OrthoArizona Surgery Center Gilbert, LLC

Medical Staff Rules and Regulations

2018

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ORTHOARIZONA SURGERY CENTER GILBERT, LLC
MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff of OrthoArizona Surgery Center Gilbert, LLC (the "Facility" or "Center") shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within the bylaws. The rules and regulations shall relate to the proper conduct of Medical Staff organizational activities and will embody the specific standards and level of practice that are required by each Medical Staff member and other designated individuals who exercise Clinical Privileges or provide designated patient care services in the facility. The overriding goal of the Medical Staff shall be to create a culture of safety and collaboration to maximize patient outcomes and satisfaction.

The Medical Staff shall formulate and implement Medical Staff Rules and Regulations, which will become effective upon approval of the Medical Executive Committee (the "MEC") and Governing Board (the "GB"). Medical Staff Rules and Regulations shall be consistent with the Medical Staff Bylaws, and with the established Facility policies. Such Rules and Regulations may be amended or repealed by a majority vote of those present at any regular meeting of the Medical Staff at which a quorum is present, and without any required previous notice of the Medical Staff meeting. All such changes in the Rules and Regulations shall not become effective until approved by the MEC and the GB.

Physicians are responsible for the quality of medical care in the Facility and must accept and discharge this responsibility in conjunction with their privileges and subject to the ultimate authority of the Medical Executive Committee and Governing Board of the OrthoArizona Surgery Center Gilbert, LLC.

The cooperative efforts of the Physicians, the Medical Executive Committee, the Medical Director and the Governing Board are necessary to fulfill the Facility's objective of providing quality care to our patients.

As a condition of maintaining their privileges at OrthoArizona Surgery Center Gilbert, LLC, the physicians practicing at the Center will comply with these Medical Staff Rules and Regulations, the Medical Staff Bylaws, and each of the Center's policies and procedures.

SECTION I

FACILITY MEDICAL DIRECTOR RESPONSIBILITIES

The Medical Director of OrthoArizona Surgery Center Gilbert, LLC (the "Facility" or "Center") will assume the following responsibilities and duties:

a. Work with the Center's Medical Staff (the "Medical Staff") and Center's Leadership to develop a Strong Culture of Safety;
b. Represent both the clinical and medical needs of the Facility, in his/her leadership role;
c. Make recommendations regarding Facility policies and procedures;
d. Make recommendations on the purchase of equipment needed to add new services and/or to maintain and improve existing services;
e. Represent the views of the Medical Staff in his/her leadership role;
f. Communicate with the Center's Governing Board (the "Governing Board") regarding the concerns, conclusions, recommendations and decisions of the Medical Staff;
g. Participate, as an ex officio member , in sub committees (as assigned by the Governing Board and/or the Center's Medical Executive Committee (the "MEC"));
h. Work with the MEC to ensure that the Peer Review Process is completed, including physician feedback in accordance with Facility policy, Medical Staff Bylaws, and Medical Staff Rules and Regulations;
i. Assist in preparation for accreditation and any and all accreditation survey processes;
j. Assist in the maintenance of standards, and engage the MEC in this process;
k. Evaluate and provide feedback regarding competence of staff, seeking MEC input into this process;
l. Develop and annually review protocols appropriate for the Facility, working with appropriate physician specialists;
m. Participate in PI activities, and actively work to engage other physicians in this activity ;
n. Communicate to the Center's administration any emergency medical equipment and supplies that are specified as necessary by the Medical Staff. Review and approve crash cart/Emergency box protocols, standards, equipment, and supplies in accordance with Facility policy, while working with the MEC;
o. As appropriate, communicate with physicians regarding patient issues and to enhance relationships between Facility and the Medical Staff;
p. As needed, act as liaison between administration and physicians;
q. As appropriate, participate in planning activities for new services, identifying needs involving changing technology, and other quality improvement activities;
r. Participate in and evaluate the Facility's Infection Control-Prevention Program;
s. Participate in and evaluate the Facility's Risk Management and Safety Program; and
t. Assist with ensuring the compliance of other physician(s)with Surgery Center's Medical Staff Bylaws and Medical Staff Rules and Regulations.

