# YORK HOSPITAL

# MEDICAL STAFF RULES AND REGULATIONS

**Foreword to Medical Staff Rules and Regulations:**

The August 2011 version of the Medical Staff Rules and Regulations was written in preparation of advancing the components of the electronic health record, to include but not limited to Computerized Physician Order Entry (CPOE). Transitioning into a complete electronic health record is occurring in multiple phases. Hence the Rules and Regulations are written proactively to accommodate those changes.

June 22, 2016

**TABLE OF CONTENTS**

# RULES AND REGULATIONS

## DEFINITIONS

The definitions set forth in the Bylaws of the Medical Staff of York Hospital shall apply to these Rules and Regulations.

## ARTICLE I. ADMISSIONS, TRANSFERS, AND DISCHARGES

**1.1** Except in emergencies, no patient shall be admitted to the Hospital unless a provisional diagnosis has been stated and the consent of the proper authority for the patient's legal permissions obtained. If there is any question concerning the admission of a patient, the Chairman of the Department to which the patient is to be admitted shall determine the necessity for, or deferment of, the admission.

**1.2** No appointee of the Medical Staff shall admit a patient to the service of another Medical Staff appointee without his consent.

**1.3** Each appointee of the Medical Staff who does not admit or attend his/her own patients at the Hospital, shall specifically designate another appointee/hospitalist of the Medical Staff with appropriate clinical privileges who shall be responsible to attend any of the appointee's patients in an emergency or in the event the appointee's patients need to be admitted to the Hospital. By acceptance of such designation, the designated appointee/hospitalist shall be required to promptly respond to the Hospital's request to attend any of the appointee's patients in an emergency or in the event the appointee's patients need to be admitted to the Hospital, and may not refuse to attend any such patients on any basis, including but not limited to the patient's source of payment.

In the event the designated appointee can not be contacted by the Hospital, or fails to promptly attend to the appointee's patients upon request, the appropriate Department Chairperson or designee may authorize any other qualified member of the Medical Staff to provide such as care as is necessary. The Department Chairperson shall notify the appointee of the designated appointee's failure to attend the appointee's patients, and the designated appointee shall be subject to corrective action.

**1.4** Appointees of the Medical Staff admitting patients shall provide, in advance, all available information as required by Hospital admission policies and as may be necessary to ensure the protection of the patient, other patients, and the Hospital staff.

**1.5** A transfer of a patient from one clinical unit to another must be initiated by an order from that patient's attending Medical Staff appointee.

**1.6** A patient may be transferred from one Medical Staff appointee's service to another appointee's service during the course of hospitalization only if the transferring appointee orders the transfer and the receiving appointee accepts the patient in transfer.

**1.7** Discharge shall be made only on order of the attending Medical Staff appointee, or his designee.

**1.8** If a patient is admitted and no orders are received or can be obtained by the nursing staff within appropriate time for the patient's care, the head nurse shall contact the Chairman of the Department to which the patient is admitted for appropriate action and orders.

**1.9** The Admissions Department (and Department of Patient Logistics, when applicable) will admit, transfer, and discharge patients without regard to age, sex, race, creed, color, or national origin.

**1.10** All patients in the Hospital who are at recognized as self harm, staff risk or suicidal risk shall be managed under policies and procedures established by the Department of Psychiatry.

**1.11** When a patient, with a York Hospital Medical Staff Physician as his ongoing care physician, is seen in the York Hospital Emergency Department by an Emergency Department attending, and agreement as to the patient's disposition cannot be made by telephone, the ongoing care physician, or his coverage, must evaluate the patient in person and make final disposition. In the event that the treating ED physician disagrees with the on-call physician's decision to send a representative and requests the actual appearance of the on-call physician, then the on-call physician is required to appear in person. If a patient is seen in the emergency department and the emergency physician feels the patient should be hospitalized but the physician who would be admitting the patient disagrees, if an agreement as to the patient's disposition cannot be made by telephone, the admitting physician will need to evaluate the patient in person and make final disposition. If a patient requires hospitalization and two services cannot agree which should actually do the admission, the Emergency Physician has final say as to which service must assume care of the patient. [EMTALA]

## ARTICLE II. TEACHING RESPONSIBILITY: HOUSE STAFF PATIENT CARE

**2.1** The Hospital Board, Medical Staff and Administration have long supported graduate medical education. While not a prerequisite for admission to the Medical Staff, Medical Staff appointees are urged to participate in the hospital's Medical Education programs, when requested, by their department chairman or his designee.

