WASHAKIE MEDICAL CENTER

MEDICAL STAFF RULES AND REGULATIONS

TABLE OF CONTENTS Page

WASHAKIE MEMORIAL HOSPITAL

MEDICAL STAFF

RULES AND REGULATIONS

DEFINITIONS:

As used in these Rules and Regulations the following terms have the indicated meanings:

Attending Physician: The physician admitting the patient (unless the patient has been formally transferred to another physician) or, if the patient was not admitted by a physician, the physician designated by a non-physician practitioner in accordance with section A .2 of these Rules.

Informed Consent: The disclosure of the procedure or treatment to be undertaken and the related anesthesia, and their nature, furnishing of information concerning alternatives (if any) and offer to provide detailed explanation of those procedures/processes, viable alternatives and material risks as required by Wyoming state law. Where permitted by law (including Wyoming state law) consent by a minor patient is acceptable for informed consent.

Invasive Procedures: Puncture or incision of the skin or insertion of an instrument or foreign material into the body, including but not limited to percutaneous aspirations and biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations but excluding venipuncture and IV therapy. Dental procedures performed at the Hospital are included within the term.

Major Anesthesia: General, spinal or major regional anesthesia or sedation which is expected to result in loss of protective reflexes, regardless of where administered in the Hospital. If any such process is ordered as standby for a procedure under local anesthesia, the procedure shall be deemed performed under major anesthesia whether or not the standby process is actually used.

Restraint: Any method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to the body.

Chemical Restraint: The inappropriate use of a sedating psychotropic drug to manage or control behavior.

Physical Restraint: Any method of physically restricting a person's freedom of movement, physical activity, or normal access to his or her body.

Seclusion: Isolation of the patient without contact with persons other than Hospital personnel when the purpose of such isolation is to control patient access to materials which may be dangerous under the circumstances or patient behavior which may be dangerous to the patient or others.

GENERAL

These rules and related Hospital policies are designed to comply with standards of state and federal regulatory agencies, federal Medicare and Medicaid programs, and the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). All patient care and related activities in the Hospital will be conducted in a manner consistent with these Rules, Hospital policies and the indicated standards.

A. ADMISSION AND DISCHARGE OF IN-PATIENTS

1. Who Can Admit: Patients may be admitted to the Hospital only by practitioners who have been appointed to the Active, or Courtesy categories of the Medical Staff and who hold admitting privileges or who have been accorded temporary admitting privileges. Except in an emergency, no treatment shall be rendered to a Hospital patient beyond the limits of the clinical privileges held by the provider at this Hospital. These privileges are on file in Administration and other appropriate departments.

2. General Duties of Admitting Practitioner and Attending Physician:

a. The practitioner admitting the patient shall:

i. be responsible for the overall direction of the patient's care,

ii. be responsible to supply a timely, pertinent and complete medical record, appropriate orders within his/her privileges, including special instructions necessary to protect patients already in the hospital and staff from patients who are or may become a source of danger from any cause whatever, and

iii. transmit reports of the condition of the patient to any referring or collaborating practitioner and information and instructions to other caregivers, including family, as appropriate.

iv. Practitioners who cannot individually (a) meet Medicare, Medicaid and JCAHO requirements for management of all aspects of prospective patient's care; (b) perform and provide all required authentication of the full history and physical or (c) authenticate orders for reimbursement purposes, shall specify at the time of each admission the name of the specific physician who is on the Active Staff who has agreed to perform those functions in the individual case. A physician designated under this rule shall be the "Attending Physician" and shall have responsibility for the patient's care and documentation of the care to the extent that the care is outside the privileges of the admitting practitioner.

b. Transfer: Whenever responsibilities of the admitting practitioner or attending physician are transferred permanently or temporarily to another practitioner, a formal transfer order shall be entered on the order sheet of the medical record by the original practitioner after he/she has made appropriate personal contact with the receiving practitioner to confirm acceptability of transfer and conveyed appropriate information concerning the patient.

c. Patient-Initiated Change of Practitioner: In the event a patient discharges his/her attending physician or admitting practitioner without arranging for another who has relevant privileges, the nursing supervisor will be notified. The Nursing supervisor will contact the attending physician who shall arrange a transfer and give the appropriate order. In the event the attending physician fails to respond or is unable to arrange a timely transfer acceptable to the patient, a member of the Medical Executive Committee shall assign an appropriate practitioner, using the Emergency Room call list if feasible.

d. Appropriateness of Admission: The admitting practitioner shall provide sufficient information at the time of admission to establish that care can be provided to meet the needs of the patient. Appropriate care area will be identified based on patient status (e.g. ICU, Medical Surgical, Obstetrics).

e. Admitting Information: If the history-physical has been performed and dictated, but not transcribed and placed on the chart at the time of admission, the person responsible for its preparation shall put an interim note on the chart so stating. The interim note be in handwriting and will include:

   i. the admitting diagnosis
   ii. statement of the patient's symptoms and general condition
   iii. other pertinent medical information and orders reasonable and necessary for the patient's immediate care and to assure the protection and safety of the patient, other patients and staff.

f. Time of First Visit: No practitioner shall admit a patient unless that practitioner is able to assume immediate, appropriate responsibility for the patient during the first twenty-four-hour period following admission. All inpatients and observation patients shall be seen by the admitting practitioner within 24 hours and appropriate documentation of the visit recorded. The following categories of cases require a documented visit of the admitting practitioner no later than the indicated time (and earlier as required by the patient's condition):

   i. acute MI and/or thrombolytic intervention, within 30 minutes;
   ii. trauma, as required by Trauma Protocol;
   iii. upon urgent request by the Emergency Department or other physician, within 30 minutes;
   iv. obstetrics admissions in active labor, within 8 hours; and

v. ICU admissions within 4 hours.

