DEPARTMENT OF ANESTHESIA

1. The Department of Anesthesia shall be organized in accordance with the provisions of the Bylaws of The Good Samaritan Hospital dealing with departmental organizations.

2. Initial privileges granted in the Department of Anesthesia shall be commensurate with the training, experience, competence, judgment, and character of the candidate. It is the responsibility of the candidate to provide substantiation.

3. Department Structure

   A. The Department will consist of anesthesiologists, nurse anesthetists, anesthesia technicians, physician assistants and other allied disciplines related to the practice of anesthesia and/or pain medicine and/or critical care medicine and/or perioperative medicine. The Department may from time to time have visitors from related areas such as representatives from PACU, SSU, or ICU.

   B. The Department will have a Chairman and a Vice Chairman of the Department. The term of office will be the same as outlined in the Medical Staff Bylaws section regarding the term of office for a department chairman. The Chairman and Vice Chairman shall be elected by the members of the Department of Anesthesia.

      1. The chairman shall be a member of the active staff, shall have demonstrated ability in at least one of the clinical areas covered by the department, and shall be willing and able to faithfully discharge the functions of his office.

      2. Term of Office: The Department Chairman shall serve a two-year term commencing on his appointment. He shall serve until the end of the succeeding year, and until his successor is chosen, unless he shall sooner resign or be removed from office.

      3. Vacancy: Upon a vacancy in the office of department chairman, the Vice Chairman of the department shall become department Chairman until a successor is appointed.

      4. The chairman shall be accountable to the Medical Executive Committee and to the Chief Medical Officer for all professional and administrative activities within his department, and particularly for quality review and evaluation functions delegated to his department;

5. The chairman shall develop and implement departmental programs, in cooperation with the Chief Medical Officer and consistent with the provisions of Section 10.4 and Article XIIK, for ongoing monitoring of practice, credentials review and privileges delineation, continuing medical education, and utilization review;

6. The Chairman shall be a member of the Medical Executive Committee, give guidance on the overall medical problems of the Hospital, and make specific recommendations and suggestions regarding his own department;

7. The Chairman shall maintain continuing review of the professional performance of all practitioners with clinical privileges and of all allied health professionals with specified service in his department and report regularly thereon to the Medical Executive Committee;

8. The Chairman shall transmit to the appropriate authorities as required by Article VI and VII, his department's recommendations concerning appointment and classification, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners in his department;

9. The Chairman shall appoint such committees as are necessary to conduct the functions of the department specified in Section 10.4 and designate a chairman and secretary for each;

10. The Chairman shall enforce the Hospital and Medical Staff Bylaws, Rules and Regulations and Policies within his department, including initiating corrective action and investigation of clinical performance and ordering consultations to be sought when necessary;

11. The Chairman shall implement within his department actions taken by the Medical Executive Committee and by the Board;

12. The Chairman shall participate in every phase of administration of his department, through cooperation with the nursing service and the Hospital administration, in matters affecting patient care, including personnel, supplies, equipment, space needs, special regulations, standing orders and techniques.

13. The Chairman shall assist in the preparation of such annual reports, including budgetary planning, pertaining to his department as may be required by the Medical Executive Committee, the President and Chief Executive Officer or the Board; and

14. The Chairman shall assess and recommend to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization,

15. The Chairman shall perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the President of the Staff, the Medical Executive Committee, or the Board.

16. The Vice Chairman shall perform the various function of the chairman during his absence, and any other function designated by the chairman

17. The Vice Chairman shall have a term of office that shall coincide with that of the chairman.

18. The Vice Chairman shall represent the Department on the Medical Staff's Performance Improvement and Monitoring Committee

C. The department will meet on a regular basis, not less than quarterly. Members of the Department may bring any topics of concern for discussion at the general meeting of the Department.

D. The Department Chairman and Vice Chairman will carry out their duties as outlined in Article XI of the Medical Staff Bylaws.

F. The Department may elect none or more members of the Department to oversee various functions and services of the Department, such as, but not limited to, Critical Care, Pain Management, or QA services.

4. Clinical Duties

A. When a complete history, physical examination, and essential laboratory tests are not recorded on the chart before the time assigned for the operation, the operation shall be cancelled unless the attending surgeon states in writing that such a delay would constitute a hazard to the patient. In this event, an examination of the heart and lungs must be recorded on the chart. An exception will be granted if the history and physical have been dictated, but not transcribed and if there are a history and physical by the anesthesiologist on the chart.

B. Each patient shall be positively identified by the anesthesiologist before field blocks, major conduction anesthesia or the placement of invasive monitoring lines. Each patient must also be positively identified by the surgeon and a member of the anesthesia service after the patient is on the operating table in the room, before general anesthesia or surgery are commenced. Appropriate documentation must appear on the hospital record.

C. Pre- and post-anesthesia rounds and assessments shall be completed and recorded in the patient record by a member of the anesthesia staff.

D. All safety standards shall be observed by anyone entering an operating area, including proper gowning, with mask and cap.

E. Rules and regulations for operating room procedures and scheduling will be followed by all physicians using the operating room facilities.

5. Any changes to the Department of Surgery Rules and Regulations, or to the Department of Cardiovascular Medicine, having to do with patient care or operating room rules must be brought to the Department of Anesthesia for review for possible inclusion in the Department of Anesthesia Rules and Regulations.

6. There shall be a biennial review of privileges in conjunction with staff reappointment. this shall be based on appraisal of professional performance, judgment, skill, and knowledge; current licensure, physical and mental health status, fulfilling the continuing education requirements; staff citizenship, including meeting attendance and medical record function; efficient use of Hospital facilities and resources; working relations with colleagues and other Hospital personnel; and the results of quality assurance activities. Guidelines from various specialty societies may be used for specific procedures. Review shall b conducted by a committee consisting of the chairman, vice chairman, and most recent available past chairman. The committee report shall be available to the Department at the annual meeting and shall be forwarded to the Medical Executive Committee and Board. Additionally, there shall be an ongoing professional practice review biannually.

   Additional privileges may be granted at any time, based on documentation of appropriate training and competence, with approval of the department chairman, the Credentials Committee, the Medical Executive Committee and the Board, ad in consideration of the Hospital's facilities and resources. Privileges may also be modified or withdrawn at any time as the result of corrective action, as provided in the bylaws.

7. A copy of the delineation of privileges, including a list of procedures, will be included in the application of each new member of the Department o f Anesthesia. The delineation of privileges must be approved by the Chairman of the Department of Anesthesia, the Credentials Committee, the Medical Executive Committee and the Board.

   A current list of the physicians in the Department of Anesthesia with his/her attending status, category or privileges and specialty will be kept inn the office of the President and Chief Executive Officer of the Hospital and with these rules and regulations.

8. Attendance at department meetings is in accordance with the requirements set forth in the bylaws of the Medical Staff.

9. All patients to undergo a procedure or anesthesia by any member of the department shall be seen before the procedure for an appropriate history and physical examination, a discussion of the procedure/anesthesia plan with relevant risks and benefits discussed with the patient for informed consent. All patients will have a post-anesthesia assessment that will be documented in the chart.

10. The Department is responsible for monitoring procedures, equipment and utilization of the anesthesia services in the Hospital.

11. The Department authorizes a Quality Assurance Committee as a standing committee.

    A. Purpose: to serve as the focus for quality assurance and peer review activities for the Department

    B. Members shall be appointed to serve on the Committee by the Chairman and will consist of at least one anesthesiologist and at least one CRNA.

    C. Meetings will occur at least quarterly; a majority of the voting members shall constitute a quorum but not less than two.

    D. Professional Practice Evaluation:

        1. Indicators recommended by the Committee and approved by the department, MEC and the Board.
        2. Threshold recommended by the Committee and approved by the department, MEC and the Board.
        3. Indicators are evaluated periodically.

    E. Cases reviewed will be discussed with the physician involved prior to final decisions. Actions and recommendations will be reported regularly at Department meetings.

SIGNATURE SHEET

The rules and regulations of the Department of Anesthesia have been reviewed and approved by the members of the Department of Anesthesiology.

DATE	Gregory S. Wickey, MD Chairman, Department of Anesthesiology
DATE	Paul J. Teiken, MD President, Medical Staff

CARDIAC CATHETERIZATION LABORATORY

I. Designation

The Cardiac Catheterization Laboratory (CCL) is organized and functions as a clinical department of the Hospital.

II. Organization

A. Medical Director

1. Appointment -- by the Sr. VP WellSpan Health; President, WGSH upon recommendation of the President of the Medical Staff and Chairman of the Department of Cardiovascular Medicine, to be reviewed every two years.

2. Qualifications
   a. Member of the active medical staff in the Department of Cardiovascular Medicine
   b. Board-certified or board-eligible in Internal Medicine and Cardiovascular Disease.
   c. Privileges to do procedures in the CCL.

3. Responsibilities
   a. Reviews professional performance of physicians working in the CCL and report to the Department of Cardiovascular Medicine.
   b. Serves as Chairman of the CCL Committee.
   c. Advises the Administration of Cardiovascular Services on selection of the clinical manager.

B. Physician staff -- practitioners with specific clinical privileges to perform procedures deemed appropriate for the CCL.

C. CCL Committee

1. Established as a committee of the Department of Cardiovascular Medicine with support membership from the Hospital staff.

2. Physician membership -- appointed by the Department of Cardiovascular Medicine.

   a. Medical Director - Chairman.
   b. Physicians with privileges to work in CCL.

3. Hospital personnel --
   a. Sr. Director Clinical Services
   b. Manager, Cardiology Services
   c. Radiation physicist -- ex-officio; will attend upon request

4. Duties -- meet monthly for
   a. Review and coordination of activities, policies and procedures.
   b. Problem-solution.
   c. To serve as the focus for quality assurance.

III. **Procedures**

A. Diagnostic Cardiac Catheterization

Diagnostic cardiac catheterizations may be performed on all patients 18 years of age or older requiring left or right heart diagnosis via catheterization at the discretion of the privileged cardiologist.

Questions regarding patient appropriateness will be referred to the Medical Director for resolution. If the Director cannot resolve the question, or if the Director is the attending physician, the matter will be referred to the Department of Cardiovascular Medicine for resolution.

B. Percutaneous Coronary Intervention

Percutaneous coronary interventions may be performed, as deemed necessary, by the Interventional Cardiologist on all patients 18 years or older.

Questions regarding patient appropriateness will be referred to the Medical Director for resolution. If the Director cannot resolve the question, or if the Director is the attending physician, the matter will be referred to the Department of Cardiovascular Medicine for resolution.

C. Electrophysiology (EP) Services

Electrophysiology procedures will be performed by the EP physician or an appropriate privileged Physician on all patients 18 years of age or older requiring a permanent pacemaker, ICD, EP study, EP ablations, or loop recorder.

Questions regarding patient appropriateness will be referred to the Medical Director for resolution. If the Director cannot resolve the question, or if the Director is the attending physician, the matter will be referred to the Department of Cardiovascular Medicine for resolution.

D. Other cardiac or vascular procedures – may be performed at the discretion of the Interventional Cardiologist or an appropriate privileged Physician.

E. Informed Patient Consent – required of all patients for procedures to be performed in the CCL.

IV. **Quality Assessment**

A. The CCL will participate in the quality assessment activities as defined by the Hospital Quality Assessment and Improvement Plan and the Cardiovascular Program Quality Improvement Committee.

B. The CCL Committee will define the scope and aspects of care that will be monitored.

C. Results of the monitoring and evaluation activities will be reported to the Department of Cardiovascular Medicine by the CCL Committee and QI Committee.

D. Medical appropriateness will be a regular aspect of care.

SIGNATURE SHEET

These Rules and Regulations for the Cardiac Catheterization Laboratory have been reviewed and approved by the Cardiac Catheterization Laboratory Committee.

Date	Tyler S. Fugate, DO; Medical Director Cardiac Catheterization Laboratory
Date	Edward J. Tadajweski, MD; Chairman Department of Cardiovascular Medicine
Date	Paul J. Teiken, MD President, Medical Staff

DEPARTMENT OF CARDIOVASCULAR MEDICINE

1. The Department of Cardiovascular Medicine shall be organized in accordance with the provisions of the Bylaws of WellSpan Good Samaritan Hospital dealing with departmental organizations (see Article IX).

2. Initial privileges granted in the Department of Cardiovascular Medicine shall be commensurate with the training, experience, competence, judgment, and character of the candidate. It is the responsibility of the candidate to provide substantiation.

3. **DEPARTMENT STRUCTURE**

   A. The Department is made up of the Division of Cardiology, Division of Cardiovascular Surgery, Division of Vascular Surgery and the Advanced Practice Clinicians

   B. The Department will elect its own Director. This person can also be the Chairman or Vice Chairman of the Department. The term of office for the Director will be the same as outlined in the Medical Staff Bylaws section regarding the term of office for a department chairman Article X.

      1) The Director of the Department will regularly (not less than quarterly) report activities of their department to the members of the Department of Cardiovascular Medicine.

   C. The Chairman and Vice Chairman of the Department of Cardiovascular Medicine will be elected by the members of the Department.

      1) The Department Chairman and Vice Chairman will carry out their duties as outlined in Article X of the Medical Staff Bylaws.

   D. Department meetings will occur in accordance with Article XIII 7.1 of the Medical Staff Bylaws. Members of the Department may bring any topics of concern for discussion at the general meeting of the Department.

4. **DIVISIONS AND DELINEATION OF PRIVILEGES:**

A. Division of Cardiology: Physicians in this category are Board qualified or certified in the specialty of cardiology.

1) Such physicians may act as consultants to others and may in turn be expected to request consultation when:

a. diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness;
b. unexpected complications arise which are outside this level of competence; and
c. specialized treatment or procedures are contemplated.

2) The Director shall appoint one or more members of this Division to oversee the interventional and non-interventional services provided at The Good Samaritan Hospital.

B. Division of Cardiovascular Surgery, Division of Vascular Surgery and Advanced Practice Clinicians: Physicians in this category are Board qualified or certified in cardiovascular surgery, cardiothoracic surgery, vascular surgery, anesthesia (anesthesiologists in this Division must have privileges to perform cardiac anesthesia at WellSpan Good Samaritan Hospital) or are Board qualified or certified in medical specialties (other than cardiology) or surgery (other than the types mentioned above).

1) Those physicians who are either medical specialists (other than cardiologists) or surgeons (other than the types mentioned above) must be a member of another Medical Staff Department and must also abide by the Rules and Regulations of that Department.

2) All physicians in this Division may act as consultants to others and may in turn be expected to request consultation when:

a. diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness;
b. unexpected complications arise which are outside this level of competence; and

c. specialized treatment or procedures are contemplated.

3. When performing procedures in operating rooms other than the operating rooms designated as the cardiovascular operating rooms for cardiac and/or vascular surgery, all physicians in this Division are subject to the same patient care and operating room rules as set forth in the Department of Surgery Rules and Regulations. These rules are:

   a. A surgical operation or procedure shall be performed only upon the informed consent of the patient or his legal representative, except in life-threatening emergencies. It shall be the responsibility of the surgeon to obtain the consent for any procedure authorized on the "Consent to Operate" form and not more than 30 days prior to the procedure. Administrative Memorandum #10-3, "Informed Patient Consent" shall be adhered to.

   b. When a complete history, physical examination, and essential laboratory tests are not recorded on the chart before the time assigned for the operation the operation shall be cancelled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient. In this event, an examination of the heart and lungs must be recorded on the chart. An exception will be granted if the history and physical have been dictated, but not transcribed and if there is a Pre-anesthesia Assessment by the anesthesiologist on the chart.

   c. Each patient must be positively identified by the anesthesiologist before field blocks, major conduction anesthesia or the placement of invasive monitoring lines (e.g. pulmonary artery catheters, etc.). Each patient must also be positively identified by the surgeon and a member of the anesthesia service after the patient is on the operating table in the room, before general anesthesia or surgery are commenced. Appropriate documentation must appear on the hospital record.

d. A fully dictated operative note by the surgeon is required for all procedures performed on both inpatients and outpatients in the operating room as prescribed by regulatory requirements.

e. All tissue removed at operation, except those specimens which may be exempted shall be sent to the Hospital pathologist, who shall make such examinations as he may consider necessary to arrive at a pathologic diagnosis.

f. Pre-and Post-anesthesia rounds and assessments shall be completed and recorded in the patient record by the anesthesia staff.

g. All safety standards shall be observed by anyone entering an operating area, including proper gowning, with mask and cap.

h. Rules and regulations for operating room procedure and scheduling will be followed by all physicians using the operating room facilities.

i. The operating room manager must be notified as to any case that has been in isolation or has infection prior to the time that the patient comes to the operating room.

