SPOTSYLVANIA

REGIONAL MEDICAL

CENTER

RULES AND REGULATIONS

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1. DEFINITIONS

1.A. The following definitions shall apply to terms used in these rules and regulations:

1. "ADMINISTRATION" The executive members of the Hospital staff, including the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO), and Assistant Administrator..

2. "ADVANCE PRACTICE PROFESSIONAL" An individual, other than those defined under "Practitioner," who provides direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. APPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Bylaws. APPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), clinical psychologists (Ph.D.) and advanced registered nurse practitioners (ARNP)

3. "BOARD OF TRUSTEE" As used herein, the Board of Trustees is the local governing body of the Hospital, delegated specific authority and responsibility, and appointed by the Board of Directors. It is the "governing body" as described in the standards of the Joint Commission and the Medicare Conditions of Participation. The Board of Trustees may also be referred to as the "Trustees" or the "Board" unless otherwise specifically stated.

4. "BOARD CERTIFIED" means certified by the appropriate medical specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, American Podiatric Medical Association, or the Council on Dental Education of the American Dental Association.

5. "CHIEF OF STAFF" A Member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital. The Chief of Staff shall be a doctor of medicine or osteopathy.

6. "CLINICAL ACTIVITIES" means authorization to provide one or more patient care services in the Hospital as an Allied Health Professional under the supervision of a Staff Member.

7. "CLINICAL PRIVILEGE" is the right granted a Practitioner to render medical care based on the Practitioner's professional license, training, experience, current competence, ability, judgment, health, character, reputation, and other relevant factors. Privileges may include the right to admit patients. "Privilege" is to be distinguished from a

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given staff status and from activities which are dependent upon staff status, such as the right to hold office and the right to vote.

8. "COMPLETED APPLICATION" An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department Chairperson, the Medical Executive Committee and/or the Board to meet the requirements of these Bylaws. Specifically, to be complete the application must be submitted in writing on a form approved by the Medical Executive Committee and the Board, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.[1] Specific to applications or requests for clinical privileges, it shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested.

9. "CRNA" means Certified Registered Nurse Anesthetist licensed in the State of Virginia.

10. "DATE OF RECEIPT" means the date any special notice or other communication was delivered personally to the addressee or, if delivered by mail, such notice or communication will be deemed received 72 hours after being deposited, postage prepaid, in the United States mail.

11. "DENTIST" means any individual fully licensed by the Virginia Board of Dentistry to practice dentistry.

12. "DEPARTMENT" means a clinical division of the Medical Staff of the Hospital.

13. "DEPARTMENT CHIEF" means those individuals who are selected to perform the credentialing, peer review functions and other activities outlined in these Bylaws (and related documents) for the various departments of the Hospital.

14. "SRMC" means the Spotsylvania Regional Medical Center.

15. "EXECUTIVE SESSION" means a session of a given body (e.g., the Medical Staff, a department, a committee) limited to those qualified to vote. Others may attend only by invitation.

16. "EX OFFICIO" means the condition of automatically being granted membership on a body by virtue of office or position held. Whether this membership

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involves voting rights shall be specified in the provision of these Bylaws and related Polices creating the ex officio membership.

17. “HOSPITAL” means Spotsylvania Regional Medical Center.

18. “MEDICAL STAFF” or “STAFF” means those licensed medical doctors, doctors of osteopathy, dentists, doctors of podiatric medicine, and oral and maxillofacial surgeons who are granted appointment to the Hospital Medical Staff and Clinical Privileges to treat patients at the Hospital.

19. “MEDICAL EXECUTIVE COMMITTEE” means the Executive Committee of the Medical Staff of the Hospital.

20. “MEDICAL STAFF YEAR” means the twelve month period from January 1 to December 31 of each year.

21. “MEMBER” or “APPOINTEE” refers to a member of or appointee to the Medical Staff of the Hospital.

22. “ORAL AND MAXILLOFACIAL SURGEON” means any Dentist who has successfully completed a post-graduate oral and maxillofacial surgery program accredited by the Commission on Dental Accreditation of the American Dental Association.

23. “PATIENT CONTACTS” shall include any admission, consultation, procedure, and/or other clinical evaluation performed at the Hospital, including inpatient, outpatient, and/or emergency department. It shall not include the utilization of the Hospital’s diagnostic services.

24. “PHYSICIAN” means any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is fully licensed in the state of Virginia to practice medicine.

25. “PODIATRIST” means any Doctor of Podiatry who is fully licensed in the state of Virginia to practice podiatry.

26. “PRACTITIONER” means any physician, dentist, podiatrist or oral and maxillofacial surgeon applying for or exercising Staff Membership and/or Clinical Privileges at the Hospital under these Bylaws.

27. “PREROGATIVE” means a participatory right granted, by virtue of Medical Staff membership and/or Staff category, and exercisable subject to the conditions imposed by these Bylaws. Prerogatives include, but are not necessarily limited to, voting rights, service on committees, and service as Medical Staff Officers.

28. “SECTION” means an organized group of specialized Practitioners within a Department.

29. “SECTION CHIEF” means those individuals who are selected to perform the credentialing and peer review functions outlined in these Bylaws (and related documents) for the various specialty units within the departments of the Hospital.

30. “SPECIAL NOTICE” means written notice sent by certified mail, return receipt requested, or personal delivery.

2. PATIENT ACCESS REQUIREMENTS

2.A. Admission Procedures

1. Infants, children and adults may be cared for within Spotsylvania Regional Medical Center

2. Patient may be admitted to the hospital only by a physician (M.D. or D.O.). Physician applicants for medical staff membership and clinical privileges who have been granted temporary privileges may also admit patients. Podiatrists, dentists and oral surgeons may co-admit with an attending physician.

3. There is a provisional diagnosis and a preliminary plan of care documented by the physician at the time a patient is admitted. Exceptions include cases of a life-threatening emergency. In such cases a provisional diagnosis and plan of care is documented within 24 hours of the admission.

4. Patients who require hospital admission who have no assigned physician will be assigned to a hospitalist or a medical Staff member according to the Emergency On-call Medical Staff roster.

5. The attending physician will examine the patient in a timely manner not to exceed twenty-four (24) hours. And is responsible for conducting a complete History and Physical as defined in the Medical Staff Bylaws.

6. The attending physician or dentist provides the clinical staff with the necessary information to ensure the protection of the patient, other patients, and Hospital personnel from infection, disease, self harm or harm to others.

7. Each admitted patient is the responsibility of the attending physician. The attending physician is accountable for:

    a. The medical care and treatment of the hospitalized patient.
    b. The completeness and accuracy of the medical record.
    c. Communication to the Hospital staff, and any and all special instructions for the care of the patient.

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d. A note covering transfer of responsibility.

e. Making arrangements for another medical staff member to be available to attend his or her patients in his/her absence.

f. Communicating to other involved Practitioners any data related to the current status of the patient. This includes clinical history for radiology, anesthesia, pathology, consultations and, when transferring patient care to another Practitioner.

g. Utilizing appropriate information technologies utilized in patient care and safety.

h. Rewriting all orders after procedures performed in the Operating Room, regardless of whether the procedure is performed at the time of the initial admission or later in the hospital stay.

i. Discharge planning and discharge orders and writing a discharge summary within 30 days.

8. A hospitalized patient is never to be without an attending physician. The hospitalized patient is assessed daily. Any attending physician unavailable to care for an assigned patient will identify a similarly qualified practitioner who is a member of the medical staff and who has admitting privileges to assume the care of the patient in his or her absence. In a situation where a physician has failed to designate, the Chief of Staff has the authority to call any qualified member of the medical staff to serve as attending. Failure to provide coverage for a patient will be reported to the involved physician's Department Chief.