**2.2** Professional and moral responsibility for House Service patients shall rest with the appointee of the Medical Staff assigned as Teaching Attending Physician/Dentist to a particular House Service for a particular period. This individual shall have the responsibility for the supervision and documentation of the patient care rendered by the residents or interns assigned to the House Service concerned, in compliance with regulatory, certifying and licensing bodies.

**2.3** All patients shall be included in the Hospital's teaching program, unless an objection is raised by the patient or the patient's parent or guardian.

**2.4** The Hospital provides and operates a sufficient number of beds so as to care properly for medically indigent and House Service patients.

## ARTICLE III. MEDICAL RECORDS

### 3.1 ATTENDING MEDICAL STAFF APPOINTEE

The attending Medical Staff appointee for each patient shall be responsible for the preparation and completion of the medical record of such patient. Chart completion responsibility, within regulatory timeframes and/or WellSpan Health Information Management Department defined protocols, rests solely with the Attending Physician/Dentist, not with the House Staff.

### 3.2 INPATIENT RECORD

(a) A complete inpatient medical record shall include: identification, history and physical examination, orders, resuscitation status signed informed consent forms, reports of diagnostic studies, and procedures, consultations, progress notes, results of all diagnostic, consultative and therapeutic services, discharge summary, diagnosis(es), discharge instructions, reconciled lists of medications given, and completed coding inquiries, autopsy report and operative records, when indicated. All entries shall be dated, timed and authenticated by the appropriate Medical Staff member. Standards for all documents and/or documentation in the patient record reflect will reflect current practice and internal/external regulatory requirements and be defined by the WellSpan Department of Health Information Management.

(b) The scope of documentation shall be comprehensive enough to:
- Reflect facts and observations about the patient's health, allergies, social and psychosocial status or needs;
- Include past and present history, tests, treatments and outcomes;
- Provide continuity of care;
- Provide information about history, current health status, and effectiveness of past, as well as current therapy;
- Provide medico-legal protection for the patient, physician and hospital;
- Support diagnosis and procedure codes to support the services rendered; and
- Be concise and complete.

(c) All entries will be in English, utilizing only approved abbreviations and symbols, medically correct anatomical terminology, and shall be as close to the time of occurrence as feasible.

(d) Handwritten entries, including signatures, must be legible times and dated.

### 3.3 HISTORY AND PHYSICAL EXAMINATION

(a) The Attending Physician on admission is responsible for assuring that the History and Physical Examination is complete. Podiatrists (per DOH exception) are permitted to perform the pre-procedure update and examination to the History and Physical for surgeries where they are listed as the primary surgeon.

(b) A complete history and physical exam shall include: chief complaint, history of present illness, current medications, allergies, past history, social history, family history, and system review, a relevant exam of negative and positive findings deemed appropriate, diagnostic impression, and the course of treatment/plan.

(c) Minimum recommended requirements for outpatient procedures involving anesthesia:
- History of Present Illness
- Physical Examination – must include relevant system/organ examination and also document examination of heart and lung
- Pertinent data including drug allergies and medications
- Indications for Procedures
- Relevant Assessment of Mental Status (oriented, disoriented, etc.)

• Diagnostic Impressions

(d) A legible written or dictated medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia. A consultation may also be used, providing it was performed within 30 days of admission and contain all necessary elements. An updated examination of the patient, including any changes in the patient's condition, is acceptable when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia.

(e) A history and physical examination must be performed and readily available in the Operating Suite before surgery. This includes both inpatient and outpatient surgery records.

(f) An Obstetrical Admission Note Form shall be completed on all obstetrical patients to supplement the Pre-Natal Forms.

(g) If the Pre-Natal Forms or records are not present on an Obstetrical patient, a History and Physical, in accord with standards previously defined shall be performed.

(h) All corrections or addendums to the patient record shall be made in the manner established by the WellSpan Department of Health Information Management.

**3.4 CONSULTATIONS**

Guidelines for consultations;

(a) A routine consultation must be performed within twenty-four (24) hours of the request and the report dictated as soon as possible, but no more than 24 hours after the consultation.

(b) If the patient's condition warrants the patient being seen on the same calendar day, the requesting physician shall request an urgent consult and convey the information by speaking directly to the consultant. The provider to provider conversation shall include the reason for the consult, the timeliness / urgency of the consult, and any and all information requested by the consultant. In the case of an urgent consult, the consulting Medical Staff appointee should convey findings to the requestor by telephone and complete the required dictation.

