GENERAL
I) ADMITTING AND DISCHARGE

01) **ADMISSION OF PATIENTS**

a) Patients may be admitted only by Physicians who have submitted proper credentials, and have been duly appointed to membership on the Professional Staff as outlined in the Medical Staff Bylaws.

b) Physicians admitting patients to the hospital must provide a provisional diagnosis and are responsible for the history and physical. A provisional diagnosis for emergency admissions shall be provided as promptly as possible. They should be as complete and accurate as possible listing all patient medications taken at home prior to admission. This listing must be reviewed and reconciled by the admitting Physician along with any new medication orders. In addition, the hospital must be provided with such information as is necessary to assure the protection of others in the hospital from any danger whatsoever from the incoming patient.

c) If a patient is admitted to the hospital for treatment of a dental problem, the dentist's name will be included on the face sheet as a co-admitter.

d) All patients admitted to the hospital will be seen within twelve (12) hours or sooner if warranted by the patient's condition.

e) A member of the Medical Staff shall be responsible for the diagnosis, medical care and treatment of each patient in the Hospital. Whenever these responsibilities are transferred to another staff member, the Physician transferring the care should contact the Physician the care is being transferred to in order to exchange pertinent patient information and assure that the transfer of care has taken place. A note covering the transfer of responsibility shall be documented in the medical record.

f) The attending Physician shall keep the patient and the patient's family informed concerning that patient's condition throughout the patients term of treatment. The attending Physician and hospital staff shall ensure that the patient (or appropriate family member or legally designated representative) is provided with information that includes, but is not limited to, the following:

(1) Conditions that may result in the patients transfer to another facility or level of care.
(2) Alternatives to transfer, if applicable.
(3) The clinical basis for the discharge.
(4) The anticipated need for continued care following discharge.
(5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the hospital.
(6) Written discharge instructions in a form and manner that the patient or family member can understand.

02) **CASE MANAGEMENT**

a) The attending practitioner is required to document the need for continued hospitalization daily after specific periods of stay (per disease categories) as identified by Case Management and/or the documentation specialist and approved by the particular clinical division and the

Executive Committee of the Professional Staff. The documentation must contain the following:

(1) An adequate written record of the substantiating the need for continued stay. A simple reconfirmation of the patient's diagnosis is not sufficient.
(2) The estimated period of time the patient will need to remain in the Hospital.
(3) Plans for post-hospital care.
(4) If a Physician receives a quality of care letter from a fiscal intermediary, he/she must forward a copy of this letter to the Case Management Department.
(5) If any questions as to the validity of admission or to discharge from the facility should arise, the subject shall be referred to the Physician Advisor for assistance.
(6) The attending Physician is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This document must contain the following:
    (a) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate.
    (b) Estimate of additional length of stay the patient will require.
    (c) Plans for discharge and post-hospital care.
(7) Upon request of the Utilization Management Committee and or other committee responsible for Case Management, the attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within a reasonable period of time. Failure to comply with this policy will be brought to the attention of the MEC for action.
(8) The discharge policy is as follows:
    (a) Patient shall be discharged only on order of the attending Physician. The discharge process and corresponding documentation shall provide for continuing care based on the patient's assessed needs at the time of discharge. Should a patient leave the hospital against the advice of the attending Physician or without proper discharge, a notation of the incident shall be made in the patient's medical record by the attending Physician. In addition to this, the patient or responsible party will be asked to sign a release absolving the Hospital and practitioner from responsibility for any liability connected with unauthorized departure of the patient.
(9) If any questions as to the medical necessity of admission to or discharge from the facility would arise, the subject shall be referred to Case Management and the Utilization Review Physician Advisor for assistance.

03) **ADMISSION OF PATIENT TO SPECIAL CARE UNIT(S)**

a) Intensive Care Unit (ICU)
    (1) Admission to the ICU will be based on the needs of the patient for specialized nursing and the need for monitoring or supportive technologies that are not available on other nursing units.
    (2) Patients may be transferred to or admitted to other nursing units at the discretion of the Chair of the Critical Care IDT and/or his/her designee or the nursing supervisor if another

patient is judged to have a greater need for the specialized services of the ICU. The attending Physician will be consulted by the nursing supervisor prior to transferring any patient out of the ICU to accommodate a patient with greater need.

(3) Patients must be seen by a Physician, either the attending Physician or a qualified consultant, e.g., critical care Physician, cardiologist, etc. within two hours of admission. Patients admitted to the ICU from the OR will have been assumed to have met this requirement.

(4) Admission to the PCU will be based on the needs of the patient for specialized nursing care and/or the need for telemetry monitoring that, in the judgment of the attending Physician cannot be accomplished on another nursing unit. Patients on this unit may have a variety of medical problems that requires a higher nursing to patient ratio than available on other floors. This is not limited to the need for telemetry monitoring. Patients should be admitted or transferred to other nursing units as soon as practical after their medical or nursing needs can be met on another nursing unit.

(5) Patients may be placed on other nursing units at the discretion of the Chair of the Critical Care IDT and/or his/her designee or the nursing supervisor if any patient is judged to have greater need for the specialized services in the PCU. The attending Physician will be consulted by the nursing supervisor prior to transferring any patient out of the PCU to accommodate a patient with greater need.

04) **ADMISSION AND DISCHARGE OF MENTALLY/EMOTIONALLY DISTURBED PATIENTS OR SUBSTANCE ABUSE**

a) Any patient admitted to the Hospital that is identified to have recent suicidal ideation, significant emotional distress or substance abuse problems shall have, a Physician order for a Psychiatric or Mental Health Professional (MHP) consult.

b) Valley Hospital and the Emergency Department are not designed for lengthy management of violent, psychiatric problems. A Mental Health Professional (MHP) or Psychiatrist will be notified as needed and arrangements will be made for transfer to an appropriate facility after initial medical screening and stabilization of any non-psychiatric medical condition. If admitted for a medical/surgical condition, the attending Physician should consider obtaining a psychiatric consultation or MHP evaluation as soon after the admission as possible.

c) If the patient presents to the emergency room the patient shall not be transferred without an appropriate medical screening examination, any necessary stabilizing treatment, and a certification, pursuant to the hospital's EMTALA policy, that the benefits or transfer outweigh the risks.

05) **OBSTETRICAL ADMISSIONS**

a) When the Obstetrics patient is admitted for signs of impending labor and delivery, an evaluation will be done by the Labor & Delivery Nurse, including the evaluation of maternal, fetal and labor situation. This will be communicated to the attending Physician. If the evaluation represents anything but a normal labor situation, evaluation by the attending Physician will be required.

06) **OUTPATIENT SERVICES**

a) To provide a service that allows admissions and discharge of patients on the same day, an Outpatient Surgery Program has been established. A copy of these guidelines will be available in the Outpatient Service Department.

07) **TRANSFER IN LEVEL OF CARE OR SERVICE**

a) All medication orders must be rewritten when the patient is transferred between different levels of care, between healthcare institutions, and following surgery. At the same time all current medication orders must be reconciled with the patient's listing of home medications. This new listing must be provided to the next provider of care.

II) CARE AND TREATMENT OF PATIENTS

01) **AUTOMATIC STOP ORDERS FOR MEDICATIONS**

a) The following automatic stop order policy on potentially dangerous drugs will be applied:
   (1) Physician's order should indicate:
      (a) Exact number of doses to be given.
      (b) Exact period of time (Days, Hours) medication is to be given.
      (c) Physician must reorder medication after the specific time or dose regimen has elapsed, or been administered.
   (2) Current medication orders will be automatically cancelled when a patient goes to surgery.
   (3) The Pharmacy is authorized under the Pharmacy & Therapeutics Committee to adjust medication therapy utilizing approved guidelines, upon consultation or Physician request. IV to PO conversions, renal dosage adjustment and warfarin monitoring and aminoglycoside dosing are included with this policy.

