Health ONE Park Ridge Surgery Center

RULES AND REGULATIONS OF
THE MEDICAL STAFF OF

Health ONE Park Ridge Surgery Center

Usted tiene derecho a:

- Una atención considerada, respetuosa y digna y a que se respeten sus valores personales, creencias y preferencias.
- Acceso a tratamiento sin discriminación por raza, origen étnico, origen nacional, color, credo/religión, sexo, edad, discapacidad mental o discapacidad física. Cualquier determinación de tratamiento basada en el estado físico de una persona o su diagnóstico se realizará basándose en evidencias médicas y en la capacidad de tratamiento.
- Respeto de la privacidad personal.
- Recibir atención en un ambiente seguro.
- Ejercer sus derechos sin estar sujeto a discriminación o represalias.
- Conocer la identidad de las personas que le proporcionan atención, tratamiento o servicios y, al cuando lo solicite, a obtener información sobre las credenciales de los proveedores de atención médica y, si correspondiera, la falta de cobertura por malapraxis.
- Esperar que el centro divulgue, cuando corresponda, los intereses financieros del médico o su propiedad en el centro.
- Recibir asistencia cuando solicita un cambio en médicos de atención primaria o especialistas o dentistas si otro médico o dentista afiliado está disponible.
- Recibir información sobre el estado de salud, el diagnóstico, el pronóstico esperado y los resultados esperados de la atención, en términos que puedan ser comprendidos, antes de la realización de un tratamiento o procedimiento.
- Recibir información acerca de resultados no esperados de la atención.
- Recibir información del médico acerca de cualquier tratamiento o procedimiento propuesto según sea necesario para dar o retener el consentimiento informado.
- Participar en decisiones acerca de la atención, tratamiento o servicios planificados y rechazar la atención, tratamiento o servicios, según las leyes y reglamentos.
- Ser informado, o cuando corresponda, que su representante sea informado (según lo permita la ley estatal) sobre sus derechos antes de que se le preste o discontinúe la atención al paciente siempre que sea posible.
- Recibir información de forma adaptada a su nivel de comprensión, incluido el ofrecimiento de asistencia de interpretación o dispositivos de asistencia.
- Que su familia esté involucrada en su atención, tratamiento o decisiones sobre los servicios hasta donde lo permita usted o la persona que toma decisiones por usted, según las leyes y reglamentos.
- Contar con la debida evaluación y control del dolor, información sobre el dolor y medidas para el alivio del dolor, y participar en las decisiones relacionadas con el control del dolor.
- Dar o retener el consentimiento informado para producir o usar grabaciones, filmaciones u otras imágenes con fines que no sean los de la atención y solicitar la cesación de la producción de las grabaciones, filmaciones u otras imágenes en cualquier momento.
- Estar informado sobre y permitir o rechazar cualquier experimento en seres humanos u otros proyectos de investigación/educativos que afecten la atención o el tratamiento.
- Confidencialidad de toda la información relativa a la atención y estadía en el centro, incluidos los registros médicos y, excepto según lo exija la ley, el derecho a aprobar o rechazar la divulgación de sus registros médicos.
- Acceder a y/o copiar sus registros médicos dentro de un plazo razonable y la capacidad de solicitar modificaciones a sus registros médicos.
- Obtener información o divulgaciones de información de salud en un plazo razonable.
- Tener instrucciones anticipadas, como testamento vital o poder legal para la atención médica y ser informado sobre la política del centro en relación con las instrucciones anticipadas/testamento vital. Esperar que el centro proporcione el formulario de instrucciones anticipadas oficial del estado si se solicita y en donde corresponda.
- Obtener información sobre las tarifas para los servicios prestados y las políticas de pago del centro.
- No sufrir restricciones en ninguna forma que no sea médicamente necesaria o que el personal utilice como medio de coerción, disciplina, conveniencia o represalia.
- Esperar que el centro establezca un proceso para la pronta resolución de las reclamaciones de los pacientes y para informar a cada paciente a quién contactar para presentar una reclamación. Poder expresar en cualquier momento reclamaciones/quejas y sugerencias con respecto al tratamiento o atención que sea (o no sea) proporcionado.
  Las reclamaciones se pueden presentar directamente ante la agencia estatal utilizando la siguiente información de contacto.