(c) For those seeking consults:

i. Inform the patient that you will be seeking a specific consultation, but you remain in charge of the patient's over-all care.
ii. Requests for consultation shall be entered as an order by the requesting Medical Staff member.
iii. Consult judiciously. Do not consult for chronic problems, but rather those acute problems requiring resolution prior to discharge. Consultations are encouraged among appointees of the Medical Staff in cases of difficult diagnosis, critically ill patients, or to seek counsel from another medical specialty. Chronic problems should be addressed at discharge with appropriate follow-up.
iv. Consult the proper individual or group based on:
    - Necessary expertise.
    - Patient preference.
    - Prior positive experience with specialist.
    - Preference of primary care provider (PCP).

- When none of above apply, refer to the on call specialist.
- Generic requests, such as "Consult surgery", are not appropriate.

v. Whenever possible, the consulting physician should call the requesting physician directly, especially if problem is urgent in nature (e.g. MI, GI bleed, perforated viscous).

(d) For those providing consultation:

i. The potential consultants or their designees must be available and willing to speak to a physician seeking a consult.
ii. The consultation always begins with an assessment and plan.
iii. Advanced practice clinicians or residents can begin the consultation process, but the consultation report is not finalized in the record until the attending physician has made recommendations after he or she has reviewed the data and, whenever possible, has seen the patient face to face. The record should list the owner of the consulting report as the attending physician and their specialty. In rare instances, a request may be made and approved by the VPMA when it is acceptable for consults to be completed by an APC when an on-site physician is not available on a daily basis.
iv. A consulting physician should not consult yet another physician until having discussed the plan with the admitting physician.
v. If immediate action is required or there is a significant change in a recommendation, the consultant should call the attending physician who requested the consult.
vi. Follow up disposition needs to be arranged by the consultant and entered into the depart document if the consultant has to see patient post-discharge. The disposition needs to be documented in the chart when the consultant signs off the care of the patient. A consultant needs to clearly state they are signing off the case.

(e) Emergency Department or Trauma Service Consultation Response Time: York Hospital attending staff members are expected to respond within thirty (30) minutes, by telephone, to calls from the Emergency Department or Trauma Service and are expected to physically be present in the Emergency Department or Trauma Unit, when requested, within 45 minutes after telephone confirmation of the request is received.

## 3.5 EMERGENCY DEPARTMENT RECORDS

Medical records of patients treated in the Emergency Department shall be completed by the responsible Emergency physician within the timeframes and protocols defined by the WellSpan Department of Health Information Management

## 3.6 PROGRESS NOTES

The frequency with which progress notes are made is determined by the condition of the patient. This may vary from several times a day in rapidly changing clinical conditions to less frequently in static conditions. There should be at least one progress note per day for inpatients on medical or surgical units.

## 3.7 OPERATIVE REPORTS

(a) Documentation of a procedure done in the operating room requires two components, a dictated operative report and a legibly completed and signed Perioperative Documentation Form. The perioperative documentation must be completed immediately after surgery. A complete operative report must be dictated within 24 hours. These two documents are required for both inpatient and outpatient surgical procedures. The dictated operative report should contain the name of the procedure(s), a comprehensive description of the findings, the technical procedures used, the specimens removed, the post-operative diagnosis, and the name of the primary surgeon and any

assistants, and estimated blood loss. The Perioperative Documentation must also have all of these elements completed as well as the Primary Surgeon's preoperative identification of the patient and a notation of estimated blood loss.

(b) Documentation of the Operative Reports and Perioperative Documentation rests with the primary surgeon, who may or may not be the attending physician.

(c) Repeated instances of-failure to complete the Perioperative Documentation immediately after surgery, or not dictating the operative report within 24 hours following surgery will be addressed. The Department Chairman will be responsible for addressing the issue individually with physicians. At the discretion of the Department Chairman or the Vice President of Medical Affairs, prolonged behavior will be referred to the MEC for discussion and action, and may require instituting the Disruptive Physician Policy.

## 3.8 ORDERS

### 3.8.1 GENERAL

With few exceptions, medical orders generally should be entered directly into the electronic health record (EHR) by the responsible practitioner. In some clinical locations or for some clinical practices defined as out of scope, electronic orders may not be available. In these instances, orders should be written. In either case, some emergency situations create the necessity of oral and telephone orders, together referred to herein as verbal orders.

