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**QUEEN OF THE VALLEY MEDICAL CENTER
MEDICAL STAFF RULES AND REGULATIONS**

Definitions:

Emergency medical condition: A medical condition that manifests 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 reasonably be expected to result in placing the health of the individual or, with respect to pregnant woman, the health of the woman or unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organ or part.

With respect to a woman who is pregnant and is having contractions: an emergency condition is when there is inadequate time to effect a safe transfer to another hospital prior to delivery or such transfer may pose a threat to the health and safety of the woman or the unborn child.

Medical screening examination: An evaluation, within the capabilities/capacity of the facility, including ancillary services routinely available to the emergency department, by qualified individuals to determine whether an “emergency medical condition” exists.



I. ADMISSION

Admission Policies:

1. The Queen of the Valley Medical Center accepts patients for care and treatment of acute or chronic organic illness and/or injuries, except for patients with certain communicable diseases that cannot be adequately isolated to protect hospital employees' and other patients' safety.
2. A patient may be admitted to the hospital only on the order of a practitioner member of the medical staff with the exception of members of the emergency services department who shall not have admitting privileges. All orders by the emergency physician are active, and are to be carried out during and/or after the admission process unless specifically discontinued, canceled or changed by the admitting physician.
3. Physicians who have admitting and treating privileges may complete histories and physicals on their patients, within their scope of practice.
4. A member of the medical staff is responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, and for educating patients regarding their illnesses. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of the responsibility is entered in the order section of the medical record.

5. The following practitioners are authorized to conduct a medical screening examination to determine if an emergency medical condition exists:
 - a. Emergency Department: Physician members of the medical staff, emergency department certified nurse practitioners and physician assistants who have practice prerogatives as allied health practitioners.
 - b. Labor and Delivery: Physician members of the medical staff, and —registered nurses who have completed the competency program and are operating under an approved standardized nursing procedure.
6. Except in an emergency, no patient is admitted to the hospital unless a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement is recorded as soon as possible.
7. In the event of a bed shortage, or problem with an admission, the department chairs and/or medical directors will be contacted for assistance with the evaluation and triaging processes for discharges and transfers. Medical staff members will be notified of the hospital status and that the hospital has no capacity for direct admissions. Chief of Staff or his or her designee will have final responsibility for the triage of patients.
8. The admitting practitioner is responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his or her patient is known to be source of danger from any cause whatsoever. For the protection of patients, the medical and nursing staffs, and the hospital, certain principles are to be met in the care of the potentially suicidal patient:
 - a. Any patient with profound psychiatric disorder should be referred to a psychiatric institution as soon as possible.
 - b. Any patient deemed a suicidal risk, either by action or statement, is evaluated for same, by the attending physician. The attending physician shall have the patient evaluated by a consulting psychiatrist or social services staff. The patient is admitted to the hospital unit appropriate to the medical condition. Twenty-four (24) hour attendant coverage is maintained until the attending physician or the designated evaluator documents in the medical record that the patient is no longer at risk. Attendant coverage is obtained per hospital policy.
 - c. It is recommended that any patient suspected to be suicidal have psychiatric consultation.
9. Admission to the Intensive Care Unit (ICU)

The facilities of the ICU are available to all members of the Queen of the Valley Medical Center Medical Staff who have been granted privileges to admit and/or treat patients in the ICU.

The approved medical staff ICU policies regarding admission, discharge and transfer criteria will be followed.

- a. To assure a consistent level of quality care to critically ill patients, physicians will comply with rules for Physician Specialist Consultation in the ICU (see Consultation). The primary-attending physician is responsible for the supervision and medical care of his/her patients in the ICU. In his/her absence, the primary-attending physician is responsible for designating a replacement physician in the order section of the patient's record.
- b. The primary attending physician or physician designee will see patients as medically necessary or within four (4) hours of admission to the ICU unless seen immediately prior to transfer/admission to the ICU. Patients, including those who are admitted directly to the ICU from the physician's office, will be seen at least daily thereafter.
- c. Patients meeting any of the following criteria may be candidates for admission to the ICU. If the patient meets ICU criteria but, in the judgment of the attending physician, ICU admission is deemed not desirable, then patients meeting these criteria do not require admission to the ICU.
 1. Patients with unstable hemodynamic parameters.
 2. Patients requiring acute mechanical ventilator assistance, or with severe respiratory distress requiring intensive nursing/respiratory care management.
 3. Patients with severe fluid and electrolyte imbalances and/or renal failure.
 4. Patients with acute or potential neurological compromise.
 5. Patients with unstable cardiac arrhythmias or ischemia.
 6. Pediatric patients.
- d. Pediatric patients requiring specialized intensive care services are generally transferred to another facility, after the physician has consulted with the family.

II. AUTOPSY CRITERIA/DEATHS IN THE HOSPITAL

In the event of an in-hospital death, the deceased will be pronounced dead by the attending practitioner or designee within a reasonable time. The body will not be released until an entry has been made and authenticated in the medical record.

An autopsy which is requested by the physician or next of kin is performed only with a completed autopsy permit form/consent, authenticated in accordance with state law. Permitted autopsies are performed by the contracted pathology service. Provisional anatomic diagnoses and the complete autopsy report are incorporated into the medical record.

For any death under coroner case guidelines (see next page), which the coroner has waived and for any death where the cause of death is unclear, or cases of potential medical-legal or educational interest, autopsy is encouraged.

