

Inova Mount Vernon Hospital
RULES AND REGULATIONS
OF THE
MEDICAL STAFF

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Inova Mount Vernon Hospital

RULES AND REGULATIONS

OF THE

MEDICAL STAFF

The following statements are to be accepted and recognized as general rules and regulations concerning the activities of the Medical Staff. These general rules shall be supplemented with detailed rules and regulations for each Department and/or Section, or Committee of the Medical Staff and with Administrative policies and procedures.

Section A

ADMISSION AND DISCHARGE OF PATIENTS

1. All patients shall be admitted by a member of the Medical Staff in accordance with policies and procedures established by the Inova Health Care Services Board and Administration of Inova Mount Vernon Hospital.

2. A dentist with clinical privileges may, with the concurrence of a physician member of the Medical Staff, initiate the procedure for admitting a patient. Such concurring physician member shall assume responsibility for the overall aspect of the patient's care throughout the hospitalization, including the medical history and physical examination.

A podiatrist with clinical privileges may, with the concurrence of a physician member of the Medical Staff, initiate the procedure for admitting a patient. Such concurring physician member shall assume responsibility for the overall aspect of the patient's care throughout the hospitalization, including the medical history and physical examination.

3. A member of the Medical Staff shall be recorded on the medical record as primarily responsible for the medical care and treatment of each patient in the Hospital, for the timely completeness and accuracy of the medical record, and for necessary special instructions. Whenever these responsibilities are transferred to another member of the Staff, a note indicating the transfer of such responsibility shall be entered on the medical record.

4. A member of the Medical Staff shall be responsible for stating to the designated hospital representative, such information regarding patients referred and/or admitted, as may be necessary, to assure the protection of other patients and hospital personnel from those who are a source of danger from any cause, or to assure the protection of the patient from self harm.

In all admissions, a provisional diagnosis shall be stated.

5. In any case, including emergency, in which it appears the patient will have to be admitted, the practitioner shall, when possible, first contact the admitting office to ascertain whether there is an available bed.

Practitioners admitting emergency cases shall be prepared to justify to the appropriate department Chairperson that the admission was bona fide. The history and physical exam must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the medical record as soon as possible after admission.

6. 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 and/or Section to which the illness of the patient indicates assignment. The Chairperson of each department shall provide a schedule for such assignment.

7. Each service patient shall be admitted by a member of the Medical Staff and shall be attended by a member of the assigned department and/or section concerned in the treatment of the disease which necessitated admission.

8. Each practitioner must assure timely, adequate professional care for his hospitalized patients by being available or having available an eligible alternate practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the hospital. Each physician shall respond to hospital call and/or a page within 30 minutes of receiving the request.

9. The admitting office will admit patients on the basis of the following order of priority:

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Emergency Admission (Refer to Provisions of Section A.5)

Urgent Admission - Those admissions so designated by the attending practitioner may be reviewed as necessary by the appropriate department Chairperson to determine priority when all such admissions for a specific day are not possible.

Preoperative Admission - Includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the appropriate department Chairperson may decide the urgency of any specific admission.

Routine Admission - Includes elective admissions of all services.

These classifications will be determined by the admitting physician. All admissions to the hospital will have an admitting note written within 24 hours of admission.

Those patients already scheduled for surgery will be classified in accordance with the above categories should a bed problem be present.

10. Bed utilization and assignment of patients shall be as follows:

Gynecology
Medicine
Pediatrics
Psychiatry
Surgery

Patients may be admitted without regard to the above bed utilization area. When deviations are made from areas indicated above, the admitting office may change such assignments when possible in keeping with transfer priorities.

11. Transfer priorities shall be as follows:

Emergency Suite to appropriate available patient bed.
Operating Suite to appropriate available patient bed.
Special Care Unit to a progressive care or general care unit.
Temporary placement in an inappropriate area or clinical service area to the appropriate area for the patient.

Except in emergencies, no patient will be transferred without prior consultation with and approval of the attending practitioner.

12. For the protection of patients, the medical and nursing staffs, and hospital personnel, the following guidelines shall be applied in the care of the known potentially suicidal patient:

12.1 Bed assignment shall be consistent with the necessity for admission.

12.2 The nursing staff shall be completely informed of the precautions to be taken.

12.3 Any patient known or suspected to be suicidal shall have consultation by a member of the Department of Psychiatry within 24 hours if the patient was not admitted by a member of that Department.

