THREE RIVERS HOSPITAL

RULES AND REGULATIONS OF THE MEDICAL STAFF

ADMISSION POLICIES Revised 01-2016

1. The hospital will admit patients suffering from all types diseases, except where facilities and personnel are insufficient to provide adequate and proper care.

2. A patient may be admitted to the hospital only by a physician, podiatrist, certified nurse midwife or dental member of the Medical Staff. Physician Assistants and Consulting Medical Staff Members will admit patients in consultation and conjunction with an Active Staff Member. All physicians will be governed by the official admitting policies of the hospital. These rules and regulations shall be applied to all active medical staff members, including physicians and nurse midwifes.

3. Except in emergency, no patient will be admitted to the hospital until a provisional diagnosis or a valid reason for admission has been stated by the admitting physician. In the case of an emergency, such information will be recorded as soon as the emergency no longer exists, and in all cases within twelve hours of the time a patient is admitted.

4. Physicians who admit patients will be held responsible for giving such information as may be necessary to assure the protection of others when his patient might be a source of danger from any cause whatever.

5. A patient to be admitted on an emergency basis who does not have a private physician or who does not indicate a preference for a specific physician, will be assigned to the physician, who is on back up call for that day of admission.

6. Except in emergency, where the condition of the patient precludes the ability of the admitting physician to obtain information, the admitting physician will be held responsible for preparation of the history and physical examination of the patient. In all instances, the admitting physician or physician assistant is responsible for documenting the reason for admission, the known history of present illness, and the physical examination. When the emergency no longer exists and it is possible to obtain information from the patient, his relatives, or other reliable sources, the physician in charge of the patient's care at that time will be held responsible for recording the history.

7. The time frame for completing the history and physical examination (H&P) shall be no more than 30 days before or 24 hours after admission, but before a surgical procedure. The H&P documentation must be available in the patient's medical record within 24 hours of admission. "Admission" means any inpatient or outpatient admission.

   If the H&P is recorded within 30 days before an admission, an updated medical record entry documenting an exam for any changes in the patient's condition must be completed and included in the medical record within 24 hours after admission and before surgery. The update can be brief and, if applicable, the practitioner may make an entry in the record stating that the H&P was "reviewed, the patient was examined, and that 'no change' has occurred in the patient's condition since the H&P was completed".

   If the primary provider chooses to "delegate" the H&P to another qualified practitioner, including mid-level practitioners, the delegated practitioner as well as the delegating practitioner will both be required to authenticate the H&P.

   If the patient has been hospitalized within the last 30 days, an interval H&P note to included changes in the patient's condition may be accepted. A copy of the previous H&P will be placed in the current chart for reference.

8. The admitting physician will be held responsible for admitting orders, for orders for drug or other therapy, for orders for diagnostic examination, for necessary special instructions and for diet served to the patient. The admitting physician's responsibility for the patient's care continues until and/or unless he turns that responsibility over to another physician.

9. Patients admitted for elective procedures will be required to have all of the pre-admission information, including financial arrangements, completed prior to their admission. Failure of the patient to comply with this policy may result in the patient being denied admission for the elective procedure unless the attending states, in writing, that delay would constitute a hazard to the patient.

10. Each member of the Medical Staff who does not reside in the immediate vicinity will name a member of the medical staff who is a resident in the area who may be called to attend his patient in an emergency or until he arrives. In case of failure to name such as associate, the physician with emergency duty will be called.

11. A member of the medical staff will be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the patient, to the relatives, and to other concerned associates of the patient. Whenever these responsibilities are turned over to another physician, a note covering the transfer of care will be entered on the order sheet of the medical record. However, in order to ensure continuity of care, no patient may be turned over to another physician unless/or until the patient and the other physician are contacted and agree to the transfer of care.

12. Patients admitted for care by Allied Health Professionals will be admitted under the care of a physician member of the Active Medical Staff. The physician supervising the care of the patient will be held responsible for the medical survey of the patient to include the medical history, physical examination, preoperative, intra-operative and postoperative management of the patient. The Allied Health Professional will provide the technical details of surgery and/or clinical care and the documentation thereof.

13. A Short Stay category of admission will be applied to those cases where the services being received do not meet intensity of service for an acute care admission as defined by Medicare standards. Medical record requirements for these patients will include a note that includes the reason for admission and/or observation as well as physical findings of the patient, and a brief summary note to include the final diagnosis, resolution of the admitting complaint as well as instructions for follow-up if needed.

