nursing units and departments including the Emergency Department. This list will be utilized to try to contact the designated back-up practitioner when a particular practitioner cannot be reached. This procedure may be utilized prior to invoking the "Chain of Command" outlined in Section I.

K. EMTALA Requirements

1. Medical Screening Examinations and Disposition of Patients
    a. All persons presenting at the Hospital for emergency medical services shall receive appropriate medical screening and stabilizing treatment in compliance with State and Federal laws pursuant to the Emergency Department policy "Medical Screening of Patients Seeking Emergency Care; Transfer of Patients with Emergency Medical Conditions". This may include admission to the Hospital and delivery of obstetrical patients.
    b. Medical screening examinations in the Emergency Department will be conducted by qualified physicians or other authorized personnel (See Nurse Practitioner/Urgent Care Clinic Standardized Procedure). Patients who are eighteen (18) weeks gestation or greater and have a pregnancy related complaint will be transported to the Labor and Delivery department for

medical screening and any necessary stabilizing treatment. When a medical screening is conducted in the Labor and Delivery department, it may be conducted by nursing professionals who meet the qualifications set forth in "Labor and Delivery EMTALA Compliance Policy".

c. No medical screening or stabilizing treatment is to be delayed in any way to inquire about the insurance status of a patient or to inquire whether the patient is able to pay for such services.
d. Medical screening examinations shall include a physical examination of potentially affected systems, as well as any available testing necessary to rule out the presence of an "emergency medical condition" as defined in the Emergency Department policy "Medical Screening of Patients Seeking Emergency Care; Transfer of Patients with Emergency Medical Conditions". When appropriate, medical screening shall include consultation with specialty physicians.
e. The contents of a medical screening examination for obstetrical patients are specified in the labor and delivery "EMTALA Compliance Policy".
    - If maternal and fetal status is determined to be stable and true labor cannot be established, the obstetrician responsible for the patient may discharge the patient. The obstetrician is responsible for certifying the patient's false labor on the OB Observation Record within twenty-four (24) hours.
    - Patients who are having contractions and have not yet delivered may only be discharged after an obstetrician has determined that the patient is stable for discharge. Stable for discharge means that within reasonable clinical confidence, the patient has reached the point where her continued care, including diagnostic work-up and/or treatment could be performed as an outpatient or later as an inpatient. Before discharging the patient, the Obstetrician must provide a plan for appropriate follow-up care with discharge instructions.

2. Transfers or Discharges of Patients
    a. All transfers and discharges of patients with an "emergency medical condition" from the Emergency Department must be in compliance with the Emergency Department policy "Medical Screening of Patients Seeking Emergency Care; Transfer of Patients with Emergency Medical Conditions, Inter-facility and Intra-facility Patient Transfers".
    b. No referral or transfer to other facilities shall be made from the Emergency Department without approval of the Emergency Department or attending physician.
    c. A patient may not be transferred if they have an "emergency medical condition" which is not stabilized unless:
        - The patient requests the transfer, or
        - A physician has determined that based upon the reasonable risks and benefits to the patient and upon the information available at the time, the medical benefits reasonably expected from the transfer outweigh the increased risk to the individual's medical condition. The physician making such a determination must complete the "Physician Assessment and Certification for Transfer" form and include a summary of the risks and benefits upon which certification is based. The patient should then be transferred with qualified personnel and with the necessary and medically appropriate transportation equipment and pertinent medical records in accordance with the Hospital policy referenced above.
3. Documentation
    a. Qualified professionals performing medical screening examinations shall document the results of their screening and testing if applicable and indicate whether the patient has an "emergency medical condition," and whether the patient has been stabilized or is stable. Particular attention should be given to evaluation of the patient's pain status, if applicable, with documentation addressing the patient's pain status on transfer or discharge.

b. The responsible obstetrician must evaluate the patient's written outpatient record within twenty-four (24) hours including any fetal monitoring strips obtained during a patient's observation period, sign the record and countersign any physician orders.

L. ER Back-up Responsibilities

1. Physicians serving on the ER back-up roster may be called to see patients who require their care in the Emergency Department or admission to the Hospital. All physicians on ER back-up call must respond within thirty (30) minutes to calls from the Emergency Department. The on-call physician must be physically present in the Emergency Department within thirty (30) minutes or as deemed appropriate by the Emergency Medicine physician or at the request of any other Medical Staff Member caring for the patient. In the case of a patient that requires admission to SARH, or transfer to another facility, the admitting/transferring physician must give orders within two (2) hours of this physician being notified about the case. The ER back-Up physician is also required to provide emergency services and/or consultation to hospitalized patients when requested to do so by another Member of the Medical Staff caring for the patient, the Department Chairman, or any other individual as listed in the chain of command identified in Section I.
2. A list of appropriate physicians will be provided to patients who can be discharged but need follow-up care.
3. When the patient does not have a personal physician, it will be the sole responsibility and authority of the attending Emergency Medicine Physician to determine the ER back-up physician to be called.
4. The Medical Executive Committee shall determine which Departments and Divisions will provide ER back-up. Any decision that affects the level of service available to the community shall be made in consultation with the Hospital administration and be subject to approval by the Board of Trustees.
5. Members of the Medical Staff under preceptoring shall not be included on the ER back-up roster until all core privilege preceptoring requirements are met.
6. ER call shall be considered mandatory for all physicians. If a Department can demonstrate it has adequate ER call coverage, the Department may submit a request for waiver of this requirement. The request for waiver must be in writing to the Medical Executive Committee for approval the Medical Executive Committee will not grant approval of a waiver without consulting with Hospital Administration to assure there will be no impact on ER call coverage or impact on other departments or services.
7. Physicians sixty (60) years of age or older may be exempted from the emergency call as long as adequate coverage continues to be provided in that specialty. Requests must be in writing to the appropriate department and Medical Executive Committee for exemption.
8. During term of office, the President of the Medical Staff may be excused from serving on the emergency back-up schedule if approved by the applicable Clinical Service Committee and the Medical Executive Committee.
9. Each ER call panel is to be comprised of physicians who have been granted privileges within that specialty. There is one call schedule and if the physician receives a call from the Emergency Department and they do not hold the privilege or it is out of their scope of care, it is their responsibility to find appropriate coverage. When an unassigned pediatric patient is presented to the Emergency Department, the Emergency Department will contact the on-call physician as follows:
    - Patients age zero (0) years – seventeen (17) years will be assigned to pediatrics; and

   Pediatric patients age five (5) years and above who require surgical intervention and have no medical condition which would require a pediatric consultation will be admitted by the surgeon. If the surgeon is uncomfortable with admitting the patient due to medical complications, a pediatric consultation can be obtained and the pediatrician can admit. If a conflict arises, the chain of command will be initiated.
10. Call Panels and Existing Physician Relationships

a. The Emergency Department will maintain a listing of on-call panels that may be comprised as follows:
    - Hospital Designated On-Call Panels (Hospital On-Call Panel) - which may include contracted and non-contracted on-call panels maintained by the Hospital;
    - Alternate On-Call Panels (Alternate On-Call Panel) - established by non-Hospital parties, where continuity of care is respected. Such panels must identify and include specialists and not solely rely on a Hospitalist to respond to requests for assistance from the Emergency Department and;
    - Designated Primary Care Coverage Arrangements – arrangements whereby a community primary care physician designates another primary care physician or Hospitalist who is a Member of the Hospital's Medical Staff with admitting privileges to care for their patients.

b. Patients presenting in the Emergency Department will be asked if they have an established relationship with a primary care physician on the staff at San Antonio Regional Hospital. Such physicians may be a specialist who has provided care to a patient for an extended period such that the patient identifies the physician as their principal physician (i.e., Cardiologist). These physicians are referred to herein as "Assigned Patient Physicians".

c. The determination as to whether an Emergency Department patient requires the services of all on-call panels or other physician rests solely with the Emergency Department physician caring for the Emergency Department patient in their sole discretion.

d. If a patient presents to the Emergency Department with need for immediate care by specialists, there is no discretion as to which physician or panel to call; the Hospital on-call panel will be called and engaged. The Hospital on-call panel physician must respond to the Emergency Department within thirty (30) minutes and be in the Emergency Department within thirty (30) minutes after being contacted by the Emergency Department or such other timing in the discretion of the Emergency Medicine physician caring for the patient. (Medical staff Rules and Regulations, Section I, L, ER Backup Responsibilities).

e. If a patient presents with an emergent condition, a condition that does not require immediate care, the Emergency Department physician may utilize an alternate on-call panel physician, a designated primary care coverage physician or an assigned patient physician. If these physicians do not respond within thirty (30) minutes their designated back-up physician will be called. If any of these alternative physicians are unavailable or do not respond as provided in the Medical Staff Rules and Regulations, in the sole discretion of the Emergency Medicine physician caring for the patient, the Hospital on-call panel physician shall be notified and must respond timely ("replacement Hospital on-call panel physician"). The replacement Hospital on-call panel physician shall become the designated on-call response physician for that patient and will provide care necessary to stabilize the patient's condition, even if the alternative panel physician arrives after the Hospital on-call panel has been engaged. In these cases, coverage by the Hospital on-call panel physician may continue through the entire inpatient stay if a safe transfer of care to an alternate on-call panel member cannot be accomplished. The determination of a safe transfer of care is in the sole discretion of the Hospital on-call panel physician.

f. Any physician requested to provide services to Emergency Department patients by Emergency Department physicians, whether the Emergency Department on-call panel physician or an alternative physician, must respond timely and must be involved in the case until the patient's condition is stabilized including the provision of treatment in the Emergency Department or as an inpatient. The requirements for the provision of care for contracted on-call physicians must be met in all cases including post discharge follow-up care, or care coordination, related to the admission as appropriate.

g. Failure to respond or provide care as provided in this policy is subject to Medical Staff and Hospital policies and procedures including the filing of a risk report in MIDAS, MPEC review and action as well as corrective action contained in agreements between the Hospital and the contracted on-call physicians.

