WASHINGTON HEALTH

MEDICAL STAFF

RULES AND REGULATIONS MANUAL

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WASHINGTON HEALTH

MEDICAL STAFF RULES AND REGULATIONS

I. Definition

Rules and Regulations apply to all Medical Staff members (and Advanced Practice Provider) regardless of staff category or department or section assignment. In addition to these Rules and Regulations, Medical Staff members shall comply with applicable federal and state regulations in effect now and in the future. Rules and Regulations are divided into those concerning patient care responsibilities and those concerning Medical Staff membership.

II. Patient Care Responsibilities

A. Admission

1. Patients may be admitted who require acute care consistent with the license of the Hospital. Admitting criteria shall be equivalent to the scope of service of each department. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated to the Admitting Department. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

2. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever.

3. The patient's care shall be managed by their attending physician. In the case of a patient applying for admission and having no physician, he/she shall be referred to the Emergency Department for disposition.

4. In case of an acute shortage of available beds, patients shall be admitted in according to the following priorities:

    a) critically ill patients whose condition may be life-threatening;
    b) non-critically ill patients who are residents of the Washington Township Hospital District;
    c) non-critically ill patients who are not residents of the Washington Township Hospital District.

    If necessary, arbitration of priority of admission shall be made by the Chief of Staff or designee.

5. Patients admitted to Inpatient Status by an Emergency Department physician between 8 AM and 9 PM must be seen by the attending/covering physician, within 6 hours. Patients admitted to Inpatient Status after 9 PM must be seen by the attending/covering physician by 9 AM the next morning on weekdays and 10 AM the next morning on weekends. An Admission Medication Reconciliation should be completed within 24-hours of admission by the attending/covering physician. If

an emergency medical condition arises during this time frame, the attending/covering physician is available and capable to see the patient, as per the Rules and Regulations.

6. Observation Unit Patient Care
    a) All physicians with current admitting privileges may serve as an attending in the WH hospital observation unit.

    b) All ED physicians and attending/covering physicians shall have direct telephone/text or face to face contact agreeing to place the patient in the observation unit under the care of the attending/covering physician. All admit orders for observation care must be entered at the time of admission to the unit. Observation unit contracted physicians will be the attending for all unassigned patients placed in the observation unit as well as any patient upon the request of their attending/covering physician.

    c) Patients placed in the observation unit between 8 AM and 9 PM must be seen by the attending/covering physician, within 4 hours. Patients placed in the observation unit after 9 PM must be seen by the attending/covering physician by 8 AM the next morning. If an emergency medical condition arises during this time frame, the attending/covering physician is required to see the patient within 30 minutes, as per the Rules and Regulations.

    d) Observation unit contracted physicians will be assigned by unit policy to provide care for all patients who cannot be seen in the above time frames and will become the attending while the patient is in the observation unit. Once such patients are discharged from the observation unit, they will be discharged/transferred back to their original attending physician for further care.

    e) All observation unit patients shall be cared for in accordance with the observation unit criteria and guidelines as developed by the Hospital administration.

B. Physician Backup

Each member of the Medical Staff shall name another member of the Medical Staff within the same clinical department who may be called to attend his patients in his/her absence.

When a physician signs out to another physician, that physician is responsible for providing appropriate medical care and/or consultation as required by the patient's needs. In case of failure to name such associate, the Chief of Staff of the Hospital shall have the authority to call any member of the staff to assume that patient's care.

C. Emergency Availability

All practitioners assuming 'on-call' responsibility for in-patient care and/or for Emergency Department coverage must be available at all times and be capable of being on site at the Hospital within an appropriate time (thirty (30) minutes maximum).

D. Consultations

1. Staff members are expected to make use of the consultative services available from members of the Medical Staff when indicated. Request for consultation shall be made by a physician.

2. Consultation is required in the following situations:

    - Patient's clinical course and/or care required are beyond the scope of the individual practitioner;

    - Diagnosis is obscure to the attending physician after routine diagnostic procedures and therapeutic measures have been completed;

    - In the Critical Care Units as outlined in the Critical Care privileging criteria.

    - When the assessment of the patient's needs or condition require specialized assessments to provide optimal care. This may include dental assessments. (Change approved by Board 5/8/02.)

3. A non-Medical Staff member with temporary privileges to consult on a specific patient cannot write orders, or be the attending physician, if not trained and competent in WeCare. (per U.1.d). Management and documentation will be performed by the Medical Staff member who obtained the consultant.

E. Patient Visits by Physician

A. Daily rounds should be initiated by 10 AM and completed, whenever possible, by 12 PM. Discharges should be complete by 12 PM.

B. All patients must be seen by a physician on each day and within twenty-fours (24) hours prior to discharge. If a patient's planned release from the Hospital is to occur beyond 8 hours but within 24 hours of the most recent physician evaluation, the following requirements must be met. The progress notes must be dated and timed and include clear documentation demonstrating the necessity for the patient's final day of hospitalization. The discharge order must include the medical conditions that should be met prior to discharge. There must be telephone communication between the physician and the nurse prior to the patient leaving the hospital.

F. Attending Physician

At the time of admission of a patient, the attending physician must be designated on the doctors order sheet. If no attending physician is so indicated, the admitting physician will automatically be designated as the "attending M.D." Prior consent must be obtained from the new designated attending physician by the physician writing the order of transfer. When there are two or more physicians involved in patient care management, one physician must be designated as primarily responsible to the involved nursing unit. The designated responsible physician should be recorded on the order sheet.