14. Swing Bed patient status is a service available for patients who were treated in an acute stay admission for at least three days, but no longer meet the intensity of service criteria as defined by Medicare standards, but continue to need skilled nursing services with physician supervision. This kind of patient will be discharged from acute care and a new medical record will be initiated. Medical Record requirements for Swing Bed status will be the same as those required for short stay patients to include the reason why swing bed status is needed, plus a copy of the acute stay history and physical.

15. The Three Rivers Hospital has defined our Qualified Medical Personnel (QMP) as a physician, PA or mid level practitioner who is on call in the emergency room. This QMP is authorized to do medical screening examinations in consultation with an MD prior to a patient being transferred out of the ER to another institution.

DISCHARGE POLICIES

1. Patients will be discharged only on order of the attending physician. Should a patient leave the hospital against the advice of the attending physician or without his knowledge, a notation of the incident will be recorded in the patient's medical record by the charge nurse on duty. Every effort should be made by the nursing and/or hospital staff to obtain a signature by the patient, acknowledging that they are leaving "Against Medical Advice", when that is the case.

2. No patient will be transferred to another medical facility until that facility has been contacted and proper arrangements have been made for the continuing care of the patient, in accordance with the COBRA Act of 1990.

3. The primary physician in charge of the patient's care is responsible for providing the final diagnosis and preparation of required discharge information, such as a discharge note or discharge summary within 48 hours past discharge. The physician in charge of the patient's care at the time of discharge is responsible to provide discharge instructions to the patient or others responsible for his care.

4. In the event of a hospital death, the deceased will be pronounced dead by the attending physician or other appropriate member of the hospital staff within a reasonable length of time.

5. It will be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy will be performed only with written consent signed by an authorized representative of the patient. When autopsies are performed, provisional anatomic diagnosis will be made part of the medical record within fifteen (15) days, except in unusual cases.

6. A stillborn fetus over 28 weeks gestation will require a stillborn certificate. When a stillborn is delivered in the hospital it will be reported to the medical record personnel so that a certificate may be issued.

PATIENT SERVICES

1. Equitable and humane treatment at all times and under all circumstances is the patient's right. In practical terms, it means that no person will be denied impartial access to treatment and accommodations that are available and medically indicated, and that the hospital will treat patients suffering from all types of diseases and/or injuries, except in cases where facilities or personnel are insufficient to provide adequate and proper care.

2. A written, signed, informed consent will be obtained prior to treatment, except in those situations wherein the patient's life is in jeopardy and suitable consent cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which a consent cannot be immediately obtained from parents, guardian or other responsible representatives, these circumstances will be fully documented in the patient's medical record.

3. The patient's right to privacy extends to the preservation of the confidentiality of his disclosures and should be such that he can communicate with his/her physician in confidence. To preserve this right, no privileged information will be released by the hospital without the written consent of the patient or his authorized representative and only to those specifically authorized by the patient to receive the information, except those required by State Laws.

4. Every patient who enters the hospital for treatment retains certain rights to privacy, which will be protected by the hospital without respect to the patient's economic status or source of payment for his care. Thus, representatives of agencies not connected with the hospital, and who are not directly or indirectly involved in the patient's care, will not be permitted access to the patient for the purpose of interviewing, interrogating or observing him, without his express consent on each occasion when such access is sought, except those required by law.

5. The patient's dignity is reflected in the respect accorded by others to his need to maintain the privacy of his body. To the extent possible, given the inescapable exposure entailed in the provision of needed care, the patient will be aided in maintaining this privacy, and as far as possible to shield him from the view of others.

6. The patient has the right to expect that every person providing services to him in the hospital is legally and professionally qualified and technically competent to provide these services. Complaints by the patient or others authorized to act in his behalf will be acknowledged and investigated by the medical staff and/or the hospital administration.

CONSULTATIONS

1. The hospital has a "Consulting Medical Staff" which consists of physicians who have documented evidence of specialized training, experience and competence in their area of expertise. When, according to the judgment of the attending physician, consultation is indicated he will make arrangements for his patient to be seen in consultation by a consultant when he is available at the hospital or via telemedicine consultation.

2. Whenever consultation is indicated and a member of the Consulting Medical Staff is not available in the hospital, the attending physician will determine who, among his peers, is best qualified to give an opinion in the field in which his opinion is sought. He will provide the necessary authorization to permit the consultant to examine his patient.

