Kids deserve the best.

SURGICENTER MEDICAL STAFF:

Rules and Regulations

TABLE OF CONTENTS

PAGE

PREAMBLE……………………………………………………………………………………….3

GENERAL OBLIGATIONS……………..…………………………………………………....3

I. DEFINITIONS ……………………………………………………………………..3

II. PATIENT MANAGEMENT……………………………………………………….3

III. ACCEPTED ABBREVIATIONS…………………………………………………..7

IV. MEDICAL ORDERS……………………………………………..………..7

V. PATIENT DEATH…………………………………………………...…...……7

VI. RESTRICTIONS ON TREATMENT OF SELF, FAMILY MEMBERS, AND COWORKERS ……………………………………………………………...8

VII. DELINQUENT MEDICAL RECORDS……………………………………....8

VIII. MEDICAL EDUCATION………………………………………………….....8

IX. CLINICAL RESEARCH AND PUBLICATION……………………………………..9

X. AMENDMENTS TO RULES AND REGULATIONS…………………...…………..9

PREAMBLE

These Rules and Regulations are approved by the Children's Hospital and Health System, Inc./Children's Hospital of Wisconsin, Inc. ("CW") and joint Board of Directors to establish standards of practice for the Medical and Professional Health Care Provider Staff who have privileges at the Surgicenter.

GENERAL OBLIGATIONS

As a condition of having privileges at the Surgicenter, Medical Staff and Professional Health Care Provider (PHP) Staff agree to abide by the Surgicenter Medical Staff Bylaws, the Medical Staff Rules and Regulations, any and all Medical Staff and CW Surgicenter policies and procedures, and any state and federal rules related to patient care and documentation.

I. DEFINITIONS

A. **Attending Physician** means an Attending Physician is privileged and has the ultimate responsibility of oversight of hospitalized patient care. When there are co-Attending Physicians, the responsibility of patient care oversight is shared by the co-Attending Physicians.

B. **Consultation** means a formalized deliberation between medical/surgical providers regarding a particular patient's care and/or the treatment of the patient.

To the extent that there are terms in these Medical Staff Rules and Regulations that are not defined in this Section 1.A. but appear in the Surgicenter Medical Staff Bylaws, such terms shall have the meaning set forth in Section 1.A. of the Children's Wisconsin Surgicenter Medical Staff Bylaws: Governance and Organizational Manual.

II. PATIENT MANAGEMENT

A. CARE OF PATIENTS UNDERGOING INVASIVE OR DIAGNOSTIC PROCEDURES REQUIRING MODERATE OR DEEP SEDATION OR REGIONAL OR GENERAL ANESTHESIA.

1. The provider performing the procedure is responsible for:

    a. Obtaining and documenting consent to any procedure requiring informed consent beyond the Consent to Admission.

    b. Providing a History and Physical Examination ("H&P") completed or countersigned by a physician that contains all of the legally required or policy-required elements and the indications for the procedure, which are clearly stated.

        i. An H&P or clinic note performed within ninety (90) days of the procedure may be utilized for dental cases; other services require an H&P or clinic note performed within thirty (30) days of the proposed procedure.

        ii. H&Ps from non-staff physicians are acceptable if they are countersigned by a privileged member of the Medical Staff.

iii. An electronic or durable, legible copy of the H&P must be filed in the patient's medical record, and the provider performing the procedure must review the H&P and sign or co-sign. By signing or co-signing this document, the Attending Provider attests to the accuracy of the H&P.

iv. An additional statement confirming the patient's status at the time of the procedure must be entered into the medical record and signed by the Attending Provider if the H&P is completed prior to the day of the procedure.

v. In an emergency, when there is no time to complete an H&P, a note containing the preoperative diagnosis and the reason for the emergency must be recorded by the Attending Physician or privileged designee prior to the procedure.

c. Completing an operative report within 24 hours of procedure, which must include:

i. Name(s) of the provider(s) performing the procedure and any assistant(s);

ii. Findings;

iii. Procedure(s) performed;

iv. Estimated blood loss as indicated;

v. Whether or not any specimens were removed and their description;

vi. Complications; and

vii. Post-procedure diagnosis.

2. If the operative report is not completed immediately, a post-procedure note which includes the elements set forth in Section B.1.(c) must be completed.

