LADMC LA Downtown Medical Center LLC

MEDICAL STAFF
RULES & REGULATIONS

LADMC LA Downtown Medical Center LLC

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SECTION 1: ADMISSIONS & ATTENDANCE

1.1 ADMISSIONS

1.1-1 Only physicians granted Medical Staff membership and clinical privileges may admit patients except as otherwise provided in the Medical Staff Bylaws. All physicians with authority to admit patients shall be governed by the hospital's admitting policy.

1.1-2 A physician member of the Medical Staff shall be responsible for the medical care and treatment of each patient, for accurately and promptly completing the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring individual and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a statement covering the transfer or responsibility shall be entered on the order sheet of the medical record. The admitting physician shall be considered the primary attending physician, unless this responsibility is transferred as described above.

1.1-3 Patients shall be cared for by their own private physicians except as otherwise provided for in the Bylaws and Rules. Patients seeking treatment who have no attending physician shall be assigned to a member of the Medical Staff at the discretion of Administration.

1.1-4 A provisional diagnosis shall be stated at the time of patient admission.

1.1-5 The admitting physician shall provide such information as may be required to enable the hospital to protect the patients already admitted from patients who are, or may become, a source of danger from any cause whatsoever.

1.1-6 Patients admitted into the ICU must be seen by a physician within four (4) hours of admission to the unit.

1.1-7 Patients admitted to the ICU at the request of a surgeon after a complex/major surgery, require that the performing surgeon (or similarly qualified surgeon) document and complete a follow up visit with the patient within twenty-four (24) hours of admission.

1.2 ATTENDANCE

1.2-1 The attending physician, or delegated and credentialed Allied Health Professional will make rounds on patients under their care at least once every 24 hours.

1.2-2 If the attending physician or delegated and credentialed Allied Health Professional is unable to see the patients daily, he must make arrangements for another physician to make daily rounds.

1.3 CONTINUED HOSPITALIZATION

1.3-1 The attending staff member is required to document the need for continued hospitalization after specific periods of stay, as identified by the hospital's Utilization Review Plan, as approved by the Governing Board.

1.3-2 Such documentation shall contain:

a. the reason for continued hospitalization;
b. the estimated period of time the patient will need to remain in the hospital; and

c. plans for post-hospital care.

SECTION 2: DISCHARGES

2.1 DISCHARGE ORDERS

Patients shall be discharged only by order of the responsible physician at the time of patient discharge.

2.2 AGAINST MEDICAL ADVICE

Should a patient leave Against Medical Advice (AMA) and without proper discharge, a notation of the incident shall be made in the patient medical record by the attending staff member and an attempt shall be made to have the patient sign an “Against Medical Advice” form for the record.

2.3 FINAL DIAGNOSIS/ DIAGNOSES

Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and shall be dated and signed by the responsible physician at the time of patient discharge.

SECTION 3: DEATHS, AUTOPSIES, & REPORTABLE CONDITIONS

3.1 DEATHS

3.1-1 In the event of patient death, the deceased shall be pronounced dead by the attending staff member(s) or his/her designee.

3.1-2 It is the responsibility of the attending physician to complete the death certificate.

3.1-3 The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those cases of incontrovertible or irreversible terminal disease wherein the patient course has been adequately documented to within a few hours of death.

3.1-4 Potential organ donors shall be identified and the families of potential organ donors made aware of the option for organ or tissue donation, using discretion and sensitivity with respect to circumstances, views, and beliefs of family members.

3.2 AUTOPSIES

2.5-1 It shall be the duty of Medical Staff members to secure meaningful autopsies whenever possible. However, an autopsy may only be performed with a valid written consent and in accordance with state statutes.

2.5-2 Provisional anatomic diagnoses shall be recorded in the medical record within three (3) days; the complete protocol shall be made a part of the record within ninety (90) days.

