WILLIAM NEWTON HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS

TABLE OF CONTENTS

WILLIAM NEWTON HOSPITAL

Medical Staff Rules and Regulations

SECTION 1 – GENERAL RULES AND REGULATIONS

1. Staff Eligibility - The active and consulting medical staff appointments are available only to licensed physicians (M.D.'s and D.O.'s), podiatrists and dentists to provide patient care services independently to patients of the hospital in accordance with the Medical Staff Bylaws.

2. Temporary License - Any medical staff appointee, who has a temporary license, may only be appointed for the same period as the expiration of the temporary license and appointment may not be extended on a temporary license.

3. Medical Staff Meetings - Regular meetings of the medical staff shall be held as mutually agreed upon by the Medical Executive Committee (MEC) and Administration.

4. Attending Physician Requirement - Every patient admitted to the hospital shall be attended by a member of the medical staff or by a physician who has been granted temporary privileges.

5. Diagnosis Requirement - Except in an emergency, no patient shall be admitted to the hospital until after a provisional diagnosis or valid reason for admission has been stated. The physician shall give sufficient information on any patient who may in any way endanger the health, safety or welfare of other patients, hospital personnel or visitors, or cause self harm.

6. Transferring patient responsibility to another practitioner - A practitioner who will be unavailable for care of a patient shall document on the patient's order sheet the name of the practitioner who will be assuming responsibility for care. The practitioner transferring care shall personally notify the covering practitioner and discuss patient information. The covering practitioner shall accept full responsibility for the patient until the care is transferred again and documented on the order sheet.

7. Content of Medical Staff Meetings - The medical staff meetings held as provided for in the bylaws shall consist of a thorough review and analysis of the clinical work done in the hospital, including consideration of deaths, unimproved cases, infections, complications, errors in diagnosis and the results of treatment from among patients discharged since the last meeting, and an analysis of clinical reports from each department and reports of committees of the active medical staff.

8. Admission and/or Transfer - The hospital shall admit patients suffering from all types of disease except when the type of care needed is not a service provided. All inpatient and observation admissions and all patient transfers to another acute care facility, including patient transfers from the emergency room, must be approved by a member of the WNH active medical staff.

9. Medical Staff Library - The hospital's medical library shall be maintained as a quick and ready source of information for members of the medical staff and shall consist of up-to-date standard text and journals on subjects pertinent to medical care in the hospital. Members of the staff shall not remove books or magazines from the library without receiving specific permission to do so from the librarian.

10. Dangerous or Contagious Infections - Members of the staff shall promptly notify the Infection Control Coordinator or hospital administration of any potentially dangerous or contagious infections that:

    a. Are known to exist in a patient at the time of his admission to the hospital.

    b. Develop and become known during the patient's hospital stay or;

    c. Appear and become known after the patient has been discharged from the hospital.

11. Infected Practitioner - A practitioner who knows that he or she has an infectious disease, should not engage in any activity that creates a risk of transmission of the disease to others.

12. Patient Discharge - Patients shall be discharged only on the order of the attending physician. A final diagnosis should be on the medical record upon dismissal. Should a patient leave the hospital against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record. Nursing personnel should get a "release against medical advice" form signed by the patient.

13. Policies, Bylaws, Rules and Regulations - Upon application to the medical staff, each practitioner shall sign an agreement to abide by the current hospital policies that apply to his activities as a medical staff member and that are consistent with the Medical Staff Bylaws, Rules and Regulations.

14. Evidence of License and Insurance - Each practitioner must annually furnish evidence of current licensure and adequate professional liability insurance.

15. Improvement Programs - Each practitioner will actively cooperate with the hospital's performance improvement, risk management and peer review programs for the purpose of monitoring and evaluating quality and appropriateness of the care and treatment provided to patients.

16. Review of Rules and Regulations - Rules and regulations shall be reviewed tri-annually by a special committee or the (MEC).

17. Physician Availability - A physician is obligated to be available, within a medically reasonable time, for follow-up care and/or emergency care for any hospital patient under the physician's care, **or** designate a qualified active staff physician to provide this coverage. Shiftwork expectation is that the provider in the Emergency Department and the hospitalist will remain on site during the shift they are committed to as per contract terms.

18. Patient Assessment - a patient admitted to acute care or an out patient admitted for observation shall be assessed by the attending or covering physician or mid level practitioner within a clinically appropriate time period based on the stability of the patient. The time period shall not exceed twenty-four (24) hours and the patient shall be assessed by the attending or covering physician or mid level practitioner at least daily thereafter.

19. Pneumococcal and Influenza Vaccines - For the purpose of increasing the rate of vaccination for local citizens at risk and consistent with national standards-of-care, inpatients may be vaccinated using pneumococcal and influenza vaccines based on WNH Medical Staff approved criteria and standing orders.

20. Continuing Education - Medical staff appointees shall participate in continuing education programs as determined by the MEC.

21. Notices of Meetings - Notices of all meetings of the medical staff and standing committees shall be posted in the library and medical staff bulletin board at least a week in advance of such meetings.

22. DNR/NCB Guidelines - Physicians will follow the hospital guidelines for "Do Not Resuscitate" (DNR) and "No Code Blue" (NCB) orders. These are reviewed and approved by the Medical Staff (see Section 21).

23. Advanced Cardiac Life Support - Medical Staff members (active, consulting and allied) who work shifts in the emergency department, conduct cardiac stress testing or regularly administer anesthesia (see sections 4 and 10), must possess current Advanced Cardiac Life Support (ACLS) certification or an equivalent approved by the MEC.

24. Orders for Patient Care -

a. *Authority to issue orders* - The following persons shall have authority to issue patient care orders at WNH:

   i. The WNH practitioner on record who is currently responsible for the patient admission or outpatient services – This includes a practitioner who is on-call to cover for the attending or consulting practitioner.

   ii. Consultant practitioners when the consultants have current and appropriate privileges at WNH and orders for their services are given by the responsible practitioner – Requests for services from a practitioner should be ordered as a 'consult' whether specialized or primary care.

   iii. Non-physician clinical providers acting within the limits of clinical protocols approved by the WNH Medical Staff – These orders require subsequent signature by the responsible practitioner, except as otherwise approved by the WNH Medical Staff and state or federal law.

   iv. Any practitioner may issue patient care orders when the responsible practitioner cannot be contacted and delay of care could result in serious injury to the patient.

   v. Practitioners who are not members of the WNH medical staff can provide signed orders for minimally invasive/low risk outpatient services.

b. *Verbal orders*

   i. Verbal orders shall not be accepted or carried out except when dictated to a person approved in the Medical Staff Bylaws, Rules and Regulations and later signed by the practitioner. Orders dictated over the telephone shall be signed, dated and timed by the person receiving the orders together with the name of the practitioner who gave the orders. At the first opportunity the prescribing practitioner shall sign, date and time the orders. An active staff member who is responsible for the care of a patient may authenticate verbal orders given by another practitioner.

   ii. Verbal orders received by non-physicians – Licensed nurses and physician assistants may receive and transcribe verbal orders from a practitioner. In addition, physical therapists, dietitians, clinical social workers, respiratory care practitioners, pharmacists, occupational and speech therapists may receive and transcribe verbal orders given by a practitioner pertaining to their respective fields.

c. *Electronic charting/orders/signature* – Electronic orders, charting and signature of medical records using the hospital's electronic records system should be utilized unless not possible in a given situation.

25. Communication response time - Medical Staff members who have patients admitted for inpatient or observation care or who are on-call for services to WNH patients should return calls/messages as soon as reasonably possible, not to exceed five (5) minutes for **stat** calls and thirty (30) minutes for **routine** calls. Departments may establish alternate criteria with MEC approval.

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SECTION 3 - HEALTH INFORMATION

1. **Complete Medical Record** - The Medical Staff shall cooperate in the preparation of a complete, accurate, and legible medical record for each patient, including but not limited to:

    a. All orders and entries in the medical record must be dated, timed, current, accurate and authenticated by the person making the entry.

    b. The medical record is not to be used for documenting non patient information such as staff performance concerns, disagreements with utilization or risk management decisions, etc.

    c. The medical record shall be confidential.

2. **Initial Medical Record Content** - The medical record of each inpatient, outpatient, swing-bed and home health patient of WNH shall include the following information and reports, with exceptions for some outpatients:

    a. Identification information that specifically identifies the patient under treatment.

    b. Consent for treatment and/or surgery properly signed by patient or patient representative. When not obtainable, the reason is entered in the patient record. Documentation that the risks, benefits, alternatives were explained to the patient by the physician prior to procedure (i.e., informed consent) must be present for invasive or high risk procedures.

    c. History and Physical, containing:

        i. Chief complaint(s) and history of present illness(es), inventory of body systems, current medications and allergies.

        ii. A complete physical examination shall be performed on every patient admitted to the hospital and the findings entered into the medical record.

        iii. Medical and family history, including assessment of patient's emotional, behavioral, and social status, when appropriate.

        iv. The history and physical shall be written within 30 days prior to admission to 24 hours following admission or prior to surgery or procedure requiring anesthesia, whichever comes first, by the attending physician. Information will be obtained from the patient, if possible, otherwise from a reliable and identified source. A H&P performed prior to admission must be updated noting any change or lack of changes in the patient’s condition. In all circumstances, when an H&P has been conducted but is not present on the chart prior to surgery, or in emergency situations where a complete H&P cannot be conducted prior to surgery, a brief admission note on the chart is necessary. The note should include at a minimum critical information about the patient’s condition including pulmonary status, cardiovascular status, BP, vital signs, etc.

v. A H&P is required for all outpatient procedures performed with sedation or anesthesia. A clinic note or emergency room note, performed within 30 days prior to the procedure that meets the requirements of an H&P, may be used and updated at the time of the procedure.

vi. If a patient is admitted as an Inpatient or Observation through the Emergency Department, the ED physician must document the patient's condition at the time of admission in the ED record. The Emergency Department note, however, cannot substitute for a H&P.

vii. Swingbed patients require an update of the H&P if admitted to SWB from William Newton Hospital. The update may be a brief H&P or a progress note updating the patient's current condition. Swingbed patients transferred from another facility require a complete H&P within 24 hours of admission.

viii. Home Health records must contain a face to face encounter note either from the hospital stay, including the H&P, or from the Physician's office. The face to face must be completed at least 90 days prior or 30 days after admission to the Home Health department. When a patient is dismissed from the hospital or swingbed, the discharge summary must be provided to the Home Health agency along with physician orders.