9. Planning for the continuity of care between the hospitalization, home, or to another setting is initiated as soon as possible after admission.

10. Progress notes should be legible, dated and authenticated.

2. B. Review by Case Managers or Physician Advisor/Medical Director, Case Management

The Case Manager (a hospital employee) will conduct reviews for both pre-admission and length of stay certification on Medicare and Medicaid patients, and patients who are on certain other plans. Such review shall be according to the following plan:

1. Pre-Admission Review

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If the Case Manager determines that a proposed admission does not meet Medicare or Medicaid criteria, or the criteria of a specific plan in which the patient is enrolled and which is subject to review, the attending physician will be notified and may appeal the decision to the Physician Adviser. If the Adviser approves the admission, it is covered unless retrospectively denied at a later time by the Quality Improvement Organization (QIO).

If the Physician Adviser does not approve the admission, the attending physician will be notified and may appeal the decision to a second Physician Adviser and a board certified specialist. If the second Physician Adviser and a board certified specialist approve, the admission is covered unless retrospectively denied at a later time by the QIO. Their decision will be final.

2. Length of Stay Review

After specific periods of time as described by the Utilization Review Plan, the Case Manager will review each designated admission for appropriate length of stay. If the attending physician anticipates keeping a patient in the hospital beyond this review, he/she must provide in the progress notes within 24 hours of the review written justification for continued hospitalization. If the Case Manager does not approve the attending physician's recommendation for continued hospitalization, the same appeals process as described above in IV.D.1 for pre-admission approval will be followed.

2.C. Planned Readmission Within 31 Days

All Medicare and Medicaid patients readmitted within 31 days of discharge are reviewed by the Quality Improvement Organization (QIO). Physicians who plan such admissions for any patient should enter in the final order and progress note before the initial discharge the anticipated date of readmission and the reason. When the patient is readmitted, the initial orders and progress note should indicate that this is a planned readmission from the date of the previous discharge, and the reason for the readmission.

2.D. Observation Procedures

1. Medical Observation (6-23 hours): The patient's condition requires monitoring and evaluation to determine if inpatient admission is indicated. A physician will monitor a patient’s response to treatment for up to 23 hours to determine if the patient’s condition improves, resulting in discharge, or warrants an inpatient admission.

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2. Surgical Extended Stay Observation (6-23 hours): Occurs postoperatively when an outpatient requires extended observation due to an unexpected complication, such as, arrhythmias, unexpected bleeding, delayed recovery from anesthesia, fluid/electrolyte imbalance, uncontrollable pain, headache or uncontrolled vomiting, or other medical symptoms requiring longer stay. A patient cannot be routinely admitted for surgical extended stay observation preoperatively. It may not be used for physician or patient convenience or for patient holding due to social reasons.

2.E. Discharge Planning

Patient discharge will be initiated only upon order of the attending physician or designee. The discharge plan is documented in the medical record and includes the goals to be attained prior to discharge, and care arrangements that will be required by the patient upon discharge from the hospital. The attending physician will provide discharge instructions to the patient and those responsible for their care. Case Managers and Social Workers provide assistance to the physicians in identifying appropriate resources and to assure continuity of care.

2.F. Discharge Orders

The patient shall be discharged only on the order of the attending physician or designee.

2.G. Patients Leaving Against Medical Advice (AMA)

Should a patient leave the Hospital against the advice of the attending physician, the attending physician should make a notation of the incident in the patient's medical record, and the patient should be requested to sign a Hospital release form.

2.H. Patient Transfers

1. Transfer of Patients to Other Facilities

   a. A hospitalized patient requiring services not provided at Spotsylvania Regional Medical Center may either be transferred to another facility to obtain that service and returned to Spotsylvania Regional Medical Center or discharged to the receiving facility.

   b. All patient transfers to other facilities will comply with the hospital policy and procedures for transfer of patients and with all legal and regulatory requirements regarding the transfer of patients from one facility to another (e.g., COBRA/EMTALA).

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c. Existing orders are cancelled when a patient is transferred.

d. The attending physician is responsible for collaborating with the receiving facility in assuring that the required services are scheduled and authorized by the accepting facility. The responsibilities of the transferring physician include:

i. Notifying the Case Manager of the planned transfer as early as possible so that the appropriate authorizations are in place prior to transfer and that arrangement for transfer, and communication with the patient and family can be initiated.
ii. Identifying and communicating with an accepting physician at the receiving facility.
iii. Completion of the approved patient transfer record outlining the physician's certification for transfer, risk and benefits of transfer and the patient's condition.
iv. Documenting an order for transfer and a final progress note in the medical record.

e. When transferring a patient to a Skilled Nursing Facility, the attending physician shall be responsible for completing in a timely manner all forms required by regulatory agencies.

2. Transfer of Patients to Spotsylvania Regional Medical Center from Outside Facilities

a. Transfers from outside of the hospital are to be coordinated with the hospital admitting or house supervisory staff and follow the procedure outlined for routine and emergency admissions. Patient transfers into Spotsylvania Regional Medical Center require administrative acceptance and an agreement by a member of the Medical Staff with admitting privileges to assume care of the transferred patient and act as the patient's attending physician.

b. As the attending physician, the accepting physician is accountable for documenting acceptance of the transfer, an admission History and Physical, developing a plan of care for communicating patient status and condition to hospital staff and other appropriate practitioners.
c. Prior to acceptance of any transfer of a patient from another facility the following must occur:

i. The hospital supervisor or bed coordinator will acknowledge that there is bed availability

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ii. Case Management will verify that the patient meets criteria for transfer and that payer authorization has been obtained.

iii. In the event that Case Management is not available or has concerns about the transfer, the hospital administrator on-call should be notified of the request for transfer.

3. Transfer of Patients within Spotsylvania Regional Medical Center

After assessing the patient and making the determination that the patient requires a change in the level of care, the attending physician will discontinue orders that are no longer needed, and document new orders necessary for the new level of care. All other orders remain in effect until discontinued by the attending physician. The attending physician will also document the appropriateness of the change in the patient's level and care.

2.I. Discharge of Minors and Incompetent Patients

Any patient who cannot legally consent to his/her own care shall be discharged only to the custody of parents, legal guardian, persons standing in loco parentis, or another responsible party unless otherwise directed by the parent, guardian, or court order.

2.J. Determining Death

The decision to withhold or withdraw life support measures shall be made and carried out in accordance with the approved Hospital policy for withdrawing or withholding life support measures in accordance with Commonwealth of Virginia. This is referenced in Hospital policies.

1. Spotsylvania Regional Medical Center will comply with the Commonwealth of Virginia § 54.1-2972 in the determination of death. A person may be pronounced dead by a qualified physician if it is determined that the individual has sustained irreversible cessation of circulatory and respiratory function. A person also may be pronounced dead if the attending physician or designee and a second qualified physician determine that there has been an irreversible cessation of all functions of the brain, including the brain stem (brain death).

2. When it is determined that brain death has occurred, all medical treatment and life support measures may be discontinued upon consent of the patient's family or other legally responsible individual. In the event the patient is to serve as a tissue, eye or organ donor, appropriate and necessary life support measures will be continued until the tissue(s), organ(s) and eye(s) have been

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removed. The hospital will follow procedures that are in compliance with § 32.1-290.1 of Code of Virginia.

3. The Washington Regional Transplant Consortium (WRTC) is notified of all deaths or impending deaths and will collaborate with hospital staff in discussing the options for organ, tissue or eye donation with the patient's family or other legally responsible individual.

