

VENTURA COUNTY MEDICAL CENTER
GENERAL RULES
OF THE VCMC MEDICAL STAFF
Page 1 of 7

1. ADMISSIONS

- 1.A Provisional Diagnosis Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In cases of emergency, the provisional diagnosis shall be stated as soon after admission as possible.
- 1.B Responsible Physician A physician with appropriate privileges shall be responsible for the medical aspects of admission, hospital care, and discharge of each patient.
- 1.C Private Patients Private patients may be admitted by physicians in private practice who are members of the Medical Staff.
- 1.D Sufficient Information The admitting physician shall be held responsible for giving such information as may be necessary to the protection of the patient from self harm and to assure the protection of others whenever his patient might be a source of danger from any cause whatever.
- 1.E E.R. Medical Screening Exam All patients presenting to the Emergency Room must have a Medical Screening Exam. This may be performed by a physician, or by a nurse practitioner or physician assistant with approved privileges, or registered nurse under standardized procedures(added 10/00)

2. HOUSE STAFF

- 2.A Resident Supervision All patients cared for at VCMC, whether as inpatients or outpatients, are the responsibility of the attending physicians. Care provided to any patient by the house staff is done so under the supervision of the attending physicians. Supervision of house staff by the attending physician occurs through direct patient-physician contact, case discussion, and critical review. All medical records must show written evidence of a clinical review of the patient by the attending physicians. (1/99)
- 2.B Resident Staff Participation The Resident Staff will participate in the diagnosis and care and treatment of such patients unless requested not to participate by the admitting physician. Members of the Resident Staff may write patient care orders. Resident physicians are supervised by members of the Medical Staff in carrying out their patient care responsibilities
- 2.C Residents on Committees Resident Physicians are assigned as non-voting members to all Medical staff Committees. The Chief (Assistant Chief in Chief's absence) shall be assigned to the Medical Staff Executive Committee and they shall work with the Medical Staff for resident assignments for other committees.
- 2.D Residency: Other Policies (Refer to Administrative Policy Manual for more policies regarding residents. Also, see below regarding CPR training).

3. TRANSFER OF PATIENT RESPONSIBILITIES

Whenever the attending physician transfers the patient responsibilities to another staff member, a note covering the transfer of responsibilities shall be entered on the order sheet of the medical record and the physician will be responsible for notifying the physician to whom he/she is transferring the patient. rev 5/96, 1/99

VENTURA COUNTY MEDICAL CENTER
GENERAL RULES
OF THE VCMC MEDICAL STAFF
Page 2 of 7

4. CONSULTATION

- 4.A Psychiatric Consultation All suicide attempt and overdose patients should be offered psychiatric consultation.
- 4.B Consultation Recommended Consultation is recommended for selected critically ill patients and in difficult diagnostic or therapeutic situations where additional expertise might be helpful in resolving the problem:
1. where the patient's condition is deteriorating for unknown reason;
 2. where diagnosis is obscure;
 3. for continued and/or multiple therapeutic choices of unusual complexity;
 4. for situations of unusual risk;
 5. for disease processes or procedures with which practitioner is not fully current or familiar;
 6. where consultation is requested by the patient or family;
 7. when declaration of brain death is required;
 8. when withdrawal of life support is being considered in non-brain dead patients.
- 4.C Required consultation The Department Chief, the President of the Medical Staff, the Medical Director, or the Service Director, may recommend or require consultation where it appears advisable in the interest of patient care.

5. CPR TRAINING REQUIREMENTS

- 5.A Resident Staff and E.R. Resident Staff and Emergency Room physicians shall every two years demonstrate proficiency in C.P.R. to the level of "advanced provider" as delineated by the American Heart Association. Demonstration of proficiency shall include both written and practical examinations.
- New members of the house staff or Emergency Room staff will have three (3) months in which to demonstrate said proficiency. Appropriate courses will be offered within three (3) months of adoption of these regulations. Possession of a current "advanced provider" card from the American Heart Association will be accepted in lieu of the above.
- 5.B Other physician members Physician members of the active, consulting and courtesy staff shall be proficient in C.P.R. Completion of formal training in cardiopulmonary resuscitation is desirable, but not mandatory for completion of this criteria.