g. Potentially Suicidal Patients: Any patient known or suspected to be suicidal shall be stabilized and admitted or transferred in accordance with the established Emergency Department policies and procedures. Any patient known or suspected to be suicidal shall have a consultation by a mental health professional within twenty-four (24) hours following admission or initial determination of suicidal risk.

h. Transfers to Other Facilities (including SNF, ICF and other Hospitals): All transfers from any part of the Hospital to any other facility (whether from the Emergency Department or a unit or outpatient setting) will be accomplished in a manner complying with the Emergency Medical Treatment and Active Labor Act ("EMTALA", also known as "COBRA"), including the following for any patient with an un-stabilized emergency medical condition (including any patient experiencing any labor contractions):

i. Unless the patient requests the transfer (with appropriate documentation) or the attending physician has documented that the patient does not have an un-stabilized emergency medical condition at the time of transfer, the attending physician must certify that the medical benefits of transfer outweigh the increased risks of transfer;
ii. The receiving facility and physician must have been contacted and agreed to accept the patient and have available space and qualified personnel for treatment;
iii. A copy of the required medical information must accompany the patient;
iv. The transfer must be affected through qualified personnel utilizing appropriate equipment;
v. All required physician certifications or patient request for transfer forms must have been completed prior to the transfer; and
vi. Appropriate interim treatment to minimize risks of transfer must have been provided.

No sanctions shall be taken against a physician who refuses to authorize transfer of a person who actually has an un-stabilized emergency medical condition when the physician indicates he/she cannot in good conscience make a required certification.

i. Discharge and Discharge AMA: Patients shall be discharged only on written order of a practitioner or execution of "discharge Against Medical Advice" forms. The attending physician and admitting practitioner (if different) shall be notified whenever a patient demands to leave the Hospital against medical advice or without proper discharge orders, and shall:

i. Document the occurrence in the patient's medical record;

ii. Document advice given to the patient regarding the risks of leaving against medical advice;
iii. Complete and where possible order the patient's signature on the Discharge Against Medical Advice (AMA) form;
iv. Provide discharge instructions, when appropriate.

B. EMERGENCY DEPARTMENT

1. Hours: The Emergency Department shall be open 24-hours-a-day 7-days-a-week. All patients presenting to the Emergency Department for evaluation or treatment shall be given a medical screening examination to determine whether or not an emergency medical condition exists.

2. Screening Exams: Under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Hospital must provide for an appropriate medical screening examination within the capability of the Hospital's Emergency Department.

At least one properly trained registered Emergency Department nurse with ACLS certification will be available at all times to perform triage functions for each individual that comes into the Emergency Department requesting examination or treatment. Triage establishes the order in which an individual will be evaluated and is not considered an appropriate medical screening examination.

For the purposes of compliance of EMTALA, a qualified medical screening examiner will be available to the Emergency Department twenty-four (24) hours a day, seven (7) days a week to perform initial medical screening examinations for the purpose of determining whether or not an emergency medical condition[1] is present. In addition to physicians, qualified medical personnel, as determined by the Board, such as nurse practitioners or physician's assistant, who have been appropriately credentialed to provide services in the Emergency Department also may be qualified medical screening examiners. The person performing the initial medical screening examination, if a non-physician, shall determine, based on his/her professional judgment, whether or not the expertise of a physician is needed to determine whether the individual has an emergency medical condition. At least one qualified physician will be available within thirty (30) minutes to the

[1] An emergency medical condition is now defined in the regulations as:

(i) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could be reasonably be expected to result in-
(A) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
(B) Serious impairment to bodily functions; or
(C) Serious dysfunction of any bodily organ or part; or
(ii) With respect to a pregnant woman who is having contractions-
(A) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
(B) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Department on a twenty-four (24) hour a day, seven (7) day a week basis.

3. Admission of Emergency Department Patients to Inpatient Status: The physician on duty in the Emergency Department shall not serve as admitting physician for Hospital admissions other than short term observation-bed admissions with anticipated release shortly via the Emergency Department, unless his/her clinical privileges explicitly grant inpatient admitting privileges.

   After consulting with the regular on-call physician who is assuming responsibility for an Emergency Department patient to be admitted to inpatient status, an Emergency Department physician may record verbal orders approved by the admitting physician, including the order to admit and for initial care. The appropriateness of those orders, decisions on when the patient is further examined and responsibility for all aspects of the patient's care from the time of entry of the verbal order is the responsibility of the admitting physician requesting entry of such orders. The admitting physician as provided in Rule H.1 shall sign such verbal orders.

4. Backup Call for Emergency Services: Physicians on the hospital's medical staff shall provide backup call coverage in accordance with the hospital's policy for unassigned call rotation. The practitioners on call shall remain in the area, reachable at a designated number and shall come to the Hospital within a reasonable time after a request to do so to evaluate, treat or admit any unassigned patient needing hospitalization or to provide expertise or backup care at the request of the Emergency Department staff or physician. Failure to respond within a reasonable time when called and requested to come is grounds for corrective action. Practitioners on call may trade call assignments only with others on the same call list. The originally assigned practitioner remains responsible until the alternate arrangement is confirmed with the Emergency Department.

5. Emergency Clinical Privileges: All Emergency Department physicians shall have current ATLS and ACLS certification. .

6. Discharge/Transfer of Emergency Department Patients: Emergency Department patients shall not be released from the facility until it has been determined that the degree of assessment, treatment and any proposed transfer complies with EMTALA obligations. Such administrative review is for procedural compliance and does not indicate concurrence with medical decisions of the responsible practitioner.

7. Disaster Response: In the event of activation of the Hospital's Medical Alert (Disaster) Plan, all practitioners shall respond immediately to the Medical Command Post in the Emergency Department lobby for assignment.

