LOMPOC VALLEY MEDICAL CENTER
(LOMPOC HEALTHCARE DISTRICT)
RULES AND REGULATIONS OF THE MEDICAL STAFF
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RULES AND REGULATIONS OF THE MEDICAL STAFF OF
LOMPOC VALLEY MEDICAL CENTER
(LOMPOC HEALTHCARE DISTRICT)
September 1, 2024

I. MEETINGS

A. The medical staff shall have a regular meeting at least quarterly at a time and place set by resolution of the executive committee.

A member who is compelled to be absent from any of the regular staff meetings or committee meetings shall be required to give prompt notification of their absence to the Medical Staff Services Office, which is acting on behalf of the chief of staff, in writing, his reasons for this absence.

B. The medical staff discussions at meetings as provided for under Section I-A of these Rules and Regulations shall constitute a thorough review and analysis of the clinical work done in the hospital. This will include consideration of deaths, unimproved cases, infections, complications, errors in diagnosis and results of treatment, from among selected cases in the hospital at the time of the meeting or discharged since the last meeting. Also included will be analysis of the clinical reports from each department and reports of committees of the active medical staff.

II. AUTOPSIES

A. CATEGORY OF PATIENTS

An autopsy should be sought when the information gained potentially will:
1. Benefit medical care to other patients (i.e., knowledge gained).
2. Provide assistance in counseling the family.

Specific cases may include but are not limited to:
1. Unexpected or unexplained deaths.
2. Intraoperative or immediate postoperative deaths.
3. Fetal demise.
4. Spontaneous or induced abortion.
5. Deaths known or suspected to have resulted from environmental or occupational hazards.

B. PERMISSION FOR AUTOPSY

Authorization for an autopsy may be given in writing by any of the following: spouse, parent, child, sibling, or legal guardian.

C. NOTIFICATION

The pathologist will notify the patient's physician of the time and place of the autopsy.

III. LABORATORIES

A. Laboratories shall be provided in the hospital to insure as complete a service as possible. Examinations which cannot be made in the hospital shall be referred to an outside laboratory approved by the medical staff.

IV. TREATMENT ORDERS

A. Standing orders shall be formulated by conference between the medical staff, and the hospital staff. They may be changed only by actual consent of the medical staff, and all personnel concerned shall receive notification of changes.

Standing orders shall be signed by the attending physician and shall be followed insofar as proper treatment of the patient will allow. When specific orders are not written by the attending physician, standing orders shall constitute the order of treatment.

B. All orders for treatment shall be documented. An order shall be considered to be in writing if dictated to a registered or licensed vocational nurse, clinical laboratory scientist, pharmacist, dietitian, physical therapist, speech pathologist, occupational therapist, or respiratory therapist and signed by the physician. Orders dictated over the telephone shall be recorded in the medical record by the individual who received the order. The individual shall sign his or her name next to the order and indicate the order is per the physician. The ordering Physician/Practitioner shall sign all telephone and verbal orders, verifying their authenticity promptly or as soon as possible after issuing the order. Medication orders dictated over the telephone shall be signed and dated as soon as possible after issuing the order, but no later than the 5th day after issuing the order.

C. Narcotics, sedatives, antibiotics, anticoagulants, corticosteroids, and tranquilizing drugs that are ordered without specific time limitation of dosage shall be automatically discontinued after one-hundred twenty (120) hours. Drugs shall not be discontinued without notifying the physician. If the order expires at night, it should be called to the attention of the physician the following morning.

D. As far as possible, the use of proprietary preparations not on the drug list shall be avoided. When such is ordered for patients by the attending physician, they will be secured and a special charge made to the patient.

E. Drugs used shall meet the standards of the United States Pharmacopeia, National Formulary, with the exception of drugs for bonafide clinical investigations. Exceptions to the rule shall be well justified.