13. Admission to and discharge from Special Care Units shall be consistent with the policies and procedures as approved from time to time by the Executive Committee of the Medical Staff.

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14. The attending practitioner shall be required to document the need for continued hospitalization after specific length of stay as identified by the utilization review procedures of the hospital and approved by the Executive Committee of the Medical Staff.

Willful or continued failure to furnish such required documentation may be cause for a request for corrective action initiated by the Chairperson of the Quality Council.

15. Patients shall be discharged only on order of the attending practitioner. Whenever possible, the discharge diagnosis shall be written in full on the face sheet of the patient's medical record when the discharge order is written.

16. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

17. It shall be the responsibility of the attending practitioner to discharge his patients consistent with the discharge policies of the Hospital so that an orderly flow of admissions and discharges may be achieved.

18. The deceased patient shall be pronounced dead by the attending physician or his designee who shall be either a member of the Medical Staff or a member of the House Service.

The body shall not be released until a signed entry is made by the attending physician, or his designee, in the medical record of the patient recording the date and time of death.

Release of the body shall conform to the statutes of the Commonwealth of Virginia and to the policies and procedures of the hospital.

19. It shall be the duty of all members of the Medical Staff to make the attempt to secure meaningful autopsies whenever possible in accordance with the guidelines for autopsy that are approved by the Executive Committee.

An autopsy shall be performed only with written consent of the legally authorized available relative signed in accordance with the statutes of the Commonwealth of Virginia.

All autopsies shall be performed by a member of the Department of Pathology and the provisional anatomic diagnoses shall be recorded on the medical record of the patient within 72 hours. The complete protocol shall be made a part of the medical record within 60 days.

The statutes of the Commonwealth of Virginia shall apply in the retention or transfer of anatomical organs. The attending practitioner, or his/her designee, shall obtain the necessary signed consent form(s).

Section B

GENERAL CONDUCT OF PATIENT CARE

1. A complete admission history and physical examination shall be completed within twenty-four (24) hours of admission by a person with privileges to do so. Critically ill patients admitted to the intensive care unit from the Emergency Department must be evaluated by an attending within 4 hours. Patients admitted to the Step Down Unit from the Emergency Department must be evaluated by an attending within 8 hours. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If the history and physical examination were performed by a non-physician, a physician member of the Medical Staff shall confirm by dated signature the findings prior to major diagnostic or therapeutic intervention or within twenty-four (24) hours, whichever occurs first.
2. The attending physician shall authenticate by dated signature the history, physical examination and preoperative note when they have been performed and recorded by a person with privileges to do so.
3. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.
4. Progress notes shall be written at least daily on all inpatients. Multiple notes daily may be appropriate for critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem or significant clinical change in patient's condition.
5. When a hospitalized patient requires surgery, and invasive procedure, blood transfusion, photography or release of their medical information, the attending practitioner shall make such disclosure to the patient and obtain such consent as he deems appropriate and the documentation of such informed consent shall be entered into the medical record.
6. All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to a duly authorized person. All orders must be authenticated. Those duly authorized are:

Licensed Registered Nurse
Licensed Pharmacist
Licensed Physician Assistant
Licensed/Registered Physical Therapist, RPT
Certified Occupational Therapist, OTR
Licensed/Certified Speech Language Pathologist, CCC-SLP
Certified Therapeutic Recreation Specialist, CTRS
Life Support Technologist
Registered Electroencephalographic Technician
Registered Dietician
Psychologists
Social Workers
Nurse Practitioners

Duly authorized persons shall perform only those functions permitted within the scope of his or her license or registration as determined by the Commonwealth of Virginia.

