Rules & Regulations

Medical Staff of Yakima Valley Memorial Hospital

Rules & Regulations

I. Admission and Discharge of Patients

A. A patient may be admitted to the Hospital only by a Member of the Staff. All Practitioners shall be governed by the official admitting policy of the Hospital. The admitting physician shall be expected to see the patient admitted within 24 hours of the patient's arrival in the hospital unless circumstances demand a more prompt visit by the physician. The admitting physician is responsible for the care of the patient from the time the patient leaves the emergency department or the admitting department.

B. A Member of the Staff shall be responsible for the medical care and treatment of each patient admitted to the Hospital. The attending Practitioner shall be responsible for the prompt completeness and accuracy of the medical records, for necessary special instructions, and for transmitting reports of the condition of the patient to the relatives of the patient. Whenever these responsibilities are transferred to another Staff Member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

C. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

D. For on-call obligations, refer to the Medical Staff By-Laws, Article IV.C.6.

E. Patient Transfers

A patient is transferred from one area or department to another upon approval by the responsible Practitioner.

1. Patients who do not have their own doctor and are seen and examined in the Emergency Room and are thought to require hospitalization shall be hospitalized under the care of the doctor on call responsible for that category of illness.

2. A patient may be transferred to another hospital for hospitalization and further care if the patient requests such transfer, and if the Practitioner who will receive the patient and assume responsibility is determined to be available and concurs in the judgment to transfer the patient.

3. A patient may be transferred to another hospital following the hospital's Policies and Procedures for EMTALA.

   Medical Screening Exams: The Board has determined that medical screening examinations may be performed by physicians on the Active Staff, Physicians Assistants, Nurse Midwives and General ARNP's.

F. Admission to critical care areas:

1. Patients must been seen by the attending Physician one (1) hour prior to or subsequent to admission to CCU unless there are extreme extenuating circumstances. If a patient is transferred to CCU for observation purposes only (due to lack of sufficient staffing on the acute care units to care for the patient) and is not critically ill, he/she does not need to be seen by the attending Physician within one (1) hour prior to or subsequent to admission if the patient has been seen by the attending Physician earlier in the day.

2. It is the responsibility of the Physician or his/her alternate to be available at all times. In the event that the responsible Physician or his alternate cannot be reached, the Medical

Director will be notified and may initiate care of the patient.

3. In cases of patients with several Physicians, a primary Physician must be designated. When the designation is unclear, the Medical Director of the CCU will assign a primary Physician.

4. The general surgeon should be in charge of a multi-trauma patient until sure that adequate evaluation is completed. If, at that time, his/her care is no longer necessary, it will be his/her responsibility to notify an appropriate sub-specialist and document the transfer of primary care in the patient record.

5. Upon entering the CCU, each patient's orders must be rewritten. When the patient is transferred from the units, orders for continuous IV infusions, narcotics, and sedatives, respiratory therapy treatments must be rewritten. All other orders will remain in effect.

   (Please also refer to Rules of the Pediatric Department for Neonatal ICU).

6. If any question as to the validity of admission to or discharge from the Critical Care Unit should arise, the decision is to be made through consultation with the intensivist on-call.

G. The attending Practitioner shall comply with the *Utilization Review Plan* and the hospital's plan to improve performance.

H. A patient shall be discharged only on a written order of the attending Practitioner. Should a patient leave the Hospital against the advice of the attending Practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record by the attending Practitioner.

I. When a patient dies in the Hospital, the deceased shall be pronounced dead by the Administrative Nursing Supervisor (ANS) within a reasonable time. The attending physician will be notified. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to the release of decedent's remains shall conform to local law.

J. It shall be the duty of all Members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent signed in accordance with state law. All autopsies shall be performed by a pathologist or by the Coroner. Provisional anatomic diagnoses shall be recorded on the medical record within 24 hours and the complete protocol should be made a part of the record within sixty (60) days.

K. Patients who are emotionally ill or are suffering from alcohol or drug abuse shall be offered appropriate referral.

II. MEDICAL RECORDS.

A. The attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current. This record shall include identification data, admission note stating diagnosis and placed on the chart at the time of admission (an acceptable alternative is to write or enter the admitting diagnosis as the first order on the order sheet), personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services, and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, clinical resume and autopsy report when performed.

B. **Inpatient:**

The History and Physical shall include the chief complaint, details of the present illness, relevant past, social, psychological and family histories, and an inventory of the body systems. In addition, a summary of the patient's psychological needs, as appropriate, and a statement of the conclusions, or impressions drawn from the admission H&P.

A current History and Physical shall be recorded and on the chart within 24 hours of admission.

