

# **MEDICAL STAFF RULES AND REGULATIONS**

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## **VALLEY GENERAL HOSPITAL MONROE, WASHINGTON**

Amended May 1988

Revised 9/92, 12/94, 7/98, 6/01, 6/03, 6/05, 06/07, 06/09

# VALLEY GENERAL HOSPITAL MONROE, WASHINGTON RULES AND REGULATIONS

The article in the Bylaws expresses the adoption of Rules and Regulations.

## 1. ADMISSION AND DISCHARGE OF PATIENTS

Active and/or Courtesy Medical Staff members granted by the Board of Commissioners with admitting privileges may admit and discharge patients to the hospital, treat inpatients and outpatients, assume responsibility for continuous care of their patients, and, where appropriate provide emergency service care and appropriate consultations.

Patients may be admitted in this hospital only by VGH hospitalists team and/or staff members who have filed written application, submitted proper credentials, and have been duly recommended for appointment by the Board of Commissioners and approved in accordance with the provisions of ARTICLE II, of the Medical Staff Bylaws. Attending staff must evaluate and complete a History and Physical within 24 hours of the patient's admission to the hospital.

- 1.1. **DISCRIMINATION:** Patients are accepted to Valley General Hospital Acute Care Services on the basis of medical need. Physicians and the hospital shall not discriminate on the basis of race, national origin, religion, or any other form of discrimination prohibited by law.
- 1.2. **CONSENT FOR TREATMENT:** Except where an emergency exists, such as if a patient lacks capacity, no patient shall be admitted without having signed an informed consent for treatment. Obtaining appropriate informed consents for diagnostic or therapeutic procedures, and/or medical treatment, is the responsibility of the attending physician (see Section 3.2 of this document and Informed Consent Policy). It shall be the responsibility of the attending physician to determine patient competency and emancipation status of minors.
- 1.3. **DIAGNOSIS:** Except in emergencies, as determined by the Medical Staff member, no patient shall be admitted to the hospital until a provisional diagnosis has been stated, and the consent to the Hospital secured through the Admitting Office. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.
- 1.4. **PHYSICIAN COVERAGE FOR HOSPITALIZED PATIENTS:** Each member must assure timely, adequate and professional care for his/her patients in the hospital. The physician is to be available at all times, or shall provide for an alternate medical staff member with appropriate privileges to provide appropriate patient care.

At the discretion of the ER physician and/or hospitalists on-duty, based on patient's diagnoses and stability, the ER physician and/or hospitalists on-duty will determine if the patient needs to be seen by the Primary Care physician prior to 8AM rounds. It is the responsibility of the ER physician and/or hospitalists to notify Primary Care Physician of the need to see patient prior to 8AM or sooner.

- 1.5. **LABORATORY REQUIREMENTS:** Each patient admitted to the hospital shall be assessed by the Attending Physician/Hospitalists/Anesthesiologist to determine if:
  - 1.5.1. Laboratory testing is required; or
  - 1.5.2. Review laboratory tests results in the patient's chart and determine if additional testing is needed.
    - 1.5.2.1. Testing pertinent to the admission/procedure must have been completed within fourteen days immediately prior to admission.

- 1.5.2.2. The laboratory that performed the testing must be licensed by the federal government (CLIA) to provide the laboratory testing results on the report.
  - 1.5.2.3. If the laboratory report is from a laboratory other than Valley General Hospital Laboratory, the report must be signed by the patient's physician/provider.
- 1.6. **UTILIZATION REVIEW:** The attending physician and/or hospitalists is required to document the need for continued hospitalization after specific periods of stay as defined in the Utilization Management Plan. The documentation shall include, but not be limited to:
- 1.6.1. An adequate written record of the reason for continued hospitalization. A reconsideration of the patient's diagnosis is not sufficient.
  - 1.6.2. An estimate of the period of time the patient will need to remain in the Hospital.
  - 1.6.3. Plans for post-hospital care.
- 1.7. **AMA (Against Medical Advice) DISCHARGE:** Patients shall be discharged only upon the written order of the attending physician and/or hospitalists. Should a patient leave without such order, documentation of the incident shall be made in the patient's medical record.
- 1.8. **"NO CODE" ORDERS:** A "no code" order is a directive that no resuscitative measures are to be undertaken to prolong life. Other than a "No Code" order, i.e., no CPR or specific orders detailing levels of acceptable resuscitative efforts shall be clearly documented in the Physician's Orders. **See DNR Policy.**
- 1.9. **ADVANCE DIRECTIVES:** Physicians shall be encouraged to discuss advance directive issues with patients prior to hospitalization. Physicians shall have the legal responsibility to determine if a directive is valid. The physician shall follow the directive, unless the physician has a moral objection to denial or withdrawal of artificial life support consistent with the directive, in which case the physician shall transfer the care of the patient to another physician who will honor the directive.