02) **CONSULTATION RULE AND CONCERNS FOR APPROPRIATENESS OF CARE**

a) Whenever any patient is found to have an admission, or subsequent to admission, a condition that is beyond approved privileges of the attending Physician, consultation by qualified Physician holding appropriate privileges is required. Consultation is encouraged when the consulting Physician is felt to have specialized expertise that may benefit the patient regardless if the attending Physician holds appropriate privileges.

b) Emergency treatment may be rendered by any member of the medical staff to any patient while attempting to secure appropriate consultation. The extent of the consultant's involvement and the transfer of attending status will be determined by mutual agreement between the consulting and attending Physician.

c) Requests for consultation require direct Physician to Physician (or their appropriate designees) contact, ideally by telephone or in person. It is not acceptable to request consultation solely by writing an order of request for consultation in the progress notes in the patient's chart. Such orders instructing the nursing unit staff to contact a Physician for consultation will not be acted upon and the Physician requesting consultation in such a manner will be contacted by the nursing unit staff and informed that they are expected to contact the consultant themselves. The requirement for consultation outlined in the first paragraph of this section will not be deemed met by writing an order for consultation or by requesting the consultation in the progress note.

d) Questions or concerns regarding the care being provided to a patient shall be addressed directly with the attending Physician or relevant consultant. If concerns persist after discussion with the relevant Physician, staff members are encouraged to bring their concerns to the nursing unit manager or charge nurse. If the nursing unit manager or charge nurse cannot resolve the concern after reviewing the care and/or further discussion with the attending Physician or consultants, the nursing supervisor should be notified. The nursing supervisor may refer the concern to the Chair of the appropriate IDT or the Chief of Staff or his or her designee if the concern cannot be resolved.

e) The Chief of Staff my transfer responsibilities for the care of a patient to another appropriately credentialed member of the medical staff if they determine that the patient's safety warrants such a transfer. Any action that results in such a transfer will be immediately referred to the Quality Council for consideration of peer review and the PRESIDENT or his or her designee will be notified.

03) **DESIGNATED ALTERNATE**

a) Each member of the Professional Staff shall name a member of the Professional Staff with equivalent scope of practice who may be called in case of emergency. In cases of failure to do so, the Chairperson of the appropriate IDT, or the Chief of Staff, has the authority to call any member of the staff should it be considered necessary.

b) Attending or Covering Physician will evaluate every patient on the day of admission and within one day of discharge. Each patient must be examined daily by the Attending Physician/Covering Physician or Credentialed APP provided they are under the supervision of the Attending/Covering Physician with authentication of note. If the patient's condition deteriorates, requires a higher level of care or becomes unstable, the patient will be evaluated by the Attending/Covering Physician as soon as reasonably possible.

04) **DIETARY CONSULTATIONS**

a) Dietary consultations will be obtained at the discretion of the attending Physician and/or dietitian, as per protocol. Guidelines are located in the Clinical Dietitians Office in the policies and procedures manual.

05) **INDUCTION OF LABOR**

a) Induction of labor will be conducted with accepted standards of care (See guidelines on the Obstetrics Unit which follow ACOG guidelines for accepted standard of care). The attending Physician shall evaluate the patient prior to induction or stimulation.

06) **INFECTIONS REQUIRING ISOLATION**

a) Isolation precautions, as established by the Infection Control Committee and the CDC, are to be followed. These guidelines are available on the Valley Hospital Intranet website in the Infection Control Folder under policy and procedures. Standard precautions are to be followed for all patients.

07) **REPORTING OF COMMUNICABLE DISEASE**

a) Communicable diseases will be reported (as per Spokane Regional Health District requirements), to the Health Department by the Infection Preventionist.

08) **MEDICATION STANDARDS**

a) The Valley Hospital will utilize the System Wide Formulary system for selection, review and utilization of medications. Non-formulary medication orders will be allowed upon submission of request to and review by the Pharmacy and Therapeutics committee, or according to policy. Medication orders must be hand printed (non-cursive) with a ball point pen or computer generated.

(1) All medication orders must be legible and include the following elements:

(a) Date and time order written.

(b) Name of medication, preferably by the generic name.

(c) Drug strength or dosage unit.

(d) Route of administration.

(e) Frequency or interval of administration. Orders for PRN medications must include a specified time interval.

(f) Indication for use is required for PRN, titrate, taper, or adjustment based upon indications or other parameters.

(g) Status of the order will be assumed to be routine unless indicated otherwise i.e. STAT, NOW, or ASAP.

(h) Pediatric orders should be approved dosage (mg per kilogram) and calculated dose.

b) The use of blanket statements of previous medication orders is prohibited. Approved pre-printed medication lists may be utilized to facilitate ordering previous medications.

c) Samples of medications supplied to Physicians may not be used on patients while in the hospital.

d) The patient's own medication can be utilized in the hospital only upon the order of a practitioner which includes the name of the medication and procedure for administration. Self-Administration of Medications (SAM) is limited to those indications or patients authorized by hospital policy.

e) The practice of using ranges for ordering medications is discouraged. PRN orders written for a frequency range (every 4-6 hours) will be converted to the lower frequency (every 4 hours).

f) Investigational Drugs and Protocols will only be used according to the Food and Drug Administration (FDA) regulations and protocols approval by the Spokane Institutional Review Board (IRB) and the Valley Hospital Professional Staff. Patient rights will be upheld through the informed consent process.

g) All additions to the Valley Hospital Formulary will be FDA approved entities.

09) **UNUSUAL OCCURRENCES, MEDICATION ERRORS AND ADVERSE DRUG REACTIONS**

a) Any unusual occurrence, including medication errors, adverse drug reactions, transfusion reactions and narcotic reversals affecting patient care will be reported to the attending Physician. An incident report form will also be completed and submitted for review and evaluation by the appropriate individuals committee. In the event of an unanticipated outcome or adverse event, the patient's treating and/or consulting Physician shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the hospital Policy on Disclosure of Treatment Outcomes.

10) **ORDERS FOR TREATMENT**

a) All orders for treatment shall be written or CPOE, dated, timed and authenticated. Advanced practice providers Staff may write orders according to privileges granted/scope of practice. Co-signatures of their supervising Physician will be required as outlined in the Valley Hospital Medical Staff, Advanced practice providers Staff Co-Signature policy. Verbal orders are discouraged except in emergent situations. A verbal order / telephone order shall be considered to be in writing if dictated to personal acting within the scope of their practice as permitted by law or to personnel who have been privileged by the Professional Staff to accept such orders. Verbal / telephone orders can only be accepted by such persons when they are acting within their sphere of competence. All verbal / telephone orders shall include the name of the ordering practitioner and shall be signed by the person to whom it was dictated. Verbal orders must be verified with the prescriber by a read back procedure. All practitioners are responsible for the timely authentication of their own orders and of the orders of Advanced practice providers Professionals they supervise.

b) Verbal orders are discouraged except in emergent situations. A verbal or telephone order shall be considered to be in writing if dictated to an R.N. and signed by the R.N. and countersigned by the physician giving the order. Registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists and CRNA's may accept verbal orders relating to their area of practice. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has written or otherwise recorded the order, and shall read the verbal order back to the physician and indicate that the individual has confirmed the order. The physician who gave the verbal order or another practitioner (who is credentialed and granted privileges to write orders) who is also responsible for the care of the patient shall authenticate date and time any order, including but not limited to medication orders, as soon as possible, such as during the next patient visit, and in no case longer than forty-eight (48) hours from dictating the verbal order. Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

c) Verbal orders are generally not be accepted for chemotherapy drug orders, investigational drug, and device or procedure protocols.

d) The treating Physician can sign date and time verbal / telephone orders issued by another Physician in their call group. A practitioner's pre-printed order, when applicable to a given patient, shall be reproduced in detail on the order sheet on the patient's record, dated and signed by the practitioner.

e) All tests and procedures ordered must be medically necessary and include diagnosis/therapeutic reason. Determination of medical necessity is the responsibility of the ordering Physician.