2.5-3 The purpose of an autopsy is to define the cause of death, to serve as a quality assurance tool, and to provide education. Specific indications for autopsy include, but are not limited to:

a. diagnostic uncertainties
b. complication of treatment or diagnostic procedures, e.g., drug reaction or transfusion
c. autopsy is requested by the family
d. to resolve questions raised by the family about patient care
e. death due to a disease which may have significant implication for organ recipients or family survivors
f. death associated with occupation or environmental hazards
g. for documentation and/or identification of genetic or congenital abnormality
h. death early in hospitalization before a diagnosis is made
i. if there is a possibility of litigation (offer to family and document)

3.3 REPORTABLE CONDITIONS

The Coroner's Office shall be notified of any death that constitutes a Coroner's Case. In accordance with state statutes, the Coroner must be notified and shall either view the body or conduct an investigation in all cases involving the following:

a. Suspicious, unexpected or unusual deaths Joann to verify Code 13
b. Sudden, violent deaths

c. Deaths due to unknown or obscure causes in an unusual manner
d. Deaths without an attending physician's visit within thirty-six (36) hours prior to the death
e. Deaths due to suspected suicide or homicide
f. Deaths in which poison is suspected
g. Any death from natural causes occurring in the hospital within twenty-four (24) hours of admission unless seen by a physician in the previous thirty-six (36) hours
h. Deaths due to trauma from whatever cause
i. Deaths due to criminal means or by casualty
j. Deaths in prison or while serving a sentence
k. Deaths due to virulent contagious disease that might be caused by or cause a public hazard

SECTION 4: CONSULTATIONS

4.1 REASONS FOR CONSULTATIONS

Except in an emergency, consultations shall be obtained by a qualified physician in cases which, according to the judgment of the attending physician

a. the patient is a medical risk or not a good surgical candidate
b. the diagnosis is obscure
c. there is doubt as to the best therapeutic measures to be utilized
d. in unusually complicated situations where specific skills of other practitioners may be needed
e. when requested by the patient or patient's family

4.2 DOCUMENTATION

A consulting physician shall record and sign a report of his findings and recommendations which shall become a permanent part of the medical record.

4.3 QUALIFICATIONS

Any qualified practitioner with clinical privileges at the hospital can be called for consultation within his area of expertise.

SECTION 5: CONSENTS

5.1 GENERAL CONSENT

A general consent for treatment form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission.

5.2 SPECIFIC CONSENT

In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of risks inherent in any special treatment or procedure, as well as any alternative modes of treatment, and the benefits of the procedure shall be explained by the physician performing the procedure and a notation shall be recorded in the progress notes. When consent forms cannot be obtained, the reason shall be documented in the patient's record.

SECTION 6: MEDICAL RECORDS

6.1 GENERAL REQUIREMENTS

6.1-1 All entries in the medical record shall be accurately timed, dated, and authenticated by the person responsible for entry

6.1-2 Symbols and abbreviations may be used in the medical record only when they have been approved by the Medical Staff. An official "do not use" abbreviations list shall be kept on file in the Health Information Management Department.

6.1-3 The Medical Executive Committee may authorize persons or classes of persons to make entries in the medical record. The following persons may make entries in the medical record within the responsibilities of their job description as required by HIPAA regulations. This list may be modified at the request of the Medical Executive Committee.

a. Members of the Medical Staff
b. Members of the Allied Health Professional Staff
c. Registered and licensed nurses
d. Dietitians
e. Physical Therapists
f. Occupational Therapists
g. Respiratory Therapists
h. Speech Therapists
i. Recreational Therapists
j. Social Workers
k. Pharmacists
l. Certified Nurse Assistants
m. Healthcare Technologist
n. Phlebotomist

6.1-4 Medical student/ residents, physician assistant students, and nurse practitioner students may also document in the record upon the request and under the direct supervision and countersignature of an active staff member.

6.1-5 All physicians making entries in the medical record shall be required to maintain an updated signature form on file with the Medical Staff Administration, containing all valid signatures to be used by the physician in the medical record. All other signatures shall be considered invalid for record completion.