## 2. MEDICAL RECORDS

- 2.1. **RESPONSIBILITY:** The attending physician shall be responsible for the timely preparation of a complete, pertinent, and legible medical record for each patient, in accordance with Medical Record Department policy. The content of the medical record shall be sufficient to support the diagnosis, and justify the treatment, and shall include, but not be limited to (patient data):
- 2.1.1. Medical History
    - Identification Data
    - Chief Complaint
    - History of Present Illness
    - Relevant Past History (including surgeries)
    - Relevant Social and Family Histories
    - Review of Systems
    - Allergies (including medication intolerances)
    - Current Medications
  - 2.1.2. Evidence of Appropriate Informed Consent (**see 3.2 of this document**)
  - 2.1.3. Physical Examination
    - Comprehensive Physical Assessment
    - Conclusions (or impressions)
    - Action Plan
  - 2.1.4. Reports of Operative and Other Invasive Procedures, Tests and Results
  - 2.1.5. Diagnostic and Therapeutic Orders

- 2.1.6. Progress Notes
- 2.1.7. Final Diagnoses
- 2.1.8. Conclusions (clinical resume)
  - Discharge Summary (**see 2.12 of this document**)
  - Patient Instructions

The above may be abbreviated in cases where hospitalization is expected not to exceed 24 hours, with the use of the Short Stay History and Physical document. If the stay exceeds 24 hours (for medical reasons), a complete medical record must be prepared, including History and Physical, and Conclusions.

For Prenatal cases, the Prenatal Record shall be considered as the full History and Physical. Interval progress notes shall be added by the attending physician to this record.

2.2. **HISTORY AND PHYSICAL:** A complete History and Physical examination shall be dictated or handwritten in the medical record **within 24 hours after admission** for all inpatients including patients requiring C-Sections, except in the following instances:

- 2.2.1. When a patient is scheduled for non-emergency surgery, the History and Physical examination shall be recorded in the patient's record prior to administration of preoperative sedation and/or transfer to the Operating Room. A brief written History and Physical will suffice if the complete History and Physical has been dictated, but is not yet available for the record.
- 2.2.2. When a patient is critically ill or too incapacitated to undergo a complete physical examination and/or give a complete history, and family members are not available for this purpose.
- 2.2.3. When a complete History and Physical examination have been performed by a member of the Medical Staff within seven days prior to admission, durable and legible copies may be used, provided there have been no subsequent changes or the changes have been recorded at the time of admission.
- 2.2.4. When copies of complete Histories and Physical examinations performed within 30 days prior to admission if accompanied by an interval admission note which includes all additions to the History and any subsequent changes in the physical findings. This provision covers obstetrical admits.
- 2.2.5. When a patient is readmitted within 30 days for the same or a related problem, an interval History and Physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available.
- 2.2.6. An outpatient History and Physical may be dictated or handwritten for:
  - 2.2.6.1. Outpatient surgical procedures as defined by St. Anthony's guidelines for outpatient services
  - 2.2.6.2. Other outpatient procedures and/or admissions that are invasive and/or that will require conscious sedation, examples include but are not limited to:
    - IV hydration
    - Transfusions
    - Scopes
    - Facet blocks
    - Lithotripsy
    - CT guided biopsy
    - Medication infusions

**All surgical procedures shall require the use of the outpatient History and Physical document unless a complete History and Physical has been performed within thirty (30) days prior to admission with no significant changes.**

**All H&P report must reflect an updated review that should read:**

H&P reviewed(circle one) Yes \_\_\_\_\_ No \_\_\_\_\_

Significant changes since H&P completed(circle one) Yes \_\_\_ No \_\_\_

If yes, significant changes noted: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