V. MASS CASUALTY ASSIGNMENTS

A. All medical staff members shall be assigned to casualty stations and it is their responsibility to report to their assigned stations. All policies concerning patient care will be the responsibility of the Disaster Committee. The Disaster Committee is composed of the members of the Joint Conference Committee and Emergency Services Subcommittee and chaired by the Joint Conference Committee Chair. All members of the medical staff of Lompoc Valley Medical Center (Lompoc Healthcare District) specifically agree to relinquish direction of the professional care of their private hospitalized patients to the Disaster Committee for the duration of such emergency. The Disaster Committee and the

administrator of the hospital will work as a team to coordinate activities and directions. In cases of evacuation from the hospital premises, the Disaster Committee, during the disaster, will authorize and direct the movement of patients in conjunction with the administrator of the hospital.

B. The plan for the care of mass casualties must be rehearsed periodically by key hospital personnel.

VI. ADMISSION TO THE HOSPITAL

A. Except in 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 delegate secured. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

B. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger for any cause whatsoever, or to insure the protection of the patient from self harm.

C. It is the policy of Lompoc Valley Medical Center (Lompoc Healthcare District) to undertake reasonable and prudent actions to appropriately assess, and provide safety for a patient who exhibits the potential for harm to themselves or others. This includes psychiatric, alcoholic, or otherwise mentally impaired patients. If the patient's medical condition does not allow for transfer to a psychiatric facility, the patient will be cared for in the acute care setting until such time as the patient's medical condition allows for transfer to an appropriate psychiatric setting.

D. Patient shall be discharged only on the order of the attending physician.

E. Patients admitted to the hospital must be seen by the admitting physician in a timely manner and according to the following timeframe:

ICU/CCU admissions: Within two (2) hours.

TELEMETRY and MEDICAL/SURGICAL admissions: Within twelve (12) hours.

HEALTHY NEWBORN NURSERY admissions: Within eighteen (18) hours.

VII. MEDICAL RECORDS

A. GENERAL

1. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data, complaint, personal history, family history, history of

present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray, and others, provisional diagnosis, medical or surgical treatment, pathological findings, progress notes, final diagnosis, condition on discharge, plans for post hospital care and autopsy report when available.

2. No medical record shall be filed until it is complete, except on order of the Quality of Care Committee.

3. Discharge summaries are required on all cases which are:
   a. Admitted, or
   b. Observed in the hospital for twenty-four (24) hours or longer.

4. The physician shall complete the medical record within fourteen (14) days of termination of the case.

5. Any member of the medical staff who fails to complete the charts of his patients within seven (7) days after discharge from the hospital shall be notified in writing. If within fourteen (14) days after the patient's discharge the attending physician has not completed these charts, the physician shall be subject to automatic suspension or limitation as outlined in section 6.3-4 of the medical staff bylaws.

6. In each of the above automatic suspensions of admitting privileges, the name of the physician whose admitting privileges have been suspended shall be listed on lists kept in the admitting office and on the bulletin board in the doctor's lounge. These suspensions remain in effect until the privileges are restored. After the medical records initiating the suspension have been completed and all of the staff member's records are in compliance with the above regulations, the chief of staff or his/her designee will order the privileges restored and the staff member's name removed from the above lists.

7. If during any year a staff member has his admitting privileges twice suspended for the above medical record time limitations, his delinquency shall be referred to the executive committee which may recommend to the Board of Directors, a punitive suspension of admitting privileges of one (1) to thirty (30) days, in addition to the automatic suspensions incurred prior to the completion of the medical records. The staff member shall be invited to the executive committee discussions regarding his possible suspension. The third and each subsequent automatic suspension for failure to complete medical records shall be similarly referred to the executive committee.

8. All records are the property of the hospital and shall be removed from the hospital jurisdiction only in accordance with court order, subpoena or statute. In the case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or by another.