_____ _____

Medical Director Date

SECTION II
Peri-Operative Care

A. Rights of Patients and Organizational Ethics

1. As a condition of maintaining privileges at the Center, all practitioners must adhere to the Center's "Patient's Bill of Rights"..

2. If a patient presents with an Advanced Directive with a "Do Not Resuscitate" component, the physician will assist in explaining the Center's "Statement of Limitations" to the patient, and the physician will work to attain an acceptable plan for the patient within the Center's policy.

3. Specific informed consent must be obtained for any/all procedures. The attending physician/practitioner and/or treating practitioner is responsible for documenting in the medical record the information provided to the patient relative to the procedure(s) anticipated. Exceptions to obtaining the patient's timely specific informed consent shall be limited to emergencies. All regulatory requirements relating to disclosure shall be followed. To indicate that the practitioner has personally provided specific information on which the patient has based his consent, both the patient and the responsible practitioner shall sign the consent form prior to the procedure being performed.

4. Prior to the patient signing the consent for anesthesia, the anesthesia provider will meet with the patient or patient's surrogate to discuss the anesthesia plan, risk and benefits, and alternatives.
5. HIPAA compliant written consent/authorization by the patient is required for release of medical information to persons not otherwise authorized to receive this information. All of the OrthoArizona Surgery Center Gilbert, LLC's HIPAA policies and procedures will be followed.

B. Medical Staff Responsibilities

A physician with clinical privileges at the Center shall be responsible for each patient in the Center. Whenever these responsibilities are transferred to another member of the Center's Medical Staff, the transferring physician must enter a note in the patient's medical record, specifying that the transfer of responsibility has occurred. .

C. Assessment of Patients

1. Preadmission Process
   a) Prior to scheduling the patient for surgery at the Facility, the physician will evaluate the patient for appropriateness of the procedure being performed in the outpatient setting, and in consideration of the following:
      - proposed procedure;
      - the patient's physical and mental status; and
      - the facility's admission criteria.
   b) Prior to the patient's admission to the surgery center, the physician/proceduralist shall explain the planned procedure and plan of care to the patient.

2. The Center shall accept patients for care, treatment, and procedures to be provided at the Center in accordance with the Center's approved procedure list.

   a) All members of the Center's Medical Staff and all clinicians granted medical staff privileges must be appointed to their position in the Center by the Center's Governing Board. The privileges granted by the Governing Board must be in writing, and must specify in detail the types of procedures that the physician/clinician may perform within the Center. Patient procedures may be

performed only by a duly appointed member of the Medical Staff of the Center that has been granted specific privileges for performing the procedure.

3. Initial Assessment

- Not more than thirty (30) days before the date of the scheduled surgery or procedure, each patient must have a comprehensive medical history and physical assessment (the "H&P") completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and Center policy. The H&P must be comprehensive in order to allow assessment of the patient's readiness for surgery, and should specifically indicate that the patient is cleared for surgery in an ambulatory setting.
- The H&P must be updated on the date of service, and prior to any procedure being performed. At a minimum, the updated H&P must assess the patient's readiness for surgery, evaluate any changes in the patient's condition since the initial H&P was completed, and indicate that the patient is cleared for surgery in the Center for the procedure to be performed. The H&P must include a physical exam of heart and lungs, the indications for surgery, and the planned procedure.
- In most cases a credentialed physician will complete the H&P. If a Primary Care Physician or other Practitioner authorized by law completes the H&P, prior to the surgical procedure, the credentialed procedural physician will validate/authenticate the H&P. Prior to the surgical procedure, the procedural physician will additionally document the indication for surgery and the planned procedure.

  Prior to performing procedures requiring general, spinal, or regional anesthesia, and those procedures involving intravenous and all conscious sedation, the practitioner must obtain a pertinent history from the patient, including any history related to the patient's prior anesthesia responses. Additionally, the practitioner must perform a pre anesthesia assessment immediately prior to induction, to evaluate the risk of anesthesia and of the procedure to be performed. A minimal pre anesthesia assessment must include assessment of the patient's cardiac and pulmonary status.