11. Cardiology Division ER Backup Requirements
    a. The Cardiology backup roster is to be comprised of Active Staff Members with privileges for invasive procedures as follows:
        - Temporary Pacemaker Insertion
        - Intra-Aortic Balloon Pump Insertion
        - Cardiac Catheterization
        - Percutaneous Coronary Intervention
    b. Cardiologists must be available to respond within fifteen (15) minutes by phone and thirty (30) minutes in person when requested (or make appropriate arrangements with another cardiologist).
    c. New cardiologists will not be placed on the emergency backup roster until they have been removed from preceptorship for cardiac catheterization and angioplasty procedures.
12. Surgery Department ER Backup Requirements
    The surgery emergency department call panel is to be comprised of physicians with comparable clinical privileges for General, Vascular and Thoracic Surgery. There is one call schedule and if the physician receives a call from the Emergency Department and they do not hold the privilege or it is out of their scope of care, it is their responsibility to find appropriate coverage.

M. Communication Skills

Communication with patients, other physicians and Hospital personnel is essential for quality patient care. Therefore, only physicians, Dentists and Podiatrists who are able to communicate in English in a comprehensible manner, both orally and in writing, may be admitted as members of the Medical Staff. The following procedure shall be used to determine whether the applicant possesses satisfactory communication skills.

1. At the discretion of the Credentials Committee Chair, the applicant may be interviewed by the Credentials Committee.
2. The Credentials Committee may also, at its discretion, require the applicant to submit additional proof of their communication skills.
3. An applicant may also submit information which demonstrates their ability to arrange for an effective means of meeting the Hospital's needs to assure that there is adequate communication of the medical and administrative information that is required to maintain the standard of patient care.

N. Observers

Physicians on the Medical Staff may have a medical observer accompany them within the facility, with approval to be granted on an individual basis in accordance with the Medical Staff Observer Policy #8710.4400.

O. Preceptor Guidelines

1. Initial preceptoring guidelines shall consist of a minimum of three cases. Additional minimum cases may be assigned by the Clinical Department/Service as applicable. Preceptoring must be done by a Medical Staff Member with similar privileges. Any privileges delineated with direct observation shall be applicable to initial cases.

2. To achieve compliance with Article V, Section 5.3 of the Bylaws, documentation of satisfactory preceptorship from other licensed acute care Hospitals can be considered as part (up to 50%) of the preceptorship process (exception: See robotics preceptor/proctor requirements below).
3. If there is no Medical Staff Member with similar privileges, the MEC may approve an outside physician with known expertise in exercising these privileges at another Hospital, solely to preceptor the physician requesting these privileges.
4. Associates in practice may act as a proctor for no more than 50% of required cases. In the event of conflicts of interest or inability to meet this requirement, an exception may be made by the MEC.

The following Departments or Divisions have additional preceptoring requirements.

Anesthesia Department Preceptoring Requirements
The newly appointed Anesthesiologist shall have ten (10) of their cases preceptored within the time frame as outlined in the Medical Staff Bylaws (Article V., Section 5.3.1.). Of the ten (10) cases needed for preceptoring, the three (3) initial cases shall be under direct observation. Of the other seven (7) cases, they may be preceptored retrospectively, or direct observation, as determined by the Chair of Anesthesia at the time of appointment.

For Pain Management physicians, ten (10) cases shall be preceptored within the time frame as outlined in the Medical Staff Bylaws (Article V., Section 5.3.1.). Of the ten (10) cases, the initial three (3) cases shall be direct observation and the remaining seven (7) either direct observation or retrospective chart review, to be determined at the time of initial appointment by the Chair of the Department of Anesthesia.

Cardiology Division Preceptoring Requirements
See Cardiology Section

Emergency Department Preceptoring Requirements
The total number of cases that are reviewed for preceptoring will be ten (10). The review can be done either concurrently or retrospectively.

Medicine Department – Requirements for Gastroenterology Privileges
Preceptorship shall consist of a minimum of three (3) upper endoscopies, and three (3) ERCPs. These cases may be reviewed by direct observation or retrospectively as determined by the medicine department chairman/designee. Direct observation preceptoring may be used for new graduates or unknown physicians.

OB/GYN Department Preceptoring Requirements
Preceptoring shall consist of a minimum of two (2) major abdominal surgeries, two (2) cesarean sections, two (2) vaginal surgeries and two (2) laparoscopic procedures by direct observation. All other privileges may be preceptored by retrospective chart review.

Robotics, OB/GYN Department Preceptoring Requirements
The surgeon will be required to perform their first three (3) robotic cases with an approved proctor under direct observation and the next five (5) cases under retrospective review. After successful completion and review by the OB/GYN Committee Chair/designee, the Surgeon will be granted unsupervised basic robotic Gynecological privileges. Upon satisfactory completion of fifteen (15) basic robotic Gynecological cases, the Surgeon may apply for Advanced Gynecological robotic privileges (see OB/GYN privilege form). An approved proctor is defined as a Surgeon who has performed twenty (20) cases in the prior two (2) years.

Exception: If a Surgeon has prior training and experience during Residency; and/or currently holds robotic privileges at another Joint Commission (TJC) accredited institution; and has performed a minimum of twelve (12) robotic cases within the prior twelve (12) months, the Surgeon may be granted robotic privileges with a minimum proctoring requirement of three (3) retrospective cases.

Pediatric Department Preceptoring Requirements
In addition to the minimum requirement of three (3) cases, circumcision will be proctoring under direct observation for a minimum on one (1) case.

Surgery Department Preceptoring Requirements
Preceptoring shall consist of a minimum of six (6) cases. The preceptor may or may not be an assistant in surgery.

Proctoring will commence with the applicant's first case and will include a minimum of six (6) cases which shall represent a reasonable variety of cases for the privileges specifically requested and will proceed until the Surgery Department Chair/designee agreed that competence has been demonstrated. The procedure may not commence until the proctor has arrived as they are expected to be in the Operating room from inception of the surgery until they are satisfied the case is proceeding to an appropriate conclusion.
Requesting Practitioner Responsibilities:

a. The practitioner must secure a proctor before the procedure and must inform the Surgery Department with the name of the proctor for each case.
b. The practitioner will discuss the case(s) with the proctor ahead of time, including the pre-operative indications and evaluation.
c. Proctoring must be for consecutive cases and completed before the end of the provisional time period. Additional time may be granted under extenuating circumstances. Failure to complete proctoring within the Provisional period may result in loss of Medical Staff membership and/or privileges.
d. In emergency cases, attempts should be made to obtain a proctor. The Surgeon however maintains the ability to proceed without a proctor for patient safety.

Robotics, Surgery Department Preceptoring Requirements
The Surgeon will be required to perform their first three (3) robotic cases with an approved proctor under direct observation and their next five (5) cases under retrospective review. After successful completion and review by the Surgery Committee Chair/designee, the Surgeon will be granted unsupervised basic robotic surgical privileges.

P. Committee/Division Chairmanship

To ensure continuity, chair of all Medical Staff Committees must be assigned to serve on that Committee for the year following serving as Chair of the respective Committee.

Q. Name Badges

All Members of the Medical Staff and AHP Staff are required to wear an SARH issued identification badge.

R. Grandfathering Provision

The Medical Executive Committee may approve additional requirements for Medical Staff members with regard to whether they are board certified or board eligible. It is the policy of the Medical Executive

Committee to exempt existing Members of the Medical Staff from these additional requirements if they are Medical Staff Members at the time the requirements are approved.

S. Patient Safety

1. Critical Test Results – All verbal or telephone reports of any critical test results will be repeated back by the physician. Whenever it is feasible to have a printed copy (fax, computer print-out, etc.) of the report with the "critical test results", it should also be used instead of relying solely on verbal/telephone information.