G. Medical Decision Making for the Incapacitated, Unrepresented Patient

In the event that a patient lacks capacity to make decisions and has no one to make decisions for them, assistance will be provided to the patient's physician(s) in making timely, thoughtful decisions regarding medical treatment according to Washington Health

Numbered Memorandum 3-251 and in compliance with State and Federal regulations.

H. Patient Transfers

Shall be considered when a patient's condition is no longer appropriate to the current care setting. Additional transfer criteria may be developed by specific Departments/Services. In making transfer decisions physicians should refer to Washington Health Numbered Memorandum 3-188 as a guide.

I. Pre-operative Verification Process

Prior to starting any invasive procedure, including those at the bedside, all members of the team conduct a final verification, or "time out", of the correct patient, procedure, site and, as applicable, implants.

J. *Discharge*

When a patient no longer requires acute care, and when satisfactory arrangements have been made to assure the continuity of care, discharge shall be considered. Patients shall be discharged only on the order of a physician, surgeon, dentist or podiatrist.

K. *Informed Consent*

The duty to describe invasive procedures to the patient and respond to the patient's questions concerning the nature of the procedure and obtain informed consent is exclusively the duty of the treating physician. Verification that informed consent has been obtained must be documented in the medical record. Refer to Washington Health Numbered Memorandum 3-177 as a guide.

L. *Blood Transfusion Consent*

The duty to describe the risks, benefits and alternatives of blood transfusion is exclusively the responsibility of the physician ordering the transfusion. Verification that informed consent has been obtained must be documented in the medical record.

M. *Pathology Examination*

All anatomical parts, tissues and foreign objects removed at operation with the exception of those surgical specimens specified by the Department of Health Services to be exempt, shall be sent to the Hospital pathologist who shall make such examinations as he/she may consider necessary to arrive at a pathological diagnosis. The findings shall be part of the patient's medical record.

A list of surgical specimens deemed exempt from pathology examination by the California Department of Public Health is available in the Operating Room. (Change approved by MEC 5/22, Board 6/12/03)

N. *Patient Rights*

The Medical Staff shall comply with State regulation and the Hospital policy regarding Patient's Rights. Refer to Washington Health Numbered Memorandum 1-104 as a guide.

O. ***Laboratory Work***

1. Pre-surgical lab work is as outlined in the Department of Anesthesiology Manual.

2. Lab work for uncomplicated obstetrical cases is as outlined in the Department of Ob/Gyn Manual, General Guidelines A. (Change approved by Board 5/8/02)

P. ***Repeated Orders***

Repeated Laboratory, EKG, x-ray and respiratory therapy orders should be renewed seventy-two (72) hours after admission and every seventy-two (72) hours thereafter.

Q. ***Do Not Resuscitate (DNR)***

DNR orders shall be documented according to Hospital policy. Refer to Washington Health Numbered Memorandum 3-149 as a guide.

R. ***Restraints and Seclusion***

Patients will be assessed for restraint and seclusion. Orders will be documented according to Washington Health Numbered Memorandum 3-303, and in compliance with State and Federal regulations. (Change approved by Board 1/9/02)

S. ***Medical Screening Exam***

All patients presenting to the Emergency Department for treatment and evaluation must be given a Medical Screening Exam (MSE) in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. Telephone orders for treatment will not be accepted.

T. ***Autopsy (approved Board 06/10/09)***

Deaths must be reported to the Alameda County Coroner according to Washington Health Numbered Memorandum 3-141.

Hospital Autopsy - Deaths that do not require being reported to the Alameda County Coroner or that the Coroner has released or declined to accept must be considered for Hospital autopsy.

All autopsies of deceased Washington Health inpatients performed at Washington Health are a free service provided by the Hospital and Pathologists. The attending physician must document an attempt to secure a consent for an autopsy for deaths that meet any of the following criteria:

Autopsy Criteria for Non Coroner's Deaths

1. Unknown cause of death

2. Unanticipated death
3. Death contributing complications which are unexplained
4. Pediatric, including neonatal, and obstetric patient deaths
5. Deaths from infectious diseases, which may have epidemiologic information
6. Deaths of patients in clinical trials
7. Deaths due to transplant rejection or complication
8. Family concerned about the patient's death. The family may independently request an autopsy.

Prior to the consented autopsy, the attending and pathologist should discuss the patient and the clinical findings. They may decide to limit to examination to relevant organ systems. The clinical staff is encouraged to attend the autopsy. The autopsy pathologist will chart the preliminary findings within 48 hours. The autopsy will be finalized within ninety days. The autopsy report will be forwarded to the appropriate Medical Staff Department(s) for further review and/or education.