### 3.8.2 ELECTRONIC ORDERS

Orders should be placed directly into the electronic health record where available pursuant to the *Wellspan Health Orders Management Policy.* Since orders may be placed directly without a paper copy, the Orders menu item within the Cerner Millennium Power Chart application should be considered the "source of truth" for all orders. Clinicians should always refer to the Orders menu within the electronic health record to review orders placed on any patient of interest**.**

### 3.8.3 VERBAL MEDICATION AND TREATMENT ORDERS

(a) Definition & Authorization of Personnel: Verbal medication and treatment orders may be dictated by a licensed physician, dentist, podiatrist, certified registered nurse practitioner, physician assistant, pharmacist, or certified nurse midwife and are defined as any medication and/or treatment order that is (a) given physically in the presence of, or (b) received via telephone by personnel authorized to receive such order as outlined in Section 3.2(b). All authorized personnel are expected to dictate only those verbal orders pursuant to their role/scope of practice within the institution. Personnel explicitly forbidden to give verbal medication and treatment orders include medical students and all Physician's/Dentist's Office Staff Nurses. The use of verbal orders by on-site providers should be limited to "life and limb" emergencies or when the clinician is engaged in a sterile field and the delay of direct entry of such order would be dangerous to the patient. In the event the ordering provider is off site, direct order entry is preferred – verbal orders may be used in the event that no suitable electronic method is available for direct order entry.

(b) Receipt of Verbal Orders: Personnel approved to receive verbal medication and treatment orders are; registered nurses, licensed practical nurses, pharmacists, physical therapists, and respiratory therapists. All authorized personnel are expected to receive only those verbal orders pursuant to their role/scope of practice within the institution. All other personnel not specifically mentioned in this section are to be considered unauthorized to receive verbal orders.

(c) Procedure For Receiving Verbal Orders: All personnel authorized to receive verbal medication and treatment orders as outlined in Section 3.2 (b) shall directly enter the order where available into the electronic health record, taking care to accurately identify the ordering provider and select the

communication type of 'verbal order' such that the order is routed to the providers electronic Inbox for authorization. Authorized receiving personnel must then read the order back, in its entirety, to the ordering individual and wait for a confirmation of accuracy from the authorized ordering personnel prior to executing the order. The ordering provider shall remain available through execution of the order in effort to satisfy any decision support alerts activated by the order. In the event of orders which are out of scope for direct computer order entry, or during time of network unavailability due to technical reasons, the receiving personnel shall document the provider's first and last name, credential, and numerical second identifier; and transcribe the verbal order as received to the Orders section of the medical record. The order must include the date and time the order was written and name of the receiving personnel along with an indication as to the method the order was received.

(d) All verbal medication and treatment orders must be electronically authenticated (counter/signed, dated and timed) by the ordering individual when readily available but not to exceed seven (7) days of issue.

### 3.8.4 WRITTEN ORDERS (Both outpatient surgery and inpatient medical records)

**(**a) Written orders will be accepted for items identified as out of scope in the *Wellspan Health Orders Management Policy*. Items that are technically enabled for direct order entry in the future may no longer be accepted as written orders.

(b) Written orders are recorded on the Physician's Treatment Record directly by the prescribing physician, dentist, podiatrist, certified registered nurse practitioner, certified nurse midwife, pharmacist, or physician assistant and may be honored immediately if clear to the transcriber.

(c) Following the initial diet order entered by a practitioner, the practitioner may document the delegation to a registered and licensed dietician/nutritionists (RDN/LDN by the PA Bureau of Professional and Occupational Affairs) the ability to modify the diet based on the needs of the patient based on the current condition under the supervision of the practitioner.

(d) Any orders written by a medical student must be validated by the supervising physician/dentist/podiatrist prior to the execution of the order.

(e) All orders written by a physician assistant must be co-signed by the supervising physician within 7 days. (per exception granted by the PA DOH).

(f) All orders for Respiratory Therapy Services written by a physician assistant must be co-signed by the supervising physician or attending physician within 24 hours. All orders for Respiratory Therapy Services written by a nurse practitioner do not need co-signed by the supervision physician or attending physician within 24 hours.

(g) All written orders must be timed, dated, and signed when ordered.

## 3.9 DISCHARGE SUMMARY

(a) Discharge summaries should be routinely documented within 24 hours of patient discharge while recognizing that rare exceptions may delay the documentation to seven (7) days after patient discharge.

(b) The Discharge Summary should provide a recap of the course of care to be used as a communication tool to subsequent care providers. The content of the Discharge Summary shall minimally include:

- Diagnoses;
- Reason for Hospitalization;
- Hospital Course;
- Procedures and Consults;
- Reconciled Medications;

- Patient Instructions;
- Transition Plan; and
- Disposition.

(c) A final progress note may be substituted for the Discharge Summary in the case of patients with problems of a minor nature who require less than a forty-eight (48) hour period of hospitalization, observation patients, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note should include the condition of the patient at discharge, medications to be taken, any instructions given to the patient and/or family.

(d) In the event of death, a summation statement should be added to the record either as a final or comprehensive progress note. This final note should indicate the reason for admission, the findings and course in the Hospital, and events leading to death.

