MEDICAL STAFF RULES AND REGULATIONS

I. ADMISSION, DISCHARGE, & TRANSFER RESPONSIBILITIES

1.1 ADMISSION

Patients may be admitted to LVSC by a Member of the Medical Staff with appropriate privileges, and shall be the responsibility of that physician until the patient is transferred to another facility, physician or discharged. This physician shall be referred to as the Attending Physician (AP). No patient shall be admitted to LVSC without a supporting provisional diagnosis or valid reason.

The following restrictions apply to certain patients:

- Patients over **300** pounds have to be approved by Anesthesia.
- Patients with active TB are not accepted at LVSC.
- Patients with **Sleep Apnea** require an anesthesia approval and evaluation.
- **ASA III & ASA IV** patients require an approval by Anesthesia.

1.2 PATIENT TRANSFERS

Patients may be transferred to another facility for further care if requested by the patient and if the practitioner who will receive the patient and assume responsibility concurs to the transfer of the patient.
Patients may be transferred to another care facility if services for care of the patient are more appropriate and if the AP concurs and the transfer does not involve an unwarranted risk. Patients may be transferred to another Staff Member, if the other Staff Member is available and agrees to accept responsibility.

The AP will be required to document the condition of the patient at the time of transfer. This documentation will accompany the patient to the receiving facility or physician.

Any patient required to go to the hospital must be transferred by ambulance.

1.3 PROTECTION FROM HARM

The AP shall be responsible for providing care and information necessary to protect his/her patient from self harm and to assure protection of others.

1.4 COMPLIANCE WITH QUALITY PROGRAMS

The AP shall comply with the Risk, Quality and Safety Management Programs.

1.5 DISCHARGE OF PATIENTS

Patients shall be discharged by written order from the AP, in compliance with LVSC discharge policy. Should a patient leave LVSC against advice of the AP, documentation of the incident shall be made in the patient's medical record.

II. MEDICAL RECORDS

2.1 MEDICAL RECORD CONTENT

The AP shall be responsible for preparation of a complete and legible medical record for each patient. It shall include identification data, complaint, past medical history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition of discharge, summary or discharge note.

To increase patient safety and minimize miscommunication within our facility there are certain abbreviations that may not be used in patient records. The list is as follows:

DO NOT USE	Instead Use
U	**Write “unit”**
IU	**Write “international Unit”**
Q.D., QD, q.d., qd	**Write “daily”**

Q.O.D., QOD, q.o.d., qod	**Write "every other day"**
Trailing zero (X.0 mg)	**Write "X mg"**
Lack of leading zero (.Xmg)	**Write "0.X mg"**
MS	**Write "morphine sulfate"**
MSO4 and MgSO4	**Write "magnesium sulfate**

2.2 HISTORY AND PHYSICAL

A complete current (within 30 days) history and physical examination report must be obtained by the day of admission on **every** patient.

The History & Physical Exam shall encompass all those systems, which customarily and usually are the standard for a complete exam within the practice of the respective specialty. At a minimum, an H&P will include:

1. Comprehensive problem-focused review/exam of the present illness/injury and symptoms.
2. Relevant past medical, surgical and family history.
3. List of current medications, including natural and herbal remedies as appropriate.
4. List of current known allergies and medication reactions.
5. Risk assessment to include any existing co-morbidity.
6. Diagnostic studies relevant to the patient's health status and for the procedure being performed per standards of specialty practice.
7. Review of abnormal findings of any ancillary studies.
8. Assessment of general condition and system review, including an examination of the heart and lungs by auscultation.
9. Pre-op diagnosis and surgical/procedural plan.

The following criteria will apply depending on the ASA classification:

ASA I: **Normal, healthy patient.**
Requires a History and Physical Exam

ASA II: **Mild, systemic disease.**
Requirements are the same as ASA I. No additional medical clearance needed if patient has 1 or 2 stable, treated conditions. Other patients that qualify as a class II may need to have additional medical clearance after review by LVSC nurse, Clinical Director, Medical Director, or Anesthesiologist.

ASA III: **Severe systemic disease that limits activity, but is not incapacitating.**
Written medical clearance by patient's primary care physician is recommended and will most likely be required after review of surgeon's history, which may result in rescheduling the procedure. If additional testing is needed, results must be on the chart prior to surgery. LVSC nurse will review test results and medical history and results will be brought to the attention of an anesthesiologist for review.

ASA IV: **Incapacitating systemic disease that is a threat to life.**
Requires medical clearance described in ASA III **and** documented clearance from the department of anesthesia.