3. **Readmission** - If a former patient should be readmitted to the hospital within 30 days for the same condition, an interval note written within 24 hours of admission shall suffice, provided the original history and examination is readily available.

4. **Clinical Diagnostic Reports** - The original authenticated reports of all interpreted diagnostic procedures shall be entered in the medical record. The hospital requests copies or comments in progress notes of diagnostic reports done in physician offices within 72 hours of admission to be made available for the record.

5. **Progress Notes** - Handwritten or electronic progress notes by the physician shall be recorded in sufficient detail and at such intervals as will accurately reveal the chronological picture and analysis of the clinical course of each patient treated in the hospital. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be completed at least daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem. Progress notes should be written at least weekly on Swingbed patients.

6. **Discharge Summary** - The attending physician shall record a summary of the clinical course for each inpatient, observation, and swing-bed patient. The summary should also include the patient's condition at discharge and discharge instructions to the patient and/or family. If the patient has had surgery, the discharge summary will be recorded by the surgeon.

7. **Final Diagnosis** - Prior to or at the discharge of any patient in the hospital, the attending physician shall record a definite final diagnosis.

8. **Consultations** - Each consultant who may have occasion to examine a patient shall document findings and recommendations on the appropriate form provided by the hospital within 24 hours of the consult and shall authenticate the report with a signature.

9. **Operative Reports** - The surgeon should record and sign a preoperative diagnosis prior to

surgery. Operative reports should be dictated within 24 hours. If an operative report is not immediately placed in the record after surgery, a hand written progress note must be entered into the medical record immediately after surgery and should contain a description of the findings, the technique used, the tissue removed or altered, blood loss, if any, and the postoperative diagnosis.

10. **Anesthesia Record** - The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. The informed consent for administration of anesthesia will be obtained by the anesthetist. (See anesthesia regulations)

11. **Autopsy Report** - When an autopsy has been performed on a patient who has been under treatment in the hospital, the complete protocol of the findings shall be made a part of the patient's medical record. When an autopsy is performed, the provisional results should be recorded on the medical record within 72 hours, where feasible. The final autopsy report will be completed and on the chart within 90 days.

12. **Pathology Report** - The original signed report of the examination performed by the pathologist of a specimen removed from a patient in surgery shall be made a part of the patient's medical record.

13. **Delinquency of Records**

a. All physician documentation in the medical record must be completed within 15 days after discharge or the record will be considered delinquent. The hospital is required to file records within 30 days.

b. A delinquent chart is one that is not complete and ready to be scanned into the EHR.

c. All portions of a patient's medical record must be prepared within the time frames provided below:

- Orders – authenticated by the prescribing or covering practitioner within 72 hours of the patient's discharge or 30 days whichever occurs first.
- History and Physical – within 30 days prior to and 24 hours following admission or prior to surgery.
- Surgical/Diagnostic Procedure – dictation immediately after surgery and handwritten note.
- Therapeutic Reports – prior to discharge (evaluation to be documented the day the physician order and progress note written)
- Birth Certificates – 5 days
- Discharge Summary – at discharge or within. fifteen days after discharge.

d. It is the responsibility of the physician to check his box concurrently for delinquent medical records.

e. If the physician fails to complete the delinquent medical record or fails to prepare a currently admitted patient's record after notice to do so within fifteen days from discharge, a notice will be sent to the Chief Executive Officer (CEO) the Wednesday following the delinquency.

f. The written notice sent out by the CEO will inform the physician that delinquent records

must be completed by noon on the following Tuesday or admitting privileges will automatically be suspended.

g. If the delinquent records are not complete within the time frame specified in paragraph 13. g., the CEO will inform the physician that admitting privileges are suspended. The Chief-of-Staff, House Supervisor and Admitting Office will also be notified.

h. The suspension shall be automatically lifted when the delinquent medical records are completed. The CEO, Chief-of-Staff, Admitting Office and House Supervisor shall be notified when the records are completed.

i. The suspended physician may request the Medical Executive Committee (MEC) to review the suspension. The MEC, at its next regular meeting, shall review the suspension and affirm, modify, or rescind the suspension.

j. After the third suspension of privileges within any three month period for failure to complete or prepare records, the staff member shall appear before the MEC for consideration of a 30 day suspension.

14. **Disposition of Records** - In case of death, absence or other disabling circumstances involving a practitioner, disposition of the records will be ordered by the Utilization/Health Information Management Committee. The committee shall determine when an incomplete chart may be filed. No medical staff member is authorized to complete a chart on a patient unfamiliar to him/her in order to retire the record.

15. **Release of Information** – Written consent by the patient, legal guardian or personal representative as designated by the patient is required for release of medical information to persons not otherwise authorized to receive this information, unless it is clearly to be used for the purpose of continuum of care.

16. **Abbreviations and Symbols** - The abbreviations must be in the Steadman's Abbreviation Book. No abbreviations will be used on a final diagnosis, including, surgical diagnosis.

17. **Record Ownership** - All patient records are the property of the hospital and may be removed from the hospital's jurisdiction only in response to a court order or subpoena.

18. **Verbal Orders** - All orders for patient care shall ultimately be documented in the medical record. Verbal orders shall be signed, dated and timed by the person receiving the orders together with the name of the practitioner who gave the orders. At the next hospital visit, the prescribing practitioner shall sign, date and time the orders. An active staff member who is responsible for the care of a patient may authenticate verbal orders given by another practitioner.

19. **Verbal orders received by Non-Physicians** - Verbal orders shall not be accepted or carried out except when given to a person approved in the Medical Staff Bylaws, Rules and Regulations and later signed by the practitioner. Nurses may accept any verbal order. Physical therapists, dietitians, clinical social workers, respiratory care practitioners, pharmacists, occupational and speech therapists, laboratory technologists and x-ray technicians may write verbal orders given by the physician pertaining to their respective fields and within state practice guidelines.

20. **Obstetrical Records** - Obstetrical records should include all prenatal information. A legible original or reproduction of the office prenatal record is acceptable.

21. **Emergency Room Records** - Every emergency room patient shall have a permanent record containing patient identification, the history, physical exam, findings, treatment and disposition. The physician involved is responsible for the record.

22. **Special Treatment Procedures** - When a special treatment or procedure is used in the treatment of a patient, the physician directing or performing the treatment procedure shall document pertinent information in the medical record.

23. **Access to Medical Records** - Access is limited to those physicians and other staff working with a patient, needing to document in the record, or conducting risk management and performance improvement activities. Access to medical records of all patients shall be afforded to members of the Medical Staff for bonafide study and research when consistent with policies preserving confidentiality. All such projects shall be approved by the MEC before records are studied.

24. **Special Confidentiality Situations** – Patient information that is extremely confidential may be filed separately from the medical record with a notation designating who is authorized to review that portion of the record. The complete record shall be readily available when required for current medical care and risk management/peer review functions. The medical record shall indicate that a portion has been filed elsewhere.

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SECTION 4 - EMERGENCY ROOM

1. The Medical Staff shall be responsible for providing a primary care physician to be available for the emergency room on an "on call basis". The doctor "on call" in the emergency room has the responsibility of being available or providing a qualified relief.

2. All members of the Medical Staff having active staff privileges in general practice, family practice, pediatrics or internal medicine shall participate in the primary care emergency call unless otherwise approved by the Medical Staff.

3. The emergency room shall maintain a list denoting the availability of specialists on the medical staff who will respond to evaluation and emergency care. The hospital will develop policy regarding this and other aspects of EMTALA law.

4. The emergency room shall be open 24 hours per day. A provider is to be on site during their shift.

5. No elective surgery requiring a scrub nurse is to be done in the emergency room.

6. General anesthesia shall not be administered in the emergency room, except when necessary for endotracheal intubation. The department shall maintain policies approved by the Critical Care Committee regarding the use of general anesthesia for intubation.

7. Every patient shall have a permanent record containing patient identification, the history, findings, treatment and disposition. The physician involved is responsible for the record. A copy of the record shall be sent to the attending physician.

8. The Medical Staff will assist in the establishment of written policies for the emergency room service.

9. Every patient who presents at WNH for emergency care shall receive a Medical Screening Exam (MSE) to determine if a medical emergency exists. An MSE can only be completed by a licensed independent practitioner (LIP) in the Emergency Department. When an OP provider is not available, a qualified competent OB nurse may perform an OB MSE. MSE is not the same as triage. Patients will receive an MSE in compliance with EMTALA laws. The screeners must have privileges at WNH.

   Patients that request to be seen directly in the Fast Track will still be treated as an ED patient until the initial MSE/Triage is completed. Please refer to the “ER and Fast Track Triage Policy”.

10. After completion of an initial exam, additional testing may be ordered by the physician, MLP or APP for a medical screening exam to be considered complete.

11. A physician, MLP or APP must evaluate at the hospital any patient who presents for emergency care in the following situations:

    a. in the judgment of the qualified screener an emergency medical condition exists or is reasonably possible.

    b. whenever a patient is to be transferred to another acute care facility.