(e) When a necropsy is performed, provisional anatomic diagnoses should be recorded in the medical record within three (3) days, and the complete protocol should be made part of the record within sixty (60) days.

**3.10 DICTATED DOCUMENTS**

(a) All dictated documents must include the date and time of dictation and date and time of transcription.

(b) Practitioners must review for accuracy and complete content and electronically sign all transcribed documents. Any document containing blank spaces should not be signed until information is entered to make the document "complete".

(c) Dictation and transcription outside of the central Hospital system is subject to the same requirements as that dictated and transcribed via the Hospital system.

**3.11 SIGNATURES**

(a) Every clinical entry must be personally and legibly signed, timed and dated. (This includes all inpatient and outpatient records.) Electronic signature is permitted per the Medical Staff Rules and Regulations and the York Health System Electronic Signature Policy, respectively.

(b) On private cases, the attending Medical Staff appointee shall countersign the history and physical examination and the discharge summary (including those written/dictated by a member of the House Staff). It shall not be necessary to countersign progress notes, drug or treatment orders, or other entries by members of the House Staff.

(c) A card file of Medical Staff appointees' signatures and initials shall be maintained in the Medical Records Department.

(d) On House Service cases, the following signatures are required:

i. Medical Service: The appointee of the Medical Staff assigned as Teaching Attending Physician must sign and date the Admission Record and must countersign the Discharge Summary and History and Physical Examination.

ii. Surgical Service: The Chief Resident must countersign the Discharge Summary. The appointee of the Medical Staff assigned as Teaching Attending Physician on Surgical Service must co-sign the History and Physical Examination and Operative Report. The appointee of the Medical Staff assigned as Teaching Attending Physician must sign and date the Admission Record.

iii. Ob-Gyn Service: The Chief Resident must countersign the History and Physical Examination and Discharge Summary. The appointee of the Medical Staff assigned as

Teaching Attending Physician must sign and date the Admission Record.

iv. Pediatric Service. The appointee of the Medical Staff assigned as Teaching Attending Physician must sign and date the Admission Record and must countersign the Discharge Summary and History and Physical Examination.

v. Psychiatric Service: The appointee of the Medical Staff assigned as Teaching Attending Physician must sign and date the Admission Record and must countersign the Discharge Summary and Physical Examination.

vi. Dental Service: The appointee of the Medical Staff assigned as Teaching Attending Dentist or the appointee of the Medical Staff assigned as Teaching Attending Physician must sign and date the Admission Record and the Discharge Summary and countersign the History and Physical Examination and Operative Report.

## 3.12 SECURITY AND CONFIDENTIALITY

All records are the property of York Hospital and shall not be removed from the Medical Record Department at any time without notification and specific permission under policy set by Director of Health Information Management. Information concerning records or their contents will only be released upon written request and permission of the patient, except to Medical Staff appointees or Allied Health Professionals in good standing who are currently involved in the care of the patient; Medical Staff appointees using charts for academic purposes (i.e., conferences, studies, etc. excluding patient identifiers); or those individuals involved in required quality assurance activities.

(a) Physicians and other providers shall obtain appropriate written patient consent using the Authorization to Access the Electronic Health Record before accessing electronic or written health records for patients with whom they have no current professional relationship, including family members and coworkers.
(b) Consent to access should be inclusive of a date range, or encounter, for which access is given, or can be granted as unconditional but not to exceed one year from the date of the consent, in keeping with Release of Information policies.
(c) The consent will be filed with the Medical Record Department and scanned into the appropriate folder in PowerChart. Practitioners who access confidential patient information without appropriate authorization will be held accountable.

## 3.13 CHART COMPLETION

All records shall be completed within thirty (30) days after the discharge or treatment of the patient, including all review, editing and authentication in keeping with record document completion standards set by the Department of Health Information Management and regulatory requirements. For the purposes of monitoring timeliness of medical records, incomplete medical records greater than 21 days post-discharge will be considered delinquent. WSH email notifications of delinquent records will be sent to practitioners a week before suspension is to occur. No medical record shall be considered complete until all assigned deficiencies are resolved.

Records remaining incomplete 30 days post patient discharge will result in the temporary suspension of clinical privileges for the delinquent practitioner.

(a) After direct communication between the Director of Health Information Management or designee and the practitioner, failure to comply will subject the practitioner to automatic and immediate suspension of clinical privileges or rights to perform patient care services in the Hospital until his charts are completed. Patients already hospitalized may be cared for, but no new patients may be cared for during the time of suspension, including admissions, consultations, surgical procedures, etc. except for patients established through on-call responsibilities. Health Information

Management Department personnel shall have the authority to review current charts of partners or other practitioners to determine that the suspended practitioner is not caring for new patients. Any variances shall be reported directly to the Vice President of Medical Affairs.

