Departmental

Rules and Regulations

of

Medical Staff of St Vincent Healthcare

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St. Vincent Healthcare
Medical Staff Departmental Rules and Regulations

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1.0 DEPARTMENT OF ANESTHESIA

1.1 BASIC ORGANIZATION
Anesthesia services shall be properly organized, directed and integrated with other related services or departments of the hospital.

A. The anesthesia service shall be directed by an anesthesiologist member of the medical staff who shall have overall administrative responsibility for the service provided. His/her responsibility should include at least:

1. Review of the quality of anesthesia care rendered by members of the Anesthesia Department in the surgical and obstetrical area or other areas of the hospital where anesthesia services are provided.

2. Availability of equipment necessary for administering anesthesia and for related resuscitative efforts.

3. Development of regulations concerning anesthetic safety.

4. Recommending of privileges for all individuals with primary anesthesia responsibility, which shall be processed through established medical staff channels.

5. Establishing a program of continuing education for all individuals having anesthesia privileges.

B. The Chairman of the Department of Anesthesia must cooperate on the development of policies relative to the functioning of anesthesiologists and various departments or services of the hospital. This may include participation in the hospital's program of cardiopulmonary resuscitation, consultation or management of problems of acute and chronic respiratory insufficiency and consultation on a variety of other diagnostic and therapeutic measures related to hospital patient care.

1.2 STAFFING
Staffing for the delivery of anesthesia care shall be related to the scope and nature of the needs anticipated and the services offered.

A. Anesthesia care shall be provided by Anesthesiologists. Anesthesiologists should be regularly available to provide anesthesia care for patients wherever it is required in the hospital. The same competence of Anesthesia personnel shall be available for obstetrical and emergency procedures as it is available for elective procedures.

B. Anesthesiologists must be able to perform all of the independent services usually required in the practice of anesthesiaology. This includes the ability to:
1. Perform accepted procedures commonly employed to render the patient insensible to pain for the performance of surgical and obstetrical procedures or when necessary, pain producing clinical maneuvers.

2. Support life functions during the period of anesthesia.

3. Provide appropriate pre-anesthesia and post-anesthesia management for the patient.

4. Provide consultation relating to various other forms of patient care such as, inhalation therapy, emergency cardiopulmonary resuscitation and special problems in pain relief, unless these responsibilities are assigned to another physician who is judged by peer evaluation to be specially well qualified and is willing and able to assume them.

C. When the physician primarily responsible for a patient's care is other than a surgical specialist or obstetrician, clearance with the Director of Anesthesia shall be obtained before any elective general anesthesia is administered to the patient.

1.3 SAFETY REGULATIONS

Appropriate precautions shall be taken to insure the safe administration of anesthetic agents.

A. Anesthesia apparatus must be inspected by the Anesthesiologist before use. If a significant leak or defect is observed, the equipment will not be used until the fault is repaired.

B. Only nonflammable agents will be used for anesthesia at any location in this hospital. A permanent sign must be posted prohibiting flammable agents.

C. With the exceptions of certain radiological equipment and fixed lighting more than five feet above the floor, all electrical equipment in an anesthetizing area shall be on an audio-visual line isolation monitor. These line isolation monitors should be tested on a routine basis. When this indicates a hazard:

1. Hospital engineer or maintenance chief shall be notified immediately.
2. Following completion of the procedure, the operating room from which the signal emanates should not be used until the defect is remedied.
3. All personnel who work in such areas shall be familiar with the procedures to be followed.

D. The condition of all operating room electrical equipment shall be inspected regularly.

E. Anesthesia personnel shall familiarize themselves with the rate, volume and mechanism of air exchange within the surgical and obstetrical suites, as well as with the humidity control. A relative humidity of at least 50% must be maintained.

F. Prior to administering anesthesia, the Anesthesiologist shall check the readiness, availability, cleanliness, sterility, where required and working condition of all equipment used in the administration of anesthetic agents.
G. Laryngoscopes, airways, breathing bags, masks, endotracheal tubes and all reusable anesthesia equipment in direct contact with the patient shall be disinfected in accordance with hospital protocol.

H. Each anesthetic gas machine shall have an index safety system and each machine shall also be provided with a gas scavenging system and an oxygen pressure lock system or a system that functions as well as or more effectively than an interlock system.

I. Except for specific emergency situations, the administration of anesthesia shall be limited to areas where it can be given safely, in accordance with the policies and procedures of the anesthesia, surgical and obstetrical, emergency outpatient and other concerned departments or services.