12. The Chief-of-Staff will appoint a physician member of the active medical staff a medical director of the emergency room each medical staff year. The physician may be reappointed.

13. The director should be a staff member for at least two years and have experience providing emergency care.

14. The emergency room provider coverage may be done with contract physicians, MLP or APP. The medical staff Medical Executive Committee will cooperate with the administration in obtaining cooperation from the Medical Staff for support of contract physicians.

15. The final responsibility for coverage remains with the Medical Staff if contract physician coverage is unavailable. The medical director of the emergency room will assure coverage is provided in accordance with regulations.

16. Dispensing of medications from the emergency room will follow policy and procedure approved by the Pharmacy Committee.

17. The emergency room is not the proper source to obtain repeated pain medication for outpatients. It is not considered medically acceptable, nor cost-effective to use the emergency room as a source to obtain pain medication on a repeated routine basis. It shall be considered a misuse of the emergency room if the patient gets pain medication repeatedly after office hours or on weekends.

    If a pattern of using the emergency room for routine pain medications is established, the attending physician and patient will be notified by the Critical Care Committee that they cannot use the emergency room for this purpose.

18. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by a disaster planning committee. The Medical Staff will cooperate in the development of the Disaster Plan. The plan will be approved by the Safety Committee.

19. The attending physician (including on call or no doc) must approve all inpatient and observation admissions as well as transfers to other acute care facilities.

20. If the ER physician believes the patient should be admitted or transferred, he will not inform the patient until the attending or on call doctor has been notified for approval and orders.

21. Patients seeking care in the Emergency Department who do not have a personal physician with WNH Medical Staff privileges will be assigned to the physician designated on the No Doc schedule and/or Hospitalist if the patient requires:

    a. Hospital admission or observation

    b. Transfer to another acute care facility

    c. Medical consultation in the Emergency Department

    Patients who are advised to seek additional medical care following Emergency Department discharge and who do not have a physician with WNH Medical Staff privileges will be given a current list of WNH physicians. While the No Doc and other members are encouraged to assist in providing continuation of care, they are not obligated to accept patients for follow-up care.

22. Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS) and Pediatric Advanced Life Support (PALS): Medical Staff members who work shifts in the emergency department must possess current Advanced Cardiac Life Support (ACLS) certification, Advanced Trauma Life Support (ATLS) and Pediatric Advanced Life Support (PALS) certification unless the Executive Committee deems otherwise.

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SECTION 5 - MEDICAL STAFF POLICIES FOR CO-ADMISSION REQUIREMENTS

1. Each inpatient of an attending physician with co-admission requirements will be admitted with another member of the active medical staff.

2. A list of co-admitting physicians will be provided to the attending physician.

3. The attending physician shall call in an alphabetical rotation the next co-admitting physician on the list. The co-admitting physician shall not make any determination as to the necessity for admission.

4. The attending physician must notify the co-admitting physician prior to the actual admission. Failure to do so will result in 10 days suspension of all staff privileges.

5. The admission form will designate who is the co-admitting physician at the time of admission.

6. If the next co-admitting physician on the list is unavailable, the admitting physician should move to the succeeding one. A master list will be kept in the Chief Executive Officer's office.

7. The responsibility of the co-admitting physician is to monitor the physician's orders, progress notes, and treatment of the patient.

8. The co-admitting physician generally will write no orders.

9. The co-admitting physician should make notations on the progress note sheets.

10. The co-admitting physician may examine the patient at his or her discretion.

11. The co-admitting physician will endeavor or preserve a normal doctor-patient relationship between the admitting physician and his patient.

12. If the co-admitting physician feels that treatment is inappropriate, he shall talk to the admitting physician and will document this in the progress notes.

13. If the co-admitter disagrees with patient management and feels that an immediate change must be made in order to prevent death or serious morbidity, the co-admitter will assume management of the patient and will continue to manage the patient until released from that responsibility by the Chief-of-Staff. In the event of this sort of emergency, the original admitting physician will be prohibited from writing any orders.

14. The co-admitter shall not be used as a consultant on the same case.

15. The co-admitters shall not be used as a temporary coverage on the same case.

16. The co-admitters will hold monthly meetings to review quality of patient care.

17. The purpose of the co-admitter is to monitor quality of patient care under the auspices of the Medical Executive Committee (MEC) of the medical staff and will report to the MEC.

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SECTION 6 - SURGERY DEPARTMENT

1. **Surgical Privileges** - A physician, dentist, or podiatrist wishing to do surgery at WNH must request specific privileges in writing. The Board of Trustees will act on such requests after reviewing recommendations from the Medical Staff. All privileges must again be requested and approved at the time of reappointment to the Medical Staff.

2. **Chief of Surgery** - The Chief of Surgery shall be appointed in accordance with bylaws and shall provide consultation on all matters of administrative and clinical nature over the operating suites. He or she will cooperate with committees which have special duties pertaining to surgery, such as the Infection Control Committee.

3. **Surgical Assistants** - It shall be the surgeon's responsibility and prerogative to determine if qualified first and second assistants are used. Assistants shall be qualified by privileges granted in this hospital to assist with surgical procedures.

4. **Policies and Procedures -** The Surgical Review Committee will assist with establishing policies and procedures that address department challenges and are consistent with current standards. All hospital employees and members of the Medical Staff will adhere to these policies and procedures.

5. **Medical Records** - The preoperative diagnosis, medical history and physical examination must be recorded in the patient's medical record prior to any surgical procedure. If not recorded, the surgery shall be postponed or cancelled by the operating room manager on duty. Emergency exception to this policy requires the attending surgeon to document in the medical record that a delay would be detrimental to the patient's health along with a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

6. **Non-physician Team** - When the surgical team consists of non-physician personnel (e.g. nurse anesthetists, dentists, podiatrists), a physician must be readily available to this team.

7. **Procedures by Dentists** -

   a. Dentist responsibilities:
      1) Dental history justifying procedure;
      2) Description of the examination of the oral cavity and a preoperative diagnosis;
      3) A complete operative report, describing the findings and techniques used. In cases of extraction of teeth, the dentist shall clearly state the number of whole teeth and fragments. Teeth shall be sent for pathologic examination at the discretion of the dentist;
      4) Progress notes pertinent to the oral condition;
      5) Clinical resume or summary statement.

   b. Discharge of the patient may be on the written order of the dentist or member of the Medical Staff.

8. **Informed Consent -** Informed consent shall be obtained prior to the operative procedure, except in those situations wherein the patient's health is in immediate jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The informed consent shall be in writing, signed, and dated by the patient or legally appropriate person and the professional doing the

procedure. In emergencies involving a minor or a mentally and/or physically incapacitated patient, and when consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained in the patient's medical record. In such instances and when time permits, a consultation may be desirable before the emergency operative procedure is undertaken. Consent is valid for up to 30 days prior to a procedure.

9. **Case Scheduling and Start Times** - Surgical cases shall be scheduled with the needs of patients, surgeons and the hospital considered. The surgeons will participate in establishing scheduling policy, including, but not limited to the following:

   a. Except for emergencies, patients shall be present in the hospital no later than 2 hours prior to the scheduled procedure.

   b. All elective surgical cases shall be scheduled so that surgery can be performed during designated regular hours. The regular hours for surgery are 7:30 AM - 3:00 PM. The director of surgical services may approve elective cases to be scheduled outside of this time in coordination with anesthesia if needed.

   c. If operating room and hospital personnel are available and prepared for the performance of surgery at the time an operation has been scheduled, the attending surgeon shall be in the room and ready to commence operating no later than 15 minutes after such time or the case scheduled may be cancelled by the operating room manager. In this situation, the next case posted will be started if possible.

   d. A complete listing of all operative procedures planned shall be made at the time the case is scheduled.

   e. No anesthesia shall be administered until the surgeon is present in the surgery department.

10. **Pathology Examination** - Any tissues, organs, body structures, or foreign materials removed from a patient during a surgical operation shall be sent for pathologic examination. The pathologist shall perform such examination as he/she may consider necessary to arrive at a pathological diagnosis. Exceptions to this policy:

    a. Specimens sent for gross examination only unless microscopic examination is requested by the surgeon or at the discretion of the pathologist.
       - Accessory digits
       - Inguinal hernia sacs in adults
       - Nasal bone and cartilage from rhinoplasty
       - Prosthetic breast implants
       - Torn menisci
       - Umbilical hernia sacs in children.

    b. Specimens excluded from routine submission to the Pathology Laboratory.
       - Bone donated to the bone bank
       - Bone segments removed as part of corrective or reconstructive orthopedic procedures (for example, spinal fusion, rotator cuff repair)
       - Bunions and hammertoes
       - Cataracts removed by phacoemulsification
       - Teeth and dental appliances
       - Fat removed by liposuction

- Foreign bodies, such as bullets, or other medico-legal evidence that are given directly to law enforcement personnel
- Foreskin from circumcision of a newborn
- Intrauterine contraceptive devices without attached soft tissue
- Medical devices, such as catheters, gastrostomy tubes, stents, pacemakers, portacaths
- Middle ear ossicle
- Orthopedic hardware without attached tissue
- Rib segments or other tissues removed only to gain surgical access
- Saphenous vein segments harvested for coronary artery bypass surgery
- Skin or other normal tissue removed during cosmetic or reconstructive procedures
- Toenails and fingernails that are grossly unremarkable
- Tonsils and adenoids from children up to 12 years of age
- Vaginal mucosa

When surgical specimens are not sent to a pathology laboratory, a descriptive note verifying the removal must be included in the operative record by the surgeon.