Usted es responsable de:

- Ser considerado con los demás pacientes y con el personal y ayudar en el control del ruido, el consumo de tabaco y otras restricciones.
- Respetar la propiedad de los demás y del centro.
- Identificar cualquier problema de seguridad de los pacientes.
- Respetar las reglas indicadas del centro durante su estadía y tratamiento.
- Contar con un adulto responsable para trasportarlo a su casa desde el centro y para que permanezca con usted por 24 horas si su médico lo indica.
- Informar si comprende claramente o no el curso de tratamiento planificado y qué se espera de usted y hacer preguntas cuando no comprenda su atención, tratamiento o servicio o lo que se espera que haga.
- Asistir a las citas y, cuando no pueda hacerlo por cualquier razón, notificar al centro y al médico.
- Proporcionar a los cuidadores la información más precisa y completa en relación a las quejas actuales, enfermedades pasadas y hospitalizaciones, medicamentos, cambios inesperados en su afección o cualquier otro problema de salud del paciente.
- Cumplir en tiempo y forma sus obligaciones financieras con el centro, incluidos los cargos no cubiertos por el seguro.
- Pago al centro por copias de los registros médicos que solicite.
- Informar a sus proveedores sobre cualquier testamento vital, poder de representación médica u otra instrucción anticipada que pudiera afectar su atención.

Puede ponerse en contacto con las siguientes entidades para expresar cualquier inquietud, quejas o reclamación que pueda tener:

CENTRO	Tracie Johanek, Administradora **(303) 792-2422**
AGENCIA ESTATAL	Attn: Howard Roitman, Division Director Colorado Dept. of Health Health Facilities and Emergency Medical Services Division 4300 Cherry Creek Drive South Denver, CO 80246 **(303) 692-2000** Así como también La junta de supervisión correspondiente en el Departamento de Agencias Reguladoras (DORA)
MEDICARE	**Oficina del Ómbudsman del beneficiario de Medicare:** **www.cms.hhs.gov/center/ombudsman.asp o llame al** **1-800-633-4227. Si tiene problemas auditivos, llame a la línea TTY/TDD gratuita al 1-877-486-2048.**

Firma del paciente: _____

Fecha: _____

Firma del testigo: _____

Fecha: _____

Health ONE Park Ridge Surgery Center

A. PURPOSE

1. Generally these rules and regulations are intended to establish guidelines for the conduct of and processes relating to Practitioners and other health care professionals who have applied for or been granted Medical Staff appointment and/or clinical privileges by the Medical Executive committee and Governing Body of Park Ridge Surgery Center. These Rules and Regulations are intended to establish guidelines for the provision of professional services in the Surgery Center.

2. Additional Rules:
   These Rules and Regulations are intended to inform appointees to the surgical center's Medical Staff of certain policies, procedures, rules, regulations guidelines, and requirements, which apply to them. There may be additional policies, procedures, rules, regulations, guidelines and requirements, which apply to such Staff appointees, and it is each Staff appointee's sole responsibility to obtain, read, understand, and abide by all bylaws, policies, procedures, rules, regulations, guidelines, and requirements of the Surgery Center and its Medical Staff.

3. These rules and regulations and all other bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Surgery Center and/or its Medical Staff, which may apply to applicants and/or appointees to the Surgery Center's Staffs are unilateral expressions of the current requirements of, and policies and procedures established by the Surgery Center relating to applicants and appointees to its Staffs. These Rules and Regulations and all other bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Surgery Center do not constitute a contract of any kind whatsoever. Applicants and appointees to the Surgery Center shall not rely on the statements contained in these Rules an Regulations, and/or all other bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Surgery Center and/or its Medical Staff as they are subject to change at any time. These Rules and Regulations and all other bylaws, policies, procedures, rules, regulations, guidelines, and requirements of the Surgery Center and/or its Medical Staff shall be interpreted, applied and enforced within the sole discretion of the Surgery Center or those individuals delegated responsibility for interpretation, application or enforcement of them by the Governing Body and Medical Executive Committee, or under these Rules and Regulations or other bylaws, policies, procedures, rules, regulations, guidelines and requirements of the surgery center and its Medical Staff.

B. ADMISSION AND DISCHARGE OF PATIENTS

1. The Center shall accept only those categories of patients whose requirements for care are compatible with the facility's equipment and the capability of the Center's personnel. Refer to facility policy regarding appropriate patient selection. Only patients whose expectation of duration of services would not exceed 24 hours will be admitted

2. Only a member of the Medical Staff shall admit a patient to the Center. All practitioners with admitting privileges shall be governed by the Centers admitting policy. Patients shall be admitted to the Center for treatment without regard to race, color, religion, sex or national origin.