1.4 STANDARDS FOR ANESTHESIA CARE

A. Pre-Anesthetic Evaluation by a physician shall include:

1. Review of the patient's medical record.
2. Interview and discuss with the patient his/her medical, anesthetic and drug history.
3. Perform any examination that would provide any information that might assist in decision regarding risk and management.
4. Order the necessary tests and medications necessary to conduct anesthesia.
5. Obtain consultation as necessary.
6. Record impressions on patient's medical record.

B. Intra-operative standards:

1. Reevaluation of patients prior to induction.
2. Careful, thorough preparation and check of equipment, drugs, fluids and gas supplies.
3. Availability, knowledge of use and proper application of the equipment necessary to conduct the anesthesia including but not necessarily limited to: functioning laryngoscope, endotracheal tube, wide selection of airways and masks, means of administering artificial ventilation, defibrillation and suctioning equipment.
4. Proper and adequate use of monitoring equipment.
5. Accurate record of events of the procedure and vital signs.

C. Post-anesthetic care requires:

1. Availability of adequate nursing personnel and pertinent equipment necessary for post-anesthetic care.
2. Awareness by a responsible physician of competence level of personnel who will carry out post-anesthetic care.
3. Indoctrination of personnel caring for patients in immediate post-anesthetic period and specific problem presented by each patient.
4. The individual responsible for administering anesthesia remain with the patient as long as his/her or her presence is necessary.
5. Discharge of patients from the post-anesthetic care facility is to be made according to the criteria established by the Department of Anesthesia:

6. At least one visit with appropriate notation on the patient's chart during early post-anesthetic period when feasible. The post-anesthetic visit can be made by an anesthesiologist or by a qualified post-operative nurse clinician.


D. Obstetrical anesthesia:

1. Except as emergency or near emergency conditions make it impractical, there should be no difference in the care provided obstetrical patients as described above.

1.5 EVALUATION OF ANESTHESIA SERVICES

A. The quality of anesthesia care provided shall be evaluated as part of the hospital's Quality Performance Improvement Program.

B. A record shall be maintained of the findings of the anesthesia quality review as well as all resultant action and follow-up.

C. The Chairman of the Department of Anesthesia shall:

   1. Monitor the quality of anesthesia care rendered by Anesthesiologists anywhere in the facility, including surgical, obstetrical, emergency outpatient and special procedure areas.
   2. Insure the work performed in the facility by all categories of personnel administering anesthesia is included in the Quality Performance Improvement Program process. Such personnel shall include: anesthesiologists, nurse anesthetists, and individuals in an approved anesthesia training program.

1.6 NEW ANESTHESIOLOGISTS

A new anesthesiologist on staff may not be assigned any call status within his/her first three weeks of work. He/she may not accept supervision responsibilities until three (3) complete weeks of pre-oping patients are finished.

1.7 PRE-OP CONSULTS

Pre-op consults will be done if possible by the anesthesiologist assigned to the room.

1.8 DEPARTMENT QUALIFICATIONS

All anesthesiologists must have completed an approved anesthesia residency program.

1.9 CALL

Anesthesia call shall run from 7:00 a.m. to 7:00 a.m. the following morning.
Anesthesiologists shall make all reasonable efforts to be available through the use of phone and beeper.

1.10 ATTENDANCE AT C-SECTIONS
Non-clinical attendance at a C-section is to be limited to one person, exception will be at the discretion of the anesthesiologist.

1.11 ANESTHETIC ADMINISTRATION
General anesthetics should not be administered without the attendance of a trained and qualified nurse anesthetist and/or physician anesthesiologist.

1.12 PRE-OP EKG’S
See Anesthesia Rule 1.19.

1.13 BLOOD UTILIZATION
When blood is administered, the reason for giving blood and the estimated blood loss should be documented.

1.14 BLOCKS/PAIN RELIEF TRANSFUSIONS
Should a patient require blocks/pain relief or transfusions authorized by the anesthesiologist after the patient leaves the PACU, anesthesia personnel should advise the surgeon.

1.15 MINIMUM TESTING REQUIREMENTS FOR SURGICAL PATIENTS
The Department of Anesthesia will determine the minimum preoperative testing that is necessary prior to the administration of anesthetic care. These guidelines and any subsequent modifications will be communicated to the Medical Staff and to the appropriate hospital departments and personnel. (Rev. 4/90)
2.0 DEPARTMENT OF EMERGENCY MEDICINE

2.1 ER CALL
A. Emergency Department backup coverage will be the responsibility of each department. In the event of an unreasolvable dispute, it will be referred to the Medical Executive Committee.
B. When a physician on call is unable or refuses to take call, the Chairperson of the Department should be contacted.