11. **Visitors** - Visitors in the surgery suites are generally discouraged due to the risk for visitor injury, compromised patient confidentiality and reduction of productivity. However, legitimate requests may be considered with the following guidelines:

    a. A request for a visitor in a surgery suite for education purposes may be made to the director of surgical services who will confer with the surgeon and anesthetist before the visitor is permitted to be in the surgical suite. When a difference of opinion occurs, Administration will be consulted.

    b. A support person may be permitted to be present during a cesarean section if the patient is receiving epidural or spinal anesthesia and this person has been properly instructed by hospital staff.

    c. Any visitor entering a surgical suite must sign a confidentiality statement and receive instruction regarding expected behavior.

12. **Preoperative Testing** - Preoperative diagnostic test results (e.g. laboratory, x-rays, etc.) should be appropriate for the patient's planned surgical procedure, general health and age. The results of preoperative tests should generally be posted in the patient record before procedure.

Adopted 7/1995
Revised 4/1998
5/1999
8/1999
8/2004
8/2007
4/2010
11/2019
Reviewed 6/2021
Revised 1/2024
Revised 5/2025

SECTION 7 - AMBULATORY CARE SURGERY

1. The ambulatory care surgery is under the medical supervision of the Chief-of-Surgery.

2. The administrative responsibilities and day to day operations are under the direction of the director of surgical services. The director of surgical services reports to the CNO.

3. The director of surgical services works with the Chief-of-Surgery on coordinating services and medical related services.

4. Ambulatory care service is staffed with at least one registered nurse and ancillary help as determined by the director of surgical services and CNO.

5. Nurses assigned to the ambulatory surgery service are qualified by experience and evaluated by the director of surgical services.

6. The surgery service shall govern the types of procedures that may be performed as ambulatory care service. (List reviewed annually)

7. The admitting physician is responsible for the patient's medical record, which must include all significant clinical information pertaining to an ambulatory care patient. (See Health Information Section 3)

8. The record must contain a history of previous surgical procedures, past and current diagnoses or problems, and currently and recently used medication.

9. The physician must dictate or write a complete description of the techniques and findings of every operative procedure performed, and authenticate the record.

10. Patients who receive other than local anesthesia are accompanied at discharge by an adult who is responsible for the patient.

11. Ambulatory care patient services are included in the quality assessment program. The ambulatory care service assessment and monitoring are based on clinical criteria, designed to identify problems in patient care and opportunities to improve care.

WILLIAM NEWTON HOSPITAL

Medical Staff Rules and Regulations

SECTION 8 – PODIATRY

1. *Qualifications*

Podiatrist shall be a graduate of an accredited school of podiatry, licensed in Kansas and granted privileges according to state law, professional scope of practice and WNH Medical Staff Bylaws, Rules and Regulations.

2. *Privileges*

A. Podiatrist privileges are limited to treatment and procedures of the foot and ankle (KSA 65-2001-c.) podiatry means diagnosis and medical and surgical treatment of all illnesses of the human foot, including the ankle and tendons which insert into the foot as well as the foot subject to subsection (d) of K.S.A. 65-2002, and amendments thereto). All podiatric procedures and other patient care shall be conducted in accordance with applicable sections of the WNH Medical Staff Bylaws, Rules and Regulations and hospital policies. Podiatric procedures include, but are not limited to:

i. Soft tissue of the entire foot. Examples include papilloma, neurofibroma, ganglion cyst, tenotomy or tendoplasty of dorsal digital tendons.
ii. Osseous surgery of the foot. Examples include bunionectomy, hammer toe, excision of accessory bones (secondary), calcaneal spurs, exostoses.
iii. Dissection. Examples include ankle fractures, total ankle replacement, and amputation of complete structures but no complete amputation of the foot.

B. MLP/APP's are permitted to practice independently ONLY in the podiatric outpatient clinic (William Newton Foot & Ankle Clinic) setting without collaboration or supervision from an Active Medical Staff physician. K.S.A 65-1113 supports this authorization for an MLP/APP to make independent decisions about advanced practice needs and medical decisions. Their scope will include examination, diagnosis, and treatment of the foot and ankle however it will not include acute trauma, surgical needs, osseous deformity, or pediatric gait abnormalities. This MLP/APP shall be directly responsible to the consumer. This MLP/APP is still required to have collaboration in the hospital setting or in any other outpatient clinic setting.

3. *History and Physical*

Podiatrist and/or MLP/APP shall record a history and physical for all patients prior to surgery.

4. *Patient Admission*

Podiatrist can admit to outpatient surgery for podiatric care. Inpatient admission for podiatric patients must be admitted with the concurrence of a consulting physician who will monitor the medical care of the patient and provide orders as necessary.

5. *Patient Discharge*

Podiatrist may discharge patients who are medically stable and who received only podiatric care during their stays. Patients who have required other medical care during their stays shall be discharged with the documented concurrence of a physician member of the active medical staff.

Revised 4/2007
Revised 11/2019
Reviewed 6/2021
Revised 7/2022
Revised 3/2023
Reviewed 1/2024

SECTION 9 –ADVANCED PRACTICE PROVIDER (/APP)

1. Definition of an APP - Certified Physician Assistant (PA-C) and Advanced Practice Registered Nurses (APRN).

2. Qualifications - Graduate of an accredited school for Physician Assistants or Advanced Practice Registered Nurses, licensed in Kansas and must apply for Allied Staff appointment.

3. APP's must comply with all applicable Medical Staff Bylaws, Rules and Regulations.

4. APP's must comply with all federal and state regulations.

5. APP's may perform, only under the direction and supervision of an Active Medical Staff physician, acts which constitute the practice of medicine and surgery to the extent and in the manner authorized by the physician responsible for the Advanced Practice Provider and only to the extent such acts are consistent with Rules and Regulations adopted by the Board of Trustees. Except as expressly otherwise provided in these Rules and Regulations, an APP may admit patients only when specifically authorized by the Medical Staff and Board of Trustees. Notwithstanding the foregoing, an APP who is performing services at the Hospital on behalf of a physician practice group or other physician organization that consists of one or more physician members of the WNH Medical Staff, may, after appropriate consultation with such APP's supervising physician, admit patients on behalf of such physician group or organization without the specific authorization of the Medical Staff and Board of Trustees when such admissions are within the scope of the APP's license and qualifications and are otherwise permitted under Kansas law. Whenever a patient is admitted to the Hospital by an APP, the APP's supervising physician or his or her covering physician on the Medical Staff will be notified of such admission. APPs may round on and otherwise participate in the care and treatment of patients admitted by such Practitioners or their supervising physician to the extent that such patient services are within the scope of the Practitioners' license and qualifications and are otherwise permitted under Kansas law. An APP shall be identified to the patient and others involved in providing the patient services as a PA-C or an APRN who is an assistant to the responsible physician.

6. Active Medical Staff physicians involved with the direction and supervision of APP must be properly identified with state regulatory agencies as the supervising physician of such APP. Active Medical Staff physicians are also required to be in town, immediately available to, and physically able to respond to assist with patient care when needed for such APP during inpatient rounds or any other inpatient or outpatient care or procedure provided to patients.

PROTOCOLS

The APP may

1. Take, evaluate and record medical histories
2. Perform physical examinations required to evaluate medical problems
3. Perform standard medical examinations
4. Order appropriate laboratory studies, x-rays, electrocardiograms and other special examinations
5. Prescribe appropriate medications as permitted under state law for APP
6. Collect specimens for pathologic examinations
7. Analyze and interpret data, formulate problem lists and establish plans for solution of clinical problems as directed by protocol and/or direct or electronic communication with the responsible physician(s) and to initiate treatment within his/her scope of competence and exercise judgment on problems requiring consultation, referral, and/or evaluation by a physician.
8. Initiate consultation requests to specialists and other health professionals
9. Counsel patients on health problems, use of medication, expected effects of treatment, diet and other health maintenance, disease prevention matters.
10. Provide services to patients who present with non-life threatening problems. In such cases, consultation is at the discretion of the midlevel practitioner or as directed by protocol.

PROCEDURES THAT CAN BE DONE BY AN APP

1. Basic cardiac life support
2. Advanced cardiac life support
3. Peripheral venipuncture
4. Peripheral venous lifelines
5. Local infiltration anesthesia
6. Biopsy of skin lesions
7. Repair lacerations involving one or more layers of closure not involving a body cavity, joint space, tendon or nerve
8. I & D of superficial and simple abscesses
9. Bladder catheterization
10. Ocular tonometry
11. Use of slit lamp
12. Removal of non-penetrating ocular foreign body

13. Removal of nasal foreign body
14. Initial interpretation of x-rays pending review by radiologists or supervising physician
15. PAP smears
16. Fit vaginal diaphragms
17. Indirect laryngoscopy
18. Insertion and removal of IUD's
19. Anterior nasal pack
20. Excision of skin and subcutaneous lesions felt to be non-malignant
21. Assist in surgery
22. Initial EKG interpretation pending interpretation by physician
23. Any emergency procedure in a life-threatening situation
24. Insert nasogastric tubes
25. Perform wound care
26. Assist physicians in performing procedures
27. Provide fracture care as directed by the supervising physician
28. Prescribe medications as permitted under state law for APP
29. History and physical
30. Developmental screening examination for children

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Revised 12/2000
Revised 12/2020
Revised 6/2021
Revised 1/2024

WILLIAM NEWTON HOSPITAL

Medical Staff Rules and Regulations

SECTION 10 - ANESTHESIA

1. General: Anesthesia shall be a part of the surgical service and conform to Kansas Administrative Regulation 28-34-17a and other applicable law.

2. Direction: The overall direction of the anesthesia service shall be provided by the Chief CRNA, who rotates each year, in cooperation with the Surgical Review Committee.