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7. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated with the name of the practitioner per the authorized person. Such orders shall be signed by the practitioner or by the attending practitioner.
8. All orders shall be authenticated by a practitioner licensed to practice in the Commonwealth of Virginia who has clinical privileges at Inova Mount Vernon Hospital. Authentication may be by written signatures or initials, rubber-stamp signatures, or computer key. When rubber-stamp signatures or computer key are authorized, the individual whose signature the stamp represents or whose computer key is authorized signs a statement that he or she alone will use the stamp or the code for the computer key. This statement is filed in the Medical Records Department. Proven violation of use of the signature stamp or computer key will result in appropriate corrective action which may result in revocation of privilege to use a signature stamp or computer key.
9. A practitioner's 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 "renew," "repeat," and "continue" without further explanations will not be acceptable.
10. All previous orders are canceled when a patient has surgery. All previous orders are canceled when a patient is transferred from a Special Care Unit to a progressive care or general care unit.
11. To the extent practicable, practitioners should try to use only those medications listed in the latest edition of the Formulary of Inova Mount Vernon Hospital. The Chairperson of the Pharmacy and Dietetics Committee and the Director of Pharmacy may approve temporary additions to the Formulary pending review of that Committee. The use of chemical symbols and abbreviations for drug names is to be discouraged.

Drugs for bona fide clinical investigations may be exceptions. Such drugs shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and the regulations of the Food and Drug Administration. Such clinical investigations shall be conducted in the Hospital in accordance with the policies and procedures of the Pharmacy and Dietetics Committee as approved by the Executive Committee of the Medical Staff.

Policies concerning Automatic Stop Orders to control the use of dangerous and toxic drugs shall be developed by the Pharmacy and Dietetics Committee and approved by the Executive Committee of the Medical Staff.

Policies and procedures for control of drugs brought into the hospital by the patient for the patient's use while hospitalized, shall be developed by the Pharmacy and Dietetics Committee and Administration and approved by the Executive Committee of the Medical Staff.

12. There will be no routine admission laboratory and radiologic screening tests.
13. The attending practitioner, or his designee, requesting radiologic service is responsible for providing on the request form the reasons for the radiologic examination.
14. The attending practitioner, or his designee, requesting pathological examination of tissue, is responsible for providing on the request form the reasons for the pathological examination.
15. All tissue removed by aspiration or biopsy shall be forwarded to the hospital laboratory for examination and interpretation. A signed tissue report shall be made a part of the patient's medical record.
16. Policies and procedures for the surveillance of hospital infections and the control thereof shall be developed and reviewed by the Infection Control Committee and Administration and approved by the Executive Committee of the Medical Staff.

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207. Transfusion and blood usage policies shall be developed and reviewed by the Transfusion Committee and approved by the Executive Committee of the Medical Staff.
18. At the time of a major disaster, external or internal, the plans developed by the Disaster Advisor as approved by the Executive Committee will be in effect.
19. Medical devices used for clinical investigations shall be in accordance with the Federal Drug Administration requirements governing use of such special functioning mechanisms.
20. Medical staff members have the responsibility to protect the integrity of clinical decision making in partnership with the Hospital, regardless of compensation or risk sharing arrangements. Clinical decisions must be based upon identified patient medical needs. Financial incentives must not be used to reduce medically necessary care.

Section C

CONDUCT OF SURGICAL CARE

1. Except in emergency, a preoperative diagnosis and essential laboratory tests shall be recorded on the medical record prior to any surgical procedure. Without such diagnosis and accompanying laboratory test results, the operation shall be canceled. In any emergency the practitioner shall make at least a comprehensive note in the medical record regarding the patient's condition prior to induction of anesthesia and the start of surgery.
2. Authorization, when necessary, shall be obtained prior to the operative procedure except in those situations wherein there may be impairment of the patient's health or the patient's life or limb is in jeopardy and suitable authorization cannot be obtained prior to the procedure because of the patient's condition.
3. In emergencies involving a minor or patient incompetent to authorize and for which authorization for surgery cannot be immediately obtained from parent, guardian, next of kin, or a Court, such circumstances shall be fully explained on the medical record. Should time permit, a consultation in such instances is desirable before the procedure is undertaken.
4. The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.
5. All tissue removed at operations shall be sent to the Department of Pathology for such examination as may be considered necessary to arrive at a tissue diagnosis. A signed tissue pathology report shall be made a part of the medical record.

The attending practitioner, or his designee, requesting such tissue examination, shall be responsible for providing on the request form such pertinent clinical information as may assist in a tissue diagnosis.

Authenticated reports of pathological tissue examination shall be placed in the patient's medical record within thirty-six (36) hours, providing such examination has been satisfactorily conclusive.