4. The body will remains at the Hospital until consent for disposition is obtained from the appropriate family member or legal guardian and an entry is made and signed in the medical record of the deceased by a member of the Medical Staff.

5. Death certificates are the responsibility of the attending physician or designee.

2.K. Autopsies

1. The Medical Staff shall attempt to secure autopsies in all cases that meet the criteria/indications for autopsies as approved by the Department of Pathology and the Medical Executive Committee, or when requested by the attending physician as follows:

    a. Unexpected/Unexplained death causing concerns with practitioner/Risk Management.

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

    c. Patients who have participated in clinical trials approved by Institutional Review Boards.

    d. Obstetrical deaths occurring during pregnancy.

    e. Death of a viable neonate with gestational age ≥ 25 weeks or ≥ 500 grams.

    f. Unexplained intrapartum death of a neonate with gestational age ≥ 25 weeks or ≥ 500 grams.

2. No autopsy shall be performed without written consent of a relative or legally authorized agent and request signed by the ordering physician unless it is a Medical Examiner case.

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3. All autopsies shall be performed at the VCUHS department of Pathology, and Spotsylvania Regional Medical Center will provide the transportation from our facility to the Pathology department at VCUHS.

4. A copy of the autopsy report shall be forwarded to the patient's attending physician and a copy included in the patient's medical record.

2.L. Medical Examiner's Cases

The attending physician or designated Hospital personnel shall notify the Medical Examiner of any cases considered Medical Examiner's cases, including accidental deaths, homicides, suicides, deaths within 24 hours of admission and deaths of undetermined causes.

2.M. Protection from Harm

1. Members of the Medical Staff shall give such information about patients that may be known and appropriate to ensure the protection of other patients, other physicians, and Hospital personnel from those who may be a source of danger from any cause whatsoever; and shall take appropriate measures to protect the patient from self harm.

2. A physician order for constant or frequent observation is required for those patients who have been identified and assessed as being at risk for suicide.

3. MANAGEMENT OF THE HOSPITALIZED PATIENT

3.A. Orders

1 Only Medical Staff members authorized by the Governing Body may order treatment and/or diagnostic testing. Orders are to be legible, complete, signed manually or electronically, dated and timed by the ordering Practitioner. Pharmacist will write orders for medication changes and diagnostic testing per approved facility protocols. Meditech physician number is required for orders signed manually.

2 Verbal and/or telephone orders are to be used infrequently. They are acceptable when given to an individual authorized by the Commonwealth of Virginia to accept verbal orders. The verbal/telephone order must relate to the clinical area in which the practitioner is privileged.

3 Verbal and/or telephone orders will read back to the prescribing Practitioner and documented that the order was 'read back and verified' signed, and dated. Verbal and/or telephone orders will be authenticated in the medical record by the prescribing practitioners within 72 hours. Authentication will include the practitioner's name, date and time of the authentication.

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4. All orders, including “Do Not Resuscitate Orders”, are cancelled when a patient goes to surgery.

5. With the exception of “Do Not Resuscitate Orders”, all orders are canceled when a patient is transferred to the Intensive Care Unit or from the Intensive Care Unit to Patient Care Areas.

6. Request for diagnostic imaging, pathology or other diagnostic testing that requires clinical interpretation contain a statement signifying the reason for the examination and sufficient clinical information to allow for an appropriate evaluation. The ordering Practitioner must sign orders submitted via fax.

7. A Practitioner must sign all patient orders within **30** days of discharge.

8. Patients should receive the same standards of care, treatment, and service throughout the Hospital each day of the week. . Practitioner orders written during a period of coverage shall be supported by documented clinical rationale to ensure consistent clinical communication in the plan of care for each patient.

9. The hospital’s Nutritional Care Manual must be approved by the Medical Staff. All patient diets must be ordered by a member of the medical staff. Special diets and nutritional treatments must be documented in the medical record.

10. Medical orders may be issued only by Practitioners who have been duly appointed to the Medical Staff, individuals who have been granted temporary privileges, and by Advance Practice Professional or by Hospital personnel specifically authorized to issue orders.

3.B. Medications

1. Medications administered to patients cared for within Spotsylvania Regional Medical Center are listed in the latest edition of the United States Pharmacopoeia, the National Formulary, and/or the American Hospital Formulary Service or AMA Drug Evaluations. Unless the FDA has approved a drug, it is not provided to Spotsylvania Regional Medical Center patients.

2. Patient treatment plans considered routine may be formulated and incorporated in writing into approved “pre-printed orders”. These routine treatment plans may be submitted by the Medical Staff and/or developed via an interdisciplinary review process through the Nurse Practice Council. Pre-

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printed order forms may only contain medications approved for use on the hospital formulary. Final review and approval by the individual physician(s) initiating the orders and/or appropriate Medical Staff committee(s)/service will occur prior to printing. All pre-printed order sets containing medications will be reviewed by pharmacy services and presented to Pharmacy and Therapeutics Committee prior to going to Medical Executive Committee.

a) Pre-printed orders shall be customized to the individual patient need which includes the level of care designation and certification. A Medical Staff member must authenticate, time and date all preprinted orders at the time they are completed.

b) Pre-printed orders shall be reviewed as necessary by the initiating physician and/or staff committee/service to reflect current patient care guidelines. A periodic review shall use the same interdisciplinary review process as in the initial development including physician review and confirmation.

c) Pre-printed orders shall include date of original development and subsequent review and revision dates. The Nurse Practice Council will assure distribution of new and revised order sets through Quality Management, which is comprised of all Department Leaders, who will provide education regarding the use of pre-printed orders to their respective staff.

3. All medication orders clearly state the name of the medication, the form, the dose, the route of administration, the administration times or the time intervals between doses. Below the signature, the prescriber includes an additional identifier (e.g., the printed name, pager number, Meditech physician number).

4. Drugs brought into the Hospital by the patient's family are not administered. Exceptions may be requested but are authorized through the Pharmacy after receiving a written order from the physician.

3.C. Who May Order Drugs

Drugs may be ordered by any member of the Medical Staff, a practitioner granted temporary privileges within the Hospital, and by members of the Advanced Practice Professional Staff who specifically have been approved by the Medical Executive Committee and the Board to order medications. Some Hospital employees are authorized to issue orders pertaining to certain duties under the supervision of a

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member of the Medical Staff. Commonwealth of Virginia licensed pharmacist will write orders and order diagnostic test per approved hospital protocols.

3.D. Questioned Drug Orders

When a drug is ordered for an unusual purpose, in an unusual amount, to be administered at an unusual frequency and/or in an unusual manner, or if there is any concern for drug reactions or drug interactions, a nurse or pharmacist shall contact the ordering physician for confirmation of the order. If, after confirmation, the nurse or pharmacist remains concerned about the order, the nurse will ask the nursing administrative representative or the pharmacist will ask the Director of Pharmacy Services or designee, to contact the physician. If the issue remains unresolved, the nursing supervisor or the Director of Pharmacy Services or designee shall contact the physician's department chief who will discuss the matter with the physician. The chief of the department may consult with other physicians if needed, and he/she will rule on the matter. If the drug is to be given as ordered, the physician will be required to sign the appropriate form if requested by the Pharmacy, nursing service, or the department chief. A nurse has the right to refuse to administer a drug or agent about which there is unusual concern. In such circumstances, the ordering physician will be expected personally to carry out the order. A pharmacist has the right to refuse or dispense a medication if they have reasonable information indicating that such a medication order will cause patient harm.

3.E. Automatic Cancellation of Drug Orders

The Commonwealth of Virginia regulates the interval for reordering medications. Narcotics are required to be renewed every 72 hours and all drug orders must be renewed once every 30 days.