Coroner Case Guidelines:

Cases authorized and performed by the Coroner do not require a permit from the next of kin. The following cases shall be referred to the Coroner:

1. All sudden, violent, unusual or unattended deaths: All cases of suspected assault, elder abuse, child abuse, or attempted suicide will be reported to the local police department or sheriff's office by the practitioner in attendance, or his or her designee. The attending practitioner or his or her designee must report death from such causes to the coroner;
2. Deaths where the deceased has not been seen by a physician within the last twenty (20) days prior to death;
3. Deaths related to or following known or suspected self-induced or criminal abortion;
4. Known or suspected homicide, suicide, or accidental poisoning;
5. Deaths that occurred as a result of an accident or injury, whether old or recent (This can be from a previous fall, traffic accident, etc.) Death of a patient directly or indirectly resulting from an accident must be reported to the coroner even though there may be considerable interval between the accident and death;
6. All cases of death on arrival or dying within twenty-four (24) hours of first medical attendance except for do not resuscitate (DNR) or hospice patients, or where the diagnosis is obscure, should be reported to the coroner by the attending practitioner, or the attending practitioner's designee;
7. Deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, or aspiration;
8. Sudden infant death syndrome (SIDS);
9. Deaths in whole or in part due to criminal means;
10. Deaths associated with a known or alleged rape or crime against nature;
11. Deaths in prison/jail or while under sentence;
12. Deaths due to contagious disease and constituting a public hazard;
13. Deaths due to occupational diseases or hazards;
14. Deaths of patients in state hospitals serving the mentally or developmentally disabled and operated by the State Department of Developmental Services or the State Department of Mental Health;
15. Deaths during surgery or during complex procedures, or due to complications of that surgery; or
16. Fetal deaths greater than twenty (20) weeks gestation without medical attendance or when the attending physician does not know the cause of death.

III. CHAIN OF COMMAND

If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse should first

contact the physician. If this contact is not successful he/she should refer the concern to the attention of the appropriate nursing chain of command.

If warranted, the appropriate nursing authority may bring the matter to the attention of the chair of the department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the chair of the department may request a consultation after conferring with the practitioner.

To clarify patient care questions, the following can be contacted in the order given:

1. Department chair (or vice-chair if chair is not available)
2. Chief of staff
3. Vice chief of staff
4. Immediate past chief of staff

For purposes of final authority the Medical Staff Chain of Command is as follows:

1. Chief of staff
2. Vice chief of staff
3. Immediate past chief of staff
4. Department chair
5. Vice chair if chair is not available

IV. CONSULTATIONS

Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his or her area of expertise. The attending physician is responsible for requesting consultation when indicated and for calling in a qualified consultant. Physician to physician communication is required.

- a. Except in an emergency, consultation is required in the following situations:
 1. Curretage or other procedures by which a known or suspected intact pregnancy may be interrupted;
 2. Tubal ligation, which may only be performed in accordance with the Patient Care Policy on Reproductive Sterilization;
 3. When the patient is not a good risk for an operation or treatment;
 4. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 5. When there is doubt as to the choice of therapeutic measures to be utilized;
 6. In unusually complicated situations where the specific skills of other practitioners may be needed;
 7. In instances in which the patient exhibits severe psychiatric symptoms;
 8. When requested by the patient's family.
- b. Consultations will show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. When

operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

- c. Physician Specialist Consultation in the ICU: In order to establish a mechanism for determining when consultation by a qualified specialist is appropriate, the organized medical staff, through its department chairs and Medical Staff Executive Committee (MSEC), has oversight responsibility for assuring that consultants are called as needed.
 1. The attending physician will make requests for consultation to the consulting practitioner.
 2. The medical director of the ICU or the chair of the Critical Care Committee may, after conferring with the attending physician, determine that a patient will benefit from a consultation with a physician specialist, and may then request that consultation.
 3. A nurse who believes that a patient would benefit from a consultation should discuss this opinion with the attending physician. If, after the discussion, the nurse continues to believe that the patient's needs are not being met, he/she should discuss the issue with the nurse manager. The clinical coordinator may then notify the medical director of the ICU, or his/her designee. The Medical Director may then choose to request a consultation after reviewing the patient's status and conferring with the attending physician.
 4. If an irresolvable conflict regarding the disposition of the patient occurs between the attending physician and the medical director, the disposition of the patient is decided through the chair of the Critical Care Committee and the subsequent chain of command up through the chief of staff.
 5. When the attending physician or designee is unavailable, and delay in appropriate therapy might adversely affect a patient, the medical director of the ICU will assume interim responsibility for arranging a patient's medical care.

V. COVERAGE OF PATIENTS

1. It is the responsibility of all the attending practitioners to arrange for twenty-four (24) hour coverage for their patients. If the practitioner does not make such arrangement, the Department Chair will appoint a practitioner to provide the necessary medical care for patients in the hospital, and will refer the matter to the Medical Staff quality assessment process for review.
2. The covering practitioner must expressly agree to the arrangement, and the covering practitioner's name must be given by the attending practitioner or the department chair to those individuals who might reasonably be expected to need the information. In any event, the emergency department and/or emergency department physicians are not appropriate alternatives to providing this coverage. If a practitioner cannot be available to respond to the nursing staff of this hospital, the emergency department, and colleagues within a reasonable timeframe, for the purpose of providing care to patients for whom the practitioner is responsible, inpatient and outpatient, the practitioner will make adequate arrangements for a qualified member of this medical staff to provide

coverage. If there is a change or substitution of coverage arrangements it is the responsibility of the attending practitioner to notify the departments who might reasonably be expected to need the information.