11) **ILLEGIBLE TREATMENT ORDERS**

a) The practitioner's orders must be hand printed (non-cursive) with a ball point pen or computer generated, written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

12) **PREVIOUS ORDERS**

a) All previous orders become null and void when a patient is transfer to a different level of care. Additionally, all previous orders are canceled when patients go to surgery.

13) **PRE-PRINTED ORDERS**

a) Pre-printed orders are orders written by the respective individual Physician or interdisciplinary teams. All pre-printed orders must be reviewed and approved by the hospital's forms committee and approved by the relevant IDT prior to use in the hospital. A six-month provisional period may be granted prior to final IDT approval. Provisional approval to be granted by the relevant IDT chair after review of other respective departments i.e. pharmacy, nursing, case management, medical records as determined by the IDT Chair.
b) Individual Physician's preprinted orders as reviewed by a registered nurse and registered pharmacist, printed by the hospital and available in patient care.
c) When pre-printed orders are utilized in the treatment of a patient, the Physician must request the use of pre-printed orders upon admission, specifically reviewing with the nurse the drug, dosage and diagnostic test(s) specific to the individual patient. The pre-printed orders will be signed, dated, time and authenticated promptly upon initiation of the orders.
d) Physician order sets will be researched, reviewed, revised and approved by the appropriate IDT, annually and/or when changes occur to determine the continuing usefulness and safety of the orders and protocols.

14) **ORDERING/DISPENSING OF DRUGS**

a) The Physician must order drugs by name, dose, route and frequency of administration. Drugs shall be dispensed from and reviewed by the hospital pharmacist, or as circumstances demand (i.e. exigent patient need, or unavailability of the pharmacist) another qualified health care professional, subject to retrospective review by the hospital pharmacist to determine:
   (1) The appropriateness of the Medication
   (2) Dose
   (3) Frequency
   (4) Route of administration
   (5) Therapeutic duplication
   (6) Real or potential allergies or sensitivities
   (7) Real or potential interactions between the prescribed medication and other medications and food
   (8) Other complications
   (9) Variations from hospital dispensing criteria
b) When the patient brings medication to the hospital with him/her, those mediations which are clearly identified may be administered by the nursing staff only if ordered by the Physician and verified and identified by the Pharmacist on duty. Upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations

from this rule and his/her decision shall be binding. Medications ordered to be "held" will be discontinued after twenty-four (24) hours in the absence of a "resume" order. The Physician must document in the medical Record a diagnosis, condition, and indication for use for each medication.

15) **RESTRAINTS: PHYSICAL (SEE COMPLETE PROCEDURE IN NURSING PROCEDURE MANUEL UNDER RESTRAINTS)**

a) The hospital policy will be adhered to.

16) **SUICIDAL PATIENTS**

a) All patients receiving treatment with a primary diagnosis or primary complaint of an emotional or behavioral disorder including those related to substance abuse or those that state a history of such will be screened for risk of suicide. If a patient is identified to be a risk for suicide, then suicide precaution interventions will be implemented, including referral to a behavioral health professional as indicated.

17) **PHYSICAL HEALTH**

a) The Medical Staff will provide a process to:
   (1) Identify and manage matters of individual Physician health that is separate from the medical staff disciplinary function.
   (2) Educate the Medical Staff and other organizational staff about illness and impairment recognition issues specific to Physicians.
   (3) Refer the affected Physician to the appropriate internal or external professional resources for diagnosis and treatment of the condition or concern
   (4) Monitor the affected Physician and the safety of patients until the rehabilitation or any disciplinary process is complete.

III) MEDICAL RECORDS

01) PREPARATION / COMPLETION OF MEDICAL RECORDS

a) The attending Physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include when relevant, identification data, complaint, personal history, family history, history of present illness, physical examination, special reports, such as consultations, clinical laboratory, radiology services, other diagnostic and therapeutic orders and results thereof, provisional diagnosis, medical or surgical treatments, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or note, clinical resume and autopsy report, when performed. The record shall also contain a report of any emergency care provided to the patient; evidence of known advance directives; documentation of consent; and a record of any donation of organs or tissue or receipt of transplant or implants. The record shall also contain a written plan of care, treatment and services appropriate to the patient's needs and where appropriate consider strategies to limit the use of restraints and/or seclusion of the patient. Such plan of care shall be discussed with the patient and shall be revised as necessary.

b) The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

c) Notwithstanding anything contained herein, all orders for medications and all other services shall be documented using an electronic system that supports clinical decision making, when that electronic system is available for use at the Hospital. Such electronic system, when available, will be accessible at the point of care and remotely, through a secure process. Electronic system orders shall be authenticated through the use of an electronic signature process consistent with applicable legal and accreditation requirements and as specified in these Rules and Regulations and Hospital Policy. Please note exceptions as outlined in the Rare User Policy.

02) PHYSICIAN OF RECORD

a) The Physician designated as the attending Physician at the time of admission shall be designated as the Physician of record. The attending Physician shall assume total responsibility for all medical, ethical and social aspects of the care of the patient. The attending Physician is responsible for discharging the patient.

b) The responsibilities of the attending Physician can be transferred to another Physician when this transfer of care is documented in the medical record by the Physician of record.

c) Advanced practice providers Professionals my dictate portions of the medical record as individually approved by the appropriate medical staff committee, with co-signatures from sponsoring Physician as outlined in the Valley Hospital Medical Staff Co-signature policy. If the history and physical is completed by a licensed independent practitioner who is not a Physician or an oral maxillofacial surgeon, the findings, conclusions and assessment of risk must be endorsed by a qualified Physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedure.

03) **ADMISSION HISTORY**

a) The attending practitioner shall be responsible for the preparation of a complete and legible medical record for reach patient. Its contents shall be pertinent and current.
b) A history and physical examination must be documented in the medical record for all inpatients, patients admitted for observation; and patients having procedures that must be either performed or directed by a physician or requiring conscious sedation or anesthesia.
c) Refer to the Medical Staff Bylaws for minimum History and Physical criteria.

04) **SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES**

a) A history and physical exam containing the information outlined above, must be recorded before all surgical procedures and invasive diagnostic procedures, whether inpatient or outpatient. When a history and physical examination, pertinent laboratory, x-ray and EKG/ECG reports are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the Attending Physician documents that such delay would be a threat to the patients' health.

05) **PROGRESS NOTES**

a) A progress note should be written by the attending practitioner (or their appropriately credentialed designee) at the time of each visit in order to document the patient's condition and continuation of care. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be legible. If not, clarification will be requested. Practitioners notified more than three (3) times of illegible writing will be referred to the appropriate IDT.

