Department Rules and Regulations
of the Medical Staff – OB/GYN
of
Providence Saint John's Health Center

Obstetrics and Gynecology
- General Guidelines
- Peer Review
- Proctoring/FPPE

1. The prenatal records must be available in EPIC when a patient is admitted in labor and an admitting note must be written by the attending physician describing any historical changes, unusual problems, and currently significant physical findings.

2. On admission, blood will be drawn for determination of blood group and type if this is not recorded on an available medical record, on all women in labor or with incomplete, threatened or missed abortion, and a blood sample will be held in the Blood Bank for cross-match with the Rho Immune Globulin, should this be necessary.

3. A dictated note describing the labor and delivery for all deliveries including operative vaginal and cesarean section is required immediately following delivery.

4. Delivery records and post-partum orders are to be completed immediately after delivery and the patient shall not be transferred from the Obstetrical Recovery Room until this has been done.

5. Cord blood will be drawn on all newborns in the delivery room for such laboratory studies as may be required.

6. Babies shall be isolated from mothers who have known communicable diseases or undiagnosed fevers.

7. Mothers with known communicable diseases will be transferred from the maternity area.

8. General or regional anesthesia is to be administered by members of the Anesthesiology Division, or by those approved by that section. The obstetrician should only administer such anesthetics in an emergency. The anesthesiologist shall be responsible to monitor the vital signs of the patient while she is in the Labor or Delivery Room, and they will assist with newborn resuscitation, if necessary. Pudendal, local or para-cervical anesthesia nay be given by the obstetrician in the delivery area. Epidural anesthesia may be administered to a patient in labor at the obstetrician's order as long as the obstetrician is readily available.

9. Oxytocic Agents
    a. Oxytocic agents shall be used during labor only if the attending physician or registered nurse gives evidence of having examined the patient on the day of induction and the physician gives orders for induction.
    b. Intravenous oxytocic agents shall be used during labor only if a qualified observer can stay with the patient or if a physician qualified to conduct the labor and delivery and to deal with any complications that may result from the use of the oxytocic agent is readily available. Oxytocic intravenous drips will be given only through microdrip devices or controlled measuring devices.

10. If a physician does not order the administration of Rho Immune Globulin to parturients or aborters when indicated by laboratory studies, they shall record the circumstances and reasons on the patient's medical record.

11. The physician who delivers a newborn shall be responsible for the care of the infant until the services of an attending pediatrician or physician with pediatric privileges have been assured.

12. Cord gases are recommended in circumstances; if there is no documentation of the reason for lack of order, case will be referred for peer review:
    a. 5 minute APGAR < 7
    b. Shoulder dystocia
    c. Operative vaginal delivery
    d. Category 3 fetal heart rate tracing
    e. Fetal bradycardia

f. Minimal/absent variability
g. Placental abruption
h. Uterine rupture
i.. Emergent cesarean section

13. Consultation is required in the following conditions for all practitioners except those who have been granted consultation privileges in the Department of Obstetrics and Gynecology:
    a. Prior to any obstetrical operation including cesarean section, with the exception of episiotomy or prophylactic use of low forceps or vacuum extraction;
    b. The use of antepartum oxytocic agents;
    c. In cases in which the patient has been in active labor without normal progress, or in which the patient has not delivered within 24 hours after rupture of placental membranes;
    d. In all cases of toxemia;
    e. When a patient shows evidence of abnormal bleeding before, during or after parturition;
    f. In abnormal presentations, including breech;
    g. In post-partum obstetrical complications;
    h. Prolapse of umbilical cord during labor or delivery;
    i. Persistent signs of fetal distress during labor; or
    j. Vaginal deliveries planned for patient who has had a previous cesarean section.

14. Members of the Family Medicine Section, who have privileges for obstetrical primary care only, must obtain consultation and assure on-site or ready availability of an obstetrician, who has consulting privileges, prior to the use of oxytocic agents for the induction of labor and prior to the use of general or regional anesthesia for any obstetrical procedure.

15. If the results of a hepatitis B surface antigen test are not documented on an obstetrical patient's prenatal record when the patient is admitted, the test will be performed at the time of admission.

16. For labor patients presenting for vaginal delivery, the patient's prenatal record may be used for an admission H&P but the physician must write an interval note upon admission.

17. All physicians with delivery privileges shall have remote access to EPIC and OBIX. If remote access is not obtained, physicians must be present in Labor and Delivery for the duration of labor.

Peer Review: The Women's Health Peer Review Committee (WHPRC) shall conduct a review of all cases relevant to obstetrical and gynecologic care referred consistent with the Medical Staff Peer Review/Performance Improvement Plan. The Committee shall report to the Obstetrics and Gynecology Committee.

Focused Professional Practice Evaluation (FPPE): See Medical Staff FPPE policy.