U. ***Medical Record Responsibilities***

1. General Rules

   a. Any member of the Medical Staff wishing to exercise admitting or clinical privileges, and any Allied Health Professional wishing to exercise clinical privileges at Washington Health must be proficient in the Washington Health Healthcare System (WH) WeCare system, and must utilize WeCare when providing healthcare within WH.

   b. Each member of the Medical Staff and each Allied Health Professional as set forth above is required to learn and competently use WeCare to assure that the clinical information in WeCare is complete and accurate, and that other members of the Medical Staff, other Allied Health Professionals, and Hospital personnel may rely upon the clinical information in WeCare. Use of WeCare is essential to the continuous quality improvement program of WH.

   c. Medical records must be documented electronically into WeCare, electronically signed and updated by all practitioners with privileges providing care to patients. Failure to provide this documentation and signing will be considered a medical records deficiency, and may lead to Medical Staff/MEC disciplinary action as described in the Rules and Regulations.

   d. WH will grant security access to WeCare only to members of the Medical Staff and Allied Health Professionals who have completed WeCare training and have demonstrated a competency rate of 80 percent or higher on the WeCare examination. For Medical Staff and Allied Health Professionals who do not successfully complete the competency examination, additional training will be available to assure a reasonable opportunity to achieve sufficient competency levels.

   e. Any member of the Medical Staff or an Allied Health Professional who is not in compliance with the WeCare training and use provisions of this Rule after a reasonable opportunity to comply will not be eligible for reappointment, and will be subject to automatic suspension of admitting and clinical privileges under Article IV, Section 6.3 of the Medical Staff Bylaws.

f. All medical records are confidential and are the property of the Hospital. They are maintained for the benefit of the patient, the Medical Staff, and the Hospital. Records may be transferred from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In cases of readmission of a patient, all previous records shall be available for the use of the attending physician, whether attended by the same physician or another. Hospital records shall be made available to committees of the Medical Staff, to physicians undertaking statistical and research projects, and in preparation of medical papers.

2. Responsibility for Record Keeping

a. For the purpose of medical record keeping, the Admitting Physician shall be the attending physician unless otherwise indicated in the admitting orders. The attending physician will remain the same for the patient during the hospital stay unless transfer of care to another attending physician is documented in the Physician Orders. In obstetrical cases involving delivery, the physician who delivers the infant shall be the attending physician for the mother and the newborn unless otherwise documented in the Physician Orders. In cases involving a major surgical procedure, the primary surgeon shall become the attending physician **un**less otherwise specified in the orders.

b. For patients admitted to Washington Health, the attending physician at the time of discharge (not necessarily the discharging physician), will be responsible for medical record completion, including the discharge summary. The admitting physician, whether or not he/she is the attending physician, is responsible for the admitting history and physical

3. History and Physical Examination

a. A history and physical examination must include the following elements:

b. Medical history, including chief complaint, details of present illness, relevant past, social and family histories, and inventory by body system;

c. Summary of the patient’s psychosocial needs as appropriate to the patient’s age;

d. Report of relevant physical examinations;

e. Statement regarding allergies, immunization status (Pediatrics Only) and current medications;

f. Statement on the conclusions or impressions drawn from the admission history and physical examination;

g. Statement on the course of action planned for this episode of care and its periodic review, as appropriate;

h. A complete history and physical examination shall in all cases be recorded within twenty-four (24) hours after admission of the patient. History and

physical exams for short stay (i.e., same day discharge) must be dictated or documented in the record by 6:00 p.m. on the day prior to surgery. History and physical exams for all other elective surgical and invasive procedures (except PTCA) must be dictated or documented in the record by noon the day prior to that procedure.

g. A completed history and physical within 30 days before the patient is admitted, or if the patient is readmitted, requires an interval note reflecting the patient's current medical condition. If the patient is admitted more than 30 days from the last admission, a new history and physical will be required. (Rev. approved by MEC 6/21/04, Board 7/14/04).

4. Dictation

The following types of documentation must be entered into WeCare and cannot be dictated into the Hospital dictation system:

- Allergies
- Problem lists
- Orders
- Progress notes

5. Orders

All orders shall be entered into WeCare.

a. Orders cannot be dictated via the Hospital dictation system.

1. Preferably, verbal/telephone orders should be given to a registered nurse. For a list of other healthcare professionals who can accept physician orders, refer to Washington Health Numbered Memorandum 3-176.

2. Verbal orders are not accepted, except in emergency situations, or in a sterile environment where electronic order entry by the practitioner is not feasible.

3. Telephone orders are accepted only when the physician giving the order is off the Hospital campus, and cannot easily access a computer. The physician must remain on the phone so the registered nurse (or health care professionals identified in Memorandum #3-176) can enter into WeCare and then read the order back to confirm it.

4. All verbal and telephone orders must be authenticated by the ordering physician within forty-eight (48) hours. The ordering physician must enter all orders in the WeCare system, except for verbal or telephone orders entered by the registered nurse (or health care professionals identified in Memorandum #3-176). In cases where the ordering physician is not available, the attending or covering physician may authenticate verbal orders.

6. Patient Problem List

- During each admission, transfer and discharge the patient problem list must be reviewed and updated for lapsed, duplicate and related problems to maintain a clear, concise and accurate problem list.

7. Progress Notes

    - Daily progress notes are required on all patients and must be dated, timed and authenticated.