3. Emergency Department On-Call Physician Responsibilities:

- a. Each medical staff department will establish policies and call schedules for physicians who serve on call to the emergency department, in accordance with the bylaws, rules and regulations and policies of the medical staff. The call schedule must list coverage physicians by name, and it must be prepared in advance to ensure that the emergency department is prospectively aware of who is on call. It is the responsibility of the on-call physician to keep the emergency department informed by direct physician to physician communication if there should arise any substitution in the coverage list once that list has been proactively submitted.
- b. Active medical staff members serving on call to the emergency department are required to respond to emergency department for the evaluation and treatment of patients with emergency medical conditions. There is no requirement that active medical staff members serving on call must accept outpatient non-emergency or non-urgent referrals (except for their own patients or patients of other medical staff members with whom they have coverage arrangements). On a case-by-case basis, the emergency department physician may call the on-call specialist to refer a stable patient for post-hospital outpatient care; the on-call specialist may, at his/her discretion, accept such referrals.
- c. Physicians on-call to the emergency department are expected to respond within twenty (20) minutes when requested to consult on or see a patient for purposes of determining the existence of, and/or stabilizing, an emergency medical condition under Emergency Medical Treatment and Active Labor Act (EMTALA). The emergency physician (or other physician requesting a call response) may extend the response time if reasonable in view of the patient's clinical circumstances.

Each on-call physician must let the emergency department know how to reach him/her immediately and remain close enough to the hospital to be able to arrive within the required time frame.

- d. All patients who present to the emergency department will receive a medical screening examination within the capability of the hospital to determine whether or not an emergency medical condition exists. Private physicians who request notification when any of their patients arrive at the emergency department will be notified after the medical screening examination and initial stabilization, as time and circumstances permit. The medical screening exam may be satisfied by the Emergency Department physician, private physician, emergency medicine physician assistant or emergency medicine nurse practitioner with appropriate practice prerogatives.
- e. When patients who present to the emergency department request to be seen by their private physician, the private physician will be called promptly. If the patient becomes unstable, or when there is a delay in contacting the private physician, or the private physician has not arrived, the emergency department physician may

assume triage and treatment protocols in order to see to the patient's medical needs.

1. If there is a dispute between the emergency physician and the on-call physician as to whether the physician should come in to evaluate and/or treat the patient in person, for purposes of EMTALA compliance, the emergency physician's opinion shall prevail. The dispute may be discussed afterward by appropriate committees and/or medical staff officials and guidance or policies may be established for future reference.
2. In the event the on-call physician is involved with a medical emergency and/or is unable to respond, then other physicians in the same specialty may be contacted. In the event no physician is able to respond, other area hospitals should be contacted for availability of such specialty services and an appropriate transfer in accordance with EMTALA standards should be affected.
3. When scheduled on call, each physician shall accept the care of all patients who are appropriately referred without discrimination on the basis of the patient's race, creed, sex, age, national origin, ethnicity, citizenship, religion, pre-existing medical condition (except to the extent it is pertinent to medical care), physical or mental handicap, insurance status, economic status, or ability to pay.
4. When an on-call physician determines that a patient should be transferred to another facility it will be his/her responsibility to carry out the transfer in accordance with hospital and EMTALA standards.
5. Any dispute between the on-call physician and the patient or the family or legal representative shall be referred to the emergency physician. No on-call physician shall presume that his or her services have been refused unless the patient or the patient's legal representative have been fully informed of the benefits of treatment offered and all reasonable steps have been taken to secure such information in writing. The emergency physician shall be informed of any such refusal of treatment.

VI. CREDENTIALS FILES

The credentials/quality assessment files shall contain information directly related to quality of care, ethical issues, information mandated by state and federal statute or medical staff to carry out review and credentialing functions. The provision of quality care depends on the competence of practitioners. Thus, material relevant to assessing the qualifications of individuals applying for clinical privileges is included in the credentials/quality assessment files. The chief of staff, with consultation with the department chair, will resolve any dispute concerning the file in which a document should be placed.

VII. DEPARTMENTAL RULES/REGULATIONS

The separate departments may have their own rules and regulations. Each department is responsible for a periodic review of the rules and regulations and clinical privilege list compiled by the department and standards of practice expected by the department.

VIII. DISCHARGE OF PATIENTS

No patient will be transferred out of the hospital without such transfer being approved by the responsible practitioner; patients are discharged only by order of the attending practitioner.

1. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record by the attending physician or his or her designee.
2. It is the responsibility of the attending practitioner to discharge patients as early as possible and convenient.
3. ICU Discharge Criteria:
 - a. Patients are discharged from the ICU when frequent observations and interventions as defined in ICU Scope of Service are no longer necessary or no longer desirable.
 - b. For patients requiring therapies not available at this facility, the attending physician, after consulting with the patient and, as appropriate, the family, is to make arrangements for referral to another facility which is equipped to meet the patient's needs.

IX. FEES

The medical staff and allied health professionals will be assessed fees in accordance with medical staff bylaws, ARTICLE XVI. The following amounts have been established, effective April 1, 2012:

Applicants	\$550.00
Allied health professional applicants	\$400.00
Locum tenens	\$550.00

Reapplication fees are charged as follows:

Active staff	\$550.00
Administrative staff	no fee
Affiliate staff	\$550.00
Courtesy staff	\$550.00
Consulting staff	\$550.00
Allied health professionals	\$400.00
Honorary staff	Exempt

The medical staff services department maintains a list of practitioners who have been allowed exemption from or reduction in fees assessment. The MSEC for good reason may make other exceptions.

X. VOTING BY MAIL

In accordance with the *Sturgis Standard Code of Parliamentary Procedure*, the following process will be followed when conducting a vote by mail.

