FOUNTAIN VALLEY REGIONAL HOSPITAL
GENERAL RULES AND REGULATIONS
OF THE MEDICAL STAFF

SECTION ONE

ADMISSION AND DISCHARGE OF PATIENTS

1. Patients Accepted for Treatment
   The Hospital shall accept patients for acute care and treatment.

2. Who May Admit
   Only a member of the Medical Staff may admit a patient to the hospital. All practitioners shall be governed by the admitting policies of the hospital.

3. Responsibility for Medical Care, Treatment, and Medical Record Completeness
   Legibility and Accuracy
   A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness, legibility, 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 to relatives of the patient. Whenever these responsibilities are transferred to another staff member a note concerning the transfer of responsibility shall be entered on the order sheet of the medical record.

4. Admitting Diagnosis
   Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible.

5. Withholding Pertinent Patient Information; Placing Healthcare Givers at Risk
   Summary suspension may result if any physician knowingly and willfully withholds any patient information which might place a healthcare giver at risk, or who admits a patient under any surreptitious diagnosis.

6. Bed Availability
   In any emergency case in which it appears the patient will have to be admitted to a hospital, the practitioner shall first contact Admitting to ascertain whether there is an available bed and give pertinent pre-admission information.

7. Admission Priorities
   The Admitting Department clerk will admit patients on the basis of the following order of priorities:

   a) Emergency Admissions
      Within twenty-four (24) hours of admission there must be sufficient documentation of the need for emergency admission. Failure to furnish this documentation or
evidence of willful or continued misuse of this category of admission will be brought to the attention of the Utilization Review Committee for appropriate action.

b) **Urgent Admissions**
This category includes those so designated by the attending practitioner and shall be reviewed as necessary retrospectively by the Utilization Review Committee.

c) **Pre-operative Admission**
This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chairman of the Department may decide the urgency of any specific admission.

d) **Routine Admissions**
This will include elective admissions involving all services.

e) **Observation** or Short Stays <twenty-four (24) hours.

### 8. Immediacy of Professional Care
Each member of the Medical Staff shall provide assurance of immediacy of adequate professional care for his patients in the hospital, being available or having available through his/her office an eligible alternate practitioner with whom prior arrangements have been made. The alternate must be a member of the medical staff with the same clinical privileges of the practitioner being covered. Failure of the attending practitioner to meet the above requirements may result in loss of Medical Staff privileges.

### 9. Alternate Practitioner Coverage
Each member of the Medical Staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is resident in the area who may be called to attend his/her patients in an emergency, or until he/she arrives. In case of an emergency, when the physician in charge is not available and appropriate efforts are made to locate him/her, or he/she has not delegated a member to substitute for him/her, the Chief of Staff or the Department Chairman can appoint a physician to handle the situation.

**Emergency Admission; No Private Medical Doctor**
A patient to be admitted on an emergency basis who does not have a private practitioner will be assigned a physician from the applicable Emergency Room Call Panels.

### 10. Protection of Patients
The admitting practitioner shall be held 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/her patients might be a source of danger from any cause whatever.
12. Patient Transfers

a) Transfer priorities are as follows:

I. Emergency Room to appropriate patient bed.
II. Intensive Care Unit to general care area.
III. Cardiac Care Unit to general care area.
IV. From temporary placement in an area designated as a geographic or clinical service area to the appropriate area for that patient.

b) No patients will be transferred from an acute unit without such transfer being approved by the responsible practitioner.

13. Potentially Suicidal Patients/5150 (The first level of care for unstable/suicidal patients)

For the protection of patients, the medical and nursing staffs and the hospital, certain principles are to be met in the care of the potential suicidal patient. A suicidal patient, not in the ICU for acute problems, should be required to have around-the-clock attendance, if on a 5150 hold, until cleared by a psychiatrist.

14. Admission to Critical Care Units:

Unless a patient was seen by the attending or consulting physician (or his/her designee) immediately prior to admission or transfer, patients admitted to the ICU/CCU, NICU and PICU will be seen by the attending or consulting physician (or his/her designees) within four (4) hours of admission or sooner if the patient’s condition warrants.

The attending practitioner is required to document the need for continued hospitalization in a Critical Care Unit daily.

If any question as to the validity of the admission to or discharge from the Critical Care Units should arise, that decision is to be made through consultation with the Chairman of the Critical Care Committee or his/her designee.

Failure to comply with this policy will be brought to the attention of the Department Chairman for decision.

Physicians must return calls from Critical Care Units, DOU, Telemetry and the Medical Floors within thirty (30) minutes. If the call is not returned, Nursing will contact the next appropriate consultant or attending physician and continue efforts to reach the original physician called. When necessary, the Critical Care Committee Chair or Clinical Department Chairman will be contacted and appropriate notification reports submitted.

15. Patient Discharge

Patients shall be discharged only on the order of the physician. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge order, a notation of the incident shall be made in the patient’s medical record.

16. Pronouncements

In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the
deceased, by a member of the medical staff or designee R.N. Policies with respect to release of remains shall conform to local law.

17. **Autopsies**
   It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the Hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnosis shall be recorded on the record within twenty-four (24) hours of the complete protocol should be made a part of the record within sixty (60) days.

18. **Criteria for Considering Autopsies**
   Autopsies should be considered in, but need not be limited to the following circumstances:

   a) Deaths in which an autopsy may help explain unknown and unanticipated medical complications;
   b) Deaths in which the cause is not known with certainty on clinical grounds;
   c) Cases in which an autopsy may help allay concerns of the family or public;
   d) Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedure and/or therapy;
   e) Deaths occurring in patients who have participated in clinical trials;
   f) Sudden unexpected or unexplained deaths which are apparently natural and not subject to forensic medical jurisdiction;
   g) Deaths occurring in the hospital within twenty-four (24) hours of admission;
   h) Deaths resulting from high risk infectious and contagious diseases;
   i) All pediatric deaths;
   j) All neonatal deaths greater than 750 gms;
   k) Deaths at any age where it is felt that an autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs.
   l) Deaths known or suspected to have resulted from environmental or occupational hazards.

   The Attending Physician will be responsible for contacting the next of kin for permission to perform and autopsy. The next of kin will be required to sign an “Authorization for Autopsy” form. Phone consents are not acceptable.

   The Laboratory will be notified that an autopsy is to be performed who will, in turn, notify the Pathologist. The Pathology Technician will be notified of the date and time of the autopsy and will subsequently notify the attending physician so that he/she may attend if desired. The Pathologist will notify the Attending Physician on the weekends and after hours and inform Medical Staff Services so that a notice can be posted in the Doctors Dining Room.

   Results from autopsies will be referred to the Attending Physician and, whenever appropriate, used in educational programs with the goal of optimizing patient care outcomes.

   Coroner’s cases and Public Administrator cases will follow the procedure outlined in Nursing Policy and Procedures relating to Patient Deaths.
19. **ET Tube Placement:**
   It shall be the responsibility of the physician placing the tube to confirm endotracheal tube placement, via chest x-ray or any other means such as bronchoscopy confirmation.

20. **Outside cancer pathology reports and tissue slides** must be reviewed by the Pathologist at this facility, prior to surgery, to re-affirm the diagnosis.

21. **Patients identified with Acinetobacter** shall be kept in isolation until discharge.

**SECTION TWO**

**MEDICAL RECORDS**

1. **The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient.** Its content shall be pertinent and current. This record shall include identification data; complaint; personal history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; principal diagnosis, condition on discharge; summary or discharge note; clinical resume; and autopsy report when performed.

