

St. Dominic – Jackson Memorial Hospital

Medical Staff Rules and Regulations

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ARTICLE I

INTRODUCTION

These Rules and Regulations of St. Dominic – Jackson Memorial Hospital (“Hospital”) are adopted by the Medical Executive Committee (“MEC”), and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges. Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws. This article supersedes and replaces any and all other Medical Staff Rules and Regulations pertaining to the subject matter thereof.

The specific responsibilities of each individual practitioner are to render specific professional services at the level of quality and efficiency equal to, or greater than, that generally recognized and accepted among practitioners of the same profession, in a manner consistent with licensure, education and expertise, and in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources, the Ethical and Religious Directives for Catholic Health Care Services, adherence to the Code of Ethics as prescribed by his or her profession, and Case Management/utilization standards in effect in the Hospital.

ARTICLE II

ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

The Hospital accepts short-term patients for care and treatment provided suitable facilities are available.

- a. **Admitting Privileges:** A patient may be admitted to the Hospital only by a practitioner on the Medical Staff with admitting privileges.
- b. **Admitting Diagnosis:** Except in an emergency, no patient will be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been written in the medical record. In the case of emergency, such statement will be recorded as soon as possible.
- c. **Admission Procedure:** Admissions must be scheduled with the Hospital's Patient Access Services Department. A bed will be assigned based upon the medical condition of the patient and the availability of Hospital staff and services. Except in an emergency, the admitting practitioner or his designee shall contact the Hospital's Patient Access Services Department to ascertain whether there is an available bed.

2.1.2 Admission Priority

Patient Access Services personnel will admit patients on the basis of the following order of priorities:

- a. **Emergency Admission:** Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. This patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient will be admitted immediately to the first appropriate bed available.
- b. **Urgent Admissions:** Urgent admission patients meet the criteria for inpatient admission, however their condition is not life threatening. Urgent admission patients will be admitted as soon as an appropriate bed is available. Urgent admissions include admissions for observation as determined by Center for Medicare and Medicaid Services ("CMS") criteria.
- c. **Elective Admissions:** Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for his or her health's sake. These patients may be admitted on a first-come, first-serve basis. A waiting list will be kept and each patient will be admitted as soon as a bed becomes available.

2.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area. Patients in active labor will be admitted directly to the Birthing Center per Hospital policy after determination that the patient is stable.

2.2 UNASSIGNED EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must provide for an appropriate medical screening examination within the capability of the Hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. Pregnant patients, greater than twenty (20) weeks gestation, with a primary obstetrical

complaint can have their medical screening exam done in the obstetrics area.

2.2.1 Definition of Unassigned Patient

Patients who present to the Emergency Department and require admission and/or treatment shall have a practitioner assigned by the Emergency Department physician if one or more of the following criteria are met:

- a. the patient does not have a primary care physician or does not indicate a preference;
- b. the patient's primary care physician does not have admitting privileges; or
- c. the patient's injuries or condition fall outside the scope of the patient's primary care physician and the patient does not have a previous patient relationship with a physician who can provide treatment.

2.2.2 Unassigned Call Service

- a. **Unassigned Call Schedule:** The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Each Medical Staff Department Chair, or his or her designee, shall provide the Emergency Department and the Medical Staff Services Office with a list of physicians who are scheduled to take emergency call on a rotating basis.
- b. **Response Time:** It is the responsibility of the on-call physician, or designee, to respond in an appropriate time frame. The on-call physician, or designee, should respond to calls from the Emergency Department within thirty (30) minutes by telephone, and must arrive at the Hospital, if requested to see the patient, to evaluate the patient within thirty (30) minutes for emergent patients or within a time frame specified by the Emergency Department physician for non-emergent patients. If the on-call physician does not respond to being called or paged, the physician's Department Chair shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.
- c. **Substitute Coverage:** It is the on-call physician's responsibility to arrange for coverage and officially update the schedule if he or she is unavailable to take call when assigned. Failure to notify the Emergency Department of alternate call coverage may result in the initiation of disciplinary action.

2.2.3 Patients Not Requiring Admission

In cases where the Emergency Department consults with the unassigned call physician and no admission is deemed necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. It is the unassigned call physician's responsibility to provide a timely and appropriate follow-up evaluation for the patient following the Emergency Department visit.

