RULES AND REGULATIONS
OF THE
MEDICAL STAFF

The following statements shall be considered general rules and regulations concerning activities of the medical Staff and are subordinate to the Medical Staff Bylaws. They may, however, be supplemented by departmental and/or section, committee, or administrative policies.

A. ADMISSION AND DISCHARGE OF PATIENTS:

A.1. All patients shall be admitted by a member of the Medical Staff. Dentists and Dentists who are oral surgeons and podiatrists who are members of the Medical Staff with clinical privileges may admit patients. A physician member of the Medical Staff will be designated by admitting dentists and dentists who are oral surgeons, and by podiatrists in the patient chart at the time of admission. The designated physician will be responsible for the history and physical examination of patients admitted by dentists and podiatrists. Dentists who are Oral surgeons who admit patients without medical problems may perform the history and physical examination if they have been granted appropriate clinical privileges. The designated physician will be responsible for the medical care of patients admitted by dentists and dentists who are oral surgeons, or podiatrists and the physician, and each is responsible for his/her portion of the patient’s record.

A.2. Except in an emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated and the consent of the Administrator or his/her delegate has been obtained. In cases of emergency, the provisional diagnosis shall be after admission as possible.

A.3. Private patients shall be attended by their own private practitioners. Private Patients who have no attending practitioner shall be assigned to a member of The Medical Staff on duty in the department or service to which the illness of the patient necessitates admission. A schedule for such assignments shall be provided by the department chairmen.

A.4. Practitioners admitting private patients shall be responsible for giving such information as may be necessary to assure the protection of other patients from those patients who are a source of danger from any cause knowledgeable to the practitioner at the time of admission.

A.5. All service patients shall be attended by a member of the Medical Staff who is on the roster of the department and/or section to which the illness of the patient indicates assignment.

A.6 Any patient who presents at the Emergency Department for a treatment for a medical condition shall receive an appropriate medical screening examination within the
capability of the Hospital’s Emergency Department to determine whether or not an emergency medical condition, or active labor, exists. Such medical screening shall be performed by an Emergency Department physician unless prior arrangements have been made with the patient’s private physician. The Emergency Department physician shall diligently attempt to notify the physician as appropriate.

Each Department of the Medical Staff shall provide a roster of on-call physicians who shall be available to the Emergency Department physicians for consultations, patients requiring admission, and treatment of patients requiring follow-up care who have no regular physician.

A.7. In emergency situations and in case of bed shortage, decisions as to priority of admissions should be made by the Emergency Room physician, with notification of the Department Chairman and the attending practitioner as indicated.

A.8 Patients shall be discharged only on written or verbal order of the attending Practitioner. The attending practitioner shall see that the record is complete, State his/her final diagnosis, and sign the record and complete the summary within 30 days of the patient’s discharge, in accordance with the Medical Staff Bylaws, Article 10.7.

B. GENERAL CONDUCT OF CARE PROVIDED DURING HOSPITALIZATION

B.1 All patients must be seen by the attending practitioner within 24 hours. A complete history and physical examination shall be written on each patient within 24 hours after admission. If a complete history and physical examination has been performed by a member of the Medical Staff within thirty (30) days prior to admission or outpatient procedure, a durable, legible copy of this report may be used in the patient’s hospital medical record, provided there have been no subsequent changes or the changes have been recorded at the time of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. The history and physical must also be reviewed at the time of admission and updated and include significant changes, which may have occurred since the report. If not done on day of surgery, the document must be reviewed and any changes or updates noted and signed and dated. If no change must write “unchanged since (date of exam)” and signed and dated. If a complete history has been recorded and a physical examination performed one week prior to the patient’s admission to the hospital, a reasonable durable, legible copy of these reports may be used in the patient’s hospital medical record in lieu of the admission history and report of the physical examination. In all instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded.

If the attending physician is not a member of the Medical Staff, or if the history and physical was completed by a nurse practitioner, the admitting physician will review the
history and physical, either signing it or indicating in the progress notes that the history and physical was reviewed. If the history and physical was completed by a nurse practitioner, that nurse practitioner’s supervising physician should review the history and physical in addition to the admitting physician. Such records shall become a part of the patient’s hospital record. The dentist and podiatrist are responsible for that part of the history and physical examination related to dentistry or podiatry.

For patients entering the hospital for surgical or invasive procedures, the scope of assessment done prior to the procedure shall include: A history and physical; review of diagnostic data; review of risks and benefits of the procedure and the need to administer blood or blood products.