9. Free access to all medical records of all patients shall be afforded to staff physicians in good standing for bonafide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the administrator, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

10. Documentation of patient care should be entered into the medical record at the time care is rendered and should include the time and date. When additional documentation is required for the completeness of the record and the future care of the patient, a late entry may be made. All late entries to the medical record must be clearly identified as late entries, must bear the date and time the entry is actually made and the signature of the person making the entry.

11. The original medical record must not be falsified, altered or destroyed. Corrections to the medical record should be made by the person making the incorrect entry. Written corrections must be made by drawing a single line through the incorrect entry, entering the correct information, initialing the correction, and entering the date of the correction. Electronic corrections are automatically recorded. The original entry must remain legible and must not be obliterated by correction fluid, multiple pen strokes, etc. If portions of the medical record are damaged or an entire entry is on the wrong chart, rewrites may be necessary. Originals must be retained along with a signed note indicating the date, time and reason for the rewrite.

12. Informed consent includes informing the patient of the following:
    a. Nature of procedure or treatment.
    b. The risks, complications, and expected benefits or effects of such treatment.
    c. Any alternatives to the procedure and their risks and benefits.

    The physician shall chart in the hospital medical record that a discussion, which included the above information, was held with the patient and that an informed consent was obtained prior to the performance of the procedure or treatment.

B. HISTORY AND PHYSICAL EXAMINATION

1. A complete history and physical examination must be dictated or otherwise completed within 24 hours after admission of the patient to the acute hospital or within 72 hours after admission of the patient to the Comprehensive Care Center. The history and physical may have been obtained up to thirty (30) days prior to admission. The history and physical examination obtained prior to admission must be updated (with any changes in condition noted) within 24 hours after admission but prior

to surgery or procedures requiring anesthetic services. The record must be authenticated by the physician. An interval history and physical note will suffice if the patient is readmitted to the hospital within thirty (30) days with the same problem. If the history and physical is not completed within the time allotted, the chart on the floor will be flagged with a notice to that effect. If the patient is transferred to the Comprehensive Care Center from the acute hospital, an acceptable substitute shall be a copy of the history and physical with progress notes or discharge summary from the acute hospital.

2. Patients scheduled for elective surgery shall have a completed history and physical examination available on the chart at the time of admission. The history must contain at least:

   a. Reason for admission
   b. Surgery contemplated.
   c. Preoperative diagnosis.
   d. Physical examination of the heart and lungs.
   e. Allergies.
   f. Current medications.

   If the history and physical examination is not present, the Health Information Management Department will make a record of the discrepancy and notify the admitting physician in writing. Each additional occurrence shall result in a one (1) week loss of elective operating room privileges. This penalty will be levied during the week following the latest occurrence.

3. <u>Prenatal History & Physical</u>
   A full history and physical (H&P), abbreviated H&P, or the patient's prenatal record is required. The H&P must be completed no more than 30 days prior to admission or within 24 hours after admission. If the H&P is performed within 30 days prior to admission, an updated note must be entered into the record within 24 hours after admission. If the patient's prenatal record is used in lieu of an H&P, the last entry on the prenatal record must be within 30 days of admission and an updated note must be entered into the record within 24 hours after admission. Otherwise, an H&P must be done.

4. On all patients at the Comprehensive Care Center, an annual update history and physical examination must be made on the anniversary date of the patient's admission or one (1) year from the last history and physical examination. If this has not been done within thirty (30) days of the date due, the attending physician's privileges of admitting to the acute hospital and the Comprehensive Care Center shall be automatically suspended.

C. CONSULTATIONS

1. A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant which is made a part of the record. When the operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.

2. In major surgical cases in which the patient is not a good risk and in all cases, medical and surgical, in which the diagnosis is obscure or when there is doubt as to the therapeutic measures to be utilized, consultation is appropriate. Judgment as to the serious nature of the illness and the question of doubt as to the diagnosis and treatment rests with the physician's responsibility for the care of the patient. It is the duty of the hospital staff, through its chief of staff and the executive committee to see that members of the staff do not fail in the matter in calling consultants as needed. The chief of staff or a member of the executive committee have the authority to call in a consultant. The consultant must be well qualified in the field in which an opinion is being sought.