1. A ballot containing proposed measures or amendments will be transmitted by medical staff services to each active medical staff member together with directions.
2. Arguments for and against proposals to be voted on may be included.
3. The ballot must be marked and returned to medical staff services within a specified time.
4. If it is necessary that a secret ballot be cast, the following process will be followed: To preserve secrecy, each member will be provided with a blank envelope, which has no mark of identification. The marked ballot will be placed in the blank envelope, which is then to be sealed. The blank, sealed envelope will be enclosed in the return mail envelope, which is to be signed by the member. This will allow the member's name to be checked against the list of members eligible to vote.
5. Ballots will be tallied in accordance with the most recent edition of *Sturgis Standard Code of Parliamentary Procedure*.
6. Results that indicate approval will be forwarded to the Board of Trustees for final approval.
7. A report will be made at the next regular meeting of the medical staff following the close of the election.

XI. MEDICAL RECORDS

The attending practitioner is responsible for the preparation of an appropriate and legible medical record for each patient. Illegible is defined as very difficult or impossible to read by the department leadership, MSEC or the chief of staff.

The contents of the medical record shall be pertinent and current. This record will include identification date (date of service); complaint; history of present illness; personal history; family history; physical examination; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative or procedure report; pathologic findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; clinical resume; and autopsy report when performed.

1. Consents

- a. A Verification of "Conditions of Admission" form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admissions office shall notify the attending practitioner whenever such verification of consent has not been obtained. When so notified, it is the practitioner's obligation to obtain proper consent before treatment is initiated.
- b. A record of the "Conditions of Admission" form will be maintained for inpatient and outpatient care.

- c. Informed Consent: Specific informed consent shall be obtained from the patient by the physician. Informed consent may be obtained from the patient by the allied health professional for care, treatment or procedures to be carried out by the allied health professional.

For additional information regarding the need for informed consent refer to the Procedural Classification Policy.

With regard to consents for minors, consult prevailing state and federal law.

Additional consent requirements exist for special situations:

1. When the likelihood of blood transfusion in an elective procedure is anticipated, specific consent meeting statutory requirements is required (Paul Gann Act).
 2. Full disclosure of financial interests or independent research interests outside of usual and customary fees for services is required when the person performing the procedure will benefit from the procedure.
 3. Certain procedures require specific State of California mandated consent, such as sterilization procedures. In such situations the prevailing mandated informed consent policy shall apply.
- d. A complete informed consent process includes a discussion of the following elements with the patient:
- The nature of the proposed care, treatment, services, medications, interventions, or procedures, including the anesthesia to be used.
 - The indications for the proposed complex procedure or treatment.
 - Material risks and benefits for the patient related to the surgery and anesthesia, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's clinical judgment. Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity.
 - Treatment alternatives, including the attendant material risks and benefits.
 - The probable consequences of declining recommended or alternative therapies.
 - Who will conduct the complex procedure or treatment and administer the anesthesia, if known at the time.
 - Indication or listing of the material risks of the procedure or treatment that were discussed with the patient or the patient's representative.
 - If applicable, that qualified medical practitioners who are not physicians who will perform important parts of the surgery or administration of anesthesia will be performing only tasks that are within their scope of practice, as determined under State of California law and regulation, and for which they have been granted privileges by the hospital.
 - The nature of the proposed care, treatment, services, medications, interventions, or procedures.

- The likelihood of achieving care, treatment, and service goals.
- Reasonable alternatives to the proposed care, treatment, and service.
- When indicated, any limitations on the confidentiality of information learned from or about the patient.

e. Exceptions to the informed consent include:

1. In the case of an emergency medical condition in which the patient is unable to provide consent, treatment may proceed without the patient's consent if no evidence exists to indicate that the patient would refuse treatment.

See definition of emergency medical condition on page 3.

Documentation must be included in the patient's health record regarding the emergency medical condition.

2. Patient requests not to be informed. The physician must document the patient's request and what, if any, information was discussed with the patient.
 3. If informed consent would upset the patient so seriously that the patient would be unable to dispassionately weigh the risks of refusing to undergo the recommended treatment. The physician must document the facts that resulted in this conclusion and what, if any, information was discussed with the patient.
- f. Except in emergency situations, an informed consent form must be properly executed prior to the procedure requiring informed consent. Documentation of informed consent in the physician's note and/or Queen of the Valley Medical Center consent form, however, need only contain the fact that informed consent was given, i.e. "informed consent was obtained".
- g. The medical record must contain documentation by the physician or licensed independent practitioner that informed consent was obtained.
- h. Recording and filming:
1. Consent for use of video or other photographic equipment will be obtained from the patient or responsible party prior to use. This will be documented in the medical record prior to the procedure.
 2. In the event the images are intended for a use other than immediate diagnostic or treatment purpose and/or Queen of the Valley Medical Center education and training, the patient's specific consent will be obtained prior to release.
 3. Patients have the right to request cessation of recording or filming.
 4. Patients have the right to rescind consent for use before the recording or film is used.
 5. The hospital does not maintain control of personal photographic equipment, for instance in obstetrical cases.

6. Images obtained for patient care purposes are the property of Queen of the Valley Medical Center, and are recorded in the medical record and retained for ten (10) years for adults, and nineteen (19) years for minors.
7. Anyone who engages in recording or filming (who is not already bound by the hospital's confidentiality policy) signs a confidentiality statement to protect the patient's identify and confidential information.

2. History and Physical Examinations:

It is the responsibility of the medical staff to assure that an appropriate medical history is taken and an appropriate history and physical examination (H&P) is conducted on patients being admitted for inpatient care, as well as prior to operative and complex procedures in either an inpatient or outpatient setting.

Patients requiring an H&P will receive a **FULL H&P**, an **ABBREVIATED H&P**, a **PRE-PROCEDURAL ASSESSMENT**, and/or a **MEDICAL RECORD UPDATE ENTRY** consistent with the requirements set forth in these rules and regulations. In general, the report should state the findings of assessments, conclusions and impressions drawn from medical history and physical examination, the diagnosis, diagnostic impression or conditions and the reasons for admission or care, treatment and services. Laterality must be included in the H&P, where applicable.