8. Emergency Department Records: The practitioner responsible for the care of the patient in the Emergency Department shall dictate a complete Emergency

Department medical record within 24 hours of the patient being discharged from the Emergency Department. Emergency Department medical records shall contain:

a. Identification of the patient;

b. Chief complaint and brief history of the disease or injury;

c. A record of the pre-hospital report form for any patient brought in by ambulance;

d. Accurate description of physical findings on examination;

e. Reports of laboratory and x-rays and other diagnostic procedures, including any special examinations;

f. Record of treatment, including medications, and response;

g. Discharge diagnosis (or impression), recorded in full, without the use of symbols or abbreviations, dated and signed by the responsible practitioner at the time of discharge.

h. Disposition of case, including instruction to the patient and follow-up care arrangements;

i. Signature or authorized authentication of the responsible practitioner;

C. MEDICAL RECORDS

1. General Provisions:

All records are the property of the hospital. Medical records may not be removed from the hospital's custody and safekeeping except by compulsion of a court order or statutory authorization. Removal of charts from the Hospital without authority is grounds for corrective action. In case of readmission to the hospital of a patient, previous records shall be available for the use of the attending physician. This shall apply whether the patient be attended by the same physician or another.

No records shall be reviewed or written on by any person other than an authorized employee, the attending physician, Allied Health staff, consulting physician or physician to whom a patient is referred or such members of the Medical Staff as may be designated by the Medical Staff, except as legal procedure may dictate.

Copying and Pasting: Medical Staff and Allied Health staff may not indiscriminately copy and paste documentation from other parts of the applicable patient's records. If copying a template, the practitioner shall make modifications appropriate for the patient. If copying a prior entry, the practitioner shall make

appropriate modifications based upon the patient's current status and condition. The practitioner must reference the date of a prior note as appropriate. When copying patient data into the record from another provider, the practitioner must attribute the information to the person who performed the task unless it is readily apparent, based upon the nature of the information copied, that the data was entered by another provider. If referencing a form within the record, the form must be referenced with sufficient detail to identify the source. Example: "for review of systems, see form dated 6/1/10."

Medical Record Content:

The Medical Record contains sufficient information to identify the patient, support the diagnosis, justify the treatment and document the results accurately.

Required Characteristics:

Identification data

Medical history and physical

As appropriate, to the age of the patient, a summary of the patient's psychosocial needs

Diagnostic and therapeutic orders

Appropriate consent forms

Clinical observations to include results of therapy

Reports of procedures, tests and results

Conclusions at termination of hospitalization-evaluation-treatment

Inpatient Medical Records shall include the following:

Identification data to include name, address, date of birth and next of kin when available. A specific number which identifies the patient and the patient's medical record.

History and Physical:

A medical history which includes chief complaint, details of present illness, and when appropriate, assessment of the patient's emotional, behavioral and social status; past, social and family histories; inventory of systems. When possible this information should be obtained directly from the patient.

A complete history and physical examination shall in all cases be dictated within 24 hours after admission or no more than 30 days prior to admission. (7 days for Medicare Patients)

A statement of conclusions or impressions drawn from the admission history and physical examination is included in the medical record.

Any history and physical dictated **7** days or more prior to admission must include an update of the patient's condition.

2. History-Physical:

a. Content and Timing: A complete history and physical examination shall in all cases be completed by a physician or oral surgeon, and except as permitted under (b) of this Rule, shall be completed, confirmed and signed prior to performance of any surgical procedure or other major diagnostic or therapeutic event and in all cases within twenty-four (24) hours after admission. If a complete history and physical examination has been performed by an appropriate person within 30 days prior to admission, a legible copy of that report may be used, provided there have been no changes subsequent to the original examination or the changes have been recorded at the time of admission. Absence of a compete H&P twenty-four (24) hours after admission shall deem the record "delinquent."

If the history and physical is not physically on the chart at the time of admission, the attending physician shall hand write a note on the progress sheet at admission, as required by Rule A.2.e.

The history-physical shall include:

i. Date of admission
ii. Identification data
iii. Chief complaint
iv. History of present illness, with pertinent family and personal history
v. Patient's pertinent psychosocial needs
vi. Pertinent findings from assessment of the systems of the body
vii. Results of physical examination
viii. Provisional diagnoses
ix. Plan of care.

b. Readmissions: If a patient is readmitted within a month's time for the same condition, the previous medical history and physical examination report, updated with an interval note reflecting reexamination within the thirty (30) days prior to readmission and any changes noted or reported at that time, may be substituted for a new report.

3. Progress Notes, Generally: Pertinent progress notes shall be recorded daily for acute care admissions, at least weekly for swing-bed admissions, by the admitting practitioner or his/her designee.

4. Consultations: See section H of these Rules.

5. Diagnostic Reports: EKG, stress EKG, and Radiology reports shall be recorded in the medical record and shall be authenticated by the originator of the interpretation, with further reports of consultation prepared and signed when such services have been obtained.

6. Obstetrical Records: In addition to general requirements for medical records, Obstetrical records shall include:

   a. Prenatal care record containing at least a serologic test for syphilis, RH factor determination, past obstetrical history, physical examination, and data concerning progress of present pregnancy;
   b. Labor and delivery record, including justification for any induction or operative procedure;
   c. Records of anesthesia, analgesia, and medications given in the course of delivery.

   A complete preoperative physical examination shall be recorded for obstetrical patients with Cesarean section delivery or post-partum tubal ligation.

7. Newborn Records: The newborn physical examination shall include all positive findings and essential negative findings.

8. Pediatric/Adolescent Records: Medical records of children and adolescents shall also contain the following information:

   a. Assessment of developmental age;
   b. Immunization status;
   c. The family's and/or guardian's expectations for, and involvement in, the assessment, treatment, and continuous care of the patient.