3. A consultation must be written before the consultant leaves the acute hospital or the Comprehensive Care Center.

D. PROGRESS NOTES

1. The frequency with which progress notes are made is determined by the condition of the patient. Acute care patients must have at least daily notes. Progress notes should give a chronological picture and analysis of the patient's status and should be written at the time of the physician's visit.

2. On all skilled nursing patients at the Comprehensive Care Center a progress note must be written at least every other month. If this has not been done within twenty-one (21) days, the attending physician shall be notified regarding the deficiency. If it is not corrected within seven (7) days the attending physician's privileges of admitting to the acute hospital and Comprehensive Care Center shall be automatically suspended and the physician shall be notified of his suspension in writing by the chief of staff.

E. EMERGENCY ROOM RECORD

1. A complete emergency room record must be dictated or otherwise completed within twenty-four (24) hours of the time that the emergency room patient is seen by the attending physician.

F. OUTPATIENT MEDICAL RECORDS

1. An adequate medical record will be maintained for each individual who is evaluated or treated as a patient at Lompoc District Hospital. This applies

to ambulatory care patients, emergency patients, outpatients, or observation patients.

2. The purpose of this medical record is to:
   a. Serve as a basis for planning patient care.
   b. Furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the hospital stay.

3. Therefore, the following medical record components are required:
   a. Appropriate history and physical, which documents the patient's condition at time of admission.
   b. Documentation of diagnosis and supporting data as necessary.
   c. Diagnostic and therapeutic orders.
   d. Evidence of appropriate informed consent.
   e. Clinical observations including the results of therapy.
   f. Conclusion at termination of evaluation/treatment.

G. If any of the above regulations are not adhered to within thirty-six (36) hours of the time limit set forth, the attending physician's privileges of admitting patients to the acute hospital and the Comprehensive Care Center shall be automatically suspended and the physician shall be notified of his suspension in writing by the chief of staff.

VIII. SURGICAL SERVICE

A. Laboratory and x-ray requirements for patients undergoing general, spinal or local anesthetic with standby are as follows:

Routine hemogram on patients over the age of eighteen years, and additional lab work as determined by pre-operative protocol recommended by the Surgery Subcommittee and approved by the Quality of Care – Acute Committee.

B. A surgical operation shall be performed only with the written informed consent of the patient or his legal representative, except in emergencies.

C. All operations shall be fully described by the operating surgeon. Operative notes must be dictated or otherwise written at the time of surgery. If a full note is dictated, a brief written summary must be in the chart at the time of surgery to include pre and post operative diagnosis, operative findings, and complications, if any. After the fourth late operative report in one year, a fine of $100 will be levied for each late operative report thereafter, payable to the medical staff. If the fine is not paid within thirty (30) days of the infraction, staff privileges will be temporarily suspended until such time as it is paid.

D. Tissue and foreign bodies removed at time of operation shall be sent according to current medical staff policy to the pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis and he shall sign his report.

E. No layman shall be permitted in the surgical room when procedures are taking place except as follows:

1. Students, for teaching purposes only.
2. Athletic trainers may be permitted to observe surgical procedures involving athletic injuries subject to the approval of the surgeon and the patient.
3. Other laypersons are subject to approval by the operating surgeon, anesthetist in charge, and operating room supervisor.

F. Assistant Surgeon
The responsibility shall be the surgeon's to determine whether a given case has the complexity, degree of involvement, and/or risk to the patient to necessitate an assistant surgeon's presence. The primary (operating) surgeon will select an appropriate assistant**,** and follow the approved policy, "Procedures Requiring an Assistant."

G. The anesthetist shall visit patients prior to their surgery and be familiar with their history, physical examination and laboratory data. Except in case of emergency, a note on the pertinent findings shall be recorded on the patient's chart by the anesthetist prior to surgery. Postoperative follow-up visits shall likewise be made and appropriate notes written on the chart. Appropriate records (e.g., anesthesia and recovery room) shall be completed for each patient.