4. When a surgeon performs cardiothoracic or vascular surgical procedures in the operating rooms designated for cardiovascular surgery, the following rules must be followed:

a. A surgical operation or procedure shall be performed only upon the informed consent of the patient or his legal representative, except in life-threatening emergencies. It shall be the responsibility of the surgeon to obtain the consent for any procedure authorized on the “Consent to Operate” form and not more than 30 days prior to the procedure. Administrative Memorandum #10-3, “Informed Patient Consent” shall be adhered to.

b. When a complete history, physical examination, and essential laboratory tests are not recorded on the chart before the time assigned for operation, the operation shall be cancelled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient. In this event, an examination of the heart and lungs must be recorded on the chart. An exception will be granted if the history and physical have been dictated, but not transcribed and if there are a history and physical by the anesthesiologist on the chart.

c. Each patient must be positively identified (using the universal protocol method) by the anesthesiologist before field blocks, major conduction anesthesia or the placement of invasive monitoring lines (e.g. pulmonary artery catheters, etc.). Each patient must also be positively identified (using the universal protocol method) by the surgeon and a member of the anesthesia service after the patient is on the operating table in the room, before general anesthesia or surgery are commenced.

d. Appropriate documentation must appear on the hospital record
   - A complete History and Physical, accurate and up-to-date.
   - Pertinent findings (x-rays, labs, catheterization data) that support the procedure
   - Documentation of review with the patient of risks of the procedure and alternative therapy
   - Rationale for the procedure

e. A fully dictated operative note by the surgeon is required for all procedures performed on both inpatients and outpatients in the operating room as prescribed by regulatory requirements.

f. All tissue removed at operation, except those specimens which may be exempted shall be sent to the Hospital pathologist, who shall make such examinations as he may consider necessary to arrive at a pathologic diagnosis.

g. Pre- and Post-anesthesia rounds and assessments shall be completed and recorded in the patient record by the anesthesia staff.

h. All safety standards shall be observed by anyone entering an operating area, including proper gowning, with mask and cap.

i. Rules and regulations for operating room procedure and scheduling will be followed by all physicians using the operating room facilities.

j. The operating room manager must be notified as to any case that has been in isolation or has infection prior to the time that the patient comes to the operating room.

5. Any changes to the Department of Surgery Rules and Regulations having to do with patient care or operating room rules must be brought to the Department of Cardiovascular Medicine for review for possible inclusion in the Department of Cardiovascular Medicine Rules and Regulations.

6. Advanced Practice Clinicians (APCs) (e.g. physician assistants, nurse practitioners, etc.) may apply to be members of the Department of Cardiovascular Medicine. Each APC will be placed in the Division in which their supervising physician is a member. APCs have no voting rights in any Division or in the Department of Cardiovascular Medicine.

- Any CRNP who will be assisting with cardiovascular/ or vascular surgical procedures, must be certified as an RNFA or enroll in an RNFA program within 2 (two) years of hire.

7. There shall be a biennial review of privileges in conjunction with staff reappointment. This shall be based on appraisal of professional performance, judgment, skills, and knowledge; including information from ongoing professional practice (OPPE) review biannually, current licensure; physical and mental health status; fulfilling the continuing education requirements; staff citizenship (including meeting attendance and medical record function); efficient use of Hospital facilities and resources; working relations with colleagues and other Hospital personnel; and the results of quality assurance activities. Guidelines from various specialty societies may be used for specific procedures. Review shall be conducted by a committee consisting of the chairman, vice chairman, and most recent available past chairman. The committee report shall be available to the Department at the annual meeting and shall be forwarded to the Medical Executive Committee and Board.

8. Additional privileges may be granted at any time, based on documentation of appropriate training and competence, with approval of the department chairman, the Credentials Committee, the Medical Executive Committee and the Board, and in consideration of the Hospital's facilities and resources. Privileges may also be modified or withdrawn at any time as the result of corrective action, as provided in the bylaws.

9. A copy of the delineation of privileges, including a list of procedures, will be included in the application of each new member of the Department of Cardiovascular Medicine. The delineation of privileges must be approved by the Chairman or Vice-Chairman of the Department of Cardiovascular Medicine, the Credentials Committee, the Medical Executive Committee and the Board.

    - A current list of the physicians in the Department of Cardiovascular Medicine with his/her attending status, category or privileges and specialty will be kept in the office of Medical Affairs.

10. A service roster is set up annually as part of the table of organization by the Department. All service obligations must be met by each member of the Department and care of a service patient must be carried to satisfactory completion by the physician initially assigned to the care of the patient.

11. Attendance at department meetings is in accordance with the requirements set forth in the bylaws of the Medical Staff.

12. Patients shall be seen as often as necessary, but not less than once every day.

13. To facilitate prompt patient care, members of the staff who are on call to the Hospitals should keep themselves within the 15-mile circle required for office and residence and be able to respond, at least by phone, within thirty minutes of being called during their call period.

14. When a Staff member requests coverage status and privileges for a physician to cover his/her practice, privileges for this physician will be restricted because of the monitoring requirements for new physicians, as set forth in the Medical Staff By-laws. Privileges will be granted to provide usual medical care within the scope of the covered practice. Performance of procedures (e.g. echocardiography, surgery, etc.) will only be permitted to provide emergency care for inpatients and outpatients of the practice. Operating privileges will only be granted to provide urgent or emergent care for patients of the covered practice.

15. The Department is responsible for monitoring procedures, equipment and utilization of the Cardiovascular Unit in the Hospital.

16. The Department authorizes a Quality Assurance Committee as a standing committee.
    A. Purpose: to serve as the focus for quality assurance and peer review activities for the Department.

    B. Membership:

        1) Ex-officio:
            (a) Department Chairman will serve as Committee Chairman.
            (b) Department Vice Chairman

        2) Other: One (1) member from each Division (other than the Division Directors, Department Chairman and Vice Chairman)

    C. Meetings will occur at least quarterly; a majority of the voting members shall constitute a quorum, but not less than 2.

    E. Professional Practice Evaluation:

        1) Indicators recommended by the Committee and approved by the department, MEC and the Board.
        2) Threshold recommended by the Committee and approved by the department, MEC and the Board.
        3) Indicators are evaluated periodically.

    F. Reporting: Actions of the Department will be reported regularly at Department meetings and the Medical Executive Committee.

17. The Rules and Regulations of the Department of Cardiovascular Medicine having to do with surgery and the operating room are binding on the members of the Division of Cardiovascular Surgery, and will be enforced by the Medical Director, Division of Cardiovascular Surgery and allied specialists, acting through the operating room manager.

SIGNATURE SHEET

The rules and regulations of the Department of Cardiovascular Medicine of the Medical Staff of the Hospitals have been reviewed and approved by the Department and approved.

_____ _____

DATE Edward J. Tadajweski, MD
Chairman; Department of CV Medicine

_____ _____

DATE Paul J. Teiken, MD
President, Medical Staff

CARDIOVASCULAR UNIT, INTENSIVE CARE UNIT, 3 SOUTH, 4 EAST, 3 EAST AND 2 EAST TELEMETRY MONITORING

I. Critical Care Committee

A medical staff committee exists for medical supervision of the Cardiovascular Unit/Intensive Care Unit and 3 South, 4 East, 3 East and 2 East telemetry (as Medical Staff Rules and Regulations Intensive Care Unit and Telemetry Monitoring provided in the Medical Staff By-Laws, Article XII; Section 12.4-3).

A. Purpose

The purpose of the Critical Care Committee is to improve the quality of care, treatment, and services for Good Samaritan Hospital patients, and to provide a forum for WellSpan Good Samaritan Hospital medical staff and employees to provide oversight and to take action on issues related to the critical care services provided to the patients in the Cardiovascular Unit (CVU), Intensive Care Unit (ICU), 3 South (3S), 4 East (4E), 3 East (3E), and 2 East (2E) telemetry. In addition, the committee is charged with recommending policies, protocols, procedures, and process improvements for appropriate delivery of critical care and cardiac services and telemetry monitoring, including oversight and evaluation of the code blue and Rapid Response Team (RRT) team process. The committee is accountable and reports to the Medical Executive Committee.

B. Duties

In addition to items described in "Medical Staff Functions" of Article XII, Section 12.3 of the Medical Staff By-Laws, the duties of the Critical Care Committee shall include, but are not limited to:

1) Monitoring:
   a) patient care treatments and services provided in the CVU, ICU, 3S, 4E, 3E, 2E telemetry:
   b) code blue, and RRT team utilization:
   c) protocols, outcomes, processes, and procedures related to a and b.

2) Develop appropriate criteria for admission and discharge in CVU/ICU, 3S, 4E, 3E, and 2E telemetry as well as provide oversight for appropriate care.

3) Review quality of care treatment and services provided in CVU/ICU, 3S, 3E, and 2E telemetry.

4) Make recommendations and implement evidence based clinical protocols, policies, procedures, and process improvements related to critical care and cardiac services provided in affected units.

C. Composition

1) The committee shall consist of the Medical Directors of the CVU and ICU, and representatives from the Department of CV Medicine, Department of Medicine, Department of Surgery, Department of Anesthesia, Department of Emergency Medicine, and Critical Care Medicine.
2) Other members include representatives of CVU/ICU, 3S, respiratory therapy, administration, education, and Quality.
3) The Medical Directors of CVU and ICU function as co-chairman.

D. Meeting Frequency

The Critical Care Committee shall meet on a minimum bi-monthly schedule. Sub-committees may be formed and meet as needed.

E. Reporting

The Critical Care Committee will make recommendations, as needed, and report to the Medical Executive Committee.

II. Medical Directors

A. Cardiovascular Unit Medical Director

1) Appointment

a) The Medical Director will be the Chairman of the Department of CV Medicine, or his/her designee approved by the Department of CV Medicine, to be reviewed every two years.
b) The Medical Director shall be Board eligible, or Board certified in Cardiovascular Disease, Thoracic Surgery, or Vascular Surgery.

2) Responsibilities

a) Review professional performance of physicians working in the CVU and report to the Quality Assurance Committee of the Department of CV Medicine.
b) Serve as Co-Chairman of the Critical Care Committee.
c) Assist in developing and refining best practice clinical models in CVU.
d) May be called upon for questions relating to appropriateness of an admission or discharge from CVU/ICU, 3S, 4E, 3E, or 2E telemetry.
e) In the absence of the CVU Medical Director, the ICU Medical Director, or his/her designee, will assume the responsibilities of the CVU Medical Director.

B. Intensive Care Unit Medical Director

1) Appointment

a) The Medical Director will be appointed by the President of the Medical Staff upon recommendations from the Critical Care Committee, or his/her designee, approved by Medical Executive Committee (MEC), to be reviewed every two years.

b) The Medical Director shall be Board eligible, or Board certified in Internal Medicine, Surgery, or Critical Care Medicine.

2) Responsibilities

a) Review professional performance of physicians working in ICU and report to the Quality Assurance (QA) Committee regarding critical care services provided in the ICU and may make recommendations to the respective department QA Committees.
b) Serve as Co-Chairman of the Critical Care Committee.
c) Assist in developing and refining best practice clinical models in the ICU.
d) May be called upon for questions relating to appropriateness of an admission or discharge from CVU/ICU, 3S, 4E, 3E, or 2E telemetry.
e) In the absence of the ICU Medical Director, the CVU Medical Director, or his/her designee, will assume the responsibilities of the ICU Medical Director.

III. Admitting Privileges For CVU/ICU

A. Admitting Process and Management for The Cardiovascular Unit and Intensive Care Unit

1) Basic care orders must be placed prior to admission with completion of orders within two (2) hours following admission.

2) All patients admitted to the CVU/ICU must have a complete medical evaluation by the attending physician or the consultant and complete CVU/ICU orders placed within two (2) hours following admission.

3) Sufficient information and orders must always be available in order that appropriate care may be instituted at the time of admission. In the absence of this, the nurse has the right and responsibility to immediately consult the Nurse Manager/Director or Nursing Supervisor to assist in obtaining such information and orders.

4) All patients admitted to the CVU/ICU are expected to be seen by the physician in charge of their care at least once daily, or more often as dictated by the condition of the patient. Appropriate progress notes are expected to routinely reflect the patient's current status. This enables all members of the health care team to keep abreast of the patient's progress regime.

B. Admitting Privileges for the Cardiovascular and Intensive Care Unit

1) Physicians may admit to the CVU/ICU with the following guidelines.

a) Department of CV Medicine, Medicine, Surgery, and OB/GYN may admit to the CVU/ICU without consultation but should obtain a consult when other special areas of expertise are required.
b) When areas of special expertise are required in the handling of critically ill patients, or in special circumstances, it is recommended that the care of the patient be transferred to the care of the consulting physician with that area of expertise when appropriate.

IV. Admitting Privileges for 3S, 3E, 2E, 4E Remote Telemetry

A. Admitting process and management for telemetry.

1) All patients admitted to telemetry must have a medical evaluation by the attending or consulting physician and telemetry orders placed within eight hours of admission.

2) Sufficient information and orders must always be available in order that appropriate care may be instituted at the time of admission. In the absence of this, the nurse has the right and responsibility to immediately consult the Nurse Manager/Director or Nursing Supervisor to assist in obtaining such information and orders.

3) All patients admitted to telemetry are expected to be seen by the physician in charge of their care at least once daily, or more often as dictated by the condition of the patient. Appropriate progress notes are expected to routinely reflect the patient's current status. This enables all members of the health care team to keep abreast of the patient's progress regime.

4) A Nursing Supervisor and/or Nurse Manager/Director have the responsibility to recommend to an attending physician that telemetry be initiated on a patient provided the patient meets the eligibility for telemetry. Should the attending physician be unavailable, the nursing supervisor will contact the CVU or ICU Medical Director for evaluation and advice.

5) When the nursing staff is uncomfortable with an admission in which a patient is placed on telemetry, the case will be reviewed by the Nursing Supervisor and attending physician.

B. Privileges for Admitting a Patient for Telemetry (3 South, 4 East, 3 East, and 2 East Remote Telemetry)

1) Physicians may place a patient on telemetry with the following guidelines.

a) Department of CV Medicine, Family Medicine, Medicine, Surgery, and OB/GYN may place a patient on telemetry without consultation but should obtain a consult when other

special areas of expertise are required.

V. <u>Guidelines for Admission – Admission Criteria to the Cardiovascular and Intensive Care Unit</u>

The initial decision to admit a patient is the responsibility of the attending physician. The following shall serve as guidelines for eligible admission:

A. Any patient with a known or suspected acute myocardial infarction regardless of complications.

B. Any patient requiring titration of cardiac drips.

C. Any patient presenting with a compromising dysrhythmia.

D. Any hemodynamically unstable patient.

E. Any patient status post cardiopulmonary arrest.

F. Unstable patients due to acute pulmonary insufficiency, including all patients requiring mechanical ventilation.

G. Unstable patients due to acute neurological events such as:
   1) Uncontrolled seizures
   2) Unconscious state with unknown etiology
   3) Ischemic or hemorrhagic stroke, including ischemic stroke post tPA infusion. Hemorrhagic strokes will be admitted with per telestroke/Neurology directive with treatment plans or if the patient/family desires no treatment of bleed.

H. Patients whose surgery is of a magnitude or nature which makes their present condition unstable or raises the possibility of instability.

I. Patients who require a higher level of care than can be provided in other inpatient areas.

J. Patients with infections of a severe nature including septic shock.

K. Any patients with excessive drug ingestion, which compromises heart rate or rhythm, and/or level of consciousness, and/or ventilatory status.

No patient in the above categories will be excluded from admission to the CVU/ICU, if room is available unless

his/her condition requires a higher level of care. In this instance, the need for admission to the CVU/ICU will be discussed with the attending physician, Nurse Manager/Director and/or Nursing Supervisor, and if necessary either the CVU or ICU Medical Director. Consideration will be given to transfer to a tertiary care facility for a higher level of care when indicated.

VI. Guidelines for Admission or Transfer of Patients for 2 East and 3 South Telemetry Monitoring

A. Prior to initiation of telemetry services, a physician or provider should begin telemetry by utilizing the telemetry protocol, whenever possible. The following guidelines should be considered before initiating cardiac telemetry. All initial orders will be for 48 hours duration. Telemetry will be ordered by diagnosis based on best practice standards and re-evaluated for continuance, based on patient condition, and continued need for cardiac monitoring.