- 2.2.7. A physical health assessment, including a medical history and physical examination is completed as noted in the policies and procedures for behavioral health units i.e., recovery center, inpatient psychiatric treatment unit, etc.
- 2.3. **PROGRESS NOTES:** Pertinent progress notes shall be recorded, dated, timed, and signed at the time of observation, sufficient to permit the 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 response to treatment. Rounds conducted and Progress notes made by attending physicians ***shall be written/documented at least daily in the patient record*** on acute care inpatients.
- 2.4. **POST-OPERATIVE NOTE:** A post-operative progress note is entered in the patient record immediately after surgical procedure by the attending surgeon. The note must include the following elements:
- Date
  - Time
  - Specimen removed
  - Pre-op Diagnosis
  - Post-op Diagnosis
  - Procedure
  - Surgeon/assistant
  - Complications
  - Condition
  - Findings
  - Anesthesia
  - EBL
  - Signature
- 2.5. **OPERATIVE REPORT:** In addition to the post-operative note, an operative report must be written or dictated immediately after surgery. The report shall contain the following required elements: (1) the name of the surgeon and (2) any assistants, (3) procedure(s) performed and (4) a description of each procedure, (5) findings, (6) estimated blood loss, (7) specimens removed, and (8) postoperative diagnosis.
- 2.6. **PRENATAL RECORD:** The current obstetrical record shall include a complete prenatal record (36 weeks or more). The prenatal record may be a legible copy of the attending physician's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
- A complete History and Physical will be required if there is no Prenatal Record for the patient.**
- 2.7. **AUTHENTICATION OF RECORD ENTRIES:** All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated by legible signature of the attending physician.

2.8. **SYMBOLS AND ABBREVIATIONS:** Medical staff is discouraged from using abbreviations in the medical record especially when writing orders. If abbreviations are used, they must be generally accepted in the medical community so they are clearly understood by care givers. Medical staff must not use abbreviations listed in VGH's Unacceptable Abbreviations and Symbols policy, #2.30.

2.9. **PROPERTY RIGHTS OF MEDICAL RECORDS:** Medical records may be removed from the Hospital's jurisdiction and safe keeping only in accordance with a valid court order, proper subpoena, or statutory requirement. Requested records shall be copied in accordance with the valid request. All original records are the property of the Hospital and shall not be otherwise removed without permission of the Chief Executive Officer, or authorized designee, and as appropriate without consent from the patient for release. In case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or another.

Unauthorized revision, falsification, alteration, or removal of charts and records from the Hospital is grounds for suspension of the member for a period to be determined by the Medical Executive Committee as expressed in Article VIII, Section 8.4 of the MS Bylaws.

Portions of the medical record may be reproduced on request of the attending physician for use in the patient's office record. Free access to all medical records of all patients shall be afforded to members of the medical staff for bona fide study and research if the confidentiality of personal information concerning the individual patients shall be preserved, as approved by the Hospital. Requests for records for research will be reviewed by the Medical Executive Committee, who shall make a recommendation regarding the matter to the Board of Commissioners.

2.10. **VERBAL ORDERS:** All orders for treatment shall be in writing, except in emergent situations where a verbal order is required. A verbal order shall be considered to be written if dictated to duly authorized persons. These persons are defined as an RN or MD; also, orders may be given regarding their particular service only to certified licensed personnel in dietary, physical therapy, respiratory therapy, social services, pharmacy (pharmacist only.)

All orders dictated over the phone shall be written, dated, timed, and signed by the appropriate authorized person to whom dictated under the name of the ordering physician. All verbal orders shall be authenticated by the responsible physician, or by his/her alternate medical staff member, by signing **within 48 hours**.

**Orders for recovery center unit patients shall be authenticated no later than seven (7) days as indicated by WAC 246-337-105: Medication Management.**

2.11. **STANDING ORDERS:** Standing Orders may be submitted to the forms committee for approval and house-wide implementation. Standing orders are those affecting all patients treated in a specific medical service or all patients with a particular diagnosis or planned surgery.

All orders for outpatient/ancillary services shall be written clearly and legibly on a prescription pad or acceptable prescription form.

2.12. **DISCHARGE SUMMARY:** Conclusions, at the termination of hospitalization, shall be written or dictated on all medical records of patients hospitalized over 48 hours. Final progress notes may be substituted for the discharge summary for patients with minor problems, such as newborns and normal deliveries, and a stay of less than 48 hours. For those who are hospitalized less than 24 hours, a final summation-type note shall be

sufficient. This clinical resume should concisely recapitulate the reason for hospitalization, the principal and all relevant additional or associated diagnoses, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, such as physical activity, medication, diet and follow-up care.