   Duties include:

   a. Recommending privileges for all individuals with primary anesthesia responsibilities.

   b. Assisting with the evaluation of equipment for anesthesia and related resuscitative equipment.

   c. Monitoring the overall quality of anesthesia care rendered anywhere in the hospital.

   d. Assisting in the establishment of safety policies relating to anesthesia activities.

   e. Being a liaison between the anesthesia staff, Surgical Review Committee, surgeons and operating room staff.

3. Anesthesia Coordinator: The Chief CRNA may delegate day-to-day responsibilities to a qualified member of the nurse anesthetist staff.

4. Anesthesia Coverage: Anesthesia services shall be available for routine scheduled procedures during normal hours of operation and for emergencies at all other times. All persons with privileges in anesthesia are required to participate in this coverage.

5. Orders: A qualified practitioner member of the medical staff must order anesthesia for each patient. Once this order is written, the nurse anesthetist may write orders relating to the patient's anesthesia event within the limits of the individual nurse anesthetist's training and abilities and relevant state or federal practice regulations. The practitioner's co-signature of these orders is not necessary on the anesthesia record nor on any preop, intraop or postop orders.

6. Safety: There shall be written guidelines, policies and procedures developed for the safe use of all general anesthetic agents used in the hospital. These shall be relevant to the safety of patients and staff, and apply to all personnel, physicians

and non-physicians who administer anesthesia and shall be evaluated and updated periodically by the anesthesia service. Safety precautions for anesthesia activities shall include at least the following:

a. Flammable anesthetic gases shall not be used at WNH.

b. If electrocautery, electrocoagulation, or other electrical equipment employing an open spark is to be used during an operation, any flammable topical agent shall be thoroughly dry before further preoperative preparation of the surgical field.

c. All operating room equipment shall be equipped with a grounding device in order to maintain a constant conductive path to the isolated electrical system.

d. A signal of electrical isolation shall be maintained and constantly monitored.

e. Periodic conductivity testing and inspection of electrical equipment shall be made, and a written report of these inspections shall be kept.

f. Safety precautions shall conform to Kansas Administrative Regulations 28-34-17a.

7. Pre-anesthesia Evaluation: There shall be a written pre-anesthesia evaluation of the patient by a qualified licensed independent practitioner, recorded prior to the patient's transfer to the operating room and before preoperative medications. The pre-anesthesia record shall include at least:

   a. Current medical condition, previous drug history, other anesthetic experiences, and any potential anesthetic problems.

   b. The surgical, endoscopic or obstetrical procedure anticipated.

   c. Pertinent information relative to the selection of anesthesia type and agents.

8. Consent for Anesthesia: See Rules and Regulations for Surgery Department

9. When Administered: No anesthesia shall be administered until the practitioner doing the surgery is present in the hospital building (except for obstetrical epidural or intrathecal administration) and has notified the staff to begin (see #16).

10. Pre-anesthesia Review: There shall be review of the patient's condition immediately prior to induction of anesthesia. This will include a review of the medical record with regard to completeness, laboratory data, and time and dosage of pre-anesthesia medication, together with a note of any change in the patient's condition as compared to that noted on a previous visit.

11. Anesthesia Record: The anesthesiologist and/or nurse anesthetist shall be responsible for recording all vital signs and events taking place during the induction of, maintenance of, and emergence from anesthesia, including dosage and duration of all anesthetic agents, other drugs, IV fluids and blood, or blood components.

12. Post Anesthesia Review: The anesthesiologist and/or nurse anesthetist shall be responsible for recording post anesthetic visits including at least one note describing the presence or absence of anesthesia related complications.

13. Discharge: The decision to discharge a patient from recovery room shall be made only by a physician, dentist, or podiatrist or in a collaboration effort with anesthesia providers.

14. Non Physician Team: When the operating team consists of only non physician personnel; i.e., dentist, podiatrist, a qualified physician must be present in the building and available to this team.

15. Conscious Sedation: There shall be hospital-wide policies and procedures for conscious sedation developed with the assistance of the anesthesia service.

16. Labor Epidural: If an anesthesia provider is committed to the administration of a labor epidural in obstetrics, a concurrent anesthetic cannot be administered in the surgery department unless that the same anesthesia provider has made prior arrangement with another anesthesia provider or physician trained in administration and monitoring of epidural anesthesia.

    In the event that more than one epidural is in progress and a cesarean section becomes necessary, arrangements for additional coverage of the other epidural, by an anesthesia provider or physician trained in labor epidural administration and monitoring, must be made.

17. Performance Review: All anesthesia activities and the performance of persons administering anesthesia shall be reviewed periodically and be incorporated in the hospital's performance improvement program. Complications shall be a part of occurrence screening and used for education and performance review.

18. Advanced Cardiac Life Support: Anesthesia providers administering general, spinal or epidural anesthesia or conscious sedation on more than an occasional basis must possess current Advanced Cardiac Life Support (ACLS) certification or an equivalent approved by the Executive Committee.

19. Nurse Anesthesia: The Certified Nurse Anesthetist (C.R.N.A.), shall be a registered nurse specially trained and granted hospital privileges to provide anesthetic patient care as a member of the surgical health care team. The nurse

anesthetist works interdependently with the practitioner performing the procedure and must have the knowledge and skills necessary to perform the following duties:

a. Carefully and critically evaluate a patient's preoperative status, anesthetic medical history and record findings in a systematic, accurate and succinct form. Special emphasis is to be made to patient cardiorespiratory status, history of allergies and intolerance to anesthesia.
b. Explain alternatives and risks of anesthesia to the patient and obtain signed informed consent for anesthesia;
c. Perform basic preoperative medication planning and ordering, including sedative, hypnotic, analgesic and anticholinergic medications for maximum patient safety and comfort.
d. Administer general anesthesia, inhalation and intravenous, to those appropriately selected patients as determined through a prior review of the method of administration applicable to each case.
e. Administer all modes of regional block anesthesia including the use of spinal and epidural regional techniques to those surgical patients who require such a method of anesthetic administration.
f. Administer those patients drugs commonly used as adjuncts to anesthesia, such as muscle relaxants, vasopressors and antiemetics as approved the Medical Staff.
g. Perform cannulation of arteries and veins for patient monitoring and delivery of fluids and medications.
h. Provide post-anesthetic management, especially until level of consciousness and patient cardiorespiratory functions have returned to normal.
i. Perform post-anesthetic patient visits and individual patient evaluation emphasizing the complications of anesthesia and record these required visits noting all pertinent anesthesia complications in the progress record.
j. Perform emergency patient intubation and provide ventilatory assistance as well as instructional efforts in these techniques.
k. Obtain basic laboratory, radiographic and electrocardiographic patient studies relevant to anesthesia delivery and airway management in cooperation with the operating and/or attending practitioner.
l. Insure that all equipment necessary for hospital patient anesthesia is in proper operating condition, in adequate supply and properly maintained to assure patient safety in cooperation with hospital staff.
m. Order the following medications when needed within the scope of practice and as approved by the Medical Staff with no requirement for co-signature:

External Medications:

1. Anesthetics – all within class
2. Antianginal – all within class
3. Antibiotics – all within class
4. Antiemetic – all within class
5. Antihypertensive – all within class
6. Lubricants – all within class

Ophthalmic Medications:

1. Anesthetic – all within class
2. Lubricants – all within class

Oral Medications/Sublingual Medications:

1. Antianginal – all within class
2. Antimetic/H2 Blocker – all within class
3. Antihypertensive – all within class (nifedipine may be ordered SL)

Anesthesia Medications:

1. Inhalation Anesthetics – all within class except flammable anesthetics
2. Injectable Anesthetics – all within class

Sedatives/Hypnotics:

1. Intravenous – all within class
2. Oral – all within class

Analgesic Medications:

1 . Injectable – all within class

Local Anesthetics:

1. Injectable – all within class

Other Injectable Medications:

1. Antihypertensive – all within class
2. Skeletal Muscle Blockers – all within class
3. Vasopressor – all within class

Cardiac Medications:

1. Injectable – all within class

Adapted 11/1996
Revised 3/2000
Revised 11/2002
Revised 12/2004
Reviewed 6/2021
Revised 1/2024

WILLIAM NEWTON HOSPITAL

Medical Staff Rules and Regulations

SECTION 11 - DEPARTMENT OF OBSTETRICS

1. **Chief of Obstetrics -** The Chief of Obstetrics shall be appointed in accordance with the Bylaws and will provide advice and support to the Medical Staff and Chief Executive Officer (CEO) on matters of clinical and administrative importance to the department.

2. **Consultation -** An attending physician without C-section privileges whose patient has been in active protracted labor or has a labor disorder, and has not responded to standard therapeutics, or a patient who at any time during labor develops symptoms, signs or other definite indications that labor will terminate in other than spontaneous or outlet forceps delivery, shall request consultation with an obstetrician on the Medical Staff.

3. **Admission of an infant -** An infant who has been discharged from the Hospital or whose birth has occurred outside the Hospital will not be admitted to the general nursery. Such an infant may be admitted to a patient room, the mother's room, or the isolation nursery. Standard infection control precautions will suffice unless otherwise indicated,

4. **Pre-procedure pregnancy test -** Except under emergency circumstances, a pregnancy test shall be performed before curettage of the uterus or any other procedure by which a suspected pregnancy may be interrupted.

5. **Sterilization -** Reproductive sterilization of a female or male shall not be performed until an informed consent has been acquired and signed Medicaid patients must have a thirty day prior authorization before sterilization can be performed.

6. **Oxytocics -** The Obstetrics Committee shall establish policies and procedures for the administration of oxytocics (Pitocin).

7. **Discharge evaluation -** A final examination of each newborn will be completed and recorded prior to the discharge of the baby from the Hospital.