9. Emergency Department Records: See section B .8 of these Rules.

10. Discharge Summary: The admitting practitioner or attending physician (if different) shall dictate a discharge summary on all patients. The summary shall recapitulate the reason for hospitalization, significant findings during hospitalization, procedures performed and treatment rendered, response to treatment, condition on discharge, and instructions (medications, diet, activity, follow-up). In all instances, the content shall be sufficient to justify the diagnosis, warrant the treatment and explain the end result.

For normal newborns with uncomplicated deliveries, or for patients hospitalized for less than 48 hours with only minor problems, a progress note may substitute for the Discharge Summary. (The medical staff defines what problems and interventions may be minor. The progress note may be handwritten. It documents the patient's condition at discharge, discharge instructions, and follow-up care required.)

When a patient is transferred within the facility from one level of care to another, and the caregivers change, a transfer summary may be substituted for the Discharge Summary. [A transfer summary briefly describes the patient's condition at the time of transfer, and the reason for the transfer.]

11. Delinquent Records: The patient's medical record shall be completed within 15 days after discharge, including progress notes, final diagnosis and dictated discharge summary. Completion of the medical record is the responsibility of the admitting practitioner except to the extent a specific part of the record is the responsibility of another practitioner under these Rules.

The Health Information Manager will produce a summary report to each physician weekly informing them of any delinquent records. They will be informed in writing when a record is 15 days delinquent. At this time the physician will be given 24-hours from the time that the letter is received to complete the delinquent records. If the record(s) is not completed within the 24-hour period, the physician will be placed on automatic suspension of admitting privileges until record(s) are completed. If in the event of three (3) or more suspensions in a calendar year, all further admitting privileges will be suspended until reviewed by the Executive Committee.

In the application of this rule, the following conditions shall apply:

a. Pending diagnostic or pathology reports shall not, by themselves, cause a record to be considered delinquent for anyone other than the person responsible to complete them;

b. The time limits shall not begin before the record is available to the practitioner for completion and shall not run during an illness preventing his/her practice in the office (if the Medical Records Department is provided verification of those circumstances);

c. The scope of the suspension and manner of its lifting are as specified in The Credentialing and Fair Hearing Plan Part C Section 1.

c. Responsibility, Generally: The admitting practitioner shall be responsible for the preparation and authentication of a complete and legible medical record for each patient, except to the extent specific documentation is expressly the responsibility of another person under these Rules. The records contents shall be pertinent and current. Each person with clinical

privileges is responsible to promptly complete records concerning the care he/she rendered. Entries in the medical record may be made by Allied Health professionals, RN's, LPN's, dietitians, respiratory, physical, occupational and speech therapists, pharmacists, MT-ASCP's and radiographic technicians.

d. Signature: All clinical entries in the patient's medical record shall be dated, timed, and properly authenticated by the individuals making them. Entries shall be made only by authorized personnel.

Authentication: All authenticating signatures entered into a patient's medical record shall be by signature, initials, electronic signature, or authorized rubber stamp.

Members desiring to employ the use of rubber stamp signatures must first notify the Hospital in writing of their intent to use other than original signatures. Each such Member also must certify that such Member will be the only person authorized to use the rubber stamp and that it will be not delegated to any other person.

e. Transcription: Dictated medical record entries shall be transcribed and integrated into the patient record within twenty-four (24) hours following the patient admission/encounter, if timely dictated.

f. Abbreviations/Symbols: Only symbols and abbreviations on the Professional-Staff approved list maintained in the Medical Records Department may be used in medical records.

g. Filing: No medical record may be filed until it is complete except on specific written order of the Chief of Staff for good and sufficient cause.

h. Release of Information: Unless its release is specifically authorized or required by law or the patient or patient's legal representative have consented in the manner required by law, medical information concerning patients shall not be released to persons not involved in the direct care of the patient, evaluation of care (including in licensing, accreditation and similar surveys), or for authorized research and administrative uses. Release of specific types of information have special requirements under the law: e.g., HIV status, AIDS diagnosis, certain drug and alcohol information. Appropriate forms of Authorization for Release or Disclosure of Medical Information are available in the Medical Records Department.

i. Peer Review Information:

i. Maintaining Confidentiality: Records and information collected by certain Medical Staff committees, Hospital board, and other

designated committees when performing activities in order to determine clinical privileges or appointment; train, supervise or discipline providers; conduct utilization review, or other activities of a peer review organization are privileged under Wyoming State law and confidential under Hospital policy. Such information shall not be disclosed beyond disclosures necessary to performance of the duties of such groups, except as determined by the Board or its delegate to be necessary for legal, administrative, accreditation, licensing or governmental review purposes.

ii. External Reviewers: External peer review may be engaged to assist in Medical Staff performance of its obligations (or in lieu of review by a group otherwise designated in the Staff Bylaws) as provided in the Staff Bylaws, Fair Hearing Plan or other Board-approved policy.

iii. External Sources; Cooperation with Other Peer Review Organizations: Whenever the Hospital receives information which raises concern about the qualifications of a person holding or seeking clinical privileges at the Hospital, it may request that that person assist it in obtaining copies of medical records or other information necessary to evaluate the concern. The person receiving the request shall comply, including providing peer review access to office records and other out-of-hospital data necessary to evaluate complications or other indications of quality concerns. The Hospital will cooperate with other peer review organizations which have a legitimate interest in peer review information held by the Hospital concerning a person who practices at such other site or is affiliated with such other program (or has applied to do so) in addition to holding privileges at the Hospital, to the extent that it determines information shared with such organizations remains protected under the Wyoming Peer Review Statute. All persons requesting or holding privileges at the Hospital consent to such disclosures.

iv. Compliance with Reporting Obligations: All appointees to the Hospital and others exercising any clinical privileges at the Hospital shall comply with the obligations of their license and professional society memberships to report reportable incidents and concerns to the appropriate licensing or peer review body for investigation and action.