2.2 BURN PATIENTS
Unassigned burn patients who require admission or consultation will be seen by the general surgeon or plastic surgeon when available.

2.3 PHONE ORDERS
Outpatient orders called in by non-Emergency Department providers shall be documented in a verbal order format and include the physician giving the order.

2.4 ADMITTING ORDERS
Admitting orders written by Emergency physicians shall be documented on Standard Form No. MR-0030.

2.5 TRANSFER TO ANOTHER FACILITY
Transfer to another facility will be in accordance with Policy No CC-008.

2.6 CORONER NOTIFICATION
The coroner shall be notified when a patient expired in the Emergency Department or is dead on arrival.

2.7 CHART REVIEW
The Medical Director or his/her physician designee will review a random sampling of Emergency Department charts every day. Predetermined criteria will be used to screen the charts for proper documentation and ensure adequate care.
3.0 DEPARTMENT OF FAMILY PRACTICE

3.1 OBJECTIVE
The objective of the Department is to assure the hospital patient the availability of excellent continuing and comprehensive care by individually qualified family physicians.

3.2 PURPOSE
The purpose of the Department of Family Practice is to provide family physicians a means to address the educational needs of department members, promote involvement of individual family physicians in the maintenance of quality standards of patient care, as well as provide a framework within which family physicians may work as a group on problems affecting the department or any individual member of the department.

3.3 MEETINGS
Departmental meetings shall be held bi-monthly. A quorum shall be constituted by those present but not less than two of the department's members. Active members are required to attend 50% of the Department and encouraged to attend all meetings of Committees of which he/she is a member. Associate, Consulting and Courtesy staff are encouraged to attend all of the Department meetings.

3.4 MEMBERSHIP
Qualifications for membership in the department shall include the following:

1) The applicant shall meet the requirements for medical staff membership as outlined in the Medical Staff Bylaws.

2) In addition, the applicant shall have expertise in the specialty of family practice as evidenced by:
   a) Successful completion of an accredited family practice residency, and/or
   b) Current board certification in family practice by the American Board of Family Practice or the American Osteopathic Board of General Practice and/or
   c) Have demonstrated abilities and competence in the specialty of family practice for a period of five or more years.

3.5 DEPARTMENT CHAIR: QUALIFICATIONS AND TERM OF OFFICE
The department chair shall be a member in good standing of the medical staff and shall be qualified by training, experience, and demonstrated ability for the position. The
department chair shall serve a two year term, commencing on the first day of the medical staff year following his/her appointment and approval. Each department chair shall serve until the end of his/her term or until a successor is elected. Election of the department chair shall follow the procedure outlined in Section 9.7-2 of the Medical Staff Bylaws.

3.6 DUTIES OF THE CHAIR

Duties of the chair shall include those delineated in sections 3.6 and 9.7 of the Medical Staff Bylaws. He/she shall review applications for privileges in the department referred to the department by the Medical Executive Committee, and take appropriate action as per section 4.3-2 of the Medical Staff Bylaws. Reappointment shall be performed as per sections 3.5 and 3.6. The chair shall preside over meetings of the department, and serve as liaison between the Medical Executive Committee and department regarding departmental functions. Quality assurance, proctoring applicants with provisional privileges, and other departmental concerns shall be the responsibility of the chair or his/her designees.

3.7 RESPONSIBILITIES OF DEPARTMENTAL MEMBERSHIP

1. Members shall fulfill the responsibilities of medical staff membership as outlined in section 3.3 of the Medical Staff Bylaws.

2. Members shall stand ready to assist the department chair in the performance of departmental responsibilities, including but not limited to chair review, proctoring newly appointed members, and serving on ad hoc committees.

3. Members shall participate in ER Call as it is defined in section 1.2-b of the general Medical Staff Rules and Regulations. Family Practitioners may fulfill this requirement by participation in the ER call schedules of other appropriate departments, one physician equivalent per physician. Because of distance and other local responsibilities, Laurel physicians have been exempted from ER call duties in medicine. Members of the Department who have clinical responsibilities outside of Billings may be exempted from ER call under the discretion of the Department Chair.

3.8 ER CALL

Members of the Department of Family Practice will be relieved of the duty and burden of ER call at age sixty (60) unless they request to continue with the responsibility.
4.0 DEPARTMENT OF MEDICINE

4.1 PROVISIONAL MONITORING:

The Department shall establish monitoring requirements for provisional staff members and be responsible for carrying out these requirements. The Department Chairperson will appoint reviewers to evaluate physician’s charts. After initial provisional period expires, the Department Chairperson will make his/her recommendation to the Credential’s Committee concerning provisional member’s staff category and privileges.

