

**El Camino Ambulatory Surgery Center, LLC  
2480 Grant Road  
Mountain View, CA 94040**

**EL CAMINO AMBULATORY SURGERY CENTER**

**MEDICAL STAFF RULES AND REGULATIONS**

The following are the Rules and Regulations of the Medical Staff of the El Camino Ambulatory Surgery Center (the “Center”):

***DEFINITIONS***

For the purposes of these Rules and Regulations, the following definitions shall apply:

1. **Medical Staff** – The Physicians who have been granted Medical Staff membership and Clinical Privileges to care for patients at the Center.
2. **Physician** – An individual with a M.D., D.D.S., D.M.D., D.P.M., or D.O. degree who is licensed to practice medicine, surgery or osteopathy in the state of California.
3. **Clinical Privileges** – The permission granted to Medical Staff members to provide patient care and includes the use of the Center’s resources that are necessary to effectively exercise those patient care Clinical Privileges.
4. **Admitting Physician** – A Physician who has been granted Medical Staff membership at the Center whose Clinical Privileges support initiating the admission of a patient to the Center.
5. **Center** – El Camino Ambulatory Surgery Center.
6. **Medical Director** – The Center’s Medical Director, Assistant Medical Director or Designee.
7. **Clinical Director** – The Center’s Clinical Director or Designee.

**Section 1. General.**

Only licensed health care professionals who have been appointed to membership of the Center’s Medical Staff and granted Privileges as set forth in the Bylaws and Rules and Regulations of the Medical Staff may treat surgical or medical patients in the Center.

**Section 2. Orders.**

- a. A Physician shall sign all orders for treatment of patients.
- b. Registered Nurses may accept verbal orders. A notation shall be made in the chart by one of the nursing staff recording the verbal order. The Physician shall sign all verbal orders.
- c. The Center may substitute generic names for brand names on medication orders, unless the Physician’s order specifies to the contrary.

### **Section 3. Controlled Substances.**

The following rules and regulations shall govern orders for controlled substances.

- a. The Center keeps all controlled substances in a locked cabinet or refrigerator.
- b. The Center dispenses controlled substances from these cabinets or refrigerators and maintains separate logs on them, in accordance with the Controlled Substances Policy.
- c. The Clinical Director maintains detailed policies and procedures with respect to controlled substances.
- d. Controlled substances are available only for use in the Center.
- e. Controlled substances from other centers shall not be brought in for use in the Center, unless authorized by the Clinical Director.

### **Section 4. Scheduling.**

- a. Only Admitting Physicians may make admissions. The Center shall not admit patients under the post-conceptual age of 45 weeks. The Admitting Physician or his/her personnel shall schedule admissions by calling and scheduling the patient. The Medical Director shall authorize any emergency admission. It is the responsibility of the Admitting Physician to assess his/her patient's suitability to undergo outpatient surgery in the Center. It is the responsibility of the attending anesthesiologist to assess his/her patient's suitability for anesthesiology services. If the Admitting Physician is unsure of the patient's suitability, he/she shall consult with the Medical Director before scheduling the patient. If the patient has a serious medical problem, it is the responsibility of the Admitting Physician to evaluate the medical problem before scheduling. The Admitting Physician shall discuss any questions regarding his/her patient's medical status with regard to the patient's care at the Center with the Medical Director or an anesthesiologist on the Medical Staff.
- b. The selection of anesthesiologists to provide anesthesiology services is the responsibility of the Governing Body of the Center. Anesthesia services shall be provided in accordance with agreements entered into with the Center.
- c. When scheduling a patient, the Admitting Physician shall give the following information to the Center: patient's name, social security number, birth date, sex, address, telephone number, employer, admitting diagnosis, proposed procedure(s), length of proposed procedure(s), assistant(s) (if any), and whether or not the patient requires anesthesiology services. The Admitting Physician is responsible for meeting any insurance preauthorization requirements for his/her performance of the scheduled procedure(s) and for the provision of this information to the Center at the time of scheduling. The Admitting Physician shall bring to the Center's attention any serious medical problems of his/her patients at this time. At the time of scheduling, the Admitting Physician shall bring to the Center's attention any special equipment needs. If there is a mutually agreeable time, the Center shall give the Admitting Physician a procedural time. This constitutes designation of an operating room for a specific time, not designation of a specific operating room. If the Admitting Physician requests anesthesiology services for his/her patient, the Center shall schedule anesthesiology coverage.
- d. The Admitting Physician shall notify the Center if he/she needs any pathology services. The Center shall send specimens to the lab of the Admitting Physician's

choice. The Center has an agreement with a local pathology group for services if the Admitting Physician does not state a preference and/or if emergency conditions develop.