8. **Prenatal documentation -** The obstetrical record shall include complete prenatal information. The prenatal documentation may be a legible copy of the patient's physician office record transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

9. **Visitors during delivery -** Fathers and/or support persons are allowed in the delivery room at the discretion of the delivering physician/midwife, except during emergency C-sections under general anesthesia.

10. **Rh factor testing -** All obstetrical patients are tested for the Rh factor and as indicated for the (Du) variant. The Rh factor will be recorded on all obstetrical records and then administration of RhoGAM and the 1st Rh factor will be documented. The administration of RhoGAM, if given, will be documented on all abortions.

11. **Labor screening -** A woman who presents to the Hospital or has been admitted and is experiencing contractions is considered in true labor, unless a physician or certified nurse midwife certifies that, after a reasonable time of observation, the woman is in false labor. Such certification can be provided by telephone if labor screening is conducted by qualified screeners who have specific privileges or documented competencies in screening for labor. The Medical Staff will determine the minimum content of an obstetric screening examination.

12. **Onsite evaluation -** A physician must evaluate at the Hospital any patient who presents in the following situations:

    a. In the judgment of the qualified screener an emergency medical condition exists;

    b. Whenever a patient is to be transferred to another acute care facility.

13. **Nurse midwives –** Certified nurse midwives (CNM) are Advanced Practice Registered Nurse and midlevel practitioners who may apply for membership to the WNH Medical Staff as Allied Health Professionals. Independent certified nurse midwives (CNM-I) are authorized under State law to provide midwife services as independent practitioners. CNM-I practitioners may perform services as independent practitioners at the Hospital, to the extent that such services are within the scope of such practitioners' licenses and qualifications and are otherwise permitted under Kansas law. Each midwife shall have a supervising physician with obstetrical privileges at WNH and the Hospital shall retain a current copy of clinical protocols established between the midwife and supervising physician. The nurse midwife:

    a. Must act within the scope of practice established by the State licensing authority, WNH Medical Staff Bylaws and clinical protocols approved by the supervising physician;

    b. Will generally treat well-women when not directly assisted by a qualified physician;

    c. Will, when performing a delivery at the Hospital, have a collaborative agreement in place with a supervising physician with obstetrical privileges at WNH and ensure that such physician or a qualified replacement is immediately available to provide any necessary assistance with such delivery, including, without limitation, performing emergency Caesarean sections. For avoidance of doubt, the foregoing requirement will apply to all nurse midwives who are members of the Medical Staff, including midwives licensed as a CNM-I.

    d. Except as expressly provided herein, CNM's may admit patients only when specifically authorized by the Medical Staff and Board of Trustees. Notwithstanding the foregoing, a nurse midwife who is duly licensed as CNM-I may admit obstetrics patients without the specific authorization of the Medical Staff or Board of Trustees when such patient admissions are within the scope of the CNM-I's license and qualifications and are otherwise permitted under State law. Whenever a patient is admitted to the Hospital by a midwife, the Mid-Level Practitioner's supervising physician or his or her covering physician on the Medical Staff will be notified of such admission.

Revised 3/2000
Revised 2/2012
Revised 12/2020
Revised 6/2021
Reviewed 1/2024

SECTION 12 - ENDOSCOPY

1. A physician who requests privileges in endoscopy shall meet the following standards.

    a. Documentation of credentials on the completion of a residency-fellowship training program, which includes the specific endoscopy procedure; OR

    b. Attendance in an endoscopy program until training in the endoscopy procedure the physician wishes to perform is adequate as judged by the Medical Executive Committee (MEC) using widely accepted guidelines for training in the specific endoscopy and any other pertinent consideration; OR

    c. Documented experience and demonstrated skills in procedures for which privileges are requested.

2. The endoscopist should provide appropriate medical or surgical care and should not be one who provides only a technical service.

3. The physician should, before endoscopy procedures are performed, do a history and physical to include:

    a. Medical condition of the patient and a comprehensive drug history.
    b. Informed consent, discussing with the patient, the benefits and risks of the procedure.
    c. Evaluate baseline vital signs and risks of sedation.

4. A full written report of the procedure and findings should be prepared immediately after the procedure. Proper follow-up and discharge instructions shall be included in the report.

5. Endoscopy privileges must be requested by procedure and are granted based on the applicant's qualifications.

6. If a physician wishes to continue to have privileges in endoscopy, he must so state on annual reappointment application.

7. Performance of the endoscopy work shall be reviewed periodically and be incorporated in the medical staff quality assurance program. Any complications shall be a part of occurrence screening and used as a review, a performance and an educational device.

WILLIAM NEWTON HOSPITAL

Medical Staff Rules and Regulations

SECTION 13 – PATHOLOGY

1. The Director of Pathology Services shall be a pathologist who is a member of the medical staff. The same procedures as outlined in the bylaws for admission to the medical staff, as all other physicians, shall be following for the pathologist.

2. Any death falling under the jurisdiction of the Cowley County Coroner must be reported to the Coroner. The Coroner is responsible for determining the need for autopsy. If an autopsy is need, arrangements will be made for the body to be transferred to the Sedgewick County Forensic Science Center.

Deaths having jurisdiction by the county coroner:

(a) Violence, caused by unlawful means or by suicide or by casualty.
(b) Suddenly when the decedent was in apparent health.
(c) When the decedent was not regularly attended by a licensed physician.
(d) When death occurs in any suspicious or unusual manner.
(e) When in police custody.
(f) When in jail or correctional institution.
(g) When the decedent is under 18 years of age.
(h) When the determination of the cause of death is held to be in the public interest.

3. William Newton Hospital does not provide private autopsy services but may help family to arrange one if that is their desire.

4. The final autopsy report shall be made a part of the patient's medical record when it becomes available.

5. A pathology report confirming the number of any teeth or fragments removed during dental surgery shall become a part of the patient's medical records. A pathology report for any specimens removed by the podiatrist shall become a part of the patient's medical record.

6. The request for examination of surgical specimens shall contain a concise statement of the reason for the examination and/or the surgical diagnosis by the attending physician.

PROCEDURES FOR SUBMITTING SPECIMENS FOR PATHOLOGIC STUDIES

1. All specimens to be sent to the Pathology Department of the William Newton Hospital are to be placed in a container filled with 10% formalin unless it is a specimen for frozen sections.

2. Frozen section pathology is not available at William Newton Hospital.

3. Each container containing a specimen is to be labeled with the patient's name, type of tissue or specimen, patient's doctor's name and date of surgery.

4. A surgical requisition is to be submitted with each specimen. See following page for information needed on requisition. Clinical history must also be included.

5. Specimens are to be delivered to the Laboratory Department. Specimens collected after hours should be taken to the clinical laboratory in a container of formalin.

6. The Pathologist can be reached by dialing.

7. Any specimen that is collected after hours can be left at the clinical laboratory with the proper preservative.

PROCEDURES FOR SUBMITTING CYTOLOGY SPECIMENS FOR PATHOLOGIC STUDIES

Any special procedures requiring the presence of the Pathologist must be coordinated through the lab.

1. Place specimen in proper fixative.

2. Make out a requisition for the specimen. It must include the patient's name, attending doctor, patient's age, specimen source, and any available history. Also state whether any preservative has been added.

3. Deliver specimen to the Pathology Laboratory. Specimens collected after hours can be taken to the clinical laboratory or refrigerated in the respiratory department.

4. Any specimen not labeled with all the pertinent information or has inadequate preservation is considered inadequate. Unless the error can be corrected, the specimen must be discarded.

PROCEDURES FOR SUBMITTING SPECIAL TISSUES
(RENAL BIOPSIES, LYMPH NODE BIOPSIES & TISSUE FOR ELECTRON MICROSCOPY)

1. Deliver the tissue immediately without any form of fixative. Refrigerate

2. Tissue must be delivered during Pathology lab hours.

3. Each specimen must have a requisition with all the pertinent information. See the surgical requisition for the needed information. Specimens must also state what special procedure is needed.

4. Please identify special sites on surgical specimens. (e.g. cone biopsies, skin biopsies, etc. as 6 o'clock, 2 o'clock etc; highest point of lymph node dissection, modified radical mastectomy specimens etc.)

5. Corrective bone surgery (femoral head etc.) will be processes as "Gross Only" unless otherwise specified. The examining pathologist judgement will guide the performance of microscopic examination at his or her assessment.

Revised 12/1994
Revised 3/1997
Revised 6/2021
Revised 1/2024

SECTION 14 - CLINICAL LABORATORY

1. Within the electronic health record, laboratory shall maintain a current list of procedures offered in house and those requiring sending to a reference lab. Lab tests labeled “send out” will require a 2-3 day turn-around time and are not available on a STAT basis.

2. The use of a "STAT" classification when ordering these tests must be based on the need of the medical emergency and status of the patient. Laboratory personnel are to drop everything else to perform a "STAT" procedure. In the event "STAT" tests are ordered on more than one patient, the order in which the tests are performed will basically be first come, first serve, unless several tests can be batched. When more than one test is ordered "STAT" on one patient, the tests will be performed in the order of the laboratory's discretion. It is to everyone’s advantage to order only the absolute minimum of "STAT" tests that it takes to evaluate the situation properly and to reserve the classification "STAT" for drastic, critical medical emergencies only - those required utmost speed to save a life.

3. In the event that the attending physician, having ordered blood for type and crossmatch, should find that the blood is not needed, he/she should state on the orders to the laboratory promptly so that the blood may be released; further, he should state on the orders to the laboratory of any need to hold blood for a given patient for over 48 hours, otherwise blood will be automatically released by the laboratory for other use.

4. If a laboratory test is sent to a referral laboratory, when the report is returned, it shall contain the name identifying the referral laboratory.

