

MEDICAL STAFF RULES & REGULATIONS

CHAPTER I

1.0 PATIENT CARE

1.1. CONTINUOUS CARE

- a. In accordance with the Medical Staff Bylaws, unless an exception or waiver applies, physicians appointed to the Medical Staff must be located within the geographic area of the hospital close enough to provide timely care for patients. Active and Consulting Staff members will be located close enough to the hospital to permit daily visits to the hospital and to allow them to take call, unless an exception or waiver applies.
- b. Each member of the Medical Staff shall provide assurance of immediacy of adequate professional care of his patients in the Hospital by:
 - i. Being available or having available an eligible alternate practitioner with similar medical staff privileges with whom prior arrangements have been made.
 - ii. Member must assure that the hospital staff knows how to get in contact with him or his on call partner at all times. It is the responsibility of the staff member to see that the medical staff on-call list is updated as defined in Medical Staff Policies.
 - iii. It is the responsibility of the admitting physician to make arrangements for another physician to care for the patient, if the patient was admitted for an on-call partner who is not the patient's physician.
 - iv. It is the responsibility of the Medical Staff Member to be available by phone within a reasonable period of time or as defined by policies and procedures.
 - v. If a member elects to terminate from his care a patient while he is in the hospital, it is the member's responsibility to continue care until another member agrees to care for the patient.
- c. In case of failure to provide required daily continuous care, the CEO or his designee, the Chief of Staff, or the Chairman of the Department concerned shall have authority to call any appropriate member of the Active Staff to provide such care. The Executive Committee may implement corrective action as set forth in the Medical Staff Bylaws.
- d. In case of failure to provide adequate coverage, the Nursing Staff may call, in the following order, the Director of Nursing, the Department Chairman, the Chief of

Staff, or designee. This person shall have the authority to make other arrangements, as necessary, to protect the patient.

- e. Any member of the staff who fails to comply with the above may be subject to disciplinary action, pursuant to the corrective action procedure of the Medical Staff Bylaws which may include automatic suspension of not greater than 30 days.

1.2. INTENSIVE CARE UNIT

- a. Any patient admitted to ICU or CCU must be seen by his attending physician, or his designated staff physician, within two (2) hours of admission.
- b. The responsible physician for all ICU/CCU patients will be at all times, clearly defined.
 - (1) The responsible physician will be the attending physician unless otherwise designated. If a patient is admitted to the ICU for more than 24 hours, consultation must be obtained from an intensivist.
 - (2) After consultation, any redefinition of responsibilities shall be written in orders.
- c. Physicians will treat ICU/CCU patients only within the parameters of their granted privileges. Specialty consultation shall be requested immediately for patients requiring treatment or procedures for which the attending physician does not have privileges.

1.3. EMERGENCY MEDICAL CARE

- a. The Chairman of the Department of Emergency Medicine shall recommend to the Executive Committee policies and procedures for the operation of the Emergency Department. The chairmen of the Medical Staff Departments shall participate in the formation of such policies at the request of the Chairman of the Department of Emergency Medicine.
- b. Any physician who refuses to respond to an emergency call or who is unavailable within a reasonable period of time when his name makes him eligible for call may be reported by the Chief of Staff, the Chairman of the Department of Emergency Medicine to the Executive Committee. The Executive Committee may implement corrective action as set forth in the Medical Staff Bylaws which may include automatic suspension of not greater than 30 days. When a physician fails to respond to emergency room call, EMTALA requirements including reporting, if applicable, will be followed.
- c. A patient to be admitted on an emergency basis who does not have an attending physician shall be assigned a physician according to the Medical Staff policies and procedures.

- d. Emergency physicians do not have inpatient admitting privileges. When a patient is admitted, inpatient care will be provided by Medical Staff Members with admitting privileges in accordance with Medical Staff policies and procedures.
- e. When a disagreement occurs between the Emergency Physician and the attending or consulting physician regarding the treatment or disposition of a particular patient, the attending or consulting physician must examine that patient and document his exam and medical decision in the medical record. If the attending or consulting physician fails to examine the patient, the Emergency Physician will notify the Chief of Staff or his designee for corrective action as set forth in the Medical Staff Bylaws.
- f. All patient care in the Emergency Department will be under the direction of a Medical Staff physician physically present in the hospital.

1.4. PSYCHIATRIC CARE

Wyoming Medical Center has no inpatient psychiatric facility. Patients who require inpatient psychiatric care and who are medically stable will be transferred according to Medical Staff policies and federal regulations (EMTALA).