   Each patient admitted to the hospital shall be reassessed by the admitting physician or designated physician at regular intervals related to the patient's course of treatment but at least daily. **This excludes normal healthy newborns.**

2. **Pertinent Progress Notes shall be recorded** at the time of each daily visit, and shall be sufficient to permit continuity of care and transferability. Whenever 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. If progress notes are dictated, they must be dictated at the time of each daily visit, with a notation in the chart indicating that “a progress note was dictated on this date.” Any critical treatment information shall be part of this note even if the transcribed note is expected shortly.

3. **The hospital records (typed or electronic version) the patient’s history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.** This report should include all pertinent findings resulting from an assessment of all the systems of the body. The report must be validated and authenticated.

   If a complete history and physical has been recorded and a physical examination performed within thirty (30) days prior to the patient’s admission to the hospital, a durable, legible copy may be used in the patient’s medical record.

   If a patient is admitted for outpatient surgery, the H&P addendum or an interval note
must be completed immediately prior to surgery and placed in the patient’s medical record. For an inpatient surgery, the interval note or addendum must be completed before 48 hours have elapsed since the date of admission.

Unscheduled Cesarean Section
For an unscheduled cesarean section, the Obstetrical History & Physical Form must be completed prior to the patient moving to the surgical suite.

If the history and physical is within thirty (30) days, the physician must review this history and physical and document that

If a complete history and physical has been recorded and a physical examination performed within thirty (30) days prior to the patient’s admission to the hospital, a durable, legible copy may be used in the patient’s medical record.

Patients receive a medical history and physical examination no more than 30 days prior to or within 24 hours after inpatient admission.

For a medical history and physical examination that was completed within 30 days prior to inpatient admission, an update documenting any changes in the patient’s condition is completed within 24 hours after inpatient admission or prior to surgery, whichever comes first.

If a patient is admitted for outpatient surgery, the history and physical addendum or an interval note must be completed immediately prior to surgery and placed in the patient’s medical record. For an inpatient surgery, the interval note or addendum must be completed before 48 hours have elapsed since the date of admission.

If the history and physical is within thirty (30) days, the physician must review this history and physical and document that

1. the contents of the history and physical exam accurately reflect the patient’s current condition without any additions or revisions,

   OR,

2. the physician must document all revisions or additions to the history and any subsequent changes in the physical findings.

   This documentation can be included in the physician’s progress note or on the History and Physical Addendum form.

   Complete history and physical examinations conducted by consultants shall be accepted as the admission history and physical if documented. A prenatal record may take the place of a history and physical for vaginal deliveries.

Contents of the History and Physical

1. Chief complaint
2. Details of present illness
3. Past medical and surgical history
4. Allergies
5. Medications
6. Relevant past social and family history (appropriate to patient’s age)
7. Review of systems
8. Physical exam inventoried by body systems
9. Statement on the conclusions or impressions drawn from the history and physical exam
10. Statement on the course of action planned for the patient for that episode of care

Contents of the Outpatient History & Physical

1. Chief complaint
2. Details of present illness
3. Relevant past medical and surgical history
4. Allergies
5. Medications
6. An appropriate review of systems
7. Impression
8. Proposed initial plan of evaluation and treatment

Except as set forth in number “3.” Below, inpatient and outpatient invasive procedures are performed only after an appropriate history, physical examination and preoperative diagnosis have been completed and recorded in the patient’s medical record. An appropriate history and physical is required regardless of the type of anesthesia planned and/or given, as well as, when no anesthesia is given (topical, local or regional block).

Patients receive a medical history and physical examination no more than 30 days prior to or within 24 hours after inpatient admission.

For a medical history and physical examination that was completed within 30 days prior to inpatient admission, an update documenting any changes in the patient’s condition is completed within 24 hours after inpatient admission or prior to surgery, whichever comes first.

Outpatient Yag/Argon Laser Ophthalmic Procedures Histories & Physicals, Require the following elements only:
Visual acuity, allergies, and any known heart disease.

Operative and Other Invasive Procedures:
If the physician performing the procedure is not the physician who documented the history and physical examination, the performing physician must document an assessment of the patient pertaining to the procedure, immediately before the procedure, in the progress notes.

This assessment must include the clinical indications, planned procedure and documentation of informed consent. The operative consultation will serve as this assessment, providing the above components are included.
3. The following procedures do not require a history and physical:

Cardiac Stress Test
Central Lines
Chemotherapy
Cholangiogram
CT Scan
CT with guided biopsy
Incision and drainage (ER cases only)
IVP
Lymphangiogram
Minor excisions
MRI without anesthesia
Outpatient Flexible Sigmoidoscopy (no Sedation)
Outpatient Liver Biopsies
Paracentesis
Thoracentesis
Ultrasound guided biopsies – Outpatient, without anesthesia
Venogram
Needle aspiration biopsies – Outpatient, without anesthesia

4. When the history and physical examination is not recorded in typed or handwritten form in the patient’s medical record before a scheduled invasive diagnostic procedure, the procedure shall be canceled unless the attending physician states in writing that the procedure is an emergency and that such delay would be detrimental to the patient. This applies to both inpatient and outpatient procedures.

5. Dental or podiatry patients admitted to the hospital must have histories and physicals completed by a physician member of the medical staff. A podiatrist or oral surgeon who has been credentialed to perform a history and physical examination may do so in accordance with rule 21, page 10 of these rules and regulations.

6. Each patient admitted to the hospital shall be reassessed by a physician at regular intervals related to the patient’s course of treatment but at least daily.

7. Operative reports
An operative or high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. The exception to this requirement occurs when an operative or other high-risk procedure a brief operative note is written immediately after the procedure (examples: before the patient is moved from the PACU, in the case of a surgery, before the patient is moved from the Cath Lab, in the case of an interventional procedure, before the patient is moved to the floor, in the case of an interventional radiology procedure), in which case the full report can be written or dictated within twenty-four (24) hours of the completion of the surgery or procedure. HAS RC.02.01.03, C 5.

8. Consultations shall 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 shall be made a part of the patient’s record. A limited statement such as “I concur” does not constitute as acceptable report of consultation.
When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

All initial consultations shall be dictated within twenty-four hours of the consultation for inpatient admissions.

9. All clinical entries in the patient’s medical record shall be accurately dated, timed and authenticated. The use of rubber stamp signatures is not acceptable. Facsimile and electronic signatures are acceptable to complete medical records.

10. Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of unapproved abbreviations is on file in the Health Information Department.

11. A discharge clinical summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours and on all expired patients and all patients admitted as observation or as an inpatient from an outpatient invasive procedure. The discharge summary must contain the reason for hospitalization, significant findings, procedures performed and treatment rendered, the condition of the patient at the time of discharge and instructions to the patient and family. A discharge note will be required on ALL admissions under forty-eight (48) hours. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.

12. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

13. Records may be removed from the Hospital’s jurisdiction and safekeeping only in accordance with a Court Order, subpoena or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. All records are the property of the hospital. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by Executive Committee of the medical staff.

14. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved through the Executive Committee of the medical staff before records can be studied. Former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital. All costs associated with such access are the responsibility of the former member.

15. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by The Medical Records Committee.

16. A practitioner’s routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient’s record, dated and signed by the practitioner.
17. **Time to Complete Records**
All of the patient’s medical records shall be completed at the time of discharge. Any medical record is considered “delinquent” if incomplete fourteen (14) days following patient discharge. Any operative report/procedure report is considered “delinquent” if not dictated immediately after the surgery/procedure.

Any Staging Form for cancer cases will be considered delinquent if not completed with fourteen (14) days from the date of discharge. Staging forms for surgical cases will be completed by the Surgeon. Staging forms for medical cancer cases will be completed by the Attending Oncologist. If there is no Oncologist on a medical cancer case, the Attending Physician will be responsible for completion of the form.

Physicians will be notified of chart deficiencies in accordance with Health Information Services Department Policy #8700-34P.

Delinquent Echos, Treadmills, TEE’s and Vascular Studies will be counted as part of the delinquent medical record.