5. The requisitions for inpatient and outpatient service shall provide at least the following information on the request: The patient's name, the requesting professional, the test required, the date and time received by the laboratory, and any special instructions and diagnosis if indicated.

6. Each actual or suspected transfusion reaction shall be evaluated and a report completed.

7. The laboratory shall only perform tests and examine specimens on the written order of individuals authorized here to order such evaluations and to receive the results:

    a. Members of the WNH active, consulting medical staff and dental staff

    b. WNH allied health and nursing staff when acting under medical staff approved protocol

    c. Optometrists who are members of the WNH Allied Health Staff

    d. Physicians granted temporary or locum tenens privileges at WNH

    e. Non-staff physicians with written or electronic order

    f. Licensed veterinarians

g. Physicians ordering through clinical contracts established with the hospital

h. Requests by neighboring healthcare facilities due to equipment problems

i. Requests by law enforcement

j. Exceptions approved by the Chief of Staff or Chief Executive Officer or their available delegates

Revised 10/2001
Revised 6/2021
Revised 1/2024

SECTION 15 - DIAGNOSTIC IMAGING

1. The Medical Director of the Diagnostic Imaging Department shall be a qualified staff radiologist who is a member of the medical staff. The Radiologist shall be appointed to the medical staff in the same manner as all other physicians in accordance with the bylaws.

2. A radiologist with privileges at WNH will interpret all imaging studies within a medically appropriate time following the patient exam, including those initially interpreted as preliminary by another practitioner.

3. Electronically signed reports of interpretation shall be filed with patient's medical records.

4. A qualified radiologic technologist or qualified radiology student shall be on duty or available at all times. At no time shall a radiologic technologist or other non-physician personnel in the Diagnostic Imaging department independently perform any interpretive diagnostic procedures.

5. An emergency drug tray shall be available in the room when contrast media are administered parenterally. The tray shall be checked monthly by a technologist for dating of medications, missing items, and for appropriateness of content.

6. For safety precautions, the following items shall be readily available at all times: Oxygen, airways, syringes, needles, intravenous sets, and appropriate intravenous solutions.

7. All requests for radiologic services shall contain the specific exam requested and indication for the examination.

8. A physician shall be present in the hospital during the injection of contrast media to patients.

Revised 8/2008
11/2019
Reviewed 6/2021
Reviewed 1/2024

SECTION 16 - PHARMACY AND DRUGS

The hospital's Director of Pharmacy, a licensed pharmacist, shall be responsible for accurate and complete internal regulation of medication use as determined by the Chief Executive Officer, Pharmacy Committee, and Kansas laws and regulations.

1. The Pharmacist shall have the authority to regulate the storing, accountability and proper dispensing of drugs and shall make periodic inspection of all drug storage and medication centers.

2. As far as possible the use of proprietary remedies shall be avoided. When such are ordered for private patients by the attending physician, the preparation will be secured.

3. All drugs or groups of drugs, which are known to be high risk, dangerous or potentially dangerous or habit forming, shall be assigned a period of administration after which they will be flagged in the hospital computer system for provider renewal or stop. The following actions may be taken:

    a. The order indicates an exact number of doses to be administered;
    b. an exact period of administration is stated in the order;
    c. the drug is reordered by physician.
    d. The types of drugs included in these categories and their periods of administration shall be decided by the medical staff and shall become the policy of the Pharmacy. These drugs shall include narcotics, antibiotics, anticoagulants.

4. Only drugs obtained from the hospital pharmacy shall be given to the patients in the hospital unless a specific order is written by the physician stating that the patient may take their own medications.

5. The automatic stop orders shall be installed on high risk drugs. The automatic stop orders shall be:

    a. Anticoagulants: 4 days
    b. Narcotics: 4 days
    c. Aminoglycosides: 4 days
    d. Antibiotics (other than aminoglycosides): 7 days
    e. Ketorolac (Toradol): 5 days

6. Investigational drugs shall be used only under the direct supervision of the principal investigator and shall specifically be approved by the Pharmacy Committee. Nurses may not administer injectable investigational drugs.

7. The intravenous chemotherapeutics, shall not be administered in the hospital. Specific exceptions are Methotrexate for the treatment of rheumatoid arthritis and patients of the Cancer Center of Kansas (CCK) by CCK staff. The Cancer Center of Kansas is a totally separate entity with their own policies and procedures in the administration of chemotherapeutics.

8. Rules for controlling prescribed vocabulary and standardizing order communication

    a. All orders must be written legibly.

    b. Preprinted order forms must be approved through a formal process that includes critical review by the pharmacy and all involved departments.

    c. Orders to "continue home medications" are prohibited unless accompanied by a statement from the ordering physician that the patient's home medications have been reviewed.
    d. The following abbreviations, acronyms and symbols shall not be used for ordering medications at WNH:

i. U (for units) or IU (for international units) – Write "unit" or "international unit"

ii. Trailing zeros – Never write zero by itself after a decimal point
Correct: Coumadin 1 mg Incorrect: Coumadin 1.0 mg

iii. Lack of leading zero – Always use a zero before a decimal point
Correct: Lidocaine 0.5 mg/kg Incorrect: Lidocaine .5 mg/kg

iv. MS or MSO4 (morphine sulfate) – Write out "morphine"

v. MgSO4 (magnesium sulfate) – Write out "magnesium sulfate"

vi. Ug (microgram) – Write "mcg"

vii. cc (cubic centimeters) – Write "ml" for milliliters

viii. A.S., A.D., A.U. (left ear, right ear, both ears) – Write out 'left ear", "right ear", "both ears"

ix. O.S., O.D., O.U. (left eye, right eye, both eyes) – Write out "left eye", "right eye", "both eyes"

x. Apothecary symbols for dram and ounces

xi. For quantities between 1 and 999, use the mg designation (500 mg instead of 0.5g)

9. Other guidelines for ordering of medications

a. Specific strength of ordered medication should be indicated.
Correct: 650 mg Incorrect: Tylenol 2 tabs
Correct: 50 mg Incorrect: 100 mg ½ tab

b. Complete drug names should be used. Written drug names should correspond to the name that actually appears on the drug package.

c. Dosage ranges should not be used for narcotics without also specifying the conditions under which the medication is to be administered.
Correct: Demerol 50-75 mg PRN moderate/severe pain
Incorrect: Demerol 50-75 mg PRN

d. Verbal orders should be used only in emergency situations.

e. If used, verbal orders should be repeated back to the prescriber to clarify that the person receiving the order understands the order as the prescriber intended it.

f. Drugs should be ordered separately. Avoid orders such as "renew previous medications"

g. STAT order means give immediately. NOW order means give within 30 minutes. These types of orders should be kept to a minimum so pharmacy has time to review the order.

10. Only credentialed medical staff shall have privileges to order injectable medications to be administered to hospital patients.

Revised 2001
2004
2005
2020
6/2021
Revised 1/2024

WILLIAM NEWTON HOSPITAL

Medical Staff Rules and Regulations

SECTION 17 - INTENSIVE CARE UNIT

1. The Intensive Care Unit is a combined intensive care, coronary and intermediate care unit.

2. The Intensive Care Unit shall be maintained and operated in accordance with written policies and procedures which are developed in consultation with the representatives of hospital services involved in critical care and the medical staff. The policies are recommended by the Critical Care Committee and approved by the Medical Executive Committee (MEC).

3. A physician who is experienced in the care of critically ill patients and experienced in dealing with the problems of intensive care units shall be designated as medical director of the unit by the Chief-of-Staff.

4. The medical director shall be responsible for carrying out the policies of the unit.

5. The policies governing the admission, discharge, and care of the patient in the Intensive Care Unit shall be furnished to the members of the medical staff.

6. Changes in the policies shall be circulated to the medical staff prior to their enactment.

7. If any question as to the validity of admission to or discharge from the Intensive Care Unit should arise, that decision is to be made through consultation with the appropriately designated medical director or in his/her absence, the Chief-of-Staff.

8. When a patient has been admitted to ICU the attending physician must see the patient in a clinically reasonable amount of time, not to exceed twelve (12) hours.

Revised 12/1998
Revised 09/1999
Revised 06/2003
Revised 03/2013
Revised 06/2021
Reviewed 01/2024

WILLIAM NEWTON HOSPITAL

Medical Staff Rules and Regulations

SECTION 18 - GUIDELINES FOR CARE AND TRANSFER OF PATIENTS NEEDING TREATMENT FOR MENTAL ILLNESS OR SUBSTANCE ABUSE.

1. General Guidelines - WNMH will provide emergency stabilizing care for patients who need immediate attention due to mental illness or substance abuse. Patients with moderate to severe problems should be transferred to appropriate facilities after evaluation and stabilization.

2. Evaluation - As with any patient requesting assistance, a medical evaluation must be completed and documented in accordance with hospital policy. Cowley County Mental Health or other resources may be consulted or asked to complete a mental health screening and recommendations discussed with the physician. However, treatment and transfer decisions remain the responsibility of the physician.

3. Transfer - Patients shall not be transferred until: a medical evaluation is completed and documented; the physician has determined that the patient is stable and/or the expected benefits of transfer are greater than the risk; the benefits and risks of transfer are explained to the patient or the legal representative as appropriate and consent given for transfer; the receiving facility has agreed to accept the patient and is notified at the time the patient is dispatched.

Revised 8/2000
Reviewed 6/2021
Reviewed 1/2024

WILLIAM NEWTON HOSPITAL

Medical Staff Rules and Regulations

SECTION 19 - USE OF THERAPEUTIC RESTRAINTS

1. Purpose - All patients have the right to be free from seclusion and restraints of any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. The use of restraints or seclusion must be used only to protect the patient or others from harm. The patient=s rights and dignity must be respected at all times. Restraints and seclusion measures should only be utilized as a last resort.