2.0 PHYSICIAN'S ORDERS, TREATMENTS, MEDICATIONS

2.1. ORDERS

- a. Pre-printed orders may be formulated by a physician and must be reviewed and updated as necessary by the physician, and approved by the Drug Utilization Review Director with input from the Pharmacy Department.
- b. All orders for treatment from an attending or consulting physician shall be in writing. All verbal orders shall be documented in accordance with hospital policy. They may be authenticated by any physician responsible for the patient's care at Wyoming Medical Center, as further set forth below.
- c. Verbal orders must be used only rarely and must not be common practice. Verbal orders should only be used to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order or enter it into the computer without delaying treatment, such as when the practitioner is outside of the Hospital and cannot be physically available or when the practitioner is attending to another patient. Verbal orders may not be used for convenience. Verbal orders shall be recorded directly onto the order sheet in the patient's medical record or entered into the computerized order entry system. All verbal orders shall be read back to the practitioner to ensure correctness. All verbal orders shall be signed by the authorized person who took the order and include the name of the person who recorded the order, if it was someone other than who took the order, the date and time the order was taken, the name of the ordering practitioner, and the name of the individual that implemented or performed what the order called for. The responsible practitioner shall verify, authenticate/sign,

date and time such order as soon as possible and no later than 48 hours after the order is issued.

- d. When the ordering practitioner is not available to authenticate his verbal order (i.e., the ordering practitioner gives a verbal order that is written and transcribed and then is “off duty” for the weekend or an extended period of time), it is acceptable for another practitioner who is responsible for the patient’s care to authenticate the verbal order of the ordering practitioner. By signing the verbal order, such a practitioner assumes responsibility for the order as being complete, accurate, and final. A practitioner with the Clinical Privileges to do so may authenticate another’s verbal order.
- e. Resident physicians may write orders. Counter-signature of the Resident physician’s orders is not required.
- f. Nurse Practitioners may write orders. Counter-signature of orders given by Nurse Practitioners is not required.
- g. Physician Assistants may write orders. These orders may be carried out prior to co-signature by the attending physician, but must be counter-signed to complete the medical record (i.e. within 30 days).
- h. All orders for drugs and biologicals (except influenza and pneumococcal polysaccharide vaccines) must be documented and signed by a practitioner with Clinical Privileges to write such orders and who is responsible for the care of the patient. Further, the prescribing practitioner must verify, sign, date and time the order as soon as possible after its issuance.
- i. Staff shall bring to the attention of the prescribing practitioner any questions or concerns they have regarding orders. Any questions about orders for drugs and biologicals must be resolved before the preparation, dispensing, or administration of the medicine.
- j. Any order for drugs or biologicals must clearly indicate:
 - i. The name of the patient.
 - ii. The age and weight of the patient (when applicable).
 - iii. The date and time of the order.
 - iv. The name of the drug (orders must indicate specific medications; i.e., “Maalox 30cc prn heartburn” not “antacid of choice”).
 - v. The route of administration.
 - vi. The exact strength/concentration.

- vii. The dosage form.
- viii. The frequency/dosing regimen.
- ix. Specific instructions for use (when applicable).
- x. The name of the prescriber.
- xi. The indication for PRN orders (i.e., pain, nausea, etc.) unless the medication has only one use (i.e., Ducolax).
- xii. Unless otherwise specified by the physician, the nursing policy for implementation of medication dose ranging orders will be followed.

2.2. CANCELLATION OF ORDERS

All previous treatment and medication orders are canceled when patients go to surgery. New orders must be completed post-operatively by the operating physician unless he indicates the procedure and the patient's post-OP status do not require any alteration in the plan of care. All previous orders are canceled when patients are transferred to a different level of care. New orders must be completed at the time of transfer.

3.0 AUTOPSIES, TISSUE AND LABORATORY STUDIES

3.1. AUTOPSIES

- a. Every member of the Medical Staff is expected to be actively interested in securing autopsies on hospital patients. Pathologists will perform an autopsy in accordance with Medical Staff Policy. If the coroner and/or district attorney has legal authority to require the performance of an autopsy, then an autopsy will be performed. All autopsies shall be performed by a duly licensed physician or his qualified representative.
- b. When an autopsy is performed, a provisional anatomical diagnosis (PAD) will be recorded in the medical record within 72 hours.
- c. Autopsy final reporting will be done in a prompt and consistent manner according to the following protocol:
 - If the final report is not completed within 30 days of the autopsy the Medical Records Director will notify in writing the responsible pathologist.
 - If the final report is not completed within 60 days of the autopsy the pathologist will be notified and documentation of this overdue report will be placed on the responsible pathologist's credentialing file.