B. Reason for Telemetry

Acute Coronary Syndrome: Unstable Angina
Acute Decompensated Heart Failure
AV Block: Second Degree or greater
Neurologic event and unexplained syncope
Risk of cardiac arrest or Hypotension
Unstable arrhythmia including long QT
AICD or Pacemaker Implementation
Antiarrhythmic change for rate control
Antiarrhythmic known to cause long QT
DNR (but arrhythmia causing discomfort)
Hypo/Hyperkalemia or Hypomagnesemia
Myocarditis or Pericarditis
Overdose of pro-arrhythmic agent
Risk of ischemia post noncardiac surgery
Step down from ICU, recent arrest
Subacute heart failure, changing therapy
Syncope related to trauma
Uncomplicated ablation
Uncomplicated PCI
Hemodynamically stable, post MI

Blunt cardiac injury
High-flow nasal cannula (HFNC) showing clinical improvement
Acute ischemic stroke (3S admission only)
Stable hemorrhagic stroke (3S admission only if chronic (not new), not reason for

admission, and CT scan indicates stable hemorrhagic with no edema)

Cardiac telemetry (excluding CVU/ICU) will automatically be discontinued at 48 hours unless a renewal order is placed by the physician.

C. Process for continuous reevaluation of telemetry utilization:

1) Triage of telemetry is an ongoing process and will be accomplished by daily progression meetings and the daily reassessment by the charge nurse of patients' telemetry needs. Potential patients who are ready for telemetry discontinuation will be identified.

2) Dayshift charge nurse will prepare a list to include the following for all patients:
   a) Number of days on telemetry
   b) Any rhythm changes in the past 24 hours

3) Dayshift charge nurse will prepare a triage sheet to include the following:
   a) DNR status with no change in baseline rhythm over the past 24 hours
   b) Normal Sinus Rhythm for the past 24 hours
   c) Hemodynamically stable with expected discharge today or the next day
   d) Criteria for initial telemetry no longer present

4) The patient's nurse or charge nurse will contact the ordering physician to discuss discontinuing telemetry.

D. Patients being admitted directly from a doctor's office, Non-Invasive Services, or the Emergency Department when a bed on 3 South Telemetry is not immediately available:

1) In the event that a patient is to be directly admitted to 2 East or 3 South Telemetry and a bed is not immediately available, the patient is to be held, monitored, and cared for in CVU/ICU (pending their bed availability) as a telemetry patient until a 2 East or 3 South Telemetry bed becomes available.

2) In the event that a bed is not immediately available for a patient being admitted from the Emergency Department and the patient is held in the Emergency Department as a boarder patient, the admitting physician should re-assess the patient for telemetry indications before transferring the patient to 2 East or 3 South Telemetry. The needs of the telemetry patient will be reassessed at a minimum of every twenty-four hours.

3) Telemetry use will be reevaluated for necessity/continuation every 24 hours after admission.

VII. Guidelines for Admission or Transfer of Patients for 4 East Remote Telemetry

A. Remote telemetry monitoring shall be for 24 hours (telemetry must be reordered every 24 hours). Telemetry will be ordered by diagnosis based on best practice standards and re-evaluated for continuance, based on patient condition, and continued need for cardiac monitoring.

B. Indications for remote telemetry:

1) Hemodynamically stable known dysrhythmia
2) Hemodynamically stable syncope, asymptomatic, with no neurological deficits
3) Hemodynamically stable postoperative patient who requires fluid or transfusions due to fluid shifts
4) Hemodynamically stable patient with an established pacemaker, hospitalized for a procedure and requiring telemetry post-procedure
5) Hemodynamically stable patient who requires IV administration of beta-blocker that had previously been taking an oral form of the drug
6) Pacemaker battery change
7) Chest pain syndrome—hemodynamically stable

C. Process for continuous reevaluation of telemetry utilization:

1) Triage of telemetry is an ongoing process and will be accomplished by daily progression meetings and the daily reassessment by the charge nurse of patients' telemetry needs. Potential patients who are ready for telemetry discontinuation will be identified.

2) Dayshift charge nurse will prepare a list to include the following for all patients:
   a) Number of days on telemetry
   b) Any rhythm changes in the past 24 hours

3) Dayshift charge nurse will prepare a triage sheet to include the following:
   a) DNR status with no change in baseline rhythm over the past 24 hours
   b) Normal Sinus Rhythm for the past 24 hours
   c) Hemodynamically stable with expected discharge today or the next day
   d) Criteria for initial telemetry no longer present

4) The patient's nurse or charge nurse will contact the ordering physician to discuss discontinuing telemetry.

VIII. Guidelines for Admission of Patients for 3 East Telemetry Monitoring

A. Remote telemetry monitoring shall be for 48 hours (telemetry must be reordered every 48 hours).

B. Indications for remote telemetry:
   1) AICD or Pacemaker implementation
   2) Hemodynamically stable known dysrhythmia with expected LOS <24 hours
   3) Hemodynamically stable syncope, asymptomatic, with no neurological deficits
   4) Chest pain syndrome – hemodynamically stable
   5) Transient ischemic attack
   6) Uncomplicated ablation
   7) Uncomplicated PCI

C. Process for continuous re-evaluation of telemetry utilization:
   1) Triage of telemetry is an ongoing process and will be accomplished by daily progression meetings and the daily reassessment by the charge nurse of patients' telemetry needs. Potential patients who are ready for telemetry discontinuation will be identified.

   2) Dayshift charge nurse will prepare a list to include the following for all patients:
      a) Number of days on telemetry
      b) Any rhythm changes in the past 24 hours

   3) Dayshift charge nurse will prepare a triage sheet to include the flowing:
      a) DNR status with no change in baseline rhythm over the past 24 hours
      b) Normal Sinus Rhythm for the past 24 hours
      c) Hemodynamically stable with expected discharge today or the next day
      d) Criteria for initial telemetry no longer present

   4) The patient's nurse or charge nurse will contact the ordering physician to discuss discontinuing telemetry.

IX. Transfer Criteria

A. From CVU/ICU, 3S, 4E, 3E, or 2E Telemetry

   1) The initial decision to transfer a patient from the CVU/ICU, 3S, 4E, 3E or 2E Telemetry is the responsibility of the attending physician, in conjunction with any consulting physician.

   2) The following serve as guidelines:

a) All patients being transferred out of the CVU/ICU, 3S, 4E,3E or 2E Telemetry shall have transfer orders placed for the appropriate level of care at the time of transfer. If there is an issue with a decision to transfer a patient, the issue will be discussed with the attending physician, Nurse Manager/Director and/or Nursing Supervisor, and if necessary, the CVU or ICU Medical Director.

b) A triage list will be maintained in the CVU/ICU, 3S, 4E, 3E and 2E Telemetry on a daily basis. This will list those patients in order of acuity that may be transferred should the need arise.

X. Rules and Regulations Pertaining to Operation of CVU/ICU

A. The CVU/ICU has policies and procedures governing:
   1) Admission criteria to the unit
   2) Admission to the unit
   3) Transfer criteria from the unit
   4) Discharge criteria from the unit
   5) Definitions of nursing roles
   6) Routine critical care orders
   7) Code Blue and drug protocol during Code Blues are detailed in the ICU Policy and Procedure Manual or in the Nursing Policy and Procedure Manuals

B. Areas with telemetry monitoring have policies and procedures governing:
   1) Admission to the unit
   2) Patient Assignment
   3) Emergency Protocols are detailed in the specific nursing unit Policy and Procedure Manual or in the Nursing Policy and Procedure Manual.

C. All new treatment modalities related to critical care must be presented to and approved by the Critical Care Committee or other medical staff committees as appropriate before implementation in the CVU/ ICU setting.

SIGNATURE SHEET

These Rules and Regulations for the CVU/ICU, 3 South, 4 East, 3 East, and 2 East Telemetry Monitoring have been reviewed and revised by the Critical Care Committee and approved.

Date	Martin LeBoutillier, III, MD Chair, Critical Care Committee
Date	Paul J. Teiken, MD President, Medical Staff

DEPARTMENT OF EMERGENCY MEDICINE

1. The Department of Emergency Medicine shall be organized in accordance with the provisions of the Bylaws of The Good Samaritan Hospital dealing with departmental organizations (see Article IX).

2. Privileges granted within the Department of Emergency Medicine shall be commensurate with the training, experience, competence, judgment, character and current capability of the candidate. Privileges will at least encompass the guidelines accepted by the American College of Emergency Physicians and the American College of Osteopathic Emergency Physicians.

3. Generally, clinical privileges will be based upon demonstrated clinical competence with proper adjustment by medical audit and peer review. Specific privileges will be granted upon documentation of satisfactory training and/or demonstration of expertise.

4. Privileges granted in Emergency Medicine have reference to the initial evaluation, stabilization and treatment of injuries, illnesses and conditions enumerated in the Emergency Medicine privilege list. They do not include or assume admitting privileges to any inpatient unit of the Hospital or use of the O.R's.

    A. The time period encompassing "initial" care is recognized to be very variable, and dependent upon such individual circumstances as patient acuity or stability, course while in ED, prognostic implications or working diagnosis, hospital resources available to the clinician, and availability of appropriate Medical Staff backup. It does not in any case extend beyond the time at which a patient is transported from the ED to an inpatient unit or an operating room. ED physicians may, under emergency circumstances, respond to and exercise privileges outside the ED, if time and circumstances permit.

5. CLASSIFICATION OF PHYSICIANS AND DELINEATION OF EMERGENCY MEDICINE PRIVILEGES will determine the circumstances under which each physician may practice in Emergency Services. Each physician will be scheduled to provide patient services in the Emergency Department in accordance with his or her privileges.

    Physicians with these privileges are expected to maintain such certifications as expire and require renewal. They are also expected to pursue ongoing continuing medical education in accordance with state and specialty board certification requirements.

6. There shall be a biennial review of privileges in conjunction with staff reappointment. This shall be based on appraisal of professional performance, judgment, skills, and knowledge, including information from the Ongoing Professional Practice Evaluation (OPPE) review biannually; current licensure; physical and mental health status; fulfilling the continuing education requirements; staff citizenship (including meeting attendance and medical record function); efficient use of Hospital facilities and resources; working relations with colleagues and other Hospital personnel; and the results of quality assurance activities. Guidelines from various specialty societies may be used for specific procedures. Review shall be conducted by the Department Chairman (or designee) and recommendations forwarded to Credentials Committee, Medical Executive Committee and the Board of Trustees for action.

7. Additional privileges may be granted at any time, based on documentation of appropriate training and competence, with approval of the Department Chairman, the Medical Executive Committee, and the Board, and in consideration of the Hospital's facilities and resources. Privileges may also be modified or withdrawn at any time as the result of corrective action, as provided in the bylaws.

8. A copy of the Delineation of Privileges, including a list of procedures, will be included in the application of each new member of the Department of Emergency Medicine. The Delineation of Privileges must be approved by the Chairman (or Vice-Chairman) of the Department of Emergency Medicine, Credentials Committee, the Medical Executive Committee and the Board of Trustees.

   A current list of the physicians in the Department of Emergency Medicine, designating category of privileges and certification status, will be kept in the Office of Medical Affairs.

9. The Department shall establish and support a Quality Assurance and Improvement Committee which shall meet at least quarterly to review information regarding quality of care provided in the F. J. Dixon Foundation Emergency Center.

The Department authorizes a Quality Assurance and Improvement Committee as a standing Committee.

PURPOSE: To serve as the focus for quality assurance and peer review activities for the Department.

A. Membership:
   1. Ex-officio
      (a) Department Chairman (will serve as Chairman or he/she may appoint a Chairman of QI)
      (b) Department Vice-Chairman

2. Other
   (a) Immediate Past Chairman of Department (if available)
   (b) Optionally, one or two members-at-large, appointed by the Department Chairman
   (c) Medical Director, F. J. Dixon Foundation Emergency Center

B. Meetings: At least quarterly; a majority of the voting members shall constitute a quorum, but not less than two.

C. Professional Practice Evaluation:
   a. Indicators recommended by the Committee and approved by the department, MEC and the Board.
   b. Threshold recommended by the Committee and approved by the department, MEC and the Board.
   c. Indicators are evaluated periodically.

D. Reporting: Monthly reports and/or minutes presented to:
   1. Medical Executive Committee
   2. Department of Emergency Medicine Meeting
   3. Physician performance findings reported to office of Medical Affairs for consideration at time of reappointment

10. The Department shall meet at least quarterly to review operational and staffing concerns and findings of the QI Subcommittee. Original minutes on file in the Medical Affairs Office and a copy in the Emergency Department.

11. EMTALA education is required and shall be completed through the WellSpan LMS module at Initial Appointment to the Medical Staff and Reappointment.

SIGNATURE SHEET

These Rules and Regulations for the Emergency Medicine Department have been reviewed, by the Department members and approved.

_____ _____

Date Ericka L. Powell, MD
Chairman, Department of Emergency Medicine

_____ _____

Date Paul J. Teiken, MD
President, Medical Staff

DEPARTMENT OF FAMILY MEDICINE

1. The Department of Family Medicine shall be organized in accordance with the provisions of the Bylaws of The Good Samaritan Hospital dealing with department organization (see Article IX). Membership shall consist of physicians engaged in in the practice of Family Medicine.

2. Privileges granted with the Department of Family Medicine shall be commensurate with the training, experience, competence, judgment, character and current capability of the candidate. It is the responsibility of the physician to provide substantiation.

3. There shall be a biennial review of privileges in conjunction with staff reappointment. This shall be based on appraisal of professional performance, judgment, skills, and knowledge, including information from the Ongoing Professional Practice Evaluation (OPPE) review biannually; current licensure; physical and mental health status; fulfilling the continuing education requirements; staff citizenship (including meeting attendance and medical record function); efficient use of Hospital facilities and resources; working relations with colleagues and other Hospital personnel; and the results of quality assurance activities. Guidelines from various specialty societies may be used for specific procedures. Review shall be conducted by the Department Chairman (or designee) and recommendations forwarded to Credentials Committee, Medical Executive Committee and the Board of Directors for action.

4. Additional privileges may be granted at any time, based on documentation of appropriate training and competence, with approval of the department chairman, the Credentials Committee, and the Board, and in consideration of the Hospital's facilities and resources. Privileges may also be modified or withdrawn at any time as the result of corrective action, as provided in the bylaws.

5. A copy of the Delineation of Privileges will be included in the application of each new member of the Department of Family Medicine. The Delineation of Privileges must be approved by the Chairman of the Department of Family Medicine (or Vice-Chairman), the Credentials Committee, the Medical Executive Committee and the Board of Directors

    - A current list of the physicians in the Department of Family Medicine with his/her attending status and classification of privileges will be kept in the Office of Medical Affairs.

6. Attendance at department meetings is in accordance with the requirements set forth in the bylaws of the Medical Staff.

7. Hospital patients shall be seen as often as necessary but not less than once every day. A healthy, stable newborn shall be seen within 24 hours of birth.

8. To facilitate prompt patient care, members of the staff who are on call to the Hospital should be able to respond, at least by phone, within thirty minutes of being called during their call period and should be able to reach the Hospital in a reasonable time.

9. The Department, in collaboration with the **Department of Medicine**, authorizes creation of a standing continuous quality improvement committee: "Family Medicine and Medicine Quality Assurance and Improvement (QA&I) Committee".

   A. Purpose: To serve as the focus for quality assurance and peer review activities regarding the care of hospitalized adults for the Department.

   B. Membership:
      1. The Department of Medicine Chairman will serve as Committee Chairman
      2. The Department of Medicine Vice Chairman
      3. The Department of Family Medicine Chairman
      4. Optionally, one or two members-at-large, appointed by the Department Chairman.

   C. Meetings: At least quarterly; a majority of the voting members shall constitute a quorum but not less than two.

   D. Professional Practice Evaluation:
      1. Indicators recommended by the Committee and approved by the department, MEC and the Board.
      2. Threshold recommended by the Committee and approved by the department, MEC and the Board.
      3. Indicators are evaluated periodically.

   E. Reporting: Action of the Committee will be reported regularly at Department meetings and the Medical Executive Committee.

10. The Department, in collaboration with the **Department of OB/GYN/Newborn Care**, authorizes creation of a standing continuous quality improvement committee: "OB/GYN/Newborn Care Quality Assurance and Improvement (QA&I) Committee".

   A. Purpose: To serve as the focus for quality assessment and peer review activities for the Department.

   B. Membership:
      1. The Department Chairman of OB/GYN/Newborn Care will serve as Committee Chairman
      2. The Department Vice-Chairman of OB/GYN/Newborn Care
      3. At least one Obstetrician
      4. At least one Family Medicine physician with Obstetrics privileges.
      5. At least one Neonatologist or Neonatal Nurse Practitioner
      6. Optionally, one or two members-at-large, appointed by the Department Chairman

7. A physician member from the Department of Anesthesia on an "ad hoc" basis.

C. Meetings
   1. To be held at least quarterly. A majority of the voting members shall constitute a quorum but not less than two.