Physicians who fail to complete their delinquent records within the period specified in the notification will be automatically suspended in accordance with these Bylaws, Article VII. A list of suspended physicians will be circulated to all Hospital Departments.

Health Information Services will send a memo monthly to the Medical Executive Committee giving the names of physicians on suspension. The Executive Committee shall determine whether the physician’s failure to complete medical records represents substantial deficiencies in the recording of key reports (including histories and physicals, consultations, operative reports and discharge summaries) which could be detrimental to patient safety or to the delivery of patient care. If so, the physician’s name shall be reported to Administration and the Chief of Staff for joint reporting to the Medical Board of California.

When a suspended physician completes his charts, he will be given a notice directing him to complete the process of reinstatement with the Medical Staff Services Department. A reinstatement assessment/fee, made payable to the Medical Staff, is required.

18. **Suspension of privileges** includes admitting privileges, surgery privileges, assisting at surgery, treatment of patients in the Emergency Room; suspended physicians may not write orders or attend patients admitted by an associate during the period of suspension, may not cover for an associate, and may not act as consultants. It is the responsibility of physicians who take ER Call to find appropriate coverage by an alternate practitioner if they are scheduled to take call and are on suspension for delinquent medical records.

19. **Podiatric Residents** are responsible for completion of all their medical records prior to graduation from the program. Residency certificates will not be awarded until records are completed.

20. **History & Physicals; Physician’s Assistants and Nurse Practitioners**
Physician Assistants and Nurse Practitioners who have been credentialed to perform a history and physical may document the history and physical examination under the supervision of a qualified physician supervisor.
Physician Assistant and Nurse Practitioner history and physicals must be cosigned by the supervising physician.

21. **History & Physical Examinations: Podiatrists and Oral Surgeons**

Podiatrists and Oral Surgeons who have been credentialed to perform a history and physical examination and admit patients may do so. In accordance with Article VI of the Bylaws, a member of the medical staff must assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the lawful scope of practice of the podiatrist.

22. **Non-clinician Dictation**

Non-clinicians may dictate a **Discharge Summary only**. Physicians utilizing the dictation services of a non-clinician do so in a private contractual agreement. Non-clinician dictators must be a licensed healthcare provider in the State of California.

The attending physician, at the time of discharge, will document the final diagnosis and all secondary diagnoses in the final progress note. The Non-clinician dictator will use these diagnoses in the dictation.

The responsible practitioner will review and authenticate each report.

The responsible practitioner shall be ultimately responsible for the timely completion and accuracy of the discharge summary. The reports must contain all of the required elements of a discharge summary as defined in the Joint Commission accreditation manual (reason for hospitalization, significant findings, procedures performed and treatment rendered, the patient's condition at discharge and instructions to the patient and family, if any).
SECTION THREE

GENERAL CONDUCT OF CARE

1. A Conditions of Service form signed by or on behalf of every patient admitted to the hospital must be obtained at the time of admission.

All orders for treatment shall be in writing. The practitioner’s ID number must be included on all medication orders. A verbal order shall be considered to be in writing if dictated by a member of the medical staff to a duly authorized person functioning within his or her sphere of competence and signed, dated and timed by the responsible practitioner. All orders dictated over the telephone shall be signed and dated by the appropriately authorized person to whom dictated with the name of the practitioner per his or her own name. Orders given in acute care units must be authenticated within fourteen days of discharge. Verbal orders must be dated, timed and authenticated within forty-eight (48) hours. Electronic signatures are acceptable for orders. Authentication of orders may be accomplished by facsimile. The statements “Resume Previous Orders or Continue Previous Orders” are unacceptable and cannot be used in the medical record.

Indication for Use

The indication for use is a required component for the following types of medication orders.

Medication Use at Discharge

Medication use at discharge must be specifically ordered by the discharging physician. Orders such as "Continue same meds", "To home with ___ Rx", etc. are not appropriate.

Unapproved Abbreviations

Use of unapproved abbreviations has been identified as a patient safety issue. FVRH has implemented a list of unapproved abbreviations. All uses of unapproved abbreviations are reportable to the Medical Staff for appropriate follow-up.

Outpatient Tests; Non-invasive

Non-invasive outpatient testing may be ordered by a physician who is not a member of the medical staff, but is duly licensed by the State of California. The physician’s current license must accompany the order for the test, along with an address and telephone number, so that the physician can be reached with the test results.

Limited invasive outpatient radiological procedures, such as CT scan with contrast, may be ordered by a physician who is not a member of the medical staff, as long as the aforementioned procedure is followed. Patients undergoing limited invasive radiological procedures will be under the direct care of the attending Radiologist, who will assume responsibility for the patient during the procedure and until discharge.
STAT Orders
All STAT orders must be given to the patient’s nurse or the Charge Nurse.

NPO Orders
All NPO orders, for patients on critical care medications, must be clarified with the physician who orders the test to determine which medications will be held and which will not.

Verbal Orders for Drugs

Verbal orders for administration of medications may be received and recorded by licensed health professionals who are expressly authorized under their practice acts to receive orders to administer drugs. This includes RN’s, LVN’s licensed psychiatric technicians, pharmacists, physicians, physician’s assistants from supervising physician only, physical therapists (in an acute care setting and for certain topical drugs only), and respiratory therapists when the orders relate specifically to respiratory therapy.

To enhance patient safety, all verbal orders must be read back to the practitioner giving the order to assure accuracy.

Verbal Orders for Other than Drugs

Verbal orders for other than drugs may be received by any licensed, registered, or nationally certified or authorized health professional provided that the orders received relate to the area of competence of the individual receiving the orders; Audiologist, Cardiopulmonary/Pulmonary Technologists/Technicians, Dietitians, Laboratory Technologists, Laboratory Technicians, Occupational Therapists, Physical Therapists, Radiological Technologists, Respiratory Technologists, Respiratory Therapists and Speech Pathologists, as specifically authorized by the Medical Staff and Administration.

All medications are to be administered by or under the supervision of appropriately licensed personnel, in accordance with applicable law and regulations governing such acts.

2. The practitioner’s orders must be written clearly, legibly and completely. Use of the Fountain Valley Regional Hospital “Letterbox Physician Order Form” is required. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood. Pre-printed order sets must be on file with the Director of the Department of Pharmacy Services. All such order sets must be reviewed at least annually by the Pharmacy and Therapeutics Committee.

3. All previous orders are canceled when patients go to surgery, and upon transfer to or from a special care unit.

4. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations.
5. **Drugs for bona fide clinical investigations** may be exceptions. These shall be used in full accordance with the **Statement of Principles Involved in the Use of Investigational Drugs in Hospitals** and all regulations of the Federal Drug Administration.

6. The Pharmacy Department shall automatically discontinue medications when one of the following situations arise:

   a. Transfer into or out of one of the following units:
      - Surgical Intensive Care
      - Medical Intensive Care
      - Direct Observation Unit
      - Pediatric Intensive Care
      - Neonatal Intensive Care

   b. Surgical procedures with the exception of the following:
      - Bronchoscopy
      - Endoscopy, Colonoscopy, PEG Placement
      - AV Shunt Placement/Revision for Dialysis Patients
      - Casting/Dressing Change
      - Chest Tube Insertion
      - Closed reduction
      - Cystoscopy
      - Wound Debridement
      - Placement of Invasive Central Lines (i.e., Hickman, Swan Ganz, Pulmonary Artery catheters, etc.)
      - Orthopedic Pin Removal
      - Tracheostomy
      - Minor repair of lacerations
      - TEE
      - Diagnostic Cardiac Catheterization (Cardiac Cath)
      - Pacemaker placement

   c. Readmission of a discharged patient

   d. Conversion of a short stay patient to an inpatient

   e. Automatic Stop Date limitations are exceeded

8. Automatic Stop Order

   a. A physician’s order for a medication within the following categories shall be considered valid for the duration described below:

      | Category          | Duration  |
      |-------------------|-----------|
      | Narcotics         | 7 days    |
      | Hypnotics         | 7 days    |
      | Antibiotics       | 5 days    |

Automatic stop orders, unless renewed by the physician, are as follows:

1. **Controlled medications (CII – CV):** 7 days
2. **Antimicrobials:** 5 days unless a specific number of days or doses are prescribed
3. Albumin: Hard Stop of 24 hours from time of order. No renewal notice will be printed.