3.2. TISSUE

An operative report describing the procedure shall be recorded by the attending surgeon immediately following the procedure. All tissues and foreign materials removed at operations shall be sent to the hospital pathologist, subject to exceptions agreed upon by the Division of Surgery. A signed report of the findings shall be made a part of the hospital record.

3.3. LABORATORY STUDIES

Appropriate laboratory studies, including Rh factor studies on pregnant women, will be performed on all inpatients, unless they were performed in the five (5) days prior to admission.

4.0 CONSULTATIONS

- a. Initiation of Consult Request: It is mandatory that providers will communicate directly with consultants when a consultation is requested.
- b. “Curbside Consults”: When a physician seeks information from another provider (also known as a “curbside consult”) it is often unclear to all the providers on the case whether an actual consultation during the hospital stay is expected. A consultation request should be accompanied by an order in the electronic medical record to clarify that a formal consultation has been requested.
- c. Placing the Consultation Order: The attending or admitting doctor will place a consult order in Cerner. When placing the order, the ordering physician can indicate that the unit secretary should call the doctor’s office or answering services to provide a reminder if appropriate. Calls will be placed seven days a week during daytime hours (8A to 6P).
- d. Consultation Reports: Each consultation report shall contain a dictated and transcribed opinion of the consultant that reflects the physical examination of the patient and review of the patient’s records including results of tests. The report should include the consultant’s opinion, advice and plans. The report should include the instructions given to the patient and/or family about care after the hospital visit, if applicable. Alternatively, a progress note or consultation report may be entered into the electronic health record.
- e. Orders: If the consultant wishes any tests or treatments to be performed urgently, the consultant should either enter the orders inter Cerner personally or call the requesting provider directly to have the orders placed. Urgent in this context means any orders that ought to be initiated within 24 hours.
- f. Follow-Up: If the patient is admitted to the hospital, the consultant should round daily until the issue prompting the consultation has stabilized. Rounding includes an in-person evaluation of the patient with a progress note. Other rounding

arrangements may be made through discussion with the physician requesting the consultation.

- g. Sign Off: If the consultant will not be providing further daily visits, the consultant should state that in the progress note and provide pertinent instructions for post-discharge care. Instructions should include whether and when outpatient follow up with the consultant is needed, any outpatient tests to be performed, any restrictions on activity, instructions on any wound care, appliances or devices, medication instructions, dietary restrictions and signs and symptoms to report to the consultant.

5.0 INFORMED CONSENT

Informed consent shall be obtained in accordance with hospital policy. A properly executed informed consent form must be in the patient's record before a procedure, except in emergencies.

6.0 MEDICAL RECORDS

6.1. MEDICAL RECORD FOR EACH PATIENT ADMITTED

- a. The attending physician shall be held responsible for the preparation of a complete and legible medical record in the Hospital's approved electronic medical record system for each patient according to the regulations formulated periodically by the Medical Records Review Director with input from the Medical Records Department and other appropriate physicians. The record shall include, when appropriate:
- identification data;
 - admitting history and physical for inpatients and registration history and physical for outpatients;
 - review special reports such as clinical laboratory, pathology, x-ray and others;
 - a record of medical or surgical treatment, to include formal operative reports, if required;
 - consultations obtained;
 - progress notes,
 - final diagnosis;
 - summary or discharge note; and
 - autopsy report when available.

- b. The record shall contain an account of the treatment and care given to the patient sufficient to show what treatment the patient received, medical necessity for treatment, and if some routine or indicated procedure was not given, the reason it was not given.
- c. Documentation of the need and effect of blood and blood products must be a part of the permanent medical record.
- d. Meaningful progress notes and visits shall be recorded whenever appropriate. All clinical entries in the medical record shall be accurately dated and authenticated. No entries may be made using copied information except as provided in the Hospital's Corporate Compliance Copy and Paste Functionality policy. Cloning of documentation is not allowed and the writer of each document is responsible for all content of the document and must ensure all material accurately reflects the care provided in the note.
- e. Orders should be completed or authenticated only by medical staff members or other individuals who have been granted the appropriate clinical privileges.
- f. History and physical examination, Emergency Department notes, operative reports, consultations, and final summaries typed or dictated by residents or physicians office staff shall be co-signed by the attending or supervising staff physician or dentist. The responsible Medical Staff member's own pertinent observations and significant physical findings should be added wherever necessary.
- g. All clinical entries in the patient's medical record shall be dated, timed, and electronically signed by the person who is responsible for providing or evaluating the service provided. A signature stamp may not be substituted for an actual signature. The practitioner must separately date and time his/her signature, even though there may already be a date and time on the document. Authentication may be made by electronic signature or initials in the Hospital's electronic medical record system.