FULL H&P

A full H&P is required for any patient who is admitted to the hospital for medical or surgical treatment. A full H&P is also required in accordance with the Procedural Classification Policy.

The full H&P must contain the following:

- Chief patient complaint and details of present illness or condition
- Past medical history to include illnesses, hospitalizations / operations
- Allergies
- Medications
- Family history
- Social history
- Review of systems
- Appropriate physical examination and vital signs
- Diagnosis or problem list
- Plan of care

ABBREVIATED H&P

Physicians may use an approved preprinted abbreviated H&P form for outpatient services or procedures; however, the physician must document an update at the time of admission when the outpatient service or procedure is rendered.

An abbreviated H&P may be utilized for minimally invasive procedures as defined in the Procedural Classification Policy and for patients in observation status up to 23 hours.

This report shall include, at a minimum, chief complaint; history of present illness; past medical history including allergies, medications, illnesses, and hospitalizations; review of systems; physical examination to include HEENT; chest and lungs, heart, abdomen and neurological status; impression; laterality; diagnosis; vital signs and informed consent as defined by policy.

PRE-PROCEDURAL ASSESSMENT

A pre-procedural assessment may be utilized in certain outpatient diagnostic areas as defined in the Procedural Classification Policy. This assessment shall be done immediately prior to the procedure and shall include at least the reasons for the procedure; pertinent history; directed physical examination; impression; laterality; pre-anesthetic rating and informed consent as defined by policy requirements.

MEDICAL RECORD UPDATE ENTRY

An updated medical record entry may be used as an admission H&P within twenty-four (24) hours of admission or prior to surgery and other complex procedures and care, if an appropriate H&P has been completed within thirty (30) days prior to admission.

If there has been no interval change in the condition of the patient, the medical record update entry may indicate that an examination was performed and there was no interval change since history and physical of said date. If there has been interval change in the condition of the patient, then the medical record update entry must thoroughly document those changes with respect to medical history, physical examination, laboratory data and treatment plan.

WHO CAN PERFORM THE HISTORY AND PHYSICAL

The history and physical can be performed by a doctor of medicine or osteopathy, or for patients admitted only for oral/maxillofacial surgery, by an oral/maxillofacial surgeon who has been granted such privileges by the medical staff in accordance with state law. The MD/DO may delegate all or part of the physician examination and medical history to an allied health professional with appropriate practice prerogatives, but the MD/DO must authenticate by signature concurrence with the allied health professional's medical record entry and assume full responsibility for the content and accuracy of the report.

Podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry. A member of the medical staff who has appropriate clinical privileges must complete the balance of the patient's history and physical examination.

Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry. A member of the medical staff who has appropriate clinical privileges must complete the balance of the patient's history and physical examination.

TIMEFRAMES FOR COMPLETING HISTORY AND PHYSICAL

The medical admission history and appropriate physical, performed by a qualified member of the Medical Staff, shall be completed and recorded no more than thirty (30) days before or twenty-four (24) hours after admission. When the medical history and physical

examination are completed within thirty (30) days before admission, an updated medical record entry documenting an examination for any changes in the patient's condition must be completed and documented in the patient's medical record immediately prior to a surgical procedure or within twenty-four (24) hours after a medical admission.

Refer to the Procedural Classification Policy for information regarding history and physical evaluation requirements specific to procedures.

When the history and physical examination are not recorded in the medical record prior to surgery or to a potentially hazardous diagnostic procedure (as required by the Procedural Classification Policy), the surgery/procedure will be postponed pending recording of the history and physical examination.

In emergency medical conditions, wherein the physician or licensed independent practitioner's judgment that a delay would be detrimental to the best interest of the patient, appropriate care will be provided. Documentation will occur as soon as possible after the care is rendered with appropriate date/time documentation. This documentation will include at least a summary of the care provided and whatever evaluation of the patient that was performed including the reason for proceeding with care without prior documentation.

3. Progress Notes

Pertinent progress notes will be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Patients will be seen, and progress notes will be entered in the medical record, in accordance with state and federal regulations. In the acute hospital setting progress notes will be entered at least daily on all patients. In the Acute Rehabilitation Unit physician progress notes will be entered into the medical record no less than three (3) times per week.

4. Operative Reports

Operative reports will include: patient name; medical record number; date and times of the surgery; name(s) of the surgeon(s) and assistant(s) or other practitioners who performed surgical tasks; pre-operative and post-operative diagnosis; name of the specific surgical procedure(s) performed; type of anesthesia administered; complications (if any); a description of techniques, findings, and tissues removed or altered; prosthetic devices, grafts, tissues, or transplants (if any). Operative reports will be dictated or written immediately following surgery for outpatients as well as inpatients, and the report promptly signed by the surgeon and made part of the patient's current medical record. If report is dictated, an immediate post-operative note to facilitate the patient's continuing care should be entered into the patient's record.

5. Obstetrical Record

The current obstetrical record includes a pertinent prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transfer to the hospital before admission, but an interval note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

6. Post Anesthesia Evaluation

A post anesthesia evaluation will be completed and documented by an individual qualified to administer anesthesia no later than forty-eight (48) hours after surgery or a procedure requiring anesthesia services.

7. Discharge Summaries

A discharge summary will be written or dictated on all medical record of patients hospitalized over forty-eight (48) hours except for normal newborn infants. Elements of the discharge summary are:

- The reason for hospitalization
- Significant findings
- Procedures performed and care, treatment and services rendered
- The patient's condition at discharge
- Instructions to the patient and family, as appropriate
- List of discharge medications (reconciled with patient discharge instructions and discharge orders)

For patients who are in the hospital for less than forty-eight (48) hours, a final summation-type progress note, along with a list of discharge medications as noted above, is sufficient.