8. Post-Operative / Post-Procedure Notes

    a. A brief post-operative/post-procedure progress note which includes all pertinent information to anyone required to attend to the patient must be completed immediately after the procedure, and prior to the patient moving to the next level of care. Required elements are:

        - name of the primary surgeon, assistants, and anesthesiologist;
        - type of anesthesia;
        - findings;
        - procedures performed;
        - descriptions of the procedures;
        - estimated blood loss;
        - complications;
        - specimens removed;
        - postoperative diagnosis

9. Operative/procedure report must be entered into WeCare or dictated within 24 hours of the time of the operation/procedure and must record the name of the primary surgeon, assistants, anesthesiologist, type of anesthesia, findings, procedures performed, comprehensive descriptions of the procedures, estimated blood loss, complications, specimens removed, and postoperative diagnosis. The note can be reported if the note includes a comprehensive description of the procedure.

10. Abbreviations

    a. Only approved symbols or abbreviations for medical records should be used. Abbreviations listed as never to be used must not appear in any portion of the medical record. Refer to Washington Health Numbered Memorandum 3-198 as a guide. (Rev. approved by MEC 6/21/04, Board 7/14/04)

11. System Features

    a. Practitioners are responsible for managing their WeCare In-Basket, which should be reviewed regularly.

    b. Copy paste and copy forward should be used sparingly and with extreme caution. The author of the documentation is responsible for the entire content; any information which is copied, pasted, imported, or reused must be reviewed and revised as necessary by the clinician completing the documentation to ensure the patient's record accurately reflects the treatment provided. To avoid plagiarism, the original author of the copied information should be

acknowledged.

c. Auto-populated information must be reviewed for timeliness and accuracy prior to electronically signing a note.

12. Discharge Summary and Discharge Diagnosis

a. Discharge summaries are required for all patients with a stay in the hospital, including inpatients, observation patients, and OB patients.

b. The discharge summary must be completed within 72 hours of discharge, and must include:
   - the reason for hospitalization;
   - significant findings;
   - procedures performed;
   - care, treatment, and services provided;
   - information relative to the condition of the patient at discharge; ,
   - instructions to the patient and/or family, particularly in regards to physical activity limitations, medications and diet. (Rev. approved by MEC 6/21/04, Board 6/14/04)

c. A discharge diagnosis is to be made available to the Health Information Management Department within forty-eight (48) hours of the patient's discharge by the patient's attending physician.

13. Medical Record Completion

a. The attending physician, surgeon, dentist or podiatrist shall assure that the record is complete as required by the Bylaws, Policies and Procedures and Rules and Regulations. Incomplete records shall become delinquent fourteen (14) days after discharge from the Hospital.

14. Core Measure Documentation

a. Compliance with core measure documentation requirements shall be mandatory. Failure to complete the discharge checklist shall be deemed an incomplete medical record and subject to the same disciplinary process (Approved by MEC 3/21/05, Board 4/13/05).

b. Core measure order sets, including the admission order set and discharge summary record, are mandatory standing orders. (Approved by MEC 1/11/08, Board 1/23/08)

c. No patient will be discharged unless core measure documentation is complete; failure to comply with core measure documentation requirements prior to discharge will result in a quality report to the Chief of Staff or designee and may result in limited suspension. (Approved by MEC 1/11/08, Board 1/23/08)

15. Coding Queries

a. Coding queries must be answered and returned to the Health Information

Management Department within 96 hours once the physician is notified.

V. ***Request for Radiologic Consultation***

Requisitions for outpatient radiological consultation may be submitted electronically or on paper, and must include the clinical findings and/or the working diagnosis, as well as the type of examination desired

W. ***Use of the Emergency Department***

1. No Staff member shall "sign out" to the Emergency Department physician to provide continuous care for his/her patients, and may only sign out to members with like privileges. (change approved by Board 5/8/02)

2. Unnecessary use of the emergency facilities is discouraged.

3. Referral of urgent patients to the Emergency Department shall, when possible, be preceded by notification to the Emergency Department staff and/or physician.

4. Critically ill or injured patients will be stabilized by Emergency Department personnel. If the patient has a private physician on the Medical Staff, that physician will be consulted regarding continuing care and disposition.

X. ***Infection Control Policies***

1. Infection Control Policies are located in the Washington Health Numbered Memoranda, Section 6.

2. All practitioners shall comply with the current hospital policy regarding Universal Blood and Body Fluid Precautions. Refer to Washington Health Administrative Memo #3-190 as a guide.

3. All practitioners shall comply with the current hospital policy regarding Tuberculosis Screening for Healthcare Workers. Refer to Washington Health Administrative Memo #2-186 as a guide.

4. All patients with infectious diseases shall be isolated according to the infection control policies. If the attending physician wishes to question the isolation precautions instituted, he or she may discuss the matter with the Infection Control Coordinator.

5. Any patient admitted with a draining wound, sinus tract or other purulent draining lesion will be placed on appropriate precautions, according to infection control policies.

6. Certain infectious diseases must, by law, be reported to the Public Health Department. It is the responsibility of the physician in charge to report the diagnosis to the Hospital Infection Control Coordinator. The list of reportable diseases and the procedure for reporting is contained in the Infection Control

Policies.

7. Initiation and maintenance of intravenous lines is governed by Infection Control Policies, located in the Infection Control Manual.

8. All practitioners shall comply with current Hospital policy regarding proper hand hygiene. Refer to the Infection Control Policies as a guide (Change approved by MEC 11/15/04, Board 12/8/04).