3.F. Drug Formulary

1. The Pharmacy and Therapeutics Committee shall develop a Drug Formulary subject to approval of the Medical Executive Committee and the Board.

2. Generic drugs. AB rated generic medications will be used where ever possible.

3. The hospital will operate with a closed formulary developed by P&T Committee and constantly updated to reflect the most recent evidence based literature for each discipline. The formulary system for non-formulary requests will be outlined in the formulary system policy and procedure. Non-Formulary medications are not stocked or routinely purchased as inventory.

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3.G. Medication Errors and Drug Reactions

1. Any medication error or apparent adverse drug reaction shall be reported immediately to the ordering physician and to the attending physician if different from the ordering physician. An entry of the medication dose given in error or the apparent drug reaction shall be recorded in the patient's medical record.

2. All suspected medication errors and adverse drug reactions shall be reported in the Meditech Quality Module under Medication Events.

3.H. Drug Samples

Drug samples are not used for hospital care.

3.I. Continuity of Care

1. The attending physician is responsible for the continuity of the patient’s medical care. When the attending physician is absent, it is the attending physician’s responsibility to arrange for another member of the Spotsylvania Regional Medical Center Medical Staff with appropriate privileges to care for the attending physician’s hospitalized patients. The attending physician or his/her designated physician member of the medical staff shall visit each hospitalized patient at least one time daily, or more often if appropriate medical care dictates. For babies in the term nursery, the baby should be seen within 24 hours of birth and thereafter at the discretion of the medical and nursing staff. If the well baby is still in the nursery after four days of life, it will be seen at least every four days until discharge.

2. Physicians shall share call only with other physicians who are members of the Medical Staff and who have comparable privileges at the Hospital.

3. If the Hospital cannot reach a physician, or the physician taking call for the physician, the Hospital will contact as available the physician’s Medical Staff officers in the following order:

   a. The physician’s Department Vice-Chief

   b. The physician’s Department Chief

   c. The Vice-Chief of Staff

   d. The Chief of Staff

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If none of the above is available, the Hospital will contact the CEO or designee.

3.J. Consents

1. Physicians will obtain a patient's informed consent for those treatments and procedures that have been specified in Medical Staff policies as requiring informed consent. Refer to hospital policy.

   Refusal to Consent: This is referenced in Hospital Policy.

3.K. Consultations

1. Any qualified Medical staff member with clinical privileges at Spotsylvania Regional Medical Center may be called upon for consultation within his or her area of expertise. Consultation is recommended in situations where the patient is not a good risk for the treatment or procedure, where the diagnosis is obscure after ordinary diagnostic procedures are completed and in unusually complicated cases.

2. To assure coverage of inpatient emergent consults, the on call specialist for the Spotsylvania Regional Medical Center's Emergency Department are required to respond if no other physician is available. This should not change your normal path of consultation. Rather, the on-call specialist will serve as a backup when all other consult options have been exhausted.

3. Tiered Consults: Emergent-physician to physician and should be there immediately; Urgent-physician to physician and should be there within 4 hours, and Routine-nurse can call, and the turnaround time is 24 hours.

3. The consultation is directly requested between the physicians and documented in writing in the medical record.

4. The request for consult includes sufficient information to provide the consultant with an understanding of the reason for the request and the expectations. If the intent is for the consultant to follow the patient during the hospitalization, this is so noted. If the intent is only for an opinion that is stated in writing.

5. The response from the consultant shows evidence of a review of the patient's medical record, pertinent findings on the examination of the patient, and the consultant's opinion and recommendations.

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6. When operative procedures are involved, the surgical consultation note is to be recorded prior to the procedure. The exception is in a life-threatening emergency.

7. Patients who are being treated for a malignancy and receiving chemotherapy or radiation therapy on an outpatient basis, and admitted to Spotsylvania Regional Medical Center by a Medical Staff member other than an oncologist are to have an oncology consult.

8. Patients placed on ventilators must have pulmonologist consult within 24 hours of placement on a ventilator.

3.L. Withdrawal and Withholding of Care

1. Withdrawal of care is defined as the removal of life support systems from a seriously ill patient. Withholding of care is defined as the withholding of further treatment in futile clinical situations.

2. When the withdrawal and/or withholding of care decision has been reached by the physician and legal guardian(s) a written, signed request and release on behalf of the patient is executed on the form currently in use at Spotsylvania Regional Medical Center. The form becomes a permanent part of the patient's medical record.

3. In addition, a written order is to be documented in the record by the attending physician.

3.M. "Do Not Resuscitate" Orders

1. When the "Do Not Resuscitate" decision has been reached by the physician and legal guardian(s) Hospital policy is to be followed.

2. Do Not Resuscitate orders are only in effect for the hospitalization during which they are executed. If the patient is discharged and readmitted a new order must be obtained by the attending physician.

4. HEALTH INFORMATION/MEDICAL RECORDS

4A. Please refer to the Medical Records Plan.

4B. Pathology Specimens

1. All tissue removed by operation shall NORMALLY be sent to the hospital pathologist who shall make examinations, as he/she may consider necessary to provide a pathological diagnosis.

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2. The following specimens may be excluded from submission to the pathologist at the discretion of the surgeon or dental specialist:
    a. Foreign bodies
    b. Therapeutic radioactive devices
    c. Teeth
    d. Pacemaker batteries
    e. Stones
    f. Cataracts
    g. Bone and soft tissue from femoral head or knee resections that are removed for the preoperative diagnosis of degenerative arthritis.

Items from the above exclusion list that are removed during surgery or other procedure and are not sent to the hospital pathologist shall be fully described in the physician's summary of the operation or procedure.

5. EMERGENCY SERVICES

5.A. The Emergency Department

The Emergency Department functions in accordance with the Hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all Practitioners who render emergency care. Only Medical Staff members, Advance Practice Professional with appropriate Clinical Privileges, and Practitioners with temporary privileges may treat patients in the Emergency Room. The Emergency Department must be staffed 24 hours a day by at least one member of the Medical Staff.

1. Written policies concerning the extent of treatment to be carried out in the Emergency Department shall be determined by the hospital and/or Emergency Medicine Department. Written procedures should be developed that are based upon these policies.

2. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record, if such exists. The record shall include:

    a. Adequate patient identifying information and full name of attending Practitioner;

    b. Information concerning the time of the patient's arrival, means of arrival and by whom transported;

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c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his or her arrival at the Hospital;

d. Description of significant clinical, laboratory and diagnostic imaging findings; including the reporting of discrepancies after patient is discharged home;

e. Diagnosis and treatment given; and

f. Final disposition, including instructions given to the patient and/or his or her family, medication prescribed and information relative to necessary follow-up care.

3. Each patient's medical record shall be signed by the Practitioner in attendance who is responsible for its clinical accuracy.

4. There shall be a continuing review of Emergency Department medical records by appropriate clinical Departments to evaluate quality of emergency medical care.

5. A "medical screening examination" is required by federal law and regulation (42 USC § 1395dd, 42 CFR § 489.24) to be provided to any person who comes to the Hospital's Emergency Department or Labor and Delivery Department and requests examination or treatment. A medical screening examination may be provided in the Emergency Department by the following individuals:

a. a Practitioner with appropriate clinical privileges;

b. a nurse practitioner or physician's assistant or by the emergency department physicians.

7. A medical screening examination may be provided in the Labor and Delivery Department for a pregnant woman who is having contractions by the following individuals:

1. a Practitioner with appropriate clinical privileges;

2. a certified nurse midwife employed by the Hospital or by a practitioner; or

3. a registered nurse in consultation with a physician.