D. INVASIVE PROCEDURES AND PROCEDURES UNDER MAJOR ANESTHESIA: Only practitioners holding relevant surgical clinical privileges may schedule surgery. Scheduled surgery must be in accordance with the procedures listed as approved on the surgeon's surgical privilege sheet. The surgeon will insure that any procedure is done in a safe and judicious manner, including appropriate selection of an assistant, if needed.

Whenever a patient is to undergo an invasive procedure (defined above) or procedure under major anesthesia (defined above), the following requirements shall be met:

1. Surgeon's Evaluation; Informed Consent: For all inpatients and all outpatients undergoing major anesthesia (defined above), a physician or oral surgeon (who may be either the surgeon or where the surgeon is not a physician, the attending physician) shall determine the appropriateness of the procedure for the patient based on at least the patient's medical, anesthetic and drug history, physical status, diagnostic data, risk/benefits of the procedure, including the planned anesthesia, and the need to administer blood or blood components. Any significant disagreement between the Surgeon/Attending Physician and the attending CRNA shall be resolved before initiating the procedure.

   The surgeon shall order the specific written informed consent of the patient or other authorized representative for the procedure (unless the patient lacks capability to consent and, after reasonable efforts to locate one, there is no authorized healthcare representative and the procedure is legally permissible under principles of implied consent for emergency treatment) in accordance with Wyoming State Law, including anesthesia and blood product options and risks, and shall sign the form so-indicating. The surgeon shall record the preoperative diagnosis, planned procedure, and document the patient's consent or refusal prior to the procedure or the cancellation of the procedure, based on patient decision not to proceed.

2. Recorded History and Physical, Consult and Diagnostic Results: Absent extreme emergency, the history and physical examination and indicated laboratory and x-ray examinations and consultations shall be completed and recorded in the medical record prior to an invasive procedure or procedure under major anesthesia. In the event of an extreme emergency, the responsible practitioner shall complete the required reports immediately following the procedure.

3. Report: The surgeon shall prepare an operative report clearly identifying the responsible surgeon and any assistants and including the preoperative diagnosis, postoperative diagnosis, a detailed account of the findings at surgery, procedure performed, details of the surgical technique utilized, identification of all specimens removed (including the number and type of teeth extracted) and of drains inserted, estimated blood loss, description of any unusual events or complications, assessment of the patient's physiologic status during the procedure, and the postoperative diagnosis. The report shall be written and dictated immediately following the procedure and the report shall be promptly signed by the responsible surgeon and made a part of the patient's medical record. Absence of a dictated operative report twenty-four (24) hours after surgery shall deem the record "delinquent."

4. Scheduling: Invasive procedures shall be scheduled only by a practitioner with clinical privileges to perform them. A practitioner with privileges to perform a procedure only under supervision of a practitioner with full privileges in the procedure may prepare the operative report, but it shall be co-signed by the

practitioner supervising. Genuine emergencies may take precedence over a scheduled operation. If the emergency status is questioned, it will be reported to the Operating Room Medical Advisor or a member of the Medical Executive Committee for evaluation, and his/her decision shall control the priority.

5. Preoperative Screening: Patients admitted for surgery shall receive appropriate preoperative screening and diagnostic testing unless adequate justification for deviation is recorded in the medical record by the admitting practitioner. The surgeon is responsible to record complete preoperative orders.

6. Ambulatory Surgery:

a. Selection/Scheduling: Only practitioners with relevant clinical privileges may schedule or admit patients for ambulatory surgery. Patients expected to require blood transfusion during surgery, or anticipated to require Hospital admission following surgery shall not be scheduled for Ambulatory Surgery. Only patients qualified by the following ASA status classifications (described more full in section E.1 of these Rules) shall be scheduled for Ambulatory Surgery:

1. Patients in ASA Class I or II
2. Endoscopy patients who do not fit fully into ASA Class I or II may be scheduled upon consent of the surgeon
3. Patients in ASA Class III upon consent of the surgeon and CRNA
4. Emergency patients if the operating room charge person, surgeon and the person administering anesthesia all agree.

b. Patients for ambulatory surgery will be scheduled by at least the day prior to the anticipated procedure. One working day prior to the procedure, the surgeon shall send the history and physical, and order sheet to the Operating Room Secretary or Ambulatory Care Nurse. The surgeon shall instruct the patient that he/she must be accompanied by someone upon leaving ambulatory surgery, if IV Sedation or General Anesthesia is used.

E. ANESTHESIA PROCEDURES AND RECORDS: Whenever general, spinal or major regional anesthesia, or monitored Anesthesia Care is to be used anywhere in the Hospital, the following requirements shall be met:

1. Pre-Anesthesia Evaluation: Either before or after the physician evaluation and procurement of informed consent (see F.1), the anesthesia service shall perform and document a pre-anesthesia visit with the patient to acquaint him/herself with pertinent facts, including the following:

a. Anesthesia choices (or recommendation) and their bases.

b. Verification of past and present medical and drug history, allergies and previous anesthesia experience(s)

c. Verification of physical status assessment relating to cardio-respiratory status and assignment of anesthesia status using the American Society of Anesthesiologists' Physical Status categories:

ASA Class I - No organic, physiological, bio-chemical or psychiatric disturbance. The pathological process is localized and not conducive to systemic disturbance; the patient is basically healthy

ASA Class II - Mild to moderate systemic disturbance, caused either by the condition to be treated surgically or by other pathophysiologic processes, i.e., diabetes, mild essential hypertension, moderate obesity or chronic bronchitis, extremes of age

ASA Class III - Severe systemic disturbances or pathology from whatever cause, i.e., diabetes with insulin dependence, moderate to severe degree of pulmonary insufficiency, angina, or healed MI.

d. Review of relevant diagnostic studies relating to anesthesia choice

e. Verification or the recommendation of anesthesia plan

f. Verification or recommendation of post-anesthesia recovery plan [e.g., ICU, PAR, out-patient observation bed etc.]