4. Concentration sodium chloride infusions (e.g., 3% NaCl): 1 DOSE

5. Ketorolac: 5 days. No renewal permitted.


7. HHN treatment with Albuterol, Ipratropium and Levalbuterol: 7 days.

9. Medications shall not be prescribed for an indefinite period of time (i.e. “continue until further notice” or “continue until discharge”). All medications must be reviewed and reordered by the physician every 30 days.

9. **Who can Consult:** Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within the practitioner’s area of expertise. The area of expertise and ability to practice is determined by the practitioner’s clinical department and the privileges, which are granted to the practitioner in the practitioner’s specific specialty.

10. **Consultations:**
    It is the duty of the medical staff to request a consultation(s) when it will benefit the quality of a patient’s care. The chairman of a clinical department, director of a service, and/or chief of the medical staff may require a consultation if it is determined that a patient will benefit from such a consultation.

    Consultations can only be obtained at the request of a physician who is involved in the care of the patient.

    **Intensivists: Responsibility for Relieving Intensivist from a Case:**
    It is the attending physician’s responsibility to notify the intensivist, when the intensivist’s services are no longer needed on a case.

    **Consultations are required in the following situations:**
    Cardiology consultation: Acute MI with Complications

11. **Except in an emergency, Consultations are recommended in the following situations:**
    a. When the patient is not a good risk for operation or treatment;
    b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
    c. Where there is doubt as to the choice of therapeutic measures to be utilized.
    d. In unusually complicated situations where specific skills of other practitioners may be needed;
    e. In instances in which the patient exhibits severe psychiatric symptoms;
    f. When requested by the patient or the patient's family.

12. **Responsibility for Requesting Consultations:** The attending practitioner is primarily responsible for requesting consultations with a qualified consultant. The requesting physician will make the first attempt at contact with the consultant. An order for the consult will be written with specific indications. The nurse will facilitate contact if the requesting physician fails to make initial contact. The requesting physician will make positive contact at the first opportunity.
13. Allegations and/or Charges by the Medical Board of California: Any Medical Staff member who has allegations and/or charges by the Medical Board of California will be referred to the Department Chair of his/her respective clinical department and/or the Chief of the Medical Staff to review the allegations.

14. Treatment of Immediate Family Members: Members of the Medical Staff advisedly should not be an attending physician, surgeon, assistant surgeon or consultant for any member of his/her immediate family, including spouse, children, parents and siblings.

15. Moderate Sedation
Moderate sedation may only be performed under the supervision of a credentialed physician as defined in these Medical Staff Rules and Regulations. See Medical Staff Policy & Procedure: Credentialing Criteria for Non-Anesthesiologists, Sedation – Moderate or Deep, Care of the Adult Pediatric and Neonatal Patient.

16. Care and Referral of Patients Who are Emotionally Ill, or Who Suffer from the Results of Alcoholism or Drug Abuse:
There shall be a provision for the care and/or appropriate referral of patients who are emotionally ill, who become emotionally ill while in the hospital, or who suffer the results of alcoholism or drug abuse.

It is the duty of the medical staff to request a consultation(s) when it will benefit the quality of a patient’s care. The chairman of a clinical department, director of a service, and/or chief of the medical staff may require a consultation if it is determined that a patient will benefit from such a consultation.

Consultations are recommended in instances in which the patient exhibits severe psychiatry symptoms. It is the physician’s responsibility to see that the consultation is obtained as soon as a patient requires immediate consultation.

Psychiatric consultation should be requested for, and offered to all patients who are emotionally ill, who become emotionally ill in the hospital, or who suffer the results of alcoholism or drug abuse. Those patients requiring services not available at Fountain Valley Regional Hospital shall be referred to a facility which provides the appropriate service. No patient may be held involuntarily without the initiation of the 5150 procedure.

Any patient known or suspected to be suicidal in intent and not admitted to the ICU for acute medical problems, shall be required to have twenty-four (24) hour attendance. This requirement can be lifted, once it is determined by psychiatric examination that the patient is not a danger to self or others. Once medically stable, the patient should be transferred to an appropriate facility for care.

17. Disagreements with ER Physicians About Patient Admissions
If the Emergency Physician feels that an ER patient should be admitted to the hospital and the ER call panel physician disagrees, the call panel physician must come to the ER to see the patient, before the patient is discharged from the ER.

18. Hand-off Communications
The primary objective of a “hand-off” communication is to provide accurate information about a patient’s care, treatment and services, current condition and any recent or
anticipated changes. The information communicated during a hand-off must be accurate.

Hand-offs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.

Hand-offs include up-to-date information regarding the patient's care, treatment and services, condition and any recent or anticipated changes.

Interruptions during hand-offs should be limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

Hand-offs require a process for verification of the received information, including repeat-back and read-back as appropriate.

The receiver of the hand-off information has an opportunity to review relevant patient historical data, which may include previous care, treatment and services.

Appropriate hand-off communication is a requirement of the medical staff.

19. **Informed Consent**

In accordance with the California Healthcare Association Consent Manual, Title 22, and the Hospital’s Administrative Policy & Procedure, it is the responsibility of all members of the medical to staff to obtain a patient's informed consent for treatment, prior to complex and/or invasive procedures, except in an emergency where a patient’s life is in jeopardy.
SECTION FOUR

1. HIPAA PRIVACY RULE COMPLIANCE

Section 1. Commitment to Privacy Rule Compliance.

The use and disclosure of health information is governed, in part, by the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (the "Privacy Rule"). Medical Staff members and allied health providers authorized to provide services at the Hospital shall protect the privacy of patients' health information as required by the Privacy Rule, other applicable law and the Hospital's privacy policies and procedures. Further, the Medical Staff and allied health providers are committed to protecting the privacy of patient health information in a manner that reasonably minimizes disruption to quality patient care.

Section 2. Organized Health Care Arrangement.

The Privacy Rule permits multiple health care providers that are Covered Entities (as defined in the Privacy Rule) and provide health care in a clinically integrated care setting, such as the hospital setting, to declare themselves an “organized health care arrangement.” Organized health care arrangement status generally permits its health care provider participants to use and disclose health information for purposes of treatment, payment and health care operations activities of the arrangement. As such, it protects patient privacy while minimizing disruption to quality patient care. Accordingly, the Hospital has organized an organized health care arrangement to facilitate the appropriate sharing of health information in the Hospital between and among the Hospital, its workforce members and business associates, Medical Staff members and allied health providers authorized to provide services at the Hospital (the "Hospital OHCA").

Section 3. Agreement to Participate in OHCA.

By applying for and exercising clinical privileges at the Hospital, each Medical Staff member and allied health provider with service authorization agrees to participate in the Hospital OHCA.

Section 4. Joint Notice of Privacy Practices.

4.1 Agreement to Comply with Terms of Joint Notice.

The Privacy Rule requires a direct treatment provider that is a Covered Entity to deliver a notice of privacy practices to a patient no later than the provider’s first date of service to the patient. Health care providers that participate in an organized health care arrangement may comply with this requirement by a joint notice. The implementation of a joint notice streamlines compliance with the Privacy Rule. Accordingly, with respect to Protected Health Information (as defined in the Privacy Rule) created or received by a Medical Staff member or an allied health provider in connection with his or her provision
of services in the Hospital, the Medical Staff member or allied health provider agrees to abide by the terms of the joint Notice of Privacy Practices of the Hospital OHCA then in effect unless the Medical Staff member or allied health provider has delivered a written notice to the Hospital specifying that he/she has opted out of the joint Notice of Privacy Practices. If a Medical Staff member or allied health provider opts out, he/she shall reference the Hospital OHCA in their individual Notice of Privacy Practices.