6.2. HISTORY AND PHYSICAL EXAMINATION

See Bylaws Chapter 14, Section 8.

6.3. OPERATIVE/PROCEDURE REPORT

- a. A pre-anesthesia evaluation must be performed within 48 hours before any surgery or procedure requiring general, regional or monitored anesthesia services. A patient is re-evaluated immediately before anesthesia induction.
- b. All patients scheduled for procedures to be performed under general, or major conductive regional anesthesia, or moderate or deep sedation, or other invasive/non-invasive procedures that place the patient at high risk are required to have a pertinent operative report.

- c. There should be appropriate documentation in the patient's medical record of pertinent information relative to the choice of anesthetic agent, anesthetic technique, and the surgical or obstetrical procedure anticipated.
- d. Final verification must be done prior to the start of any procedure identified in 6.3.b above.
- e. The operative/procedure note will be completed immediately after surgery/procedure and will include the necessary elements of a Post-OP/Procedure Note in accordance with the Medical Staff Policy: Date, time, surgeon, assistant (if any), pre-OP diagnosis, post-OP diagnosis, procedure, findings, specimens (if any), estimated blood loss (if more than minimal), signature. If a dictated post-op report has been transcribed or is electronically prepared and placed on the patient's chart prior to the patient being transferred to the next level of care, then a hand-written post op note is not required. For procedures performed without moderate to deep sedation or anesthesia (may include procedures using local anesthesia/analgesia) the following items may be omitted if inappropriate: pre-op and post-op diagnosis, assistant, findings, specimens. Examples (non-inclusive) laceration repair, circumcision, insertion of a central line.
- f. The post-anesthesia evaluation will be completed and documented within 48 hours after any surgery/procedure during which general, regional, or monitored anesthesia has been administered to a patient by a practitioner who is qualified to administer anesthesia.
- g. The dictated operative/procedure report will be documented within 24 hours after surgery/procedure.

6.4. DISCHARGE SUMMARY

- a. A clinical resume shall be dictated or prepared on all medical records of patients hospitalized over 48 hours and all deaths, regardless of length of stay, within 24 hours of the patient's discharge unless the patient is discharged to the care of the discharging physician. The clinical resume should recapitulate the reason for hospitalization; significant findings; procedure(s) performed and the treatment rendered; condition of the patient on discharge; and any specific instructions given to the patient and/or family. These may include physical activity, medication, diet and follow-up care. All clinical resumes shall be authenticated by the responsible practitioner.
- b. A final progress note may be substituted for the clinical resume in cases of patients with problems of a minor nature who require hospitalization for less than 48 hours and in cases of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note may include any instructions given to the patient and/or family relative to physical activity, medication, diet, and follow-up care.

6.5. COMPLETION OF MEDICAL RECORDS

- a. Medical records must be completed as soon as practicable at the time of service or shortly thereafter, and in no case later than 30 days of discharge from the hospital, except where necessary medical information is not available.
- b. No medical record shall be filed until it is completed, except on order of the Medical Records Review Director with input from the Medical Records Department and other appropriate physicians.
- c. Only those symbols and abbreviations which have been approved by the Medical Staff, a list of which is on file in the Medical Records Department, shall be used in the medical record.
- d. Medical Staff members whose privileges have been suspended for delinquent records, and who are the only trained available physician for the type of care necessary, may admit patients only in emergency, life-threatening situations. However no elective procedures may be completed. The Chief of Staff, or his designee, shall be notified of all admissions under this section. All admissions and procedures made under this section shall be subsequently reviewed by the Executive Committee to affirm that an emergency, life-threatening condition existed and that this section was appropriately applied.
- e. Medical Staff members who are consistently delinquent in completing their medical records will be subject to the provisions set forth in the Medical Staff Bylaws.
- f. Clinical laboratory examinations, radiology and nuclear medicine examinations, or treatment, and any other diagnostic or therapeutic procedure, except as provided in 6.5.g.h.i., should be dictated (with a handwritten note when appropriate) within the following time frames: Outpatients - 72 hours, Routine inpatients - 48 hours, Emergent patients - 24 hours.
- g. A summary of initial findings of cardiac cath reports shall be documented in the chart immediately following the procedure with a dictated report to follow within 7 days. Other cardiovascular laboratory reports, Dopplers, and Echoes should be dictated with a handwritten note when appropriate within the following time frames: Outpatients - 72 hours, Routine inpatients - 48 hours, Emergent patients - 24 hours.
- h. Surgical Pathology written reports will be available to the physician and in the medical record within 48 hours with an acceptable threshold of 80% allowing for special procedures (i.e. fixation, stains, consultation). Verbal reports may be available as soon as 24 hours.
- i. EEGs and evoked potential reports shall be documented in the chart within the following time frames: Routine - 5 business days, Urgent - 48 hours, Emergent - 24 hours.