6. An Operative Report shall be dictated immediately following inpatient or outpatient surgery. The report shall be signed and made a part of the patient's medical record.
7. The Department of Surgery shall maintain surveillance of and develop policies for the surgical suite as approved by the Executive Committee of the Medical Staff.
8. A patient admitted for dental care is a dual responsibility involving the dentist and physician member of the Medical Staff. Dental admissions shall be requested by the dentist and admitted by a Physician member of the Medical Staff.
 - 8.1 Dentists' responsibilities:
 - 8.1.1 A detailed dental history justifying hospital admission.
 - 8.1.2 A detailed description of the examination of the oral cavity and a pre-operative diagnosis.
 - 8.1.3 A complete operative report describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the Hospital pathologist for examination.
 - 8.1.4 Progress notes as are pertinent to the oral condition.

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- 8.1.5 Clinical resume.
 - 8.2 Physicians' responsibilities:
 - 8.2.1 Medical history pertinent to the patient's general health.
 - 8.2.2 A physical examination to determine the patient's condition prior to anesthesia and surgery.
 - 8.2.3 Supervision of the patient's general health status while hospitalized.
 - 8.3 The discharge of the patient shall be on written orders of the dentist and the physician member of the Medical Staff.
9. A patient admitted for podiatric care is a dual responsibility involving the podiatrist and physician member of the Medical Staff. Podiatric admissions shall be requested by the podiatrist and admitted by a physician member of the Medical Staff.
- 9.1 Podiatrists' responsibilities:
 - 9.1.1 A detailed podiatric history justifying hospital admission.
 - 9.1.2 A detailed description of the examination of the human foot and a pre-operative diagnosis.
 - 9.1.3 A complete operative report describing the finding and technique. All tissue shall be sent to the Hospital pathologist for examination.
 - 9.1.4 Progress notes as are pertinent to the podiatric condition.
 - 9.1.5 Clinical resume.
 - 9.2 Physician's responsibilities:
 - 9.2.1 Medical history pertinent to the patient's general health.
 - 9.2.2 A physical examination to determine the patient's condition prior to anesthesia and surgery.
 - 9.2.3 Supervision of the patient's general health status while hospitalized.
 - 9.3 The discharge of the patient shall be on written orders of the podiatrist and the physician member of the Medical Staff.

Section D

CONSULTATIONS

1. The attending practitioner is primarily responsible for requesting consultation when indicated and for selecting the qualified consultant.
 - 1.1 Consultations are requested by the Physician thru personal contact with the physician being consulted. It is the responsibility of the Physician to ascertain that the requested consult has occurred within the time period agreed during the physician to physician contact, or another consultant be contacted.
2. All consultations shall be requested and answered on the appropriate consultation form of the Hospital and shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the signed opinion and recommendations of the consultant.
 - 2.1 When operative procedures are involved, the consultation shall be recorded on the patient's medical record prior to the operation except in emergency situations.
3. Consultations shall be required in accordance with the laws of the Commonwealth of Virginia.
4. A consultant is a practitioner well qualified to give an opinion within the area of his expertise.
5. Departments and/or Sections may develop requirements for consultations within the area of expertise concerned.
6. Protocol for medical practice in a Special Care Unit may include requirements for consultation as approved by the Executive Committee of the Medical Staff.

Section E

EMERGENCY SERVICES

1. Members of the Medical Staff may use the facilities of the Emergency Department to examine and treat patients in accordance with their delineation of privileges. Practitioners will not be assigned to duties in the Emergency Department in the hospital for which they have not been granted privileges, except as may be covered in the Disaster Plan.
2. The staffing of the Emergency Department shall be by contractual arrangements between the Hospital and a medical group. All Emergency Department physicians will be members of the hospital staff, subject to the same credentialing process and delineation of privileges as other staff members.
3. Any patient who presents at the Emergency Department for 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. A 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 patient's private physician as appropriate.
4. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record. The record shall include:
 - 4.1 Adequate patient identification.
 - 4.2 Information concerning the time of the patient's arrival and by whom transported.
 - 4.3 Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital.
 - 4.4 Description of significant clinical, laboratory, and roentgenologic findings.
 - 4.5 Diagnosis.
 - 4.6 Treatment given.
 - 4.7 Condition of the patient on discharge or transfer.
 - 4.8 Final disposition including instruction given to the patient and/or his family, relative to necessary follow-up care.
5. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.
6. The Department of Emergency Medicine shall review the Emergency Department medical records to evaluate quality of emergency medical care. Reports shall be submitted to the Executive Committee at least quarterly.
7. There is an approved plan for the care of mass casualties. All physicians shall be assigned to posts, either in the Hospital, the auxiliary hospital, or in mobile casualty stations. No physician will perform any duties other than those assigned. The Chief of the Disaster Committee in the Hospital and the Chief Executive Officer will work as a team to coordinate activities and directions. In case of evacuation of patients from one section of the hospital or evacuation from the hospital premises, the Chief of the Disaster Committee, during the disaster will authorize the movement of patients by direction of the Chief Executive Officer of the Hospital. All policies concerning patient care will be a joint responsibility of the Chief of the Disaster Committee and the Chief Executive Officer of the