06) **OPERATIVE/PROCEDURAL REPORT**

a) Operative/Procedural reports shall include a preoperative diagnosis, a detailed account of the findings at surgery, name and the details of the surgical technique, postoperative diagnosis and tissue or specimens removed or altered. Operative/procedural notes shall be written and dictated immediately following surgery, and the dictated report shall be included as a part of the patient's current medical record within twelve (12) hours after completion of surgery. A brief written operative note must be documented immediately and before the patient is transferred to the next level of care. The following shall be included:
   (1) Pre-operative diagnosis
   (2) Name of surgeon and any assistants
   (3) Description of findings
   (4) Estimated blood loss
   (5) Technical procedure used
   (6) Identification of any specimens removed and disposition of each specimen
   (7) Post-operative diagnosis

07) **CONSULTATION REPORT**

a) Consultations shall be obtained through written order of the attending Physician but requested by Physician to Physician.

b) The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultation's opinion and recommendations. The report shall be made a part of the patient's record. A limited statement, such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consulting note shall be recorded prior to the operation, except in emergency situations so verified on the record. Consultations shall be completed with 24 hours of request. Unless the requesting Physician agrees and documents a longer timeframe allowed.

08) **OBSTETRICS RECORD**

a) Obstetrical records must include a complete prenatal history and a relevant physical examination with twenty-four (24) hours of admission. The pre-natal record may include a durable, legible copy of the attending practitioner's office record but must also include a written interval note that includes pertinent additions to the history and any subsequent changes in the physical findings. For pre-op history and physical, the history and physical done prior to admission within 30-days may be updated the day of surgery with the statement, "the patient was reassessed and no changes in current status was found".

09) **NURSERY RECORD**

a) Nursery record with any complications must have a discharge summary completed

10) **CLINICAL ENTRIES/AUTHENTICATION**

a) All clinical entries in the patient's medical record, including written and verbal orders, shall be accurately dated, timed and signed. Authentication of verbal orders shall be defined as review of order by written signature, identifiable initials or computer key. The use of rubber stamp signature is not acceptable under any condition.

11) **STANDARDIZED ABBREVIATIONS AND SYMBOLS**

a) Abbreviations may be used for documentation in medical records providing they follow the current issue of "Medical Abbreviations: 14,000 Conveniences at the Expense of Communication and Safety" by Neil M. Davis. This shall be used as the reference guide at Valley Hospital to assist in interpreting abbreviations and symbols used in documentation of the medical record. Those abbreviations designated by the medical staff as unapproved even if listed in this reference, will not be used in any medical records. The book is located in the Medical Record/ Health Information Management Department and additional copies can be made available to each nursing unit upon request.

12) **AMBULATORY ARE DOCUMENTATION**

a) An appropriate medical record shall be kept for every patient receiving ambulatory care which shall be incorporated in the patient's master patient file, if such exists. The records shall include:
   (1) Adequate patient identification
   (2) Time of arrival
   (3) Pertinent history of the injury of illness

(4) Description of significant clinical, laboratory and radiological findings
(5) Diagnosis
(6) Treatment given
(7) Evidence of informed consent
(8) Condition of patient of discharge or transfer
(9) Final disposition, including instruction given to the patient and/or family, relative to necessary follow up care

b) In addition to the Ambulatory Care Documentation, the following documentation is necessary for ambulatory procedure care:
   (1) Clinically significant medical history and results of physical examination which related to the procedure and/or diagnosis, including surgical indications, and patient's tolerance for the procedure
   (2) Required documentation:
      (a) Indications for outpatient procedure
      (b) Current medication / dosage
      (c) Allergies / medicine reactions
      (d) Co-morbidities
      (e) Assessment of mental status
      (f) Exam specific to procedure
      (g) Exam specific to co-morbidities
      (h) Pre procedure note on operative day by Physician, surgeon, or individual qualified to administer anesthesia (not necessary if history and physical is written on operative day). Required documentation for IV sedation (including conscious sedation) or general, spinal, epidural.
      (i) Heart / Lung exam
      (j) Assessment of general condition. This relates to the patient's overall expected tolerance to anesthesia administration and the procedure.
      (k) Anesthesia history
      (l) Findings and techniques of the procedure, including a pathologist's report on all tissues removed during the procedure, except those exempted by the board.
   (3) Post-procedure documentation (includes type of anesthesia, i.e., local, spinal, etc.), including any other drugs given during procedures.
   (4) Condition of patient on discharge including recovery from anesthesia, patient's tolerance and condition following procedure.

13) **DENTIST'S/PODIATRIST'S RESPONSIBILITIES**

a) A detailed podiatric/dental history justifying hospital admission
b) A detailed podiatric/dental description of the examination of the surgical or procedure anticipated within the scope of the podiatrists/dentist's medical education, training or experience.
c) A Physician member of the Professional Staff shall be responsible for the written history and physical examination and care of any medical problem that may present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

d) Oral surgeon and Podiatrist may obtain privileges to perform history and Physician examinations as well as to provide medical care for the patient by presenting documentation of their ability to do so to the Credentials Review Committee.
e) A complete operative report, describing the findings and techniques
f) Progress notes as are pertinent to the podiatric/dental condition
g) Discharge summary (or discharge note if under two (2) days length of stay)

14) **FINAL DIAGNOSIS AND DISCHARGE SUMMARY**

a) The final diagnosis shall be recorded in full, without the use of abbreviations or symbols, dated and authenticated by the responsible practitioner. Whenever possible the final diagnosis shall be documented at the time of discharge.
b) A discharge summary shall be dictated on all medical records of patient hospitalized over forty-eight (48) hours.
c) A final progress note may be substituted for the discharge summary in case of patient with problems of minor nature who require less than a forty-eight (48) hour period of hospitalization.
d) In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. Specific information to be included in a discharge summary:
   (1) The reason for hospitalization and treatment
   (2) Any significant findings
   (3) Any procedures performed
   (4) Patient disposition and condition when released
   (5) Instructions provided to the patient and his/her family
   (6) Final diagnosis
e) A transfer summary may be substituted for the discharge summary in the case of the transfer of the patient to a different level of hospitalization residential care with the organization.
f) A death summary shall be recorded in all cases in which the patient expires.

15) **REMOVAL OF MEDICAL RECORDS**

a) Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records, including imaging films, are the property of the hospital and shall not otherwise be removed from the premises. In cases of patient readmissions, all previous records shall be available for the use of the attending Physician. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of records from the hospitals is grounds for suspension of the practitioner for a period to be determined by the MEC.

16) **ACCESS TO MEDICAL RECORDS**

a) Access to all patients' medical records shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the Chief of Staff and approval of the HIM Director, former members of the Medical Staff shall be permitted access

to information from the medical records of their patients, covering all period during which they attended such patients in the hospital.

b) Any Physician on the Medical Staff may request a release of patient information providing that said patient is under his/her care and treatment. Such releases, as a routine matter, will not require an Authorization to Release Protected Health Information form to be signed by the patient. The intent of these Rules & Regulations is to address a Physicians need to have information available in his/her office in order to treat patients who may come to his/her office after having been seen, treated or tested at the hospital. Persons not otherwise authorized to receive medical information shall require written authorization from the patient, his/her guardian, his/her agent or his/her heirs.

c) Certain types of information, including, but not limited to, psychiatric medical records, alcohol and drug abuse records and HIV records are protected by statute, and require a signed authorization from the patient or a court order before being released to any person.

d) Information should not be released to a patient's family member unless a signed authorization has been obtained from the patient, guardian, or legally authorized individual.

17) **PERMANENTLY FILED MEDICAL RECORD**

a) A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the MEC, the Chief of Staff or PRESIDENT with an explanation of why it was not completed by the responsible practitioner(s).