6.2 CONTENT

The attending staff member shall be responsible for the preparation of a complete and legible medical record for each patient. The contents of the medical record shall be pertinent and current; and shall include the following:

a. Informed consent for medical or surgical treatment
b. Patient identification data

c. Chief complaint
d. Medical history, including chief complaint, present illness, relevant past, social and family histories (appropriate to patient's age)
e. Inventory by body system/ review of systems
f. Physical examination
g. Summary of psychosocial needs as appropriate to patient age, as applicable
h. A provisional/ differential diagnosis upon admission
i. Diagnostic and therapeutic orders
j. Progress notes
k. Reports of operative and other invasive procedures and tests
l. Pathology findings
m. Special reports such as radiology, clinical laboratory, respiratory, physical, occupational, and speech therapies, consultations, donation of organs, transplants and/or implants
n. Final diagnosis/diagnoses
o. Condition on discharge
p. Discharge summary
q. Discharge instructions to include diet, activity, medication, and follow-up instructions
r. Autopsy report, if applicable

6.3 HISTORY & PHYSICAL

6.3-1 GENERAL

a. A complete history and physical examination shall be completed and signed within twenty-four (24) hours of the patient admission and must contain the required elements 6.2-a through 6.2-i, noted above. This can be completed by the attending physician, or his/her designee.
b. If a complete history has been performed by a physician or his designee at another facility within thirty (30) days of the patient's current admission, a durable, legible copy may be used in the medical record. The attending physician, or his/her designee, must validate and sign this report within 24 hours of admission and an interval admission note which includes any additions to the history and any subsequent changes in the physical findings must be recorded.
c. In the case of a patient re-admitted for the same or related problem within thirty (3) days of discharge, the medical record may be updated by an interval note describing any changes in the patient condition. The interval history and physical must be completed and signed within twenty-four (24) hours of admission and the original history and physical examination should be readily available.

6.3-2 PSYCHIATRIC EVALUATIONS

An initial Psychiatric Evaluation must be completed within twenty-four (24) hours of admission to a Psychiatric care unit. This documentation shall also serve to fulfill the state requirement of initial evaluation of a patient if done prior to a medical physician evaluation. For Psychiatric Consultations requested for patients in other medical units, the existence of a Psychiatric Consultation must be documented immediately in the medical record. The Psychiatric Evaluation must contain the following elements:

1. Patient identification data
2. Present complaint
3. History of Present Illness
4. Psychosocial History
5. Mental Status Exam, which includes the following (as applicable)
    a. Appearance
    b. Orientation to person, place, and time
    c. Speech
    d. Mood
    e. Affect
    f. Though content
    g. Behavior
    h. Insight and adjustment
6. Plan of care/treatment

6.4 PROGRESS NOTES

6.4-1 Pertinent progress notes shall be recorded at the time of observation. These shall be sufficient to permit continuity of patient care and to facilitate patient transfer, if necessary.

6.4-2 Progress notes shall be written daily on all patients and include the following elements:

a. Clinical diagnoses and/or differential diagnoses
b. Unusual occurrences
c. Changes in medications or treatment
d. Updates to physical examination
e. Updates to review of systems

6.4-3 If a physician utilizes an Allied Health Professional to make daily rounds, the Allied Health Professional may only complete those documentation types as requested in the designation agreement and the attending physician must co-sign all progress notes within 14 days of the patient discharge.

6.5 ORDERS

6.5-1 GENERAL REQUIREMENTS

All orders for treatment shall be in writing or via computerized provider order entry (CPOE) and shall be timed, dated, and signed by the provider. The phrase “continue previous orders” is not an accepted mode of verifying any orders for a patient; each order must be verified.

6.5-2 WRITTEN ORDERS

Written orders may be utilized when CPOE is not possible. All orders shall be written clearly, legibly, and completely. Orders which are illegible or improperly written shall not be carried out under rewritten or clarified by the individual whose responsibility if it to carry out the order. Procedure for such occurrences is as follows:

a. Upon receipt of a questionable or illegible order, the individual responsible for carrying out the order shall first review it with the provider
b. If doubt remains as to the clarification by the provider, the individual responsible for carrying out the order shall refer the matter to his/her supervisor.