4.2 ER CALL

Members of the Department of Medicine must request to be removed from ER call by petitioning the Department of Medicine Chairperson. This request must specifically ask for approval to be removed from ER call responsibilities.

4.3 INFORMED CONSENT

Informed consent must be obtained by department members prior to the performance of a surgical/invasive procedure.

4.4 NO CODE ("DO NOT RESUSCITATE") POLICY

Members, when writing a "No Code" or "Do Not Resuscitate" order, shall comply with hospital policy.

4.5 SUBSECTIONS OF THE DEPARTMENT

Psychiatry shall be a subsection of the Department of Medicine.

4.7 RESIDENT SUPERVISION GUIDELINES

The Resident Supervision Guideline Grid for the Department of Medicine is to be enforced according to the Family Practice Resident Supervision Policy and both documents will be addendums to the Department Rules and Regulations. All changes to the Supervision Guideline Grid are approved by the Department and forwarded to the Medical Executive Committee for final approval.
5.0 DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

5.1 CURRENT COMPETENCY
Any Board Qualified or Board Certified obstetrician who has been out of the active practice of obstetrics for two years (full-time practice with complicated and uncomplicated cases) must re-apply for privileges.

5.2 NEWBORN COMPLICATIONS
In case of any serious complication of a newborn, the attending physician shall call a pediatrician in consultation.

5.3 DIRECT COOMB’S TEST
An appropriate laboratory test shall be done for the detection of hemolytic disease in the newborn and shall be recorded on the chart.

5.4 ATTENDANCE OF FAMILY MEMBERS
Fathers and/or other support persons may be in the delivery room at the discretion of the attending physician and with the consent of the mother.

5.5 PHOTOGRAPHS/VIDEO TAPEING IN THE DELIVERY ROOM
With the consent of the mother and at the discretion of the attending physician, photographs may be taken in the delivery room. Videotaping of the delivery is prohibited. After the birth and the newborn is diagnosed as stable, video taping can be performed with the consent of the mother and at the discretion of the attending physician.

5.6 UNATTENDED DELIVERIES
All deliveries unattended by a physician will be reviewed by the Department.

5.7 PLACENTAL EXAMS AND CORD BLOOD
Placental exams and cord blood samples should be performed for all stillborns.

5.8 BLOOD LOSS DOCUMENTATION
Estimated blood loss shall be documented on all deliveries.
5.9 **VAGINAL DELIVERY WITH PREVIOUS C-SECTION**
If a mother wishes to deliver vaginally and she has had a previous C-section, an obstetrician should be readily available during labor.

5.10 **NO PRENATAL CARE CALL SCHEDULE**
A. Call responsibility begins at 7:00 a.m. Mondays.

B. The first physician to see the patient is determined to be the attending physician.

C. If the patient has made an appointment, indicating intent, that physician will continue to provide the patient's care.

D. If a patient is assigned to an obstetrician on the "no prenatal care" call schedule, that obstetrician becomes her physician of record.

5.11 **QUALITY REVIEW**
Obstetrical care will be reviewed by the Department.

5.12 **ULTRASOUND INTERPRETATION**
The obstetrician using the portable real-time ultrasound machine will be responsible for interpreting and documenting the ultrasound findings in the patient's chart. Radiology consultation will be at the discretion of the obstetrician.

5.13 **PRE-TERM ADMISSIONS**
Medical record documentation for preterm admissions will include the patient's prenatal profile and an admitting note indicating whether or not the patient's medical problems are pregnancy related.

5.14 **RH TYPING**
All Rh positive mothers will be retyped immediately postpartum unless the attending physician has cared for the patient through more than two pregnancies and cancels the order.

5.15 **ER CALL**
ER call is a daily obligation commencing at 0700 and ending at 0700 twenty four (24) hours later. When a physician reaches the age sixty (60) and is practicing Gynecological medicine only, he/she may make a formal request to the department to be granted a relief from ER call with the understanding that if granted, the leave would be for a maximum of two (2) years with the expectation that at the end of that time the provider would resume taking call.
5.16 HOLLISTER FORM/OBSTETRICAL H&P

Reference Section 4.3 General Staff Rules and Regulations - Medical Record Section

5.17 POLICIES AND PROCEDURES FOR PRACTICE OF THE NURSE MIDWIFE

A. Definition of a Certified Nurse Midwife:
A Certified Nurse-midwife (CNM) is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse Midwives.