2.2.4 Unassigned Patients Returning to the Hospital

Unassigned patients who present to the Emergency Department will be referred to the practitioner taking unassigned call that day unless a patient-physician relationship has been developed and the patient is no longer considered "unassigned".

2.2.5 Guidelines for Departmental Policies on Unassigned Call

Pursuant to the Medical Staff Bylaws, Departments may adopt rules, regulations, and policies that are binding on the members of their Department. The following rules should be used in developing departmental policies regarding unassigned emergency call obligations:

- a. Unassigned call duties should be based on the physician's clinical core privileges; physicians with admitting privileges are expected to serve on the unassigned call roster regardless of their staff category.
- b. Unassigned call duties shall be assigned by the Department Chair and approved by the MEC.
- c. Unassigned call duties may be divided by department, specialty, or subspecialty.
- d. A physician may request an exemption to being on the "unassigned" call roster when they reach the age of sixty (60) OR have served at least sixteen (16) years on the call roster. Physicians should notify their department chairs one year in advance of their intentions for the exemption. The exemption request will be granted only if it does not compromise the department's ability to fulfill the Hospital's EMTALA obligations as determined by the department chair, MEC and Board.
- e. An impairment which is alleged to limit a physician's ability to provide unassigned call services shall also be grounds for limiting the physician's privileges for providing care to their assigned or private patients.
- f. Departmental policies concerning unassigned call, including the frequency of call, must be approved by the Medical Executive Committee and the Board.

2.2.6 Use of the Unassigned Call Roster

The unassigned call roster may be used as default consultation coverage when a practitioner cannot obtain consultation on his or her patient on a voluntary basis.

2.2.7 Failure to Meet Unassigned Call Obligations

All failures to meet unassigned call responsibilities shall be reported to the Vice President of Medical Affairs, Department Chair and the MEC. Recurrent failure to meet call obligations may result in corrective action per the Medical Staff Bylaws.

2.3 TRANSFERS

2.3.1 Transfers From Other Acute Care Facilities

Transfers from other acute care facilities must meet the following criteria:

- a. The patient must be medically stable for transfer;
- b. The patient's condition must meet medical necessity criteria;
- c. The patient must require, and this Hospital must be able to provide, a higher level of care or a specific inpatient service not available at the transferring facility;
- d. Responsibility for the patient must be accepted by a physician with appropriate privileges at this Hospital; and
- e. The transfer must be approved by Patient Access Services.

2.3.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. All practitioners actively providing care to the patient will be notified of all transfers per the methods noted in Hospital policy.

2.3.3. Transfers To Another Hospital

Patients who are transferred to another hospital must follow the Hospital policy on transfers in order to comply with EMTALA.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The admitting practitioner, or designee, is responsible for providing the Hospital with necessary information to protect the patient from self-harm and others.

Acute care admissions of suicidal patients will not be accepted except for those patients requiring medical stabilization or when transfer to an inpatient psychiatric facility cannot be facilitated. Once the patient's medical condition is stabilized, the patient will be evaluated and transferred to an appropriate outpatient or inpatient psychiatric facility.

2.5 PROMPT ASSESSMENT

All new admissions must be personally assessed by the attending physician or his or her designated covering practitioner and have a history and physical examination completed and on the record within 24 hours. Patients admitted to critical care units must be seen within two (2) hours OR in a timely manner as determined by the patient's condition by the admitting physician or designee if the patient is stable. Unstable patients must be seen as soon as possible in a time period dictated by the acuity of their illness.

2.6 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician or his or her privileged designee who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. These instructions should include, if appropriate:

- a. A list of all medications the patient is to take post-discharge;
- b. Dietary instructions and modifications;
- c. Medical equipment and supplies;
- d. Instructions for pain management;
- e. Any restrictions or modification of activity;
- f. Follow up appointments and continuing care instructions;
- g. Referrals to rehabilitation, physical therapy, and home health services; and
- h. Recommended lifestyle changes, such as smoking cessation.

2.7 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the Hospital against the advice of the attending physician, or without a discharge order, Hospital policy shall be followed. The attending physician shall be notified that the patient has left against medical advice.

2.8 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken so that a patient remains in the Hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the MEC.

ARTICLE III

MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access to and make entries into the medical record. The attending physician is responsible for the preparation of the physician components of the medical record for each patient in a complete and legible manner.