In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment. The responsible practitioner will authenticate and be responsible for all summaries. Medical record delinquency status cannot be applied to Allied Health Professionals for discharge summaries not countersigned by their sponsoring physician.

8. Permanent Filing of the Medical Record

A medical record will not be permanently filed until it is completed by the responsible practitioner or is ordered to be filed by the director of health information services.

9. Miscellaneous Rules Pertaining to the Medical Record

- a. **Electronic Signatures:** Electronic signatures will be recognized as an acceptable practice to authenticate medical record and ancillary service reports. A signed statement must be on file in the Medical Staff Services Department attesting that the practitioner will use a personal identification number (PIN) and unique password and that these numbers will not be shared with others. All dictated and transcribed documents utilizing the medical center's transcription service (e.g. history and physical examination, operative report, discharge summary) will be authenticated utilizing electronic signature.
- b. **Rubber Stamp Signatures.** Rubber stamp signatures are not authorized for use in the medical record.
- c. **Protection of Health Information.** All members of the medical staff will abide by Health Insurance Portability and Accountability Act regulations.
- d. All clinical entries in the patient's medical record are accurately timed, dated and authenticated.

- e. Final diagnosis is recorded in full, without the use of symbols or abbreviations, dated and signed by the responsible practitioner at time of discharge of all patients.

10. Medical Record Completion

The patient's medical record will be completed promptly, including progress notes, final diagnoses and discharge summary and authenticated or signed by a physician within two (2) weeks [fourteen (14) days] following the patient's discharge or availability of the medical record.

- a. Notification of Delinquent Records. In order to comply with this regulation and to avoid medical record delinquency status, the following procedure will be followed. Each week a warning letter will be sent to each medical staff practitioner who has incomplete medical records that will become delinquent during the following week unless any given practitioner has specifically requested in writing not to receive deficiency notice. This request must be renewed every two (2) years. This notification will state the number of incomplete records and the date and time by which the records must be completed to prevent imposition of delinquency status.

On the day prior to the trigger date, health information services will place a reminder telephone call to each practitioner with delinquent records indicating the approaching deadline. If the record remains incomplete after 10:00 a.m. on the following day, the procedure for delinquent medical records shall ensue.

- b. Medical Record Delinquency Process: Delinquency is effective at 10:00 a.m. on the following day. On this day a letter documenting that the start of the delinquency status day count has begun will be sent to the practitioner. Health information services will monitor medical record delinquencies. The chief of staff (COS) and the chief medical officer will be notified when the practitioner has accumulated thirty (30) days of delinquencies within a rolling twelve (12) month period. Upon notification, the COS will request the practitioner to appear at the next MSEC to present an explanation and a plan of correction. An automatic suspension of all medical staff privileges will become effective until all deficiencies have been resolved, and the MSEC and/or COS or designee has accepted the plan of correction.
- c. MSEC Deliberation and Action: Practitioners who have accumulated thirty (30) days or more of delinquency within a twelve (12) month rolling period shall have their term of appointment for membership in the Medical Staff shortened to one (1) year and shall be assessed a reapplication fee double the amount of the standard fee. Each such action shall be reviewed and approved by the MSEC. Practitioners who persist in accumulating delinquency in excess of the stated threshold shall be subject to additional fines as determined by the MSEC. In the case of persistent delinquency over the course of four (4) reapplication cycles, the practitioner shall be subject to dismissal from membership in the Medical Staff. In the case of cumulative delinquencies [sixty (60) days or more in any rolling six (6) month period], the practitioner shall be subject to disciplinary action up to and including restriction or loss of medical staff membership and/or privileges.
- d. Request for Extension: Practitioners may request an extension of time in which to complete delinquent records from the chief of staff or his/her designee. Health

information services may not grant extensions, however, this department may postpone the delinquency status procedure when the physicians inform them of a vacation, protracted illness, or other extended absences.

XII. PHYSICIAN ORDERS

1. An order is considered to be in writing if dictated to a licensed nurse or other authorized person and signed by the attending practitioner.
2. All written orders must be in ink, must be clear, complete and legible, and must include signature, date and time.

All medication orders must also include the following elements:

- a. full name of medication (avoid abbreviations and acronyms);
 - b. strength/concentration;
 - c. dose;
 - d. route;
 - e. frequency/rate.
3. Allied health professionals who may enter orders in the patient's medical record include the following:
 - Acute care nurse practitioners
 - Certified nurse midwives
 - Certified registered nurse anesthetists
 - Physician assistants
 4. Any order that is incomplete, illegible or otherwise questionable is clarified prior to dispensing or administration.
 5. The metric system is preferred for medication orders. Orders for medications are by the dose required and not by volume.
 6. Patient allergies, including none known if appropriate, are present in the medical record for all patients.
 7. The Medical Staff approved standardized dosing times are utilized at all times unless otherwise ordered by prescriber.
 8. Except in the case of an emergency or urgent situation, all orders for medications are entered in the medical record prior to dispensing and/or administration. In the case of emergency or urgency the orders will be reduced to writing or electronic format as soon as practicable and will be signed, dated and timed by the prescriber.
 9. Verbal orders, even when permitted pursuant to Sections 14 and 15, below, are discouraged. When the prescriber is present; any such orders are signed, timed, and dated prior to the prescriber leaving the unit. No verbal orders are taken for chemotherapy.

10. Dangerous Abbreviations: The following abbreviations are considered to be dangerous for patients and are prohibited from use in the medical record. Additional dangerous abbreviations may be selected for non-use upon approval by the MSEC and upon notification of the medical staff.