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5.B. Physicians on Call for the Emergency Department

The hospital will work with the Medical Staff to ensure that there are a sufficient number of qualified and competent practitioners to provide ED back up call in those core specialties determined necessary to provide emergency services in order to meet the emergency needs of the community and in accordance with the services provided at the hospital. Certain specialties may be exempt from Emergency Department call if they provide services that are generally provided on an elective basis and not determined to be required on an emergent basis. Full coverage in a specialty is defined as four or more for that specialty. Less than full coverage in a specialty is defined as a Potential Needs Specialty, and will be addressed jointly by the Medical Staff in cooperation with the Hospital under the Hospital's physician coverage policy. Any specialty with four or less practitioners may be considered in this category.

1. There shall be a daily call list for each Medical Staff specialty, determined to be an emergency department on call core specialty, identifying the individual Medical Staff member on call for each 24 hour period. Some hospital based physicians (Radiology and Pathology) and Dermatology may be exempt from Emergency Department Call. The SRMC Hospitalists group will be available to manage the direct hospital inpatient issues for patients in the following specialty areas Internal Medicine, Family Practice and Pediatrics. Medical Staff Services will develop and implement on-call schedules for back-up Emergency Department call responsibilities in cooperation with the Chief of each department. All other department chiefs will assist and enforce call schedules for his/her respective departments.

   The Provisional Medical Staff shall consist of those physicians eligible for staff membership who are being considered for advancement to the Active Medical Staff or Affiliate Medical Staff. All physicians initially applying for any category of privileges, who are granted privileges, shall be assigned to the Provisional Medical Staff for a period of one (1) year from date of appointment. Each member of the Provisional Medical Staff shall accept emergency on- call coverage for emergency care services within his/her Medical Staff Department or Division as specified by the requirements of the assigned Medical Staff Department or Chief of Staff.

2. No patient may be directed to another location, including but not limited to a physician's office or a different hospital, until: (i) that patient has been fully evaluated according to law and the requirements of these Rules and Regulations, and (ii) the patient has been evaluated by a specialty physician as deemed appropriate by the Emergency Department physician or other SRMC physician.

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3. Physicians on call for the Emergency Department shall be responsible for seeing patients. When requested by an Emergency Department physician regardless of the patient's financial status. On-call physicians are not required to remain in the Hospital during the period of on-call duties.

4. Responsibilities of a physician on-call for the Emergency Department shall include the following:

   a. 25 % of days per month for call coverage schedule with proportion of weekends and holidays;

   b. determining that personal communications equipment (e.g. beeper) is in satisfactory working order;

   c. informing his or her answering service of the on-call responsibility, including any delegation of on-call responsibility;

   d. informing the Medical Staff Services, in writing and at least 48 hours in advance, if on-call responsibility is transferred to another physician and ensuring that that physician is qualified to take call and is aware of his/her responsibilities;

   e. respond within 15 minutes by telephone or when paged (the interventional cardiologist and neurologist must respond to call or page within 5 minutes);

   f. personally coming to the SRMC Emergency Department within 30 minutes when requested to do so by the Emergency Medicine physician (the interventional cardiologist on call must respond personally to the facility and be ready to begin catheterization within 30 minutes of the initial page or call);

   g. accepting a patient who is seen while on call for the initial follow-up visit, if medically appropriate, within the time frame recommended by the Emergency Department physician, or other SRMC physician.

5. An Advance Practice Professional may not respond instead of the physician requested by the Emergency Department physician; and

6. A physician on specialty medicine call (e.g., cardiology, neurology) may not defer calls to the Internal Medicine Service if the specialist is specifically requested by the Emergency Department physician.

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5.C. Failure to Respond

1. In the event a physician fails to fulfill any of the above Emergency Department on-call responsibilities, a written referral for the event will be sent to Department Chief, Chief of Staff and Medical Staff Services. Emergency Department will follow all EMTALA regulations.

2. If a practitioner is on call, and fails to meet the responsibilities in 5.B. above, this may be ground for automatic relinquishment of clinical privileges as defined in Medical Staff Bylaws. If a practitioner is on call and refuses to come in, such refusal or failure to respond is grounds for automatic relinquishment of clinical privileges as defined in Medical Staff Bylaws. Such automatic relinquishment will be subject to review by the Medical Executive Committee at its next regular meeting.

5.D. Patients Without a Physician on the Medical Staff
Patients presenting in the Emergency Department who do not have a physician on the Medical Staff will have a screening examination by the Emergency Department. Emergency Department physicians may refer patients with surgical, obstetrical, or other problems requiring extensive evaluation or admission to the appropriate specialist on call for the Emergency Department. The Emergency Department may also assist patients in finding appropriate resources and organizations.

5.E. Patients with a Physician on the Medical Staff

1. When a patient presents in the Emergency Department who has a physician on the Medical Staff, the Emergency Department staff will provide the appropriate medical screening examination and inquire of the patient if he/she wishes the private physician to be called about presence in Emergency Department. If the patient does not want the private physician to be called, an Emergency Department physician will see the patient. The Emergency Department physician will provide the private physician a written report of the patient's evaluation, management, and disposition. With the patient's permission, the Emergency Department physician will contact the patient's private physician before referring the patient to another physician except in dire emergencies.

2. If the patient wishes his/her private physician to be notified, the Emergency Department will notify the private physician of the patient's presence in the Emergency Department. The private physician may request that the Emergency Department physician manage the patient, or the private physician will assume patient care and responsibility for the patient's evaluation, management, and disposition. The private physician will be

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expected in the Emergency Department within one hour. The Emergency Department physician will render any emergent and/or life saving care necessary to the patient until such time as the private physician may assume management of the patient's care.

5.F. Emergency Department Follow-up Visit

1. When an Emergency Department physician treats and discharges from the Emergency Department a patient without a private physician on the Medical Staff, the Emergency Department physician may refer the patient to an appropriate member of the Medical Staff or other healthcare agency which can assist the patient. Medical Staff Services shall maintain a volunteer post-sickness call list for general internal/family medicine. The Emergency Department physician may choose a name from this list for referral purposes. Emergency Department physician will give the patient specific post-care instructions, including the name, address, and phone number of the follow-up physician.

2. The physician to whom a patient is referred shall provide prompt, appropriate follow-up care as indicated by the patient's condition. If the practitioner refuses to see the patient, he/she must make an effort to refer the patient elsewhere to ensure continuity of care.

5.G. Patients Having Attempted or Threatened Suicide

1. A physician must make the final disposition of any patients presenting in the Emergency Department after having attempted or threatened suicide. The responsible physician will determine the need for a psychiatric consultation in conjunction with continued medical treatment. Determination of disposition will be made via collaboration between the responsible physician and the consulting Psychiatrist, based on the medical and psychiatric needs of the patient. Patients may be admitted to a hospital inpatient unit with or without psychiatric services, the Psychiatric Unit or transferred to another facility.

5.H. Emergency Preparedness

1. The Medical Staff shall participate in the development of the Hospital's Emergency Operation Plan designed to manage the consequences of emergencies that disrupt the Hospital's ability to provide patient care. The Emergency Operation Plan shall describe the preparedness, response and recovery procedures to follow when emergencies occur and that addresses the following:
    - maintaining or expanding services
    - conserving resources

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- curtailing services
- supplementing resources from outside the local community
- closing the hospital to new patients
- staged evacuation
- total evacuation

This plan will be based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The Emergency Operations Plan will be developed in accordance with The Joint Commission standards.

6. GENERAL OPERATION - PATIENT CARE ACTIVITIES

6.A. Clinical Pathways

Clinical pathways may be developed by members of the Medical Staff in cooperation with other members of the hospital's staff. After adoption and approval by the Medical Executive Committee, clinical pathways may be implemented. Clinical Pathways are to be used as benchmarks for patient care and safety, and should not be deemed to be the only acceptable treatment plan.