6. DISCHARGE

Patients shall be discharged on order of a physician. At the time of discharge, the responsible physician will see that the record is complete, including final diagnosis, procedure reports, discharge summary and record signatures. All records must be completed within fourteen (14) days following the patient's discharge from the hospital.

7. MALPRACTICE

In accepting appointment to the Medical Staff, each practitioner agrees to notify the hospital of all malpractice actions and their eventual outcome.

VENTURA COUNTY MEDICAL CENTER
GENERAL RULES
OF THE VCMC MEDICAL STAFF
Page 3 of 7

8. MEDICAL RECORDS

- 8.A Responsible physician The responsible physician shall complete the medical record for each patient.
- 8.B Attending staff documentation Every medical record shall contain written evidence of patient care and critical review of the patient by a member of the attending staff.
- 8.C Entries All medical record entries will be legible, dated and signed (01/02)
- 8.D Medical Record Content The Medical Record shall contain the following information
- 1 Identification Data.
 - 2 Medical History and physical pursuant to section 8E below
 - 3 Diagnostic and therapeutics Orders pursuant to section 8F below
 - 4 Informed consent, where appropriate
 - 5 Reports of procedures, tests and results (Operative notes will be completed pursuant to section 8G below) .
 - 6 Progress notes pursuant to section 8H below.
 - 7 Consultation reports
 - 8 Discharge summary pursuant to section 6 above and 8I below
- 8.E Medical History & Physical The medical history and physical shall be completed by a qualified physician no more than 7 days before or 24 hours after an admission (rev12/01 (COP 482.22c.5). If a complete physical examination has been performed within 30 days prior to admission, an updated physical exam and history noting any interval changes must be performed no earlier than seven days before admission.

Other individuals who are permitted to provide patient care services independently may perform the medical history and physical examination, if granted such privileges and if the findings, conclusions, and assessment of risks are confirmed or endorsed by a qualified physician prior to major diagnostic or therapeutic intervention or within 24 hours, whichever occurs first.

A durable legible copy of the appropriate physical examination shall be on the chart for admissions and prior to all surgeries with general or major regional anesthesia. When the history and physical examination is not recorded before the time slated for surgery, the surgery shall be canceled unless the attending surgeon states in writing that such a delay would be detrimental to the patient.

The history and physical shall include:

- (a) chief complaint
- (b) details of present illness, including, when appropriate, assessment of the patient's emotional, behavioral, and social status
- (c) relevant past, social and family histories appropriate to the age of the patient
- (d) review of body systems
- (e) statement of conclusions or impression drawn
- (f) Statement of the course of action planned

In regards to children and adolescents, the medical history shall also include:

- (g) an evaluation of patient's developmental age
- (h) consideration of educational needs and daily activities, as appropriate
- (i) the parent's report or other documentation of patient's immunization status.
- (j) the family's and/or guardian's expectations for, and involvement in, assessment, treatment and continuous care of the patient.