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Hospital. In their absence, the Deputy Chief of the Disaster Committee and an alternate in Administration are next in line of authority respectively. All physicians on the Medical Staff of the Hospital specifically agree to relinquish direction of the professional care of their patients, service and private, to the Chief of the Disaster Committee in case of such emergency.

8. The various departments of the Staff will provide a roster of physicians on-call for consultations, acceptance of cases needing admission to the Hospital who have no regular physician, follow-up care, etc. This is an obligation of Staff membership.

- 8.1 A physician may be relieved of the responsibility of taking call after twenty-five years of active medical staff service to the Hospital.

Section F

SPECIAL CARE UNITS

Appropriate committees of the Medical Staff representing each special care unit, as outlined in the Bylaws, shall adopt specific regulations governing that unit.

A copy of the procedures are available on the individual units and in the Nursing Office.

Section G

CLINICAL DEPARTMENTS

Each department shall formulate such rules and regulations as are necessary for the efficient functioning of the department. These rules and regulations will be reviewed initially and as modified by the Bylaws Committee, the Medical Staff Executive Committee, and the Governing Body. After approval of the reviewing bodies, a copy will be circulated to each member of the department.

Section H

MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. All records shall be kept on forms provided by the Hospital. The medical record shall contain such information which is in compliance with applicable provisions of law and JCAHO requirements. For any outside reports, the source facility shall be clearly identified and the date performed shall be indicated.
2. An admission history and physical examination shall be completed within twenty-four (24) hours of admission. If a complete history and physical examination has been obtained within a week prior to admission by a person with privileges to do so, 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. If a complete history has been recorded and a physical examination performed one week prior to the patient's admission to the hospital, a reasonably 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 such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded.
3. In the event a patient is admitted to the hospital for the same condition within 30 days of discharge, the history and record of physical examination of the previous admission, along with an interval history and physical examination reflecting any subsequent changes, may be used in the medical record. The medical record shall document a current, thorough physical examination prior to the performance of surgery.
4. The attending physician shall countersign by dated signature the history, physical examination, and pre-operative note when they have been recorded by a non-physician with privileges to do so. All portions of the chart shall be completed within 30 days after discharge. The physician will be notified as follows: The Executive Committee may increase the dollar amount of the Medical Staff Dues at a daily rate based on the delinquency of the Medical Records of that practitioner.
 - 4.1 Each Tuesday the Medical Record Department will notify physicians in writing of all incomplete records. The notice will contain a listing of all patients' records requiring completion, and include the age of each record, the date of discharge, and the deficient items. If a physician has records that are twenty-three (23) days delinquent after allocation, a letter will be sent that states that the physician's admitting privileges will be suspended if those records are not completed within seven (7) days. This letter will also state that if records become forty-five (45) days delinquent, the physician will be placed on the next Medical Staff Executive Committee agenda to recommend revocation of privileges, and will state the date of that meeting. The physician will be asked to complete their records prior to the date of the Executive Committee meeting or to appear before the Committee on that date to explain why they cannot complete their records. A copy of this letter will be sent to the physician's department Chairperson.
 - 4.2 Physicians with charts thirty (30) days or older after allocation will be placed on suspension. The "Suspension List" will be posted in the Patient Registration and Surgery Posting Departments. Copies will also be sent to the Medical Staff Office, the Department Chairmen, the President of the Medical Staff, the Chairperson of the Medical Record Committee, the Administrator and the Finance Director.
 - 4.3 As suspended physicians call to arrange admissions or post surgeries, the admitting and posting staff will inform each physician that his/her delinquent charts must be completed before he/she can admit.
 - 4.4 If a physician's records become forty-five (45) days delinquent after allocation, a request will be forwarded to the Medical Staff Executive Committee to recommend revocation of privileges. If all delinquent records are not completed by the date of the next Medical Staff Executive Committee meeting, and if the physician