3. Patients scheduled to have general anesthesia, supplemental local anesthesia, or intravenous sedation

must be accompanied, upon admission and discharge, by a "responsible individual" licensed to drive a motor vehicle unless exempted by the attending physician.

4. A member of the Medical Staff shall be responsible for:
    - The medical care and treatment of each patient in the Center.
    - The timely and accurate completion of the medical record.
    - Special / unusual patient care instructions.
    - Reports on a patient's condition to the referring practitioner and relatives of the patient.
    - Notifying the Center of complications or infections that occur after discharge from the facility

5. Whenever patient care responsibilities are transferred to another medical staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records by the transferring physician.

6. No patient shall be admitted to the Center until a provisional diagnosis or valid reason for admission has been documented.

7. Each practitioner must provide competent professional care of his / her patients.

8. It is a Medical Staff policy that there be written orders from the attending practitioner for any patient (s) admitted to the Center with regard to a specific examination or non-routine laboratory work, x - rays, electrocardiograms, etc. Patients may have an EKG performed at the discretion of their attending physician or anesthesiologist. There shall be no routine pre-operative laboratory requirements. Diagnostic studies may be performed at the discretion of the attending physician or anesthesiologist, based on the patient's health status. Standing orders may be utilized if on file with the facility. This shall be signed and dated by the medical staff member treating the patient.

9. All patients transferred to an inpatient facility shall be arranged by the attending practitioner though direct contact with the receiving facility. This practitioner shall also be responsible for informing the patient's family or significant other of the impending transfer. The inpatient facility should be certified by CMS as a Medicare provider.

10. Patients shall be discharged only after a written order by the attending practitioner or Medical Director. Patient's leaving the Center against the advice of their physician, and without a documented discharge order, shall have a notation of the incident made in the medical record.

11. In the event of a patient death, the deceased shall be pronounced dead by the attending practitioner or his / her designee. The body shall not be released until an entry has been made in the medical record and signed by a member of the Medical Staff. Approval by the Medical Examiner's Office is necessary to release the body to the funeral director.

12. The admitting physician must remain in the building until his/her patient is received in PACU.

C. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include:
    - Identification data.
    - Chief complaint.
    - Personal history.
    - Evidence of Informed Consent
    - History of present illness or condition for which treatment / procedure is scheduled.
    - Physical examination.
    - Special reports such as consultations.
    - Clinical laboratory and radiology services.
    - Provisional diagnosis.
    - Medical or surgical treatment.
    - Operative report.
    - Pathological findings.
    - Condition on discharge.
    - Autopsy report, if performed.

2. An admission history and physical examination shall be recorded prior to the start of any procedure. This report shall include findings from a review of pertinent body systems which includes:
    - Chief complaint
    - Details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral and social status
    - A review of the patient's pain history and an assessment of the patient's current pain
    - All relevant past medical, social, and family histories
    - Inventory of body systems
    - A comprehensive, current physical examination
    - Clinical impression
    - Plan of care

    If a complete History and Physical examination was performed in the office of the attending or admitting practitioner within the thirty (30) days prior to the patient's admission to the surgery center, a reasonably durable and legible copy of these reports may be used in the patient's medical record in lieu of the admission History and Physical as the current History and Physical. However, if the History and Physical examination was performed more than seven (7) days prior to the Patient's admission to the surgery center, an addendum must be submitted that includes all additions or subsequent changes to the History and Physical. This copy and the addendum must

be submitted and authenticated by the attending physician before any surgery or diagnostic intervention.

For all of these circumstances, the copy of the History and Physical must be signed by an Appointee to the Medical Staff with an interval admission note that includes all additions to the History and Physical.

3. When the history and physical examination are not recorded before a surgical or diagnostic procedure, the procedure shall be postponed pending receipt of documentation, except in the case of an emergency. Only in cases where the attending practitioner states in writing that such delay would be detrimental to the patient shall the case proceed.

4. Personnel employed by Medical Staff members specifically trained and approved to perform history and physical examinations may do so as long as the attending practitioner countersigns the findings, conclusions and assessment of risks thereby endorsing the document.

5. Consultations shall show evidence of:
    - A review of the patient's record by the consultant
    - Pertinent findings on examination of the patient
    - The consultant's opinion and recommendations

    This report shall be made a part of the patient's record.

6. Symbols and abbreviations shall have only one meaning and may be used only when the Medical Staff has approved them. An official record of approved abbreviations shall be kept on file in the facility.