3. Except in emergency, consultation is required in the following instances:

   A. When the patient is not a good medical or surgical risk;

   B. Where diagnosis is obscure after ordinary diagnostic procedures have been completed;

   C. There is doubt as to the best therapeutic measures to be utilized;

   D. In all elective surgical cases where the third-party payor requires consultation prior to surgery; and

   E. When requested by the patient or his authorized representative.

4. A consultation is not complete or satisfactory unless it includes an examination of the patient and review of the patient's medical record. The consultant will make a record of his findings in every case and will sign it. This report will be made a part of the patient's medical record.

5. When consultation is required for elective surgery, the consultation will be completed prior to the performance of the surgery, the consultant will enter a progress note stating that the consultation was performed and the report is available.

6. If it is felt that any case meets the criteria for consultation and one was not obtained, the case will be referred to the Quality Review Committee of the Medical Staff for review. The Quality Review Committee has the delegated responsibility to see that members of the medical staff comply with the State and Federal regulations for obtaining consultations.

PRESCRIPTION OF TREATMENT

1. Orders for treatment may be given for patients in the hospital only by a staff physician, dentist or other person legally authorized to write prescriptions in the State of Washington and in accordance with their prescriptive authority. No change in orders may be made except with the approval of the responsible practitioner, or according to the Therapeutic Interchange Policy, previously adopted by the medical staff.

2. All orders for treatment will be in legible writing or entered into electronic order entry. Verbal orders for drugs shall only be issued in emergency or unusual circumstances and shall be accepted only by a licensed nurse, pharmacist, or physician and shall be immediately recorded and signed by the professional hospital employee to whom dictated with the name of the practitioner per his/her own name. All orders, including verbal orders, must be dated, timed and authenticated promptly, within 48 hours, by the ordering practitioner or another practitioner of the same or higher licensure responsible for the care of the patient.

   With the exception of influenza and pneumococcal polysaccharide vaccines that may be administered pursuant to physician-approved hospital policy after an assessment of contraindications, orders for drugs must be documented and signed by a practitioner responsible for the care of the patient who is authorized to write orders per hospital policy and state law.

3. The professional hospital employees who are authorized to accept orders are: Licensed nurses may receive all orders for patient care. Orders for specific diagnostic or therapeutic treatment may be given to pharmacists, physical therapists, laboratory technicians/technologists, cardiopulmonary therapists or radiology technicians who are functioning within their area of competence. If any professional hospital employee consistently accepts orders that are not within their specific knowledge, skills, abilities or job duties, the privilege of being able to accept orders will be rescinded.

4. All drugs administered to patients will be those listed in the latest edition of the Three Rivers Hospital Formulary, which is available in all locations throughout the hospital where medications are dispensed or distributed for immediate and easy reference by the medical staff and the hospital's professional staff.

5. Orders for administration of medications or for therapeutic treatment will be instructive, accurate and as complete as possible which includes a description of the treatment, the name of each drug or agent used, the dosage, concentration or intensity of the drug, agent and/or treatment, and the time interval, frequency or duration of treatment or medication.

6. Therapeutic diets are prescribed in written orders in the patient's medical record by the attending physician and are as complete as possible. When up-to-date manual of regimens for therapeutic diets are approved jointly by the Dietitian and the Medical Staff, orders for diet as per manual are acceptable.

7. Order sets or guidelines may be formulated by an individual medical staff member or committee. When standing orders or routine orders or guidelines are applicable to a given patient, the orders in their entirety will become a part of the patient's medical record. They must be dated and signed by the responsible practitioner. Order sets or guidelines must be reviewed and approved by the individual practitioner or medical staff in January every two years in order to continue their use.

8. To prevent adverse reaction from certain classes of drugs, automatic stop and rewrite policies that require physicians to re-order these drugs at specified intervals will prevail. Drugs will not be discontinued without consulting with the attending physicians to determine if he wants the drug continued or stopped. The schedule for automatic stop and re-order medications are as follows:

   A. Unless otherwise specified, all previous orders for treatment will be automatically cancelled prior to surgery and new orders written for post-surgical care.

   B. Drugs that are listed in Schedule II, controlled substances that are ordered without time limitation will be flagged for physician review after 72 hours unless they are re-ordered.

   C. Drugs that are listed in Schedule III and IV, controlled substances, that are ordered without time limitations will be flagged for physician review after 5 days unless they are re-ordered.

   D. Antibiotics and anticoagulants that are ordered without time limitations will be flagged for physician review after 7 days unless they are re-ordered.

   E. Corticosteroids that are ordered without time limitations will be flagged for physician review after 5 days unless they are re-ordered.

   F. Oxytocics that are ordered without time limitations will be flagged for physician review after 24 hours unless they are re-ordered.