Y. ***Patient Smoking Policy***

The Medical Staff recognizes that Washington Health is a smoke-free environment. Physicians are encouraged to order nicotine replacement procedures for hospitalized patient and promote smoking cessation programs for patients and consider prescription of nicotine replacement products for hospitalized patients. (Rev. approved by MEC 6/21/04, Board 7/14/04)

Z. ***Standardized Procedures***

The Medical Staff has approved the following standardized nursing procedures:

- Standardized Procedure for ED Care Initiated by the Authorized Registered Nurse. (Rev. IDPC 08/05/2020, MEC 08/17/2020, JCC 08/24/2020)
- Standardized Procedure for Peripherally Inserted Central Catheter (PIC Catheters) (Rev. IDPC 09/02/2020, MEC 09/21/2020, JCC 09/28/2020)
- Standardized Procedure for Pronouncement of Patient Death (Rev. IDPC 08/05/2020, MEC 08/17/2020, JCC 08/24/2020)
- Standardized Procedure for Removal of Jackson-Pratt, Hemovac, & Penrose Surgical Drains (Rev. IDPC 09/02/2020, MEC 09/21/2020, JCC 09/28/2020)
- Standardized Procedure for Medical Screening Examination for the Obstetrical Patient Performed by Registered Nurse (Rev. IDPC 07/01/2020, MEC 07/20/20, JCC 07/27/2020)
- Standardized Procedure for Sexual Assault Examination (Rev. IDPC 07/01/2020, MEC 07/20/2020, JCC 07/27/2020)
- Standardized Procedure for Evaluation of Patients with Behavioral Emergencies and Involuntary Holds by Authorized Registered Nurses (Rev. IDPC 09/02/2020, MEC 09/21/2020, JCC 09/28/2020)
- Standardized Procedure for Rapid Response Team (Rev. IDPC 11/04/2020, MEC 11/162020, JCC 11/23/2020)
- Standardized Procedure for Pressure Ulcer Prevention (Rev. IDPC 08/05/2020, MEC 08/17/2020, JCC 08/24/2020)
- Standard Procedure for Midline Catheter Insertion, Removal, and Management (Rev. IDPC 09/02/2020, MEC 09/21/2020, JCC 09/28/2020)
- Standardized Procedure for RSTU COVID-19 Nurse Initiated Protocol (IDPC 11/04/2020, MEC 11/16/2020, JCC 11/23/2020)

AA. ***Form Evaluation Protocol***

All requests for new or revised forms and order sets shall be processed through the EPIC Physician Steering Committee in accordance with Hospital policy. All patient instructions, new forms or forms with significant revisions that will become part of the medical record

shall be approved by the appropriate departmental committee(s) and the Clinical Evaluation Committee. Following appropriate Medical Staff approval, proposed forms will then be returned the EPIC Physician Steering Committee for processing. (Rev. approved by MEC 6/21/04, Board 7/14/04)

BB. ***Telemedicine***

Telemedicine is the use of electronic communication or other communication technologies to provide or support clinical care at a distance. The following services may be provided via telemedicine: diagnostic medical imaging, EKG interpretation, and communication of laboratory results.

CC. ***Medical Decision Making for the Incapacitated, Unrepresented Patient***

In the event that a patient lacks capacity to make decisions and has no one to make decisions for them, assistance will be provided to the patient's physician(s) in making timely, thoughtful decisions regarding medical treatment according to Washington Health Numbered Memorandum 3-251, and in compliance with State and Federal regulations.

III. Staff Membership Responsibilities

A. Department Assignment and Clinical Privileges

Each member shall be assigned to one (1) department and shall request a level of clinical privileges within that department. Except as defined in specific staff categories, each member shall also have delineated privileges. Documentation of appropriate training and experience to support the level and the delineated privileges will be required. Members may request additional privileges in other departments, with evidence of training and experience.

B. ***Liability Insurance***

Minimum professional liability insurance coverage must be maintained by all practitioners in the amounts of $1,000,000/occurrence and $3,000,000/aggregate as designated by the MEC and the Board of Directors.

C. ***DEA Certificate Schedules***

All practitioners are required to maintain schedules 2, 2N, 3, 3N, 4, and 5 on their DEA certificates. (Change approved by MEC 8/19/02, Board 9/11/02).

D. ***Solicitation and Advertising***

All members of the Medical Staff and Allied Health Professionals of Washington Health shall govern their professional conduct with regard to solicitation and advertising with concern for the principles of medical ethics. Advertising, whether in professional or non-professional publications, shall not identify Washington Health without the permission of the Washington Health Administration. Violation of this policy may result in expulsion from the Washington Health Medical Staff (Change approved by MEC 10/19/04, Board 12/8/04).

E. ***Procedure for Initiation of Special Studies***

The MEC must approve the initiation of special studies, surveys, or procedural changes.

F. ***Credential File Access***

- Any request by a staff member to view his/her own credentials file must be submitted in writing to the department chairperson and to the Chief of Staff. Access to physicians' personal credentials files is available only upon approval by the Chief of Staff or designee, and must contain the reason for the request. Any review of files will require a specific reason for doing so. Reviews will be individually logged with time, date, and stated reason. The log will be kept by the Medical Staff Secretary.

- A Medical Staff member shall be granted access to his/her own credentials file in the Medical Staff Office in the presence of the Chief of Staff or designee. The member may receive a copy of only those documents addressed personally to the member.