7. The attending physician must establish a primary diagnosis, which shall be recorded in full. These entries must be timed and signed by the responsible practitioner at the time of patient discharge.

8. The Practitioner must enter a brief operative progress note in the Medical Record immediately after the procedure, providing sufficient and pertinent information for use by any Practitioner who is required to attend the patient. The complete report must be written or dictated immediately following the procedure, authenticated by the surgeon and filed in the medical record as soon as possible after surgery. Operative and major procedures require reports that must contain as applicable, the following:
    (1) Name of primary surgeon and assistants
    (2) Findings
    (3) Technical procedures used

(4) Specimens removed
(5) Postoperative diagnosis

9. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information in accordance with HIPAA guidelines, regulations and facility policy.

10. Records may be removed from the Center's jurisdiction only in accordance with a court order, subpoena or statute in accordance with HIPAA guidelines, regulations and facility policy. All records are the property of the Center and shall not be removed from the premises without permission of the Administrator. In the case of re - admission of a patient, all previous records shall be available for the use of the attending practitioner or another physician assigned to that patient's care. Unauthorized removal of charts from the Center is grounds for suspension, the terms of which shall be determined by the Medical Executive Committee.

11. All members of the Medical Staff shall have access to medical records for requirements such as committee work, quality review studies or for specific review and monitoring requested by the Medical Executive Committee. Records must be handled in such a manner so as to preserve the confidentiality of individual patient information.

12. In the event that a medical record remains incomplete by reason of death, resignation, or the inability or unavailability of the responsible practitioner to complete a record, the record will be submitted to the Medical Executive Committee who shall consider the circumstances and may enter such reasons in the record and order it filed. A medical record shall not be permanently filed until it is completed by the practitioner, or is ordered to be filed as if complete by the Medical Executive Committee.

13. A practitioner's routine standing order shall be reproduced in detail on the order sheet of the patient's record and dated and signed by the practitioner.

14. At the time of discharge the patient's medical record shall include the surgical / diagnostic procedural notes and final diagnosis. The written or dictated operative report must be completed within 24 hours of the procedure. The written or dictated operative report, any final laboratory results, or other essential reports not available at the time of discharge shall be added immediately upon receipt. If the record remains incomplete thirty (30) days after receipt of all reports, the Administrator shall notify the practitioner that his / her privileges to admit patients shall be suspended until the records have been completed. A practitioner will automatically be temporarily suspended in the form of withdrawal of his admitting, surgical, and / or clinical privileges thirty (30) days after he is given a warning of delinquency for failure to complete medical records. The temporary suspension will continue until the medical records are

completed, unless there are known extenuating circumstances or practitioner provides a justifiable rationale to the Medical Director. If the medical records are not thereafter completed within ninety (90) days, following written warning of delinquency of medical records, all admitting, surgical, and / or clinical privileges of the practitioner will be permanently suspended, and the appropriate State Board of Examiners will be notified of non-compliance and suspension. Should the practitioner wish to be re - appointed to the medical staff, he or she must re - apply for staff privileges. The scheduling and business office shall also be notified of this action. This shall apply to all Medical Staff members.

15. All HIPAA regulations which include but are not limited to consents, patient notification and releases will be strictly enforced, adhered to and followed.

17. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted access to information from the medical records of their patients, covering periods during which they attended patients in the Center.

18. No practitioner shall prescribe or treat employees of the Center without utilizing an appropriate patient record. Practitioner shall exercise only those clinical privileges or specific services specifically granted to him/her by the Governing Body.

D. GENERAL CONDUCT OF CARE

1. A general consent form signed by, or on the behalf of, every patient admitted to the Center shall be obtained at the time of admission. The admitting person shall notify the attending practitioner whenever consent has not been obtained. When so notified, it shall be the practitioner's obligation to obtain informed consent before the patient may be treated at the Center.

2. All orders for treatment shall be in writing. A verbal order shall be handled the same as one in writing, if dictated to a duly authorized person. An authorized person shall be a registered nurse. All orders dictated over the telephone shall be signed by the authorized person with the name of the practitioner and his / her own name. The practitioner shall authenticate such order as soon as possible. All standing orders must be signed as soon as possible after the order has been given. Failure to do so shall be brought before the Medical Executive Committee for appropriate action.

3. Any drugs ordered verbally by the responsible practitioner during local IV sedation shall be documented on the anesthesia record when / as given by the monitoring RN. The responsible practitioner shall sign this order immediately post - operatively.