6.B. Dismissal of Practitioner by Patient or Patient's Family

Should a patient or patient's family dismiss the attending Practitioner from the care of the patient, the Chief of Staff or designee, upon notification of the dismissal, shall provide the patient or the patient's family with the names of three other qualified members of the Medical Staff. It shall be the responsibility of the patient or the patient's family to contact one of these Practitioners, or a member of the Medical Staff of their choice, to assume care of the patient. The dismissed Practitioner shall remain responsible for the care of the patient until a replacement is obtained. Should the patient or the patient's family refuse to allow the dismissed Practitioner to provide care prior to obtaining a replacement, it shall be the responsibility of the Chief of the Department to which the dismissed attending Practitioner is assigned to name a Practitioner to provide care until a replacement is obtained.

6.C. Adult Critical Care

1. The adult critical care areas shall consist of the Intensive Care Unit (ICU), and any other critical care units developed. Enforcement of the policy and procedures, and Rules and Regulations pertaining to the ICU shall be the responsibility of the SRMC Critical Care committee and, where appropriate, its designee, the Leader of Critical Care Services. Enforcement of the policy and procedures, rules and regulations pertaining to the ICU shall be the responsibility of the SRMC Critical Care Committee and, where appropriate, its designee, the Leader of Critical Care Services.

6.D. Intensive Care Issues

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1. The Medical Director of the Intensive Care Unit is responsible for developing and approving policies appropriate to the care and management of seriously ill patients transferred to that unit and may, if necessary, assume the total management of the patient in an emergency.

2. The Attending Physician (appropriately credentialed designee) examines the patient prior to admission, on admission and at least daily during the critical care stay.

3. All orders are cancelled at the time of transfer to the unit and are rewritten by the attending or designee.

4. If it is the intent of the attending physician to transfer the care of this patient to an intensivist, an order is recorded in the record indicating the transfer. If the order is not present, the transferring physician remains the attending physician with all the responsibilities that role entails.

6.E. Admissions

1. Criteria for Admission: The Critical Care Units are reserved for those patients requiring a greater than usual intensity of medical care and treatment, and the admission of patients not meeting those criteria shall be actively discouraged. A patient admitted to the Critical Care areas shall be in accordance with the admission criteria established and reviewed annually by the SRMC Critical Care Committee.

2. Admitting Physicians: Any physician duly appointed to the Medical Staff may admit patients to any of the units. The admitting physician is responsible for the care of the patient while in the unit. Any change in physician responsibility must be noted in the physician's orders and progress notes, and must be communicated to the nursing staff.

6.F. Ventilator Management

Patients placed on ventilators must have pulmonologist consult within 24 hours of placement on a ventilator. Only physicians with privileges in ventilator management shall manage a ventilator for patients requiring such respiratory assistance. Each physician responsible for ventilator management of a patient shall write orders regarding ventilator parameters. A physician order shall indicate the name of the physician responsible for ventilator management and the name of the responsible physician when there is a change in the ventilator manager.

6.G. Newborn Special Care Nursery

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The attending physician in charge of the newborn and the nurse in charge of the nurseries shall be notified when the delivery of a potentially high-risk infant is expected. Continuity of care for all infants, and especially for high-risk infants, shall be initiated in the delivery area, with constant observation for distress. The term "high-risk infant" means any infant, including a newborn, who, on the basis of socioeconomic, genetic, or pathophysiologic history prior to delivery, or on the basis of findings since birth, manifests or is likely to manifest persistent or significant signs of distress, including, but not limited to the following:

1. Any infant with a birth rate below 2000 grams or of less than 34 weeks gestation, and any other low-birth rate or premature infant who shows abnormal signs.

2. Any infant showing persistent or significant signs of illness may include those with sustaining respiratory distress, significant congenital anomalies, tumors, seizures, significant infections, or other conditions that pose an immediate threat to neonatal survival.

3. Any infant with serious breathing difficulties or excessive lethargy.

4. Any infant whose mother is drug addicted or habituated, or having any other illness or conditions which may severely affect the fetus.

1. Any infant requiring major, surgical procedures.

6.H. Behavioral Health Services

1. Patients may be admitted to the psychiatric unit only upon order of a psychiatrist with admitting privileges.
2. All patients with a primary psychiatric diagnosis may be admitted to the psychiatric unit only.
3. A psychiatric evaluation will be completed within 24 hours of admission.
4. The attending psychiatrist shall have the ultimate responsibility for the diagnosis and treatment of his/her patient and shall be accountable to the Board.
5. A verbal or documented physician order is required for the behavioral health application of a restraint. The order must be obtained within one hour. Orders are to be time-limited, specify the reason for the restraint, and include start and stop times not to exceed four (4) hours for adults (18 years and older). The physician must renew the restraint order at each four, two or one hour intervals, not to exceed eight (8) hours for adults If continuation is warranted after these renewals, the physician must perform a face to face clinical reassessment of the patient. If ongoing need is indicated, a new physician order must be written, not to exceed the timeframes listed above.

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6.I. Electronic Intensive Care Unit (eICU)

1. The Wide Area Treatment and Communication Hub provide additional monitoring and assessment of patients. These assessments are documented and filed with the patient's medical record.
2. eWATCH physicians' will document plan of care and initiation of new therapies as warranted by patient condition. The documented plan of care may be implemented by the eWATCH staff without first contacting the attending/managing physician. Any new therapies initiated by the eWATCH physician, the attending/managing physician will be notified of significant changes. Written documentation of care will be provided on eWATCH Progress Notes.
    a. Examples of plan of care adjustments in Category II:
        i. Ordering of Lab tests (Chemistry, Hematology, Anticoagulation, Microbiology)
        ii. Ordering of Radiological studies
        iii. Ordering of ABGs; Nebulizer treatments; Oxygen therapy; adjustment of ventilator settings
        iv. Medications: management of hyperglycemia; anticoagulation therapy; pain and sedation; adjustment of IV fluids and rates; electrolyte replacement therapy; antibiotic levels and intervals; vasopressor does titrated or weaned off
        v. Medications; management of hyperglycemia; anticoagulation therapy; pain and sedation; adjustment of IV fluids and rates; electrolyte replacement therapy;
        vi. Nutrition modified or rated adjusted
        vii. Activity levels adjusted; Physical Therapy needs adjusted
3. eWATCH physicians will intervene in Life-Threatening situations and communicate with the attending/managing physician as soon as possible. Non Life-Threatening conditions will be communicated to the attending/managing physician. In emergent situations where the eWATCH physician is unable to reach the attending/managing physician, in a reasonable period of time, he/she will use their best judgment regarding interventions.
4. The physician presence at the bedside
    a. The attending/managing physician during the eWATCH hours of operation will be notified anytime the patient's condition requires a bedside physician's presence.
        i. The eICU WATCH physician is responsible to contact the attending/managing physician anytime physician presence is required at the bedside.
        ii. The attending/managing physician is responsible to designate who should respond to issues requiring direct bedside physician presence.

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iii. The attending/managing physician will contact or designate whom to contact for the bedside procedure.
iv. The attending physician's designee is responsible to respond to the eICU WATCH physician's request for bedside procedures within a timely and appropriate fashion.

6.J. Medical Supervision of Hospital Services

1. Anesthesia Services must be managed by a member of the Medical Staff.

2. The Laboratory Director must be a member of the Medical Staff. If not a Pathologist, then a Pathologist will be retained on a consultative basis.