The history and physical is to be reviewed and so indicated by the admitting Physician if the referring physician is not on the Medical Staff or if the History and physical was completed by a nurse practitioner. If the history and physical was completed by a nurse practitioner, that nurse practitioner’s supervising physician should review the history and physical in addition to the admitting physician. In emergency situations in which there is inadequate time to record the history and physical examination before the procedure, a brief note, including the pre-operative diagnosis, is recorded before the surgery.

B.1.1 When such history and physical examinations are not recorded before the time stated for the operation, the operation shall be cancelled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

B.2 All orders for treatment shall be in writing, dated, and signed by the practitioner giving the orders. Orders shall be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the duly authorized person. The use of the terms “renew”, “continue” and “repeat” without further explanation is not acceptable. Orders may not contain abbreviations found on the IHS “Do Not Use Abbreviation List”. Verbal orders may be dictated to authorized staff members as defined by the Inova Health System policy entitled “Verbal and Telephone Physician Orders”. All verbal orders shall be verified (by asking for the practitioner’s hospital number) signed, dated, timed and authenticated within the time frame specified by state regulations.

All diagnostic and therapeutic orders shall be in writing and documented in the Patient’s medical record by the practitioner giving the order. Orders shall be given only by (i) Practitioners granted clinical privileges to write orders by the Inova Health Care Services Board, (ii) Nurse Practitioners and Physician Assistants to the extent permitted by applicable laws and regulations of Virginia, Hospital and Medical Staff policies, and consistent with such individual’s approved clinical protocol or practice agreement and the scope of practice of his or her supervising physician and (iii) by licensed resident/ fellow physicians in approved residency/ fellow rotations.
B.3 Physician’s progress notes should be written on a daily basis.

B.4 Unless otherwise specified, orders shall automatically terminate as follows:
- Orders for Schedule II drugs shall automatically terminate after 10 days.
- Orders for antibiotics shall automatically terminate after 10 days.
- Patients going to surgery will have medications stopped and reordered post-operatively.
- Patients transferring into or out of CCU, PCU and the Emergency Department will have medications reviewed and reordered.

B.5 The attending practitioner of each patient should determine the admission and discharge of his/her patient to and from the Critical Care Unit. In case of an Emergency, decisions as to the priority of admission or transfer should be made by the Unit and the Chairman of the Department of Medicine, with notification to the attending practitioner of the decision. All patients admitted to the Critical Care Unit shall be seen by the attending or consulting physician and dentist (when appropriate) within six (6) hours.

B.6 The attending practitioner shall be held responsible for the preparation of a complete medical record for each patient. The dentist or podiatrist shall be responsible for completing those portions of the medical record pertaining to dentistry or podiatry. This record shall include:
- Identification date; when not obtainable, the reason shall be entered in the record;
- The medical history of the patient;
- The report of a relevant physical examination;
- Diagnostic and therapeutic orders;
- Evidence of appropriate informed consent; when consent is not obtainable, the reason shall be entered in the record;
- Clinical observations, including results of therapy;
- Reports of procedures, tests, and the results;
- Conclusions at termination of hospitalization or evaluation/treatment

No medical record shall be filed until it is complete, except on order of the Medical Record and Utilization Review Committee.

B.7 All operations performed shall be fully described by the surgeon. All tissue and specimens removed at the operation shall be sent to the Hospital Pathologist, except for those items listed:
- Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopaedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;
- Traumatically injured members that have been amputated and for which examination for medical or legal reasons is not considered necessary;
• Therapeutic radioactive sources;
• Foreign bodies, such as bullets, that for legal reasons are given directly in the chain of custody to law enforcement representatives;
• Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible post-operatively, such as foreskin from the circumcision of the newborn infant;
• Placentas that are growly normal and have been removed in the course of non-operative obstetrics;
• Teeth, skin and subcutaneous tissue removed for cosmetic surgery, with the exception of reduction mammoplasty (including tissue from suction lipectomy);
• Nail plates with no attached periungual tissue.

The following specimens will receive gross examination only:
• Lipoma of cord;
• Femoral heads (fractures);
• Nasal cartilage;
• Tonsils and adenoids – ages 12 and under;
• Cosmetic surgery Meniscus;
• Varicose veins;
• Ingrown toenails;
• Bunions;
• Coracoacromion ligament;
• Undersurface acromion;
• Rotator cuff;
• Distal end clavicle

B.8 It shall be the responsibility of the attending practitioner to obtain appropriate informed consent from each patient or the patient’s legally authorized representative for any treatment or procedures. The attending practitioner shall make such disclosures as the practitioner deems necessary to obtain appropriate informed consent.