In order to practice medicine, all healthcare providers who exercise privileges in the facility are required to utilize the electronic health record (EHR) in order to meet regulatory requirements and provide efficiencies in delivering healthcare to the community. All healthcare providers will undergo appropriate EHR training, and comply with security guidelines, per the Hospital's policy on use of the EHR.

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means.

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual will contact the practitioner, request a verbal order for clarification, read back the order, and document the clarification in the medical record. This verbal order must be signed by the ordering practitioner as described in Subsection 4.4.2.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

Prohibited Abbreviations, Acronyms, and Symbols: The MEC shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders. These will include at a minimum:

- U for Units
- IU for International Units
- QD for Daily
- QOD for Every Other Day
- Trailing Zero (X.0)
- Always Use Leading Zero (0.X)
- MS or MSO4 for Morphine Sulfate
- MGSO4 for Magnesium Sulfate

Situations Where Abbreviations Are Not Allowed: Abbreviations, acronyms, and symbols may not be used in recording the final diagnoses and procedures on the face sheet of the medical record.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

Time limits for performance of the history and physical examination are noted in the Medical Staff Bylaws.

3.5.2 Who May Perform and Document the Admission History and Physical Examination

Who may perform the history and physical examination are noted in the Medical Staff Bylaws.

3.5.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by CMS or comparable regulatory authority.

A complete history and physical examination is required for all admissions, all surgeries requiring anesthesia (general, regional, monitored anesthesia care (“MAC”), or deep sedation), and all observation patients. A complete history and physical examination report must include the following information:

- a. Chief complaint or reason for the admission or procedure;
- b. A description of the present illness;
- c. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;
- d. An age-appropriate social history;
- e. A pertinent family history;
- f. A review of systems;
- g. Cardiorespiratory exams and other relevant physical findings;
- h. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

A focused history and physical examination report, used for outpatient procedures that do not require anesthesia, should include the following information:

- a. Chief complaint or reason for the admission or procedure;
- b. A description of the present illness;
- c. Past medical history, including current medications, allergies, and current diagnoses;
- d. A review of systems relative to the procedure planned;
- e. Relevant physical findings, including an evaluation of the cardiac and respiratory systems and the affected body area;
- f. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

3.5.4 Admitting Physician is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the admitting physician or his or her designee.

3.6 PREOPERATIVE DOCUMENTATION

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

- a. all invasive procedures performed in the Hospital's surgical suites;
- b. certain invasive procedures performed in the Radiology Department and Catheterization Lab (angiography, angioplasty, myelograms, abdominal and intrathoracic biopsy or aspiration, pacemaker and defibrillator implantation, electrophysiologic studies, and ablations); and
- c. certain invasive procedures performed in other treatment areas (bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, central arterial line insertions, and elective electrical cardioversion).

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be cancelled if a history & physical is not completed. In cases of procedures performed by podiatrists and dentists, the pre-anesthesia evaluation may suffice for the update to the history and physical examination.

3.7 PROGRESSNOTES

The attending physician or his or her designee will record a progress note each day for each patient encounter on all hospitalized patients. Progress notes must document the reason for continued hospitalization. A physician must see the patient, and document the visit, on the first day following admission, within one (1) day of discharge and at least every third day during the hospitalization. ICU patients must be seen daily by a physician. Progress notes documented by non-physicians do not need co-signature by the physician. It is noted that progress notes are required five (5) days per week for patients admitted to the acute rehabilitation unit.

3.8 OPERATIVE/PROCEDURE REPORTS

Operative reports will be written or dictated immediately after surgery, and in no case later than twenty-four (24) hours after the end of the procedure, and the report promptly signed by the surgeon and made a part of the patient's current medical record. Operative/procedure reports will include:

- a. the name of the Licensed Independent Practitioner(s) who performed the procedure and any assistants and a description of their tasks;
- b. the pre-operative diagnosis;
- c. the name of the procedure performed;
- d. a description of the procedure performed;
- e. the type of anesthesia administered;
- f. findings of the procedure;
- g. complications, if any;
- h. any estimated blood loss;
- i. any specimen(s) removed;
- j. any prosthetic devices, transplants, grafts, or tissues implanted; and

- k. the postoperative diagnosis.