2. Definition - Restraints are any device attached or adjacent to the patients' body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. This includes, but is not limited to, the following devices:
   - Bedrails
   - Posey vest
   - Ankle and Wrist restraints
   - Gerichairs
   - Seclusion room

3. Orders and Time Limits - The physician must order the specific type of restraint and the maximum time frame for the use of restraints. This time frame cannot exceed 4 hours for adults, 2 hours for adolescents ages 9-18, and 1 hour for anyone under age 9. A Licensed Independent Practitioner must assess the patient within 1 hour of ordering restraints. Renewal orders for restraint or seclusion can be given up to every 4 hours. The patient must be assessed by the physician every 24 hours.

Revised 6/2000
Reviewed 6/2021
Reviewed 1/2024

SECTION 20 - DO NOT RESUSCITATE AND TERMINAL CARE ORDERS

The hospital shall develop guidelines to be followed on "Do Not Resuscitate@ orders, or orders concerning terminal care. The guidelines shall be approved by the Medical Staff and Board of Trustees.

1. The guidelines will be used to assist in decisions, assure the patient's rights are upheld and promote appropriate orders and proper documentation.

2. The guidelines are developed in consultation with the Medical Staff, Nursing Service, Social Service, Administration and sources outside the hospital as needed.

3. The guidelines will describe the appropriate communications with patient, family and hospital staff.

4. Problems of the terminal patient will be addressed.

5. Problems with the refusal of treatment will be addressed.

6. In the absence of a written properly documented (DNR - No Code Blue) order, all cardiac and respiratory arrest normal resuscitation procedures will be undertaken.

Guidelines - Do Not Resuscitate

These guidelines are intended to assist the physician and hospital staff in addressing the issues associated with "Do Not Resuscitate@ (DNR - No Code Blue) orders and to assist with decisions associated with refusal of treatment by the patient and/or family, healthcare attorney in fact or guardian. These guidelines are compatible with the hospital=s philosophy and mission statements, and policies on patient's rights.

For the purpose of these guidelines, the following terms are defined:

"D.N.R." - "No Code Blue" - When either of these terms is used, the patient will receive all medically appropriate therapeutic care, but cardiopulmonary resuscitation (CPR) will not be initiated unless otherwise ordered by the physician.

Terminal Care Orders - An order whereby a patient will not be maintained by extraordinary measures. It applies to extraordinary measures now in effect or yet to be undertaken.

Extraordinary Measures - Any medical procedure of intervention that:

1. Utilizes mechanical or other artificial means to sustain or supplant a vital function; and

2. Serve only to artificially prolong the dying process when in the judgment of the attending physician, death is imminent with or without the utilization of such artificial procedures; and

3. Is not deemed necessary to alleviate pain or to provide comfort care.

Competent Patient - A patient shall be considered to be competent if the patient is:

1. An adult (18 years of age or older, or an emancipated minor); and

2. Conscious; and

3. Able to understand the nature and severity of the illness involved; and

4. Able to understand the consequences of alternatives to the proposed treatment; and

5. Able to make informed choices concerning the course of treatment.

Incompetent Patient - A patient shall be considered to be incompetent if the patient:

1. Is a minor (under 18 years of age unless the patient is an emancipated minor); or

2. Is unable to understand the nature and severity of the illness involved; or

3. Is unable to understand the possible consequences of, and alternatives to, the proposed treatment; or

4. Is unable to make informed and deliberate choices concerning the course of treatment; or

5. Has been declared legally incompetent by a court.

Procedures:

1. If terminal care orders are being considered, the patient's attending physician must determine if a DNR or a Terminal Care Order is medically appropriate, based on the patient's underlying terminal illness or irreversible medical condition.

2. If the attending physician determines that a DNR or a Terminal Care Order is medically appropriate, the physician must then attempt to discuss the matter with the patient, explaining the basis for, and the consequences of, a DNR or a Terminal Care Order. If the patient is incompetent, this discussion must be held with the patient's family, legal guardian or Durable Power of Attorney for Healthcare. All such discussions must be noted on the patient's medical record. The notation of such discussions shall include at least the following information: persons present, information conveyed by physician, and decision of family and legal guardian.

3. If the patient is competent, the patient must consent to the entry of a DNR or Terminal Care Order. If the patient is not competent, the patient's family members, legal guardian or Durable Power of Attorney for Healthcare must consent to the entry of the DNR or Terminal Care Order. In either case, the attending physician MUST indicate on the patient's medical record that consent has been obtained and the procedure by which the consent was obtained.

4. If a competent patient disagrees, or in cases of incompetency, if there is any disagreement by the family, healthcare attorney in fact or by the legal guardian, a DNR or Terminal Care Order may not be implemented.

5. If, in accordance with procedures 1 through 4, it is determined that a DNR or Terminal Care order should be implemented, the attending physician must record this, in writing, on the patient's chart. Unless there is a DNR or Terminal Care order on the patient's chart, extraordinary measures shall be used and cardiopulmonary resuscitation shall automatically take place in the event of a cardiac or respiratory arrest.

6. The fact that a patient possesses a donor card or has expressed a wish to donate his or her body under the Uniform Anatomical Gift Act shall not be a factor in classifying or evaluating the medical condition of a patient at this hospital. A donor card activates certain steps only after the death of a patient has been ascertained - it does not determine the course of treatment during life.

- The hospital Ethics Committee may be consulted. The purpose of an Ethics Committee consult is to identify the available ethically sound choices for the given situation and present these to the patient, physician and/or family as appropriate (See Critical Care Committee duties).

- Situations will arise in which authority for healthcare decisions is not readily apparent. An example is an incompetent patient with no immediate family, no Durable Power of Attorney for Healthcare and no advance directive. Another example is when family members have the authority to make decisions, but disagree with each other. These situations will be handled on a case by case basis. If necessary, the Chief Executive Officer or delegate will intervene on behalf of the patient. Actions may include, but are not limited to: review by hospital legal council; request for immediate court action; arbitration between interested parties, or; making a decision about healthcare in collaboration with the Chief of Staff and/or Chairman of the Board of Trustees.

Revised 9/1999
Revised 6/2021
Reviewed 1/2024

SECTION 21 - SURGICAL LASER USE

1. All laser utilization by physicians and surgeons at William Newton Memorial Hospital will be overseen by the joint Laser/Surgical Review Committee.

    A. In addition to the medical staff members on the Surgical Review Committee, members of the joint Laser/Surgical Review Committee shall include: Laser Safety Officer, Operating Room nurse manager and representatives from Anesthesia and Administration.

    B. Duties of the Laser/Surgical Review Committee are:

        1. Delegate the authority and responsibility for the supervision of hazard evaluation and control of laser hazard to the laser safety officer.

        2. Approve safety protocols, policies and procedures for laser use.

        3. Review and evaluate complications, quality and appropriateness of care associated with laser use.

        4. Assist in determining the needs of the institution regarding types of lasers to be purchased.

        5. Establish guidelines for maintenance.

        6. Develop laser documentation forms which include checklists for equipment and nursing notes.

        7. Define in-house education and training requirements for staff.

        8. Develop a patient education program.

        9. Make recommendations to the Medical Executive Committee (MEC) regarding applications for laser privileges.

2. Laser Credentialing Guidelines:

    A. Physician must be a member of the medical staff at William Newton Memorial Hospital.

    B. Physicians must request privileges specific to the laser equipment to be used.

    C. Physician must provide documentation of attendance from a laser course specific to the physician's specialty.

        1. The course will include both didactic and clinical components. The didactic component must include laser physics, safety, techniques and troubleshooting. The clinical component must provide hands-on experience with inanimate and animate tissue sources.

    D. In lieu of item C, the physician must provide documentation of a residency/fellowship training program in which the techniques of laser surgery are a part of the curriculum.

E. Demonstrate continued competence in the use of the laser. Privileges to use each laser will be reviewed at reappointment in accordance with the medical staff bylaws.

F. For each type of laser for which privileges are requested, the above credentialing guidelines must be repeated.

Revised 9/99
Revised 6/21
Reviewed 1/24

SECTION 22 – OUTPATIENT CLINICS

Outpatient Clinics: WN Pediatrics, WN Wound Care, WN Sunflower OB/GYN, WN Cardiology, WN Surgery and Specialties, WN Orthopaedics, Rural Health Clinics (Cedar Vale, Dexter, Moline, Sedan).

a. Patient care and treatment services shall be under the direction of a physician.

b. Appropriate professional and nonprofessional personnel shall be provided.

c. Policies and procedures shall be written, and shall be revised as necessary.

d. Adequate records shall be maintained.

WILLIAM NEWTON HOSPITAL

Medical Staff Rules and Regulations

SECTION 23 – RESIDENT MOONLIGHTING

Purpose:
This policy outlines the guidelines and restrictions for resident moonlighting at William Newton Hospital. Moonlighting refers to any additional work or clinical activities performed by a resident outside of their regular duties and responsibilities at the institution.

Guidelines:
Residents must have an unrestricted license in the state of Kansas.

1. Hospitalist residents must be specialized in Internal Medicine, Family Medicine or Med Peds.

2. ER residents must be specialized in Family Medicine, Emergency Medicine, or Med Peds (unless approved by Medical Executive Committee, MEC.)

3. Resident must be in senior status final year of their residency program, unless approved by, Service Chief, Chief of Staff and MEC.

4. Residents must obtain written approval from the program director before engaging in any moonlighting activities.
5. Moonlighting activities must not interfere with the resident's ability to fulfill their duties and responsibilities at the institution. (Get hour restrictions from Residency Program.)

6. Residents must maintain appropriate licensure and liability insurance coverage for any moonlighting activities.

7. Residents must not disclose any confidential or proprietary information obtained during moonlighting activities.