4.2 Revisions to Joint Notice.

The Hospital may revise the Hospital OHCA's joint Notice of Privacy Practices, in its reasonable discretion, upon thirty days notice of a revision (with a copy of the revised joint notice) to the Medical Executive Committee (unless the compliance date of a law necessitates a shorter notice period). If the Medical Executive Committee does not object to the revised joint Notice of Privacy Practices before the expiration of the notice period, it shall become effective and binding upon Medical Staff members and allied health providers with service authorization upon expiration of the notice period.

Section 5. Corrective Action.

Whenever a Medical Staff member or allied health provider with service authorization uses or discloses health information in a manner inconsistent with the Privacy Rule, other applicable law, the Hospital's privacy policies and procedures or the Hospital OHCA's joint Notice of Privacy Practices, such use or disclosure will be deemed disruptive to the operations of the Hospital and contrary to the Medical Staff Bylaws/Rules and Regulations and Hospital policies. If the Medical Executive Committee determines that such an inconsistent use or disclosure has occurred, it may undertake such corrective action as it deems appropriate in accordance with the Medical Staff Bylaws/Rules and Regulations.
SECTION FIVE

GENERAL

1. Identification of High Risk Areas of the Hospital

The medical staff has identified the following high-risk areas of the hospital:
- Emergency Room
- Surgery
- Obstetrics
- Neonatal ICU

2. Categories of Allied Health Professionals Eligible to Apply for Practice Privileges

- Marriage, Family, Child Counselor
- Licensed Clinical Social Worker
- Registered Nurse First Assistant (RNFA)
- RNFA Intern
- Clinical Psychologist
- Speech Pathologist/Audiologist
- Orthotist
- Operating Room Technician
- Occupational Therapist
- Physician's Assistant
- Surgical Orthopedic Technologist
- Reproductive Technologist
- Nurse Practitioner
- RadioFrequency Ablation Techs (RFA)
- Surrogate Non-Clinician Dictators (must be a licensed healthcare provider)
- RN Nurse Midwife

3. Smoking Policy

Fountain Valley Regional Hospital (FVRH) is a smoke-free campus. The campus is defined as all property located within the geographic area bordered by Euclid Street, Warner Avenue, and Mt. Hope. This includes the parking lots (including inside vehicles), grass areas, entrances and exits, and driveways surrounding the main hospital and East Tower. This also applies to all properties or facilities associated with FVRH and vehicles owned or leased by FVRH, which are operated and/or maintained by FVRH personnel. This includes the medical office buildings where the Hospital maintains office space and the areas surrounding those buildings. Tobacco use is defined as holding, carrying or using a lighted cigarette, cigarette, cigar or pipe of any kind, mouth pipetting, emitting exhal- ing smoke of any kind. The Medical Staff supports this policy (ADM-S-6.0).

4. Professional Liability Insurance Limits

The current limits for professional liability insurance coverage for the medical staff and allied health staff are 1,000,000 per occurrence/3,000,000 aggregate, with an insurance carrier admitted to do business in the State of California. From time to time, the Medical Executive Committee may recommend a change in these limits to the Governing Board and when approved, said change will be reflected in these Rules and Regulations.
5. **On-Call Physician Consultants Accepting Patients:**
All on-call physician consultants must assure acceptance of patients in an emergency medical condition regardless of the patient's ability to pay.

6. **Supervision of House Staff**

All House Staff will be under the direct supervision of the attending physician.

If patient care is provided by residents, interns and/or medical students, such care shall be in accordance with the provisions of a program approved by and in conformity with: the Council on Education of the American Medical Association, the American Osteopathic Association Board of Trustees through the Committee on postdoctoral training and the Bureau of Professional Education, the American Dental Association, the American Podiatry Association, or the Education and Training Board of the American Psychological Association and/or the residency training programs of the respective specialty boards.

Except in an emergency, all other patient care by interns, house officers, residents or persons with equivalent titles, not provided as specified above, must be provided by a practitioner with a current license to practice in California, with membership and current clinical privileges on the Medical Staff of Fountain Valley Regional Hospital & Medical Center.

7. **Physician's Assistant (DHS 70706.1) & Nurse Practitioners**

**Application:**
Physician's Assistants and Nurse Practitioners shall apply to the Allied Health Staff in accordance with Article IV of the Bylaws of the Medical Staff.

**Supervision:**
A Physician's Assistant or Nurse Practitioner who practices in Fountain Valley Regional Hospital & Medical Center shall be supervised by a physician member of the medical staff.

**Medical Records:**
Physician’s Assistants and Nurse Practitioners shall be subject to the same requirements regarding the quality and timeliness of documentation in the medical record as their supervising physician(s). The supervision physician(s) will be required to validate and countersign all entries in the medical record, documented by the Allied Health Practitioner being supervised, within twenty-four hours.

**Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation**
Allied Health Practitioners shall be subject to FPPE and OPPE on appointment and periodically.

**Annual Competency Assessment; Allied Health Professionals**
Allied Health Professionals shall be evaluated annually by their supervising physician for current competence.
SECTION SIX

ROUTINE ORDERS OF THE PROFESSIONAL STAFF

1. **Admission Labs**
   Based on assessed patient needs, admission laboratory tests are at the discretion of the attending physician.

2. **It is mandatory that PTT, protime and platelet estimate or count be on the chart prior to tonsillectomy and adenoidectomy surgery.**

3. **A hemogram with a platelet count will be completed for each labor patient on admission.**

4. **Requirement for Pregnancy Test:** A pregnancy test must be performed in the hospital for any patient between the ages of twelve (12) and fifty-two (52) on all women who have not had previous hysterectomy and who are undergoing surgical procedures involving general or conductive anesthesia. If possible, a routine UCG should be done prior to x-rays on all female trauma patients of childbearing age who have not been sterilized. Pregnancy test may be waived by direct order of the admitting physician. Incomplete abortions do not require a pregnancy test.

5. **Therapeutic abortion procedures** will require a positive pregnancy test, blood type and Rh factor.

6. **Preop Lab Work:** Based on assessed patient needs, by both the surgeon and anesthesiologist, the appropriate lab work will be performed and recorded within seventy-two (72) hours prior to surgery. In an extreme emergency*, this requirement may be waived.

   Patients who are being screened or cross matched for blood must complete this component within seventy-two (72) hours prior to the scheduled surgery date.

   *Emergency is defined as a condition which could result in serious permanent harm to a patient or in which life of the patient is in immediate danger and any delay in administering treatment would add to that danger.

7. **An electrocardiogram and chest x-ray are recommended on all surgical patients, age fifty-five (55) and over for females and fifty (50) and over for males, who will be undergoing general anesthesia.**

8. **Pulmonary function testing will require a written order by the physician.**

9. **Outpatients scheduled for treadmills and EKG's** must have a prescription from the referring practitioner which should include a rationale for the exam.

10. **Critical cases falling in the category of pediatric care** will be admitted to the Pediatrics ICU unless the unit is full at which time, patients can be admitted to the ICU.
11. **Rule Out Myocardial Infarction Protocol** is:

   a. Admit to ICU or Telemetry
   b. Myoglobin and Troponin on admission (or in ED) and repeat in 4 Hours.
   c. CBC, UA, lipid panel, BMP, PT, PTT STAT
   d. CKMB/CK every 8 hours x 3; then QAM for 2 days
   e. CPK isoenzyme if CPK elevated.
   f. EKG on admission and PRN chest pain
   a. Consider Beta Blocking agent and anticoagulation

12. **Laboratory tests performed in acceptable outside State licensed laboratories** will be accepted if performed within seven days of admission, with a copy of the test available on admission for the patients chart.