D. Professional Practice Evaluation:
   1. Indicators recommended by the Committee and approved by the department, MEC and the Board.
   2. Threshold recommended by the Committee and approved by the department, MEC and the Board.
   3. Indicators are evaluated periodically.

E. Reporting:
   1. Recommendations based on quality concerns will be forwarded to the respective Department Chairman, who will have final authority on further action.
   2. Committee actions will be reported at Department meetings and to the Medical Executive Committee.

11. **Required Education for Physicians with Delivery Privileges:**
   a) Initial Appointment: Access to all five (5) Relias OB modules must be completed by the end of the first six (6) months of Provisional status.
   b) Reappointment: All five (5) Relias OB modules must be completed within the two-year reappointment cycle.

SIGNATURE SHEET

The rules and regulations of the Department of Family Medicine of the Medical Staff of the Hospital have been reviewed and approved by the Department.

DATE	Elizabeth Muhiire-Ntaki, MD Chairman; Department of Family Medicine
DATE	Paul J. Teiken, MD President; Medical Staff

FAMILY MEDICINE RESIDENCY PROGRAM

I. DEFINITION OF A RESIDENT

A Family Medicine Resident is a physician in training qualified for and maintaining a Pennsylvania State training license and who is a physician employee of or affiliated with WellSpan Good Samaritan Hospital Family Medicine Residency Program, having a specific set of clinical privileges but not eligible for full appointment to the Hospital medical staff.

II. BASIC CLINICAL PRIVILEGES FOR FAMILY MEDICINE RESIDENTS

A. Under the supervision of attending staff, residents have privileges to:

1. Interview and examine patients, review relevant medical records, results of laboratory, radiologic and special procedures, consultant's notes, etc., for the purposes of patient care and furthering their own education;

    a. History and Physicals may be performed, but countersignature by a staff member is required within 24 (twenty-four) hours.

    b. Orders and progress notes may be written. Progress notes of all residents must be countersigned by a staff member within 24 (twenty-four) hours.

2. Order appropriate medications, laboratory, radiologic, and special procedure services and physician consultations for patient care;

3. Perform indicated procedures

    a. Under the direction and supervision of an attending physician or consulting physician involved in the case;

4. Prepare appropriate documentation regarding patient care including but not limited to history and physical, daily notes, procedure notes, and discharge summaries.

A. Resident's ability to perform privileges is delimited by the following principles:

1. When acting under the supervision of an attending or consulting physician, a resident's privileges are limited by:

   a. the privileges of the attending, and
   b. the judgment of the attending.

2. Residents may perform procedures under the supervision of WellSpan Good Samaritan Hospital medical staff. List of potential procedures include but is not limited to:

Amniotic Fluid Index	Neonatal Circumcision
Arterial Puncture for ABGs	Non-Stress Test Interpretation
Central Line Placement	Splinting of Fractures ~R)
I & D of Abscess	Paracentesis
Lumbar Puncture	Thoracentesis
Vaginal Deliveries	

3. Residents may act in emergency situations including but not limited to Codes as the situation dictates and within the limits of their capabilities and may initiate or direct activities independently in the absence of more senior staff. Residents are required to be certified in Basic Life Support (BLS, Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Neonatal Resuscitation Program (NRP) and in Advanced Life Support in Obstetrics (ALSO).

4. Written or verbal resident orders are to be carried out within the scope of their supervising physician's privileges.

   a. If a nurse or other staff member questions the appropriateness of an order, the following avenues for resolution of the dispute exist, to be followed in order:

      - Discuss the area of disagreement with the resident as soon as possible for clarification or changing the order, failing that,
      - Discuss the order with other nursing, pharmacy or other staff who may be more familiar with the procedure, failing that
      - Discuss the order with the supervising resident, failing that
      - Discuss the order with the supervising attending staff, failing that

- Discuss the issue with the program director, failing that
- Discuss the issue with the department chair, failing that
- Discuss the issues with the President of the Medical Staff.

III. RESPONSIBILITIES OF WGSH FAMILY MEDICINE RESIDENTS

A. Abide by all applicable sections of the bylaws of the WellSpan Good Samaritan Hospital Medical Staff.

B. Abide by all the applicable rules and regulations of the WellSpan Good Samaritan Hospital Medical Staff.

C. Abide by all the applicable rules and regulations of the Department of Family Medicine as well as the applicable rules and regulations of the department of which his/her supervising physician is a member.

D. Abide by the terms of the WGSH Family Medicine Residents contract.

E. Abide by the policies of the Residency and the Hospital.

IV. RULES AND REGULATIONS FOR WGSH FAMILY MEDICINE RESIDENTS:

A. In the in-patient and out-patient settings, the resident will function under the applicable rules and regulations of:

- The WGSH Family Medicine Residency
- WellSpan the Good Samaritan Family Practice Centers
- The Family Medicine Residency Review Committee
- The American Osteopathic Board of Family Physicians and/or the American Board of Family Medicine
- The appropriate licensing board of the State of Pennsylvania
- The Drug Enforcement Agency
- The Accreditation Council for Graduate Medical Education (ACGME)

B. Disciplinary issues will be handled by the Family Medicine Residency Program Director as outlined by WGSH Family Medicine Residency Program policy and procedures, using his/her best judgment/discretion. Residents may follow due process guidelines as outlined in the Program's Grievance Policy.

V. PRIVILEGES OF FAMILY MEDICINE RESIDENTS:

A. Residents may attend all General Medical Staff functions including business meetings, social functions, etc. without payment of dues and as the guests of the Medical staff,

B. Residents may attend as non-voting members the meetings of the Department of Family Medicine,

C. Residents may attend as non-voting members any meeting of standing or ad hoc Medical Staff committees.

VI. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

A. A supervising physician must be a current member of the WellSpan Good Samaritan Hospital medical staff.

B. Residents are assigned to the WellSpan Good Samaritan Hospital for the primary purpose of receiving education and training in the field of Family Medicine. It is the responsibility of supervising physicians involved with resident physicians to ensure that the quality of the education given to the supervised resident physicians is maintained at a high level, and that the patient care delivered by the resident physicians pursuant to their education and training is appropriate in content and of consistently high quality.

C. The ultimate responsibility for all patient care rests with the supervising physician.

D. The medical record must document that a member of the medical staff (i.e. the supervising physician) has seen the patient and concurs with the diagnosis and treatment plan. The supervising physician must also demonstrate his/her continued supervision of the resident physician by appropriate documentation on the chart. This includes co-signature of progress notes and orders as outlined in the Medical Staff Bylaws and Medical Staff Rules and Regulations.

E. The WellSpan Good Samaritan Family Medicine Residency Program Director will provide all supervising physicians a written description of the role, responsibilities, and patient care activities of the resident physicians. This description will include identification of the mechanisms by which supervising physicians and the Program Director make decisions about each resident physician's progressive involvement and independence in specific patient care activities.

VII. GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)

WellSpan Good Samaritan Hospital Family Medicine Residency Program participates in WellSpan Health GMEC.

A. Duties - meet regularly to advise and review concerning the following matters:

1. Establishment of and compliance with institutional policies affecting graduate medical education.

2. Compliance with requirements of the appropriate Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME).

3. Establishment, enhancement and implementation of policies and procedures for selection, evaluation, promotion, and dismissal of residents.

4. Establishment and implementation of institutional policies and procedures for residents and faculty, regarding discipline and adjudication of grievances, which maintain fairness and due process.

5. Appropriate and equitable funding for resident positions, benefits and support services.

6. Appropriate learning environment, including working conditions and work hours of residents.

7. Ethical, socio-economic, medical/legal, and cost-containment issues affecting graduate medical education.

B. Membership (all with vote except as noted) - should ordinarily consist of at least the following:

1. WellSpan Health Chief Academic Office/Director of Medical Education (DME)---Chair
2. All Residency and Fellowship program directors in WellSpan Health
3. Peer-selected Chief Resident or / Fellow Resident Representative(s) approved by their Program Director
4. Vice President of Medical Affairs: WellSpan Good Samaritan Hospital, WellSpan York Hospital
5. Administrative Director of Medical Education (ADME) / Designated Institutional Officer (DIO)
6. All Residency Program Coordinators (ex-officio without vote)

B. The updates from this committee will be presented by the WGSH Residency Program Director or Associate Program Director as following:

1. Quarterly to the Medical Executive Committee
2. Yearly the Board of Directors.

SIGNATURE SHEET

The Rules and Regulations of the Family Medicine Residency Program Rules and Regulations of the Hospital have been revised, reviewed, and approved on the dates indicated.

Date	Abdul Waheed, MD Residency Program Director Graduate Medical Education Committee
Date	Paul J. Teiken, MD President, Medical Staff

MEDICAL RECORDS COMMITTEE

1. PREPARATION AND COMPLETION

A. The attending physician shall be held responsible for the preparation of a complete and legible medical record for each patient and the record shall conform to standards or regulations of any applicable accrediting or regulatory body. All medical records shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately and facilitate continuity of care among healthcare providers. A complete medical record shall include:

-Identification data
-Chief complaint
-Details of present illness
-Past medical history
-Family and social history
-Summary of patient's psychosocial needs
-Relevant inventory of body systems
-Relevant physical examination
-Statement of conclusions or impression drawn from the medical history and physical examination
-Diagnosis or diagnostic impression
-Reason(s) for admission or treatment
-Goals for treatment and treatment plan
-Special reports such as: Consultations, Clinical, Laboratory, Radiology and Others
-Provisional diagnosis
-Medical or surgical treatment
-Orders
-Anesthetic record, where necessary
-Evidence of informed consent for procedures and treatment where necessary
-Pathological findings, where necessary
-Progress notes
-Principal diagnosis;
-Secondary diagnoses
-Condition on discharge
-Disposition
-Discharge Summary or discharge note
-Discharge instructions
-Autopsy report when applicable

B. Upon discharge, the attending physician or dentist shall record all relevant diagnoses established by the time of discharge, as well as all operative procedures performed. This information shall be recorded using acceptable disease and operative terminology that includes topography and etiology when appropriate. Final diagnoses shall be documented without the use of symbols or abbreviations.

C. All entries in the patient's medical record shall be accurately dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided in accordance with Medical Staff Bylaws, Rules and Regulations as well as applicable WellSpan Health (WSH) system-wide policies and procedures**.**

D. Physical therapists may accept referral orders from physician assistants and nurse practitioners without physician countersignature as long as the point-of-origin rests with the licensed physician. Rehabilitation therapy students' entries must be countersigned by a therapist from their respective discipline (Occupational and Physical Therapy, Speech Language/Pathology and Audiology).

E. Symbols and abbreviations may be used only when they have been approved by the WSH Forms Committee. An official record of approved symbols and abbreviations, as well as a list of specific abbreviations not to be used, is available on the WSH iNet (Health Information Management Department Portal - Abbreviation List for WellSpan Health).

F. No medical record shall be filed until it is completed, except on order of the Hospital's Performance Improvement and Monitoring (PIM) Committee in the event that the responsible physician has expired or has relocated without a forwarding address.

G. In accordance with regulatory standards and in accordance with Health Information Management (HIM) policy, all medical records shall be completed within 30 (thirty) days after the discharge or treatment of the patient, including all review, editing and authentication. No medical record shall be considered completed until all assigned deficiencies are resolved. Notices of records available for completion, delinquent records and suspensions will be sent to the Practitioners according the HIM policy and procedure. Failure to comply with the designated timeframes set forth in the policy will result in automatic and immediate temporary suspension of clinical privileges until the record is deemed to be complete.

1. During the temporary suspension of privileges:
    - Patients already hospitalized may be cared for, but no new patients should be admitted to the Practitioner's service.
    - Consults already ordered can be completed, but no new consultation shall be followed.
    - Procedures already scheduled may be completed by the Practitioner, but no new procedure may be scheduled.
    - Except On-Call or Emergencies: To be determined

2. Any variances shall be reported directly the Vice President of Medical Affairs.

2. HISTORY AND PHYSICAL EXAMINATION
(Also refer to Department of Surgery Rules & Regulations)

A. A history and physical examination shall be recorded within twenty-four (24) hours of admission or observation status and prior to surgery or procedure with anesthesia services (but not more than 30 days prior to admission)

B. If a complete history has been recorded and a physical examination performed within thirty (30) days prior to admission, a durable and legible copy of this report may be used. In such instances however, an interval admission note shall be recorded including any additions to the history and any subsequent changes in the physical findings.

C. If the History and Physical is greater than thirty (30) days old, a new, complete History and Physical must be documented in the medical record. A History and Physical may be valid beyond thirty (30) days and up to a maximum of one year only in the case of a specific treatment regimen that involves a series of steps for completion (i.e., IV therapy, wound care). However, at each visit for the specific regimen, the History and Physical must be reviewed and a written indication of no change in condition, or if applicable, changes since last visit.

D. Standard "Short Form" (SSU) history and physical examination form may be used for inpatients whose hospital stay is anticipated to be up to forty-eight (48) hours or for ambulatory procedure unit patients who must be admitted following surgery and remain hospitalized no more than forty-eight (48) hours. A history and physical addendum or admission note outlining the reason for inpatient admission must be included for the latter.

Short form history and physicals shall cease to be adequate if the patient's hospitalization is prolonged beyond forty-eight (48) hours for any reason.

E. INPATIENT HISTORY AND PHYSICAL CONTENT REQUIREMENTS

1. Medical history
   - -Chief complaint
   - -Details of present illness
   - -Relevant past, social and family histories
   - -Inventory of body systems
   - -Current medications and dosages
   - -Any known allergies, including medication reactions

2. Summary of patient's psycho-social needs, as appropriate (may be addressed in Nursing Admission Assessment and/or Social Services Assessment).

3. Physician examination should include heart, lung, mental status and remaining body systems to the degree of detail pertinent to the age and sex of the patient, the patient's symptoms, other physical findings and diagnostic data.

4. Statement of the conclusions or impressions drawn from the admission history and physical.

5. Plan for diagnostic and/or treatment measures.

F. OUTPATIENT HISTORY AND PHYSICAL CONTENT REQUIREMENTS

1. History to include:
   (a) Indications/symptoms for procedure
   (b) Current medications and dosages
   (c) Any known allergies, including medication reactions
   (d) Existing co-morbid conditions, if any.

2. Physical examination (NO ANESTHESIA, OR TOPICAL, LOCAL, OR REGIONAL BLOCK):
   (a) Assessment of mental status; AND
   (b) An examination specific to the procedure proposed to be performed.

3. Physical examination (IV SEDATION):
   (c) (a) and (b) above; AND
   (d) Exam of heart and lungs by auscultation.
4. Physical examination (GENERAL, SPINAL, OR EPIDURAL):
   (e) (a), (b), and (d) above, AND
   (f) Assessment of and written statement about patient's general condition.

Anesthesia combinations require a physical relevant to the highest level of anesthesia provided.

G. Except when a history and physical is performed on the day of surgery, there shall be a pre-procedure note on the day of surgery by a physician, or individual qualified to administer anesthesia, evaluating the patient's current status for surgery.

H. Pre-procedure notes on patients undergoing spinal or general anesthesia shall include an anesthesia history, including risk of anesthesia, by a person qualified to give anesthesia. (May be a component of pre-admission and/or pre-anesthetic evaluation).

I. **Podiatric and Dental Patients:**

The submission of an H&P, prior to the patient's hospital admission or registration, by a Provider who may not be a member of the Hospital's medical staff or who does not have admitting privileges in the Hospital, or by a qualified licensed Provider who does not practice at the Hospital but is acting within their scope of practice under State law or regulations, may be permitted.

a. A pre-operative H&P, completed by a non-credentialed Provider will be accepted if the H&P has not been completed more than thirty (30) days prior to the patient's surgery or procedure requiring anesthesia services.
b. The H&P must contain the elements the organization defines as minimal content in Bylaws of the Medical Staff Article III (3.7-2) "Outpatient History and Physical Content Requirements".
c. To be accepted into the patient's medical record, a Provider who is credentialed and privileged to perform an H&P must:
   - Review the H&P document and determine if the information is compliant with the organization's defined minimal content
   - Update information and findings as necessary, which may include a description of the patient's condition and course of care since the H&P examination was performed

- Sign and date any document with updated or revised information as an attestation that it is current

d. When more than one qualified Provider participates in performing, documenting and authenticating an H&P for a single patient, the Provider who authenticates the H&P will be held responsible for its contents.

e. Patients scheduled for procedures requiring only local anesthesia: The Podiatrist will be responsible to update the H&P addendum as it relates to podiatric care.