3. Operative documentation must be signed by the provider who performed the procedure and the surgeon of record.

4. The anesthesia service or the provider administering the sedation is responsible for all aspects of sedation/anesthesia care, including:

a. Conducting a pre-sedation/pre-anesthesia assessment prior to the start of the sedation/anesthesia.

b. Discussing and documenting relevant sedation/anesthesia options and risks with the patient and/or family.

c. Developing and documenting the sedation/anesthesia plan.

d. Administering sedation/anesthesia and monitoring the physiological status according to Surgicenter standards.

e. Continuing post-procedure assessment and monitoring as appropriate for the patient's sedation and physiological status with appropriate handoff.

f. Completing all required documentation in the patient record as defined by Medical Staff and Surgicenter policy.

NOTE: Elements of this sedation/anesthesia must either be personally performed by a

privileged physician or delegated to a qualified individual pursuant to Surgicenter policy, but the physician must either be physically present or immediately available to assist the qualified delegate continuously until the patient has met criteria for discharge from a phase 1 recovery area according to Surgicenter policy.

5. Dental and podiatry providers are responsible for:
    a. Ensuring that an H&P is completed or countersigned by a physician.
    b. Providing a day of surgery specialty-specific H&P update to include the pre-procedure diagnosis, a summary of clinically pertinent positive and negative findings which justify the need for the procedure, and a detailed description of the examination of the focused area.
    c. Performing the procedure.
    d. Completing the immediate post-procedure note or operative note which completely describes the findings and technique. In the case of extraction of teeth, the dentist should indicate the number and type of teeth and fragments removed.
    e. Arranging for an Attending Physician to manage the hospitalization of the patient if necessary.
    f. Recording pertinent daily progress notes.
    g. Documenting the discharge diagnosis.

B. CONSULTATION

Collaborative conversations between providers about patients help us provide better and safer care. These conversations do not involve an actual exam of a patient, may or may not involve review of patient information, and do not constitute a formal consult. These discussions may involve conversations between providers outside of, or as a part of, an existing provider-patient relationship. The CW Medical Staff assumes that these discussions do not constitute a binding physician-patient or PHP-patient relationship, as applicable.

The individual or service consulted may always request that a formal consult be ordered before offering an opinion or advice.

1. A consultation may occur when:
    a. There is a need for further evaluation or when patient care needs exceed the expertise or clinical privileges of the Attending Provider or
    b. A family or patient requests a consultation.
2. An order should be entered and the intent of the consult, the type of consult, and the level of involvement expected should be clarified.
3. All consults should be documented in the medical record.
4. Types of consult:
    a. Opinion only regarding diagnosis or management

b. Assistance with diagnosis or management

c. Treatment of a stated condition

d. Co-management

5. Responsibilities of the service requesting the consult:
   a. The requesting provider or designee must communicate to the consultant:
      i. The specific patient care issues that need to be addressed.
      ii. The urgency of the consult:
         a. **Emergent** consults for immediate threat to life or limb.
         b. **Urgent** consults for those issues not seen as an immediate threat to life or limb.
         c. **Routine** consults for those issues that do not meet either an emergent or urgent status.
      iii. Pertinent past history and findings relevant to the consult.
      iv. Whether diagnostic tests/treatments/procedures may be ordered, scheduled, or performed by the consulting service.
      v. How and whom to contact to discuss findings and consultant recommendations.
   b. Thoughtfully consider the recommendations and findings from each consultant and clearly communicate to other members of the health care team and the family any changes in the plan of care.
6. Expectations and responsibilities of the consultant:

   a. Communicate to the requesting Attending Provider or designee any specific requirements or prerequisites (e.g. NPO status or diagnostic evaluations).

   b Final recommendations should be communicated to the patient/family only after a discussion with the requesting provider or designee has occurred.

   c Arrange for ongoing follow-up after discharge when indicated or formally document a sign-off of the consultant's involvement in the patient's ongoing care.

C. ALTERNATIVE PLAN OF CARE

Code status is presumed to be a full code unless there are alternate code orders entered. Conversations with patients and families about alternate care plans should be documented in an "Altered Code" note. This note type can be accessed in the Altered Code narrator in

the electronic health record. A patient with advanced directives should have documentation on their anesthesiology plan in place regarding care.

D. TELEPHONIC CONVERSATIONS OR ELECTRONIC COMMUNICATION

Telephonic conversations or electronic communications regarding care that occur among providers and patients and/or families should be documented in the patient's health record.

III. ACCEPTED ABBREVIATIONS

Use of abbreviations should be kept to a minimum. The only abbreviations to be used in the medical record are those that are published in Stedman's Abbreviations, Acronyms & Symbols or abbreviations that are not on the Joint Commission "Do Not Use" list. Please refer to the Patient Care Policy & Procedure: *"Abbreviations"* for a list of unapproved abbreviations.