   The Medical Staff defines critical test results requiring verbal read-back as follows:
   a. Any critical laboratory value as defined in the Clinical Laboratory Departmental Policies and Procedures.
   b. Any abnormal radiology finding deemed by the Radiologist to require immediate verbal physician notification.
      - The Radiologist must call the attending Surgeon to report both positive and negative results for a possible foreign body in the operating room.
      - The Radiologist must call the ordering physician to report an acute cerebrovascular accident/stroke.
   c. Any arterial blood gases (ABG) critical limits as defined in Respiratory Therapy Departmental Policies and Procedures.
   d. Any pathological findings deemed by the Pathologist to require immediate verbal physician notification.
2. Abbreviations – The Medical Staff will refrain from using the abbreviations noted on the "Do Not Use" abbreviation list approved by the Medical Executive Committee and refer to Stedman's Abbreviation, Acronyms, and Symbols book for acceptable medical abbreviations.
3. Universal Protocol – Site Marking and Time-Out – Universal protocol guidelines are used prior to surgical or all operative and other invasive procedures that expose patients to more than minimal risk, including procedures done in settings other than the Operating Room, such as special procedure units or at the bedside (e.g. for procedures requiring informed consent). See Universal Protocol, Nursing Policy and Procedure.

   This includes:
   a. Site marking requirements apply to procedures involving laterality (right-left distinction), multiple structures (e.g., fingers, toes, lesions) or multiple levels (e.g. spine).
      - Mark the site with the initials by the person performing the verification. In situations where initials are not practical (e.g., eye surgery), an alternate mark on the skin may be used (e.g., arrow, small dot, etc.).
      - Endoscopic procedures involving paired organs (fallopian tubes, ovaries, lungs) shall have an initial on applicable side which remains visible after draping.
      - When the site marking is not practical or site marking is refusing by the patient, an alternate method of site identification should be used (distinct wrist band, temporary suture around the surgical site, etc.).
   b. Pause immediately prior to the start of the procedure. At a minimum, the Surgeon, Anesthesiologist, and the Circulating Nurse will participate in the pause/time-out procedure and verify:
      - Patient's name.
      - Patient's MRN/FIN (or other approved identification number).

- Procedure (word-for-word) as it is written on the consent form, including the Surgeon's name.
- Site and side marking: The surgical/procedure team will visually look at the site and site marking (if the site marking is required) verifying that the site prepped matches the consent form site and side. Note: The physician performing the procedure will mark the side (if required) if they have not previously done so.
- Correct patient position.
- Correct implant and special equipment/requirements available.

Active communication techniques shall be used. Each member of the team may signal their concurrence verbally, with a nod, or with some other gesture.

Any member of the team may suspend the time out and hold the procedure if there is a discrepancy or uncertainty as to the patient, the procedure, the side and site, the position, equipment or any other condition.

Should an interruption occur during the time out, all steps shall be repeated to completion before the procedure begins.

The fact that a time out was successfully completed shall be documented in the patient's medical record. The documentation need not necessarily list all the matters reviewed, the discussion held or the exact time it was carried out.

T. Confidentiality/HIPAA Privacy Regulations

The Federal Health Insurance Portability and Accountability Act ("HIPAA") as implemented by the HIPAA Privacy Regulation and the HIPAA Security Regulation (42 CFR Parts 160 and 164), requires the Hospital to implement policies and procedures to protect the privacy and security of "protected health information". Protected health information includes any health-related information that identifies or could be used to identify an individual, including patient medical and billing records. HIPAA applies both to the Hospital and to Members of the Medical Staff. The Health Information Technology of Economic and Clinical Health ("HITECH") Act requires breaches of security of unsecured protected health information to be reported to the Department of Health and Human Services and to the affected individual:

1. The Hospital and Members of its Medical Staff practicing in the Hospital's facilities are an "organized health care arrangement" under HIPAA. This allows the Hospital and Members of the Medical Staff to comply jointly with HIPAA by adopting joint privacy practices for the Hospital. It also allows them to share protected health information for the purpose of operating the Hospital.
2. The Hospital has adopted privacy practices for the use and disclosure of patient information within the Hospital. These privacy practices are summarized in the Hospital's Notice of Privacy Practices, which is furnished to patients and posted at the Hospital's facilities.
3. The Notice of Privacy Practices applies to all patient health information created or received in the course of providing health care or conducting business operations at any location operated by the Hospital. The Notice is given jointly on behalf of the Hospital and the Members of the Medical Staff. It does not, however, apply to patient health information at other locations, such as a Medical Staff Member's private office.
4. Each Member of the Medical Staff shall abide by the terms of the Notice of Privacy Practices and of the Hospital's policies and procedures for health information privacy and security, as amended from time to time. Medical Staff Members may not adopt or distribute a different notice of privacy practices

relating to health information at Hospital locations. They may adopt their own notice of privacy practices at their private offices as necessary to comply with the Privacy Regulations.

5. Members of the Medical Staff may have access to patient health information as necessary to assist the Hospital or the Medical Staff with administrative or peer review functions. These include, for example, medical direction, administration of departments and services, and Medical Staff activities such as quality assurance and peer review. They include paid and volunteer services, whether or not they are performed pursuant to contract. Use of such information must conform to Hospital policies on use and disclosure of patient information, including the Policy on Use and Disclosure of Protected Health Information by Medical Staff Members for Hospital administrative purposes.

U. Hospitalist Physicians Program

1. Purpose: The Hospitalist Physicians Program was established to ensure continuity of care and efficient care for patients admitted through the Emergency Department who, at the time of admission, do not have an established professional relationship with a Member of the Medical Staff. Primary responsibility for the care of such patients may be assumed by Hospitalist physicians who have entered into a hospitalist services agreement with the Hospital subject to the terms and provisions of this Rule.
2. Hospitalist Physician Contracts: All contractual arrangements between Hospital and Hospitalist for Hospitalist physicians services shall expressly require full compliance with the Medical Staff Bylaws, Rules and Regulations and policies including the terms and conditions of this Rule.
3. Hospitalist Physicians – Services
    a. Hospitalist physicians shall be responsible to provide necessary primary care services for unassigned patients (i.e., patients who do not identify a current relationship with another Member of the Medical Staff in the Departments of Family Medicine or Medicine or other specialists with whom the patient has an ongoing relationship). The Emergency Department will contact the specialist identified by the patient if the Emergency Department determines that the Emergency Department patient is presenting with a problem that requires the care of that specialist.
    b. Hospitalist physicians may also provide coverage for patients referred by other primary care physicians, with prior arrangements kept in writing in the Emergency Department, and may provide consultations as requested by other Members of the Medical Staff. Other Members of the Medical Staff may refer patients to Hospitalist physicians for primary care services, when clinically appropriate. Other primary care physician Members of the Medical Staff, however, are not required to refer patients to the Hospitalist physicians. Physicians from other specialties may elect to refer patients to other Members of the Medical Staff, when clinically appropriate, for primary care services.
    c. If a primary care physician or specialist declines to admit their own patient who is deemed appropriate for admission, the patient will be referred to the Hospitalist physician on-call to assume full responsibility of that patient's care including selection of any appropriate consultations.
    d. If a patient identifies an established relationship with a specialist who is a Member of the Medical Staff during their Hospital encounter, any Hospitalist whether or not under contract with the Hospital must utilize that identified specialist if the patient requires that specialist's care unless required by the patient's insurance contract.
4. Hospitalist Physicians – Qualifications: All Hospitalist physicians must continuously meet each of the following qualifications:
    a. Be qualified for membership and privileges in the Department of Medicine or Department of Family Medicine.
    b. Be Members in good standing of the Medical Staff at San Antonio Regional Hospital.
    c. Demonstrate training, experience and current clinical competency for the non-surgical management of acute facility inpatients.