6.5-3 TELEPHONE ORDERS

Telephone orders shall be entered on behalf of the providers if dictated to a registered nurse, pharmacist, respiratory therapist, occupational therapist, physical therapist, or social worker. These orders shall be signed by the person to who they were dictated and the name of the physician giving the orders shall be documented. The physician or his designee shall countersign such orders within forty-eight (48) hours.

6.5-4 STANDING ORDERS

When specific orders are not written by the attending physician, hospital protocols will constitute the orders for treatment. Standing orders shall be reviewed on an annual basis and revised as necessary. These orders shall be followed insofar as proper treatment of the patient will allow.

6.5-5 DO NOT RESUSCITATE (DNR)

Do Not Resuscitation orders must be written/entered by the attending physician. This order may be given verbally only if transcribe by two licensed nurses.

6.5-6 LABORATORY AND RADIOLOGY ORDERS

All Laboratory and Radiology orders must include a reason for the order.

6.5-7 DIETARY ORDERS

a. Therapeutic diets shall be prescribed by the attending staff member. Where any doubt exists as to the intent of the order, the diet clerk will contact the responsible provider for clarification. If the provider cannot be reached, the Clinical Dietician will interpret the order as deemed best and subsequently advise the provider of the interpretation. For obscure or special diets, the provider should contact the Clinical Dietician directly. The following are accepted standards for dietary interpretation:
    1. DAT/ Diet as Tolerated = GI Soft Diet
    2. Low Sodium = Cardiac Diet/ 2mg Sodium Restricted Diet
    3. Low Potassium = Renal Diet
    4. Diabetic Diet = Carbohydrate Consistent Diet
    5. Dysphasia Diet = Pureed Diet
    6. Low Calorie Diet = 1500 Calorie Restricted Diet

6.6 DISCHARGE SUMMARY

A discharge summary shall be completed for all inpatients and shall include:

a. Reason for admission

b. Significant findings
c. Procedures performed and outcomes of said procedures
d. Treatment rendered
e. Condition of patient on discharge
f. Discharge instructions
g. Medications and prescriptions rendered

6.7 DELINQUENCIES

6.7-1 The medical record should be complete at the time of patient discharge, including progress notes, final diagnosis and discharge summary. Where this is not possible because final laboratory or essential reports have not been received at the time of discharge, the medical record shall be made available to the attending physician and shall be completed within fourteen (14) days. The medical record is then considered Delinquent if incomplete more than fourteen (14) days.

6.7-2 If the record remains incomplete fourteen (14) days after discharge, the CEO or designee may notify the responsible physician that they will be placed on the Suspension List if they record remains incomplete thirty (30) days after the patient discharge. A notice of delinquency shall be sent to the physician via certified mail, indicating the suspension of admitting privileges will occur if the record is not completed by the end of the thirty (30) days.

6.7-3 MEDICAL RECORD SUSPENSION LIST

The Medical Records Suspension list shall contain the list of providers who have records that have been incomplete for greater than thirty (30) days. If a provider is placed on this list, they shall not be permitted to admit any new patients.

a. If they are responsible for the care of patients in the hospital at the time of suspension, they shall continue to be responsible for those patients until discharge; however, no new patients may be admitted.
b. If a provider has remained on the list for a consecutive forty-five (45) days, their Medical Staff privileges shall be terminated. The provider may elect to apply for reinstatement of staff membership. However, approval of an application for reinstatement can only be made after the completion of all delinquent medical records.
c. If patients are admitted under the name of a partner/associate of a provider who is on the Medical Record Suspension List, the provider listed on the admission/discharge shall be responsible for the completion of the medical record.

6.8 INCOMPLETE RECORDS

6.8-1 No medical record shall be filed until it has been completed by the responsible physician, except on order of the Medical Executive Committee. No staff member may complete a record on a patient unfamiliar to him who is deceased or otherwise permanently unavailable. A notation and the date shall be made in the medical record,

indicating the reason the record is being filed prior to completion. Once filed incomplete, the record shall not be modified at a later date.