D. Treatment of Patients

1. Medical Staff Responsibilities

a) All orders for treatment and medication shall be in writing and authorized only by a licensed physician or other practitioner as allowable by state law, and appropriately credentialed by the Center in accordance with the Medical Staff Bylaws.

b) A Verbal Order shall be considered to be in writing if dictated to a duly authorized person, functioning within his/her sphere of competence, and signed by the responsible ordering practitioner. All orders dictated over the telephone (the "Dictated Phone Orders") shall be signed by the appropriately authorized person to whom the order was dictated, and such Dictated Phone Orders shall include the name of the ordering practitioner, the date and time the order was given, and the full signature of person taking the order. The responsible ordering practitioner shall authenticate such orders within 30 days (the "Authentication of the Dictated Phone Order"); the exception to the Authentication of the Dictated Phone Order shall be that Schedule II and IV medications that are ordered during Dictated Phone Orders must be authenticated by the prescribing practitioner within 24 hours of receipt of the

Dictated Phone Order. Failure of the prescribing practitioner to timely authenticate the Dictated Phone Order shall be referred to the Medical Executive Committee for appropriate action.

Registered Nurses are qualified to accept and transcribe Verbal Orders, regardless of the mode of transmission. Verbal Orders include those orders that are inclusive of medications, diagnostic procedures, and contrast administration orders.

c) The practitioner's orders must be complete and legible. Illegible or improperly written orders shall be clarified with the ordering physician prior to implementing the order.

d) The admitting practitioner is responsible for providing such information as may be necessary to assure the protection of the patient from self-harm. If the patient is considered to be a source of danger, either from the patient personally or due to the patient's medical status, the admitting practitioner is responsible for providing such information as may be necessary to and to assure the protection of others, including other patients, staff, and visitors.

2. Coordination of Care

a) In case of readmission of a patient, all previous records shall be available for the use of the physician. This shall apply whether the patient is attended by the same practitioner or by another practitioner.

b) When the procedure will not be performed, including circumstances in which it is determined that the patient is not a good risk for the procedure, or in instances in which the patient exhibits severe psychiatric symptoms, the practitioner is responsible for:

- Contacting the referral physician and notifying him that the patient procedure will not be done;
- Notifying the patient and/or surrogate of the reason for cancellation of the procedure; and
- Placing documentation in the medical record regarding the cancellation or termination of the procedure, along with reasons for canceling/terminating the procedure.

c) In any instance in which required consultative expertise is not timely available, and the patient cannot be timely or safely transported elsewhere, the physician/practitioner must timely contact the contracted acute care hospital to obtain immediate assistance/consultation for the appropriate physician specialty.

d) If a RN or other patient care provider has any reason to doubt or question the care provided to any patient, he/she shall timely refer the matter to the attention of a superior. The superior may in turn refer the matter to the Center Administrator. If warranted, the Center Administrator may bring the matter to the attention of the Medical Director. In cases in which the care of the Medical Director is at issue, the Center Administrator may refer the matter to the attention of the President of the Medical Staff, who will assess and act on the situation.

3. Use of Medications

a) When applicable to a specific patient, a physician's routine orders may be reproduced in detail on the order sheet of a patient's record. Prior to the initiation of such orders, the orders shall be dated, and signed by the physician.

b) The Medical Director shall be timely consulted when, in the opinion of the Center Nursing Staff or Center Pharmacist, a medication dosage ordered by a prescribing practitioner represents a potential hazard to the patient, and the prescribing practitioner disagrees with the opinion of the Center Nursing Staff and/or the Center Pharmacist, Examples of potential hazards to the patient include but are not limited to excessive medication dosage, incompatibility with other prescribed medications, and/or contraindications based on the patient's condition.

c) The metric system must be used when prescribing all medications. The use of a leading decimal point should be avoided. The practitioner should place a zero before the decimal point.

d) Practitioners shall abide by all applicable federal and state regulations/laws in reference to prescribing, dispensing, and administering medications.