5. Coordination with Other Practitioners
    a. Hospitalist physicians shall be responsible to admit and serve as the attending physician for unassigned patients in, or referred from, the Emergency Department requiring inpatient primary care.
    b. Unassigned Emergency Department patients requiring surgical or other sub-specialty care shall be referred to a Surgeon or other sub-specialist in accordance with call panels established and operated in accordance with this section. Surgeons and other specialists to whom such unassigned patients are referred shall consult with Hospitalist physicians for primary care or other Members of the Medical Staff who are on the call panels. The Hospitalist physicians shall function as the primary care physician and shall coordinate the care for such patients.
    c. Hospitalist physicians shall utilize established surgical and specialty call panels to address the surgical and specialty care needs of unassigned patients.
    d. Hospitalist physicians shall utilize the Hospital's Case Management Department to refer discharged unassigned patients to the care of other primary care, surgical or specialty physicians utilizing call panels established and operated in accordance with this section. The call panels to be used shall be those in effect as of the date of discharge. Hospitalist physicians shall not discharge patients to their own private office or clinic practice or to themselves or to other Hospitalist physicians to be followed at other facilities.
6. Administration and Review
    a. The Hospitalist physicians program shall be overseen by the "Hospitalist Program Committee". The members of the Hospitalist Program Committee shall be: the President of the Medical Staff (or President-Elect), who shall serve as Chair; the Chairs (or Vice-Chairs) of the Departments of Medicine, Family Medicine, Surgery, Emergency Medicine and OB/GYN (or their designees); the Chief Executive Officer (or designee); the Chief Nursing Officer (or designee); one representative selected by each Hospitalist Group shall be invited to participate as non-voting members. Only Medical Staff Members of the Committee shall be entitled to vote. The Hospitalist Program Committee shall assure that the program operates in compliance with this Rule and shall report directly to the Medical Executive Committee. Any Member of the Medical Staff may communicate comments or concerns to the Committee relating to the Program. The Hospitalist Program Committee shall respond in writing to such communication. The Hospitalist Program Committee shall function as an Ad Hoc Committee established by the Medical Executive Committee and meet as least as needed until the Medical Executive Committee decides to establish the Committee in the Bylaws or to modify or discontinue it.
    b. The President of the Medical Staff and any member of the Hospitalist Program Committee may consult with the Chief Executive Officer to address issues related to compliance with this Rule. Violation of any Medical Staff Bylaws, Rule or Regulation, or policy, including this Rule, may result in disciplinary action as provided in Medical Staff Bylaws.
    c. This Rule and the Hospitalist Physicians Program shall be reviewed and shall be subject to re-approval within three (3) years from the date of the Board's approval of the Rule.

II. DEPARTMENT/DIVISION POLICIES

A. Allied Health Professional Staff

1. Definitions
   Allied Health Professionals (AHPs), Nurse Practitioners and Physician Assistants are dependent practitioners who:
   a. Are permitted by law to provide patient care services within the scope of their license;
   b. Are qualified by training, experience and current competence in a discipline permitted to practice in the Hospital;
   c. Function in a medical support role to physicians who have agreed to be responsible for such AHPs;
   d. Are not Members of the Medical Staff.
2. Purpose
   The purpose is to establish the rules and procedures for credentialing and the authorized activities of AHPs who assist in the care patients.
3. Conditions of AHP/Prerogatives, Obligations, Terms and Conditions
   a. AHP Prerogatives
      i. Provide such specifically designated patient care services as are granted by the Board of Trustees upon recommendation of the Medical Executive Committee and consistent with any limitations stated in the Bylaws and policies governing AHPs practice at SARH, and other applicable, State, Medical Staff or SARH policies;
      ii. Serve on committees when so appointed;
      iii. Attend open meetings of the Medical Staff or the Department;
      iv. Exercise such other prerogatives as the Medical Executive Committee, with the approval of the Board of Trustees, may accord AHPs.
   b. AHP Obligations – General Obligations
      i. AHPs must have a supervising physician;
      ii. AHPs and sponsoring or supervising physicians shall agree in writing to comply with the provisions of this Article;
      iii. Meet the basic responsibilities required by Section 2.7, Basic Responsibilities of Medical Staff Members, of the Medical Staff Bylaws;
      iv. Meet the general qualifications required by Section 2.3-1, General Qualifications, of the Medical Staff Bylaws;
      v. Meet the obligations of article IV, Appointment and Reappointment, of the Medical Staff Bylaws;
      vi. Physician assistants shall complete a Delegation of Services Agreement which is to be signed by all supervising physicians; the Delegation of Services Agreement shall include provisions for physician supervision and shall be subject to approval by the Interdisciplinary Practice Committee, the Medical Executive Committee and the Board of Trustees;

vii. Nurse Practitioners' practice privileges will be based on standardized procedures which shall include provisions for physician supervision and shall be approved by the Interdisciplinary Practice Committee, the Medical Executive Committee and the Board of Trustees, and signed by all supervising physicians;
viii. Retain appropriate responsibility within their area of professional competence for the care and supervision of each patient in SARH for whom services are provided;
ix. Participate when requested in quality review program activities and in discharging such other functions as may be required from time to time;
x. When requested, attend meetings, of the Staff, the Department, and the Division;
xi. Refrain from any conduct or acts that could be reasonably interpreted as being beyond the scope of practice authorized by the Board of Trustees;
xii. Shall provide when requested, a listing of medical record numbers of patients with whom care, or procedures, were provided. This information will be utilized to identify records for random peer review and OPPE;
xiii. AHPs and supervising physicians shall be subject to peer review under the MPEC process;
xiv. AHPs and supervising physicians shall be subject to OPPE and FPPE.

c. Patient Care Related Obligations – Allied Health Professionals
   i. AHPs are authorized to perform only those activities expressly permitted under a duly approved "Delineation of Privileges" which have been approved by the Interdisciplinary Practice Committee, respective Clinical Department, Medical Executive Committee and Board of Trustees;
   ii. AHPs may not perform or document the history and physical and/or consultation(s). However, progress note(s) or discharge summary may be performed under the supervision of the supervising physician who are required to countersign all entries made in the medical record by their respective AHPs within twenty-four (24) hours;
   iii. AHPs that are authorized to dictate reports into medical records shall use their own dictation number and state the name of the attending/supervising Medical Staff Member for whom they are dictating the report. Dictated reports must be forwarded to the attending/supervising Medical Staff Member for counter-authentication.
d. Supervising Physicians
   i. A physician Member of the Medical Staff must complete the history and physical (Medical Staff Rules and Regulations, Section 1, A-4, General Rules and Regulations – Admission);
   ii. All hospitalized patients must be seen daily by a physician Member of the Medical Staff (Medical Staff Rules and Regulations, Section 1, A-5, General Rules and Regulations – Admission), and document their visit accordingly in the medical record;
   iii. Supervising physician is required to come to the Emergency Department to evaluate the patient when requested by the Emergency Department or treating physician;
   iv. Patients must be seen by the supervising physician on the day of discharge from the Emergency Department and/or from an inpatient status;
   v. All patients must be admitted and discharged by a Member of the Medical Staff (Medical Staff Rules and Regulations, Section I, A-1, General Rules and Regulations – Admission);
   vi. All requests for consultations are to be made physician to physician;
   vii. Supervising physicians are required to countersign all entries made in the medical record by their respective AHPs within twenty-four (24) hours.

   For all patients for which an AHP is participating in care and treatment, the supervising physician must perform a pertinent examination and so document their visit on a daily basis.

B. Anesthesia Department

Scope of Service: The Department of Anesthesia shall provide Anesthesia Services in all Operating Rooms and other locations in the Hospital when necessary. In addition, the Department of Anesthesia shall oversee the delivery of conscious sedation and anesthesia by non-Anesthesiologists in areas such as Endoscopic Services, Radiology Department, and the Emergency Department. The Department shall also direct Post-Operative Recovery Services in the Hospital.

Membership: The Anesthesiologist must be board certified or board eligible by the American Board of Anesthesiology at the time of initial application to the Medical Staff. Board certification must be maintained throughout the tenure of Medical Staff membership. If board eligible at the time of initial application, then the board certification must be achieved within five (5) years. At the time of initial application, the applicant must successfully complete an interview with three (3) Active Staff Anesthesiologists in the Department. Certified Registered Nurse Anesthetists (CRNAs) must be supervised by an Anesthesiologist.

Minimum Criteria: To qualify for Vertebroplasty or Kyphoplasty through the Department of Anesthesia the practitioner must be board certified in the subspecialty of Pain Management in Anesthesiology, have a current California X-Ray Supervisor and Operator Permit, and has successfully completed a Fellowship in Pain Management and can demonstrate experience in performing at least five (5) Vertebroplasties and five (5) Kyphoplasties during the Fellowship; or has attended at least twenty-five (25) hours of lecture/workshop training specifically geared for Vertebroplasty and Kyphoplasty, of which ten (10) hours needs to be "hands on" training on either live patient or on cadavers; or if no Fellowship in Pain Management has been completed, the practitioner needs to have attended at least twenty-five (25) hours of lecture/workshop training specifically for Vertebroplasty and Kyphoplasty, of which ten (10) hours needs to be 'hands on" training on either live patients or on cadavers.

Preceptoring: At least one case each needs to be preceptored under direct observation of a Member of the Medical Staff that has similar privileges.

C. Emergency Medicine Department

Scope of Service: The Department of Emergency Medicine is established to provide appropriate, optimum, and timely care to all patients who present to San Antonio Regional Hospital for emergency care. The Emergency Department is a Level II facility and provides emergency health services, twenty-four (24) hours a day, seven (7) days a week to patients of all ages. The Department is responsible for the immediate treatment of any medical or surgical emergency. SARH is a designated Paramedic Base Station and follow ICEMA policies.