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does not appear before the Executive Committee to offer an explanation for their failure to complete their records, the Medical Staff Executive Committee will, by majority vote, forward a recommendation to the Inova Inova Health Care Services Board for revocation of the physician's privileges.

4.4.1 If the physician's privileges are revoked by the Inova Inova Health Care Services Board the physician may be granted temporary privileges (pursuant to Article 6.3) provided that the delinquent medical records have been completed.

4.4.2 The physician may re-apply for privileges by paying the application fee and updating file information, as required.

4.5 Special arrangements to admit a patient while on suspension can be made only through the hospital administrative staff or the President of the Medical Staff. Arrangements will be made for the physician to complete all delinquent charts within 24 hours.

4.6 Physicians who fail to comply with this administrative request will be reported to their respective department Chairperson for further appropriate action.

4.7 Suspension does not relieve a physician of his/her on-call responsibilities to the Emergency Department.

5. Operative reports shall include a pre-operative and post-operative diagnosis, a detailed account of the findings at surgery as well as the details of the surgical technique and specimens removed. Operative reports shall be dictated immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record.
6. Each verbal or written order for special treatment procedures, such as restraint or seclusion, shall be time limited.
7. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, and recommendations. This report shall be made a part of the patient's record.
8. All clinical entries in the patient's medical record shall be accurately dated and authenticated.
9. Symbols and abbreviations may be used only when they have been approved by the Executive Committee. An official record of approved abbreviations shall be kept on file in the Medical Record Department.
10. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.
11. A discharge summary shall be dictated on all medical records of patients hospitalized except for those with problems of a minor nature requiring less than 48 hours of hospitalization. For these latter exceptions, a written final summation-type progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be signed by the responsible practitioner. Both final notes and discharge summaries should contain instructions to the patient relative to physical activity, medication, diet, and follow-up care where pertinent.
12. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

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13. A Record may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the hospital. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another.
14. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research projects approved by the Medical Record Committee consistent with preserving the confidentiality of personal information concerning the individual patient.
15. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Staff Executive Committee. In the case of incomplete records left due to death, absence (long illness or leaving the area) or revocation of privileges of a physician, the Department Chairperson shall assign the completion of that record to another staff member familiar with the patient during the admission in question. If there are no other physicians familiar with the case, the chart will be retired with deficiencies.
16. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the practitioner.

Section I

INFORMATION SECURITY

1. The Medical Staff at Inova Mount Vernon Hospital recognizes 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.
 - 1.1 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:
 - 1.1.1 review of a chart of a patient with which the physician has no authorized involvement;
 - 1.1.2 unauthorized disclosure of patient medical record information;
 - 1.1.3 being found responsible for permitted access to a person not otherwise authorized to have gained access to the patient's medical record;
 - 1.1.4 for purposes of this provision, "authorized" shall mean involved in the patient's care, either as an attending or consultant, or participating in the review of the patient's care on behalf of the hospital or hospital committee.
 - 1.2 An alleged violation will first be presented to the Inova Health Systems Committee on Information Security and Confidentiality (IHSCISC), 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.
 - 1.3 At the time 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.
 - 1.4 Depending on the severity of the alleged violation of security, the IHSCISC may recommend, among other things:
 - 1.4.1 that the physician, the physician's medical associates and employees, be barred from access to the information system for a period of not less than 30 days;
 - 1.4.2 permanent loss of access to the information system by the physician, the physician's medical associates and employees;
 - 1.4.3 that the Administrator, or other authorized members of the Medical Staff, initiate a request to the Executive Committee for corrective action regarding the clinical privileges of the physician.

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Adopted by the Medical Staff of Inova Mount Vernon Hospital

Date: November 21, 2019

Janis Caruso, M.D.
President

Approved by the Inova Health Care Services Board

Date: December 20, 2019

Charles Beard
Chairperson