18) **COMPLETION OF MEDICAL RECORDS**

a) The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The written or dictated discharge summary shall be completed within thirty (30) days of discharge. When final laboratory and or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.

b) Medical records on which there is a dictation to be transcribed will include the transcription date.

19) **DELINQUENT MEDICAL RECORDS AND PHYSICIAN SUSPENSION**

a) Patient medical records are required to be completed with thirty (30) days of discharge. A record will become delinquent thirty one (31) days after patient discharge.

b) In the case of records remaining incomplete beyond thirty (30) days, including dictation and required ** signatures, the Physician will be notified via a suspension letter by the Chief of Staff that he/she has been suspended

c) This means:

(1) The Physician may continue to treat inpatient until discharged. Long stay patient must be transferred to another Physician within 7 days of the suspension notification.

(2) The Physician may not schedule any future procedures or admissions. The Physician must notify any scheduled patients not yet admitted of the cancellation of the scheduled admission. (This includes patients scheduled for any elective surgeries or outpatient procedures).

(3) The Physician may not assist in surgery.

(4) The Physician's orders will not be acknowledged and/or carried out by hospital staff, except for those patients in house at the time privileges were suspended.
(5) Privileges may be reinstated up on completion of delinquent records, subject to approval of the Chief of Staff. Exemptions for illness/LOA shall only be allowed with the specific approval of the Chief of Staff.
(6) **Required signatures include:
    (a) History and Physical
    (b) Emergency Room Report
    (c) Operative Report
    (d) Consultation
    (e) Discharge Summary
    (f) Orders

20) **ALTERATION/CORRECTION OF MEDICAL RECORD ENTRIES**

a) Only the original author of medical records entry is authorized to correct or amend an entry. Any corrections must be dated and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated, including the use of "white-out".
b) To correct or amend entry, the author should cross out the original entry with a single line, ensuring that it is still readable, enter the correct information, sign with legal signature and title, and enter the date and time the correction was made.
c) Any alteration in the medical record made after the record has been complete is considered to be an addendum and should be dated, signed and identified as such.

IV) LEGAL

01) **PRIVILEGES**

a) Operations performed shall be consistent with privileges granted. A current copy of privileges is maintained in the Medical Staff Office and available for review in the hospital computer system.

b) Processing of an application may take approximately 60 - 90 days after all pertinent information has been received. To avoid delays in approval of privileges, all information must be forwarded to us in a timely manner.

02) **REPORTS TO LAW ENFORCEMENT**

a) The hospital shall report to a local law enforcement authority as soon as reasonably possible, taking into consideration a patient's emergency care needs, when the hospital provides treatment for a bullet wound, gunshot wound, or stab wound to a patient. A hospital shall establish a written policy to identify the person or persons responsible for making the report.

b) The report required under subsection (1) of this section must include the following information, if known:

(1) The name, residence, sex, and age of the patient.

(2) Whether the patient has received a bullet wound, gunshot wound, or stab wound; or all of the above.

(3) The name of the health care provider providing treatment for the bullet wound, gunshot wound, or stab wound.

(4) Any bullets, clothing, or other foreign objects that are removed from a patient for whom a hospital is required to make a report pursuant to subsection (1) of this section shall be preserved and kept in custody in such a way that the identity and integrity thereof are reasonably maintained until the bullets, clothing, or other foreign objects are taken into possession by a law enforcement authority or the hospital's normal period for retention of such items expires, whichever occurs first.

(5) Any hospital or person who in good faith, and without gross negligence or willful or wanton misconduct, makes a report required by this section, cooperates in an investigation or criminal or judicial proceeding related to such report, or maintains bullets, clothing, or other foreign objects, or provides such items to a law enforcement authority as described in subsection (4) of this section, is immune from civil or criminal liability or professional licensure action arising out of or related to the report and its contents or the absence of information in the report, cooperation in an investigation or criminal or judicial proceeding, and the maintenance or provision to a law enforcement authority of bullets, clothing, or other foreign objects under subsection (4) of this section.

(6) The Physician-patient privilege described in RCW 5.60.060(4), the registered nurse-patient privilege described in RCW 5.62.020, and any other health care provider-patient privilege created or recognized by law are not a basis for excluding as evidence in any criminal proceeding any report, or information contained in a report made under this section.

(7) All reporting, preservation, or other requirements of this section are secondary to patient care needs and may be delayed or compromised without penalty to the hospital or person required to fulfill the requirements of this section.

(8) If the patient states his or her injury is the result of domestic violence, the hospital shall follow its established processes to inform the patient of resources to assure the safety of the patient and his or her family.

c) A health care provider or health care facility may disclose health care information, except for information and records related to sexually transmitted diseases which are addressed in RCW 70.02.220, about a patient without the patient's authorization to the extent a recipient needs to know the information, if the disclosure is:

(1) To a person who the provider or facility reasonably believes is providing health care to the patient.

(2) To any other person who requires health care information for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, actuarial services to, or other health care operations for or on behalf of the health care provider or health care facility; or for assisting the health care provider or health care facility in the delivery of health care and the health care provider or health care facility reasonably believes that the person:

(i) Will not use or disclose the health care information for any other purpose; and

(ii) Will take appropriate steps to protect the health care information

(b) To any person if the health care provider or health care facility reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual

(c) For payment, including information necessary for a recipient to make a claim, or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he or she may be entitled.

(d) A health care provider shall disclose health care information, except for information and records related to sexually transmitted diseases, unless otherwise authorized in RCW 70.02.220, about a patient without the patient's authorization if the disclosure is:

(i) To federal, state, or local public health authorities, to the extent the health care provider is required by law to report health care information; when needed to determine compliance with state or federal licensure, certification or registration rules or laws, or to investigate unprofessional conduct or ability to practice with reasonable skill and safety under chapter 18.130 RCW. Any health care information obtained under this subsection is exempt from public inspection and copying pursuant to chapter 42.56 RCW

(ii) (b) When needed to protect the public health.

03) **CHILD, ADULT, DEPENDENT, DEVELOPMENTALLY DISABLED PERSON ABUSE/NEGLECT REPORTING**

a) In compliance with Washington State Law, when and if there is reasonable cause to believe that a child or adult dependent or developmentally disabled person has suffered instance of non –accidental injury, neglect, sexual abuse and /or cruelty, she/he shall report such an

incident, or cause a report to be made, to the proper law enforcement agency or to the Department of Child Protective Services. The report shall be made at the first opportunity, but in no case longer than forty-eight (48) hours. Failure to report is a misdemeanor.

b) When any practitioner has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040
   (1) An immediate oral report must be made by telephone or otherwise to the proper law enforcement agency or the department of social and health services and, upon request, must be followed by a report in writing. Such reports must contain the following information, if known:
      (a) The name, address, and age of the child
      (b) The name and address of the child's parents, stepparents, guardians, or other persons having custody of the child
      (c) The nature and extent of the alleged injury or injuries
      (d) The nature and extent of the alleged neglect
      (e) The nature and extent of the alleged sexual abuse
      (f) Any evidence of previous injuries, including their nature and extent
      (g) Any other information that may be helpful in establishing the cause of the child's death, injury, or injuries and the identity of the alleged perpetrator or perpetrators.