Except in emergency, where delay in treatment would adversely affect the patient’s recovery and the patient’s life or limb is in immediate jeopardy, appropriate informed consent shall be obtained prior to such treatment or procedures.

Appropriate informed consent shall be documented in the patient’s medical record. In The event appropriate informed consent is not obtainable, the reason for lack of consent and the necessity for treatment shall be fully explained and recorded in the patient’s medical record by the attending practitioner.

Written informed consent for termination of human pregnancies, treatment of breast tumors, and sexual sterilization shall be obtained and documented in accordance with the laws of the Commonwealth of Virginia and Hospital policies.
Appropriate informed consent for the treatment of minors and individuals unable to give informed consent shall be obtained in accordance with the laws of the Commonwealth of Virginia and Hospital policies.

Appropriate informed consent for treatment with investigational drugs and devices or human research shall be in accordance with federal regulations, laws and regulations of the Commonwealth of Virginia and Hospital policies.

In the event a patient or a patient’s legally authorized representative refuses to consent to treatment or procedure, such refusal shall be documented in the patient’s medical record by the attending practitioner.

All consents to treatment shall be consistent with the Patient Self-Determination Act and the Virginia Health Care Decisions Act.

B.9 Clinical Resume of the patient’s discharge summary shall be written in such manner as to include the following:

B.9.1 Patient’s name, age and sex; date of admission and date of discharge; attending physician’s or dentists’s name.

B.9.2 All relevant diagnoses established by the time of discharge; all operative procedures performed; other procedures performed and treatment rendered.

B.9.3 Cause for admission; chief complaint; history of present illness.

B.9.4 Physical examination with pertinent physical findings and significant laboratory reports.

B.9.5 Clinical course in the Hospital; condition on discharge; and recommended follow-up care. Consideration should be given to instructions relating to physical activity, medications, diet and follow-up care and any specific instructions given to the patient and/or family as pertinent.

B.9.6 Final diagnosis. In the event of death, a summation statement should be added to the record either as a final progress note or as a separate resume. This final note should indicate the reason for admission, the findings and course in the Hospital, and the events leading to death.

B.9.7 Death Summaries: All inpatient deaths must have a death summary regardless of length of stay. The discharge or death summary must be completed by the attending of record within three (3) days – 72 hours of discharge.
The Death Summary is entered in the electronic health record or dictated for transcription. The content of the Death Summary should be consistent with the rest of the record and include the following:

1. Admitting date and reason for hospitalization;
2. Date and Time of Death;
3. Final diagnosis;
4. Succinct summary of significant findings, treatment provided and patient outcome;
5. Goals of Care – if patient was placed on DNR/palliative/comfort/hospice care status;
6. Documentation of all procedures performed during current hospitalization and complications (if any).

B.10 Only symbols and abbreviations approved by the Executive Committee shall be used in the medical record. This list shall be maintained in the Medical Record Department and be available for reference at all times.

B.11 The Medical Record and Utilization Review Committee, Case Management Committee, the Procedure and Surgical Case Review Subcommittee and/or the Infections Committee shall at any time be empowered to all to its meetings any physician in cases where a chart does not completely explain itself or where questions arise as to the propriety or necessity of treatment, as outlined and carried out by the physician. Should the respective physician not be able to clear up any doubt about the chart or the care of the patient, it shall be the function of the respective committee to report to the chairman of the department involved. The chairman of the department shall have the duty and the power to discuss with any member of his/her department any deficiency that may appear in charting or in the care of the patient. Any necessary disciplinary action shall be initiated pursuant to Article 10 of the Medical Staff Bylaws.

B.12 All records are the property of the Hospital and may be removed from the Hospital’s jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. Access to patients’ records shall be available to only those physicians actively treating the patient or who have treated the patient in the past, or to other persons in accordance with applicable statutes or regulations. Patients’ records, required to be reviewed in accordance with the Medical Staff Bylaws, shall be available to the appropriate committees at the request of the Chairmen and shall be reviewed during a formal meeting of such committees. Patient statistics will be available to those physicians requesting statistics which pertain to patients they have treated. Requests for statistics of other physicians will be submitted in writing to the Chairman of the Medical Record and Utilization Review Committee, stating the reason the statistics are needed.

C. Consultations:
C.1 The attending practitioner is primarily responsible for requesting a consultation for a
patient and for selecting the consultant.