H. Surgeons must be in the operating room ready to commence operation at the time scheduled and in no case shall the operating room be held longer than thirty (30) minutes after the time scheduled. Surgeons must be present at the beginning of induction of anesthesia.

IX. OUTPATIENT SURGERY

A. A surgical outpatient is a patient who stays in the hospital less than twenty-four (24) hours.

Outpatients fall into two categories:

1. Patients in the first category shall be those requiring general, spinal, epidural or standby anesthesia and are required to have available prior to surgery those studies outlined in section VIII A, and history and physical examination by a physician.
2. Patients in the second category are those requiring a local anesthesia only. These patients are required to have available prior to surgery, a note including preoperative diagnosis, surgery contemplated, preoperative medication, allergies, current medications and physical examination of the heart and lungs.

X. OBSTETRICS AND GYNECOLOGY

A. No layman shall be permitted in either the surgical or delivery room when procedures are taking place except as follows:

1. Students for teaching purposes.
2. Father or other appropriate persons in the delivery room only at the discretion of the attending physician.
3. Father or other appropriate persons in the surgical room for observation of cesarean section, only at the discretion of the attending physician.

B. When therapeutic abortion is contemplated, the correct rules as set by the Supreme Court and local laws will be followed.

C. In all cesarean sections a qualified person acceptable to the obstetrician familiar with the resuscitation and care of newborns and not a member of the operating team shall be present in the operating room to care for the baby.

XI. ICU/CCU

A. Special referrals are at the discretion of the attending physician.

XII. EMERGENCY SERVICE

A. Each member of the medical staff with emergency call responsibilities who may become unavailable shall name another medical staff member with comparable privileges who is available to be called to attend patients in an emergency.

B. Unless excused by the chief of staff for physical disability, each member of the active medical staff and provisional medical staff under the age of sixty (60) years with the exception of radiologists and pathologists and anesthesiologists shall serve on the hospital emergency admission list. Periods of service shall be on a rotation basis as determined by staff membership.

C. If a patient is seen in the emergency department and is felt to require admission to the hospital or transfer from the emergency department to another facility for a higher level of care, there shall be medical staff consulting physician collaboration with the emergency department. The term, ‘Consulting Physician,’ includes physicians covering on call for the Emergency Department and Hospitalist physicians.
The intent is to maximize patient safety, efficiency and physician communication when patients require hospital admission or transfer to another facility.
The need to transfer patients from LVMC arises when patients require higher levels of care or specialized services unavailable at LVMC. In these instances, the patient will be transferred to a facility where the needed services can be provided.
Determination to transfer and coordination of care:

- It is at the discretion of the Emergency Medicine physician to determine when a consult is needed.

- Consulting physicians shall respond when a request is made by the Emergency Medicine physician when based on his or her judgment, the services of the consulting physician are required. The consulting physician shall respond in accordance with LVMC Medical Staff Rules and Regulations, applicable law and regulation.
- Final decisions to transfer a patient is at the discretion of the consulting physician(s). A thorough review and discussion of the case shall occur between the ED physician and consulting physician(s) in determining the best course for the patient.
- The Emergency Medicine physician is not required to request consults when in his or her medical judgement, it is clear a transfer to another facility is in the best interest of the patient.
- Rationale for transfer shall be documented in the medical record in all cases.

The Emergency Medicine physician will initiate transfers. There may be times when assistance of the consulting physician(s) is needed to discuss a case directly with medical staff of the receiving facility and/or initiate care management prior to transport to the receiving facility. The consulting physician(s) will communicate medical interventions needed prior to transport to the Emergency Medicine physician.