04) **CORONER CASES: CIRCUMSTANCES UNDER WHICH A DEATH SHOULD BE REPORTED TO THE LOCAL CORONER'S OFFICE:**
   (1) Coroner's Jurisdiction over remains: The jurisdiction of bodies of all deceased persons who come to their death suddenly when in apparent good health without medical attendance within the thirty-six hours preceding death; or where the circumstances of death indicate death was caused by unnatural or unlawful means; or where death occurs under suspicious circumstances; or where a coroner's autopsy or postmortem or coroner's inquest is to be held; or where death results from unknown or obscure causes, or where death occurs within one year following an accident; or where the death is caused by any violence whatsoever, or where death results from a known or suspected abortion; whether self-induced or otherwise; where death apparently results from drowning, hanging, burns, electrocution, gunshot wounds, stabs or cuts, lightning, starvation, radiation, exposure, alcoholism, narcotics or other addictions, tetanus, strangulations, suffocation or smothering; or where death is due to premature birth or still birth; or where death is due to a violent contagious disease or suspected contagious disease which may be a public health hazard; or where death results from alleged rape, carnal knowledge or sodomy, where death occurs in a jail or prison; where a body is found dead or is not claimed by relatives or friends, is hereby vested in the county coroner, which bodies may be removed and placed in the morgue under such rules as are adopted by the coroner with the approval of the county commissioners, having jurisdiction, providing therein how the bodies shall be brought to and cared for at the morgue and held for the proper identification where necessary.
   (2) Notice to Coroner: It shall be the duty of every person who knows of the existence and location of a dead body coming under the jurisdiction of the coroner as set forth in RCW

68.50.010, to notify the coroner thereof in the most expeditious manner possible, unless such person shall have good reason to believe that such notice has already been given. Any person knowing of the existence of such dead body and not having good reason to believe that the coroner has notice thereof and who shall fail to give notice to the coroner as aforesaid, shall be guilty of a misdemeanor.

b) Non-Coroner cases: It shall be the duty of all staff members to encourage autopsies whenever appropriate. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies are the responsibility of the Hospitals Pathologist, except for Coroner's cases. The following will be used as criteria for performance of autopsies:
   (1) Whenever there is a clinical uncertainty regarding the condition or injuries which may have contributed to death
   (2) Unexplained or unexpected deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies
   (3) To help explain unknown or unanticipated medical complications
   (4) Most obstetrical deaths
   (5) Unexplained neonatal and pediatric deaths

05) **INFORMED CONSENT**

a) Consent for treatment
   (1) All patients admitted for treatment must have a signed hospital consent form at the time of admission except as provided under ED treatment providers.

b) Consent for operation, anesthesia, and medical care
   (1) Invasive/Surgical Procedures – It is the policy of the hospital, in accordance with the law of the State of Washington that the obtaining of consent from a patient or the patient's representative, for a surgical procedure in the hospital shall be the responsibility of the attending Physician or person medically trained to perform the procedure. This consent may be completed and signed in the Physician's office or after the patient arrives at the hospital, but must be signed, dated and timed by the Physician, patient (or patient's representative) and, a witness prior to the time that the patient is prepared to go to surgery or the appropriate department for the special procedures. If the surgical permit is signed the same day as the surgery and/or procedure, the Consent Forms must also include the time, date and signature that the forms were signed. Whenever possible, military time should be used. The exception to this shall be in the event of an emergent situation. In emergency cases, the reason why a signature cannot be obtained must be documented on a Consent Form or the Progress Notes. The Consent Form shall be signed by the patient, only after the risks and benefits of the procedure, alternative treatment methods, current health status of the patient, plan of care, and other information necessary to make a fully informed consent has been explained to the patient by the responsible Physician. Each Consent Form shall include:
      (a) The legal name of the hospital where the procedure is to take place
      (b) The name of the specific procedure for which consent is being given
      (c) The name of the responsible practitioner who is performing the procedure
      (d) A statement that the procedure, including the anticipated benefits, material risks, and alternative therapies, were explained to the patient or the patients legal representative

(e) Signature of the patient or the patient's legal representative.
(f) The form must also comply with the requirement of applicable state law

(2) A surgical consent is valid for an indeterminate period. The main consideration is that the patient's condition has not changed since the consent was signed. Any questions or problems regarding surgery consents must be referred to an Administrative Supervisor.

(3) Refusal – Consent must be complete for any refusal of blood or blood products

c) Consent from minors

(1) Ordinarily, consent must be obtained from the legal guardian of the child. An emancipated minor (married to a spouse 18 years of age or older or mature and independent minors earning their own livelihood and retaining their own earnings) may consent to procedures if able to understand to purpose and risks

d) Emergencies

(1) In circumstances where the life or future well-being of the patient would be jeopardized by delay, surgical consent shall not be required. The Physician's progress note will detail the emergency circumstances. Consent for treatment confined to the emergency room is covered by the Emergency Room Consent to Treat form

e) Consent by telephone

(1) When immediate consent is necessary for an incompetent or under age patient, consent may be obtained from the patient's authorized representative by telephone. The conversation must be monitored by two (2) employees of the hospital or members of the Professional Staff, who will sign as witnesses on the surgical Consent Form.

V) PATIENT RIGHTS

01) **ADVANCED DIRECTIVES**

a) It is the policy of the Hospital to respect and encourage patients to control the decisions relating to the rendering of their own health care, including the decision to have life sustaining treatment withheld or withdrawn in instances of terminal or permanent unconscious conditions.

b) Communication through Advanced Directives will guide Healthcare providers and surrogates in medical decisions for the patient, if the patient loses decision making capacity. Advanced Directives, however, are not required in this facility to receive care.

02) **INVESTIGATIONAL TREATMENT AND RESEARCH**

a) The Physician desiring to use an investigational drug or device must complete an FDA form.

b) Requests for use of investigational drugs must be approved by the P&T committee or its chairperson. Investigational devices must be approved by the Operative and Invasive IDT or its chair.

c) The investigational drug or device must be reviewed and approved by the Institutional Review Board (IRB) of Spokane, Washington.

d) Whenever a practitioner utilizes investigational devices or investigational drugs, the practitioner shall be responsible for obtaining an informed consent specifically relating to such investigational devices and/or investigational drugs and shall notify the Hospital's Institutional Review Board. Said Consent Form shall comply with federal regulations concerning investigational drugs and devices.

03) **BRAIN DEATH POLICY**

a) Brain death must be determined by a licensed Physician based upon established procedures and clinical criteria. If invasive tests are indicated a neurologist or neurosurgeon may be asked to consult. See Brain Death Policy in the Nursing Policy and Procedure Manual.

b) The Physician will document in the chart:

(1) A written note describing appropriate examination and laboratory findings to support diagnosis of brain death.

(2) All the notes are to be dated and timed

(3) When brain death is determined, the time of this note will be used as the time of patient's death.

04) **RESUSCITATIVE STATUS**

a) "Guidelines for Foregoing Life-Sustaining Treatment." (See Nursing Policy and Procedure Manual).

b) No Code/Limited Code orders and guidelines (See Nursing Policy and Procedure Manual).

VI) OTHERS

01) **TREATMENT OF FAMILY MEMBERS OR SELF-TREATMENT**

a) Treatment by practitioners of immediate family members or self-treatment should be reserved only for minor illnesses or emergency situations. Practitioners may not self-prescribe to immediate family members any controlled substances. Written records must be maintained of any written prescriptions or administration of any drugs.

02) **OPERATING OR ASSISTING IN SURGERY ON IMMEDIATE FAMILY MEMBERS (i.e. spouse, children, parent)**

a) Operating/Assisting on Immediate Family Members

(1) It is recognized by the Professional Staff of Valley Hospital that this action represents a serious error in judgment by the attending surgeon. It is also recognized that there may be extenuating circumstances that may necessitate this action.

(2) Operating on an immediate family member will be permitted only in the following circumstances:

(a) There must be no reasonable alternative available

(b) For elective procedures, the attending must submit in writing to the Executive Committee or its designees a detailed request for permission to perform the procedure

(c) The Executive Committee or its designees must make its recommendation to the Board for final approval.