Membership: Applicants applying to the Department of Emergency Medicine fall under three categories; the criteria for each are as follows:

- Emergency Medicine Core Privileges: The applicant must be board certified in Emergency Medicine by a board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association or the Royal College of Physicians and Surgeons of Canada or actively participating in the process leading to certification by an approved board appropriate to the privileges requested (department members have six (6) years from the date of initial appointment to complete the certification process). Exceptions to the board requirements: Members whose initial board certification has expired; or Members who meet Grandfathering Provisions in the rules and regulations.

- Emergency Medicine Primary Care (aka Fast Track) Privileges: The applicant must have completed at least two (2) years of postgraduate training in Emergency Medicine, Family Medicine, Internal Medicine or Surgery.

- Urgent Care Privileges: Applicants applying for Urgent Care privileges must have completed at least one (1) year of post-graduate training.

Policies:

1. Patient Care
   a. While it is the primary responsibility of the Emergency Medicine physicians to attend the needs of the patient in the Emergency Department, these physicians may be asked to attend inpatients in need of immediate care in the following situations:
      - All life threatening emergencies that occur in the Hospital involving inpatients will be at the request of the nurse in charge.
      - In all situations where the Emergency Medicine physician may be requested to respond to an emergency or a non-emergency situation out of the Department, the Emergency Medicine physician will respond only when their absence from the Department will not jeopardize the health and welfare of a patient or patients in the Emergency Department.

      THESE PROCEDURES ARE <u>NOT</u> PERFORMED IN THE EMERGENCY DEPARTMENT. (THE FINAL DETERMINATION IS AT THE DISCRETION OF THE ATTENDING EMERGENCY PHYSICIAN):
      - Any non-emergency procedure that would disrupt the normal function of the Department
      - Any procedure which cannot be performed without adequate pain control
      - Any procedure requiring general or major regional anesthesia
      - Major flexor tendon repairs
      - Open reductions
      - Routine deliveries
      - D&C
      - Elective outpatient blood transfusions
      - Elective cardioversions
2. Pain Control
   If a physician does not provide adequate pain control, the Emergency Medicine physician will intervene, discontinue the procedure and will initiate the chain of command.

D. Family Medicine Department

Scope of Service: Family Medicine is comprehensive medical care with particular emphasis on the family unit. The Family Medicine physician is not limited by the patient's age or sex, or by a particular organ system of disease entity.

Membership: Initial applicants must have successfully completed an ACGME or AOA approved Family Medicine Residency and be board certified/board admissible by the American Board of Family Medicine or the American Osteopathic Board of Family Physicians; or actively participating in the process leading to board certification (members who do not complete the certification process within two (2) years of their initial appointment will automatically have their privileges terminated). Note: Recertification is not required of Members whose board certification has expired.

Policies: Current certification in neonatal cardiopulmonary resuscitation is a requirement for attendance at Cesarean Sections.

Newborn Examination: Newborns must be examined by the attending physician within twenty-four (24) hours of birth or prior to discharge if the baby is admitted under the twelve (12) hour stay program.

Additional Privileges: Privileges not included on the Family Medicine privilege form must be requested through the applicable Department/Committee.

E. Medicine Department

Scope of Service: The Medicine Department provides inpatient and outpatient medical care. The Medicine Department includes, but is not limited to, the following specialties: Internal Medicine, Pulmonary Medicine, Cardiology, Allergy, Gastroenterology, Rheumatology, Hematology, Oncology, Nephrology, Endocrinology, Dermatology, Neurology, Physical Medicine, Psychiatry, and Addiction Medicine.

Membership: Applicants must be board admissible/certified or have successfully completed an approved Residency program in the physician's specialty.

Committee Membership: Membership on the Medicine Committee shall consist of the Chair/designee of the following Divisions, Cardiology and Gastroenterology and others as selected by the Department of Medicine Chair.

Preceptor Assignment: The Department/Division Chair will be responsible to assign an appropriate preceptor to all new Members of the Medical Staff. The preceptor and the new Member will be notified in writing.

1. Cardiology Division

Scope of Service: The purpose of the Cardiology Division shall be to develop and enhance the Cardiology Program at San Antonio Regional Hospital. The Division shall be accountable to the Department of Medicine. The Division shall provide care to outpatients and inpatients of all ages with cardiology problems.

Membership: Applicants must be board certified or admissible or be in the last three (3) months of an approved Cardiology training program and hold ACLS certification.

Preceptorship: Preceptors will be assigned by the Cardiology Division, unless the Division chooses to delegate that responsibility to the Director of the Cardiac Catheterization Laboratory.

a. Cardiac Catheterization Laboratory
    i. Category I – Diagnostic Cardiac Catheterizations
        - Full catheterization privileges at another Joint Commission accredited institution.
          AND
        - Documentation of two hundred (200) procedures completed since training, with an acceptable level of competence.
          OR
        - Postgraduate training in Invasive Cardiology, satisfying or equivalent to the admissibility requirements of the American Subspecialty Board of Cardiovascular Disease.

PLUS

- Direct observation of a minimum of three (3) successfully completed cases. Performance criteria includes: case selection, catheter selection, techniques, arrhythmia and pain management, and resuscitation and emergency measures.

ii. Category II – Percutaneous Transluminal Coronary Angioplasty (PTCA)

- Full privileges for PTCA privileges at another Joint Commission accredited facility.
  AND
- Two hundred (200) cardiac catheterizations.
  AND
- A minimum of two (2) PTCA training courses.
  AND
- A minimum of three (3) diagnostic cases with preceptor approval at this facility (may be waived at discretion of Cath Lab Director).
  OR
- Completion of formal PTCA training program with two (2) letters from Department Chiefs or direct supervisors with specific reference to the applicant's coronary angioplasty ability
  PLUS
- Direct observation of a minimum of six (6) cases. Performance criteria include case and lesion selection, catheter and balloon selection, lesion crossing and inflation techniques, arrhythmia and pain management, and resuscitation and emergency measures.

iii. Cardiology (Non-Invasive)

- Holter Monitors/Pacemaker Evaluations
  A minimum of three (3) holter monitors and a minimum of three (3) pacemaker evaluations over-read by assigned physician or Medical Director of Non-Invasive Cardiology.
- Treadmill Stress Test
  A minimum of three (3) procedures with assigned physician or the Medical Director of Non-Invasive Cardiology.
- Pharmacological Stress Test
  A minimum of three (3) procedures with assigned physician or the Medical Director of Non-Invasive Cardiology.
- Echocardiograms with Doppler and Color Flow
  A minimum of three (3) echocardiograms over read and tapes reviewed by assigned Cardiologist or Medical Director of Non-Invasive Cardiology.
- Transesophageal Echocardiogram
  Cardiologists will be preceptored by preceptor for a minimum of three (3) TEE procedures.

iv. Criteria for Catheter-Based Peripheral Vascular Interventional Privileges
The practitioner must meet the minimum criteria as defined in Appendix A.

Cardiology Committee Membership: The cardiology committee will include all active cardiologists, one (1) physician from the department of medicine, one (1) from the department of family medicine, one (1) radiologist, one (1) anesthesiologist, one (1) cardiac surgeon, one (1) emergency physician, plus representation from nursing and administration.

Cardiology Program Directors: Medical directors shall be cardiologists, and will be recommended by the cardiology division to administration for the following three (3) areas:

a. Coronary care unit
b. Catheterization laboratory

c. Non-invasive services (including cardiac rehabilitation)

Medical directors and the director of cardiac surgery shall present statistical reports to the cardiology division.

Cardiac Catheterization Lab:

a. Temporary Privileges: Temporary privileges will not be granted for procedures in the Catheterization Laboratory or for cardiac invasive procedures in the CCU.
b. Late Arrival of Cardiologist: If a physician is twenty (20) minutes or later for a scheduled procedure without calling to advise the Cath Lab of circumstances, this will be documented. If the physician still has not arrived after thirty (30) minutes after the scheduled time in the assigned room, the procedure will be cancelled.
c. Surgical Stand-by – Cardiac Lab
    i. The Cardiologist will determine what level of surgical standby is required.
    ii. The Cardiac Catheterization Laboratory will notify the Cardiovascular Coordinator as to which level of standby will be utilized.
    iii. Levels of surgical standby for Cardiac Catheterization Laboratory interventional procedures are as follows:

Level I	Surgical standby required (room available during daytime hours). After hours thirty (30) minutes.
Level II	• Surgical team notified but is not on site. If the services of the surgical team are required they will be on site in thirty (30) minutes. Daytime at Cardiologist's discretion. • Operating rooms in use at cardiologist discretion.
Level III	No surgical standby required.

d. Intravascular Contrasts: Maximum on intravascular contrast for procedures done in the Cath Lab is 4cc per kg of Isovue 370, if exceeded the director is to be notified.