4. A practitioner's order must be legible and complete. Orders, which are illegible or improperly written, shall not be carried out until clarified by a registered nurse.

5. All drugs and medications administered to patients shall be those recommended by the Medical Executive Committee and approved by the Governing Body. Requests for additions to or deletions from the formulary should be submitted to the Medical Executive Committee listed in the latest edition of one of the following: United Stated Pharmacopoeia, National Formulary, American Hospital Formulary or AMA Drug Evaluations.

6. Any practitioner with clinical privileges in this Center can be called for consultation within his/ her area of expertise.

7. The good conduct of medical practice shall include the proper and timely use of consultation. Judgment as to the serious nature of the illness and the question or doubt as to the diagnosis and treatment rests with the practitioner responsible for the care of the patient. It is the duty of the Medical Executive Committee to see that those with clinical privileges do not fail in the matter of calling consultants as needed. Consultation shall be requested in the following situations:
    a. When the patient is not an acceptable risk for the operation or treatment
    b. When the diagnosis remains obscure after ordinary diagnostic procedures have been completed
    c. When there is doubt as to the choice of therapeutic measures to be utilized
    d. In unusually complicated situations where specific skills of other practitioners may be needed
    e. When requested by the patient or the family

8. The attending practitioner shall be responsible for requesting a consultation when indicated and for designating who he / she feels is a qualified consultant. The practitioner shall provide written authorization permitting another practitioner to examine his / her patient. Only in an emergency shall this written authorization be dismissed. The initial attending practitioner shall remain responsible for the patient's care, unless such care is transferred to another practitioner. The successor practitioner must place evidence of acceptance of the transfer of care must be placed in the patient's medical record.

9. When a nurse questions the care provided to any patient, or has reason to believe that a consultation is needed and not obtained, he / she shall notify the Clinical Nurse Manager of that area or the Center Administrator. The Administrator may bring the matter to the attention of the Medical Director. When circumstances dictate, the Medical Director may personally request a consultation.

10. There shall be no unlawful division of fees.

11. No practitioner shall prescribe or treat employees of the Center without utilizing an appropriate patient record.

12. All specimens shall be sent to the contracted certified pathology groups, except for special circumstances and as otherwise noted by the facilities "exempt specimen list."

13. To provide for a quality peer review, an Active Staff Physician must complete twenty (20) cases within a two-year period in order to qualify for reappointment.

14. To provide for a quality peer review, a physician must complete ten (10) cases within a 12-month period in order to qualify to move from Provisional Status to Active Status.

E. GENERAL RULES REGARDING SURGICAL CARE

1. Policies, regulations and rules for the surgical suite shall include:
    a. Reservations for operations
    b. Information required in making the reservation
    c. Change of schedules
    d. Requirements prior to anesthesia and operating, including:
        1. Preoperative evaluation and documentation review done in operating suite to include review of the patient's present condition and medical record content, including diagnosis, laboratory procedures and informed consent, history and physicals and final diagnosis
        2. Positive identification of the patient
        3. Time of admission to operation suite

    e. Charting requirements in the operating suite, including documentation of verbal orders and maintaining the OR Record
    f. Care and transportation of patients:
        1. To the surgical suite
        2. Within the surgical suite
        3. To the recovery room
        4. To progressive recovery
    g. Efficient utilization of operating rooms
    h. Appropriate handling of contaminated cases
    i. Temperature and humidity control
    j. Trace gas analysis, ambient air testing
    k. Biomedical testing
    l. Sterilization / disinfecting of surgical instruments
    m. Proper surgical attire and observation of all rules of sterile technique and universal safety precautions

2. The preoperative diagnosis, history and physical exam, indications for surgery and ordered laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be postponed.

3. A written, signed, informed surgical consent will be obtained prior to the operative procedure, except in those situations where suitable signatures cannot be obtained due to the patient's condition. In emergencies, involving a minor or unconscious patient, and when consent for surgery cannot be obtained from parents, guardian or next of kin, full documentation of the circumstances under which the surgery occurred must be recorded in the patient's record. If time permits, a consultation may be desirable before the emergency operative procedure begins.

