Ogallala Community Hospital

Rules and Regulations

1. The hospital may admit all types of cases. A patient of the medical staff may be admitted to the hospital only by a member of the medical staff governed by the official admitting policy of the hospital.

2. A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital for prompt completeness and accuracy of the medical record, for the necessary special instruction and for transmitting reports of the condition of the patient to the referring practitioner. Acute care patients shall be attended by their own private physicians or designate at least once every 24 hours. Skilled care patients shall be seen at the discretion of the attending but at least twice a week.

3. If a medical staff member is anticipating he/she will be unavailable to respond to patient care needs within ½ hour, he/she is responsible to name a member of the active medical staff who is available to respond in ½ hour and who may be called to attend patients in emergency. In case of failure to name such associate, the ER on-call physician will be called initially and the administrator of the hospital shall have the authority to call any member of the staff, should he/she consider it necessary.

4. Each member of the active medical staff shall take their turn on emergency call.

5. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever, or to assure protection of the patient from self harm.

6. Each member of the medical staff will secure autopsies when deemed medically and legally necessary. No autopsy shall be performed without written consent of next of kin or legally authorized person except as may be required by law. All autopsies shall be performed by the hospital pathologist or by a physician delegated this responsibility under state law or regulations.

7. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current.

8. A complete history and physical examination shall be performed and documented within 24 hours of admission or registration of the patient. Physical examinations may be used from the previous hospitalization if the examination was within 30 days. Physical examinations may be accepted from a doctor's office if the examination was done within 30 days of admission and meets the standards as defined by hospital policy and procedure. If the patient was transferred from another hospital, the physical examination may be accepted if done within the last 30 days provided they are updated

within 24 hours of admission or registration by the attending physician. These requirements are set forth in more detail in the Medical Records policy titled "Documentation Requirements for the Medical Record."

9. Laboratory and x-ray work will be ordered as desired by the attending physician.

10. A complete history and physical examination shall be documented before the time stated for operation or the operation shall be canceled unless the attending surgeon indicates it is an emergency procedure.

11. Surgical Operations:

    a. A surgical operation shall be performed only on consent of the patient, or his/her legal representative, except in emergency when delay due to inability to get authorization would threaten the patient's life. Reason for proceeding without consent shall be thoroughly documented in the record and the administrator informed.

    b. All operating surgeons shall have a qualified physician to assist at major operations when deemed medically necessary by the surgeon.

    c. All operations performed shall be fully described in the operating surgeon's report.

    d. Pre-surgical lab and x-ray results must be completed and recorded prior to the time stated for the operation unless the attending surgeon indicates it is an emergency procedure or the tests are not pertinent to the surgery.

12. The operative reports shall be dictated or written immediately after surgery. All tissue removed surgically shall be sent to the hospital pathologist for examination at the discretion of the surgeon, with the following exceptions:

    a. Specimens that by their nature or condition do not permit fruitful examination, such as cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;

    b. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

    c. Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;

    d. Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;

e. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.

13. Anesthesia will be administered by a qualified practitioner who is credentialed and privileged according to the Medical Staff Bylaws. The anesthesia practitioner shall maintain a complete anesthesia record, which will include evidence of both the pre-anesthetic evaluation and the post-anesthetic assessment of the patient. An intraoperative anesthesia record will be documented for each patient who receives general, regional or monitored anesthesia. The surgeon of record is responsible for the overall care of the patient during any procedure.

14. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission but an interval admission note must be documented that includes pertinent additions to the history and subsequent changes in the physical findings. In the event a prenatal record is not present, a complete H & P must be provided.

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

16. Final diagnosis shall be documented in full without the use of symbols or abbreviations, dated, and authenticated by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

17. A discharge summary (clinical resume) shall be documented or dictated on all medical records of patients within fifteen (15)-days after the patient's discharge. All summaries shall be authenticated by the responsible practitioner. Observation patients do not require a discharge summary if the final progress note includes discharge disposition, final diagnoses and discharge plan of care.

18. Medical records are the property of the hospital and must not leave the hospital's jurisdiction and safekeeping except as a result of court order, or as may be otherwise required by law. 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.

19. Access to all medical records of all patients shall be afforded to staff physicians in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients and with approval of the administrator.