- e. If the Admitting Physician or attending anesthesiologist requests, the Center shall perform finger stick hematocrit, glucose determinations, or dipstick urinalysis on site. The Admitting Physician or attending anesthesiologist shall arrange for any other lab studies before admission. The Admitting Physician or attending anesthesiologist shall attempt to forward reports of studies to the Center at least two (2) days before the procedure(s).
- f. The Admitting Physician shall notify the Center at the time of scheduling if he/she requires any type of radiology services.

### **Section 5. Admitting.**

- a. The Center's staff may contact the patient at work or at home to assist with any financial matters pertaining to the patient's care at the Center or to gather medical information. If any problems arise from this screening, the Center shall notify the Admitting Physician of the problem(s) for resolution before admission. If the patient refuses direct contact by the Center, then the Admitting Physician shall be responsible to convey the necessary information regarding the patient to the Center before admission.
- b. The Center requires that all patients (or their legal representatives) sign an Authorization and Consent to Surgery, Anesthesia, Diagnostic or Therapeutic Procedures Form. The patient and/or person signing the consent must exhibit the ability to use judgment and follow post-discharge instructions.
- c. It is each Physician's responsibility to obtain and document informed consent from his/her patient or patient's legal guardian.
- d. Prior to all elective procedures, the Center obtains a written, signed, informed procedural consent. The Center obtains consents to treatment and releases that conform to the current edition of the California Healthcare Association's Consent Manual, or to the Center's legal counsel's recommendation.
- e. In emergencies involving a minor, an unconscious patient, or an incompetent patient where the Center cannot immediately obtain consent for surgery from the parents, , guardian or next of kin, the Center obtains the following:
  - i. Documentation by the Admitting and Consulting Physician's in the medical record that the patient is incompetent and a description of the emergency condition which requires immediate treatment; and
  - ii. If time permits, an attempt shall be made to contact the parents, spouse, or legal guardian as applicable. In the event a minor is a Ward of the Court, if time permits, the Physician shall notify such Court or legally appointed guardian.
- f. In non-emergent situations, the Admitting Physician shall obtain a court order authorizing treatment in any case where non-emergency treatment is proposed, the patient is a minor or incompetent, and no surrogate decision-maker is available.
- g. Patients must have a history and physical examination dated within thirty (30) days prior to the date of surgery in the chart. Patients who receive anesthesia care from an anesthesiologist shall receive a preoperative medical evaluation and physical

examination from an anesthesiologist. The anesthesiologist shall document this evaluation of the patient's condition in regard to his/her ability to tolerate the anesthetics and the planned procedure(s) in the patient's chart. In addition, either the treating physician or anesthesiologist reevaluates the patient immediately before administering moderate or deep sedation or anesthesia and documents this evaluation in the patients chart.

- h. If the anesthesiologist is uncertain about a patient's condition, he/she may request a more thorough medical evaluation before deciding whether or not to proceed with the scheduled procedure(s) including, but not limited to, the appropriate consultations and further laboratory testing.

### **Section 6. Discharging.**

- a. Surgery patients shall recover in the Post Anesthesia Care Unit ("PACU") under the care of the Center's PACU staff nurses. The patient shall meet the Center's discharge criteria before discharge from the Center. The Admitting Physician must order the patient's discharge.
- b. Except as provided herein, upon discharge from the Center, the patient may not drive and the patient must have a responsible adult accompany them home. The Operating Physician may immediately discharge, via a written order, patients who have had local anesthesia; these patients may drive home unaccompanied as long as the operative site does not interfere with driving (e.g., hand or foot surgery). Both the patient and responsible adult shall receive the Center's post-operative instructions and the Admitting Physician's post-operative instructions, if any. Depending on the type of procedure(s) performed, a nurse from the Center may call between 24 - 72 hours after surgery to check with the patient on his/her status.
- c. The Admitting Physician shall arrange for the transfer of a patient to an appropriate facility if any complications develop that are beyond the scope of the Center. The Center shall assist the Admitting Physician in this procedure. If the Admitting Physician is, for whatever reason, unavailable at the time, then the Center, through a Medical Director or an anesthesiologist on staff, shall arrange for such transfer and shall contact the Admitting Physician as soon as possible. In case the Admitting Physician does not have admitting privileges at the receiving hospital, the Center shall use its transfer agreement with the receiving hospital to facilitate the transfer.
- d. An anesthesiologist shall be present in the facility until all patients who received care from an anesthesiologist have been medically discharged. For those patients receiving local anesthesia or conscious sedation under the Admitting Physician's supervision, it is the Admitting Physician's responsibility to remain in the facility until the patient has been medically discharged. Medical discharge shall include a patient's readiness to be transferred to 23-hour stay process.