VENTURA COUNTY MEDICAL CENTER
GENERAL RULES
OF THE VCMC MEDICAL STAFF
Page 4 of 7

8. MEDICAL RECORDS (cont'd)

- 8.F Orders: Diagnostic & Therapeutic
- 1 All orders for treatment shall be in writing, dated and timed.
- Verbal Order
- 2 A verbal order shall be considered to be in writing from a practitioner when received, either in person or by telephone, by nurses and technicians of specific departments who have been authorized to receive such orders for:
- A **administration of medications:** R.N., L.V.N., Licensed Psych. Tech., Pharmacist, physician (and P.A. from Supervising physician only) physical therapists (for certain topical drugs only), and respiratory therapists when the orders relate specifically to respiratory therapy
- B **other than drugs:** Licensed, registered or nationally certified health professional provided that the orders received relate to the area of competence of the individual receiving the orders: audiologists, cardiopulmonary/pulmonary technologists/technicians, dietitians (except parenteral nutrition), laboratory technologists, occupational therapists, physical therapists, radiological technologists, respiratory technologists, respiratory therapists, and speech pathologists. (Per DHS 6/26/93)
- C All orders dictated over the telephone shall be signed by the professional staff, noting date and time and the practitioners's name. A responsible physician shall authenticate such orders within 48 hrs.(rev10/00)
- D Verbal orders are to be used infrequently and not primarily for the convenience of the ordering practitioner. (rev 7/02)
- E All staff receiving a verbal order shall read back the complete order for verification (rev 01/03)
- F It is not acceptable to allow covering physicians to authenticate verbal orders for convenience or to make this a common practice. (rev 01/03)
- G Do-not-resuscitate orders cannot be verbally communicated
- The operative report shall include the pre-operative diagnosis, description of findings, technique used, and tissue removed or altered. A handwritten operative report shall be entered in the medical record immediately after the completion of any invasive procedure. Handwritten note must include: name of primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis as well as estimated blood loss. A dictated, detailed, operative/procedure report shall be completed, authenticated, and filed in the medical record as soon as reasonably possible after any invasive procedure requiring more than simple local anesthesia (Surg Comm 11/01; Exec. Comm 12/01).
- 8.G Operative reports
- 8.H Progress notes
- Progress notes, including nursing and others. Notes reflect the course of hospitalization and significant changes in patient status. Abnormal tests are discussed. Progress notes must be timed and dated.

Amendments Approved:

Exec Comm: 1/14/03

Med. Staff: _____

Governance _____

VENTURA COUNTY MEDICAL CENTER
GENERAL RULES
OF THE VCMC MEDICAL STAFF
Page 5 of 7

8. MEDICAL RECORDS (cont'd)

- 8.I Discharge Summary Conclusions at the termination of hospitalization shall be recorded in the discharge summary. The summary shall concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or the family. Instructions shall relate to the physical activity, medication, diet, and follow-up care.
- 8.J Non-removal of Records Medical records may not be removed from the hospital except under a court order, subpoena or state statute. There are no exceptions to this rule.
- 8.K File Complete No medical record shall be filed until it is complete, except on order of the Medical Records Committee.
- 8.L Record Completion Records shall be completed within 14 days of patient discharge. If the record is not completed within this time period, including signatures, it shall be deemed delinquent. Any medical record not completed within 16 days of becoming delinquent will result in the practitioner's suspension (rev 4/01)
- 8.M Suspension: Delinquent Medical Records A limited suspension, withdrawing all admitting and other related privileges until medical records are complete, shall be imposed by the President of the Medical Staff, or his or her designee, on all practitioners who have not completed medical records as in Sec. 8G above. For the purpose of this Section, "related privileges" means voluntary on-call service for the emergency room, performing surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the hospital for future patients. Members whose privileges have been suspended for delinquent records may admit or care for patients only in life-threatening situations. (rev 4/01)

When a physician is notified that there are incomplete records, the physician must attempt to complete all available records to stop the suspension clock. If the practitioner completes his records on the day of suspension, he will still be assessed one day of suspension. However, if the practitioner is on suspension more than one day, the day he completes his records will not be counted as a day of suspension.

In the event of lost or misplaced dictation, including operative reports, the Medical Records Department will immediately contact the practitioner by phone followed by written notice. The practitioner will have two weeks from the date of verbal notification to complete the medical record to avoid suspension.

A practitioner will not be suspended while on vacation if all available records which would lead to suspension are completed prior to vacation. It will be the physician's responsibility to contact the Medical Record Department to notify them of his/her vacation dates. In the event of illness of greater than one weeks duration, the suspension process will be suspended upon notification to the Medical Records Department. If a practitioner has an extended illness greater than four weeks, the Medical Records Department should be notified so an alternate method for completing his charts can be implemented.

The Director of Medical Records will notify practitioners of their incomplete medical records and of suspensions for medical records delinquencies as directed by the Executive Committee. Copies of such actions shall be forwarded to the Medical Staff Office and Hospital Administration on a regular basis.

9. STANDING ORDERS OR POLICIES

Standing orders or policies pertaining to these Rules and Regulations shall be formulated by conference between the Medical Director and the Administrator.