6.8-2 At the request of the Medical Records Committee, the Medical Executive Committee is permitted to declare the records complete of physicians who fall under the following categories:

a. deceased
b. moved out of the community and no longer have medical staff privileges
c. are unavailable to complete their records for any reason
d. clinical privileges have been terminated for any reason

6.9 RELEASE OF INFORMATION

6.9-1 Written consent of the patient (or legal representative) is required for release of medical information to persons not otherwise authorized to receive such information.

6.9-2 Records of all patients shall be made available to members of the Medical Staff for bona fide study and research projects approved by the Medical Staff, provided such projects can be carried out in accordance with policies formulated to preserve the confidentiality of personal information concerning patients.

6.9-3 Records may be removed from the hospital's safekeeping and jurisdiction only in accordance with a court order, subpoena, or statute.

6.9-4 All records are the property of the hospital and shall not otherwise be removed without permission of the CEO.

6.9-5 Unauthorized removal of charts or patient information from hospital premises shall be grounds for suspension of the staff member for a period to be determined by the Chief of Staff.

6.9-6 In the event of readmission of a patient, all previous records shall be made available for the use of the attending physician and any staff member who renders service/treatment to the patient.

SECTION 7: DRUGS & MEDICATIONS

7.1 DRUGS AND MEDICATIONS

7.1-1 All drugs and medications administered to patients shall be from the list in the latest edition of the United States Pharmacopeia-National or AHFS Drug Information.

7.1-2 Drugs of bona fide clinical investigation or research shall be exceptions. These shall be used in full accordance with the Statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the U.S. Food and Drug Administration.

7.2 ORDER RENEWALS AND STOP ORDERS

All drugs, scheduled and non-scheduled, have a thirty (30) day renewal time frame except for the following: Antibiotics (7) Seven days; Narcotic/Hypnotics (7) Seven days; Anti-tussives (10) Ten days and Anti-emetics (5) Five days. This does not preclude the physician from ordering a medication for a time period different from the above, but, in the absence of a specific order, these limits shall be utilized. Orders must be entered in the patient record as specified in Section 6.5.

7.3 PATIENT EDUCATION

It is the responsibility of the attending physician to educate the patient regarding prescribed medications and possible side effects, food-drug interactions, etc.

7.4 GENERIC MEDICATION SUBSTITUTIONS

Generic equivalents may be substituted for prescribed medications unless otherwise specified by the attending physician.

7.5 HOME MEDICATIONS

All medication brought into the hospital by a patient shall be sent to the Pharmacy for proper storage or identification. The pharmacist shall verify that the medications are in fact those that the attending physician has prescribed or permitted. Any such medication shall be administered as directed by the attending physician.

SECTION 8: ALTERNATE/ EMERGENCY CARE

Each member of the Medical Staff shall designate another member of the Medical Staff to be called in an emergency to attend his patients in the event the attending physician is not available or until the attending physician can be present. When a designated member has not been named or when the designated member cannot be contacted, the CEO or Chief of Staff shall have the authority to contact the on-call physician or other member of the Medical Staff to attend the patient.

SECTION 9: CONTINUING MEDICAL EDUCATION

9.1 GENERAL REQUIREMENTS

Continuing education requirements for members of the active staff shall be in compliance with the requirements established to accreditation bodies and state licensing boards. Each Medical Staff member or other staff members with clinical privileges shall participate in continuing education activities that relate to privileges granted.

9.2 CARDIOPULMONARY RESUSCITATION

All members of the Medical Staff are encouraged to participate in pertinent self-assessment programs and in basic cardiopulmonary resuscitation training unless additional advanced training is a requirement of requested privilege. Basic Life Support and/or Advanced Cardiac Life Support certifications are recommended for all physicians.

9.2-1 All Urgent Care physicians, surgeons, and Allied Health professionals are required to maintain adult and pediatric resuscitation certifications.