4. Use of Diagnostic Procedures

a) Patients admitted to the Center shall have services performed that are on the order of practitioners with clinical privileges at the Center, or consistent with State law, of other practitioners authorized by the Medical Staff and the Governing Body to order the services. Ordered services shall be clearly identified by the ordering physician.

b) When diagnostic procedures are performed, a properly credentialed physician will provide the interpretation. In accordance with written Medical Staff Policies, a radiologist shall provide authenticated reports to the ordering physician for all radiologic examinations performed in the Center. In accordance with written Medical Staff Policies, a pathologist will provide authenticated pathology reports to the ordering physician for all pathology services. These radiology and pathology services may be provided by Center approved contracted services.

c) A practitioner who receives financial gain from the operation of a clinical or pathology laboratory, radiology or other diagnostic service used by the Center for patient referrals must timely disclose their interest in writing to the Center Administrator and to all other persons required by law.

5. Use of Operative and Invasive Procedures

a) Operative and invasive procedures will be ordered and performed following approved medical utilization guidelines.

b) An immediate operative note will be entered into the Medical Record, which minimally includes; Name of surgeon and assistants, operative findings, procedure performed, specimens removed, post-operative diagnosis, estimated blood loss, and complications.

c). Anesthesia care will be delivered by Anesthesiologists or CRNAs who are Center credentialed and privileged in anesthesiology/anesthesia care and who are contracted to provide such service. The CRNAs will be under the supervision of an anesthesiologist or other physician privileged for supervision of CRNAs.

d). Tissue and specimens removed during a procedure must be sent to an approved laboratory (JCAHO or CAP accredited and CLIA licensed) for analysis.

e) All tissue and specimens removed shall be sent to the pathologist except:

- clot, atheromatous plaque, residual vein tissue from graft harvest, endarterectomy, vascular surgery
- normal/degenerative bone and cartilage resected or removed during joint reconstruction, arthroplasty, and fracture surgery with the following exceptions – if there is suspicion of pathologic fracture or osteomyelitis, tissue must be sent, all femoral heard must be sent for evaluation, both gross microscopic, from hip replacement and/or endoprosthetic surgery; tissue from total knee replacement should still be sent for gross examination only
- tissue from routine arthroscopic debridement, including synovium, articular cartilage, meniscus, and bone/osteophyte.
- "normal" skin subcutaneous fat, muscle, tendon, joint capsule, or scar tissue from skin, subcutaneous tissue and joint reconstruction surgery (including plastic surgery except in cases where malignancy is involved)
- tissue from wound debridement for trauma, including grossly contaminated or devitalized tissue
- foreign bodies (including bullets) or resonstruction plates of any sort (document with photograph and/or radiograph)
- Lamina and ligamentum flavum removed for visualization during disc surgery (disc material must still be sent for evaluation)
- Prostheses (document with photograph)
- Orthopaedic appliance (document with photograph)
- Therapeutic radioactive sources inserted by radiotherapist
- Traumatic amputation specimens

Photographic documentation of such exempted specimens (of appropriate size and definition) should be attached to the patient's medical record for a legal record of the exempted specimen(s).

6. Use of Emergency Services

a) Emergency Services of the Center shall be under the direction of the Medical Director.

b) The Medical Director will review and approve crash cart/Emergency Box protocols, standards, equipment, and supplies in accordance with Center policy, and while working with the MEC. The Medical Director will work in conjunction with the Medical Staff to identify any additional emergency equipment and supplies that are needed, as well as the quantity and locations for availability of such supplies. The Medical Director will timely communicate the Medical Staff requests for additional emergency equipment and supplies to the Center's administration.

c) Immediate emergency care shall be provided by the admitting physician and anesthesia provider providing care, or other appropriately credentialed practitioner, based on immediate availability.

d) Before transferring a patient to an acute care hospital, the Facility shall provide services within its capacity in order to minimize any deterioration of the patient's condition.

e) Cases requiring emergency services or transfer to acute care facilities require a written order by a credentialed physician.

f) All transfers shall be reviewed by the MEC as part of the Center's Peer Review process.

g) Every physician available in the Center must respond to a "code blue" unless it would endanger a current patient in a current procedure.