In the event of death, a summation statement will suffice and shall indicate at least the reason for admission, the findings and hospital course, including the events leading to death and the suspected cause of death.

**In the event of a patient transfer to a long-term care facility, a complete discharge summary must be dictated within 24 hours.**

- 2.13. **RECORD COMPLETION:** All practitioners are required to complete and authenticate medical records within thirty (30) days following the patient's discharge with the exclusion of extraordinary circumstances. Electronic signatures or faxed authentication is acceptable. Failure to complete records after three (3) notifications shall constitute grounds for automatic suspension of privileges as specified but not limited to Article VIII, Section 8.3 of the MS Bylaws and Delinquent Medical Record Policy. Records shall be considered complete when reports have been transcribed and all record entries are dated, timed, and authenticated.

Practitioners shall not be sanctioned for the following:

- If patient records are not available at the time of visit in the records department
- Advanced notification of vacation, travel, or sick days to records department

### **3. SURGERY/ANESTHESIA**

- 3.1. **SCHEDULING OF SURGERY:** Surgery times shall be scheduled in accordance with these policies: Surgery and Procedure Block Scheduling and Procedure for Scheduling Surgical procedures. Open block time is available for physicians who need to schedule procedures, but may not require a standard block of time during the week.
- 3.2. **INFORMED CONSENT:** Except in emergencies in accordance with hospital policies, a surgical invasive\* procedure should not be performed without the approved WSMA informed consent form being signed and available at the Hospital. The physician shall be responsible for obtaining and completing this form and delivery of the informed consent to the Hospital.

**Whenever multiple procedures are scheduled on one patient, each physician must obtain an informed consent for each procedure.**

**\*Invasive procedure shall be as follows but not limited to GI endoscopy procedures, blood transfusion, invasive radiological procedures, angiogram and/or discograms and procedures listed in the patient, procedure, and site verification hospital policy #3.39.**

- 3.3. **ANESTHESIA RECORD:** The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-operative anesthesia evaluation, intraoperative anesthesia care, administration of all anesthetic agents, and post-anesthesia follow-up of the patient's condition.
- 3.4. **TISSUE REMOVED IN SURGERY:** All tissue (except those excluded by policy) specimens removed at surgery shall be sent to the hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis

and he/she shall sign his/her report. The authenticated report shall be made a part of the patient's medical record.

- 3.5. **SURGICAL ASSISTANT:** Surgical assistants also known as Registered Nurse First Assistants or any practitioner who have filed written application, submitted proper credentials, and have been duly recommended for appointment by the Board of Commissioners and approved in accordance with the provisions of ARTICLE II, of the Medical Staff Bylaws may assist in Surgery.
- 3.6. **PREOPERATIVE DATA REQUIREMENTS:** The following data must be available in the patient's medical record prior to the patient's entry into the operating room:
- 3.6.1. History and Physical **must** be complete with the exam of the appropriate system by the second physician performing the second procedure whenever applicable.
  - 3.6.2. Hemogram or CBC (*as determined by the anesthesiologist*)
  - 3.6.3. EKG on patients over age 50 *as determined by the anesthesiologist*)
  - 3.6.4. Surgical Consent please refer to Informed Consent Policy and Section 3.2 of this document

**If the anesthesiologist believes further diagnostic tests would be appropriate for the anesthetized patient, he/she may order these.**

- 3.7. **INDICATIONS FOR SURGERY:** Indications for surgery must be documented in the History and Physical and/or the operative record.

**“Medical evaluations”: All patients with identified systemic disease/illness have a medical evaluation prior to surgery in order to develop a multi-disciplinary perioperative plan of care.”- refer to policy 500.55 “Guidelines for Preoperative Management of Surgical Patients”**

#### **4. EMERGENCY SERVICES**

- 4.1. **PHYSICIAN COVERAGE:** Physician coverage of the Emergency Department has been provided through contractual arrangements between the Hospital and an emergency physician's group. Back-up coverage shall be the responsibility of all primary care active staff members on a rotation basis, unless exceptions have been made by the Primary Care Department. Specialists may be on call by advance arrangement, and the on-call guidelines policy.

Emergency Room Physicians shall give priority to Emergency Department patients in the event of simultaneous emergencies.

In an emergency, any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as life-saving measure or to prevent serious harm – regardless of his or her medical staff status or clinical privileges – provided that the care, treatment, and services provided are within the scope of the individual's license.