- Member's opportunity to request correction/deletion of, and to make an addition to information in the file:
  a) when a member has reviewed his/her file as provided above, he/she may address to the Chief of Staff or designee, a written request for correction or deletion from the file. Such request shall include a statement of the basis for the action requested;
  b) the Chief of Staff or designee shall review such a request within a reasonable time and shall recommend to the MEC, after such review, whether or not to make the correction or deletion requested. The MEC, when so informed, shall either ratify or initiate action contrary to this recommendation by a majority vote;
  c) the member shall be notified promptly, in writing, of the decision of the MEC;
  d) in any case, a member shall have the right to add to his/her own credentials file, upon written request to the MEC, a statement responding to any information contained in the file.

G. ***Operating Room Authority***

1. The Director of Perioperative Services is responsible for the scheduling of all operations. The Director shall use, as his/her guideline for scheduling procedures, the best interest of the patient, available staff, and available operating rooms.

2. The Director of Perioperative Services will have the general responsibility for the enforcement and compliance of the Operating Room Rules and Regulations as set forth. In the absence of the Director of Perioperative Services, the Operating Room Manager or Charge Nurse may call upon the Associate Administrator, Department of Surgery Chair (or designee) Operations & Support.

H. ***Emergency Department Call Roster Responsibilities*** **(Changes approved by MEC 12/20/04, Board 1/12/05)**

1. The Hospital shall be responsible for developing an on-call rotation of medical specialists, which consists of members with appropriate privilege level designation. Individual physicians shall participate on the roster pursuant to a contract with the

Hospital. On-call rotation schedules shall be maintained in the ED.

2. When a Staff member is on call for the Emergency Department call roster, that physician is responsible for and cannot refuse to evaluate a patient in an emergency situation anywhere in the Hospital, provided that the emergency falls within the member's area of clinical privileges.

3. On-call rotation schedules shall be maintained in a manner that best meets the needs of the residents of the District, considering the services offered by the Hospital and the availability of physician specialists.

4. Accurate rosters of on-call specialists and sub-specialists shall be retained for a period of five years.

5. Transfer arrangements with other hospitals that can provide the specialty service shall be made to cover the service when an on-call physician is not available. If a patient presents needing care when a specialty is not covered, the patient shall be transferred in accordance with Hospital policy.

6. When an on-call physician is contacted by the ED and requested to respond, the physician must do so within thirty (30) minutes, as required by these Rules & Regulations. The ED physician, in consultation with the on-call physician, shall determine whether the patient's condition requires the on-call physician to see the patient immediately. The determination of the ED physician shall be controlling in this regard.

7. An on-call physician is responsible for the care of a patient until the emergency medical condition is stable. An on-call physician shall not require insurance information or a co-payment before assuming responsibility for care of the patient.

8. A refusal or failure to timely respond shall be reported immediately to the appropriate Department Chairperson who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Medical Executive Committee for further investigation and appropriate disciplinary action. In this situation, the Department Chairperson shall notify the Chief of Staff and the Chief Executive Officer of the event.

9. In the case of a subsequent referral to an on-call physician, a copy of the Emergency Department record, including diagnosis and initial treatment may be placed in the on-call physician's mailbox. The Emergency Department shall inform the patient of his/her responsibility to make an appointment with the referral physician.

I. ***Medical Record Completion***

Failure to meet the medical record requirements of the Medical Staff described in this document will result in the following corrective action. After the third suspension or when the cumulative number of suspension days reaches 20 within any Medical Staff year for failure to complete medical records, the member will be referred to the MEC for review of their Medical Staff status.

The month after a physician meets the threshold, a letter will be sent to the physician from the Clinical Evaluation Committee notifying him/her of the referral to MEC. If sanctions are deemed by the MEC to be necessary, they will follow the procedure defined below. (approved by MEC 2/29/02, Board 3/13/02)

1. Warning letter from the MEC for first referral to the Medical Executive Committee;
2. 30-day limited suspension for a second referral within a Medical Staff year to the MEC;
3. 60-day limited suspension for a third referral within a Medical Staff year to the MEC;

4. Termination of Medical Staff appointment to include submission of an 805 report to the Medical Board of California for a fourth referral within a Medical Staff year to the MEC

In addition, corrective action will apply to members failing to adhere to meeting attendance requirements. Meeting attendance will be reviewed at the completion of each Medical Staff year.

Each year, in December, members will receive notification of their meeting attendance status for the current Medical Staff year. In June, at the end of the Medical Staff year, those members who do not meet the 50% meeting attendance requirement will be referred to the MEC for review of their medical staff status. If sanctions are deemed by the MEC to be necessary, the MEC will follow the procedure defined below.

1. Warning letter from the MEC for first referral to the Medical Executive Committee;
2. 30-day limited suspension for a second referral to the MEC;
3. 60-day limited suspension for a third referral to the MEC;
4. Termination of Medical Staff appointment to include submission of an 805 report to the Medical Board of California for a fourth referral to the MEC.

J. ***Physician Availability***

To assure the availability of the physicians and continuity of patient care, all members must:

1. provide the Medical Staff Office, at the time of appointment and reappointment and as may be necessary, with the name of a physician with like privileges who may be called in the member's absence;

2. maintain a reliable system by which to be reached during non-business hours. An answering service is recommended; however, if a pager system or cell phone is used, it must be easy and effective for patients and Hospital Staff to use;

3. be available at all times while on-call. It is not appropriate to ask an answering service to "hold" calls.

