Rules & Regulations
Medical Staff of MultiCare Yakima Memorial Hospital d/b/a Yakima Valley Memorial

Table of Contents

Page

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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 applicable admitting policy of the Hospital. The admitting physician shall be expected to see the patient within 12 hours of the patient's admission (18 hours for healthy newborns; 24 hours for psychiatric unit patients) to 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 Provider On-Call Policy.

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. (See Physician Responsibility in Patient Transfers to Outside Facility Policy)

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 be 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 reentered. When the patient is transferred from the units, orders for continuous IV infusions, narcotics, and sedatives, respiratory therapy treatments must be reordered. All other orders will remain in effect.

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. Autopsies shall be secured by the Attending Physician as guided by Medical Staff approved criteria, and in accordance with applicable state regulations governing the performance of autopsies by the Medical Examiner. If an autopsy is indicated, the Attending Physician should request permission from the family or guardian for a complete or limited autopsy. Efforts to obtain permission shall be documented in the medical record, and consents, if obtained, should be in writing signed by the family or guardian and placed in the medical record. Autopsies to be performed by the medical examiner shall be governed by applicable state law. 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.

   The hospital shall attempt to secure autopsies in all cases of unusual deaths and of medical legal and educational interest, and inform the Medical Staff (specifically the attending physician) of autopsies that the hospital intends to perform.

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. Entry into the electronic medical record shall include identification data, admission note stating diagnosis, 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 if performed.

All clinician documentation created as part of a patient encounter must be recorded in the electronic health record (EHR) by direct entry or transcription, with the exception of drawings and approved YVM paper forms. If necessary, because of EHR unavailability or for entry on drawings or approved YVM paper forms, handwritten documentation must be legible.

B. 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.

The Medical Staff Bylaws contain the timeliness requirements of an H&P.

C. 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.

D. Operative/procedure reports shall include the following:
- Date and times of the surgery;
- Preoperative diagnosis;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- Description of the surgical technique and findings;
- Postoperative diagnosis;
- Description of the tissue or specimens removed or altered;
- Surgeon or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
- Estimated blood loss (EBL) documented for surgeries or procedures where there is an anticipated blood loss or an occurrence of unanticipated blood loss;
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

Operative reports shall be electronically entered immediately following the procedure for outpatients and inpatients. A brief electronic operative/procedure note should be entered in the record at the time of surgery and before the patient is transferred to the next level of care to bridge the time gap until the operative/procedure 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 electronic 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. A brief electronic procedure note should be placed in the EHR or an electronic addendum should be added at the time of procedure, before the patient is transferred to the next level of care to bridge the time gap until the procedure report is typed.

E. 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 be recorded prior to the operation, except in emergency situations so verified on the record.

F. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated.

G. Symbols and abbreviations may be used only if they are not on the list of unapproved abbreviations. An official record of unapproved abbreviations should be kept on file in Health Information Management.

H. A formal discharge summary shall be electronically entered 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 three (3) days of discharge. Content of the discharge summary shall contain the reason for hospitalization, significant findings, procedures and treatment provided, patient’s discharge condition, patient and family instructions (as appropriate) and attending physician’s signature. For patients with problems of a minor nature and hospitalized less than 48 hours, a final summation typed progress note shall be sufficient.

I. 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.

J. 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.

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

L. 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.

M. A patient's medical record should be complete at time of discharge, including the final diagnosis, signatures, and dictated clinical resume.

N. An incomplete chart of a patient whose practitioner has permanently moved away or is unable to complete the chart because of incapacitating illness, death, or no longer being on the hospital's medical staff shall be the responsibility of the Medical Executive Committee. The MEC may delegate this signature to CMIO or designee after approval if required for technical reasons. In the event that a verbal order remains incomplete aforementioned reasons or due to refusal by the assigned physician, the CMIO or designee may authenticate and close the order for administrative purposes. Verbal order refusals requiring administrative closure will be tracked and trended for quality review.

O. **Medical Records Delinquency**:
It is the responsibility of all credentialed practitioners to complete their medical records within seven (7) days from the discharge date. 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 seven (7) days. The practitioner will be informed that they have a seven (7) 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.

Delinquent charts that accumulate during vacation time shall not be counted until the Practitioner returns to work. Practitioners must notify the Health Information Management

Department of their planned absence in advance. Available chart completion shall be completed prior to planned absence.

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 seven (7) day grace period the practitioner may contact a medical staff officer and request an extension for chart completion.

Practitioners whose privileges have been administratively removed more than three times in a rolling 12 month period will be required to attend the next regularly scheduled Medical Executive Committee to explain their reasons for failing to comply with this regulation. Their admitting privileges will not be reinstated prior to attendance at this meeting.

P. **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 daily (consistent with II.C).

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. Verbal orders are acceptable only when necessary to provide needed patient care such as during a procedure or in emergent situations, physician is in a procedure or cannot gain access to the Electronic Health Record (EHR). Verbal orders should be confirmed using the repeat – back process to confirm accuracy.

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

The physician who gave the verbal order shall authenticate and date 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.

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
5. Withhold or withdraw life support (including Do Not Resuscitate 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. See Intensivist Consultation Policy for Patients in the CCU

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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