(d) At the discretion of the Board, the attending may be asked to present that request in person

(e) Decision by the Board (or its designees) will be final

(f) For the purpose of this policy, the term "operating" will include any invasive procedure or the administration of anesthesia, but does not include minor emergency room procedures

03) **MEDICAL STUDENTS / MEDICAL RESIDENT / PHYSICIAN ASSISTANT STUDENT / NURSING STUDENT**

a) The following rules shall apply to Medical Students, Medical Residents, Physician Assistant Students and Nursing Students-affiliated through a current contractual agreement.

(1) All applicable criteria based on each institutions contract must be met before the applicant can rotate through the Hospital.

OPERATIVE AND INVASIVE PROCEDURES
VII) ADMITTING AND DISCHARGE

01) **ADMITTING TIME FOR SURGICAL PATIENTS**

a) All patients must complete recommended lab and associated medical work-up prior to surgery. All patients shall present at a time reasonable for processing prior to surgery. ** This includes ankle, and retrobulbar blocks that will not be converted to general unless there is threat to life, limb or actual open globe.

b) Pediatric – Infants of less than forty-four (44) weeks post conceptual age will be admitted overnight.

c) Accurate Inpatient Admission versus Outpatient Surgery orders need to be on the record prior to surgery. If complications arise on an Outpatient (SDC) surgery client, orders to "Place in Observation" are required if the concern persists beyond the allotted six hours for routines recovery, along with the proper documentation as to the details of the complications or concerns. Observation is not pre-determined; orders must be written post operatively. Situations that require an unplanned inpatient admission post operatively need also to be clearly documented.

02) **RECOMMENDED ADMISSION WORK-UPS FOR SURGICAL PATIENTS**

a) Recommended admission work-ups for surgical patients including NPO Status will be followed via departmental guidelines. See outpatient general, spinal & epidural anesthesia diagnostic test in outpatient surgical guidelines in the outpatient surgery department.

03) **RULES GOVERNING ADMINISTRATION OF ANESTHESIA**

a) Refer to existing anesthesia polices.

04) **SURGICAL RESPONSIBILITY OF ANESTHESIOLOGIST AND SURGEON**

a) When anesthesia, or supervised anesthesia, is scheduled, the Anesthesiologist will be responsible for pre and post-operative anesthetic orders.

b) When a CRNA or non-medically directed anesthesia is utilized, i.e., labor epidurals, the CRNA will be responsible for the pre and post-operative anesthesia orders

c) The operating surgeon has the primary responsibility for all pre and post-operative orders other than those relating to anesthesia.

d) The anesthetist shall maintain a complete anesthesia record to include evidence of a pre anesthesia evaluation and post anesthetic follow-up of the patient's condition.

05) **EXAMINATION OF TISSUE**

a) All tissue and foreign material removed in surgery shall be sent to the hospital pathologist who shall make such examination as she/he may consider necessary to arrive at a pathological diagnosis and issue a pathology report.

(1) Certain specimens, which are felt by the surgeon to be grossly normal and in which there is no clinical suspicion of a significant underlying pathologic process need not be sent to the hospital pathologist. A list of such specimens is available in the Operating Room and Pathology Department. However, the removal and nature of such tissues or foreign

bodies must be carefully documented in the operative note and nurse's notes. Specimens which may be handled in this manner are referred to in Tissue Exam protocol in OR.

06) **SCHEDULING EMERGENCY SURGERIES**

a) When a surgery is in progress, emergency cases will be placed in the first room available. If this room has a scheduled case, it shall be the duty of the surgeon scheduling the emergent case to contact the surgeon who has the scheduled case to request the use of the room.

07) **SURGERY TIME SCHEDULED**

a) Surgeons must be in surgery and ready to commence operations at the time scheduled. When a surgeon is twenty (20) or more minutes late, the patient may be removed from surgery and the scheduled time forfeited. The patient should be scheduled in the next available time slot. It will be the responsibility of the Circulator to notify the appropriate supervisor to notify the surgeon to-follow to determine reorganization of the surgery schedule. The to-follow surgeon will have the option of accepting a late start time or proceeding as scheduled.

08) **DENTAL AND PODIATRIC SURGERY**

a) Surgery under local anesthetic
   (1) All podiatrists or dentists performing elective surgery under local anesthetic shall schedule during regular OR hours when MD/DO anesthesia is available to render emergency care. This is no intended to restrict the ability of theses providers to provide emergent care.

b) Podiatrists/Dentists Responsibilities
   (1) A detailed podiatric/dental history justifying hospital admission
   (2) A detailed podiatric/dental description of the examination of the surgical or other procedure anticipated within the scope of the podiatrists/dentist's medical education, training or experience.
   (3) If the Oral Surgeon or Podiatrist is not credentialed to do so, a Physician member of the Professional Staff shall be responsible for the written history and physical examination and care of any medical problem that may present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.
   (4) Oral surgeons and Podiatrists may obtain privileges to perform history and physical examinations as well as to provide medical care for their patients by presenting documentation of their ability to do so to the Credential Review Committee.
   (5) A complete operative report, describing the findings and techniques
   (6) Progress notes as are pertinent to the podiatric/dental condition
   (7) Clinical resume (or summary statement)

VIII) CARE AND TREATMENT OF PATIENT

01) **FAMILY PRACTICE PHYSICIAN / PEDIATRICIAN ATTENDING A C-SECTION**

a) The attendance of the Family Practice Physician/Pediatrician at deliveries will be in accordance with current guidelines.

02) **OBSERVATION OF C-SECTION**

a) Significant others only may observe the C-Section with the permission of the attending OB and anesthesiologist.

03) **OBSERVING SURGICAL PROCEDURES**

a) Lay persons desiring to observe may do so only after receiving permission from the operating surgeon, the OR director and the patient in accordance with the established protocol for "Observers – Shadowers Policy"

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04) **ELECTIVE ABORTIONS**

a) It is the policy of the Hospital that abortions are not performed at this facility. In the event an abortion is required due to severity of a patient's medical condition, the following process will be followed:
   (1) Notify Nursing Supervisor
      (a) Must complete the Ethics consultation form
   (2) Notify the Ethics Chair
      (a) Copy of the Ethics Consultation must be made available to the chair for review
   (3) Notify Department Director
   (4) Notify Administrator on call
   (5) Notify Chief of Staff
   (6) If the Chief of Staff is not available the Operative and Invasive IDT Chair and Co-Chairs of the Obstetrics and Pediatrics IDT Chairs will be notified.
   (7) Ethics Committee will assemble based on the criteria outlined in the Medical Staff Bylaws
   (8) Approval of the procedure will be determined by the Ethics Committee based on the medical and therapeutic indications as follows:
      (a) A medical condition where the life of the mother is in danger (reasonable proof of such a condition rests with the attending Physician and consultant); OR
      (b) Fetal condition that is incompatible with life (reasonable proof of such a condition rests with the attending Physician and consultant).

IX) LEGAL
X)

01) **REQUIRED CONSULTATION**

a) See Consultation Rule

02) **SURGICAL CONSENTS**

a) See Informed Consent

03) **EMTALA / EMERGENCY DEPARTMENT**

a) Any individual who presents to the Emergency Department and requests an examination and treatment will be provided a Medical Screening Examination to determine whether or not an emergency medical condition exists, unless such examination is refused by the patient. Triage does not constitute a Medical Screening Examination.