### **Section 7. Medical Records.**

- a. The Admitting Physician shall be responsible for the preparation of a complete medical record for each patient undergoing a procedure in the Center. The entries in a patient's record for each admission shall include, but are not limited to:

1. Identification data;
  2. Chief complaint or purpose of admission;
  3. Preoperative medical evaluation and physical examination, which shall include medical illnesses and/or conditions; indications for surgery; clinical findings relevant to the proposed procedure; current medications; allergies and/or sensitivities;
  4. Admitting diagnosis or impression;
  5. Personal history;
  6. Relevant laboratory, radiologic, or special reports (initialed by the Admitting Physician);
  7. Care rendered (anesthetic, medical and/or surgical treatment);
  8. Operative report, including final diagnosis;
  9. Discharge note with the patient's condition at discharge;
  10. Disposition, recommendations and instructions given to the patient; and
  11. Authentication and verification of contents by healthcare professionals
- b. Prior to admission, the Center's staff will flag preoperative studies and EKGs on the chart with a signature tab. The Admitting Physician or anesthesiologist shall sign or initial all preoperative studies and EKGs that are on the chart at the time of surgery.
  - c. The medical records may contain approved pre-printed forms. The Medical Director and Clinical Director must approve all pre-printed forms.
  - d. No medical record shall be filed until it is complete, signed by the Admitting Physician and, if anesthesiology services were provided, anesthesiologist, and if applicable, reviewed by an appropriate committee, except on orders of the Medical Director.
  - e. The treating physician will assess the patient on the day of surgery and attest that he/she has reviewed the history and physician examination dated within thirty (30) days prior to the date of surgery and note any changes, if any. Patients who receive anesthesia care from an anesthesiologist shall receive a preoperative medical evaluation and physical examination from an anesthesiologist. The anesthesiologist's assessment may be accepted by the treating physician as the assessment of the patient on the day of surgery. The anesthesiologist shall document this evaluation of the patient's condition in regard to his/her ability to tolerate the anesthetics and the planned procedure(s). In addition, either the treating physician or anesthesiologist reevaluates the patient immediately before administering moderate or deep sedation or anesthesia and documents this evaluation in the patients chart.
  - f. Brief descriptions are acceptable for the systems review, past history, etc.
  - g. The Admitting Physician (or his/her assistant) shall dictate a standard operative report immediately after the procedure. If the Admitting Physician does not dictate the operative report within seventy-two hours of completing the procedure(s), the Center shall send a facsimile delinquency notice to the Admitting Physician. This operative report shall include the pre-operative and post-operative diagnoses, the name(s) of the Physician(s), procedure(s) performed appropriate to the diagnosis, complications, estimated blood loss and medications used. In addition, the Admitting Physician shall complete and sign a written operative progress note (on the Center's preprinted form) immediately after the procedure. The Admitting Physician shall sign all operative reports.

- h. An anesthesiologist shall complete and sign a discharge note on all patients receiving care from an anesthesiologist. For conscious sedation cases, the physician performing the procedure shall sign a discharge note.
- i. The anesthesiologist shall maintain an anesthesia record on all patients undergoing general or regional anesthesia or monitored anesthesia care by the anesthesiologist in accordance with the Anesthesiology Rules and Regulations. The anesthesiologist shall complete and sign the anesthesia record immediately after completion of the procedure. When an anesthesiologist is not directly involved with the patient's care in the operating room, then the circulating nurse shall be responsible for the intraoperative record under the supervision of the Admitting Physician, in accordance with Policy No. 8005 – Procedural Sedation and Analgesia.
- j. A pathologist shall examine all specimens (with the exception of those excluded under Policy No. 7012 – Surgical Specimen Handling) removed during surgery, and the pathologist's signed report of the examination shall be made a part of the patient's medical record. The Admitting Physician must initial all lab reports of relevant specimens sent from the operating or procedure rooms.
- k. The completion of medical records shall occur within fourteen (14) days after the procedure(s). After fourteen (14) days, a medical record is deemed incomplete if the Operative Report has not been dictated and signed, or if other physician documentation is outstanding. If a Physician does not dictate within seventy-two (72) hours of performing the procedure(s), the Center will fax a delinquent notice to the Physician's office. This fax will be followed up with a phone call confirming the office's receipt of the fax. On the fifteenth (15<sup>th</sup>) day of an incomplete medical record, the Center will prepare a "Notice of Suspension of Medical Staff Clinical Privileges", which the Medical Director will sign and send to the Physician via Certified Mail. The Physician's Medical Staff Clinical Privileges will remain suspended until his/her medical record(s) are completed. (See Bylaws, Section 6.7.1g.).
- l. Medical records are the property of the Center and are held in strict confidence by the Center. The Center shall not release information without the written consent of the patient or his/her legal guardian (or as otherwise permitted by law.)
- m. The removal of medical records from the premises (including the Center's storage facility) may only occur in accordance with a court order, subpoena, or state statute or regulation. The Medical Records Department shall be the custodian of records.

**Section 8. Adoption and Amendments.**

These Rules and Regulations shall become effective when approved by the Governing Body. The Governing Body may amend these Rules and Regulations.

Approved on 3/28/2013

By: The Governing Body



By: Steven F. Kanter, MD  
Member