A H&P is considered current if it is less than thirty (30) days old **and** an update is performed within the first twenty four hours of admission, or prior to sedation or anesthesia. An update to the H&P summarizes any changes that have occurred or should note that there are no changes since the original H&P. The update can be recorded in the progress note.

If the original H&P is greater than thirty (30) days old, a complete new H&P shall be recorded within 24 hours of admission.

Outpatient:

Patients utilizing outpatient areas for invasive procedures and/or the administration of anesthesia/sedation, shall have a current H&P recorded and on the chart at he time of the surgical procedure.

The operating surgeon or his/her employed designate (PA, ARNP) or Medical Consultant dictates the H&P no more than thirty (30) days prior to surgery. The anesthesiologist (MD or CRNA) performs the pre-anesthesia assessment and determines if the patient is safe to undergo anesthesia. The signed anesthesia pre-op assessment is accepted as an update to the H&P.

If anesthesia has concerns regarding proceeding with the case due to significant health changes since the H&P were performed, the operating surgeon will re-examine patient prior to any anesthetic or sedative medications and update the H&P. The case will proceed only if Surgeon and Anesthesia agree.

For moderate sedation the physician requesting sedation and or performing the procedure will update the H&P prior to start of procedure. For patients requiring ambulatory treatment, such as infusion of blood products, chemotherapy, wound care, etc, a current H&P shall be recorded and on the chart at the time of the first treatment.

C. When the history and physical examination are not recorded before an operation (or any potentially hazardous diagnostic procedure), the procedure shall be held until the history and physical examination is complete unless the attending Practitioner states in writing that such delay would be detrimental to the patient.

D. All acute care hospital patients will be seen daily and a pertinent progress note shall be written by the attending or on call physician, P.A., ARNP, or Resident. When 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.

E. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be dictated immediately following surgery for outpatients and inpatients and promptly signed by the surgeon and made a part of the patient's current medical record. A brief handwritten operative note should be placed in the progress record at the time of surgery to bridge the time gap until the report is typed.

A post-anesthesia evaluation must be completed and documented in the medical record by a practitioner who is qualified to deliver anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services.

A dictated labor and delivery note shall be required and shall include a detailed account of the course of labor and the details of the delivery. The description should include such features as the time involved, any use of oxytocin for inducing or augmenting labor, and any operative technique employed. These reports shall be dictated immediately following the delivery and promptly signed by the delivering Physician and made part of the patient's current medical record. A brief handwritten note should be placed on the labor and delivery sheet at the time of the delivery to bridge the time gap until the report is typed.

For diagnostic cardiac angiographic and cardiac catheterization reports, a procedure report will be dictated immediately following the procedure. Findings will be dictated within 24 hours after the Cardiac/Surgery Conference that follows the procedure. A brief handwritten procedure note should be placed in the progress note at the time of procedure to bridge the time gap until the report is typed.

F. Consultation 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. A limited statement such as "I concur" does not constitute an acceptable report of the consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

G. All clinical entries in the patient's medical record shall be authenticated and as required dated. The use of rubber stamp signatures is acceptable only if the Practitioner whose signature the rubber stamp represents, is the only one who has possession of the stamp and is the only one who will use it. A written attestation by the physician must be signed and filed prior to use of a rubber stamp.

H. Symbols and abbreviations may be used only when they have been approved by the Staff. An official record of approved abbreviations should be kept on file in Health Information Management.

I. Final diagnosis shall be recorded in terms of Standard Nomenclature in full, without the use of symbols or abbreviations, and dated and signed by the responsible Practitioner at the time of discharge of any patient. This is as important as the actual discharge order and shall be a condition of discharge.

J. A formal discharge summary shall be written or dictated on all medical records of patients who die and for all patients who or are hospitalized over 48 hours. This summary shall be dictated within fourteen (14) days of discharge. For patients with problems of a minor nature and hospitalized less than 48 hours, a final summation typed progress note shall be sufficient.

K. Records may be removed from the Hospital only in accordance with a court order, subpoena, statute, or the patient's written consent. All records are the property of the Hospital and shall not otherwise be taken away without permission of the CEO. In case of readmission of a patient, all previous medical records shall be available for use of the attending Practitioner. This shall apply whether the patient be attended by the same Practitioner or by another. Unauthorized removal of charts from the Hospital is ground for suspension of the Practitioner for a period to be determined by the MEC.

L. Medical records of all patients shall be available to Members of the Staff for bonafide study and research consistent with preserving the confidentiality of personal and medical information concerning the patient.

M. A medical record shall not be permanently filed until it is completed by the responsible Practitioner or is ordered filed by the MEC.

N. A Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the Practitioner.

O. A patient's medical record should be complete at time of discharge, including the final diagnosis, signatures, and dictated clinical resume. When this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in the Health Information Management Department for fourteen (14) days after discharge.