Official “Do Not Use” List ¹

Do Not Use	Potential Problem	Use instead
U (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write “unit”
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write “International Unit”
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for “I” and the “O” mistaken for “I”	Write “daily” Write “every other day”
Trailing zero (X.0mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO ₄ and MgSO ₄	Can mean morphine sulfate or Magnesium sulfate Confused for one another	Write “morphine sulfate” Write “magnesium sulfate”

¹ Applies to all orders and all medication-related documentation that are handwritten (including free-text computer entry) or on pre-printed forms.

*Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

11. When ordering p.r.n. medications, the need for the medication is included as part of the order. For example, morphine sulfate 2 mg IV q 3 hours p.r.n. pain.
12. All orders must be re-done when a patient changes to a different level of care. Changes in level of care include:
- Outpatient to inpatient
 - To or from ICU
 - Discharge or admit to another facility (including the acute rehabilitation center)
 - After surgery
13. Automatic Stop Orders: Automatic stop orders will be enforced on all medication orders in accordance with approved policies and procedures, in addition to the following:
- a. Narcotic orders are effective for seven (7) days only. The practitioner must renew the order every seven (7) days unless the practitioner orders other limitations or extensions. The orders will not be discontinued without contacting the practitioner.

- b. Antibiotic orders are effective for seven (7) days only. The practitioner must renew the order every seven (7) days. The orders will not be discontinued without contacting the practitioner. This includes antibiotics added to IV's.
- c. All other medication orders are effective for thirty (30) days only. The practitioner must renew orders every thirty (30) days. The orders will not be discontinued without contacting the practitioner.

14. Verbal Orders

Verbal or telephone orders are to be authenticated promptly and may be taken by the following health care professionals for patient care activities that are within his/her scope of practice:

- Acute care nurse practitioner
- Certified nurse midwife
- Certified registered nurse anesthetist
- Clinical nurse specialist
- Imaging technologist
- Laboratory technologist
- Licensed vocational nurse
- Occupational therapist
- Pharmacist
- Physical therapist
- Physician assistant
- Radiation therapy technologist
- Radiology technologist
- Registered dietitian
- Registered nurse
- Respiratory therapist
- Speech and language pathologist

15. Verbal Medication Orders

- a. All verbal orders for medications must be signed, dated, and timed by the practitioner or attending physician within forty-eight (48) hours.
- b. Verbal orders for administration of medications may be received and recorded by licensed pharmacists or registered nurses, licensed vocational nurses (e.g. LVN's may not take verbal orders/telephone orders for IV medications), physical therapists (for certain topical drugs only and certified and/or registered respiratory therapists (when the orders related specific to respiratory therapy), functioning within the scope of their licensure. Telephone orders are signed by the person who received the telephone order with the name of the attending practitioner accompanying his or her own name.
- c. Telephone orders in the Emergency Department: Schedule II-V medications will be administered by telephone order only after a physician's or emergency medicine nurse practitioner's examination of the patient in the emergency room.

XIII. PROCTORING

All Medical Staff members initially granted clinical privileges shall complete a period of proctoring in accordance with the requirements set forth in the Medical Staff Bylaws.

1. The department chair will assign a proctor with unrestricted privileges and appropriate clinical knowledge of the involved area or function that he or she will proctor. Nurse midwives will be proctored by the procedure outlined in the nurse midwife protocols.
2. A practitioner may proctor an employee or another member of the same professional partnership or corporation at the discretion of the department chair.
3. If no medical staff member has the necessary expertise to proctor, special arrangements may be made for proctoring by non-medical staff members (which may be at sites other than the hospital) and/or by staff members who have related privileges.
4. The department chair shall assign one or more proctors to each practitioner who is required to complete proctoring and each proctored practitioner is responsible for assuring that his or her cases are proctored. The proctors and the proctored practitioners shall be given each other's names and telephone numbers.
5. When conflict arises between the proctor and the proctored member, the chair of the department shall be notified. The chair will review the issues with both the proctor and the proctored member and at his/her discretion may assign a new proctor to the proctored member.
6. If an assigned proctor is unable to fulfill these responsibilities, that proctor shall notify the department chair, who shall assign another proctor.
7. Functions and Responsibilities of Proctors:
 - a. The proctor shall be responsible for evaluating the proctored practitioner's performance from the time of admission until discharge and shall evaluate the indications for admission, discharge, diagnostic work-up and therapy management.
 1. If surgery or an invasive procedure is performed, the proctor shall evaluate the indication for the procedure, the technique for the procedure, how it is performed, and the pre-operative, operative, and post-operative care of the patient.
 2. If medical care is provided, the proctor shall review the care of the patient, utilizing the patient's chart, discussions with the practitioner, and actual observation, as necessary, as the basis for review.
 - b. For each case that is proctored, the proctor shall complete the proctoring form and submit it to the department chair through the medical staff services department. Proctoring reports shall be completed fully and in a timely manner after the patient's discharge.
 - c. The proctor's primary responsibility is to evaluate the proctored practitioner's performance. However, if the proctor believes that intervention is warranted in order to avert harm to a patient, he or she may take any action he or she finds reasonably necessary to protect the patient.

- d. If the proctor and the proctored practitioner disagree on the appropriate treatment of a patient the dispute shall be referred to the department chair or chief of staff for resolution.
- e. A practitioner may serve solely as a proctor, or as both a proctor and a surgical assistant.
 - 1. A practitioner serving solely as a proctor, for purposes of assessing and reporting on the competence of another practitioner, is an agent of the hospital. The proctor shall receive no compensation directly or indirectly for this service.
 - 2. A practitioner serving as both a proctor and a surgical assistant shall be considered an agent of the hospital for purposes of the former but not the latter. The proctor shall receive no compensation directly or indirectly for the patient for his service in that capacity, but he or she may receive compensation for his or her service as an assistant. The proctor shall have the same duty to participate or intervene in the care of the patient as would apply if the proctor were serving solely as a surgical assistant, without regard to the additional role as a proctor.