C.2 Psychiatric consultation and treatment shall be offered to all patients who attempt
suicide.

C.3 Consultations may be performed by the following:

C.3.1 Members of the Medical Staff who have been called in for consultation by a
member of the Medical Staff of Inova Fair Oaks Hospital.

C.3.2 Non-members of the Medical Staff who request and receive temporary privileges
for specific patients (see Bylaws 7.4). Consulting physicians who are not members of the
Medical Staff may not write orders.

D. Educational Activities:

D.1 Medical Staff departmental meetings shall include a discussion constituting a
thorough review and analysis of the clinical work done in the Hospital.

D.2 The Medical Staff shall be expected to participate in continuing medical education
offered within the Hospital and may be asked to provide documentation of participation
in other programs.

D.3 Recommendations shall be forwarded from committees concerned with quality
improvement for topics to be considered for educational meetings. Whenever possible,
CME activities will be scheduled at departmental meetings, Tumor Board meetings,
Medical Staff meetings, and when otherwise indicated.

D.4 Every member of the Medical Staff is expected to be actively interested in securing
autopsies. No autopsy shall be performed without written consent of the nearest relative
or legally authorized agent. All autopsies shall be performed by the Hospital Pathologist
or by a board-qualified Pathologist on the Staff to whom he/she may delegate the duty.

D.4.1 Important or significant findings of autopsies shall be referred to the appropriate
departments for educational purposes.

D.5 Disbursements of funds from the Medical Staff douse shall be determined annually
by the Executive Committee of the Medical Staff with priority consideration to
Continuing Medical Education and the Medical Library.

E. Medical Staff Leadership:

E.1 The Medical Staff has a leadership role in organization performance improvement
activities. The Medical Staff provides leadership for the process measurement,
assessment, and improvement. These processes include, though are not limited to, those within the:

- Medical assessment and treatment of patients;
- Use of medications;
- Use of blood and blood components;
- Use of operative and other procedures;
- Efficiency (relationship between the outcomes – results of care – and the resources used to deliver patient care) of clinical practice patterns; and significant departures from established patterns of clinical practice.
- Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes. The processes include, though are not limited to:
  - Education of patients and families
  - Coordination of care and other practitioners and Hospital personnel, as relevant to the care of an individual patient;
  - Accurate, timely, and legible completion of patients’ medical records.
- Ensure that when the findings of the assessment process are relevant to an individual’s performance, the Medical Staff is responsible for determining their use in peer review or the ongoing evaluations of a licensed independent practitioner’s competence.
- Ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members.

F. INFORMATION SECURITY;

The Medical Staff at Inova Fair Oaks Hospital recognize that confidentiality of all patient information is an ethical obligation of health care providers. With the use of the new information systems, the magnitude and availability of this information will be much more widespread. Therefore, the potential for unauthorized disclosure is increased.

F.1 Violations of security of the information system by a physician or physician group (or by an employee of either) includes, but is not limited to:

- Review of a chart of a patient with which he/she has no authorized involvement;
- Unauthorized disclosure of patient medical record information;
- Being found responsible for permitted access to a person not otherwise authorized to have gained access to the patient’s medical record;

For purposes of this provision, “authorized” shall mean involved in the patient’s care, either as an attending physician, consulting physician, or non-physician practitioner supervised/employed by such physician; or participating in the review of the patient’s care on behalf of the Hospital or Hospital committee.
F.2 An alleged violation will first be presented to the Inova Health Systems Committee on Information Security and Confidentiality (HSCISC), WHICH WILL ASSESS THE SEVERITY OF THE VIOLATION AND MAKE A RECOMMENDATION TO THE Executive Committee of the Medical Staff of the Hospital. The Executive Committee may take action based on the recommendation.

F.3 At the time of the IHSCISC considers the alleged violation, or before an adverse action is recommended by the Executive Committee based on the recommendations of the IHSCISC, the physician will be afforded the opportunity to present information regarding the alleged violation.

F.4 Depending upon the severity of the alleged violation of security, the IHSCISC may immediately and temporarily suspend access to the information system by the physician, his/her medical associates and his/her employees pending review by the Executive Committee of the Medical Staff and may recommend, among other things:

- The physician, his/her medical associates and his/her employees, be barred from access to the information system for a period of not less than 30 days;
- That the physician, his/her medical associates and/or his/her employees be permanently barred from access to the information system;
- That the Administrator, or other authorized members of the Medical Staff, initiate a request for corrective action regarding the clinical privileges of the physician to the Executive Committee.

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