E. Patient Discharge

1. Prior to discharge the anesthesia provider will assess the patient for recovery from anesthesia. The assessment will include the following:
a) Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
b) Cardiovascular function, including pulse rate and blood pressure;
c) Mental status;
d) Temperature;
e) Pain;
f) Nausea and vomiting;
g) Postoperative hydration; and
h) Any other assessment necessary based upon the specific surgery or procedure performed.

2. The practitioner performing the procedure will evaluate the patient and write discharge orders. The orders will include the following:
a) Medication orders to include but not limited to any post-operative analgesia and resumption of or deletion of pre-operative medications as recorded on the Medication Reconciliation form;
b) Any activity restrictions;
c) Dietary restrictions;
d) Follow up appointments; and
e) Any other specific care instructions.

F. Education of Patients and Family

1. The physician is responsible for assuring that all patients and families receive appropriate education.

2. Printed instruction sheets or patient care brochures provided to patients and/or families either at the Center or at time of discharge shall be approved for clinical relevance and patient safety by the Medical Director/MEC. Such sheets or brochures shall not, however, be used by the practitioner as the sole source of information for purposes of obtaining the initial informed consent.

G. Continuity of Care

1. Patients requiring transfer for acute medical services will be sent to the facility of their choice unless a life-threatening situation requires an alternate facility.

2. The procedural physician or his designee will notify the acute care hospital prior to a transfer. In all cases, except in transfer to an emergency room, there will be a designated practitioner who has agreed to accept the care of the patient (the "Accepting Practitioner"). In all cases, the procedural physician or his designee will explain the reason for the transfer to the Accepting Practitioner.

3. In the event of an emergency, the receiving emergency room practitioner will be contacted regarding the patient's immediate transfer. Medical care within capabilities of the facility shall be provided to the patient.

4. Appropriate personnel and equipment shall accompany the patient on the transfer. Copies of all appropriate medical records shall be transferred with the patient.

5. In the event of patient death, within a reasonable time the deceased shall be pronounced dead by the attending practitioner or another practitioner, who is authorized by law to pronounce a patient dead. All deaths will be reported to the Coroner as required by local regulations/laws. The Medical Director and MEC shall review all patient deaths at the Center or known deaths occurring within 72 hours of discharge.

SECTION III

H. Management of Information

1. Accurate and complete medical records shall be timely prepared and maintained for each patient receiving care.

2. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated by persons authorized to assess, write orders and treat patients. The medical record must be clear, concise, complete, and accurate.

3. If an error is made when documenting the medical record, a single line will be drawn through it with a designation above the entry with date, time, and initials. The correct entry is then written with the date, time, and authentication of the practitioner. In no event shall the erroneous entry be obliterated or erased.

4. Symbols and abbreviations may be used only when approved by the Medical Director, MEC and Governing Board. (the "Approved Abbreviations") An official record of the Approved Abbreviations should be kept on file in the Center Administrator's office and available in each area where patient care is rendered. Each symbol and abbreviation shall have only one meaning.

5. There will be a listing of "Do Not Use" abbreviations, which have been approved by the Governing Board. The use of the Do Not Use abbreviations is NOT allowed in the medical record.

6. The ordering physician must authenticate all patient orders. Any practitioner who co-signs a history, physical examination, or other medical record entry for another practitioner or another individual authorized to make such entry has responsibility for the order or the information bearing his/her authentication.

7. Physician orders for radiology and pathology services will indicate the reason for the request, and record relevant clinical information.

8. Pertinent progress notes shall be recorded at the time of observation, and shall be sufficient to ensure continuity of care and transferability. The progress notes should provide a chronological report of the patient's course in the Center and should reflect any change in the patient's condition, and the results of treatment.

9. Allergies and untoward reactions to drugs and biological must be recorded in the medical record.

10. All medications administered shall be documented in the patient's medical record. Documentation shall include medication name, concentration, dosage, route, and patient response.