- 4.2. **ER PHYSICIAN RESPONSIBILITY FOR INPATIENTS:** Should an emergency room patient require hospitalization, care of the patient shall be assigned to the physician who has the responsibility for admitting or directly to the patient's family personal physician. In the event an emergency involving an inpatient when the attending physician is not immediately available, the ER physician shall be asked to provide emergency care Until the attending physician is present.

Upon Emergency Room entry to the hospital, the patient shall receive care by Emergency Department Physicians until stabilized, or until the attending physician is present.

- 4.3. **REFERRALS FROM THE EMERGENCY DEPARTMENT:** When the Emergency Department physician determines that a patient requires hospitalization, he/she will contact the patient's regular physician or their designated alternate with such a recommendation. If the patient does not have a regular physician on the medical staff, the physician on call for the Emergency Department (4.1) will be notified with the recommendation and will be responsible for the admission. If a patient without a regular physician is admitted to a subspecialist and only primary care follow-up is required after discharge, follow-up care will be assigned to the primary care physician on call at the time of admission.

For patients that are not admitted and who do not have a regular physician on the medical staff, follow-up care from the Emergency Department will be assigned to the physician on call at the time of the Emergency Department visit. Such patients will be given two weeks in which to call the physician's office to make an appointment. No staff member shall imply that recommended follow-up care is free of charge. Patients will be responsible for any fees and other charges incurred in a follow-up clinic visit. After that time, the physician is no longer obligated to see those patients. Financial responsibility for follow-up care to a PCP and/or specialist whenever applicable shall be expressed to those patients prior to discharge in ER.

When an on-call physician or his or her group practice has formally discharged a patient from their practice – for whatever reason but through a process recognized and approved by the Washington State Medical Association – it is no longer appropriate for the Emergency Department to refer such patients to that provider or clinic. In such cases, the physician and/or clinic are exempted from the medical staff bylaws requirement for emergency follow up.

The Emergency Department will make every effort to avoid referring patients to those physicians and/or clinics from which they have been previously discharged.

When, in the judgment of the physician formally discharging a patient from their care, it is in that patient's best interests that the Emergency Department be notified of this action, a copy of the letter sent to the patient should also be sent to the Medical Director of the Emergency Department so that this can be noted on the patient's hospital record.

Any deviation from the foregoing protocol should be reported directly to the medical director of the Emergency Department for further investigation.

- 4.4. **TRAUMA PATIENTS:** Regardless of primary admitting physician, the ER practitioner on-duty shall activate the code for Full Trauma Team or Modified Trauma Team depending on severity during patient's triage. Those medical staff members specialty identified on the Trauma Team Activation policy shall respond to trauma call per policy. All other specialties unless otherwise identified shall respond in accordance with policy ID#3.38.

## 5. **CONSULTATIONS**

- 5.1. **QUALIFICATIONS:** Any qualified member with clinical privileges in this Hospital shall be called for consultation within his/her expertise whenever necessary unless unavailable. If unavailable, the licensed independent practitioner shall seek consultation with an external expert whenever feasible.

- 5.2. **SITUATIONS IN WHICH CONSULTATION SHOULD BE CONSIDERED:** Except in an emergency, consultation is recommended in the following situations:
- 5.2.1. When the patient is not a good risk for operation or treatment;
  - 5.2.2. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
  - 5.2.3. Where there is doubt as to the choice of therapeutic measures to be utilized;
  - 5.2.4. Where the patient exhibits severe psychiatric symptoms;
  - 5.2.5. When requested by the patient or his/her family, and;
  - 5.2.6. When the patient is not making progress as expected.
  - 5.2.7. **Consultation is Required in the Following Situations:**
    - 5.2.7.1. Discontinuation of life support;
    - 5.2.7.2. In unusually complicated situations where specific skills of other members may be needed;
    - 5.2.7.3. Declaration of brain death; irreversible coma, and
    - 5.2.7.4. On ventilator > 48 hours.
- 5.3. **REQUEST PROCESS:** The attending member is responsible for requesting consultation when indicated and for calling in a qualified consultant. He/she will provide written authorization (in the form of an order on the order sheet) to permit another attending member to attend or examine his/her patient and shall state the nature and extent of the services desired.
- Inpatient routine consultations must be completed within 24 hours. Emergent or urgent consultations must be done immediately. Immediate means practitioner to call back within 20 minutes and see patient within 60 minutes.
- 5.4. **CONTENT:** Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. Except in emergency, so verified on the record, when operative procedures are involved, the consultation note shall be recorded prior to operating said procedure.
- 5.5. **PATIENT SAFETY:** If a nurse or other health care professional (HCP) has any reason to doubt or question the care provided to any patient, or feels that appropriate consultation is needed and has not been obtained, the HCP shall call this to the attention of the attending physician. If not satisfied, the HCP may consult with his/her supervisor who in turn may refer the matter to the Chief Operating Officer/Chief Nurse Executive. If warranted, the Chief Operating Officer may bring the matter to the attention of the Department Chairperson or President of the Medical Staff wherein the member has privileges. Where circumstances are such as to justify action, the Department Chairperson or President of the Medical Staff may him/her self request a consultation.