VENTURA COUNTY MEDICAL CENTER
GENERAL RULES
OF THE VCMC MEDICAL STAFF
Page 6 of 7

10. SURGICAL PROCEDURES

- 10.A Surgical Consent Written, signed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained. In emergencies involving a minor or unconscious patient, in which consent for surgery cannot be obtained from parents, guardian, or next of kin, these circumstances should be fully explained on the patient medical record.
- 10.B Labs and pre-op tests The ordering of labs and other pre-operative tests will be left to the discretion of the surgeon and the anesthesiologist based on the individual needs of the patient.
- 10.C Commence operation Surgeons must be in the operating room and ready to commence operation at the time scheduled. In no case will the operating room be held longer than fifteen (15) minutes after scheduled time of operation.
- 10.D Operations described All operations performed shall be fully described immediately after surgery. The operative record shall be countersigned by the Medical Staff physician in attendance. All tissues removed at operation; with the following exceptions, shall be sent to the hospital Pathologist, who shall make such examinations as may be considered necessary to arrive at a diagnosis and who shall sign such report. The following list of specimens removed during surgery may, at the discretion of the surgeon, be exempt from the requirement of pathology examination:
- Specimens removed during surgery
1. Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body or removed only to enhance operative exposure.
 2. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.
 3. Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary.
 4. Foreign bodies (e.g. bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.
 5. Specimens known to rarely, if ever, show pathological change and removal of which is highly visible post-op., such as the foreskin from the circumcision of a newborn infant.
 6. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.
 7. Teeth, provided the number, including fragments, is recorded in the medical records.
 8. Tissues debrided from areas of trauma.
 9. Cartilage or bone removed in the course of septoplasty/rhinoplasty.
 10. Ventilation tubes removed from the tympanic membrane or external auditory canal.
 11. Arch bars.
 12. Dentures and intra-oral prosthetic splints.
 13. Toenails and fingernails.
 14. Burn debridement specimens.
 15. K-wires and Steinmann pins.
 16. Breast implants.
 17. Normal bone, muscle tissue, adipose tissue, skin, or cartilage removed incidental to the primary procedure.
 18. Scribner shunt parts, Hickman catheter parts.
 19. Unused donor site skin removed for application as a skin graft.
 20. Orthopedic hardware, i.e. screws, nails, etc.
 21. Meniscus fragments removed at arthroscopy.
 22. Phalanges removed for hammer toe.
 23. Sutures removed at surgery.
- 10.E Oral/Dental/Podiatric Surgery Patients admitted for oral or dental surgery or podiatric surgery shall be under the joint responsibility of a doctor of dental surgery or podiatrist and a physician. The doctor of dental surgery or podiatrist shall be responsible for documenting treatment including the surgical reports. A physician shall be responsible for the general care of the patient, including the general medical history and physical.

VENTURA COUNTY MEDICAL CENTER
GENERAL RULES
OF THE VCMC MEDICAL STAFF
Page 7 of 7

11 AUTOPSIES

- 11.A Securing Autopsies
Performed by Pathologist
Information/ Education
- 11.B Autopsy as Part of Record
- 11.C Autopsy Criteria
- Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without written consent of a relative or legally authorized agent. All autopsies shall be performed by the hospital Pathologist, or a physician to whom he may delegate the duty. Autopsies shall be used as a source of clinical information in performance improvement and continuing medical education programs of the Medical Staff.
- When autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within three (3) days, and the complete protocol shall be made part of the record within 60 days. An exception for special studies may be established by the Medical Records Committee.
- The following criteria shall be used to identify deaths in which an autopsy should be performed:
- 1 Unanticipated death;
 - 2 Death occurring while the patient is being treated under an experiment regimen;
 - 3 Intra-operative or intra-procedural death;
 - 4 Death occurring within 48 hours after surgery or an invasive diagnostic procedure;
 - 5 Death incident to pregnancy or within seven (7) days following delivery;
 - 6 All deaths on the psychiatric service;
 - 7 Death where the cause is sufficiently obscure to delay completion of the death certificate;
 - 8 Death in infants/children with unexplained congenital malformations;
 - 9 Deaths Reportable to the Coroner (See Hosp. Admin Policy)