04) **EMERGENCY DEPARTMENT PATIENTS/CALL SCHEDULE RESPONSIBILITIES**

a) The Emergency Department is responsible for immediate recognition, evaluation, treatment, stabilization and disposition of patients in response to any medical or surgical emergency. The Emergency Department Physician or appropriately trained and supervised Physician extender shall see all patients admitted to the Emergency Department except those who are to be seen by their private Physician. The patient's Physician's requests will be honored with the understanding that the Emergency Department Physician reserves the right to institute lifesaving and limb saving procedures. If ongoing care and/or specialized care are needed, the appropriate on call Physician will be called.

b) Definition of a medical screening exam: The Emergency Department shall provide an appropriate medical screening exam within the capabilities of the hospital's emergency department. This will include an appropriate history, physical examination and use of ancillary services routinely available, regardless of ability to pay or source of payment. This examination will be used to determine whether or not an emergency medical condition exists. Generally an "emergency medical condition" is defined as active labor or as a condition manifesting such symptoms that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to bodily organ or function, or serious jeopardy to the health of the individual or unborn child.

c) The medical screening examination may be conducted by:
   (1) An emergency department Physician (MD/DO)
   (2) An emergency department Physician assistant (PA)
   (3) An emergency department nurse practitioner (ARNP)
   (4) The individual's primary care Physician or delegate, if present in the department
   (5) In the case of a women in active labor, the nursing staff designated in the labor and delivery unit. The patient will be taken directly to L&D unless triage indicates otherwise.
   (6) In the case of sexual assault, the medical screening examination may be performed by appropriately trained emergency department personnel under written Physician directed protocols.

d) Stabilization

(1) Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting condition set forth below:
   (a) A patient is stable for discharge, when within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions; or, the patient requires no further treatment and the treating Physician has provided written documentation of his/her findings.
   (b) A patient stable for transfer if the treating Physician has determined, with reasonable clinic confidence, that the patient is expected to leave the hospital and be received at second facility, with no material deterioration in his/her medical condition; and the treating Physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.
   (c) A patient does not have to be stabilized when:
      (i) The patient, after being informed of the risk of transfer and the hospital's treatment obligations, requests to transfer and signs a transfer request from
      (ii) Based on the information at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a Physician signs a certification which includes a summary of risks and benefits to this affect.
   (d) If a patient refuses to accept the proposed stabilization treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician shall document the patient's refusal in the patient's chart, which refusal shall be witnessed by the Emergency Department supervisor/director. If the patient so desires, the patient will be offered assistance in finding a Physician for outpatient follow-up care.
(2) Transfer
   (a) The Emergency Department Physician Shall obtain the consent of the receiving hospital facility before the transfer of an individual. Said person shall also make arrangements for the patient transfer with the receiving hospital.
   (b) The condition each transferred individual shall be documented in the medical records by the Physician responsible for providing the medical screening examination and stabilizing treatment.
   (c) Upon transfer, the Emergency Department shall provide a copy of appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on call Physician who has refused or failed to appear within a reasonable period of time in order to provide stabilizing treatments.

(3) Consultation, Referrals & Emergency Department Call

(a) When the Emergency Department Physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall be permitted to request the services of a specific private Physician. This request will be documented in the patient's medical record.

(b) The Physician whom the patient requests shall be contacted by a person designated by the Physician in charge of the Emergency Department and that person will document the time of the contact in the patient's medical record.

(c) An appropriate attempt to contact the Physician will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:

(i) Attempted to reach the Physician in the hospital.

(ii) Called the Physician at home

(iii) Called the Physician at his/her office; and

(iv) Called once on the Physician's pager

(d) The rotation call list, containing the names and phone numbers of the on call Physicians shall be posted in the Emergency Department. In the event that the patient does not have a private Physician, the private Physician refuses the patients request to come to the Emergency Department, or the Physician cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private Physician to provide the necessary consultation or treatment for the patient. A Physician who has been called from the rotation list may not refuse to respond. The Emergency Department Physician's determination shall control whether the on call Physician is required to come in to personally assess the patient. Any such refusal shall be reported to the PRESIDENT and Chief of Staff for further action pursuant with the Disruptive Practitioner Policy and may constitute grounds for revocation of the Physician's Medical Staff appointment and privileges.

(e) When requested, Physicians on call are obligated to provide appropriate and timely emergency evaluation and/or follow-up care for patients seen in the Emergency Department. The on call Physician is obligated to see the patient in follow up only for the complaint for which they have been referred.

(f) Call Schedule Responsibilities:

(i) Active and Affiliated Staff Physicians with appropriate privileges will be placed on the Emergency Department call schedule in their primary practice specialty. Participation in other call coverage is optional, as long as the Physician has the privileges to cover the call.

(ii) The MEC and the Board shall retain ultimate authority for making determinations regarding call requirements based upon the needs of the Hospital and its patients, and upon the Hospital's obligation to ensure that the services regularly available to its Hospital patients are available to the Emergency Department. In the event any Physician or specialty represented on the Active Staff is excused from call, the MEC and the Board shall document the reasons, and shall ensure that such decision does not negatively impact upon the Hospital's ability to fulfill its obligations as outlined above.

(iii) Physicians called are required to respond to Emergency Department call by telephone within twenty (20) minutes. If requested to come in, they are required to do so within one (1) hour after responding by telephone.

(iv) The system for providing on call coverage, including specification of which specialties shall cover call and the minimum obligations therefore, shall be reviewed and approved in writing by the Board, based on the recommendations of the MEC and shall be reviewed on an annual basis.

(g) Emergency Department Physicians

(i) The Emergency Department Physicians will provide care to patients when they are seen in the Emergency Department. Emergency Department Physicians will responded to floor "call code" emergency or near code only if they are not involved in a code in the ED. The Emergency Department Physician will determine if he/she can safely leave the Emergency Department.

XI) DEVELOPMENT

01) The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Hospital, the Board, and the community.

XII) ADOPTION, AMENDMENT & REVIEWS

01) Request for changes to the Rules & Regulations can be made by any member of the Professional Staff. A proposed change to the Rules & Regulations will first be evaluated by the relevant IDT/committee prior to being referred to the Bylaws Committee for review. Any recommended changes will be made by the Bylaws Committee and then forwarded to the Medical Executive Committee and will be subject to the approval of the Board. The Rules and Regulations shall be reviewed and revised as needed, but at least every two (2) years.

XIII) DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

01) Amendments to these Rules & Regulations approved as set forth herein shall be documented by either:

a) Appending to these bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the PRESIDENT, the Chairperson of the Board of Trustees and approved by corporate legal counsel as to form.

b) Restating the bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these bylaws since their last restatement, which restated bylaws shall be dated and signed by the Chief of Staff, the PRESIDENT and the Chairperson of the Board of Trustees approved by corporate legal counsel as to form.

02) Each member of the Medical Staff shall be given a copy of any amendments to these bylaws in a timely manner

XIV) SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT

01) The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Rules and Regulations in the event of exigent and compelling circumstances affecting the operations of the hospital, welfare of its employees and staff, or provision of optimal care to patients. However, should the Board so suspend, override, supplement or replace such rules and regulations, it shall consult with the Medical Staff at the next regular staff meeting (or at special called meeting), and shall thereafter proceed as provided in XI10 for adoption and amendment of Rules & Regulations. If an agreement cannot be reached, the Board shall have the ultimate authority as to adoption and amendment of the Rules & Regulations, but shall exercise such authority unilaterally only when the Medical Staff has failed to fulfill its obligations and it is necessary to ensure compliance with applicable law or regulation, or to protect the wellbeing of patients, employees or staff.