K. ***Physician Hand-Off and Covering Physician Guidelines***

The following are guidelines for the Medical Staff regarding "hand-off" situations, particularly, those situations that involve the transferring of on-call patient care responsibilities:

1. At the time of transfer of patient care responsibility to an on-call physician ("sign-off"), there must be clear 2-way communication with an opportunity for feedback of up-to-date information regarding:

    a) The patients who are covered and their locations;
    b) Current condition/status of patient(s) and relevant ongoing interventions;
    c) Any anticipated changes or likely problems to occur during the coverage period;
    d) any pending diagnostic studies that should be checked or followed up during the coverage period;
    e) Consultants involved and the scope of their activity and involvement in the case;
    f) Discharge planning considerations, especially if the patient is to be discharged during the period of coverage.

2. There must be clear communication to answering services and, when appropriate, nursing units, as to which physician in on-call and any permanent or temporary changes in the on-call schedule.

3. The physician is responsible for insuring that the answering service should, at all times, know who is covering a physician's patients and the answering service should be easily reached by calling the physician's office number when the office is closed.

4. Covering physicians should always be available through a phone call to the attending physician's office, which is then picked up by the answering service. Additional methods to contact the on-call physician are permissible (e.g., direct paging) as long as instructions to each nursing unit involved are clear and concise.

5. The attending physician or the physician covering the attending physician shall have the ultimate responsibility for responding to patient care issues. If there are multiple consultants involved and if the there is any confusion, disagreement, or other lack of clarity regarding which physician should respond to a problem the attending physician, or the attending physician's coverage, is responsible for responding to the problem in a timely manner.

6. If an attending physician is signing off on a case and will be transferring care of the patient to a new physician, the attending MUST:

    a) Confer with the physician who will be assuming the care of the patient.
    b) Place an order in the medical record transferring the patient to the new attending physician's service.

7. Urgent and emergent consultations for acute changes in a patient's condition should, whenever possible, be made through physician-to-physician verbal communication.

L. ***Photo I.D.***

All members of the Medical Staff are required to obtain appropriate photo identification issued by Washington Health and to display the identification prominently above the waist while in the Hospital.

M. ***Medical Staff Meeting***

There will be four general staff meetings held on the second Tuesday in September, January, March and June. The Annual Dinner/Dance will be held in May with installation of Medical Staff Officers.

N. ***MEC/Medical Staff Dispute Resolution Process***

Disputes between the Medial Executive Committee (MEC) and voting members of the Active Staff shall be resolved as follows. If at least one-third of the members of the Active Staff sign a petition proposing a change to the Bylaws, Rules and Regulations and policies or procedures or objecting to an action of the MEC relating to the Bylaws, Rules and Regulations, policies or other official MEC actions, the petition shall be presented to the full MEC. The MEC shall then arrange to meet with representatives of those who have signed the petition to discuss and attempt to resolve the matter. If the MEC and representatives mutually agree, consultants or a mediator may be engaged to assist. If a matter relating to bylaws, rules and regulations or policies is not resolved within 180 days, both the MEC and the representatives shall prepare written statements of position which shall be considered by the Board of Directors.

O. ***Requesting and Providing Confidential Peer Review Information***

During the processing of an application, reapplication or corrective action investigation, the Medical Staff requests information from another peer review body regarding its peer review of the practitioner for medical disciplinary cause or reason, in accordance with California Business and Professions Code § 809.08, the practitioner will pay reasonable costs associated with obtaining such information. Failure to pay reasonable costs will result in an automatic withdrawal of the practitioner's application or reapplication or the practitioner will be deemed to have resigned. Such action shall not entitle the practitioner to the procedural rights set forth in Article VII of the Bylaws and will not be reported to the Medical Board of California or the National Practitioner Data Bank

P. ***Medical Students***

Academic Medical Center Affiliated (AMCA) Medical Students may function in patient care roles at the Hospital as follows:

1. Pursuant to the provisions of written affiliation agreements approved by the Hospital and the Medical Staff;

2. In compliance with protocols established in conjunction with the (AMCA) Program Director regarding the scope of the Medical Student's authority, direction and supervision, and any other conditions imposed by the Hospital or Medical Staff; and

3. Subject to the following:

    a. Medical Students shall at all times wear a Washington Health photo identification badge that indicates the student's level of education and role at the Hospital;

b. Medical Students may examine patients, participate in patient care and assist at procedures only with the consent of the attending physician and under the direct supervision of a Supervising Physician, who shall be a qualified Medical Staff member with a (AMCA) Clinical Faculty appointment or who is a member of the medical staff in good standing who has been approved as a Supervising Physician by the Medical Staff in conjunction with the AMCA Program Director;

c. Medical Students may record initial histories and progress notes in the medical record provided, however, that all entries in the medical record shall include identification of student status and be countersigned by the Supervising Physician within 24 hours; and

d. Medical Students may write orders provided, however, that each such order must be countersigned by the Supervising Physician prior to being carried out.