3. Nuclear Medicine must be managed by a physician member of the Medical Staff and must be a designated authorized user of radioisotopes.

4. Radiology Services must be managed by a member of the Medical Staff.

5. Emergency Services must be managed by a member of the Medical Staff.

6. Cardiopulmonary Services must be managed by a member of the Medical Staff.

7. Behavioral Health Services must be managed by a member of the Medical Staff.

6.K. Women's and Children Services

1. The governing body appoints a physician as Medical Director of the obstetrics services who meets the qualifications specified within the Medical Staff Bylaws. The Medical Director must be board certified.

2. A physician with Caesarian privileges must be capable of performing c-section within 30 minutes of notice.

3. A physician with OB privileges must be available for patient treatment within 10 minutes during administration of Oxytocic agent to an ante partum patient.

4. The governing body shall appoint a physician as a Medical Director of the organized newborn service who meets the qualifications specified in the Medical Staff Bylaws. In addition, the Medical Director must meet the qualifications specified for the medical direction of the highest level of newborn service provided b the hospital.

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5. A newborn shall be examined upon admission to the intermediate level nursery within 24 hours of birth.

7. SURGICAL SERVICES

7.A. General

1. Enforcement of rules and regulations pertaining to the Operating Room procedures shall be the responsibility of the Multidisciplinary Operating Room Committee and, where appropriate, its designee, the Leader of Surgical Services. The Leader of Surgical Services shall have the responsibility for the administrative supervision of the Operating Room, and the Post-Anesthesia Care Unit (PACU), and shall have the authority to plan and execute the daily operative schedule. Surgical Services will be managed by a physician who is a member of the Hospital Medical Staff.

2. The Operating Room schedule shall begin promptly each day. The time scheduled for each operation shall be defined as the time when the surgery should begin.

3. The Leader of Surgical Services shall have the responsibility for designing a schedule based on the maximum efficient use of the Operating Rooms and Anesthesia Services.

4. When a sponge or other count is incorrect, an x-ray shall be taken before the patient leaves the Operating Room.

5. Any personnel with an open infection shall not be permitted to enter the Operating Room suite.

6. All orders, including "Do Not Resuscitate Orders", are cancelled when a patient goes to surgery

7. B. Scheduling Surgery

1. Specific, contemplated procedures shall be designated on the schedule with the name of the patient, diagnosis, and surgical procedure.

2. Cases requiring frozen sections should be posted as such at the time the case is scheduled.

3. An emergency case shall take precedence over elective surgical cases not already in progress.

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4. The operating surgeon shall be named when the case is scheduled, and shall be responsible for the surgical care of the patient before, during, and after surgery.

5. If the operating surgeon is more than 15 minutes late for any scheduled case without contacting the Leader of Surgical Services or designee, that case may be canceled and the patient returned to his/her room by the Operating Room staff. The Operating Room shall be released promptly when a case is canceled or when the patient and surgical team are not available as scheduled.

6. If a surgical procedure is canceled, the surgeon shall document in the medical record the reason for the cancellation.

7. The patient will not be anesthetized until the operating surgeon is present in the operating suite.

8. Schedules for Saturdays, Sundays, and holidays shall be modified according to policies that may be, from time to time, established by the Operating Room Leader of Surgical Services.

7.C. Infection Control

1. The Operating Room Department will use Universal Precautions for all cases.

2. Extra protective devices (e.g., reinforced gloves resistant to lacerations) may be available upon request, in accordance with Operating Room policies.

3. All personnel entering the operating restricted area must observe the dress code.

4. Protective wear (gowns, gloves, masks, shoe covers) shall be removed prior to leaving the surgical area.

7.D. Safety

All personnel entering the Operating Room shall observe all safety precautions as specified in Operating Room policies.

7.E. Preoperative History and Physical and Diagnostic Tests

1. Except in emergencies, before a patient is taken to surgery that requires general or regional anesthesia, a history and physical must be documented in the medical record prior to patient being taken to the Operating Room.

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2. The results of any preoperative diagnostic tests shall be documented in the medical record prior to the patient's being taken to the Operating Room.

7.F. Anesthesia

1. Except in rare emergencies, a pre-anesthesia evaluation shall be conducted on each patient and shall include such information as may be necessary to determine the capacity of the patient to undergo surgery and to formulate an anesthesia plan. This evaluation shall include a review of objective diagnostic data; an interview with the patient regarding medical, anesthetic, and drug history; and a report of the patient's physical status. The findings of the pre-anesthesia evaluation shall be recorded prior to surgery. All entries must be legible, dated and authenticated.

2. A record shall be maintained of all events taking place during the induction of, maintenance of, and emergence from anesthesia, including:
   a. The dosage and duration of all anesthetic agents;

   b. Other drugs, intravenous fluids, blood, or blood products;
   c. The technique(s) used;

   d. Unusual events during the anesthesia period; and

   e. The status of the patient at the conclusion of anesthesia.

3. Patients shall be discharged from the Post-Anesthesia Care Unit (PACU) according to guidelines as established by the PACU score.

7.G. Women's Health

1. Obstetrical Operating Room

   Enforcement of the Rules and Regulations pertaining to the Obstetrical Operating Room shall be the responsibility of the Surgical Operating Room Committee and, where appropriate, its designee, the Leader of Women's and Infants' Services. The Leader of Women's and Infants' Services or designee shall have the responsibility for the administrative supervision of the Obstetrical Operating Room and shall have the authority to plan and execute the daily operative schedule. Infection Control and Safety Policies should be followed as defined in Surgical Operating Room Procedures.

2. Labor and Delivery Policies and Procedures

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Labor and Delivery policies and procedures shall be contained in the Labor and Delivery Policy Manual that shall be maintained in the Labor and Delivery Unit.

7.H. Surgical Assistant

1. In the case of hospital based Surgical Assistant and private physician scrubs they shall met the following criteria:

    1. A graduate of an accredited school of nursing with an R.N. degree who is licensed as an R.N. by the Virginia Board of Nursing; in addition to a first assisting course, certified training program or on the job training under the direct supervision or a Certified Registered Nurse First Assist (CRNFA) or surgeon. Initial and annual competency are monitored by Senior Leader of Surgical Services and maintained in Human Resources.

    2. A graduate of an accredited school of practical nursing who is licensed as a practical nurse by the Virginia Board of Nursing with a minimum of one year operating room scrub experience; in addition to a first assisting course, certified training program or on the job training under the direct supervision or a Certified Registered Nurse First Assist (CRNFA) or surgeon. Initial and annual competency are monitored by Senior Leader of Surgical Services and maintained in Human Resources.

    3. A physician's assistant who is certified by the Virginia Board of Medicine with a minimum of one year operating room scrub experience;

    4. A graduate of a surgical technology program accredited by the AMA's Committee on Allied Health Education and Accreditation, who is certified by the Association of Surgical Technologists, with a minimum of one year operating room scrub experience; in addition to a first assisting course, certified training program or on the job training under the direct supervision or a Certified Registered Nurse First Assist (CRNFA) or surgeon. Initial and annual competency are monitored by Senior Leader of Surgical Services and maintained in Human Resources.

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5. A graduate of the Eastern Virginia Medical School Surgical Assistant Program, or other comparable program acceptable to the Credentials Committee, who is certified by the National Surgical Assistants Association, with a minimum of one year operating room scrub experience; or

6. A surgical technologist with a minimum of three years operating room scrub experience. Such a surgical technologist must have at least a high school education or its equivalent and may function as a surgical assistant in the absence of individuals with greater overall skills and qualifications. In addition to a first assisting course, certified training program or on the job training under the direct supervision or a Certified Registered Nurse First Assist (CRNFA) or surgeon. Initial and annual competency are monitored by Senior Leader of Surgical Services and maintained in Human Resources.

