

# **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.

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## **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 cannot 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. Medical record 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 medical history and physical examination must be completed and documented no more than 30 days before or within 24 hours after admission, registration, or observation status, but prior to surgery or a procedure requiring anesthesia. A consultation may be used, providing it was performed within 30 days of admission and contains all necessary elements. An updated examination of the patient, including any changes in the patient's condition, is required when the medical history and physical examination are completed within 30 days before admission, registration, or observation status. The update must be completed within 24 hours after admission, registration, or observation, 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 accordance with WellSpan policy MAP 138-Documentation in the Patient Record and the Epic Chart Correction Guide.

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) A post-procedure note must be completed immediately after a procedure (before the patient goes to the next level of care). The note must contain the following:
- Name of the procedure(s)
  - Description of the findings
  - Specimen removed
  - Estimated blood loss
  - Post-operative diagnosis
  - Name of the primary surgeon and any assistants

- b) A complete operative report must be completed within 24 hours. The operative report should contain:
  - Name of the procedure(s)
  - A comprehensive description of the findings
  - The technical procedures used
  - Specimens removed
  - Estimated blood loss
  - Post-operative diagnosis
  - Name of the primary surgeon and any assistants
  - Documentation of the post-procedure note and operative reports rests with the primary surgeon, who may or may not be the attending physician
- c) Repeated instances of failure to complete the post-procedure note immediately after surgery, or not completing 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 MAP 316 *WellSpan Health Orders Management Policy*. Physicians/APC's should always refer to orders activities 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 3.8.3 (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 3.8.3 (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 MAP 316 *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 Downtime Orders 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) The prerogatives of a dependent physician assistant shall be to: write orders, and give oral orders, subject to the limitations of his/her license, if any, which must be countersigned by the supervising physician in a timely fashion as determined by federal or state regulations.

(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) With rare exceptions, a Discharge Summary should be recorded for all inpatient and observation visits, excluding normal newborn and maternity cases, within 24 hours of 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.) Per MAP 305 Electronic Signatures/Authentication, 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 Residents cases, the following signatures are required:
- (d)i. Medical Service: The appointee of the Medical Staff assigned as Teaching Attending Physician must countersign the History and Physical Examination and Discharge Summary
  - (d)ii. Surgical Service: The appointee of the Medical staff assigned as Teaching Attending Physician on Surgical Service must countersign the History and Physical Examination, Operative Report and Discharge Summary.
  - (d)iii. Ob-Gyn Service: The appointee of the Medical Staff assigned as Teaching Attending Physician must countersign the History and Physical Examination, Operative Report when applicable and Discharge Summary.
  - (d)iv. Pediatric Service: The appointee of the Medical Staff assigned as Teaching attending Physician must countersign the History and Physical Examination and Discharge Summary. (d)v. Psychiatric Service: The appointee of the Medical Staff assigned as Teaching Attending Physician must countersign the History and Physical Examination and Discharge Summary.
  - (d)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 countersign the History and Physical Examination, Operative Report and Discharge Summary.

### **3.12 SECURITY AND CONFIDENTIALITY**

**Refer to WellSpan policies *MAP 106-Confidentiality and Information System Access* and *MAP 145-Uses and Disclosures of Protected Health Information*.**

### **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. No medical record shall be considered complete until all assigned deficiencies are resolved. Notices of records available for completion, delinquent records, and suspensions will be sent to the practitioners according to HIM policy and procedure. Failure to comply with the designated timeframes set forth in the policy will result in automatic and immediate temporary suspension of clinical privileges until the record is deemed to be complete.

- (a) During the temporary suspension of clinical privileges:
  - Patients already hospitalized may be cared for, but no new patients should be admitted to the practitioner's service.
  - Consultations already ordered may be completed, but no new consultations shall be allowed.
  - Procedures already scheduled may be completed by the practitioner, but no new procedures may be scheduled.
  - Exceptions for on-call or emergencies will be at the discretion of 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 \$1,000 fine will be assessed at the fourth occurrence of suspension (consecutive or nonconsecutive). Fines are payable to the York Hospital Medical Staff Fund within 30 days.

### 3.14

#### **INCOMPLETE CHART COUNT PROCEDURE**

- (a) Practitioners will have continuous access to their Epic in-basket to facilitate medical record completion.
- (b) The monitoring of medical record completion will be the responsibility of the Medical Record Department of York Hospital.
- (c) Communication regarding suspended practitioners will be sent via e-mail to 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) Communication regarding delinquent records will be sent via e-mail to residents who fail to complete their delinquent records. Copies of the e-mails will be forwarded to the appropriate Residency Program Director and their designee; the Medical Education Coordinator; and the Director, Medical Record Services.
- (e) As physicians complete their assigned delinquent records, the Medical Record Department of York Hospital will clear them from suspension. When clearing a practitioner, calls will be placed to Admissions, Emergency Department Administrative Office, and the Operating Room. A priority e-mail will also be distributed to appropriate individuals
- (f) Medical record 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
- v. Registered nurses practicing in the Emergency Department to identify emergency medical conditions in low complexity cases during a state of emergency or epidemic through activation of the Hospital Incident Command System

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

June 7th, 2021  
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.

  
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CHAIRMAN OF THE BOARD OF DIRECTORS

6/7/2021  
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	August 28, 2019
April 25, 1991	August 25, 1999	September, 2007	October 27, 2010	September 25, 19
March 30, 1993	July 27, 2001	October 24, 2007	December 22, 2010	October 23, 2019
March 29, 1994	January 28, 2004	December 19, 2007	August 3, 2011	May 18, 2021
June 28, 1995	July 28, 2004	March 2008	August 28, 2013	
March 20, 1998	May 25, 2005	June 25, 2008	July 25, 2014	