WASHAKIE MEDICAL CENTER

MEDICAL STAFF RULES AND REGULATIONS

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Approved by the Board of Directors 09.01.2022
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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.

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.

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. 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.

3. 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.

4. 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.

5. 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.

C. 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.

D. 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.

E. 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.

F. ORDERS:

1. 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.

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

3. 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.

4. 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.

G. 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.

H. 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.

I. 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.

J. 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.

K. 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.

L. 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.

M. 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.

N. 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. .

O. PATIENT RIGHTS:

All persons holding clinical privileges at the Hospital shall be aware of the content of the Hospital policy 1912 Patient Rights and Responsibilities 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.

P. MISCELLANEOUS: All suspected or known child abuse cases shall be reported by the practitioner and Hospital Personnel to the appropriate protective agencies as per the Abuse or Neglect of a Child-Identification and Reporting Policy 581