13. **Whenever a myelogram is ordered**, consultation with either an orthopedic surgeon, neurosurgeon or neurologist is mandatory, with the consultant concurring in the request for myelography.

14. **X-ray In Hand At Admission**:

   Written interpretation of x-rays which are performed outside of the Hospital may be accepted with the film; however, they must have been taken within thirty (30) days prior to admission. These x-rays may be subject to interpretation by the Hospital Radiologist and may have to be repeated in the hospital if immediately indicated.

15. **EKG’s In Hand At Admission**:

   Written interpretation of EKG’s which are performed outside of the hospital may be accepted with the EKG, however, they must have been performed within the past seven (7) days prior to admission. These may be subject to interpretation by a panel Cardiologist and may have to be repeated at the time of admission, if immediately indicated.
SECTION SEVEN
OPERATING ROOM GUIDELINES & GENERAL RULES REGARDING SURGICAL CARE

Scheduling:

1. Surgical cases will be scheduled with the following provisions:
   a. Maximum of 9 Operating Rooms until 3 p.m. 5 days a week.
   b. Maximum of 6 Operating Rooms including Open heart rooms will be available until 5 p.m. for emergencies and Add on cases. General emergency case may bump one of the general anesthesia rooms.
   c. Maximum of 5 operating rooms including Open Heart Room will be available until 7p.m. for emergencies and add-on Cases. General emergency cases may bump one of the general anesthesia rooms.
   d. Two General operating rooms for add-on cases will be available until 9 p.m. One additional room is available ONLY for emergencies. In addition, another Open Heart Room is available for cardiac emergencies.
   e. All add-on cases and elective cases must be scheduled with the reasonable expectation that the patient will leave the Recovery Room by 11 p.m.
   f. One OR will be available for emergencies ONLY from 11 p.m. until 7 a.m.

2. Weekend elective surgical cases will be scheduled with the following provisions:
   a. Maximum of 4 operating rooms will be available on Saturdays.
   b. Maximum of 2 rooms available for elective general cases. One room until 3 p.m. and the other room until 5 p.m. The 3rd room is ONLY for urgent/emergent cases. In addition, a cardiac operating room will be available for urgent/emergent cardiac cases.
   c. Saturday elective scheduling will be offered on a “to follow” basis only.
   d. On Sundays, 2 general operating rooms will be available ONLY for urgent/emergent general cases. One additional room will be available for cardiac urgent/emergent cases.
3. Cardiac Anesthesia coverage will be available 24 hours a day, 7 days a week.
4. Neonatal Anesthesia coverage will be available 24 hours a day, 7 days a week.
5. Obstetrical Anesthesia “In house” coverage will be available 24 hours a day, 7 days a week.
6. Each Friday, the surgery schedule will begin at 0800 to allow for OR inservice.
7. A time may be held for a doctor no more than two (2) hours. If the office does not call back with the required information after two (2) hours, the time will be automatically released.
8. Names of the surgeon and assistant must be listed on the printed OR schedule.
9. Block scheduling is allowed. Any surgeon or group of surgeons desiring block time must receive prior approval by the OR Block Committee. Uncommitted block time must be released five (5) scheduling days prior to the day of surgery.
10. When there are cancellations in the schedule, the charge nurse and/or the scheduler will attempt to consolidate the schedule. Surgeons will not be allowed to schedule procedures in the cancelled time slot that are too lengthy for the allotted time.
11. In the event that an emergency* surgery must take precedence over a procedure already scheduled, the surgeon with the emergency must confer with the scheduled surgeon to determine which procedure must be done first.

If an agreement cannot be reached, the Chairman of the Department of Surgery is to be contacted for a solution. The surgeons and/or the Chairman of Surgery must then notify the OR staff regarding which case will be performed first.

*Emergency is defined as condition which could result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

**Dual Responsibility for Patient Care**

1. A patient admitted for dental care is the dual responsibility of the dentist member and physician member of the Medical Staff.

   a. The Dentist is responsible for:
      i. a detailed history justifying hospital admission;
      ii. a detailed description of the examination of the oral cavity and a preoperative note;
      iii. a complete operative report, describing the findings and technique. In cases of extraction of teeth, the Dentist shall clearly state then number of teeth and fragments removed;
      iv. progress notes as are pertinent to the oral condition;
      v. clinical resume.
b. The Physician is responsible for:
   i. medical history pertinent to the patient’s general health;
   ii. a physical examination to determine the patient’s condition prior to anesthesia and surgery;
   iii. supervision of the patient’s general health status while hospitalized.

c. The patient’s discharge shall be on written order of the Dentist.

2. A patient admitted for podiatric care is the dual responsibility of the podiatrist member and physician member of the Medical Staff.

   a. The Podiatrist is responsible for:
      i. a detailed podiatric history justifying hospital admission;
      ii. a detailed description of the examination of the feet and a preoperative diagnosis;
      iii. a complete operative report, describing the findings and technique;
      iv. progress notes as are pertinent to the condition of the feet;
      v. clinical resume.

   b. The Physician is responsible for:
      i. medical history pertinent to the patient’s general health;
      ii. a physical examination to determine the patient’s condition prior to anesthesia;
      iii. supervision of the patient's general health status while hospitalized.

   c. The patient’s discharge shall be on a written order of the Podiatrist.
Preoperative Requirements

1. Except in severe emergencies*, the preoperative diagnosis and laboratory tests must be recorded on the patient’s medical record prior to any surgical procedure. If not recorded, the operation shall be postponed. In any emergency, the attending physician and/or surgeon shall make at least a comprehensive noted regarding the patient’s condition prior to induction of anesthesia and start of surgery.

   When the surgeon is other than the admitting physician, a written consultation must also be on the chart prior to surgery.

   *Emergency is defined as a condition which could result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

2. If a patient is actively bleeding, hemoglobin and hematocrit shall be done as close as practical to the time of surgery.

3. An electrocardiogram and chest x-ray are recommended on all surgical patients, age fifty-five (55) and over for females and fifty (50) and over for males, who will be undergoing general anesthesia and will be done unless specified otherwise by the practitioner in his written orders.

4. A coagulation screen consisting of a Pro Time, PTT and platelet count or estimate is mandatory prior to tonsillectomy and adenoidectomy.

5. Anesthesiologists will make individualized arrangements for preoperative anesthetic evaluations.

Consents

1. A written order for consent for surgery must be on the physician’s order sheet. Written, signed, witnessed surgical consent shall be obtained prior to all invasive procedures except in those situations wherein the patient’s life is in jeopardy and suitable signature cannot be obtained due to the condition of the patient. The physician is responsible for documenting informed consent. This includes discussing with the patient the risks, benefits and alternatives to the procedure being performed. In emergencies, patients for which consent for surgery cannot be immediately obtained from the patient, parents, guardian or next of kin, a consultation shall be required in order to determine the existence of an emergency situation which requires immediate treatment without further delay.

   In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained, the physician must fully document the nature of the emergency and the need to perform surgery to avoid jeopardy to the patient’s life or health.

2. Should an additional surgery be required during the patient’s hospitalization, an additional consent must be obtained.
3. If two (2) or more specific procedures are to be performed at the same time by the same surgeon, they may all be described on the same consent form.

4. If two (2) surgeons are performing two (2) separate procedures, each must have a separate consent.

5. Consent for exploratory laparotomy should state “Exploratory Laparotomy” and list alternatives of major differential diagnostic possibilities.