ASA V: **Moribund patients not expected to survive without the operation.**
These patients **will not be treated** at LVSC.

H&Ps from primary care physicians need to be reviewed by the AP. Any abnormal findings or special instructions need to be discussed by the AP with the patient prior to the surgery. This is not a LVSC responsibility because LVSC does not call patients until 24-48 hours before surgery.

Example: If the primary care physician states on the H&P that the patient needs to stop his Coumadin 5 days prior to surgery, LVSC staff won't discover this until 24-48 hours before the scheduled surgery when LVSC calls the patient for his/her assessment.

If a patient is readmitted for treatment of the same or related problem within 30 days following discharge from the LVSC, the previous history and physical must be updated to reflect any subsequent changes.

2.3 OPERATIVE NOTES

Operative reports shall include indications for surgery, detailed account of the findings at surgery and details of the surgical technique. A comprehensive operative report shall be dictated within 72 hours of surgery and signed by the surgeon and made a part of the patient's current medical record within twenty

one (21) days. To bridge the time gap until the report is typed, the AP shall place a brief handwritten operative note in the progress record at the time of surgery. Any complications will be documented in the operative note. Any practitioner with un-dictated operative reports 72 hours following the day of the operation(s) shall be automatically suspended for operative privileges until the dictation is completed. If dictation is not received within twenty one (21) days **privileges will automatically be terminated**. Vacations and illness will be considered exceptions to the above policy and the age of the record will be adjusted for the amount of time the physician was unavailable.

2.4 CONSULTATIVE REPORTS

Consultation reports shall document review of the patient's record, pertinent findings on examination, and consultant's opinion and recommendations. When operative procedures are involved, the consultative note shall be recorded prior to the operation, except in emergency situations. This report shall be made a part of the patient's record.

2.5 DATE AND AUTHENTICATION

All clinical entries in the patient's medical record shall be accurately dated and authenticated. Electronic signatures through clinical computer systems are acceptable as authentication of the report.

2.6 FINAL DIAGNOSIS

Final diagnosis shall be recorded in terms of Standard Nomenclature in full, without the use of symbols or abbreviations, dated and signed by the AP at the time of discharge.

2.7 RELEASE OF MEDICAL INFORMATION

Written consent of the patient or authorized representative of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

2.8 REMOVAL OF RECORDS

Records may not be removed from LVSC jurisdiction except in accordance with a court order, subpoena, statute, or the patient's written consent. All records are the property of LVSC and shall not be taken away without permission of the Administrator or his/her designee. In case of readmission of a patient, all previous medical records shall be available for use of the AP. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from LVSC is grounds for suspension for a period to be determined by the Medical Executive Committee (MEC).

2.9 RECORDS FOR STUDY AND RESEARCH

Medical records of patients shall be available to members of the Medical Staff for a bonafide study and research upon approval of the MEC consistent with preserving the confidentiality of personal and medical information concerning the patient. Former members of LVSC shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients at LVSC subject to the discretion of the Administrator. Any study or research documents for presentation must be submitted for prior review and approval to the LVSC Governing Board.

III. GENERAL CONDUCT OF CARE

3.1 CONSENT FORM

A general consent form, signed by or on behalf of each patient admitted to the LVSC, must be obtained at the time of admission. It shall be the AP obligation to obtain proper consent before a patient is treated at LVSC. The admitting nurse will notify the AP whenever such consent has not been obtained.

A specific consent form that informs the patient of the risks inherent in any special treatment or surgical procedure shall 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.

3.2 TREATMENT ORDERS

All orders for treatment shall be in writing. Orders must be written clearly, legibly and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse. The use of "renew," "repeat," or "continue orders," is not acceptable.

A verbal order shall be considered to be in writing if dictated to a duly authorized licensed RN and reviewed and signed by the responsible practitioner. All orders dictated over the telephone shall be signed by the appropriately authorized person who took the dictation and will include the name of the practitioner giving the orders. The responsible practitioner shall authenticate such orders and failure to do so shall be brought to the attention of the MEC for appropriate action.

Drugs & medications administered to patients shall be those listed in the latest edition of LVSC Formulary.

3.3 SURGICAL PROCEDURE SITE VALIDATION

To identify the intended site of incision or insertion the site must be marked such that the mark will be visible after the patient has been prepped.