The anesthesia service shall note and discuss with the physician any unresolved concerns raised by the planned approach to anesthesia if the physician's evaluation and plan differs from the CRNA's evaluation and plan, and shall record findings and recommendations. Any major disagreements between the attending CRNA and the Surgeon/Attending Physician shall be resolved prior to initiating the procedure.

2. Anesthesia Record and Monitoring: The person administering anesthesia shall prepare and sign a detailed record of all substances administered (including blood and blood components, IV fluids and drugs) and the ongoing measurement and assessment of the patient's physiologic status during administration of anesthesia. That record shall function as documentation of both the order and its execution.

3. Post-Anesthesia Care and Documentation: The person in charge of the patient's care in the immediate post-procedure period shall complete a post-anesthesia monitoring record recording the patient's condition on admission to the area, the patient's physiological and psychological status in the post-anesthesia period including vital signs and state of consciousness, all IV fluids, drugs and blood/blood components administered, any unusual events or complications and their management in the immediate post-procedure period, the patient's condition upon release from the area

(or termination of special post-anesthesia monitoring). Discharge will be based on the Aldrete Score.

F. PATHOLOGY REPORT: All tissues, foreign bodies and prosthetic devices or appliances removed during a procedure shall be noted in the operative record, without exception, and all such materials shall be sent to the hospital pathologist for such examination as he/she may consider necessary to arrive at the pathological diagnosis, except:

1. Foreign bodies turned over to law enforcement personnel may be described by number, type and disposition;
2. Cataract
3. Foreskin
4. Toenail/fingernail
5. Nonpathologic bone or bone fragment, arthroscopy shavings
6. Placentas (unless requested)
7. Portions of ribs removed to enhance operative exposure
8. Recurrent urinary calculus
9. Scar tissue
10. Teeth
11. Orthopedic hardware
12. Gallstones.

The pathologist shall prepare and sign such examination of materials submitted to the department as he/she may consider necessary to provide a report of accountability and diagnosis for the medical record. All specimens removed shall become the property of the Hospital and may be disposed of in any manner legally permitted.

G. ORDERS:

1. Verbal Orders: All orders for medications, diagnostics, or treatment shall be in writing. Verbal orders may be dictated only to registered nurses, registered physical therapists, registered respiratory therapists, registered pharmacists, registered dietitians, licensed medical technologists, registered radiological technicians and registered physical, occupational and speech therapists acting within their scope of practice and privileges, but shall be immediately recorded on the order sheet by the recipient, who shall note the date, time, originator of the order and shall sign his/her own name as the person receiving and recording it. All verbal orders must be signed by their originator within twenty-four (24) hours after they are given.

2. Legibility: All orders shall be recorded clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or otherwise clarified.

3. Surgery: All previous orders are canceled when patients go to surgery. An order to "resume pre-surgery orders" may be written immediately post-operatively, when appropriate, and if written reinstates all orders in effect at the time the patient was

sent to surgery in addition to any continuing orders given thereafter. Practitioners issuing such an order have the responsibility to assure that it does not conflict with or duplicate additional orders given in surgery or PAR areas which will be carried out in addition to prior orders.

4 Intensive Care: All orders are automatically canceled when the patient goes to surgery or transfers into or out of the Intensive Care Unit.

5. Standing Orders: Standing orders for use in patient treatment may be formulated by each member of the Medical Staff. All requests for use of standing orders must be approved by the Medical Staff before initial use and reviewed by that committee annually thereafter. Once approved, standing orders shall undergo documented annual review, and constitute the practitioner's orders for treatment of all patients for whom he/she directs their use until rescinded by specific orders. A copy of the standing orders shall be placed in the chart of each patient to whom they apply, and be signed by the initiating practitioner in the manner applicable to phone orders.

6. Stop Orders: In the absence of specific contrary orders on the patient's chart, automatic stop orders will be enforced after 96 hours for narcotics and hypnotics. All orders for respiratory therapy will automatically be discontinued after seventy-two (72) hours and will not be re-instituted until the ordering practitioner has documented the results of the respiratory therapy in achieving the desired goals. No orders will be instituted until the goals of continued therapy are stated.

H. CONSULTATIONS:

1. General: Any qualified practitioner having appropriate privileges in a relevant field of practice in this Hospital may be called for consultation in that field. The admitting practitioner is responsible for requesting consultation when indicated and for personally obtaining a qualified consultant, by direct communication wherever possible, and informing the attending physician of the request (if the admitting practitioner is not the attending physician).

2. Duty to Perform: Physicians shall comply with reasonable requests for consultation within the area of the requested consultant's expertise and privileges.

3. Records: The consultant shall prepare and sign a report showing evidence of a review of the patient's record by the consultant, pertinent findings on his/her examination of the patient, and 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 consultation.

4. Offer of Consult in Psychiatric Cases: Mental Health consultation or referral shall be obtained for all patients who have attempted suicide, or have taken a chemical overdose. The fact that such services were offered will be documented in the medical record.

I. RESOLUTION OF ERRORS/DISAGREEMENTS: If a Hospital employee questions the appropriateness of an order given or refused or the quality of care provided to any patient and is unable to resolve the issue directly with the practitioner responsible for the order or care, he/she shall call the issue to the attention of the nursing supervisor, who will contact the Hospital Administrator on call, and the Chief of the Medical Staff. The Chief of the Medical Staff may request a consultation or initiate such further investigation or action as is warranted by the circumstances.