Cardiology Department (Non-Invasive):

a. Electrocardiogram Panel Membership Criteria
   The EKG panel will be comprised of physicians who:
    i. Are board certified in Cardiology.
    ii. Is a member participating on the STEMI Emergency Department call panel or Echo Panel.
    iii. Exception: Members presently serving on the EKG Panel will remain on the Panel under the Grandfathering Provision in the Medical Staff Rules and Regulations.
    iv. Physicians who read their own EKGs will continue to perform their own EKG interpretations.

   Members request to be added to the EKG Panel must be submitted to the Cardiology Division for approval and forwarded to Medicine Department and Medical Executive Committee for final approval.
b. Physicians reviewing any non-invasive cardiac study must notify the referring physician of any significant abnormality.
c. Computerized EKG analysis must be over-read by a qualified physician.
d. Turnaround Time:
    i. Appropriate STAT Echocardiograms must be read within six (6) hours after contacted by ordering physician
    ii. Stroke Echocardiograms must be read within twenty-four (24) hours of completion

iii. Routine Echocardiograms must be read within forty-eight (48) hours of completion, excluding weekends and holidays
iv. Cardiologists on the Echo Panel must read Stroke Echocardiograms within 24 hours and, at a minimum, 80% or greater within a two rotation cycle panel. In the event these guidelines are not followed, the member will be removed from the Echo Panel.

e. Back-up for stat echoes shall be determined as follows: It is up to the physician requesting the stat echo to contact the reading physician to notify them of the study to interpret.
f. Stat echos for unassigned patients will be read by the Echo Panel Member assigned for that week with physician to physician consult by the ordering physician.
g. Holter Monitors: For inpatients and outpatients, when the Technician is unable to contact the physician when there are concerns regarding Holter recordings, he must leave a message with the exchange that the physician is requested to call. The exchange must be advised of the urgency of the message. If there is no response from the physician within two (2) hours, the Medical Director of Non-Invasive Cardiology is to take over management of the case until the physician responds (Technicians must communicate to subsequent shifts when a physician has been reached).
h. Routine EKGs not read within 48 hours shall be placed in the box to be read by the panel physician.
i. All preoperative EKGs are to be read by 11:00pm the night before surgery. Those not read should be placed in the general box to be read by any physician before 7:00am the next day.
j. Holter monitors and treadmills not read within seventy-two (72) hours will be read by an assigned physician.

2. Gastroenterology Division

Scope of Services: The purpose of the Gastroenterology Division is to provide care to outpatient and inpatients of all ages with gastroenterology problems.

Membership: Applicants must have completed an accredited training program in Gastroenterology.

Chairman Selection: The Division Chair shall be appointed by the President of the Medical Staff in consultation with the Department Chair (candidate must be a Member of the Division and an Active Member of the Medical Staff for the last two (2) years and have Gastroenterology privileges).

Committee Selection: All Members of the Division shall be Members of the Gastroenterology Committee. In addition, the Committee must include two (2) non-Gastroenterology Members of the Medicine Department and one (1) Member from the Surgery Department.

Maintenance of Privileges for ERCP:

a. To maintain ERCP privileges, Medical Staff Members are required to attend new equipment and technology education in-service programs as needed.
b. Practitioner must provide documentation of a minimum of ten (10) cases in the preceding twenty-four (24) months.
c. Patient Selection and Documentation of Indications:
    i. It is highly recommended that patients requiring an ERCP procedure be transferred to a tertiary medical center when:
        - Assessed ASA score is three (3) or higher.
        - Procedure attempted and unsuccessful.
        - Previous anesthesia complications.
        - Patient is pregnant.
    ii. Patients with an ASA score of three (3) or higher and ICU/CCU patients are to be performed with the assistance of an Anesthesiologist.

iii. ERCPs are performed only after documentation of indications on the approved Endoscopic Services form.

Block Scheduling Guidelines:

1. The physician assumes responsibility for scheduling only those cases that can be accommodated during his/her block time. Cases that exceed that time frame will be rescheduled as time permits.
2. Schedulers are on duty from 07:00-14:00 Monday to Friday as long as the unit is open. To schedule an outpatient procedures fax the information to: **909 920-4772.**
3. Inpatient procedures may be called to **909-920-4991**
4. Weekend & after hours emergency cases are scheduled through surgery at **909-920-4848**
5. The last procedure must begin at least 30 minutes before the end of the scheduled block time in order to be completed before the next physician's time slot. (earlier for a double or ERCP)
6. All procedures scheduled after the first cases booked for the day are scheduled "to Follow" at 30 minute increments. Start times are given as estimates.
7. A physician requiring to "bump" the schedule with an emergency case is required to speak directly to the physician who is being bumped. Emergency cases are considered highest priority.
8. Block time is released at 8 pm for the next day
9. Elective procedures must be started by 15:00.
10. After hours & weekends are for Emergency procedures only, except when special circumstances exist. All emergency cases are subject to peer review.
11. "Open block time" is reserved for inpatient add-on cases by the on call physician.
12. When scheduling be sure to mention if the patient is in isolation. Isolation patients to be scheduled at the end of the lineup.
13. Cases requiring general anesthesia are to be scheduled through the OR, **909-920-4848.**
14. When going on vacation, please let the ESU charge RN & ESU scheduler know ahead of time so that we can let other physicians utilize that block time

F. OB/GYN Department

Scope of Service: The scope of care provided by the OB/GYN Department is devoted to the health care of women. It encompasses both normal and abnormal processes of the female reproductive system, including the medical and surgical management of disorders, pregnancy and childbirth, and primary and preventative medical care.

Department Membership:

1. Initial applicants must provide proof of satisfactory completion of an ACGME or AOA approved Residency and be board certified in Obstetrics/Gynecology, or subspecialty of, by a board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Board of Obstetrics/Gynecology (AOBOG) or actively participating in the process leading to certification by an approved board. Department Members have six (6) years from the date of initial appointment to complete the certification process. Those Members who do not complete the certification process within six (6) years will automatically have their privileges terminated.
2. All members of the OB/GYN Department who hold OB privileges are required to satisfactorily complete a fetal heart monitoring course and repeat the course every four (4) years and provide proof of completion (exception: Perinatologists are not required to complete this training requirement).
3. All Members of the OB/GYN Department who hold obstetrical privileges are required to satisfactorily complete a breast feeding management education course once in a lifetime and provide proof of completion.

4. All Members of the OB/GYN Department who hold obstetrical privilege are required to satisfactorily complete two (2) simulation drills per reappointment period; a six (6) month grace period shall be granted if the requirement has not been met by the reappointment expiration. Failure to complete the requirement following the grace period shall result in an automatic suspension of Medical Staff privileges until said requirement is fulfilled.

OB/GYN Department ED Call Exemption Criteria:
Physicians may be exempted from the emergency call panel after sixty (60) years of age or twenty (20) consecutive years of service to this Hospital as long as adequate coverage is maintained. A request for exemption must be in writing and will be considered for approval at the next Department meeting and subsequent MEC meeting. If there is more than one (1) request, first consideration will be given to the physician with the greater seniority in years of services.

Policies:

1. Antepartum
    a. Prenatal lab work is to be filed in the delivery area before the patient is admitted in labor; such prenatal lab work will include: CBC, blood and Rh typing, rubella titer, serology, antibody screening, Hepatitis B Surface Antigen, urine culture, and urinalysis. Genetic testing/counseling should be offered to women thirty-five (35) years of age and over at the time of delivery. A maternal serum alph-feto protein is strongly recommended. Diabetic evaluation is recommended. A beta Strep culture should be obtained.
    b. A prenatal history and physical should be on file in the delivery area prior to the patient's due date, preferably at thirty-six (36) weeks gestation.
    c. Stress and non-stress tests, when performed outside of the Hospital, should be documented on the prenatal record.
2. Intrapartum
    a. All patients admitted to the Labor and Delivery Area in active labor shall have a CBC and auto differential group + Rh (OB) as soon as possible.
    b. The admission history and physical for all routine obstetrical patients must be completed on the obstetrical admission physical examination form or a complete history and physical must be dictated.
    c. When called by the Registered Nurse to respond to a patient in active labor, the physician will arrive within thirty (30) minutes of the call.

3. Postpartum
    a. Isolation technique will be followed as established by Hospital policy. A patient on the maternity unit with a fever of unknown origin of 100° F or above on two (2) occasions, six (6) or more hours apart, must be transferred to another Nursing Unit if the cause of the fever is undetermined.
    b. All patients should have a postpartum hemoglobin or hematocrit prior to discharge.
    c. All patients who are Rh negative should be screened for Rhogam administration. All patients who are candidates for Rhogam should receive it within seventy-two (72) hours of delivery, including patients who are to be permanently sterilized. All patients having therapeutic or spontaneous abortions and who are Rh negative should receive Rhogam.
    d. Rubella vaccination should be given to patients having a titer indicating a non-immune status.
    e. The Obstetrician/designee must see patients daily in conjunction with the consulting practitioner.