Q. Residents (PGY-2 and above)

Resident Physicians are not independent practitioners, and are not board certified or board eligible. As such, they are not eligible for Medical Staff membership nor are they entitled to the rights and privileges of a Medical Staff Member. However, they may practice at Washington Health in roles as follows:

a. In accordance with rules and provisions of the American College of Graduate Medical Education (ACGME), the Council on Education of the American Medical Association, the American Osteopathic Association Board of Trustees through the Committee on postdoctoral training and the Bureau of Professional Education, and/or the residency training programs of the respective specialty boards;

b. In compliance with written training protocols established by the Medical Staff in conjunction with their Program Director regarding the scope of their authority, direction and supervision, and any other conditions imposed by the Hospital or Medical Staff;

c. Pursuant to a written affiliation agreement between the hospital and a sponsoring institution and in accordance with rules and provisions at their sponsoring institution.

d. The sponsoring institution shall provide professional liability insurance for each trainee and maintain compliance with all applicable ACGME rules and accreditation standards. The sponsoring institution shall immediately inform WH of any changes to their program accreditation status; and

e. Subject to the following:

1. Resident Physicians must possess a current Post-Graduate Training License (PTL) in accordance with CA State Law;
2. They must be in good standing at their sponsoring institution;
3. They will wear a Washington Health name badge identifying their

level of training and role at the Hospital;

4. They may examine patients, participate in patient care and assist at procedures and/or deliveries only with the consent of the attending physician and under the supervision of a Supervising Physician who shall be a qualified Medical Staff Member with a clinical faculty appointment at their sponsoring institution or shall be a qualified Medical Staff member in good standing and approved by the Medical Staff as a Supervising Physician in conjunction with their Program Director;
5. They may record initial histories and progress notes in the medical record provided, however, that all entries in the medical record shall include identification of their trainee status and be countersigned by the Supervising Physician within 24 hours; and
6. They may write orders provided, however, that each order must be co-signed by the Supervising Physician within 24 hours.

R. Fellows

Fellows that meet criteria for Medical Staff membership may apply for privileges in the generalist field in which they were trained. If they don't qualify for membership, they must follow the rules for residents.

IV. Finances

A. *Application Fee*

1. There shall be an application processing fee payable at the time the application is submitted.

2. Application fees shall be assessed in the following amounts (change approved 11/01/19):

Application for Medical Staff Membership	$600.00
Application for Locum Tenens Temporary Privileges	$600.00
Reapplication for Locum Tenens Temporary Privileges	$450.00
Application for Temporary Privileges (approved by Board 6/12/02)	$250.00
Telerad for Medical Staff Membership	$150.00

B. *1-Year Reappointment Fee*

A reappointment processing fee of $500 will be required for any practitioner who has 10 or more delinquent medical records as of the date his or her reappointment application is due. This fee reflects the increased cost of reappointment processing for practitioners placed on a one-year re-credentialing cycle. (Change approved by MEC 3/21/2022 and Board 4/13/2022)

C. *Annual Dues*

1. The MEC with the approval of the Active Staff will establish the amount and manner of

disposition of annual dues, if any. Dues are payable at the beginning of each new Medical Staff year (July 1). Failure, unless excused by the MEC for good cause, to render payment within two months of the start of the new staff year (September 1) shall, after special notice of the delinquency, result in summary suspension of staff membership (including all prerogatives) and clinical privileges until the delinquency is remedied. When a member's suspension has reached a maximum of 14 days, he/she will be deemed to have resigned. (Change approved by Board 11/13/02.)

2. Staff dues are assessed by the Medical Staff in the following amounts per Medical Staff year: (Change approved by Board 7/10/02, 11/01/19)

For Active, Consulting, Ambulatory, Administrative Staff, Advanced Practice Providers, and Provisional/Active and Provisional Advanced Practice Providers who join the staff July through December of the current year.	$300.00
For Provisional/Active Staff, Ambulatory, and Provisional Advanced Practice Providers who join January through June of the current year.	$150.00
For Courtesy and Provisional/Courtesy Staff who join the staff July through December of the current year.	$400.00
For Provisional/Courtesy Staff who join January through June of the current year	$200.00
Dentists (does not include oral surgeons).	$100.00
Honorary and Retired Staff	$0.00
Telerad	$100.00
Members on Leave of Absence - the full amount becomes due and payable when privileges are reinstated.	

3. Authority to Disburse Medical Staff Funds - The signature of any two Medical Staff Officers shall be required for disbursal of Medical Staff funds over $500.00. Any one Medical Staff Officer may sign checks in amounts up to $500.00.

4. Medical Staff Budget - The annual Medical Staff budget along with a balance sheet and cash flow statement will be presented to the Medical Executive Committee prior to the start of the Medical Staff year and to the General Staff at the September quarterly staff meeting.

5. Expenditure Limits - Any expenditure over $500.00 shall require the approval of the MEC. Request for Medical Staff funds shall be directed in writing to the MEC who will evaluate the request. It may be brought to the general staff if appropriate. Verbal requests for funds at Staff Meetings without previous consideration of the MEC shall not be allowed.

D. ***Stipends***

The Medical Staff shall pay the stipend of the Chief of Staff and the amount will be reviewed periodically by the MEC. The Medical Staff may provide a stipend to other officers or chairpersons at the discretion of the MEC.

V. ***Amendment to the Rules and Regulations***

Rules and Regulations shall be amended as outlined in the Medical Staff Bylaws, Article IX.

APPROVED by the Medical Staff on May 19, 2025
APPROVED by the Board of Directors on June 11, 2025