IV. MEDICAL ORDERS

A. General Rules

1. There are no standing orders that apply universally to all hospitalized patients.
2. When possible, medical orders should be entered into the electronic health record by the ordering provider as per Surgicenter policy.
3. A facsimile transmitted order with signature is acceptable as a written order.
4. All medical orders must be reviewed, modified as needed, and authenticated by the ordering provider or designee with the exception of those orders which are done under a delegated medical protocol.

B. Verbal Orders

Verbal orders must comply with Surgicenter policy. Please refer to the Patient Care Policy & Procedure: "*Patient Care Orders*."

C. Refusal to Sign/Authenticate an Order

In the circumstances that a listed provider or designee(s) refuses to authenticate an order, the provider or designee shall reject the order and select the reason for the rejection. Medical Records personnel will then review the rejected order and determine the reassignment of that order. In cases where there is a dispute regarding who the ordering provider should be, it will be assigned to the Attending Physician of record for the day the order was written.

V. PATIENT DEATH

Managing the death of a patient, tissue donation, and consent for an autopsy shall be done in accordance with Surgicenter policy. Please refer to the following Patient Care Policies & Procedures: *"Care of a Dying Patient and Disposition of a Body*," "*Consent for Treatment*," and as applicable.

VI. RESTRICTIONS ON TREATMENT OF SELF, FAMILY MEMBERS, AND COWORKERS

All providers must comply with Surgicenter policy. Please refer to the Administrative Policy & Procedure: *"Self or Co-worker Diagnosis and Treatment of Work-Related Injuries or Other Health Related Problems"* as it relates to treating self, family members, and coworkers.

VII. DELINQUENT MEDICAL RECORDS

An incomplete medical record is considered delinquent fifteen (15) days post-discharge or date of service as defined by Surgicenter policy. Please refer to the Administrative Policy & Procedure: *"Medical Records – Completion of the Medical Record"* for the detailed process on suspension of privileges for delinquent medical records.

VIII. MEDICAL EDUCATION

A. All patients are eligible to be observed by or to receive care from medical trainees (fellows, residents, and students) unless the Attending Physician or the family objects to trainee participation.

B. Fellows and Residents

1. The Medical College of Wisconsin Affiliated Hospitals ("MCWAH") employed

   a. All fellows and residents are considered to be under the supervision of the teaching director of their respective programs while assigned to the Surgicenter.
   b. While participating in patient care activities, fellows and residents are responsible to the patient's Attending Physician and are subject to these Rules and Regulations of the Medical Staff and policies and procedures of the Surgicenter.

2. Non-MCWAH employed

   a. All fellows and residents are considered to be under the supervision of the teaching director of their respective programs while assigned to the Surgicenter.
   b. While participating in patient care activities, fellows and residents are responsible to the patient's Attending Physician and are subject to these Rules and Regulations of the Medical Staff and policies and procedures of the Surgicenter.
   c. Fellows and residents are permitted to assume increasing levels of responsibility for patient care activities commensurate with their individual progress in experience, skill, knowledge, and judgment, as determined by their program directors.
   Fellows not employed by MCWAH must be credentialed.

C. Medical Students

Medical students may observe only. They are responsible to the Admitting Physician they are observing.

D. Medical Staff and PHP Staff member responsibilities

Medical Staff and PHP staff members are expected to collaborate and communicate with trainees in order to jointly provide safe and quality care to patients. Concerns about a trainee's conduct or patient care should immediately be reported to the trainee's teaching director or Department Chair or designee.

IX. CLINICAL RESEARCH AND PUBLICATION

In order to perform research on human subjects at Children's Wisconsin Surgicenter, all investigators must obtain the approval of the Children's Wisconsin Institutional Review Board in accordance with CW's policy. Please refer to the Administrative Policy & Procedure: "*Research: The Process of Conducting Research on Human Subjects at Children's Hospital of Wisconsin and Affiliates*." Such projects must be approved by the Surgicenter Medical Executive Committee.

X. AMENDMENTS TO RULES AND REGULATIONS

These Rules may be amended at any regular or special meeting of the Medical Executive Committee. Such amendment shall become effective once approved by the Board of Directors of the Hospital.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Adopted by the Medical Staff:

Approved by MEC:

Approved by the Board: December 13, 2023
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~