P. An incomplete chart of a patient whose Practitioner has permanently moved away or is unable to complete the chart because of incapacitating illness or death shall be the responsibility of the Medical Executive Committee.

Q. Medical Records Delinquency:

It is the responsibility of all credentialed practitioners to complete their medical records within thirty (30) days from the date the record has been allocated to them for completion. Those records not closed within this time frame will be considered delinquent.

A delinquent record is defined as missing dictations and/or signatures for history and physicals; operative reports; consultation reports; procedure reports; progress notes and physician orders.

The Health Information Management Department will notify practitioners and office managers weekly of records that are older than thirty (30) days. The practitioner will be informed that they have a ten (10) day grace period to complete the records. Failure to do so will result in an administrative removal of their hospital privileges. The practitioner will be required to arrange for continuity of medical care of his hospitalized patients and arrange for coverage of his/her medical backup/call responsibilities. In addition, he/she shall not be able to admit patients to the hospital or see patients in the Emergency Department. Surgeons may not perform any previously scheduled inpatient or outpatient surgery or schedule any surgical procedures while his privileges have been administratively removed. If a Practitioner fails to make such arrangements, the Practitioner's patients then in the Hospital whose treatment by such Practitioner is terminated by the voluntary resignation of clinical privileges shall be assigned to another Practitioner by the Department Chairperson. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.

Notification of suspension shall be delivered to the practitioner via certified mail and electronic notification will be sent to appropriate hospital departments and personnel.

In the event of extenuating circumstances that may prevent completion of the records within the ten (10) day grace period the practitioner may contact a medical staff officer and request an extension for chart completion. [rev. 10/12]

R. House Staff Records, Attending Co-Signature

1. All patients admitted to the care of the Resident Staff will also have an attending physician who has appropriate privileges to care for the patient and/or supervise the Resident physician in providing care to the patient. The Resident has no independent privileges, but provides care under the attending physician as directed by him/her and under his/her privileges. The attending physician of record at the time of admission is responsible for the timely completion of records, as stated previously in this section, except when that responsibility has been transferred by written order to another attending physician.
2. The Resident physician may make any and all entries into the medical record, including dictated summaries (H&P, Discharge procedures, etc.), progress notes, and orders.
3. The attending physician may alter any Resident entry by striking any word(s), replacing or adding as indicated and initialing the changes.
4. Attending co-signature of Resident notes is required (consistent with II.D): daily for patients who are acute, unstable, and/or undiagnosed; every other day for stable patients.
5. All dictated summaries performed by the Resident will indicate the attending physician and be co-signed by him/her.
6. The attending physician will co-sign the discharge order.
7. Resident documentation must conform to the standards of record keeping as delineated elsewhere in these rules. Deficiencies should be addressed by the attending physician in the form of a signed addendum.

III GENERAL CONDUCT OF CARE

A. A general consent form, signed by or on behalf of each patient admitted to the Hospital, must be obtained at the time of admission. It shall be, except in emergency situations, the Practitioner's obligation to obtain proper consent before a patient is treated in the Hospital. A specific consent form that informs the patient of the risks inherent in any special treatment or surgical procedure shall be obtained. Written, signed, informed, surgical consent forms shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor, incompetent or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian, or next of kin, these circumstances shall be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. Should a second operation be required during the patient's stay in the Hospital, a second consent form should be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they shall all be described and consented to on the same form.

B. All orders for treatment shall be in writing. *All medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided*. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of renew, repeat and continue orders is not acceptable.

A verbal order or telephone order is a medical order given verbally by a practitioner.

Telephone and verbal orders may be accepted by a licensed or registered healthcare practitioner whose scope of practice allows them to take orders.

Verbal orders are authenticated within 48 hours. In some instances, the ordering practitioner may not be able to authenticate his or her verbal order (for example, the ordering practitioner gives a verbal order that is written and transcribed, and then he or she is off duty for the weekend or an extended period of time). In such cases, for a temporary period expiring on January 26, 2012, it is acceptable for another practitioner who is responsible for the patient's care to authenticate the verbal order of the ordering practitioner.

The following orders shall not be accepted verbally:

1. Initiate chemotherapy orders
2. Initiate investigational agents
3. Prescribe controlled substances upon discharge from hospital
4. Initiate radiation therapy orders

C. All previous orders are cancelled when a patient is taken to Surgery.

D. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs for bona-fide clinical investigations may be exceptions. These shall be used in accordance with the statement of principles involving the use of investigational drugs. (See Hospital pharmacy policy to control the use of dangerous and toxic drugs).