9.2-2 ACLS/PALS training will be waived for those MDs who are Board Certified/Eligible in Critical Care, Emergency Medicine and Anesthesiology. Resuscitation practice is part of the scope of training for these professionals and the skills they have exceed those presented in ACLS/PALS.

9.3 MODERATE SEDATION

Any non-Anesthesiologist who chooses to perform Moderate Sedation must request this privilege via Medical Staff and undergo the appropriate credentialing process to obtain approval. Education and training requirements are as outlined by the Procedural Sedation Policy and Procedure.

SECTION 10: DISASTER PLAN & EMERGENCY PREPAREDNESS

10.1 DISASTER PLAN

In the event of any major disaster, there shall be a plan for the care of mass casualties based upon the hospital's capabilities in conjunction with other emergency facilities in the community. This plan shall be reviewed and approved by the Medical Executive Committee on an annual basis, but can be modified at the time of a disaster to better suit the specifics of the disaster.

10.2 DISASTER RESPONSIBILITIES

10.2-1 All physicians may be assigned to posts and it shall be their responsibility to report to the post.

10.2-2 The Chief of Staff and the CEO shall work as a team to coordinate activities and directions.

10.2-3 In the event that patients must be evacuated from one section of the hospital to another or from the premises, the Chief of Staff of the CEO shall authorize the movement of patients.

10.2-4 All policies concerning direct patient care shall be a joint responsibility of the Chief of Staff and the CEO.

10.3 EMERGENCY PREPAREDNESS

The disaster plan shall be rehearsed at least annually, preferable as part of a coordinated drill in which other community emergency service agencies participate. The drills shall include the Medical Staff, administrative, nursing, and other personnel and there shall be a written report and evaluation of all drills.

SECTION 11: MEDICAL STUDENT/ RESIDENT MEMBERSHIP

11.1 QUALIFICTIONS

Resident staff membership shall be held by post-doctoral trainees in training programs of teaching institutions who are not eligible for another staff category and who are either licensed or registered with the appropriate state of California licensing board. They must also maintain Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS) Certification and other credentialing documents.

11.2 APPOINTMENT

Post-doctoral trainees who are enrolled in accredited residency training programs and who meet the above qualifications shall be appointed to the Resident Staff of the department assigned to the given specialty. Members of the Resident Staff are not eligible to hold office within the Medical Staff, but may participate in the activities of the Medical Staff. They may also participate in the activities of the Medical Staff through membership on the Medical Staff committees in a non-voting capacity.

11.2-1 DURATION OF APPOINTMENT

Appointment to the Resident Staff shall be for one (1) year and may be renewed annually. The observational period required for provisional staff members shall not apply to the Resident Staff. Resident Staff membership terminates with termination from or completion of the training program.

11.3 PREROGATIVES

All medical care provided by a Resident Staff member is under the supervision of members of the medical staff of the assigned department with privileges granted for the medical care/ procedures provided.

SECTION 12: RESTRAINTS

The use of mechanical restrains shall require clinical justification and shall be used only to prevent a patient from injuring themselves or other, or to prevent serious disruption of the therapeutic environment.

1. Mechanical restraints shall not be used as a means of punishment or for staff convenience.
2. Each order for restraints shall be time limited and must be renewed every four (4) hours
3. PRN (as needed) orders cannot be used to authorize the use of restraints

SECTION 13: GENERAL RULES REGARDING SURGICAL CARE

13.1 SURGEONS

The following Physicians and Surgeons may carry out procedures in the operating room:

- A surgeon with full privileges within his/her specialized field.
- A new staff member of the surgery department, with proctoring in accordance with the Medical Staff Bylaws, Rules and Regulations.
- Physicians in specialties other than surgery who may be granted privileges for certain surgical procedures, after appropriate review and approval by the surgery department.
- Physicians permitted to serve only as assistants.

13.2 SURGICAL PRIVILEGES

A copy of each member's privileges shall be available within the surgical suite and shall be available to the surgery supervisor or his/her designee for each shift. Information regarding any specific practitioner's privileges will be made available to any practitioner scheduled to participate in a surgical operation.