G. Pediatrics Department

Scope of Service: The scope of care provided by the Pediatric Department is the medical management of pediatric and neonatal patients. Pediatrics includes the care and treatment of infants, children and adolescents.

Department Membership: Applicants must have successfully completed an ACGME or AOA approved Residency program in Pediatrics and must be board certified or board admissible in pediatrics by a board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Board of Pediatrics; or actively participating in the process leading to board certification. Department Members have six (6) years from the date of initial appointment to complete the certification process. Those Members who do not complete the certification process within six (6) years will automatically have their privileges terminated. Recertification is not required of Staff Members whose original board certification has expired. Applicants for Pediatric subspecialties must provide evidence of satisfactory completion of accredited Fellowship training in their pediatric subspecialty.

All Members of the Pediatric Department who hold general core privileges/routine newborn care are required to satisfactorily complete a breast feeding management education course once in a lifetime and provide proof of completion (excludes pediatric subspecialists).

Policies:
NICU Privileges and Attendance at C-Sections - NICU admission privileges are granted as follows:

1. Full privileges will be granted to board certified or board admissible Neonatologists who have another Neonatologist to provide backup coverage. Pediatrics may continue to care for their patients up to their privilege level under the supervision of the Neonatologist.
2. Proof of current certification in neonatal cardiopulmonary resuscitation is a requirement for attendance at all C-Sections.
3. Consultations: When newborns require neonatal care the nurse may be allowed to contact the Neonatologist for consultation. Pediatricians will be responsible for physician to physician consultations in all other cases in accordance with these Rules and Regulations, Section E.

H. Radiology Department

Scope of Service: The Radiology Department provides inpatient and outpatient imaging services, imaging guided procedures, gamma knife and therapeutic nuclear medicine treatments to patients of all ages.

Membership: Applicants must be board certified by the American Board of Radiology, the Canadian Board of Radiology, or the Royal College of Radiology, England or attainment of board certification within three (3) years of initial appointment. Membership in this department is limited by exclusive contracts with the Hospital.

I. Surgery Department

Scope of Service: The Surgery Department provides surgical care to inpatients and outpatients of all ages, on a scheduled or emergency basis. The department includes General Surgery, Cardiac Surgery, Vascular Surgery, Thoracic Surgery, Orthopedic Surgery, Otolaryngologic Surgery, Podiatric Surgery, Urologic Surgery, Neurologic Surgery, Plastic Surgery, Oral and Maxillofacial Surgery, Ophthalmologic Surgery, and Pathology.

Department Membership: Initial applicants must be board certified in General Surgery, or subspecialty of, by a Board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Board of Surgery (AOBS), the Royal College of Physicians and Surgeons of Canada or the America Board of Foot and Ankle Surgery (ABFAS) or actively participating in the process leading to certification by an approved board appropriate to the privileges requested. (Exception: Applicants requesting surgical assistant privileges only). Department members have six (6) years from the date of initial appointment to complete the certification process. Those members who do not complete the certification process within six (6) years will automatically have their surgical privileges terminated. Recertification is not required of members whose original board certification has expired.

Committee Membership: Membership on the Surgery Committee shall consist of representatives from multiple surgical specialties and a representative from Pathology.

Perioperative Operations Sub-Committee: A Sub-Committee will review performance goals on a regular basis to ensure maximum efficiency and utilization of the Operating Room. This Committee will be made up of the Chiefs of Surgery and Anesthesia, or their designees, along with the Director of Surgery, and the Chief Nurse Executive. This Committee will be charged with ensuring that targets for block utilization, room utilization, and performance indicators such as on time starts and turnover times are continually monitored for improvement.

Policies:

1. Late Arrival of Surgeons
   First hour Surgeon must be available to see their patient in the holding room by 7:00am.
   a. Any Surgeon tardiness that results in two (2) late first-hour starts (in the same day block room) in a quarter will receive a warning letter from the Department of Surgery.
   b. Any Surgeon who receives a warning letter and has two (2) delays in the subsequent quarter will lose first case of the day scheduling privileges and will have to follow the first case placed in their block room regardless of the case length. Reinstatement of first-hour cases will be in effect starting in the next quarter if no further delays occur.
   c. After the patient has been in the Operating Room for twenty (20) minutes and the Surgeon is not available, the patient may be returned to their room on the Nursing Unit.
   d. Anesthesiologists shall not put a patient under anesthesia until the Surgeon is not only in the Hospital but available to start the procedure.
   e. It is the responsibility of the Surgeon to remain in the Surgery Department after the induction of the patient has been initiated.
   f. If an outside emergency arises, the Surgeon shall notify the Anesthesiologist and the Nursing Staff immediately.
2. Scheduling Surgical Cases
   a. There are seven (7) Operating Rooms available for scheduling cases Monday through Friday.
   b. For any procedure being performed where active TB is suspected/being ruled out and when AFB smears or cultures are ordered (e.g. biopsy of pulmonary nodule, bronchoscopy) the scheduling physician must notify surgery.
3. Block/Reserved Surgery Schedule
   a. The Surgery Committee, with the recommendation of the Perioperative Operations Committee, may grant a Surgeon the privilege of reserving a block day (2). This privilege is based on consistent and predictable utilization of the time provided. Partial block time may be available on days with lower demand.
   b. To qualify for block scheduling, a Surgeon must perform an average of six (6) or more hours a week of elective surgery over a three (3) month period. Surgeons shall be granted an initial

allocation of one (1) full block day per month if utilization meets criteria and additional days may be added. There are a limited number of block rooms with at least one (1) room set aside for first come first served scheduled cases. Blocks are granted based on the ability to consistently utilize the time provided and with the approval of the Surgery Department Chair. Surgeons requesting block time must make application in writing to the Perioperative Operations Committee.

c. Hospital Administration will provide the Perioperative Operations Committee a quarterly review of the utilization rate by Surgeon to determine satisfactory use of the block schedule. A utilization report will be given to the Committee by the Nursing Director of Surgery in January, April, July and October for each preceding quarter.
d. To maintain a block privilege, a Surgeon must utilize an average of 65% of the block time. Failure to utilize the full allotment may result in reduction of block time.
e. The Committee will notify a surgeon in writing within four (4) weeks of any decisions made regarding the granting or removal of block surgery time. In the event that a surgeon loses some or all of their block time, patients already scheduled for surgery will not be cancelled.
f. Block release times will vary by specialty and type of practice. Specialties and practices that are mainly elective in nature will have a one (1) week release time, e.g. Ophthalmology, Otolaryngology, Plastic Surgery, Podiatry and total joints. Specialties and practices that have a mix of elective and urgent cases will be released seventy-two (72) hours prior, e.g. Gynecology, Urology, Neurosurgery, and Orthopedics. Specialties and practices with frequent referrals from the Hospital Emergency Department will have their blocks released twenty-four (24) hours prior. Robotic cases must be scheduled two (2) weeks in advance. Specific release times will be determined by the Perioperative Operations Committee.
g. Surgeons who are unable to utilize their block day because of other commitments (meetings, vacations, etc.) must release those days one (1) week prior to the day in question so that the released day will not be counted as unused time in the utilization rate. Exceptions will be made for Surgeons with illness or personal emergency.

4. Elective Surgery:
   a. A scheduling clerk is available for posting and may be reached at extension 24975 or 26010. Scheduling hours are as follows: Monday through Friday: 0800-1630
   b. The first case of the day is scheduled for 7:30am. All other cases thereafter are scheduled on a "to follow" basis. Specific times are not given on the "to follow" cases.
5. Emergency Surgery:
   In the event of an emergency surgery that must take place as soon as possible, a surgeon may "bump" any case in the first available Operating Room Suite. The operative Surgeon is required to notify the "bumped" surgeon as a courtesy.

   In case of Abuse: If the surgical nurse or affected physicians feel that a Surgeon has abused the use of a category, the alleged abuse should be documented and submitted in writing with all the evidence to the Surgery Committee for appropriate action.
6. "Not Before":
   A case may be scheduled as a "not before…." if the operative surgeon has previous commitments and is not available before the given time. The "not before" time shall be construed as the earliest time that a case can begin. It may be later than this time.

SURGEON'S ASSISTANTS

1. In order to be eligible for surgical assisting privileges, the following criteria must be met:
   a. Any practitioner who has completed a Residency from an ACGME accredited institution; OR

b. Documentation of a minimum of three (3) months training in surgical assisting at an accredited training institution. Applicants under these criteria must be approved for surgery assisting privileges by the Department of Surgery only.
OR
c. Documentation of experience in surgical assisting at another institution to attest current competency.