8. Responsibility of the Proctored Practitioner:

The proctored practitioner shall be responsible for notifying one of the assigned proctors of each patient whose care is to be evaluated. For surgical or invasive medical procedures that will be observed, the proctored practitioner shall be responsible for arranging the time of the procedure with the proctor.

The proctored practitioner shall provide the information that is requested by the assigned proctor regarding the patient and the planned course of treatment.

9. Proctoring Duration:

- a. Each practitioner granted clinical privileges must be proctored on the minimum number of cases as established by the MSEC or at least for a number of cases covering the practitioner's scope of practice. Each department may adopt proctorship guidelines, consistent with these general requirements, specifying the minimum number of cases or procedures to be proctored, if appropriate, when the proctor must be present, and other particulars as are appropriate.

In no event will such guidelines be construed to restrict the flexibility of the department chair to expand the nature and scope of proctorship requirements as reasonably necessary to evaluate the performance of any given practitioner.

If at the time of completion of the minimum number of cases required for general or special privileges, the department chair concludes that the practitioner should be proctored on additional cases the department chair shall notify the proctored practitioner.

After six months of appointment, practitioners who have had sufficient activity to complete proctoring for core privileges but have not complied with the proctoring requirements will be ineligible to serve on call schedules or take shift assignments until the appropriate documentation has been submitted to the Medical Staff Services

Department. In the event the provisional practitioner fails to satisfactorily complete the proctoring requirement during their provisional appointment period, the department chair shall report the deficiencies to the MSEC, through the Credentials Committee, and corrective action may be initiated in accordance with the procedure set forth in the medical staff bylaws. This provision does not, however, preclude the initiation of corrective action at an earlier time.

Whenever a practitioner applies for a new privilege(s), but does not exercise the privilege(s), or complete the proctoring process on the new privilege within a minimum one (1) year period, the privilege(s) will automatically be terminated, without hearing rights, at the completion of the reappointment cycle. Re-application for the specific privilege is not precluded; however, the practitioner must provide evidence of additional training and/or experience in the privilege that was obtained after the initial application for the privilege(s).

b. Reciprocal Proctoring:

Reciprocal proctoring is defined as receiving proctoring reports from other institutions. Reciprocal proctoring may be accepted to supplement actual observation on the premises, at the discretion of the department chair. At least one (1) case, however, must be done at this hospital.

In accepting reciprocal proctoring, the Department Chair should consider the membership status and privileges of the proctor at the other hospital, whether the practitioner being proctored is a candidate for the same range and level of privileges at both hospitals, and whether or not copies of the actual proctoring reports will be provided and maintained in the credentials file.

c. Proctoring Review

A review, report, and recommendation regarding removal of proctoring by the department chair will be in accordance with Article V of the medical staff bylaws.

XIV. PROFESSIONAL LIABILITY INSURANCE STANDARDS

In accordance with medical staff bylaws, the MSEC is charged with the responsibility of establishing the liability insurance limit and the types of liability insurance carriers for the medical staff.

1. The liability insurance minimum for the medical staff will be one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) aggregate.
2. Physicians who serve on the medical staff without clinical privileges, will be exempt from carrying malpractice liability insurance.
3. Allied health professionals will carry professional liability insurance in the amounts established for medical staff members.
4. Each member granted clinical privileges shall maintain professional liability insurance with one or more of the following carriers or types of carriers of coverage:

- a. An insurance carrier admitted by the California Department of Insurance to transact a casualty insurance business in California.
 - b. A Physician Mutual Cooperative Trust that operates under California Insurance Code Section 1280.7.
 - c. The University of California Professional Liability Program.
5. The MSEC may, at its discretion, investigate the integrity, financial stability or other characteristics of any specific insurance carrier as described above, and declare it to be disqualified for purposes of meeting these professional liability insurance requirements. The MSEC will not approve or consider for approval any type of carrier or coverage arrangement other than those specifically described above.
 6. The insurance shall apply to the member's medical practice at Queen of the Valley Medical Center. If a practitioner is covered by a carrier that meets one of the above descriptions but does not insure all of the practitioner's patient care activities at the Queen of the Valley Medical Center, supplemental coverage by another carrier that meets one of the above descriptions must be obtained.
 7. Proof of insurance coverage must be provided in the form of certificates of insurance, which will be maintained in each practitioner's credential's file or electronic credentials record. Information about insurance coverage must be provided at the time of appointment, reappointment, insurance policy expiration, change in coverage, and upon request from the medical staff services department.

XV. STUDENTS, INTERNS, RESIDENTS

Students, interns and residents who are at the hospital for educational programs and are not under contract with the hospital, shall be observers only. They shall not be involved in hands-on patient care. Refer to the medical staff Policy on Patient Care Observers.

XVI. SPECIAL CARE UNITS

Special care units, such as emergency room, recovery room, intensive care unit, coronary care unit, newborn intensive care unit, shall be governed by the rules and regulations or policies developed within the departments of this medical center having primary responsibility in these areas, in conjunction and with the approval, of the medical staff.

Utilization Management:

The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the physician advisor for case management of the Queen of the Valley Medical Center or the physician advisor's designee. This documentation must contain:

1. A clinical justification of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
2. An estimated period of time the patient will need to remain in the hospital.
3. Plans for post-hospital care.

4. Upon request of the physician advisor for case management or designee, the attending practitioner must provide clinical justification of the necessity for continued hospitalization of any patient, including an estimate of the number of additional days of stay and the reasons for the additional days.
5. Refer to the Utilization Review Plan for additional information.

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