   G. Drugs administered in combination with Schedule II, controlled substances, are considered to be part of the same order. Therefore, the re-order must include the co-administered drug.

9. A list of standard abbreviations will be maintained by the nursing staff or ward clerk supervisor with review and approval by the Medical Staff.

10. To the extent possible, medications taken by a patient in the hospital will be controlled and documented. Patients who bring their own medications into the hospital will be asked to send them home with their relatives or friends or to give to the nurse or pharmacy for safekeeping while they are in the hospital. If they are given to

the nurse or pharmacy for safekeeping, they will be returned to the patient upon discharge, unless the attending physician writes an order stating that these medications should not be returned to the patient because of possible jeopardy to his health.

11. The attending physician may specifically order that the patient may use his own medications. In such event, medications will be positively identified and examined to ensure acceptable quality for use in the hospital. The medication will be properly labeled and kept in the Pharmacy and administered as ordered by the attending physician. Any medication not used at the time of discharge will be returned to the patient unless the attending physician orders otherwise.

12. Self medication by a patient is permitted only if it is specifically ordered by the attending physician. In such event, medications will be positively identified and examined to ensure acceptable quality for use in the hospital. The order to permit self-administration by the attending physician must include the name of the drug, the dosage, the route of administration, time and frequency.

13. There will be written policies and orders to guide the action of the nurses and other hospital personnel when a medical emergency is imminent or arises and a physician is not present. These will include:

    A. Delineate the circumstances for which particular policies and orders are to be followed;

    B. Delineate the minimum qualifications or training of persons who may execute particular orders;

    C. Provide for a physician to be called as rapidly as possible; and

    D. Be approved by the medical director of each committee; and appropriate representatives of the nursing and administrative staffs.

14. There will be written procedures, approved by the director of each committee, for the use of defibrillation, respirators, and other special medical equipment and for the performance of the special, emergency or medical procedures.

15. Standing orders for administration of a drug or other treatment during an emergency must include: a description of the treatment which includes the name of each drug or other agent; the dosage, concentration or intensity of a drug or other agent; the route or method of administration; and specific criteria for use of drugs or treatment.

16. Orders for medications and treatment will be to treat and improve identified medical conditions of patients and will not routinely be ordered primarily for nursing convenience. Such things as catheters and sedatives will be used only as required by patient condition. Restraints will be used only to assure the protection of the patient from self-harm, or to assure the protection of others when a patient might be a source of danger from any cause whatsoever.

17. Policies will be developed and approved by the medical staff to guide the medical, nursing and administrative staffs in "No Code" situations. These policies refer only to the use of heroic measures such as intubation and life support ventilation, defibrillation, and other emergency medical procedures, not the use of maintenance medications and therapy.

18. All adverse effects or significant variance from acceptable standards of care that are documented in the patient's medical record will be referred to the Medical Staff Quality Review Committee for review, evaluation and, if necessary, recommendations.

19. The Pharmacist will review, analyze and propose drug therapy in a consulting role for hospital inpatients on a discretionary basis or at the request of any medical staff member for his or her individual patient.

INFECTION CONTROL GUIDELINES

1. The Infection Control Committee is delegated the responsibility to evaluate, recommend, and implement policies and procedures, subject to the Medical Staff and Hospital Administration approval, aimed at investigating, controlling and preventing the spread of infections in the hospital. The Infection Control Committee is delegated the responsibility to review, evaluate and make recommendations concerning infections of patients and personnel within the hospital. The committee will develop and implement procedures and criteria for reporting and reviewing infections. The Quality Review Committee will review the policies and procedures of all hospital services concerning infection control measures.

2. The Medical Director of the Infection Control Program is a physician member of the Active Medical Staff, appointed by the Chief of Staff, who is responsible and accountable to the Medical Staff for the overall professional administrative functions of the Infection Control Program.

3. Discharged charts will be screened according to previously approved criteria and referred to the Quality Review Committee for peer review if criteria is not met.

ADOPTION, APPROVAL, EFFECTIVE DATE:

The medical staff shall initiate and adopt these rules and regulations as it may deem necessary for the proper conduct of its work and shall periodically, at least every two years, review and revise these rules and regulations to comply with current staff practice as well as State and Federal guidelines.

ADOPTED by a majority vote of the Three Rivers Hospital Medical Staff, meeting in regular session, with a quorum present on January 20, 2016.

BY: _____
Chief of Staff

APPROVED by a majority vote of the Governing Board of Directors, meeting in regular session, with a quorum present on January 26, 2016.

BY: _____
Chairman, Governing Board of Directors