13.3 SURGICAL ASSISTANTS

Surgical assistants are required for major procedures unless excepted by hospital policy and procedure. The choice of surgical assistant for any operative procedure shall be left to the discretion of the responsible surgeon.

13.4 REQUIRED DOCUMENTATION

13.4-1 When more than one (1) procedure is to be done, the surgeon performing each procedure must identify him/herself on the operative book, the consent form, the anesthesia record, and the surgical dictation.

13.4-2 A history and physical examination must be in the chart when the patient is admitted to the operating room suite.

13.4-3 The record shall contain appropriate screening test results based on the needs of the patient, accomplished and recorded within seventy-two (72) hours prior to surgery.

13.5 SURGEON RESPONSIBILITIES

The operating surgeon is responsible for the preoperative diagnosis, evaluation, and preparation of the patient, and for surgical postoperative care of each patient upon whom he/she operates.

13.6 OUTPATIENT SURGERY

Outpatient surgery shall be conducted in accordance with the rules and regulations for that service, as set forth in its manual.

13.7 SCHEDULING SURGERY

13.7-1 All elective surgery and emergency cases will be scheduled with the nurse in charge of the surgery suite, or his/her designee in accordance with the rules and regulations for that service, as set forth in its manual.

13.7-2 At hours when the operating suite is closed, emergency cases will be scheduled with the supervisor of nurses in charge of that particular shift.

13.7-3 A list of guidance for emergency operations will be prepared and posted in the surgical suites, and the nurse in charge will be authorized to follow this guide in scheduling surgery. In case of conflict, the Chief of Surgery or Chief of Staff shall make the determination.

13.7-4 Initial scheduling of all cases shall be for 7:30 A.M., unless the hour is already full. All personnel involved shall be ready and the patient should be wheeled into the operating room at 7:30AM. Scheduling of 7:30 AM cases is a privilege, and the right to schedule a case at 7:30 A.M. may be lost if the surgeon and his/her assistant comes late repeatedly.

13.7-5 Surgeons should be in the hospital fifteen (15) minutes before the scheduled time and in the operating room, ready to begin the operation at the scheduled time. The operating room may be held no longer than fifteen (15) minutes after the scheduled time.

13.8 ANESTHESIA

13.8-1 The Anesthesiologist shall be assured that there has been a recent preoperative physical examination with appropriate laboratory data in the clinical record on all patients assigned to him/her. The pre-anesthesia evaluation must include appropriate documentation of pertinent information relative to the choice of anesthesia and the surgical procedure anticipated must be documented with 24 hours.

13.8-2 This evaluation must include the patient’s previous drug history, other anesthetic experience, and any potential anesthesia problems.

13.8-3 The anesthesiologists shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient’s condition.

13.8-4 Explosive anesthesia will not be used in the operating room.

13.9 INSTRUMENT COUNTS

Sponge, needle, and instrument counts will be done on all cases as defined in policy and procedure.

13.10 VISITORS:

Visitors will not be permitted in the operating room during surgery, other than visiting practitioner, qualified medical students, authorized technicians, medical photographers, student nurses, and other persons specifically authorized by the patient, surgeon, and surgery supervisor.

13.11 POSTOPERATIVE NOTES

Frequent postoperative noted will be written in sufficient detail to describe the patient’s condition clearly at all times.

13.12 DISPOSITION OF TISSUE

13.2-1 All tissue removed during operations shall be sent to the hospital pathologist, who shall make such examination as he/she considers necessary to arrive at a pathological diagnosis. The pathologist's report shall be made a part of the patient's medical record.

13.12-2 No specimen of any nature removed during surgery may be taken from the hospital without the expressed consent of the pathologist.

LA DOWNTOWN MEDICAL STAFF RULES & REGULATIONS

ADOPTED BY THE MEDICAL STAFF ON: February 06, 2020

SIGNED BY: Jacob N. Flores, MD - Chief of Staff

APPROVED BY THE GOVERNING BOARD ON: February 06, 2020

SIGNED BY: Vicki Rollins, Governing Board Committee Chair