## 6. PHARMACY

- 6.1. **FORMULARY AND GENERAL SUBSTITUTIONS:** Whenever possible, physicians are requested to prescribe drugs listed in the Hospital Formulary of Valley General Hospital.
- 6.2. **THERAPEUTIC SUBSTITUTIONS:** Therapeutic substitutions, previously approved by the Medical Staff through its Pharmacy and Therapeutics committee, may be made by the hospital pharmacist from drugs ordered by the physician to more therapeutically acceptable drugs or similarly therapeutic drugs within the hospital formulary after consultation with the ordering physician, unless previously approved by the medical staff.
- 6.3. **AUTOMATIC DISCONTINUATION:** Schedule II Narcotics shall be discontinued automatically *after three days, unless reordered by the attending physician.* Antibiotics shall be automatically discontinued *after seven days' use, unless reordered*

**by the attending physician.** Schedule III, IV and V controlled substances will be automatically discontinued after seven days unless reordered by the attending physician. Discontinuation shall not occur without notification of the attending physician.

- 6.4. **QUESTION OF THERAPEUTIC VALUE:** If the pharmacist has any reason to doubt or question the drug therapy provided to any patient, the matter shall be called to the attention of the prescribing physician, and if the matter cannot be resolved, it will be called to the attention of the Chairperson of the Pharmacy and Therapeutics Committee who may in turn refer the matter to the physician involved. If warranted, the matter may be brought to the attention of the Department Chairperson wherein the member has clinical privileges.
- 6.5. **PROPOSED DELETIONS AND ADDITIONS:** All proposed deletions or additions to the hospital formulary shall be submitted in writing to the Pharmacy and Therapeutics Committee for their consideration. The recommendations from the Pharmacy and Therapeutics Committee will be reported to the Medical Staff.

## 7. GENERAL

- 7.1. **INFRACTION OF THE RULES:** Infractions of these rules and regulations shall be reported to the Medical Executive Committee as soon as possible and may be grounds for corrective action as defined in the Medical Staff Bylaws, Policies and Procedures, as applicable.
- 7.2. **AUTOPSIES:** It shall be the duty of all staff members to secure meaningful autopsies when warranted, or when properly requested. Except for cases under the jurisdiction of the Medical Examiner, an autopsy may be performed only with written consent, signed in accordance with State Law. These autopsies shall be performed by the hospital pathologist. Provisional and anatomic diagnosis shall be recorded in the medical record **within 48 hours after gross dissection** and complete protocol should be made a part of the record **within six weeks**. See Indications for Autopsy Policy.
- 7.3. **HOSPITAL DEATH:** In the event of a Hospital death, the deceased shall be pronounced dead within a reasonable time by the following designees in order of preferences:
- 7.3.1. Attending Physician/Designee;
  - 7.3.2. Emergency Room Physician;
  - 7.3.3. Registered Nurse (only in the event of a "No Code" death) (Please refer to hospital-wide DNR Policy)
- 7.4. **PATIENT TRANSFER:** The patient shall be transferred when his/her medical condition cannot be treated at the hospital with the medical staff, nursing staff, space, equipment, or when other necessary resources are not available. The patient may be transferred at patient's request, and/or if the benefits of transport outweigh the risks, as certified by the attending physician on the transfer form. Transfers are to be "appropriate," per Federal Law.
- 7.5. **PROFESSIONAL LIABILITY ACTIONS:**  
Medical Staff and Allied Health members are required to report to the Administrator any suits or claims involving Hospital patients made against them for malpractice within thirty (30) days of the claim or during the reappointment cycle whichever occurs first. Any claim incurred at any clinical organization must also be reported within 30 days of claim.
- 7.5.1. Medical Staff and Allied Health Members are required to report any final judgments or settlements to the Administrator involving malpractice claims.