J. SPECIAL UNITS: ICU

1. Admission/Discharge: If there are questions concerning the appropriateness of a patient's admission to or discharge from the Intensive Care Unit, or concerning case priority when the unit reaches capacity, the Intensive Care Unit Medical Advisor or his/her designated alternate shall consult with the attending physician. In the event of their inability to resolve a conflict on priority, the determination of the Intensive Care Unit Medical Advisor shall control.

   a. Inter Qual criteria shall be used as guidelines for appropriateness of admission and discharge in this unit.

   b. See "Orders" relating to cancellation of prior orders upon transfer to the ICU.

K. NON-SMOKING: The Hospital is a non-smoking facility. Practitioners, Allied staff and Hospital staff shall not smoke on the premises. Patients are not permitted to smoke in the facility.

L. INSURANCE: Any person seeking, holding or exercising any form of clinical privileges at the Hospital shall maintain professional liability coverage in an amount not less than $1,000,000 per occurrence/claim and $3,000,000 aggregate from a company qualified to do business in Wyoming and reasonably acceptable to the Hospital. Each person seeking, holding or exercising any form of clinical privileges at the Hospital shall provide proof of insurance for the privileges sought or granted and shall promptly notify the administrator at any time such coverage lapses, is terminated, decreases below required levels or is canceled for any reason. If coverage is obtained on a claims-made basis, any person seeking, holding or exercising privileges at the Hospital agrees to maintain extended reporting coverage ("tail insurance") for a period not less than four years after the last date on which he/she exercised any clinical privileges at the Hospital.

M. CONSENTS:

1. Duty to Obtain Informed Consent: It is the obligation of the practitioner performing the procedure to make the initial determination of patient capability to give consent and to obtain the appropriate person's informed consent (defined above) before initiating any operative and other invasive and/or procedure involving anesthesia.

2. Duty to Complete Forms: Where written documentation of the informed consent for a specific treatment or test is required under these Rules, it is the responsibility of the surgeon or other designated practitioner to make the required disclosures to the appropriate person, and write appropriate orders for that person's informed consent.

3. From Whom Consent Obtained: As used in this Rule, the term "appropriate person" includes all persons authorized under Wyoming Law to make their own care decisions (which includes minors of specified ages for various kinds of treatment) and other persons properly authorized under Wyoming Law to serve as healthcare representatives for patients who are legally incapable of making their own decisions at the relevant time (parents, guardians, persons named in a healthcare power of attorney, courts, etc.). See the Hospital policy concerning Consent for Withdrawal of Life Sustaining Procedures for specifics on determining advance patient directives and authority of healthcare representatives under a healthcare power of attorney.

N. INFECTION CONTROL:

1. It is the Medical Staff's responsibility to initiate and discontinue isolation precautions in a timely and appropriate manner. The Infection Control Committee may also initiate or discontinue isolation precautions, in accordance with the Hospital Infection Control Plan.

2. The Infection Control Committee shall be notified of any nosocomial infections identified after discharge from the Hospital.

3. All persons holding and exercising any form of clinical privileges at the Hospital must comply with Hospital policies and procedures, including infection control procedures mandating the use of personal protective equipment (PPE) in patient care situations in which splashing or soiling from the patient's body fluids is likely to occur.

O. SAFE MEDICAL DEVICES ACT: The Medical Staff Executive Committee or appointees designated to serve as an ad hoc subcommittee thereof shall carry out the responsibility to determine whether there is a potential connection between a reported patient injury, illness or death and a medical device for purposes of reporting requirements, as requested by the Administrator and/or Hospital Risk Manager.

P. RESIDENTS, INTERNS, STUDENTS: Medical students and others in medical training will be permitted to accompany a physician on the medical staff in the Hospital, provided that the physician shall introduce the person and explain his presence to all patients whose care he will be participating in, and the student/trainee shall leave if so requested by a patient.

No resident, intern or student shall be permitted to perform any patient treatment, evaluation or service for which a license, certificate of registration or other form of license approval is required unless the person holds the required license, approval or a legally recognized

exemption therefrom and has obtained temporary or other clinical privileges permitting his/her involvement in the specific activity within the Hospital. A medical student on assignment to a local physician on the Staff of this Hospital may be granted permission to perform solely acts which could be delegated to an unlicensed assistant by presenting an appropriate letter from his school confirming his enrollment and assignment. All interns and students assisting in the practice of a physician who is a Staff Appointee shall be subject to a requirement that the intern or student perform the authorized activities solely under the direct and personal supervision of the sponsoring Appointee.

Q. PHARMACEUTICAL/MEDICATION

1. Surgery/ICU: See Surgery Protocols concerning cancellation of orders upon surgery.

2. Formulary; Investigative Drugs: Only drugs and medications listed in the latest edition of either United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations will be included in the Hospital formulary. Only those drugs and medications listed in the formulary may be ordered or administered at the Hospital.

3. Medications Brought in by Patients: Patients will not be allowed to use medications not dispensed by the Hospital unless authorized to do so by specific order in the patient chart. Absent such an order, all medications brought into the Hospital by the patient, family or friends will be held and returned to the patient at discharge, if such return is lawful.

4. Self-Administration: Patients may self-administer medications by specific order of an authorized practitioner, in accordance with Hospital policy.

5. Significant Medication Error/Adverse Reaction: The Adverse Drug Reaction policy shall be used in determining whether a medication error or adverse reaction shall be automatically included in review by the Risk Committee along with Pharmacy. .