20. Medical records shall be classified as delinquent if not completed in their entirety within fifteen (15) days after patient's discharge or if an individual deficiency is not completed within 15 days of the allocation date. A temporary suspension of a Medical Staff Member's admitting privileges, effective until medical records are completed,

shall be imposed automatically after warning of a delinquency for failure to complete medical records within fifteen (15) days. The suspension process is outlined in the policy "Documentation Requirements for the Medical Record."

21. All orders for treatment shall be in writing which includes the recording of orders in an electronic medical record. All orders shall be considered to be in writing if dictated to licensed nursing personnel, registered pharmacists, respiratory therapy personnel, registered physical therapists, or laboratory personnel and authenticated by the ordering practitioner. Verbal orders shall be authenticated by the person who gave the verbal order. All verbal orders will be authenticated by the responsible practitioner or a physician who has assumed responsibility for such physician's patients within forty-eight (48) hours. All authenticating signatures entered into a patient's medical record shall be by signature, initials or electronic signature.

22. Drugs used shall be those listed in the Ogallala Community Hospital Formulary, with the exception of drugs for bona fide clinical investigations or in an unusual clinical situation as ordered by the attending physician.

23. Order for any drug for induction of labor will be given by the attending physician for the individual patient. In other words, it will not be a standing order at any time. The administration of such drugs shall be closely and carefully supervised by the attending physician.

24. Induction of labor. The following rules will relate to induction of labor:

    a. There will be no inductions of labor that are not medically indicated.

    b. Medically indicated inductions are those cases that, in the opinion of the attending physician, would present greater danger to the mother and/or infant if the pregnancy were allowed to continue.

    c. Inductions will be done at a time when RNs are in attendance to monitor the patient.

    d. The attending physician must be immediately available.

25. A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the medical staff on the basis of the individual's training, experience, and competence. A satisfactory consultation includes examination of the patient and the patient's medical record. A documented opinion, authenticated by the consultant, must be included in the medical record. The consultation note shall be recorded prior to an operation except in an emergency. It is the duty of the attending physician to request a consultation.

26. A patient admitted for dental care is a dual responsibility involving the dentist and the attending physician member of the medical staff.

The dentist's responsibilities are as follows:

a. A dental history.

b. A description of oral examination.

c. A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the hospital pathologist for examination per established rule.

d. Progress notes pertinent to the oral condition.

The attending physician's responsibilities are as follows:

a. Medical history pertinent to the patient's general health.

b. A physical examination to determine the patient's condition.

c. Supervision of patient's general health status while hospitalized.

27. Medical screening examinations will be provided at the hospital in accordance with federal and state law. Professionals designated to conduct medical screening examinations are physicians, nurse practitioners or physician assistants and, in the case of women in labor, qualified labor and delivery registered nurses (Qualified Medical Personnel). Every patient presenting to the Emergency Department for emergency services will receive a medical screening examination by a physician assistant, nurse practitioner, or physician. A physician assistant/nurse practitioner may evaluate patients presenting to the Emergency Department per medical staff approved guidelines. If the Emergency Department record is completed by a physician assistant/nurse practitioner, it must be counter-authenticated by a physician.

28. MASS CASUALTY ASSIGNMENTS. All physicians shall be assigned to posts, either or in a mobile casualty station. The Chief of Staff in the hospital and the Administrator will work as a team to coordinate the activities and directions in the hospital. In case of evacuation from the hospital premises, the Chief of Staff, during the disaster, or his/her deputy, will authorize the movement of patients by direction of the Administrator, and all policies concerning patient care will be the joint responsibility of the Chief of Staff or his/her deputy, and the hospital Administrator. In their absence, the Secretary of the Medical Staff, and the alternate in administration, are next in line of authority, respectively. All physicians on the medical staff of the hospital specifically agree to relinquish the direction of the professional care of their patients to the physician delegated to be in charge of Admission and Disposition of emergency casualties.

29. Physician Assistant/Nurse Practitioners can enter admission orders for a patient being admitted either from the clinic or emergency room if within the attending physician's protocols or with the approval of the attending physician.

30. Physician Assistant/Nurse Practitioners may document initial History and Physical. The History and Physical must be counterauthenticated by the physician.

31. Physician Assistant/Nurse Practitioners may document admission orders. .

32. Physician Assistant/Nurse Practitioners may document Discharge Summaries, which must be counterauthenticated by the physician.

Adopted by the active medical staff of Ogallala Community Hospital at the regular Medical Staff Meeting on _____, 2013.

_____
Chief of Staff

_____
Secretary

Approved by the Board of Directors on February 14, 2013.

_____
Secretary
Board of Directors