3. ORDERS

A. Patients shall be discharged on written order of the attending physician or dentist or based on a nursing assessment of patient compliance to discharge criteria approved by the medical staff.

B. All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or another practitioner who is responsible for the care of the patient and is authorized to write orders in accordance with applicable WSH system-wide policies and procedures and state regulations.

C. Verbal orders shall be taken only by the following personnel:

1. a licensed physician, dentist, or podiatrist
2. Registered Nurse
3. Pharmacist (pertaining to drugs)
4. Physical Therapist (pertaining to physical therapy)
5. Respiratory Therapist (pertaining to respiratory therapy treatments)
6. Certified Registered Nurse Practitioner, Certified Physician Assistant and Certified Nurse Midwife.

All verbal orders (including telephone) shall include the date, time, and full signature of the person taking the order with the name of the physician. All medication and treatment verbal orders must be signed by the ordering individual when readily available, but not to exceed seven (7) days of issue.

If the physician is not the attending, he/she must be a partner or covering physician and must be knowledgeable about the patient's condition.

D. Written and verbal orders may be given by a certified nurse practitioner, certified nurse midwife, physical therapist, or physician assistant as long as they are in conformance with applicable hospital and medical staff policies.

E. Physician Assistant written orders must be countersigned by the supervising physician within 10 (ten) days.

F. Physical Therapist orders must be countersigned by the respective supervising physician(s).

4. PROGRESS NOTES

Progress notes shall be written on every patient. The frequency with which they are written shall depend on the condition of the patient, but not less than daily by the Attending Physician.

5. CONSULT REPORTS

Consultation reports shall document the opinion of the consultant, reflecting, when appropriate, an examination of the patient and the patient's medical record(s). The date, and in the case of a Stat consult request, the time that the consult was rendered shall be documented in at least one of the following areas of the medical record: 1) physician progress notes or 2) included in dictated consult report or 3) documented on consult form.

6. OPERATIVE REPORTS

Operative reports for outpatient and inpatient surgery must be recorded immediately following surgery. A post procedure note must be completed immediately after a procedure (before the patient goes to the next level of care). A complete operative report must be completed within 24 hours of the procedure. Operative reports must include a description of the findings, technical procedures used, specimen(s) removed, preoperative and postoperative diagnoses, and name of the primary surgeon and, if applicable, assistants.

7. DISCHARGE SUMMARIES/NOTES/INSTRUCTIONS

A. A clinical discharge summary shall be recorded for every inpatient and observation discharge (excluding normal newborn, maternity and obstetrical observation visits) no matter the length of stay. It shall concisely summarize the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the patient's condition on discharge, and any specific instructions given to the patient and/or family, as pertinent.

B. A final summation-type discharge note may be substituted for a discharge summary in the case of patients with problems of Short Stay Unit (SSU) who require less than a forty-eight (48) hour period of hospitalization or normal newborn infants (no matter the length of stay).

C. When pre-printed instructions are given to the patient or family, the

record should so indicate. Consideration should be given to instructions regarding physical activity, limitations, medications, diet and follow-up.

8. POSSESSION, ACCESS AND RELEASE

A. All medical records are the property of the Hospital and shall not be removed from any Hospital premise except by court order, subpoena, statute, written order of the President & CEO or his/her designee, or when it has been deemed medically necessary for assessment and treatment that an original radiograph, specimen block, specimen slide and/or cardiac catheterization film be released. Authorized Hospital staff shall be responsible for processing such releases in accordance with Hospital policies and procedures.

B. The written consent of the patient or his/her legal representative is required before medical record information may be disclosed unless otherwise provided for by law and /or regulation. Such disclosures shall be made consistent with Hospital policies and procedures.

C. Any and all prior medical records of patients admitted as inpatients or outpatients shall be made available for the use of attending physicians.

D. In accordance with Hospital policies and procedures, medical record information shall be made available to Medical Staff members in good standing for bona fide study and research, consistent with preserving the privacy and confidentiality of patients, providers and the Hospital. Unless specifically approved, no patient-, provider-, or Hospital—identifiable information may be published and/or presented. All requests for research/special studies must have the written approval of the President & CEO or his/her designee, and when deemed necessary, the appropriate professional staff committee or other approval body.

Signature Sheet

The Medical Record Rules and Regulations of the WellSpan Good Samaritan Hospital Medical Staff have been reviewed, revised and approved.

Date	Paul J. Teiken, MD President; Medical Staff

MEDICAL STAFF

1. The purpose of the Rules and Regulations are to delineate and implement the principles set forth in the Bylaws as they apply to the mechanism of Staff Function (see Bylaws, Article XV and Article XII, Section 4).

2. The meetings of the Medical Staff, both Departments and Committees, shall be held as provided in Article XIII of the Bylaws.

3. During a disaster, the Hospital Disaster Plan shall be followed. The emergency department physician on duty at the time shall be medical coordinator for the disaster and shall be responsible for activating the Disaster Plan. In the absence of an emergency department physician, the responsibility shall follow in order to the emergency department physician on call, the President of the Medical Staff, the Vice President, the Chairman of Surgery and the Chairman of Medicine. The Medical Staff shall respond to the Physicians' Lounge when notified of a "disaster" by the PBX operator.

4. The Medical Staff shall be actively interested in securing autopsies. All autopsies shall be performed by the Hospital pathologist, or by a physician delegated this responsibility. Authorization of autopsy shall, in all instances, conform to Act 575 of the General Assembly of the Commonwealth of Pennsylvania.

5. All questions and problems coming before the Medical Staff, not covered by the Bylaws or these Rules and Regulations, shall be referred to the Executive Committee for consideration. The Medical Executive Committee shall report its recommendations to the active Medical Staff in a regular or special meeting.

6. Admissions:

   (a) Patients may be admitted to the Hospital only by a member of the Hospital Medical Staff in accordance with the Bylaws.

   (b) Patients may only be admitted with the knowledge and direct authorization of the attending physician or his representative.

   (c) The attending physician shall provide the Hospital with a provisional diagnosis and such information as necessary to assure that other patients and staff are not exposed to any source of danger, such as infectious disease or a psychotic episode. This will allow for room assignments based on patient needs and medical and nursing assessments.

(d) Care cannot be initiated without medical orders. On elective admissions, preadmission testing is encouraged.

(e) Attending physicians are expected to visit patients at least daily.

7. **Residents:**

(a) History and Physical may be performed, but countersignature by a staff member is required.

(b) Orders and progress notes may be written. Countersignature of orders is required for first-year residents (P.G.Y. 1) by an upper-level resident or staff member. For reimbursement (fiscal) reasons, progress notes of all residents must be countersigned by a Staff member.

(c) May attend department meetings without voting privileges.

(d) Invasive procedures with a high degree of risk may not be performed without preceptor supervision.

(e) Professional attire and conduct is expected at all times.

(f) Resident participation in Code Blue situations, if and when they arise, in any part of the Hospital.

(g) Full cooperation with staff physicians is expected.

(h) Chart documentation will be neat, legible, and complete to be able to stand up under professional and legal scrutiny.

(i) Care provided by residents will be reviewed by the supervising physician. The supervising physician will provide the results of this review to the Director of the Accredited Residency Program.

(j) Supervision of residents by members of the medical staff shall be in compliance with the rules set forth in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and The Good Samaritan Family Practice Residency Rules and Regulations.

8. **Diet Orders:**

   a) All diets, especially diets for diabetic patients, should be ordered as promptly as possible after the patient's admission.

   b) Dietary consultation should be ordered at least one day before the contemplated discharge date of the patient when possible so that adequate consultation time can be arranged between the Dietician and the patient.

   c) A Physician may delegate the responsibility of managing an individual patient's diet to a Registered Dietitian consistent with the Medical Nutrition Therapy Order, Writing Protocol and Scope Protocol. The Physician remains responsible to supervise and direct the Registered Dietitian's management of the patient's care.

9. All persons (including medical and nursing staff), attending deliveries, regardless of type or location, must be currently certified as having successfully completed the Neonatal Resuscitation Course designed by the American Heart Association and the American Academy of Pediatrics, or a Board Certified or eligible Anesthesiologist.

10. **Emergency On-Call:**

   A. Procedures

      (1) The decision to call the on-call physician for care of the emergency patient will be made by the Emergency Department (E.D.) physician. Whenever possible, he/she will personally speak to the called Physician about the case.

      (2) The called physician should appear in person in the E.D., or at least respond by phone, within 30 minutes (policy of all clinical departments). The physician is expected to physically be present in the Emergency Department when requested, within 45 minutes after telephone confirmation of the request is received.

      (3) If the called physician does not respond, the E.D. physician will refer the case to the appropriate Department Chairman (or in his/her absence, the Vice-Chairman, then the President of the Medical Staff).

(4) If the on-call physician has been requested to come in by the E.D. physician, the patient will not be transferred to another facility until he/she has been evaluated by the physician.

(5) If the called physician does not feel it is clinically appropriate to care for the patient (for whatever reason), or if the called physician cannot be physically present for care within the 45 minutes due to clinical responsibilities elsewhere, it is the called physician's responsibility to coordinate with the Emergency Department physician the appropriate care and/or transfer of that patient in a timely manner. It is not the duty of the Emergency Department physician to solely arrange for the transfer of the patient. The called physician and the Emergency Department physician shall collaborate the care and transfer of the patient. If the care and transfer of the patient cannot be arranged in a timely manner, the called physician may be asked to participate in care or continue to co-facilitate care with the Emergency Department physician until which time the transfer can be accomplished.

11. **Schedule Policies:**

(1) For any given service, all appropriate physicians will be equally listed on the schedule unless excused, or another arrangement approved, by unanimous agreement of the involved physicians.

(2) Another appropriately privileged staff physician may agree to provide alternative coverage for the listed physician (especially pertinent for group practices). Since the printed schedule is preserved as a record of call responsibility, the E.D. must be notified of and understand the alternative arrangements.

(3) The listed physician (or alternate physician) is responsible to be available for response within 30 minutes.

(4) The schedule is published on the 15th for the following month. Changes must be submitted in writing before that date.

(5) If the call schedule is to be changed after it is published, the physician making the change is personally responsible to notify the Emergency Department of the change.

12. **Students**

The Hospital may accept bona fide students from appropriate professional schools for participation in training programs. These include students of medicine (allopathic and osteopathic), dentistry, podiatry, advance-practice nursing and physician assistants.

A. Conditions of Participation

(1) To affirm authorization from the school, the Hospital must have either a master agreement in place or receive specific, written authorization for the student(s) in advance of attendance at the Hospital.

(2) A member of the Medical Staff must agree in writing to serve as a sponsor/proctor for the student.

(3) Evidence of professional malpractice insurance coverage of the student must be received by the Hospital. This will be provided by the school and not the Hospital, unless specifically arranged in advance.

B. Responsibilities and Privileges of the Student:

(1) At the beginning of the rotation at the Hospital, the student must register with the Medical Affairs office. The appropriate application form must be completed, and the agreement signed to abide by all hospital policies, procedures and rules.

(2) With the consent and supervision of the sponsor/proctor, the student may take histories from and examine patients pertaining to their professional field.

(3) A procedure may only be performed under the direct supervision of a sponsor/proctor who has privileges for the procedure.

(4) The student may make entries in the medical record, identifying the author as a student, and these must be countersigned by the sponsor/proctor.

(5) No orders may be written by the student.

(6) The student may have access to medical records, lab reports, radiographic studies, etc., as they pertain to specific patients, but confidentiality must be maintained, in accordance with Hospital policies and procedures.

C. Responsibilities of the Sponsor/Proctor

(1) Supervise the activities of the student in the Hospital and its associated facilities.

(2) Assure that the student performs only within his or her professional area.

(3) Authorize and countersign any entries in the medical record.

13. **Training Application:**
A Practitioner seeking temporary privileges for educational or training privileges on the Medical Staff or clinical privileges must apply for membership or privileges using the WellSpan Training Application. Refer to Credentialing Policy for additional details.

14. **Inpatient consultations:**

A. A routine consultation must be performed within twenty-four (24) hours of the request and the report dictated as soon as possible, but no more than 24-hours after the consultation.

B. If the patient's condition warrants the patient being seen on the same calendar day, the requesting physician shall convey the information by speaking directly to the consultant. The Provider-to-Provider conversation shall occur within thirty (30) minutes and include the reason for the consult, the timeliness/urgency of the consult and any and all information requested by the consultant. In the case of a stat consult, the consulting Medical Staff appointee should convey findings to the requestor by telephone and completed the required dictation.

C. For those **seeking consults:**
i. Inform the patient that you will be seeking a specific consultation, but you remain in charge of the patient's over-all care.

ii. Requests for consultation shall be entered as an order by the requesting Medical Staff member.

iii. Consult judiciously: Do not consult for chronic problems, but rather those acute problems requiring resolution prior to discharge. Consultations are encouraged among appointees of the Medical Staff in cases of difficult diagnosis, critically ill patients, or to seek counsel from another medical specialty. Chronic problems should be addressed at discharge with appropriate follow-up.

iv. Consult the proper individual or group based on:
- Necessary expertise
- Patient preference
- Prior positive experience with Specialist
- Preference of Primary Care Provider (PCP)
- When none of the above apply, refer to the on-call
- Generic requests, such as "consult surgery", are not appropriate

v. Whenever possible, the consulting physician should discuss the care plan with the admitting physician, especially if another consulting physician is involved in the care.

D. For those **providing consultation:**

i. The potential consultants or their designees must be available and willing to speak to a physician seeking a consult

ii. A consultation always begins with an assessment and plan.

iii. Advanced Practice Providers (APPs) or Residents can begin the consultation process, but the consultation report is not finalized in the record until the attending Physician has made recommendations after he/she has reviewed the data and, whenever possible, has seen the patient face to face. The record should list the owner of the consulting report as the attending Physician and their specialty. In rare instances, a request may be made and approved by the VPMA when it is acceptable for consults to be completed by an APC when an on-site Physician is not available on a daily basis.

iv. A consulting Physician should not consult yet another Physician until having discussed the plan with the admitting Physician.

v. If immediate action is required or there is a significant change in a recommendation, the consultant should call the attending Physician who requested the consult.

vi. Follow up disposition needs to be arranged by the consultant and entered into the depart document if the consultant has to see patient post-discharge. The disposition needs to be documented in the chart

when the consultant signs off the care of the patient. A consultant needs to clearly state they are signing off the case.

E. A consult may be declined by the consulted physician when there is a circumstance that, in the reasonable judgment of the consulted physician, would prevent him/her from accepting the consult. The consultant should verbally communicate his/her wish to decline the consult to the attending physician. Only when both parties agree that the reason for declining the consult is sound, may the consult be declined. Otherwise, all consults should be accepted and completed as previously stated. This rule supersedes all other departmental rules regarding consultations.

F. If the consulted physician and the attending physician cannot come to an agreement regarding the consultant's decline, and the patient's condition will not be adversely affected by a delay in the completion of the consult, the matter should be referred to the Department Chairman of the Consulted physician's department for final determination.

G. In an emergent situation, the Emergency Room call schedule may be utilized to obtain the appropriate consultant. Because of the patient's emergent condition, these consults should not be declined by the consulted physician.

15. **Behavior Health Consultations**

(1) A medical staff physician should order a psychiatric consultation for a patient who, in the judgment of the medical staff physician, requires a psychiatrist to assist in the treatment of an emotionally ill patient, or a patient who is suffering from the results of alcoholism or drug abuse.

(2) Crisis Intervention Services can be referred by medical staff members for behavioral health issues which are immediate, and the individual is at risk and/or is endangering themselves or others.

16. **Telemedicine Consultations:**

Definitions:

- **Originating Site:** Location of Patient
- **Distant Site:** Location of Practitioner

Required Elements:

All treatment recommendations will:

a. Provide patients with quality care, meeting or exceeding the originating site expectations
b. Meet the professional standards of the originating site medical staff
c. Be performed on a timely basis within the expectation of the originating site medical staff
d. Follow patient care protocols as established by the originating site
e. Ensure patient confidentiality according to WellSpan Health policy
f. Be documented in the patient's medical record
g. Be eligible to quality review at the originating and distant sites

17. **Medical Staff Code of Conduct Policy:**

A. Purpose: The purpose of this policy is to ensure optimum patient care by promoting a safe, cooperative and professional health care environment, and to prevent or eliminate conduct that disrupts operations at The Good Samaritan Hospital, affects the ability of others to do their jobs, creates a hostile work environment for employees or other medical staff members, or interferes with the ability to work competently.