4. The anesthesiologist or the anesthetist shall maintain a complete anesthesia record to include:
    - Documentation of pre - anesthetic evaluation
    - Obtaining a written Informed Anesthesia Consent
    - Intra - operative course
    - Post - anesthetic follow - up for the patient's condition

All medications administered during the course of an anesthetic shall be recorded on the anesthetic record. The purpose of this record shall be to correlate changes in the patient's condition and vital signs with pharmacological interventions, whether the surgeon or the anesthesiologist initiates these interventions. The presence on the anesthesia record of a medication, which was administered by or on the order of the surgeon, shall in no way imply that the anesthesiologist verified the administration or the dosage of this medication, merely that the anesthesiologist has received a communication that the medication was given to the patient. This applies specifically to local anesthetics and topically - applied controlled substances. The anesthesiologist shall neither be responsible for signing nor for witnessing the wastage of a controlled substance that has been administered by a surgeon.

5. The Medical Director has the authority to define what is a life-threatening situation. The Medical Director may delegate the responsibility for deciding if additional physicians shall be needed to assist those with surgical privileges. The Medical Director shall monitor the surgical case log to oversee adherence to this standard and shall consult with the Administrator as needed regarding violation of this rule.

6. All specimens removed during surgery, except for those listed on the facilities "exempt specimen list", shall be sent to the contracted Center pathologist who shall make any necessary examinations of the tissue to arrive at a diagnosis. His / her authenticated report shall be made a part of the patient's medical record. Decisions on specimen exemptions shall be recommended by the Medical Executive Committee and approved by the Governing Body.

7. The immediate post - operative observation of the patient shall be conducted in the recovery room. A registered nurse shall remain in close observation of the patient at all times. There must be continuous observation and recording of the patient's condition including level of consciousness,

infusions, vital signs, the condition of any dressing, tubes, catheters, drains or any complications. Following the initial acute recovery phase the patient may proceed to the progressive PACU under the observation of a registered nurse until discharged. Each patient shall remain in the Center until that patient meets the criteria for medical discharge.

F. EMERGENCY and DISASTER PREPAREDNESS

The Center shall have an Emergency Preparedness Plan for the care of an internal or external disaster or emergency. This plan shall incorporate center personnel from all areas. A formal evacuation plan, employee responsibilities and center preparedness are covered in the Center's policies and procedures under "Evacuation Plan". The Evacuation Plan will be performed at least once annually during normal center operating hours.

G. ACCOUNTABILITY AND LEGAL REQUIREMENTS

1. The Center and the Medical Staff shall adhere to all of the legal requirements of the State of Colorado.
2. The Governing Body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality healthcare in a safe environment. The Governing Body assumes full legal responsibility for the health care services of the center.
3. Each member of the medical staff, as well as Advanced Practice Professionals, must possess malpractice insurance in the amount of $1 million Comprehensive General Liability / $3 million Health Care Professional Liability.
4. The medical staff will actively participate in the Quality / Performance Improvement program and activities of the facility in order to assure quality of care. Active Medical Staff members must participate in peer review if requested to do so.
5. Active Medical Staff members must have medical staff privileges at Sky Ridge Medical Center

H. SUPERVISORY RADIOLOGIST

1. The center will maintain, or have available, diagnostic radiologic services. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.

    (a) *Standard: Radiologic services.* The center will maintain, or have available, radiologic services according to needs of the patients.

    (b) *Standard: Safety for patients and personnel.* The radiologic services, particularly ionizing radiology procedures, will be free from hazards for patients and personnel.

        (1) Proper safety precautions will be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as

appropriate storage, use, and disposal of radioactive materials.

(2) Periodic inspection of equipment will be made and hazards identified will be promptly corrected.

(3) Radiation workers will be checked periodically, by the use of exposure meters or badge tests, for amount of radiation exposure.

(4) Radiologic services will be provided only on the order of practitioners with clinical privileges or, consistent with State law, of other practitioners authorized by the medical staff and the governing body to order the services.

(c) *Standard: Personnel.* (1) A qualified full-time, part-time, or consulting radiologist will supervise the ionizing radiology services and will interpret only those radiologic tests that are determined by the medical staff to require a radiologist's specialized knowledge. .

(1) Only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures.

(d) *Standard: Records.* Records of radiologic services will be maintained.

(1) The radiologist or other practitioner who performs radiology services will sign reports of his or her interpretations.

(2) The center must maintain the following for at least 5 years:

(i) Copies of reports and printouts.

(ii) Films, scans, and other image records, as appropriate.

Adopted by the Medical Executive Committee for the Medical Staff of Park Ridge Surgery Center, on 28th of January 2015.

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Chairperson, Medical Executive Committee

Adopted by the Governing Body on the 28th of January, 2015

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Chairperson, Governing Body