11. Appropriate personnel MUST accompany all patients transferring to the Center from another health care facility (hospital), and the patient's Medical Record MUST be brought to the Center (including current day Medication Administration Record).

12. All Center patients being sent to other facilities MUST have the appropriate medical record information sent with them. This includes those patients who require a higher level of care. The general patient information sheet, the History and Physical, any and all emergency documentation, and a copy of the advanced directive (if one exists) will be sent to the receiving facility.

13. Special procedure reports must be dictated or written in the medical record immediately after the procedure, and will contain a description of the findings, the technical procedures used, any specimens removed, the procedure diagnosis, and the condition of patient on conclusion of procedure. When there will be a transcription and/or filing delay, a progress note, comprehensive enough to permit continuity of care, must be entered in the medical record immediately after the procedure.

14. All medical records shall not be permanently filed until completed by the responsible practitioner(s) or as ordered filed by the Governing Board. An incomplete record will not ordinarily be filed if the responsible practitioner holds clinical privileges in the Center. No practitioner shall be permitted or requested, for any reasons, to complete a medical record on a patient unfamiliar to him, regardless of the status of the practitioner who is responsible for completing the record.

15. All pre-printed and routine orders (particularly those involving medications) (the "Pre-Printed Orders") shall be initially evaluated and approved by the Medical Director, MEC, and Governing Board. Thereafter, the Pre-Printed Orders shall be evaluated and approved annually by the Medical Director, MEC, and Governing Board. Any change in Pre-Printed Orders shall require approval by the Medical Director, MEC and Governing Board.

16. Center approved appropriate safeguards shall be applied to protect confidential records and to minimize the possibility of loss and/or destruction of the records. All Center HIPAA policies and procedures shall be followed.

17. In accordance with Center Policies and Procedures, medical records may not be removed from the Center's jurisdiction and safekeeping. In accordance with established Center Policies and Procedures, the medical record or copies of the record may be released subject to a properly issued court order, subpoena, or a statute. All records are the property of the Center and shall not otherwise be removed from the Center without specific written permission of the Center Administrator. Unauthorized removal of Center property, including medical records, is grounds for referral to appropriate personnel for corrective action.

18. Practitioners shall abide by information management requirements that, because of their relevancy to the subject matter in those sections, have been delineated in other sections of these Rules and Regulations.

19. Disciplinary action related to incomplete and timely completion of medical records is addressed in the Facility's Medical Staff Bylaws.

SECTION IV

I. Management of Human Resources

1. Residents (Physicians in Training)- Physicians in training shall consist of those licensed physicians who are participating in an approved residency and or fellowship program.

Physicians in Training shall be credentialed pursuant to the Medical Staff Bylaws. It shall be clearly understood that any medical activities performed by Physicians in Training at the Facility shall be under the direct supervision of a Medical Staff member. Medical staff activities shall be limited to the privileges granted to the supervising Medical Staff member. In accordance with the Medical Staff Bylaws, the evaluation of medical care provided by an individual Physician in Training shall be the responsibility of the supervising Medical Staff member, the Medical Director, the MEC, and the Governing Board.

2. Management of Center personnel shall be the responsibility of the Administrator or designee. Any concerns or complaints regarding an employee's performance by a member of the Medical Staff shall be addressed with the Director of Nursing or Administrator.

SECTION V

J. Management of the Environment

1. The Center's Safety Officer has the authority to institute appropriate control measures or studies at any time that he/she makes a reasonable finding that such measures or studies are necessary to protect patients, visitors or personnel from environmental hazards.

2. The Disaster Plan should make provision within the Center for:

   a) Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.

   b) An efficient system of notifying and assigning people.

   c) Procedures for the prompt discharge or transfer of patients in the center who can be moved without jeopardy.

3. Designation of the most appropriate facility for transfer if definitive care is needed by the patient.

4. All practitioners shall be assigned to posts, and it is their responsibility to report to their assigned stations. The staff will work as a team to coordinate activities and directions. In case of evacuation of patients from the Center to another location, or evacuation from Center premises, the Center Administrator or his/her designee will authorize the movement of patients.