7. A graduate of an accredited school of medicine with an M.D. or D.O. degree who is licensed to practice Medicine and Surgery by the Virginia Board of Medicine with a minimum of one year operating room experience.

8. A graduate of an accredited school of medicine with a M.D. or D.O degree holding a temporary license as an intern or resident and a intern or resident in an surgical education program. When first assisting an intern or resident will be under the direct supervision of sponsoring surgeon at all times rendering patient care.

8. APPOINTMENTS AND RESIGNATIONS

8.A. Appointments

Applicants for appointment to the Medical Staff and Advanced Practice Professional staff shall complete an orientation program. The orientation program will include an introduction and hands-on training where applicable, for all information technology systems necessary for the care of patients in the hospital.

8.B. Resignations

1. A request for resignation from the Medical Staff shall not be accepted until approved by the Medical Executive Committee. No resignation from the

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Medical Staff will be accepted until Emergency Department on-call coverage is completed. The resigning Practitioner shall not be responsible for on-call coverage for a period greater than 30 days from receipt of the request of resignation or until approved by the Board. It shall be the responsibility of the resigning Practitioner to arrange on-call coverage. Upon acceptance of Practitioner's resignation, he/she is not eligible to reapply to the Medical Staff for a period of six months.

2. No resignation from the Medical Staff will be accepted until Medical Records are complete, and all ongoing hearings or appeals have been resolved.

3. Failure to comply with the above stipulations will result in automatic relinquishment of privileges. As Staff member's resignation from the staff, in an effort to avoid investigation or imposition of sanctions will be reported as such to the Medical Executive Committee. Such actions are contrary to the Medical Staff Bylaws, and should the Practitioner resigns under these circumstances, the incident will be reported to the National Practitioner Data Bank, and to the Virginia Board of Medicine.

9. PHYSICIANS-IN-TRAINING

9.A. Definition

Physicians-in-training are defined as physicians who have completed medical school, may be licensed in the Commonwealth of Virginia, but who have not yet completed residency and are therefore not qualified to apply for Medical Staff membership and privileges at Spotsylvania Regional Medical Center. The physician-in-training may receive a part of his/her training under the supervision of one or more members of the Medical Staff (supervising physician) as a portion of an accredited postgraduate training program; provided that Hospital has contracted with the accredited postgraduate training program to provide such supervision and training. Clinical training activity is defined in a job description, and may include direct patient care activity, which exceeds observation alone.

9.B. Application Process

The physician-in-training shall submit a letter from an official of the sponsoring residency or fellowship program to certify the trainee's status and that he/she meets the necessary health requirements as outlined in Hospital policy and verify liability insurance coverage consistent with the requirements of the Medical Staff.

9.C. Clinical Activities and Responsibilities of the Sponsoring Physician

Residents shall act within the limits of his/her job description under the supervising physician with appropriate clinical privileges in that specialty. In no case will

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interns/residents act in lieu of the supervising physician, or his/her associate. The intern/resident may perform a History & Physical examination, write daily progress notes, and write daily orders under the supervision of supervising physician. The History & Physical examination, daily progress notes, and daily orders must be countersigned by the supervising physician within 24 hours. The supervising physician will submit a written letter attesting to the supervisory responsibilities outlined in this section.

9.D. Responsibilities of the Physician-in-training

The physician-in-training shall comply fully with associated policies, all applicable provisions of the Medical Staff By Laws, the Medical Staff Rules and Regulations, all Hospital policies, rules, and regulations, and the Rules and Regulations of his/her respective department.

9.E. Identification

The physician-in-training will wear clothing and identifying badge that clearly shows his/her name, status and training program.

9.F. Quality

Each participant's performance regarding progressive involvement and independence in specific patient care activities will be assessed and documented by supervising physicians, and communicated to the appropriate Graduate Education program.

10. STUDENTS

10.A. Definition

Students: persons who are actively enrolled as students in an accredited LCME/AOA/CPME school of medicine: medical doctor, osteopathy, or podiatry; or physician assistant program that has contracted with the Hospital for the clinical supervision of its students. The accredited LCME/AOA/CPME educational program shall have a contract with the Hospital.

Sponsoring physician: The Medical Staff member under whose direct supervision the student may observe healthcare processes at the Hospital.

10.B. Application Process

The student in conjunction with the sponsoring physician shall request from the Medical Staff Services approval for a clinical rotation. The student's academic program must verify that the student is in good standing and meets the necessary health requirements as outlined in Hospital Policy. The academic program must also verify that the school's professional liability insurance extends coverage to the

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clinical rotation and must provide a current certificate of insurance. The Hospital may charge the program a fee for each clinical rotation.

10.C. Clinical Activities and Responsibilities of the Sponsoring Physician

Students shall act within the limits of his/her job description under the sponsoring physician with appropriate privileges. In no case will students act in lieu of the sponsoring physician. The sponsoring physician will submit a written letter attesting to the supervisory responsibilities outlined in this section. Participation in clinical conferences, rounds, and discussions is open to the student. Students may write in the medical record, but their documentation is not in lieu of the sponsoring physician's documentation in the medical record. Entries made by students must be co-signed by the sponsoring physician–within 24 hours. Students may not write orders.

10.D. Involvement of Hospital Staff

Needed services of specific Hospital staff members (e.g. instruction and compliance monitoring in surgical scrub and other sterile technique) may be available at the discretion of such staff members upon the personal request of the sponsoring physician to the staff member in advance of such needs.

10.E. Identification

Students will wear clothing and identifying badge that clearly shows his/her name and status and training program.

10.F. Responsibilities of the Sponsoring Physician

The sponsoring physician assumes professional and legal responsibility for the student's actions and communications in connection with the care of patients at Spotsylvania Regional Medical Center during the period of training, holding Spotsylvania Regional Medical Center harmless for any such acts, and for their consequences. The supervising physician will submit a written letter attesting to the responsibilities outlined in this section.

10.G. Performance Assessment

The sponsoring physician is solely responsible for assessing and reporting the student's academic performance when required.

10.H. Students From Non-Accredited Medical School Programs

Students from non-accredited medical school programs may be permitted to rotate with physicians members of the medical staff upon successful demonstration of the following:

a. The Medical Executive Committee must approve all applications from non-accredited programs at least one month prior to the start of any rotation (This includes observation only);

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b. Detailed curriculum for the rotation must be submitted to Medical Staff Services from sponsoring physician via electronic format at least one month prior to the rotation;

c. Curriculum submitted by sponsoring physician must be reviewed by the Medical Executive Committee prior to the start of the rotation;

d. Maximum number of students per physician is three, however, the Medical Executive Committee will determine how many students a physician may have;

e. An administrative fee may be accessed prior to the start of a clinical rotation; and,

f. Each student will be issued a hospital Identification Badge upon the completion of all necessary items and hospital orientation.

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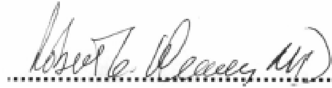
11. AMENDMENTS

Amendment to the Rules and Regulations of the Medical Staff is addressed in the Medical Staff Bylaws at Article 11.B.

12. ADOPTION

These Medical Staff Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all Medical Staff Rules and Regulations or Hospital policies pertaining to the subject matter thereof. Henceforth, all activities and actions of the Medical Staff and of each individual exercising Clinical Privileges or Activities at the Hospital are taken under and pursuant to the requirements of these Rules and Regulations.



_______________________________________ December 17, 2013_______________

Chief of Staff Date

____ January 8, 2014____________________

Chairperson-Board of Trustees Date

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