The marking should occur as follows:

- At or near the incision site.
- By the AP performing the procedure – write "Yes" or initials on or near the site where the procedure will be performed. The site must be visible after the patient has been prepped and draped.
- Use marker that is sufficiently permanent to remain visible after completion of the skin prep.
- Patient should be involved, awake and aware, if possible.
- Teeth – indicate on documentation or mark the operative tooth on the dental radiographs or dental diagrams. Dental restorations are exempt.
- Spinal Procedures – Preoperative skin marking of the general level is done. When the approach involves right vs. left, then the mark must so indicate. Inter-operatively the exact inter-space(s) to be operated on should be precisely marked under fluoroscopy.

3.4 "TIME OUT" BEFORE STARTING PROCEDURE

A final verification of the correct patient, procedure, site and implants needs to occur before starting any procedure. Active communication among all members of the surgical/procedure team needs to take place to verbally confirm the correct person, correct procedure, correct side, correct site, correct patient position and immediate availability of correct implantable devices.

"**Time Out"** procedure is as follows:

- Immediately before starting any procedure;
- Occurs in the location where procedure is done;
- Involves entire operative team, active communication and documented in Intra-op record;
- Includes review of H&P, consent, schedule
- All images are properly labeled and displayed;
- All special equipment & correct implants are available;
- Any discrepancy is resolved prior to the start of any procedure.

The "**Time Out**" will be completed even when procedure marking does not take place. For inter-operative spinal procedures the "**Time Out**" should occur at the time the inter-space is marked.

When multiple procedures are performed on same patient, a "**Time Out**" is taken prior to each procedure.

3.5 PATHOLOGY SPECIMENS

A sample specimen of all pathological tissue removed during surgery shall be sent to LVSC's contracted pathologist who shall make such examination 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.

Exemptions from the above rule are limited to:

1. Benign bone; skin; muscle; fat; or tissue that is not customarily sent to pathology for evaluation. Examples of which include:
    - Toenails
    - Teeth
    - Scar tissue / Redundant tissue
    - Nasal Septal Cartilage
    - Tonsils and adenoids at surgeon's discretion
    - Vas deferens tissue at the surgeon's discretion following vasectomy.
2. Appliances or hardware

IV. CONSULTATIONS

4.1 THE RIGHT TO REQUEST A CONSULT

An added professional opinion is not only the right of the AP, but is the patient's right as well. It is the duty of the Medical Staff, through its MEC to insure that a practitioner seeks consultation when indicated.

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 the Executive / Clinical Director or Medical Director. If warranted, the Executive/ Clinical Director or Medical Director may bring the matter to the attention of the practitioner involved.

4.2 QUALIFIED CONSULTANTS

The AP is primarily responsible for requesting consultation when indicated and shall provide written authorization to permit another AP to attend or examine his/her patient, except in an emergency. The Consultant is to be briefed on the problem involved. Any Practitioner with clinical privileges in the LVSC may be called for consultation within his/her area of expertise.

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.

V. SCHEDULING OF SURGICAL CASES

5.1 HOW TO SCHEDULE

The Medical Staff member or their staff will schedule patients with the LVSC scheduling personnel.

Physicians will be assigned surgical time blocks by the LVSC scheduler and the LVSC Clinical Director.

Patients requiring chest x-rays, blood tests, or pre-anesthetic medical evaluation by a family physician, internist, pediatrician or cardiologist must have arrangements made prior to the date of surgery by the AP office. These reports should be returned (faxed) to the AP's office and also to LVSC so abnormal findings or special instructions can be addressed by the AP with the patient in a timely manner prior to the surgery/procedure. LVSC personnel will coordinate retrieval of this information so it is available to the anesthesiologist and AP on the day of surgery/procedure.

5.2 SCHEDULING TIMES

Surgery start time (anesthesia start) is 7:00am on all regular/scheduled days. Anesthesia induction and patient preparation will be initiated accordingly. Surgeries must be completed by 5:00, unless approved by the Medical Director.

VI. PRACTITONER CONCERNS OR GRIEVANCES

LVSC Medical Staff Members should contact the LVSC Medical Director, LVSC Administrator, LVSC Clinical Director or Medical Executive Committee Designee for resolution.

VII. AMENDMENTS

The MEC shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review, revise and amend them to comply with current Medical Staff practice. Any resolution to amend or modify the Rules and Regulations must be approved by the MEC by two-thirds (2/3) vote of those present. Adoption of such shall become effective following approval of the GB. If there is conflict between the Bylaws and the Rules and Regulations, the Bylaws shall prevail.