- j. Emergency physician report shall be documented in the chart within 24 hours.

6.6. CONTROL OF AND ACCESS TO PATIENT RECORDS

- a. Free access to all medical records of all patients shall be afforded to staff physicians in good standing for bona fide study and research, consistent with preserving the confidential nature of personal information concerning the individual patients. Research proposals shall be submitted to and approved by the Institutional Review Committee. Subject to the discretion of the Chief Executive Officer, former members of the Active Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patient in the hospital.
- b. All medical records are the physical property of Wyoming Medical Center and cannot be taken from the confines of the hospital, except in accordance with a court order, subpoena or statute. Unauthorized removal of medical records may result in suspension from the Medical Staff.
- c. Written consent of the patient is required for release of medical information to those not authorized. The medical record is a confidential document and access is restricted to the patient, to the patient's authorized representative, to the attending physician, and to the hospital staff with legitimate need for such access.
- d. In case of re-admission of a patient, previous records shall be available for the use of the attending physician.
- e. Release of medical information shall be pursuant to hospital policy.

7.0 MEDICAL STAFF DISASTER ASSIGNMENTS

In the event of disaster the Medical Staff shall provide professional services in accordance with the existing hospital disaster plan.

CHAPTER II RESIDENTS

Section 1. GENERAL GUIDELINES:

- 1.1. History and physical examinations performed by residents may be placed on the patient's chart and may serve as the required history and physical under the Medical Staff Bylaws only with the approval of the attending physician of the patient. Countersigning of the history and physical by the attending physician will serve as evidence of such approval.
- 1.2. Since the resident is in training and is not a member of the Medical Staff and has not been approved for membership by the Medical Staff, he or she may not assume the duties of a member of the Medical Staff. When a resident is assigned to the care of a patient, the attending physician or his designated physician representative must be available for supervision, or counsel to the resident. (In an emergency situation, the resident may proceed with necessary treatment as would a member of the Medical Staff.)
 - a. All new residents of the Family Practice Residency Program shall undergo during their orientation, a discussion as to medical staff function, bylaws, general rules, regulations, and policies, in addition to a general orientation to the hospital.
 - b. The officers of the Medical Staff have the responsibility and authority to intervene, as necessary, in patient care provided by members of the Medical Staff, as well as by residents. The Program Director of the Family Practice Residency Program is responsible for all activities of residents, and the officers of the Medical Staff shall immediately contact the Program Director in the event of an intervention into patient care. In other situations, the chain of command policy for the hospital will be followed.
 - c. The history and physical, if done by a resident, may be considered sufficient for the hospital record, if agreeable and co-signed by the attending physician. The responsibility for having adequate and timely histories, physicals, and discharge summaries for all patients shall be that of the attending physician.
 - d. Residents shall respond to all Code Blue and Code Green, and shall adhere to the established protocols approved by the Medical Staff.
 - e. Progress notes may be written by residents in lieu of attending physician progress notes. All histories, physicals, and discharge summaries written by residents in lieu of physicians shall be countersigned by the attending physician.
 - f. The attending physician shall make rounds on all patients seen in conjunction with residents.
 - g. Family Practice residents may not "cover for" a member of the Medical Staff. The attending physician or his representative must be available at all times for consultation with any resident cooperating in the care of a patient within the hospital. Patients seen in the emergency room are, by definition, within the

hospital, and members of the Medical Staff may not “sign out” to residents for the purpose of Emergency Room coverage.

- h. Family Practice Program participants need to function within the parameters of the Medical Staff Bylaws, Rules and Regulations and all Departmental Rules, Regulations, and protocols. Residents are bound by the provisions for confidentiality and medical record completion. Breaches of any of these provisions shall be brought to the attention of the Program Director for action if necessary.
- i. The Medical Executive Committee shall be the body through which members of the Medical Staff exchange information about the quality of care, treatment, and services and education needs of the residents with the Graduate Medical Education Committee. To this end, the Program Director of the Family Practice Residency Program shall be a standing member of the MEC. In addition, the Program Director will prepare a report at least annually for submission to the MEC and the Board of Directors. The Board and Executive Committee retain all authority to direct patient care and medical management within the hospital as is legally required.