6. The Fountain Valley Regional Hospital and Medical Center Sterilization permit, in addition to the surgical consent, is required on all females under age fifty-two (52) and on all males, undergoing a surgical procedure which will render them sterile.

   The additional State of California Consent for Sterilization must be signed prior to elective primary sterilization procedures following the rules of the CHA Consent Manual

   The Hysterectomy Informed Consent must be signed by patients having this procedure for other than primary sterilization.

7. Transfusions (Gann Act):

   The physician must document informed consent for blood transfusion prior to the patient going to surgery.

Assistants:

1. If an assistant is required, but not present at the beginning of a case and within the Operating Room area, the primary Surgeon and Anesthesiologist will determine if it is safe to proceed with the surgery, excluding cardiac surgery, in which both the cardiac surgeon and first assistant must be present in the surgery suit prior to the induction of anesthesia. The assisting surgeon may be a general surgeon.

   (The OR area is defined as the Operating Rooms, locker rooms, surgical lounge, recovery room and related spaces.)

2. Minor surgery is classified as:
   a. usually less than one (1) hour surgery time;
   b. small number of instruments;
   c. simple prep and drapes;
   d. no assistant required.

3. The following procedures REQUIRE an assistant:

   **Obstetrical/Gynecological Procedures**

   Abdominal excision of cervical stump
   Abdominal Hysterectomy
   Anterior exenteration
   Anterior repair and Kelly Plication
   Cesarean section
   Closure of Rectovaginal Fistula by low anastomosis Stapler-EEA
Excision of vulva skin with split thickness skin graft
Fimbrioplasty
Goebell-Stoeckel fascia lata sling operation for urinary incontinence
Jones operation for correction of double uterus
Laparotomy Ovarian cystectomy
Laparotomy Ovarian cystectomy
Laparotomy Salpingectomy
Laparotomy Wedge resection of the ovary
Le Forte operation (for uterine prolapse)
Manchester operation
Marshall-Marchetti-Krants operation
McIndoe Vaginoplasty for neovagina
Mering operation (for pruritus vulva)
Operative Laparoscopy – At the surgeon’s discretion
Panniculectomy
Posterior exenteration
Radical vulvectomy with Bilateral superficial inguinal lymph node dissection
Radical Wertheim Hysterectomy with Bilateral pelvic lymph node dissection
Reconstruction of the vulva with Gracilis myocutaneous flaps
Reconstruction of vagina by Gracilis Myocutaneous flap
Rectovaginal fistula repair reconstruction of the urethra
Richardson composite operation (for uterine prolapse)
Simple vulvectomy
Staging of Gynecologic Oncology patients with exploratory laparotomy
Total pelvic exenteration
Total vaginal hysterectomy with and without bilateral salpingo-oppherectomy
Total vaginectomy
Transection of Goebell-Stoeckel fascia strap
Tuboplasty reanastomosis of the fallopian tube
Tuboplasty reimplantation of the fallopian tube
Vesicovaginal Fistula Repair
Warren flap operation for fourth degree tear
Williams operation for neovagina

Other Surgical Procedures
Abdominal aortic aneurysm
Abdominal perineal resection
Adrenalectomy
Aneurysm, Cerebral
Aortic Valve Replacement
Aorto Bifemoral Bypass Graft
Coronary Artery Bypass Graft (See CV/TS Division Rules & Regulations)
Esophagectomy Surgery
Exploration Laparotomy for Pelvic Mass
Gastric Stapling
Hepatic Surgery, Major
Hernia Repair, Diaphragmatic
Hernia Repair, Hiatal
Ileal Conduit
Intracranial Vascular Reconstruction
Lobectomy, Pneumonectomy
Mitral Valve Replacement
Nephrectomy-Partial/Total
Open Heart Procedures (Septal Defect, etc.)
Pancreatic Surgery
Parotidectomy
Suprapubic Prostatectomy
Thoracic Aneurysm
Whipple Procedure

When an assistant is required, the procedure must have progressed to the point where an assistant is no longer needed and, at the discretion of the surgeon, the assistant may leave the suite. It is understood that the first closing sponge, needle and instrument count must be completed and correct before the assistant may leave.

In the case of a cesarean section, the peritoneum must be closed before the assistant may leave.

4. When a breast biopsy with possible mastectomy is scheduled by a physician with privileges for biopsy only, a surgeon with the privileges to perform a mastectomy must be available in the hospital when the biopsy is performed. Additionally, said surgeon must see the patient and complete a consultation prior to surgery.

5. Medical students cannot be used as first assistants.

6. To insure the availability of surgical back-up at all times, even during an emergency which renders the primary surgeon incapable of continuing a procedure, the following procedure will be followed:

a. If there is another surgeon already assisting at the procedure, he/she will assume the primary surgeon role and responsibilities and will proceed with the procedure.

b. If another specialist other than a surgeon was assisting (i.e., Family Practitioner), or if the role of requisite surgeon assistant is vacated due to the assistant taking over, then the following steps will be initiated to obtain another surgeon:
   i. During regular business hours, the OR will contact the switchboard to overhead page "any available surgeon report to the OR". If there is no response within a reasonable time frame, Medical Staff Services will be contacted and requested to call surgeons on campus to determine availability and secure an assistant.
   ii. During the evening and night hours, the OR will contact the ER and request that the surgeon on the back-up panel be contacted and called in to assist.

c. If an assistant is needed but a surgeon is not required as the assistant, Steps b i) and ii) will be followed with the pages and calls being directed to physicians who have assisting privileges, (i.e., "any available surgical assistant report to the OR")

d. In all cases, appropriate measures will be taken to stabilize and maintain patient health and safety.
Admission Procedure

1. At least one (1) day prior to surgery, but no more than seven (7) days prior, the patient reports to the O.P. admitting office and completes the necessary forms. The patient is informed that admission to the hospital may be required in the event of unforeseen circumstances and signs the Conditions of Admission from in the event that he/she must be admitted.

2. The patient is then directed to the pre-admission Nurse where a brief assessment is done, orders are checked, and the patient is directed to the appropriate departments for preoperative tests.

3. When tests are complete, the patient returns to the Pre-admission Nurse and the patient Instruction Sheet is reviewed. The patient signs the instruction sheet and is given a copy.

4. The day of surgery, the patient returns to a nursing floor three (3) hours prior to the surgery and nursing personnel prepare the patient for surgery at the appropriate time.
   a. Patients are instructed prior to the day of surgery to leave valuables at home. All items brought by the patient are given to the responsible adult accompanying the patient.
   b. Regardless of the time of surgery or at what time the patient will arrive, the chart, with History and Physical and all available lab work will be present in the chart on the surgical floor for review by the anesthesiologist by 6:00 a.m.

Day of Surgery:

1. The time scheduled for surgery is considered induction time. To make this possible, it is necessary for the surgeon and his assistant (when one is required) to be present at least fifteen (15) minutes prior to the scheduled time.

2. The surgeon shall provide appropriate pre and postoperative diagnosis at the time of surgery.

3. Sponge and needle counts are performed on every case. An instrument count is done on all intra-abdominal and intra-thoracic procedures. If any count is incorrect, an x-ray must be taken.

4. The Anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient’s condition. The Anesthesiologist can order any necessary tests or extra care which he/she may feel indicated.

5. All specimens removed during surgery (including teeth and fragments) shall be sent to the Hospital Pathologist who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. The Pathologist’s authenticated report shall be made a part of the patient’s medical record. Any retained hardware, foreign bodies, etc., shall also be sent to the Hospital Pathologist for purposes of identification. Examinations which cannot be made in the Hospital Laboratory shall be referred to an outside, approved Laboratory.
6. All surgical procedures shall be fully described and dictated, by the surgeon, for transcription immediately following the surgical procedure. No “routine” operative reports will be accepted. Findings cannot be “routine”.