5. The disaster plan shall be rehearsed at least twice a year. The drills, which should be realistic, must involve the medical staff, as well as administration, nursing and other Center personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills shall be made.

6. Fire Drills shall be performed quarterly.

7. Each member of the Medical Staff and Allied Health Professional Staff will participate in an initial orientation concerning the Environment of Care and participate in drills as appropriate.

SECTION VI

K. Surveillance, Prevention, and Control of Infection

1. The Infection Preventionist has the authority to institute any appropriate control measures or studies when it is reasonably felt that there is existing danger to patients, visitors, or

personnel.. The Infection Preventionist may place any patient in isolation precautions without the order or approval of the procedural practitioner.

2. The Infection Control Plan and effectiveness of systems shall be reviewed annually.

3. The Medical Director/Center Administrator shall make recommendations regarding the amount of time the infection control practitioner spends on surveillance, prevention and control of infection.

4. Each member of the Medical Staff is responsible for informing the Infection Preventionist of any infections that their patients develop post operatively.

5. Each member of the Medical Staff and Allied Health Professional Staff (the "Medical/Allied Staff") are required to provide information regarding their personal TB testing, and they must annually sign an acceptance or declination of the influenza vaccine. When the member of the Medical/Allied Staff decline annual influenza vaccination, they must provide a reason for declination.

6. Each member of the Medical/Allied Staff MUST follow the Center's Infection prevention policies and procedures, including appropriate hand hygiene.

7. Each member of the Medical/Allied Staff MUST complete initial and annual education regarding principles of infection transmission and prevention.

SECTION VII

L. Quality Assessment and Performance Improvement ("QAPI")

1. All practitioners shall support and participate in the planned, systematic, organization wide approach to designing, measuring, assessing and improving organizational performance and patient care.

2. Continuing education shall be relevant to the patient care services provided and shall be based, to the degree possible, on the findings of Governing Board quality related activities. Documentation shall be maintained in the Center.

3. There shall be an annual review of the Medical Director's performance as it relates to his/her role as facility Medical Director, and his/her role on the MEC.

4. Peer Review will be part of the organization's ongoing QAPI program and shall be considered at time of reappointment.

SECTION VIII

M. Collaboration with Governing Board

1. The Medical Staff is accountable to the Medical Director, MEC and Governing Board for the quality of all medical care provided to patients and for the ethical conduct and professional practice of its members.

2. Each member of the Medical Staff and Allied Health Professional is expected to participate in the development of a "Culture of Safety".

3. The Medical Director shall communicate to the MEC and the Governing Board his/her recommendations for clinical privilege appointments, re-appointments, and termination of appointments.

4. The Medical Director shall communicate to the MAC and the Governing Board his/her findings, actions, and recommendations concerning efforts to improve organizational performance and assess/improve activities of practitioners with clinical privileges.

5. The Medical Director shall recommend to the MEC changes in Medical Staff Rules and Regulations.

6. The Medical Director shall review and recommend approval to the MEC and the Governing Board all patient care operational policies and procedures.

SECTION IX

N. Collaboration with Management and Administration

1. The Medical Director shall collaborate with Center management to achieve effective communication and efficient planning, directing, coordinating, providing and improving health care services.

2. The Medical Director is a member of the top leadership team and shall participate in strategic business planning, budgeting, and patient care reviews and new patient services.

3. All practitioners shall comply with requirements of the EDGE Risk Incident Reporting Program.

4. Emergency services involving basic life support and/or first aid measures shall be provided to visitors and staff members. The Center first responder protocols shall be followed. A medical record shall be prepared for all treatments.

5. The Medical Director shall regularly communicate with the Administrator in preparing, activating, and achieving the plan for staffing, Culture of Safety, and provision of care in a safe and efficient manner.

Approved by the Medical Director

By _____
Date _____

Approved by the Medical Executive Committee

By _____
Date _____

Approved by the Chairman of the Governing Board

By _____
Date_ _____