B. Standard of Conduct: It is the policy of The Good Samaritan Hospital that all persons within its facilities be treated with courtesy, respect, and dignity. To that end, all medical staff members shall conduct themselves in a professional and cooperative manner. Medical staff members who engage in unacceptable behavior shall be subject to review in accordance with the Medical Staff Code of Conduct Policy (MA-05) and corrective action procedures set forth in Article VI of The Good Samaritan Hospital Medical Staff Bylaws.

18. **Electronic Health Record:**

It is expected that all Providers on the Medical Staff utilize the Hospital's Electronic Health Record approved by WellSpan Health to the fullest extent possible. In order to be granted access to the Electronic Health Record, all Providers who need access will be required to attend an approved training session geared specifically to the type of utilization required. In order for a Provider to exercise their delineation of privileges, they must adopt all components of the Hospital's Electronic Health Record.

By not complying with the expectations of the Hospital's Electronic Health Record the Provider's ability to exercise Hospital privileges will be administratively suspended until which time the Provider adopts use of the Electronic Medical Record.

SIGNATURE SHEET

The rules and regulations of the Medical Staff of the Hospital have been reviewed by the Medical Executive Committee and approved.

_____ _____

Date

Paul J. Teiken, MD
President, Medical Staff

MEDICATION MANAGEMENT

1. **Scope of Medication Prescribing:**
    a. Medications are prescribed by the practitioner or practitioners responsible for the care of the patient as specified under 42 CFR§482.12(c) and authorized to write such orders by hospital policy and in accordance with State law.
        i. PA Code Title 49, Chapter 16: Medicine General Provisions
        ii. PA Code Title 49, Chapter 17: Medical Doctors
        iii. PA Code Title 49, Chapter 18.121: Physician Assistants
        iv. PA Code Title 49, Chapter 18.601: Perfusionists
        v. PA Code Title 49, Chapter 21.251: Certified Registered Nurse Practitioners
        vi. PA Code Title 49, Chapter 25: Osteopathic Medicine
    b. Orders for drugs and biologicals may be documented and signed by other practitioners not specified under 42 CFR§482.12(c) only if such practitioners are acting in accordance with State law, including scope-of practice laws, hospital policies, and medical staff bylaws.
    c. It is the responsibility of each provider to prescribe within limits of the aforementioned regulations.

2. **Medication Prescribing:**
    a. All medication orders must be in writing, including the date and time, and signed by a practitioner.
        i. Medication orders entered via CPOE are considered written and appropriately signed.
        ii. Medications ordered by a physician assistant must be authenticated and signed by the attending/supervising physician within 10 days.
    b. Verbal orders should be limited and must meet the following criteria:
        i. In an emergency when the provider is involved in a procedure/surgery and is unable to write/enter the order in a timely manner.
        ii. When the provider is not in the facility and an order is required within a timeframe that cannot wait for the provider to arrive.
        iii. When the provider is not in the immediate vicinity and an order cannot wait for the provider to arrive.
    c. Verbal orders can only be given to a registered pharmacist by a licensed provider. Pharmacists may not accept a verbal order from anyone other than the provider themselves.

d. Verbal orders must be co-signed by the ordering provider within 7 days of the initiation as required by the Pennsylvania Department of Health.
e. All medication orders must, at a minimum, contain the following:
    - medication name
    - dosage strength - metric nomenclature
    - route of administration
    - frequency of administration
f. Prescribing criteria for specific types of medication orders (eg. PRN orders, hold orders, titration orders, taper orders, dose range orders, etc.) are located in the WellSpan system pharmacy policy: *Required Elements of Medication Orders*.
g. All medication orders must have, somewhere in the medical record, documentation of the diagnosis, condition, or indication for use for each prescribed medication.
h. General prescribing best practices:
    i. The metric system should be used for all units of measure.
    ii. Only abbreviations appearing on the WellSpan approved list may be used.
    iii. Leading decimal points should be avoided (0.1mg not .1mg)
    iv. Trailing decimal points shall be avoided (10mg not 10.0mg)

3. Medication Availability:

a. A list of available formulary medications is maintained in the electronic health record.
b. Non-formulary medications may be obtained following a discussion between the physician and pharmacist regarding possible use of formulary alternatives.
c. Providers may request that a medication be reviewed for formulary inclusion. *The request process is outlined in Wellspan Good Samaritan pharmacy policy 3.1: Pharmacy & Therapeutics Committee, Formulary Management.*

4. Pharmacy Receipt of Medication Orders

a. Drugs and biologicals must be prepared in accordance with Federal, State and local requirements, recommendations of professional organizations and accepted standards of practice (e.g., ASHP, USP, ISMP), and the orders of the practitioner or practitioners responsible for the patient's care as specified under 42 CFR Section 482.12(c).

5. Pharmaceutical Compounding

a. Compounding is defined as process of combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product or bulk drug substance to create a sterile medication. Reference: *USP General Chapter <797> Pharmaceutical Compounding – Sterile Preparations; 2008.*

b. All practitioners involved in compounding of pharmaceuticals shall receive training and evaluation based on the complexity of the compounding performed.

SIGNATURES

The Rule and Regulations for Medication Management have been reviewed and approved by the Wellspan Good Samaritan Hospital Pharmacy & Therapeutics Committee.

_____	_____
Date	Sergei L. Joffy, MD Co-Chairman, Pharmacy & Therapeutics Committee
_____	_____
Date	Muhammad N. Khan, MD Co-Chairman, Pharmacy & Therapeutics Committee
_____	_____
Date	Paul Teiken, MD President, Medical Staff

DEPARTMENT OF MEDICINE

1. The Department of Medicine shall be organized in accordance with the provisions of the Bylaws of The Good Samaritan Hospital dealing with departmental organizations (see Article IX).

2. Initial privileges granted in the department of Medicine shall be commensurate with the training, experience, competence, judgment, and character of the candidate. It is the responsibility of the candidate to provide substantiation.

3. Advanced Practice Clinicians such as psychologists, physician assistants, nurse practitioners, etc. may apply to be members of the Department of Medicine but do not have a classification. Such professionals may function within the limits of their license.

4. There shall be a biennial review of privileges in conjunction with staff reappointment. This shall be based on appraisal of professional performance, judgment, skills, and knowledge; current licensure; physical and mental health status; fulfilling the continuing education requirements; staff citizenship (including meeting attendance and medical record function); efficient use of Hospital facilities and resources; working relations with colleagues and other Hospital personnel; and the results of quality assurance activities. Guidelines from various specialty societies may be used for specific procedures. Additionally, there shall be an ongoing professional practice review biannually.

5. Additional privileges may be granted at any time, based on documentation of appropriate training and competence, with approval of the department chairman, the Credentials Committee, and the Board, and in consideration of the Hospital's facilities and resources. Privileges may also be modified or withdrawn at any time as the result of corrective action, as provided in the bylaws.

6. A copy of the delineation of privileges, including a list of procedures, will be included in the application of each new member of the Department of Medicine. The delineation of privileges must be approved by the Executive Committee and Chairman of the Department of Medicine.

7. A service roster is set up annually as part of the table of organization by the Department. All service obligations must be met by each member of the Department and care of a service patient must be carried to satisfactory completion by the physician initially assigned to the care of the patient.

8. Attendance at department meetings is in accordance with the requirements set forth in the bylaws of the Medical Staff.

9. Patients shall be seen as often as necessary; but not less than once every day.

10. To facilitate prompt patient care, members of the staff who are on call to the Hospitals should be able to respond, at least by phone, within thirty minutes of being called during their call period.

11. The Department in collaboration with the Department of Family Medicine authorizes a Quality Assurance Committee as a standing committee.

A. Purpose:
To serve as the focus for quality assurance and peer review activities for the Department.

B. Membership:
1. Department of Medicine Chairman will serve as Committee Chairman
2. Department of Medicine Vice-Chairman.
3. Department of Family Medicine Chairman
4. Immediate Past Chairman of Department (if available).
5. Optionally, one or two members-at-large, appointed by the Department Chairman

C. Meetings:
At least quarterly; a majority of the voting members shall constitute a quorum, but not less than two.

D. Professional Practice Evaluation:
1. Indicators recommended by the Committee and approved by the department, Medical Executive Committee and the Board.
2. Threshold recommended by the Committee and approved by the department, Medical Executive Committee and the Board.
3. Indicators are evaluated periodically.

E. Reporting:
Actions of the Committee will be reported regularly at Department meetings.

SIGNATURE SHEET

The rules and regulations of the Department of Medicine of the Medical Staff of the Hospital have been reviewed by the Department and approved.

_____	_____
DATE	Musaddiq Waheed, MD Chairman, Department of Medicine
_____	_____
DATE	Paul J. Teiken, MD President, Medical Staff

DEPARTMENT OF OBSTETRICS / GYNECOLOGY AND NEWBORN CARE

1. The Department shall be known as the Department of Obstetrics/Gynecology and Newborn Care and shall be organized and shall function in accordance with Article IX of the Medical Staff By-laws.

   The purpose of the Department shall be to provide optimal care for all patients who are treated under the Department of Obstetrics/Gynecology and Newborn Care, to maintain a high level of professional performance for all physicians authorized to practice within the Department, and to provide teaching programs necessary for continuing education within the Department.

2. The Officers of the Department shall be the Chairman and the Vice-Chairman in accordance with Article X of the Medical Staff By-laws.

3. The Department will meet every other month to discuss business matters and also as a committee-of-the whole to discuss peer review activities.

4. Rules of order: Parliamentary questions shall be satisfied by provisions set forth in the Organized Medical Staff By-laws. Questions not satisfied by the above will be referred to Roberts' Rules of Order.

5. Appointment and reappointment shall be subject to the policies and procedures outlined in Article IV of the Medical Staff By-laws.

6. Privileges:

   a) Questions of privileges shall be handled in accordance with Article VII of the Medical Staff By-laws.

   b) There shall be a biennial review of privileges in conjunction with Staff reappointment. This shall be based on appraisal of professional performance, judgments, skills and knowledge, including information from the Ongoing Professional Practice Evaluation (OPPE) review biannually; current licensure; physical and mental health status; fulfilling the continuing medical education requirements; Staff citizenship (including, meeting attendance and medical record function); efficient use of hospital facilities and resources; working relations with colleagues and other hospital personnel; and the results of quality assurance activities. Review shall be conducted by the Department Chairman (or designee) and recommendations forwarded to the Credentials Committee, Medical Executive Committee and Board of Directors for action.

c) A copy of the Delineation of Privileges, including a list of procedures, will be included in the application of each new member of the Department of Obstetrics /Gynecology and Newborn Care. The Delineation of Privileges must be approved by the Chairman (or Vice-Chairman) of the Department of Obstetrics/ Gynecology and Newborn Care, the Credentials Committee, the Medical Executive Committee and the Board of Directors.

- A current list of the physicians in the Department of Obstetrics /Gynecology and Newborn Care, designating category of privileges and certification status will be kept in the Office of Medical Affairs.

d) Additional privileges may be granted at any time based on documentation of appropriate training and competence with approval of the Department Chairman, the Credentials Committee, Medical Executive Committee and the Board of Directors, and the consideration of the hospital's facilities and resources.

e) Privileges may also be modified or withdrawn at any time as the result of corrective action as provided in the Bylaws.

f) **Required Education for Physicians with Delivery Privileges:**
- Initial Appointment: Access to all five (5) Relias OB modules must be completed by the end of the first six (6) months of Provisional status.
- Reappointment: All five (5) Relias OB modules must be completed within the two-year reappointment cycle.

7. Consultations:

A. Consultations are required in the Department for the following indications in obstetrical patients:

- Physicians are to seek appropriate consultations for medical or surgical complications of pregnancy
- In major surgical cases in which the patient is not a good risk and in all cases in which the diagnosis is obscure or when there is doubt as to the best therapeutic measures to be utilized, consultation will be required.
- Judgment as to the serious nature of the illness and the question of doubt as to the diagnosis and therapy rests with the physician responsible for the care of the patient.

B. The consultant must be well qualified to render an opinion in the field in which his opinion is sought.

C. Satisfactory consultation shall include examination of the patient and the record, and written opinion signed by the consultant, and made part of the medical record.

D. When operative procedures are involved the consultation note, except in extreme emergencies, shall be recorded on the chart prior to the operation.

8. Cesarean Sections:

Cesarean section is to be performed by an Obstetrician who is a Board Certified or Board Eligible physician if, in his judgment, this is the safest method of delivery for the health of the mother and the fetus.

Other physicians with obstetrical privileges are to seek appropriate consultation of an Obstetrician who is Board Certified or Board Eligible for the patient whom they are attending; who they feel may require a cesarean section.

A. There shall be a Provider present at all Cesarean Sections who shall be responsible for the care of the infant. A Neonatologist, Neonatal Nurse Practitioner or appropriately privileged Provider shall be present at any high-risk or emergency Cesarean section or at any time required by the discretion of the attending obstetrician.

B. There shall be required consultations with a Neonatologist, Neonatal Nurse Practitioner or appropriately privilege Provider for the following:

1. Neonates requiring intubation or prolonged bag and mask resuscitation or with 5-minute APGARS of less than 7.
2. Neonates less than 36 weeks gestation, small for gestational age, or under 2000 grams with or without complications.
3. Neonates with complications such as cyanosis, anemia (hemoglobin less than 14 in newborns), neonatal seizures, erythroblastosis or severe unexplained jaundice.
4. Any infant being transferred to or from a regional intensive care nursery.
5. Neonates cared for in the sick Nursery longer than 24 hours.

9. Sterilization:

Sterilization may be performed by a duly-privileged physician upon due consultation between physician and patient.

Other physicians must consult a duly-privileged physician for sterilization of their patients. The attending physician may seek appropriate medical, surgical, or psychiatric consultation prior to tubal ligation in selected cases.

10. Operating Room:

Department members having operating privileges or using operating room facilities shall be subject to the operating room policies and procedures.

An operation or procedure shall be performed only on the informed consent of the patient or her legal representative, except in life threatening emergencies, and shall be the responsibility of the physician or associated medical group performing the operation or procedure to obtain the consent for any procedure authorized on the "Consent to Operate" form, and not more than 30 days prior to the procedure.

When a complete history, physical examination, and essential laboratory tests are not recorded on the chart before the time assigned for the operation, the operation shall be canceled unless such delay would constitute a hazard to the patient. In this event, an examination of the heart and lungs must be recorded on the chart.

A full operative note by the surgeon is required for all operations and procedures on both in- and out-patients.

Each patient must be positively identified by the surgeon and a member of anesthesia service before an operation is commenced. Appropriate documentation must appear on the hospital record.

All tissue removed at operation, including all placentas, shall be sent to the hospital pathologist who shall make such examinations as he/she may consider necessary to arrive at the pathological diagnosis.

Visitors, other than physicians, are not permitted in the operating room without the permission of the department chairman and a notification of the operating room supervisor.

11. All decisions concerning and pertaining to the Department of Obstetrics/Gynecology and Newborn Care will be decided upon by the Chairman of the Department, acknowledging the advice of the other members of the Department.

12. Immediate post-delivery care of the newborn is the responsibility of the physician attending the delivery. This responsibility continues until the Neonatologist, Neonatal Nurse Practitioner and/or Family physician assigned to care for the newborn admits the newborn to his/her service. In cases where there is any evidence that a newborn may need resuscitation at the time of delivery, the Neonatologist, Neonatal Nurse Practitioner or Family physician designated to care for the newborn should be notified, and every effort should be made to have the Newborn Care Provider present at the time of the delivery.

13. It is the responsibility of the Department of Obstetrics/Gynecology and Newborn Care to specify Emergency Department coverage for patients requiring OB/GYN consultations. All physicians shall provide such Emergency Department coverage on a rotating basis, and it is the responsibility of the physician scheduled to arrange coverage if he/she is unable to serve the assignment.

14. All safety standards shall be observed by anyone entering an operating room or delivery area, including proper gowning with mask and cap, and shoe covers as required.

15. The Department Chairman shall designate a member of the Department to serve on the Operating Room Committee annually.

16. Attendance at department meetings is in accordance with the requirements set forth in the bylaws of the Medical Staff.

17. Patients shall be seen as often as necessary but not less than every 24 hours.

18. To facilitate prompt patient care, members of the staff who are on call to the Hospital need to respond in person within 30 (thirty) minutes of a stat consult.

19. The Department in collaboration with the Department of Family Medicine authorizes a Quality Assurance and Improvement Committee as a standing committee known as “OB/GYN and Newborn Care” Quality Assurance and Improvement Committee”.