- 7.6. **QUALIS ACTIONS:** Medical Staff Members are required to report to the Utilization Review Coordinator any denial or quality of care concern letters on hospitalized patients at Valley General Hospital from QUALIS within seven (7) days of receiving the letter.
- 7.7. **PRACTICE STANDARDS:** Unit structure standards and policies are adopted by each Medical Staff Department.
- 7.8. **CONTINUING MEDICAL EDUCATION:** Appointees of the Active and Courtesy Medical Staff shall have 50 hours of continuing medical education at the time of reappointment. Allied health practitioners shall provide appropriate continuing education units at the time of reappointment according to privileging criteria. The Chief of Service shall determine if appointees with less than the required hours have enough relevant continuing education to warrant reappointment on an exception basis.

Any medical staff/allied health member who are currently certified in their specialty as recognized by the State of Washington, including but not limited to, American Board of Medical Specialties, National Commission on Certification of Physician Assistants, and American Nurses Credentialing Center, shall serve as having met criteria for continuing education documentation in their field with the stipulation that proof of attendance and program content shall be submitted upon request.

- 7.9. **COMPLIANCE WITH CMS (CENTERS FOR MEDICAID AND MEDICARE SERVICES) BILLING REGULATIONS:** Every attending physician must comply with CMS regulations regarding the documentation for Medicare and Medicaid Billing. Professional service fees may not be billed to patients if the attending physician did not perform or directly and personally oversee the services rendered.
- 7.10. **MEDICAL STAFF SUPERVISION OF ALLIED HEALTH PRACTITIONER AND/OR STUDENTS:** All medical staff members identified as sponsoring physicians or preceptors for allied health practitioners and/or students are directly responsible for all clinical activities provided in the Hospital. Examples of clinical activities include, but are not limited to, reviewing and planning of patient care, co-signing patient charts, teaching surgical and procedural techniques, remaining available for patient care consultation on a 24-hour basis, whenever applicable.

Any student including but not limited to medical students, residents, or physicians in training shall follow the hospital's policy #2.33 and 2.34 as applicable.

- 7.11. **CONFIDENTIALITY:** All members of the Medical Staff, Allied Health Professionals associated with that staff, and their respective employees and agents, shall maintain the confidentiality, privacy and security of all individually identifiable health information in records maintained by the Hospital or by business associates of the Hospital, in accordance with any and all privacy and security policies and procedures adopted by the Hospital to comply with current federal, state and local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act or 1996 ("HIPAA") Privacy Regulations, 45 CFR Sections 160 & 164. Protected Health Information, as defined in the HIPAA Privacy Regulations, shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with the Hospital's health information privacy policies and applicable law. Medical record information about a patient whom a Medical Staff member is treating can be furnished by the Medical Staff member to any health care provider within the Hospital who has responsibility for that patient's care."
- 7.12. **EMTALA (Emergency Medical and Treatment and Active Labor Act):** all providers shall comply with the requirements of EMTALA and associated regulations (42 USC 1395 dd42 USC 1395dd).

**OB Medical Screening:** A qualified labor and delivery nurse may perform a medical screening exam in consultation with the attending physician to determine the presence/absence of active labor in the full term patient (>20 weeks gestation or greater) who is an established patient of a physician with OB privileges at the hospital. Hospital policy #1100.67.

The Rules and Regulations shall have the same force as the bylaws and shall be amended according to Article X of medical staff bylaws.

ADOPTED by the Medical Staff of Valley General Hospital:

**APPROVED IN FILE**

\_\_\_\_\_  
President of the Medical Staff, Valley General Hospital

**June 4, 2009**

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Medical Director, Valley General Hospital

\_\_\_\_\_  
Date Signed

APPROVED by the Board of Commissioners, Public Hospital District No. 1 of Snohomish County dba Valley General Hospital:

**APPROVED IN FILE**

\_\_\_\_\_  
Board of Commissioners, Valley General Hospital

**June 30, 2009**

\_\_\_\_\_  
Date Signed

**APPROVED IN FILE**

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Board of Commissioners, Valley General Hospital

**June 30, 2009**

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Date Signed

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