In a circumstance where a patient remains in the Emergency Department awaiting transfer to a higher level of care, or awaiting placement at another facility, or awaiting an available bed for inpatient admission, there shall be collaboration between the Emergency Department Physician and the Consultant Physician(s) regarding the ongoing medical management of the patient. This will require that the physicians of each Service Line ensure that the care of the patient is transferred to their respective colleagues at change of shift, if applicable. Orders necessary to ensure a cohesive ongoing plan of care for the patient shall be made with input and collaboration of both/all parties.

D. DEFINITION OF EMERGENCY RESPONSE TIME

Members of the medical staff participating in the emergency department on-call panel should:

1. Respond to pagers or phone calls within twenty (20) minutes.
2. Arrive in the emergency department within sixty (60) minutes after being contacted and requested to come in immediately.

XIII. PROFESSIONAL LIABILITY INSURANCE LIMITS

A. It will be the responsibility of each member of the medical staff to have in his malpractice insurance policy appropriate coverage for any aspects of medicine which he intends to practice within the hospital.

B. Physician shall provide Hospital with certificate evidencing required coverage and providing for not less than twenty (20) days prior notice to Hospital of the cancellation of such coverage.

C. The minimum amount of malpractice coverage per individual medical staff member is to be $1,000,000/$3,000,000.

XIV. CPR PROFICIENCY

A. Documentation of proficiency in basic cardiopulmonary resuscitation is recommended for appointment and reappointment to the Active medical staff, provisional Active staff, Emergency Department staff, and provisional Emergency Department staff.

XV. MEMBER CONDUCT

Medical staff members will fulfill their medical staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior.

A. Behavior out of these bounds includes abusive, combative, obstructive actions, as well a willful refusal to communicate or comply with reasonable rules of the medical staff and hospital.

XVI. MEDICAL SCREENING EXAMINATION

Any individual who comes to the hospital requesting or in need of examination or treatment of a medical condition will be provided a medical screening examination (MSE), within the capacity of the hospital, to determine whether or not an emergency medical condition exists.

1. The MSE will be conducted in the emergency department by the following categories of professionals determined by the medical staff to be qualified to perform the MSE:
   a. An emergency department physician;
   b. An NP or PA practicing under the supervision of the ED physician within the scope of his or her licensure and qualifications; and
   c. A member of the active medical staff, in accordance with Paragraph 4 below, as determined by the medical staff by demonstrated competencies and privileging.
2. All patients presenting to the emergency department will be entered in the central log and triaged according to the hospital’s standard screening protocols.
3. Requirements for the MSE:
   a. The MSE will be performed based on medical staff and emergency department approved guidelines, policies, protocols and algorithms. and applicable laws, regulations and EMTALA guidelines.

b. If an individual presents to the emergency department with a condition related to pregnancy, after 18 weeks, the MSE should be provided by qualified staff in labor & delivery.

4. An MSE performed by qualified members of the medical staff described in Paragraph 1.c above will be rendered as follows:

   a. A qualified member of the medical staff may provide an MSE in the emergency department for a regular or private patient if the physician is present in the department when the patient would receive the MSE as determined by triage acuity or by order of arrival.

   b. If the patient's physician has not arrived by the time the emergency physician would normally examine the patient (as determined by triage acuity or by order of arrival), the emergency physician will perform an MSE.

   c. If the emergency physician determines that the patient does not have an emergency medical condition, and does not require immediate further examination or treatment for his/her condition (such as suturing a non-emergent injury), the patient may wait for his or her private physician to arrive in the department for further evaluation and treatment. Emergency department staff will continue to monitor the patient's condition, including vital signs, per hospital policy, and alert the emergency physician or other department provider if there is a change in the patient's clinical status or further emergency services are clinically indicated for the patient's condition before the arrival of the patient's physician.

   d. The MSE and other emergency services required for the patient's condition will not be delayed for the arrival of the patient's physician.

   e. The MSE, further examination and treatment and disposition of the patient rendered by a qualified member of the staff will be in accordance with hospital and department policies, and documented in the patient record, in the same manner as the services are provided to patients with the same or similar presenting complaint, signs and symptoms.