    A. <u>Purpose:</u>
    To serve as the focus for quality assessment and peer review activities for the Department.

    B. <u>Membership:</u>

1. The Department Chairman of OB/GYN/Newborn Care will serve as Committee Chairman.
2. The Department Vice-Chairman of OB/GYN/Newborn Care
3. At least one Obstetrician
4. At least one Family Medicine physician with Obstetrics privileges
5. At least one Neonatologist or Neonatal Nurse Practitioner.
6. Optionally, one or two members-at-large, appointed by the Department Chairman
7. A physician member from the Department of Anesthesia on an "ad hoc" basis.

C. Meetings:
At least quarterly; a majority of the voting members shall constitute a quorum but not less than two.

D. Professional Practice Evaluation:
1. Indicators recommended by the Committee and approved by the department, MEC and the Board.
2. Threshold recommended by the Committee and approved by the department, MEC and the Board.
3. Indicators are evaluated periodically.

E. Reporting:
1. Actions of the Committee will be reported regularly at Department meetings and the Medical Executive Committee.
2. For any quality concerns regarding a member of the Department of Family Medicine, the Chairman of the Department of Family Medicine will be included as an ad hoc member of the QA&I Committee for any recommendation discussions prior to taking such to the respective Department and/or Medical Executive Committee.

20. All persons (including medical and nursing staff) attending deliveries, regardless of type or location, must be currently certified as having successfully completed the Neonatal Resuscitation Course designed by the American Heart Association and the American Academy of Pediatrics.

21. EMTALA education is required and shall be completed through the WellSpan LMS module at Initial Appointment to the Medical Staff and Reappointment.

SIGNATURE SHEET

The Rules and Regulations of the Department of Obstetrics/Gynecology and Newborn Care of the Medical Staff of the Hospital have been reviewed and approved by the Department.

_____ _____

Date Nathan A. Keller, MD
Chairman, Department of Obstetrics/Gynecology and Newborn Care

_____ _____

Date Paul J. Teiken, MD
President, Medical Staff

DEPARTMENT OF RADIOLOGY

1. The Department of Radiology shall be organized in accordance with the provisions of the Bylaws of The Good Samaritan Hospital dealing with department organizations (see Article IX).

2. Initial privileges granted in the Department of Radiology shall be commensurate with the training, experience, competence, judgment, and character of the candidate. It is the responsibility of the candidate to provide substantiation.

3. There shall be a biennial review of privileges in conjunction with staff reappointment. This shall be based on appraisal of professional performance, judgment, skills, and knowledge; current licensure; physical and mental health status; fulfilling the continuing education requirements; staff citizenship (including meeting attendance and medical record function); efficient use of Hospital facilities and resources; working relations with colleagues and other Hospital personnel; and the results of quality assurance activities. Guidelines from various specialty societies may be used for specific procedures. Review shall be conducted by a committee consisting of the chairman, vice chairman, and most recent available past chairman. The committee report shall be available to the department at the annual meeting and shall be forwarded to the Medical Executive Committee and Board. Additionally, there shall be an ongoing professional practice review biannually.

4. Additional privileges may be granted at any time, based on documentation of appropriate training and competence, with approval of the department chairman, the Medical Executive committee, and the Board, and in consideration of the Hospital's facilities and resources. Privileges may also be modified or withdrawn at any time as the result of corrective action, as provided in the bylaws.

5. A copy of the Core Privileges, including a list of additional procedures, will be included in the application of each new member of the Department of Radiology. The Privileges must be approved by the Executive Committee and Chairman of the Department of Radiology.

    A. A current list of physicians in the Department of Radiology with their attending status, category or privileges and specialty will be kept in the Administrative Office.

6. An "on-call" roster will be issued monthly. All "on-call" obligations must be met by each member of the Department of Radiology. Radiological consultation must be carried out satisfactorily by the "on-call" radiologist. Each radiologist is responsible to seek consultation for procedures or interpretations as appropriate.

7. The Department will meet in accordance with the requirements set forth in the bylaws of the Medical Staff, but no less than quarterly to discuss departmental matters and as a committee-of-the-whole to discuss peer review activities.

8. To facilitate prompt patient care, members of the staff who are "on-call" shall be able to respond, at least by phone, within thirty minutes of being called during the on-duty period.

9. Coverage physicians will be subject to the Department Rules and Regulations. Exceptions to this policy may be recommended by the Department Chairman for good cause.

10. All patients with a reaction to contrast media must be evaluated by a physician before being allowed to leave the facility where the procedure was performed.

11. Radiology Practitioner Assistants are not permitted to act as solo practitioners and must be under the supervision of medical staff radiologists as outlined on the Radiology Practitioner Assistant's privilege list.

12. For all invasive procedures performed by a radiology practitioner assistant (RPA) (i.e. procedures that require the use of a needle) informed consent must be obtained from patient such that the patient is aware that the procedure will be performed by the RPA.

13. For non-invasive studies, the RPA must introduce himself/herself to the Patient as a "radiologist practitioner assistant". The RPA must give the patient the option of having the procedure performed by the radiologist. Documentation of the discussion with the patient and the patient's decision should be placed in the patient's hospital record.

14. The Department authorizes a Performance Improvement Group as a standing group.

A. Purpose:
To serve as the focus for performance improvement and peer review activities for the Department.

B. Membership:
1) Department Vice-Chairman will serve as Group Chairman
2) Department Chairman
3) One or two members-at-large, appointed by the Department Chairman.

C. Meetings:
Bi-monthly; a majority of the voting members shall constitute a quorum, but not less than two.

D. Professional Practice Evaluation:
1) Indicators recommended by the Committee and approved by the Department, MEC and the Board.
2) Threshold recommended by the Committee and approved by the Department, MEC and the Board.
3) Indicators are evaluated periodically.

E. Reporting:
Actions of the Group will be reported regularly at Department meetings.

SIGNATURE SHEET

The rules and regulations of the Department of Radiology have been reviewed, revised and approved by the members of the Department of Radiology.

DATE	Stephen R. Whitmoyer, MD Chairman, Department of Radiology
DATE	Paul J. Teiken, MD President, Medical Staff

REHABILITATION SERVICES

I. PURPOSES OF DEPARTMENT

This department is established to provide comprehensive rehabilitative services to the patients on the Rehabilitation Unit, the hospital and such out-patients as may require evaluation and therapy. Rehab services will include those measures which will hasten the recovery and restoration of the ill or handicapped with physical, cognitive, perceptual and/or sensory impairment to the fullest physical, mental, social, vocational and economic usefulness of which he or she is capable.

These services will include, but not be limited to diagnostic/therapeutic services, the use of physical modalities, nursing, physical therapy, occupational therapy, speech and language therapy, social services, dysphasia, electrodiagnosis, electrotherapy, nutritional services, , chaplaincy services, prosthetics/orthotics and other related programs such as, pain management, cardiac and pulmonary rehabilitation, per Medicare guidelines.

II. CONTINUING GOALS OF THE DEPARTMENT

A. To provide comprehensive Rehabilitation Services to patients on the Rehabilitation Unit and in the Hospital in an interdisciplinary manner to assist the patients in improving their function, and overall quality of life.

B. To provide a Consulting and Therapeutic Service in Physical Medicine and Rehabilitation to patients requiring such services.

C. To coordinate the Department's Education and Service Activities with all hospital Educational Patient Service Activities toward continuing comprehensive Health Care.

D. All Department members will function in accordance with the bylaws and rules and regulations of the Professional Staff of The Good Samaritan Hospital.

E. To establish and maintain a Quality Assurance and Improvement program in accordance with the policies and procedures set forth by the Hospital.

III. CLINICAL SERVICES AVAILABLE

A. Physical Medicine and Rehabilitation Medicine

This service provides primary care to inpatients on the Rehabilitation Unit including but not limited to comprehensive evaluation of disability and remaining abilities, medical management, direction and supervision of the rehabilitation team, leader of family conferences, and interdisciplinary team conferences. The service of electrodiagnostic testing/ electromyography/nerve conduction studies is provided as requested. This service also provides consultation in Physical and Rehabilitation Medicine to acute care inpatients at The Good Samaritan Hospital.

B. Rehabilitation Nursing

This service provides a systematic and comprehensive assessment and treatment of the individual's functional health patterns as it relates to the patient's physical rehabilitation needs with special emphasis on skin integrity, pain management, bowel and bladder function, respiratory and circulatory systems. Twenty-four hour/day care shall emphasize health maintenance, discharge planning, and teaching in an interdisciplinary manner.

C. Physical Therapy

This service provides individualized assessment/evaluation to patients who have impairments, functional limitations, disabilities or changes in physical function and health status resulting from injury, disease, or other causes. Therapeutic management is focused on maximizing functional independence, preventing further impairment or disability and maintaining health. Services may include: therapeutic exercise, functional training (self care, community and work integration or reintegration), manual therapy, prescription/application of assistive, orthotic and prosthetic devices and equipment, wound management, therapeutic modalities (electrotherapy, physical agents and mechanical modalities), patient education, prevention and wellness services (screenings and health promotion) and consultation. Home evaluations are performed with the therapists, patient and family (when applicable) to assess the home environment to assist in discharge planning. Treatment for lymphedema, using manual lymph drainage and complete decongestive therapy, is available for outpatients.

D. Prosthetics/Orthotics

Contracted services are available to inpatients and outpatients as needed for evaluation and fabrication of custom prosthetics/orthotics. The physical therapy department oversees the prosthetic/orthotic services and is responsible for ordering and evaluating devices as appropriate**,** with a written physician’s order.

E. Occupational Therapy

This service provides assessment and treatment of occupational performance and performance components of patients with physical disabilities and related psychosocial impairments for the purpose of maximizing independence, preventing further disability, and maintaining health. Individualized evaluations and treatment may include self-care, homemaking, transfers, prevocational and vocational/leisure activities, pre-driving screening, community re-entry, therapeutic modalities and positioning/upper extremity splinting, as well as sensory-motor, cognitive, and perceptual motor skills. Home evaluations are performed with the therapists, patient and family (when applicable) to assist in discharge planning.

F. Speech and Language Pathology

This service directs its activities toward maximizing communicative competence (expressive and receptive communication, processing and sequencing of information) and maximizing the use of oral and pharyngeal sensory motor functions to promote safe and adequate nutritional intake and safe ingestion of oral medications. Therapy is based on the patient's individual needs to promote independence at home, improve social quality of life, and in cases of oral and pharyngeal needs, assuring the least restrictive diet is ingested.

G. Social Services

This service provides an assessment of the patient's family support system and the social environment in which the patient lives. The service develops with the patient, family and Interdisciplinary Team**,** strategies to enhance a patient's functional potential, implements follow through until discharge**,** designs a discharge plan, utilizing community resources that meet the basic needs of the patient and family.

H Activities

Group and individual recreational and social activities are available and coordinated by the Occupational Therapy Department.

I. Nutritional Services

This service assesses nutritional needs; and visits, plans and educates the patient and/or family so as to improve or maintain good health. *A* registered dietitian will provide this service as ordered by the physician or nurse or as requested by the patient or his/her family. In addition, this service works closely with special functions in regards to dietary modifications by Recreational Therapy.

J. Chaplaincy Services

This service provides spiritual care to the patient via an initial visit by the chaplain and follow-up visits at the request of the patient**/**family or staff. The chaplain also serves as liaison to the patient's**/**family's congregation and/or spiritual leader.

IV. ORGANIZATION

A. The Department of Physical Medicine and Rehabilitation is a Division within the Department of Medicine. It functions as a patient service area. Patients are accepted on primary and referral basis from physicians and from official and private agencies having definite rehabilitative interests relative to the health management of their patient's physiatry needs.

B. Membership of the Department

1. Medical Director of the Department of Rehabilitation Medicine must be a certificant or eligible for certification by the American Board of Physical Medical and Rehabilitation or the American Osteopathic Board of Physical Medicine and Rehabilitation.

2. Members of the Department of Physical Medicine and Rehabilitation - Must be a certified or eligible for certification by the American Board of Physical Medicine and Rehabilitation or the American Osteopathic Board of Rehabilitation Medicine.

3. Support Medical Personnel - Support Medical Personnel such as physical therapist, rehabilitation nurse, occupational therapist, social worker, speech pathologist and audiologist appointed to the Department by hospital administration functions within the Department. These Professionals shall be duly credentialed through employment contract.

V. PROFESSIONAL PRIVILEGES

A. Insofar as the use of the facilities of the Department of Physical Medicine and Rehabilitation are concerned:

1. Members of the Department have privileges, as determined by the Hospital Medical Staff. A member may accept patients for consultation with recommendation for treatment, for consultation with treatment or for transfer to him (her) with full responsibility and care.

B. Rehabilitation Services staff members of the Department will carry out their assignments in their special fields as prescribed/referred by members of the Department of Rehabilitation or as prescribed/referred by other physicians of the hospital staff.

VI. MEETINGS

A Weekly Interdisciplinary Team Meetings are held to plan programs and facilitate discharge planning for in-patient acute rehabilitation and Transitional Care Unit patients. Monthly interdisciplinary communication is held for outpatients receiving two services or more to aid coordination of program. See Outpatient Interdisciplinary Care Planning Procedure.

B Regular meetings of the Rehabilitation Services Medical Staff Committee are held to oversee and guide departmental concerns regarding Rehabilitation Services.

VII. INTERDEPARTMENTAL COOPERATION

This Department shall cooperate with all other hospital departments, the Medical Executive Committee and the Board of Directors in matters regarding patient care, hospital policy and general hospital welfare.

IX. REHABILITATION UNIT

There shall be a designated Rehabilitation Unit which shall provide comprehensive Rehabilitation Services, which shall include, but not be limited to the following:

- Physical Therapy
- Occupational Therapy
- Social Services
- Prosthetic Consultations
- Orthotic Consultations
- Rehabilitation Nursing
- Speech/Language Pathology Therapy
- Dysphagia
- Nutritional Services
- Activities
- Chaplaincy

These services shall be coordinated into an integrated program, along with all other required hospital services toward the total rehabilitation of the handicapped patient.

X. **PREADMISSION SCREENING**

A. Referrals for evaluation for admission to the Rehabilitation Unit can be made from a variety of sources. There must be documentation in the medical record or on file indicating the preadmission screening process was utilized to determine whether admission is appropriate.

B A formal Pre-Admission Assessment must be completed as part of the screen for appropriateness of admission.

C. There must be documentation of physician review of the patient's functional capacity and need for inpatient rehabilitation (noted on the Pre-Admission Assessment).

D. Patients will be accepted to the rehabilitation unit only by the approval of the Medical Director of Rehabilitation Services or whomever he designates. Pre-admission screening must be completed prior to acceptance for admission to the Rehabilitation Unit. When required, precertification by third-party payors must be completed prior to admission to the Rehabilitation Unit.

E Verbal notification of denial shall be communicated to the referral source, patient's physician and patient and/or family as appropriate.

F. The Rehabilitation physician will sign off approval for Pre-Admission no greater than 48 hours prior to admission to the Rehabilitation Unit.

XI. **ADMISSION CRITERIA**

A. Prior to admission, patient's condition and medical history are reviewed in consultation by a physiatrist *and* rehabilitation nurse to determine if patient meets criteria for admission and will benefit from intensive in-patient rehabilitation.

B. Problems requiring an intensive rehabilitation program will be treated through an interdisciplinary coordinated team approach. The rehabilitation program includes close medical supervision* by a physician with specialized training or experience in rehabilitation, 24-hour rehabilitation nursing, physical therapy, occupational therapy and speech therapy, if needed. Additional services provided include social services, nutritional service, audiology, prosthetics-orthotics, psychological services and spiritual care.

*Close medical supervision" refers to 24-hour physician availability and medical evaluation of the patient with regular documentation in the medical record

C. The therapy hour requirement for rehabilitation patients refers to a minimum of three (3) hours of therapy per day, five (5) out of seven (7) days per week, or 900 minutes of therapy over seven (7) days if indicated by the physiatrist

D. The Department of Rehabilitation requests that consultations be used in the following types of cases:

1. All early adults, middle adults, and elderly patients referred for an acute, inpatient rehabilitation admissions are assessed for appropriateness based upon their functional deficits. Patients must have a deficit(s) that requires retraining in an acute rehabilitation setting under the guidance of an interdisciplinary team. This retraining should include rehabilitative care with the focus of enhancing the self care and mobility function of the patient. Examples of diagnoses in the Inpatient Rehabilitation Unit include (per CMS guidelines):
    a) Stroke
    b) Spinal Cord Injury
    c) Congenital Deformity
    d) Amputation
    e) Major Multiple Trauma
    f) Fracture of femur/hip fracture
    g) Brain Injury
    h) Neurological disorders (Multiple Sclerosis, motor neuron diseases, polyneuropathy, Muscular Dystrophy and Parkinson's Disease)
    i) Burns
    j) Active, polyarticular rheumatoid arthritis, psoriatic arthritis and seronegative arthropathies
    k) Systemic vasculidities with joint inflammation
    l) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight-bearing joints).
    m) Knee or hip replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:
        1) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.
        2) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.
        3) The patient is 85 or older at the time of admission to the IRF.