E. All tissue and foreign bodies removed during surgery shall be sent to the Hospital's pathologist who shall make such examination as he or she may consider necessary to arrive at a pathological diagnosis.

Identification, including pertinent information relative to the case, shall accompany the specimen. The Pathologist's report shall be made a part of the patient's medical record.

F. All tissues removed at operation, except those noted below, shall be sent to the Hospital's pathologist to make such examination as he or she may consider necessary to arrive at a pathological diagnosis. Identification of specimen and clinical diagnosis shall accompany the specimen. The pathologist's report shall be made a part of the patient's medical record.

Exemptions from Rule "f" above are limited to:

1. Cataract
2. Teeth, provided the number, including fragments, is recorded in the medical record.
3. Ear tubes.
4. Cartilage from septoplasties.
5. Retinal detachment hardware.
6. Muscle from strabismus surgery.
7. IUD's.
8. Placentas that are grossly normal and have been removed in the course of operative or non-operative obstetrics.
9. Bone tissue from alveoloplasties.
10. Orthopedic appliances and other prostheses.
11. Segments of ribs, bones, and soft tissue removed only to enhance the surgical procedure.
12. Bunions and corns.
13. Skin scars.
14. Foreskin from the circumcision of a newborn infant.
15. Foreign bodies (for example bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.
16. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.
17. Hernia sacs that appear normal to gross inspection.
18. Pterygiums and pinguercuae.
19. Arthroscopic specimens (except at surgeon's discretion).
20. Tonsils from patients eleven (11) years of age and younger. Those with asymmetric tonsils, or a visible abnormality, will be sent for pathological evaluation.

G. Certain specimens may not require microscopic examination and thus a gross diagnosis may be sufficient. These specimens include:

1. Specimens from the exempted list (f) above for which the surgeon wishes pathological examination and documentation.
2. Arthroscopy specimens.
3. Bone submitted to Bone Bank.
4. Varicose veins.
5. Nasal cartilage and bone.
6. Toenails.
7. Atheromatous plaque.
8. Intervertebral disc, bone, and soft tissue.
9. Aborted fetuses.

H. Practitioners who care for patients in hospital-sponsored ambulatory care (including Same Day Surgery) areas, emergency care areas, and hospital-sponsored home care areas, must follow the same Medical Staff Bylaws, Rules and Regulations and must have the same departmental privileges as those Members who care for inpatients. Emergency Care coverage will be provided in these areas in the same manner as prescribed by the Staff Bylaws and Rules and Regulations. Hospital policies that have been approved by the Staff will be followed by each eligible Practitioner when providing patient care in these areas.

IV. CONSULTATIONS.

A. The right to added professional opinion is not only that of the attending Practitioner, but is the patient's privilege. It is the duty of the Staff, through its departmental Chairperson and MEC to insure that a Practitioner seeks consultation when indicated. The consultant must be qualified to give an opinion in the service in which it is sought. This should require evidence of special training and experience in this service. The consultant's findings and opinion shall be recorded, signed and become a part of the medical record.

B. The attending Practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He/she shall contact the Consultant and brief him/her on the problem involved and shall provide written authorization to permit another attending Practitioner to attend or examine his/her patient, except in an emergency.

C. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of her/his supervisor who in turn may refer the matter through the hospital *Chain of Command Policy*. If warranted, hospital personnel may bring the matter to the attention of the Chairperson of the department wherein the Practitioner has clinical privileges where circumstances are such as to justify such action the Chairperson of the department may request a consultation.

D. Any qualified Practitioner with clinical privileges in the Hospital may be called for consultation within his or her area of expertise.

E. Critical Care Units.

Any critically ill patient may be admitted to the CCU by his/her Physician. It is the responsibility of the attending Physician to request suitable consultation by a Physician with Intensive Care privileges. The Nursing Supervisor may suggest to the attending Physician or his/her designee, that consultation be obtained. If satisfactory solution is not obtained, the Nursing Supervisor may then notify the Chairperson of the Department.

Intensive care surgical patients, six (6) years and under require Pediatric consultation (does not include routine PAR patients sent to CCU for after hours care). Critical Care medical patients, six (6) years and under, require Pediatric consultation and it is suggested the Pediatrician be the attending Physician while the patient is in the CCU.

F. Consultation is recommended at least as follows:

1. When a patient is not a good risk for surgery or treatment.
2. For all patients, especially critically ill, where the diagnosis is obscure or where there is doubt as to the best therapeutic measures to be utilized.
3. For all cases where there is use of an investigational drug in research.
4. Where known or suspected pregnancy may be interrupted.
5. In unusually complicated situations, where specific skills of other Practitioners may be needed.
6. In instances in which the patient exhibits severe psychiatric symptoms.
7. When requested by the patient or his/her family.

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