R. ADVANCE DIRECTIVES; DEATH; AUTOPSIES; ORGAN DONATION:

1. Furnishing of Copies: All practitioners holding clinical privileges at Hospital shall furnish to Hospital at the time of admission copies of any current Advance Directives which the patient may have furnished to their office, with patient consent. Practitioners should be aware of the Hospital's obligation to distribute additional information and Advance Directive forms to patients in compliance with the Patient Self-Determination Act. Because the nature of the decisions recorded on an Advance Directive, and of the decision whether or not to execute one at all, involve medical decisions, practitioners with privileges at the Hospital will be prepared to discuss those issues with their patients prior to their admission to the Hospital, where appropriate. Practitioners shall also be aware of the limitations in Wyoming law on attending physicians serving as witnesses to Advance Directives or as patient-designated representatives under a Wyoming Health Care Power of Attorney, and shall not act in violation of such restrictions.

2. Location of Advance Directives: Advance Directives submitted to the Hospital by patients or practitioners (and information supplied by the patient concerning such documents, revocations, disqualifications and new documents) will be placed in the front of the patient medical record and it is the responsibility of all practitioners to be aware of the content of such documents and to act in accordance with them.

3. Hospital Policy: It is the policy of the Hospital to honor determinations of patients and their authorized healthcare representatives with respect to treatment decisions, including withdrawal of life support. No patient shall be discriminated against or have access to properly authorized care conditioned upon whether or not he/she has executed an Advance Directive.

4. DNR Orders and Withdrawal of Life Support:

   a. DNR Orders: Absent an explicit DNR order, appropriate attempts at cardiopulmonary resuscitation will be made routinely upon cardio-pulmonary arrest. A DNR order, like all other treatment decisions, requires informed consent of an authorized person (the patient if capable of medical decision-making and of legal age to do so). Practitioners entering such an order shall first obtain appropriate consent to do so. Equivocal orders (slow code) will not be accepted, but an order specifying particular treatment which is not to be administered in accordance with otherwise applicable policy will be accepted.

   b. Withholding/Withdrawing Life Sustaining Treatment: Patients who are capable have the right under Wyoming State law to determine what treatment they will accept and reject, including treatment which is life-sustaining. Wyoming State law further provides for a system of advance decisions and designation of healthcare representatives for a patient no

longer capable of making his/her own decisions, and imposes certain safeguards in the exercise of those decisions. All practitioners at the Hospital will cooperate in obtaining documentation and making decisions required to implement patient rights under that law and will comply with the Hospital's policy on "Withholding/Withdrawal of Life Sustaining Procedures."

i. Transfer of patients: Any practitioner who is unwilling to honor the patient's directive or decision of the patient's authorized representative shall promptly arrange a transfer of the patient to a practitioner who is willing to abide by the decision.

ii. Resolution of Medical Issues: If any patient or patient representative authorized to make treatment decisions on behalf of an incapable patient disagree with the attending physician's determination of capability or other medical status upon which decision rights depend, they may have the determination reviewed by the Bioethics Committee. All practitioners shall cooperate with that review, and if unable to accept its determination, shall transfer the patient to the care of another practitioner who can, if so requested by the patient or patient representative.

iii. Documentation: Upon decision to withhold/ withdraw life-sustaining treatment, the practitioner shall enter appropriate, explicit orders in the patient's medical record.

5. Death: Death of a Hospital patient shall be officially pronounced by the attending physician or his/her designee within a reasonable time after notice by Hospital staff. Practitioners shall be aware of and conform to requirements for notice to the Medical Examiner, and shall comply with Hospital policy concerning release of bodies. No deceased patient shall be released until the pronouncement has been made and recorded and signed in the medical record, the organ donor form has been completed, and written instructions to the funeral director have been completed specifying any infectious process.

6. Autopsies: All autopsies shall be performed by an appropriate pathologist, unless the Medical Examiner asserts authority in the case. The admitting practitioner (or by agreement, the attending physician) shall actively seek to obtain permission for autopsy in the following cases and to respond to questions of the person authorized to give consent:

a. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.

b. All deaths in which the cause of death is not known with certainty on clinical grounds.

c. Deaths in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding the same.

d. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures, and/or therapies.

e. Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.

f. Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.

g. Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as (1) person dead on arrival at hospital, (2) deaths occurring in hospital within 24 hours of admission, and (3) deaths in which the patient sustained or apparently sustained an injury while hospitalized.

h. Deaths resulting from high-risk infectious and contagious diseases.

i. All obstetric deaths.

j. All neonatal and pediatric deaths.

k. Deaths at any age in which is believed that autopsy would disclose a known or suspected illness which also may have bearing on survivors or recipients of transplant organs.

l. Deaths which are subject to a Medical Examiner investigation, including autopsy are deaths, according to Wyoming State Law.

If consent for autopsy is declined in any case covered by this rule, the effort to obtain it and its refusal shall be documented in the patient record. Provisional anatomic diagnosis shall be recorded in the medical record by the person performing the autopsy within seventy-two (72) hours following autopsy and the complete report, excluding any tissue reports, which require longer to complete shall be made a part of the record within sixty (60) days following autopsy.

7. Organ Donation: Refer to Washakie Medical Center Policy on Organ and Tissue Donation.

S. PATIENT RIGHTS:

All persons holding clinical privileges at the Hospital shall be aware of the content of the Hospital policy on Patient Rights and shall honor those rights and facilitate patients' exercise

of those rights, including those related to access to information, patient decision-making about proposed treatment and withholding/withdrawing life-sustaining treatment, use of advance directives and confidentiality.

T. MISCELLANEOUS: All suspected or known child abuse cases shall be reported by the practitioner and Hospital Personnel to the appropriate protective agencies.

These RULES AND REGULATIONS, adopted on the indicated dates, shall supersede and replace all prior Rules and Regulations.

Approved by vote of the Medical Staff on _____, _____.

_____
Chief of the Medical Staff

Approved by the Banner Health Board on _____, _____ .

_____