E. The candidate must demonstrate a functional disability and/or medical need which requires the continuing availability of a physician to ensure safe and effective treatment.

F. The candidate demonstrates physical conditions or functional impairments which can be expected to improve significantly within a reasonable period of time evidenced by documentation of continued improvement.

G. The candidate must state verbally or non-verbally a willingness to participate in the rehabilitation program.

H. This unit shall admit early adults, middle adults and elderly patients.

I. The Rehabilitation physician will document that the patient is able to be educated and can be expected to show significant improvement in the patient's condition and level of functioning within a stated reasonable period of time.

J. The candidate must be medically stable, enabling the patient to participate in a rehabilitation program.

K. The candidate must have freedom from mental disorders which preclude active participation in a rehabilitation program.

L. The Rehabilitation Unit can assist patients with functional deterioration due to a physician illness requiring restoration to a higher functional level where interdisciplinary therapy is needed.

XIII. PATIENTS ADMITTED TO THE INPATIENT REHABILITATION UNIT

A. The physiatrist will be the physician of record.

B. Medical and surgical consultation and/or follow-up will be ordered, as needed based on the condition of the patient. In an emergent situation, the physiatrist and/or consulting medical physician will be notified in a timely fashion.

C. A History and Physical and Post Admission Physician Evaluation must be completed within 24 hours of admission and must reflect goals and identify the patient as appropriate for admission to the Rehabilitation Service.

D. The physician will document face to face contact and functional status of each patient a minimum of three (3) days per week.

E. Patient and family conferences will be held as needed for discharge planning and for patient and family education.

F. Functional assessment and evaluations shall be completed by each discipline as ordered, within two days of admission or referral. An interdisciplinary meeting must be held and documented on the chart within one week, and then weekly thereafter to document progress, or lack thereof, according to the goals. The interdisciplinary team will communicate and review patient progress or lack thereof on a daily basis.

G. Progress notes shall be written at the attending physician's discretion reflecting the patient's status/progress relating to the goals.

H. Rehabilitation orders for therapies will only be accepted if written or approved by the physiatrist.

I. The Functional Independent Measure (FIM) will be utilized by the rehabilitation team documenting admission to discharge functional status.

J. Discharge planning will be in accordance with the approved Policies & Procedures of the Rehabilitation Unit.

XIV. **INFECTION CONTROL**

Infection control within the Rehabilitation Department shall be in accordance with the policies and procedures set forth by the Infection Control Committee.

XV. **CONDUCT**

Members of this Department shall abide by the Bylaws and rules of the WellSpan Good Samaritan Health System and shall act in accordance with the professional code as laid down by the American Medical Association, the Pennsylvania Medical Society, American Osteopathic Association and Pennsylvania Osteopathic Medical Association.

SIGNATURE SHEET

The rules and regulations of the Rehabilitation Services of the Medical Staff of the Hospital have been reviewed and revised by the Department and approved as written.

Date	Tiffany Downs, MSN, , RN, Nurse Manager, Rehabilitation Unit
Date	Patricia P. Guzowski, MD Medical Director, Rehabilitation Unit
Date	Paul J. Teiken, MD President, Medical Staff

ROBOTICS COMMITTEE

To carry out this responsibility, the Committee shall:

1. Participate in patient studies for the purposes of reviewing and evaluating the quality of care within the Robotics Program. The Committee shall review all clinical work performed under its jurisdiction whether or not any particular practitioner whose work is subject to such review is a member of that Department.

2. Reporting: This committee will recommend actions based on quality concerns to the respective Department Chairman. The Department Chairman will have final authority on follow-up of quality concerns recommended by the committee. Actions of the Committee will be reported regularly at Department meetings

3. Establish guidelines and make recommendations to the Credentials Committee for the granting of clinical privileges and the performance of specified services within the Robotics Program and submit the recommendations required under Articles IV and V regarding the specific privileges each staff member or applicant may exercise.

4. Conduct or participate in, making recommendations regarding the need for continuing education programs pertinent to findings of review, evaluation and monitoring activities in the state-of-the-art Robotic Surgery techniques and equipment.

5. Coordinate the patient care provided by the Committees' members with nursing and ancillary patient care services and with administrative support services.

6. Submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning:
   i. Findings of the Committee's review, evaluation and monitoring activities, actions taken thereon and the results of such action;
   ii. Recommendations for maintaining and improving the quality of care provided by the Robotics Program; and
   iii. Such other matters as may be requested from time to time by the Medical Executive Committee

7. The Committee with meet on a quarterly basis.

8. **Proctor Qualifications:** Any Surgeon who wishes to be an in-house proctor for a Medical Staff member in the same specialty on the daVinci Robotic Surgical System must accumulate a total of at least 40 cases per rolling year to qualify. All requests for in-house proctors should be formally submitted to the Robotics Committee for approval and will be based upon qualifications and quality.

SIGNATURE SHEET

The Rules and Regulations of the Robotics Committee have been reviewed and approved by the members of the Robotics Committee

Date	Kurt A. Graupensperger, DO Chairman, Robotics Committee
Date	Paul J. Teiken, MD President, Medical Staff

DEPARTMENT OF SURGERY

1. A surgical operation or procedure shall be performed only upon the informed consent of the patient or his legal representative, except in life-threatening emergencies. It shall be the responsibility of the surgeon to obtain the consent for any procedure authorized on the "Consent to Operate" form and not more than 30 days prior to the procedure. Administrative Memorandum #10-3, "Informed Patient Consent" shall be adhered to.

2. When a complete history, physical examination, and essential laboratory tests are not recorded on the chart before the time assigned for operation, the operation shall be cancelled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient. In this event, an examination of the heart and lungs must be recorded on the chart.

3. Each patient must be positively identified by the anesthesiologist before field blocks, major conduction anesthesia or the placement of invasive monitoring lines (e.g. pulmonary artery catheters, etc.). Each patient must also be positively identified by the surgeon and a member of the anesthesia service after the patient is on the operating table in the room, before general anesthesia or surgery are commenced. Appropriate documentation must appear on the hospital record.

4. A fully dictated operative note by the surgeon is required for all procedures performed on both inpatients and outpatients in the operating room as prescribed by regulatory requirements.

5. All tissue removed at operation, except those specimens which may be exempted shall be sent to the Hospital pathologist, who shall make such examinations as he may consider necessary to arrive at a pathologic diagnosis.

6. Pre- and Post-anesthesia rounds and assessments shall be completed and recorded in the patient record by the anesthesia staff.

7. **CONSULTATION**

    a) In major surgical cases in which the patient is not a good risk, in cases where the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to utilize, consultation should be considered.

b) Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and therapy, rests with the physician responsible for the care of the patient.

c) (It is the duty of the Hospital staff, through its chairmen and departments, chief of services and executive committee) to see that members of the staff do not fail in the matter of calling in consultants as needed.) The consultant must be well-qualified to render an opinion in the field in which his opinion is sought. A satisfactory consultation shall include examination of the patient and the record, and written opinion, signed by the consultant which is made part of the record.

d) When operative procedures are involved, the consultation note, except in extreme emergency, shall be recorded on the chart prior to the operation.

8. All safety standards shall be observed by anyone entering an operating area, including proper gowning, with mask and cap.

9. **PRIVILEGES**

a) Eligibility to perform independent surgical procedures shall require that the practitioner possess the qualifications of the responsible surgeon, as defined in the Statements of Principles of the American College of Surgeons. (See attached).

b) There shall be a biennial review of privileges in conjunction with staff reappointment. This shall be based on appraisal of professional performance, judgment, skills, and knowledge; current licensure; physical and mental health status; fulfilling the continuing education requirements; staff citizenship (including meeting attendance and medical record functions); efficient use of Hospital facilities and resources; working relations with colleagues and other Hospital personnel; and the results of quality assurance activities.

c) Guidelines from various specialty societies may be used for specific procedures. Review shall be conducted by a committee consisting of the chairman, vice chairman, and most recent available past chairman.

d) The committee report shall be available to the department and forwarded to the Medical Executive Committee and Board. Additionally, there shall an ongoing professional practice review biannually.

e) Additional privileges may be granted at any time, based on documentation of appropriate training and competence, with approval of the Department Chairman, the Medical Executive Committee, and the Board of Directors, and in consideration of the Hospital's facilities and resources. Privileges may also be modified or withdrawn at any time as a result of corrective action, as provided in the bylaws.

10. An Operating Room Committee shall be appointed annually by the Chairman of the Department, consisting of at least three members of the Surgical Department, with representatives of Hospital administration acting as ex-officio members.

    a) This committee shall address itself to problems arising in the functions of the operating room suite and will refer recommendations to the Surgical Department.
    b) This committee shall formulate an equitable schedule for time preference for listing cases in the operating room. Emergency cases shall have priority in the operating room schedule.

11. Rules and regulations for operating room procedure and scheduling will be followed by all physicians using the operating room facilities.

12. The Rules and Regulations of the Department of Surgery are binding on the members and will be enforced by the Chairman of the Department acting through the operating room director.

13. Department attendance will be in accordance with the requirements as set forth in the bylaws of the Medical Staff.

14. Visitors, other than physicians, are not permitted in the operating room without permission of the Operating Room Administration.

15. Some operative procedures may require use of a qualified surgical assistant. The final decision regarding the necessity for an operating assistant rests with the surgeon. This decision, including the number and qualifications (i.e. physician or non-physician) will be based on consideration of the following criteria.

    a. Complexity of procedure
    b. Degree of hazard to patient
    c. Anticipated length of procedure
    d. Amount of technical assistance (retraction, etc.) needed

16. **GENERAL DENTISTS AND PODIATRISTS**

Criteria for Hospital Admission:

a) Patient to be admitted under attending physician's service. The physician will be responsible for medical evaluation and continuing care.
b) Consultation with other staff physicians, if indicated, prior to or at time of admission.
c) Appropriate pre-op dental or podiatric orders written.

17. Patients shall be seen as often as necessary as but not less than once every 24 hours.

18. The operating room manager must be notified as to any case that has been in isolation or has infection prior to the time that the patient comes to the operating room.

19. To facilitate prompt patient care, members of the staff who are on call to the Hospital should keep themselves within the 15-mile circle required for office and residence (Bylaws Article 3) during their call period.

20. When a staff member requests the category of “coverage” status and privileges or a physician to cover his/her practice, privileges for this physician will be restricted because of the monitoring requirements for new physicians, as set forth in the Medical Staff Bylaws (Section 3.5). However, the staff member bears the responsibility for arranging the proctoring of the coverage physician. A formal orientation of the coverage physician to the operating room prior to the coverage physician’s assignment is required. The coverage physician will not be listed on the call schedule for the Emergency Department, nor will the staff member he/she is covering. Operating privileges will only be granted to provide emergency care for patients of the covered practice. Elective surgery will not be permitted. These restrictions will apply to coverage physicians whose period of coverage will be less than three weeks. Exceptions to this policy may be recommended by the Department Chairman for good cause.

21. The Department authorizes a QA&I Committee as a standing committee.

A. Purpose:

To serve as the focus for quality improvement and peer review activities for the Department.

B. Membership:

1. Ex-officio
   (a) Department Chairman will serve as Committee Chairman.
   (b) Department Vice-Chairman.

2. Other
   (a) Immediate Past Chairman of Department (if available).
   (b) Optionally, one or two members-at-large, appointed by the Department Chairman.

C. Meetings:

At least quarterly; a majority of the voting members shall constitute a quorum but not less than two.

D. Professional Practice Evaluation:

a) Indicators recommended by the Committee and approved by the department, MEC and the Board.

b) Threshold recommended by the Committee and approved by the department, MEC and the Board.

c) Indicators are evaluated periodically.

E. Reporting:

Outcomes of reviewed cases will be communicated in writing to the practitioner involved with the ability to respond with additional information back to the committee if in disagreement. Actions of the Committee will be reported regularly at Department meetings.

SIGNATURE SHEET

The rules and regulations of the Department of Surgery have been reviewed by the Department of Surgery and approved.

Date	Kurt Graupensperger, DO Chairman, Department of Surgery
Date	Paul J. Teiken, MD President, Medical Staff

THE CANCER COMMITTEE

I. PURPOSE

The Cancer Committee is a standing committee of the Medical Staff and provides leadership to the Cancer Program via multidisciplinary participation. The Committee is responsible for goal setting, planning, initiating, implementing, evaluating and improving all cancer-related activities throughout the Wellspan Good Samaritan Hospital. The Committee will follow the requirements outlined in the most current Commission on Cancer Program Standards.

II. ORGANIZATIONAL STRUCTURE

A. The Cancer Committee's Physician Membership must include, but is not limited to representation from:
   1. Cancer Committee Chair, may be a physician of any specialty
   2. Diagnostic Radiology
   3. Pathology
   4. General Surgery
   5. Medical Oncology
   6. Radiation Oncology
   7. Cancer Liaison Physician

B. Non-Physician Membership must include, but is not limited to representation from:
   1. Cancer Program Administration
   2. Oncology Nursing
   3. Social Work/Case Management
   4. Tumor Registry
   5. Cancer Conference Coordination
   6. Quality Improvement Professional
   7. Clinical Research
   8. Psychosocial Services
   9. Survivorship Program

C. Additional representation recommended may include:
   1. Physician member(s) representing the five major cancer sites of WellSpan
   2. Palliative Care Professional
   3. Genetics Professional
   4. Registered Dietitian Nutritionist
   5. Rehabilitation Services Professional
   6. Pharmacist
   7. Pastoral Care
   8. American Cancer Society Cancer representative

D. The Cancer Committee Chair is a physician who may also fulfill the role of one of the required physician specialists. The Cancer Liaison Physician must be a member of the Cancer Committee, an active member of the medical staff, and may fulfill the role of one of the required physician specialties. The CLP serves as the physician quality leader and oversees the Cancer Committee in the absence of the Chair.

E. A member of the Cancer Committee is designated to coordinate one of the following major areas of the Oncology Program:
   1. Cancer Conference
   2. Quality Control of Cancer Registry Data
   3. Quality Improvement
   4. Community Outreach
   5. Psychosocial Services Coordinator
   6. Survivorship Program
   7. Clinical Research

F. The Coordinator's roles and responsibilities include:
   1. Contributing to the development of Program annual goals and objectives;
   2. Monitoring the activity of their assigned area of responsibility and reporting per the standard's requirements to the Cancer Committee;
   3. Recommending appropriate corrective action if activity falls below the annual goal, requirements or expectations of their designated area.

III. MEETINGS

The Cancer Committee will meet at a minimum on a quarterly basis. Special meetings of the Committee may be called as needed.

IV. RESPONSIBILITIES

A. The Cancer Committee is responsible for all oncology program activities at WellSpan Good Samaritan Hospital. This includes:

   1. Developing and evaluating annual goals and objectives for:
      (a) Addressing barriers to cancer care
      (b) Community Outreach
      (c) Quality Improvement
      (d) Evaluation of treatment per evidence-based guidelines
      (e) Programmatic Endeavors Related to Cancer Care
      (f) Psychosocial Support

2. Establishing the annual frequency, format and multidisciplinary attendance requirements for cancer conferences;

3. Ensuring, monitoring and evaluating the required number of cases discussed at cancer conferences to meet the designated percentage of cases discussed prospectively;

4. Establishing and implementing an annual quality control plan to evaluate the integrity of cancer registry data and activities;

5. Completing site-specific analysis that includes comparison and outcome data and disseminating those results to the medical staff and relevant parties;

6. Reviewing the required number of analytic cases to ensure that pathology reports include the data elements outlined in the College of American Pathologists' protocols;

7. Providing a formal mechanism to educate patients on cancer-related clinical trials;

8. Monitoring community outreach activities on an annual basis;

9. Sponsoring one cancer-related education and screening activity each year;

10. Completing and documenting the required studies measuring quality and outcomes;

11. Implementing and monitoring one improvement directly affecting patient care;

12. Establishing subcommittees/workgroups as needed to achieve program goals.

SIGNATURE SHEET

The Rules and Regulations of The Cancer Committee have been reviewed and approved by the members of the Committee.

Date	Neenos Alnoor, MD Chairman, The Cancer Committee
Date:	Neenos Alnoor, MD Site Director Wellspan Medical Oncology and Hematology
Date:	Paul J. Teiken, MD President, Medical Staff