2. Surgical assistants must be Members of the Medical Staff or Allied Health Professional Staff. Dentists may only assist in surgical cases involving their own expertise.
   a. When the responsible Surgeon deems a procedure to be an unusual hazard, it is their responsibility to obtain additional qualified assistants for the safe conduction of the surgery.
   b. The surgical assistant shall be present for the time deemed necessary by the Surgeon.
3. Robotic Surgery Assistants:
   a. Must be a licensed, practicing physician, or Physician Assistant who currently hold surgical assist privileges.
   b. Must have documented evidence of having completed one (1) hour of hands on robotic orientation and skill testing conducted by Intuitive daVinci representative or prior training and experience during Residency and/or currently holds surgical robotic privileges at another TJC accredited institution and has performed a minimum of twelve (12) robotic cases within the prior twelve (12) months. (See Rules and Regulations for preceptoring requirements)
   c. Must have documented evidence of having observed one (1) successfully completed robotic surgery case including set-up, patient positioning, orientation of equipment, surgeon preferences, and the operative procedure (including undocking of robotic equipment).

SURGERY EQUIPMENT PROTOCOL

Equipment owned by the Hospital may be used by any Surgeon who has privileges to work in the Operating Room. One-of-a-kind surgical equipment and instruments may be requested by two (2) Surgeons simultaneously. The following criteria will be used to make the decision of who will have preference.

- Surgeons working on their block day will have preference over those who are not.
- Immediate life threatening emergencies will have priority over elective cases.
- In all other cases requests will be handled on a first-come, first-serve basis.

SURGICAL PROCEDURES THAT REQUIRE AN ASSISTANT

1) There will be one scrub nurse/tech on all cases
2) There will be a qualified circulating RN who is responsible for perioperative patient care
3) The surgeon will arrange for an assistant for the case and inform the surgery scheduler
4) Use of an assistant in those cases which do not require an assistant shall be at the discretion of the surgeon
5) Emergency procedures are excluded (An emergency is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administered treatment would add to that danger.)

ENT/OTOLARYNGOLOGY

Procedures can generally be performed without assistance, although circumstances might arise (on an individual basis) in which an assistant would be indicated.

OPHTHALMOLOGICAL PROCEDURES:

Procedures can generally be performed without assistance, although circumstances might arise (on an individual basis) in which an assistant would be indicated.

NEUROSURGICAL PROCEDURES:

1.85 Craniotomy for aneurysms; elective
1.90 Craniotomy for AVM; elective

UROLOGICAL PROCEDURES:

6.55 Radical Retroperitoneal Lymphadenectomy
7.30 Prostatectomy - Suprapubic Radical
7.35 Prostatectomy - Suprapubic Simple
7.40 Prostatectomy - Retropubic Radical
7.45 Prostatectomy - Retropubic Simple
7.50 Prostatectomy – Perineal
7.70 Any non-endoscopic prostatectomy
8.40 Pelvic Lymph Node Dissection
8.50 Laparoscopic Lymphadenectomy
1.20 Nephrolithotomy
1.30 Nephrectomy
2.40 Ileal Loop Urinary Diversion
4.00 Robotic Surgery

GENERAL SURGICAL PROCEDURES:

1.35 Abdominoperineal resection
2.25 Hepatectomy/partial
2.30 Hepatectomy/lobectomy
2.35 Hepatectomy/segmentectomy
2.40 Biliary tract surgery
2.75 Radical pelvic surgery
3.62 Esophagogastrectomy
4.40 Pulmonary resection/pneumonectomy
4.45 Pulmonary resection/lobectomy
4.50 Pulmonary resection/segmentectomy
4.55 Pulmonary resection/wedge
4.60 Pulmonary resection/sleeve

CARDIOVASCULAR/CARDIAC CATH/VASCULAR PRIVILEGES

1.05 Exploratory Cardiotomy
1.15 Cardiorrhaphy
1.30 Indirect myocardial revascularization
1.35 Ligation & Division of patient ductus
1.40 Resection, aortic co-arctation
1.45 Cardiotomy/repair septal defects
1.50 Cardiotomy/valvuloplasty, valvotomy or insertion of prosthetic valve
1.55 Coronary endarterectomy/endarterotomy
1.60 Aortocoronary bypass
1.65 Excision myocardial aneurysm
1.70 Excision intracardiac tumor

2.10 Arterial embolectomy/thoracic aorta
2.20 Thromboendarterectomy or bypass/thoracic arch & branches
2.30 Thromboendarterectomy or bypass/thoracic aorta
2.40 Resection aneurysm renal, mesenteric, hepatic
2.50 Resection aneurysm thoraco abd. aorta
2.60 Resection aneurysm pulmonary artery
2.70 Arteriorrhaphy/thor.aorta/branches
2.80 Venous thrombectomy/chest
2.90 Portal shunt
3.00 Splenic shunt

PLASTIC AND RECONSTRUCTIVE SURGERY:

Procedures can generally be performed without assistance, although circumstances might arise (on an individual basis) in which an assistant would be indicated.

OB/GYN PROCEDURES

1.00 Cesarean Section
2.00 Hysterectomy; at surgeons' discretion
3.00 Ovarian Cancer Debulking

APPENDIX A

Catheter-Based Peripheral Vascular Interventions:
The practitioner must meet the minimum criteria as defined for their respective department.

The granting of these privileges will be by the respective Department Chairman of the applicant. Only those physicians in the following fields qualify for consideration: Interventional Cardiologists, Interventional Radiologists, and Vascular Surgeons.

Catheter based interventional procedures on extracranial or intracranial vessels are excluded from this consideration and shall have no change in present status of the granting of privileges.

The physician performing peripheral catheter-based intervention procedures should have the following minimal training and skill required for competency. The Department Chair shall, after consulting with the respective Division Chair when appropriate, shall determine, and based upon the evidence provided by the applicant, if the applicant has fulfilled the requirements listed below.

For those physicians with fellowship training in catheter-based interventional procedures, minimum criteria are as follows:

Formal Training to Achieve Competence in Peripheral Catheter Based Interventions

Training requirements for cardiovascular physicians:

- Duration of training*—12 months
- Diagnostic coronary angiograms ≠—300 cases (200 as the primary operator)
- Diagnostic peripheral angiograms – 100 cases (50 as primary operator)
- Peripheral interventional cases§ — 50 cases (25 as primary operator)

Training requirements for interventional radiologists:

- Duration of training±—12 months
- Diagnostic peripheral angiograms—100 cases (50 as primary operator)
- Peripheral interventional cases§ — 50 cases (25 as primary operator)

Training requirements for vascular surgeons:

- Duration of training —12 months ll
- Diagnostic peripheral angiograms¶—100 cases (50 as primary operator)
- Peripheral interventional cases§—50 cases (25 as primary operator)
- Aortic aneurysm endografts—10 cases (5 as primary operator)

Requirements for non-fellowship trained physicians:

For those physicians who have not had formal fellowship training in peripheral catheter-based interventional procedures, yet request privileges at SARH, they will need to meet the following criteria before being considered for possibly being granted these privileges.

1. Provide documentation of current clinical activity specific to the privileges requested.
2. Completion of training in catheter-based interventional procedures within a twenty-four (24) month period.
3. Training under the proctorship of either a formally trained vascular interventionalist or a vascular interventionalist fully competent and credentialed to perform the full range of procedures sought after by the candidate.
4. 50 CME Category 1 hours specifically related to vascular medicine, of which at least 30 hours must be specifically related to catheter-based interventional medicine. The CME must be completed within a 24-month period.
5. The physician must be board certified in their respective specialty field. Only those physicians in the following fields qualify for consideration: *Interventional Cardiologists, Interventional Radiologists, and Vascular Surgeons.*

6. The following are the minimum number of procedures the candidate must have completed. The case mix should be evenly distributed among the different vascular beds:
   Procedural requirements for competency:
   a. Diagnostic peripheral angiograms – 100 cases (50 as primary operator)
   b. Peripheral interventions – 50 cases (25 as primary operator)
   c. No fewer than 20 diagnostic/10interventional cases in each area, excluding extracranial cerebral arteries≠
   d. Percutaneous thrombolysis/thrombectomy – 5 cases
      i. For interventional cardiologists, two of these five cases may be coronary thrombolysis.

FPPE Requirements:

1. Interventional Cardiology
   Minimum of (2) two direct observations per "bundled" procedure(s):
   - Left Heart Catheterization, Right Heart Catheterization, Cine Angiogram, Pericardiocentesis
   - Percutaneous Coronary Intervention; includes Stents & PTCA, Arthrectomy/Rotablator, IVUS, FFR
   - Intra-Aortic Balloon
   - Pacemaker, Permanent
   - Automatic Implantable Defibrillator (AICD)
   - Balloon Valvuloplasty

   Percutaneous Transluminal Peripheral Angiogram/Angioplasty (PTA) - 3 cases

2. Interventional Radiologists: 3

3. Vascular Surgeons: Surgery department members require 8 cases proctored