(b) At the discretion of Medical Affairs, practitioners who are suspended three times within a 12-month period will be fined $500 at the third occurrence (consecutive or non-consecutive). A $1000 fine will be assessed at the fourth occurrence of suspension (consecutive or non-consecutive). Fines are payable to the York Hospital Medical Staff Fund within 30 days.

## 3.14 INCOMPLETE CHART COUNT PROCEDURE

(a) Physicians will have continuous access to their Millennium inboxes to monitor the type and amount of work to be done.

(b) The monitoring of chart completion will be done the responsibility of the Health Information Management (HIM) Department.

(c) Communication regarding suspended physicians will be sent the following individuals/departments on a weekly basis:

- Director, Logistics
- Director, Surgical Services
- Administrative Director Emergency Department
- Department Chairpersons and their designees
- Residency program Directors and their designees
- Administrative Director, Medical Affairs
- Medical Education Coordinator
- Director, Medical Record Services
- Attending physician (and designees) and residents (and designees)

(d) Priority emails will be mailed to residents who failed to complete their overdue records at regular intervals to be determined by the Department of HIM and carried out by the Medical Record Department of York Hospital. Copies of the emails will be forwarded to the appropriate Residency Program Director and their designee; the Medical Education Coordinator; the Director, Medical Record Services; and the Physicians' Chartroom.

(e) As physicians complete their assigned records, HIM will clear them from suspension. When clearing a physician, calls will be placed to Admissions, Emergency Department Administrative Office, and the Operating Room. A priority email will also be distributed to appropriate individuals.

(f) Chart completion is a recognized part of patient care and shall remain the final responsibility of each physician.

## 3.15 TRANSFER OF SERVICES

A patient may be transferred from one physician's service to another during the course of hospitalization. The current procedure for effecting a transfer of service is as follows:

(a) The transferring physician orders the transfer of the patient to another physician's service.

(b) The physician to whom the patient has been transferred acknowledges acceptance of the patient in transfer.

(c) All transfers of service must be clearly documented on the Physicians Treatment Record.

(Steps (a) and (b) may be in the form of a written or oral order.)

## 3.16 PATIENT RESTRAINTS

(a) Physicians are required to follow the York Hospital Restraint/Adaptive/Protective Devices Policy and the Restraint Protocol for Invasive Catheters, Lines and Tubes, including Endotracheal Tubes, and the Restraint Protocol for Patients with Dementia, and any other applicable restraint protocols and/or policies.

(b) PRN restraint orders are never acceptable and will not be executed.

## ARTICLE IV. PATIENT RIGHTS

**4.1** A Patient's Bill of Rights consistent with the Pennsylvania Department of Health regulations and approved by the Medical Executive Committee and by the Board shall be followed in the Hospital.

## ARTICLE V. OPERATIVE PROCEDURE

**5.1** Operative Procedures shall be performed in accordance with the Operating Room Regulations.

**5.2** Patients for inpatient surgery shall be admitted long enough in advance to have the necessary preparation. The medical history, physical examination, and appropriate work will be recorded on the patient's medical record by an appointee of the Medical Staff except under emergency patient care conditions.

## ARTICLE VI. INFECTION PREVENTION & CONTROL

**6.1** All appointees of the Medical Staff are bound by the Isolation Policies and Procedures Manual of the Hospital. Each practitioner is responsible for ensuring that every patient with known or suspected infection is placed on appropriate isolation precautions. Copies of the Isolation Policies and Procedures Manual shall be available at every patient unit, and in the Office of the Vice President of Medical Affairs.

**6.2** The Hospital Infection Control Officer may order that appropriate cultures be obtained on patients with known or suspected infections in cases of disagreement concerning diagnosis and/or need for isolation; the matter will then be referred to the Department Chairman of the attending Medical Staff appointee for discussion and appropriate action.

**6.3** Each Department of the Hospital should offer at least one educational program for its members each year on infection control.

## ARTICLE VII. REPORTABLE CASES

**7.1** Certain cases are reportable to government agencies and the State Medical Examiner as required by law. A list of reportable cases is available for review in the Office of the Vice President of Medical Affairs.

## ARTICLE VIII. REPORTABLE CONDUCT BY PHYSICIANS

**8.1** Certain conduct by physicians is reportable to government agencies and the State Medical Board as required by law. A list of reportable conduct by physicians is available for review in the Office of the Vice President of Medical Affairs.