B. Definition of Midwifery Practice:
Midwifery practice as conducted by CNM’s is the independent management of women’s healthcare, focusing particularly on pregnancy, childbirth, the postpartum period, case of the newborn, and the family planning and gynecological needs of women. The certified nurse-midwife practices within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client. Certified nurse-midwives practice in accord with the Standards for the Practice of Nurse Midwifery, as defined by the American College of Nurse-Midwives.

C. Definition of Consulting Physician:
Consulting physician means a physician who is a member of the Active Staff of the Department of OB-GYN at St. Vincent Healthcare and who has agreed with the practicing nurse midwife to provide collaboration and consultation services and accept patient referrals when indicated.

D. Types of Management:
Midwifery care is primarily intended for healthy women. However, when women experience medical, gynecological and/or obstetrical complications, the certified nurse midwife can continue to be instrumental in their care.

This collaboration (co-management) provides for the following pattern of care for the high-risk client:

1. Consultation is the process whereby a CNM, who maintains primary responsibility for the woman’s care, seeks the advice or opinion of a physician or another member of the healthcare team.

2. Collaboration is the process whereby a CNM and physician jointly manage the
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care of a woman who has become medically, gynecologically or obstetrically complicated. The scope of collaboration may encompass the physical care of the client, including delivery, by the CNM, according to a mutually agreed upon plan of care. When the physician must assume a dominant role in the care of the client due to increased risk status, the CNM may continue to participate in physical care, counseling, guidance, teaching and support. Effective communication between the CNM and physician is essential for ongoing collaborative management.

3. **Referral** is the process by which the CNM directs the client to a physician or other health professional for management of a particular problem or aspect of the client’s care.

E. **General CNM Policies:**

1. Physician consultation will be provided for each nurse midwife patient after the initial visit, at admission to the hospital and during the prenatal course if there are deviations from normal.

2. The nurse midwife shall practice in accordance with ACNM standards, State and Federal regulations governing midwifery practice and Elizabeth Seton Prenatal Clinic Practice Guidelines.

4. Nurse midwives without prescriptive authority may write in-house medication orders according to standing orders and/or ESPC practice guidelines. Exceptions require consultation with a staff CNM or physician.

5.18 **RESIDENT SUPERVISION GUIDELINES**

The Resident Supervision Guideline Grid for the Department of Pediatrics is to be enforced according to the Family Practice Resident Supervision Policy and both documents will be addendums to the Department Rules and Regulations. All changes to the Supervision Guideline Grid are approved by the Department and forwarded to the Medical Executive Committee for final approval.

5.19 **LABOR AND DELIVERY NURSE**

A woman who is experiencing contractions is in true labor unless a physician certifies, after a reasonable period of observation, that the woman is in false labor. A Labor and Delivery Nurse may functions as a “Qualified Medical Person” (QMP). As a QMP, the L&D nurse may examine and observe a woman who is experiencing contractions and make an assessment of whether the woman is in true labor; provided, however, that if a QMP makes an assessment that the woman is in false labor, a physician must certify the diagnosis of false labor via phone conversation or actual visit before the individual can be discharged.
6.0 DEPARTMENT OF ORTHOPEDICS

(Deletion of all Department Rules and Regulations was approved 10/2009)

7.0 DEPARTMENT OF PEDIATRICS

7.1 NEWBORN EXAM
If a physical examination has not been performed on a newborn infant within twenty-four (24) hours of birth, the nurse in charge will notify the Director of Newborn Services or Designee.

7.2 PEDIATRICIAN ATTENDANCE
Pediatrician shall attend C-sections.

7.3 UNASSIGNED NEWBORNS
Unassigned newborns are referred to the on-call Pediatrician at the time of delivery.

7.4 MANAGEMENT OF NICU PATIENTS
Infants admitted to the NICU shall be managed by a Pediatrician or Neonatologist.

7.5 NEWBORN SCREENING
Primary care providers will follow-up on abnormal newborn screening.

7.6 PEDIATRIC SPECIAL CARE UNIT
A pediatric consult shall be required for all admissions to the Pediatric Special Care Unit.

7.7 ER CALL
ER call will be taken by the assigned on-call Pediatrician.

7.8 RESIDENTS
A. All orders written by Residents must be verbally approved by the Attending or the orders must be co-signed by the Attending prior to implementation of the orders.
B. The Resident Supervision Guideline Grid for the Department of Pediatrics is to be enforced according to the Family Practice Resident Supervision Policy.
8.0 DEPARTMENT OF SURGERY

(Deletions of sections 8.1 -8.9 and 8.11-8.12 were approved 3/2010)

8.10 ER CALL

General surgeons will be relieved of ER call at age fifty-five (55) unless they request to continue with the responsibility. All other surgical subsections will take call until the age of sixty (60) unless they request to continue with the responsibility.