7. The surgeon must remain in the Hospital, for all patients requiring general or spinal anesthesia, until the patient is transported to the Recovery Room or ICU.

8. The operating surgeon is responsible for following the patient unless the patient does not need to be followed surgically.

**Students, Observers, Vendors, Allied Health Affiliates**

In all situations where an outside observer or student will be present in the OR, the patient must be informed and permission given. Additionally, the appropriate confidentiality statements must be signed by the student or observer.

1. Students enrolled in teaching programs supported by this Hospital are allowed in the OR for appropriate surgery experience provided they are accompanied by the appropriate supervisory personnel and/or Medical Staff members.

2. Surgical supply/equipment vendors may be permitted in the OR for the purpose of demonstrating the use of their equipment but will not participate in the performance of the surgical procedure.

3. Allied Health Affiliates (i.e., private scrub nurses) may be permitted in the OR after having completed the credentialing process as outlined in the Medical Staff Bylaws.

**Discharge Procedures:**

1. Following surgery and recovery, the patient is transferred to the unit until a discharge score is met.

2. Discharge criteria includes:
   a. Vital signs stable;
   b. Swallow, cough and gag reflex present;
   c. Able to ambulate;
   d. Tolerates clear liquids;
   e. Absence from respiratory distress;
   f. Alert and oriented.

3. The anesthesiologist will document the presence or absence of anesthesia complications prior to discharge from the Recovery Room for those patients who receive other than local anesthesia.

4. Written Discharge Instructions, as ordered by the surgeon, are given to the patient, with any necessary explanations. A copy of these instructions remains on the chart.

5. The patient is discharged via wheelchair, accompanied by a responsible adult.
6. Patients having received general anesthetic and/or IV sedation are not allowed to drive themselves from the Hospital.

**Secondary Treatment Surgeries:**

**These procedures will not require that all preoperative orders be rewritten:**

1. Bronchoscopy, colonoscopy, gastroscopy
2. Casting/dressing change
3. Chest tube insertion
4. Closed reduction
5. Cystoscopy
6. Debridement
7. Invasive Line Placement
   a. Central Lines
   b. Hickman Catheter or equivalent
   c. Swan-Ganz
8. Pin Removal
9. Tracheotomy
10. Minor Repair of Lacerations

## SECTION EIGHT

**OUTPATIENT SURGERY**

Outpatients scheduled for surgery shall follow the following procedure:

The purpose of the Outpatient Surgery Service is to permit the healthy patient to have a minor operation in a comfortable, safe and sterile surrounding with minimal separation from family and home.

**Criteria**

This program will only accommodate those patients for which ambulatory surgical service would be a proper service. The following factors are to be considered in determining if the service should be used:

1. **Class I** - No organic, physiologic, biochemical or psychiatric disturbance. Normal healthy patient.
2. **Class II** – Mid-moderate systemic disturbance; may or may not be related to reason for surgery (i.e., hypertension, and diabetes mellitus).
3. **Class III** – Patient with systemic disease that may limit activity and maybe incapacitating. Defined as a patient with existing disease, controlled or not.

Cases scheduled for general anesthesia will require:

1. A recent patient history and record of physical examination. H&P performed and recorded by a qualified M.D. within previous 24 hours. H&P may be brief, however, must
describe examination of the area of the body to be affected by surgery, heart, lungs and orientation.

2. HCT can be ordered at the discretion of the Anesthesiologist or the Surgeon except under the following conditions; pediatric patients under 2 years old, patients over 70 years old and co-morbidities such as, history of anemia, bleeding, other bleeding disorders, invasive procedure.

3. Appropriate screening tests, based on the needs of the patient, accomplished and recorded within 72 hours prior to surgery.

4. UCG within a week of surgery on all menstruating females 55 years and younger. Exceptions would be history of tubal-ligation or hysterectomy.

5. Basic metabolic panel is not required routinely unless medically necessary. Patients under going dialysis, history of renal failure, diabetes, on diuretics, - with in 24 hours of surgery. For neonates and very young patients within a week of surgery.


7. EKG, CXR and other lab tests will be at the discretion of the surgeon and or anesthesiologist.

   a) EKG Exceptions – Patients categorized as Class III – Within 3 months of surgery acceptable for males 50 years and older and for females 55 years and older (assuming there are no active anginal symptoms).

   b) CXR – Routine testing not required. Patient must have a documented clinical indication. Usually acute, clinically apparent, respiratory symptoms, or changes in chronic respiratory symptoms.

8. PT & PTT: Routine testing not required unless medically indicated for patients undergoing tonsillectomy and for all patients currently taking anti-coagulant medications within a week of surgery. All other times – at the discretion of the surgeon and or the anesthesiologist.

9. Type and Screen: All patients who have donated autologous blood units or have directed donor units available.

10. The assigned anesthesiologist will have the right to cancel any scheduled surgery when, in his/her opinion, the patient is not a satisfactory risk.

Surgical procedures acceptable for outpatient surgery include, but are not limited to:

   a. Dilation and Currettage, Therapeutic Abortion
   b. Cystoscopy with or without retrograde studies
   c. Circumcision
   d. Urethral Dilatation
   e. Myringotomy
   f. Excision or biopsy of skin or subcutaneous tumor
   g. Removal of foreign body
h. Hernia
i. Esophagoscopy with or without dilatation
j. Bronchoscopy
k. Laryngoscopy
l. Orthopedic procedures
m. Cast change or application
n. Joint manipulation
o. Closed reduction
p. Routine dental operative procedures
q. Minor podiatry procedures
r. Augmentation mammoplasty
s. Laparoscopy with or without tubal ligation
t. Tonsillectomy and Adenoidectomy
u. Cataract extraction and certain eye surgeries
v. Breast biopsy

Anesthesia and elective surgery on outpatients may be performed in any of the operating rooms in the surgery suit. Post-anesthesia recovery care is given in the Recovery Rooms of the hospital.

Anesthesia Care:

1. Selection of anesthetic agents to be used will be left to the discretion of the Anesthesiologist, or if local anesthesia is used with no Anesthesiologist standby, to the discretion of the surgeon. Class III & IV patients will have an Anesthesiologist standby.

2. Spinal, extremity blocks, caudal and epidural anesthesia may be done at the discretion of the anesthesiologist.

Preoperative Requirements:

1. Patients must be NPO 8 hours prior to the start of surgery.

2. Based on assessed patient needs, by both the surgeon and anesthesiologist, the appropriate lab work will be performed and recorded within seven (7) calendar days prior to the surgery date. In an extreme emergency*, this requirement may be waived.

Patients who are being screened or cross matched for blood must complete this component within seventy-two (72) hours prior to the scheduled surgery date.

*Emergency is defined as a condition which could result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

3. Chest X-ray & EKG:
   Female Patients: Fifty-five (55) years of age and over having general anesthesia, unless ordered otherwise or surgeon documents recent reports.

   Male Patients: Fifty (50) years of age and over having general anesthesia, unless ordered otherwise or surgeon documents recent reports.
4. A pregnancy test must be performed in the Hospital on all women between the ages of twelve (12) and fifty-two (52) who have not had previous hysterectomy and who are undergoing surgical procedures involving general or conductive anesthesia. Pregnancy test may be waived by direct orders of the admitting physician if he documents sterilization or recent reliable laboratory pregnancy test.

5. Laboratory test performed in acceptable outside state licensed laboratories will be accepted if performed within seventy-two (72) hours with a copy of the test available on admission for the patient’s chart.

6. A surgery consultation should be on the chart if the surgeon is not the admitting physician.

SECTION NINE

Medical Staff Policies and Procedures

Policies and Procedures of the Medical Staff, approved by the Medical Executive Committee and the Governing Body, shall become a part of these Rules and Regulations.

Reviewed, Revised, Approved:

September 27, 2012 Medical Executive Committee
October 4, 2012 Governing Body