## ARTICLE IX. ORGAN DONATIONS

**9.1** Organ procurement and transplantation at the Hospital shall be handled as required by, and in a manner consistent with, the Report of the Organ Procurement and Transplantation Committee as approved by the Board, a copy of which Report is available for review in the Office of the Vice President of Medical Affairs.

## ARTICLE X. AUTOPSIES

**10.1** It shall be the responsibility of each appointee of the Medical Staff actively to seek autopsy permission from the next of kin of all patients who have died during their stay at the Hospital. If the attending Medical Staff appointee is not available, his designee may obtain the permission. The final authority as to the adequacy of the consent shall be the pathologist acting as prosector for the autopsy.

**10.2** It shall be the responsibility of the attending Medical Staff appointee or his designee to notify the Coroner of any case that is considered a Coroner's case or of any case in which there is a question as to the cause of death. The following are classified as Coroner's cases:

(a) all patients brought to the Hospital to be pronounced "dead," except those who have died from natural causes if the attending Medical Staff appointee will sign the death certificate;

(b) all patients dying from any cause whatsoever within twenty-four (24) hours after admission, or where the medical attendant has changed in the past twenty-four (24) hours;

(c) all cases of death from homicide, suicide, poisoning, or criminal abortion (in cases where toxic agents may have caused the illness, any gastric contents, urine, or other available excreta should be preserved, properly labeled, and in the event of the patient's death, should be forwarded to the morgue with the body or to the Pathology Department for analysis, and the Coroner's office notified of their existence);

(d) all deaths from accidents of any type (automobile, industrial, mines, home, burns, drownings, cave-ins, shooting, etc.) where the death occurs within a period of one (1) year and one (1) day following the accident;

(e) all cases of criminal assault, or any cases in which external violence acted as a contributory cause and where death occurred within a period of one (1) year and one (1) day after such violence;

(f) all cases of death in the Operating Room;

(g) all cases in which the cause of death is under reasonable suspicion, in which a definitive diagnosis cannot be made with reasonable certainty, in which the cause of death is not properly certified, or in which the attending Medical Staff appointee is physically unable to supply the necessary data;

(h) stillborn or fetal deaths (over sixteen (16) weeks gestation) where the patient has had no prenatal care and the attending Medical Staff appointee is physically unable to supply the necessary data, or any baby dying less than twenty-four (24) hours after birth;

(i) all cases of death of children where there is reasonable cause to suspect that the child died as a result of child abuse;

(j) all deaths of prematurely born infants where the cause of death is not properly certified; and

(k) all cases which suggest the death was sudden, violent, suspicious in nature, or is the result of other than natural causes.

## ARTICLE XI. LEGAL PERMISSIONS

**11.1** Legal permissions shall be obtained as required by, and in a manner consistent with, the Hospital's Informed Consent Policy, a copy of which is available for review in the Office of the Vice President of Medical Affairs.

## ARTICLE XII. MISCELLANEOUS

### 12.1 COVERAGE

Each appointee of the Medical Staff shall be expected to have on record with the telephone desk, or in his office, an alternate Medical Staff appointee who could be contacted for emergency or other problems of patient care in his absence. If such a name is not on file, or the alternate Medical Staff appointee is unavailable, the Department Chairman or senior departmental member available shall have the right to arrange for substitute care to be rendered to the patient, pending the return of the attending or admitting Medical Staff appointee.

### 12.2 BIRTH AND DEATH CERTIFICATES

Birth and death certificates are the responsibility of the attending Medical Staff appointee or member of the House Staff, and are to be completed within twenty-four (24) hours. Certified nurse practitioners may also certify the cause of death and/or authenticate a death or fetal death certificate for patients under their care.

### 12.3 ADMINISTRATION OF DRUGS

A drug shall be administered directly by an appointee of the Medical Staff or by a House Staff member or by a professional nurse or a licensed practical nurse with pharmacy training. A medical student may also administer drugs, but only under the supervision of a Medical Staff member or House Staff member. Properly trained technicians may administer drugs within established Hospital guidelines. Graduate practical nurses, graduate nurses, and students from approved schools of nursing may be authorized to administer drugs, but only under the supervision of a registered professional nurse or a Medical Staff appointee, or a House Staff member.

### 12.4 QUALIFIED MEDICAL PROVIDER (QMP) AUTHORIZATION

The following categories of Qualified Medical Providers are determined to be qualified and authorized by the York Hospital Board of Directors to perform initial medical screening examinations as required by EMTALA:

a. In the Emergency Department:

i. Physicians, including house staff under direct attending supervision
ii. Advanced Practice Clinicians (Nurse Practitioners and Physician Assistants)
iii. SAFE RNs (for the victims of sexual assault when only an evidentiary exam is required)
iv. Crisis Counselors for psychiatric complaints not involving ingestions or trauma

b. In the Labor & Delivery unit:

i. Physicians, including house staff under direct attending supervision
ii. Advanced Practice Clinicians (Certified Nurse Midwives, Nurse Practitioners and Physician Assistants)
iii. Labor & Delivery Nurses

## 12.5 TREATMENT OF FAMILY MEMBERS

As a general policy, Medical Staff appointees should not treat themselves, members of their immediate families, or other individuals whose relationship with the Medical Staff appointee may compromise the Medical Staff appointee's objectivity. Medical Staff appointees should also refrain from treating individuals outside of a bona fide provider – patient relationship; this restriction would apply to writing prescriptions for friends and co-workers.

In an emergency, where there is no other qualified provider available, Medical Staff appointees may treat themselves, immediate family members, or other individuals for whom treatment would be generally inappropriate under this policy until another qualified provider becomes available. While Medical Staff appointees should not normally serve as a primary or regular care provider for an immediate family member, there are some situations where routine care is acceptable for short-term, minor problems. This does not include performing surgery or administering anesthesia to an immediate family member. Medical Staff appointees should not prescribe controlled substances for themselves or immediate family members.

When a Medical Staff appointee provides treatment for any patient, including an individual for whom treatment would be generally inappropriate under this policy, the Medical Staff appointee must obtain a patient history, perform a physical examination and appropriately document the treatment.

Medical Staff appointees providing treatment to themselves or their immediate family members should be mindful of State and Federal laws and regulations regarding proper prescribing, record keeping, and the requirement for a bona fide provider – patient relationship, as well as the American Medical Association's Code of Ethics and ethical statements and policies of other professional societies. Medical Staff appointees should also be mindful of Medicare regulations which prohibit payment for services to immediate relatives.

## 12.6 COMMUNICATION

The Medical Staff of York Hospital recognizes that electronic communication via email is the primary source of communication to meet the needs of our Hospital and Medical Staff. Electronic communication is a necessary tool to practice medicine and to be a responsible partner in the York Hospital community.

(a) All medical staff members shall maintain a Wellspan Health email address at all times.\

(b) Individual Wellspan Health addresses will be made available in the Wellspan Health Email Directory. Non-Medical Staff members will be discouraged from communicating to Medical Staff members via email.

(c) Distribution lists of Medical Staff members will be secure and maintained by the Medical Affairs Office, in an effort to prevent unauthorized use.

(d) Transmittal of patient data is permitted only within the WellSpan email network, assuming that the recipients of the email are entitled to receive the confidential information. Transmittal of patient data for any reason, outside of the WellSpan email network, will be considered an unauthorized disclosure of confidential information.

(e) It shall be the responsibility of all Medical Staff members to review the information sent to their email addresses at least every other day.

Use of the Cerner Inbox at least twice weekly is equally important in receiving important clinical and administrative communication**.**

## ARTICLE XIII. ADOPTION AND AMENDMENT

### 13.1 AMENDMENT

These Medical Staff Rules and Regulations may be amended or repealed, in whole or in part, as provided by Sections 12.1 and 12.2 of the Medical Staff Bylaws.

### 13.2 ADOPTION

#### 13.2-1 MEDICAL STAFF

The foregoing Medical Staff Rules and Regulations were adopted and recommended to the Board by the Medical Staff in accordance with and subject to the Medical Staff Bylaws.

_____
PRESIDENT OF THE MEDICAL STAFF

_____
DATE

#### 13.2-2 BOARD

The foregoing Medical Staff Rules and Regulations were approved and adopted by resolution of the Board after considering the Medical Staff's recommendation.

_____
CHAIRMAN OF THE BOARD OF DIRECTORS

_____
DATE

Including amendments adopted:

| | | | | |
|---|---|---|---|---|
| April 27, 1989 | June 8, 1998 | July 27, 2005 | January 28, 2009 | June 22, 2016 |
| July 26, 1990 | August 10, 1998 | September, 2006 | March 25, 2009 | |
| April 25, 1991 | August 25, 1999 | September, 2007 | October 27, 2010 | |
| March 30, 1993 | July 27, 2001 | October 24, 2007 | December 22, 2010 | |
| March 29, 1994 | January 28, 2004 | December 19, 2007 | August 3, 2011 | |
| June 28, 1995 | July 28, 2004 | March 2008 | August 28, 2013 | |
| March 20, 1998 | May 25, 2005 | June 25, 2008 | July 25, 2014 | |