3.9 POST-OPERATIVE/PROCEDURE NOTES

If there is a delay in getting the operative/procedure report in the medical record, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. Operative/procedure notes will include:

- a. the name of the Licensed Independent Practitioner(s) who performed the procedure and any assistants;
- b. the name of the procedure performed;
- c. findings of the procedure;
- d. any estimated blood loss;
- e. any specimen(s) removed; and
- f. the post-operative/procedure diagnosis.

3.10 POST-ANESTHESIA NOTES

A post-anesthesia evaluation shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving anesthesia or deep sedation. The note shall be entered by an anesthesia provider or by the physician who administered the deep sedation. This note should contain the following information:

- a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
- b. Cardiovascular function, including pulse rate and blood pressure;
- c. Mental status;
- d. Temperature;
- e. Pain;
- f. Nausea and vomiting; and
- g. Postoperative hydration.

3.11 CONSULTATION REPORTS

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by CMS or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The Consultation Report should be completed and entered in the patient's chart within the time frame specified by the physician ordering the consult and no later than 24 hours after receipt of notification of the consult request. If a full consult note is not immediately available after the consultation, a note should be documented in the record containing the consultant's assessment and plan for the care of the patient. If a consultation is performed by a non-physician, the consulting physician must cosign the consultation.

If the report is not in the record within the prescribed time, an explanatory note should be recorded in the record. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

3.12 OBSTETRICAL RECORD

The obstetrical record must include a medical history, including a complete prenatal record if available, and an appropriate physical examination. A copy of the practitioner's office prenatal record may serve as the history and physical for uncomplicated vaginal deliveries if it is legible and complete and the last prenatal visit was within thirty (30) days of admission. If the office prenatal record is used as the history and physical examination, an update must be performed as described in the Medical Staff Bylaws will be documented.

3.13 FINAL DIAGNOSES

The final diagnoses will be recorded in full, without the use of symbols or abbreviations, dated and signed by the discharging physician in the discharge summary, transfer note, or death summary of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the physician will be required to document such in the patient's record.

3.14 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries are the responsibility of the discharging physician or his or her privileged designee.

- a. **Content:** A discharge summary will be written or dictated upon the discharge or transfer of hospitalized patients. The discharge summary is the responsibility of the discharging physician and will contain:
 1. Reason for hospitalization;
 2. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
 3. Condition of the patient at discharge;
 4. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
 5. Final diagnoses.
- b. **Short-term Stays:** A discharge summary is not required for uncomplicated inpatient and observation hospital stays of less than 48 hours, uncomplicated vaginal deliveries, and normal newborn infants, provided the discharging physician enters a final progress note or completes a Discharge Form documenting:
 1. The condition of the patient at discharge; and
 2. Instructions given to the patient and family, including medications, referrals, and follow-up appointments.
- c. **Deaths:** A discharge summary is required on all inpatients who have expired and will include:
 1. Reason for admission;
 2. Summary of hospital course; and
 3. Final diagnoses.
- d. **Timing:** A Discharge Summary is encouraged to be entered and signed in the medical record within seventy-two (72) hours, but in no case later than thirty (30) days after discharge, transfer, or death.

3.15 DIAGNOSTIC REPORTS

Diagnostic reports (including but not limited to inpatient EEGs, EKGs, echocardiograms, stress tests, Doppler studies) must be read by the physician scheduled to provide the interpretation service within 24 hours of availability of the test. Failure to provide prompt interpretation of diagnostic tests may result in removal from the reading list.

3.16 ADVANCED PRACTICE PROFESSIONALS

The attending or supervising physician will review and authenticate all consultations and discharge summaries prepared by the Advanced Practice Professional. The signature signifies that the attending or supervising physician has reviewed the patient's medical record and approved the care rendered by the Advanced Practice Professional.

3.17 RESIDENTS AND FELLOWS IN TRAINING

Residents and fellows in training, who are not moonlighting outside of their training program, must have their history and physical examinations, operative notes, and operative reports cosigned within one calendar day by the attending physician or their physician designee. They must also have their discharge summaries cosigned by the attending physician or their physician designee within thirty (30) days after discharge of the patient. If the attending physician enters their own independent note, there is no need to cosign the resident or fellow's progress note for that day.

3.18 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, the record will be made available to any member of the Medical Staff attending the patient and to members of Medical Staffs of other hospitals upon written consent of the patient or by the appropriate Hospital authority in an emergency situation. Medical records will otherwise be disclosed only pursuant to court order, subpoena, statute or otherwise required by law. Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

- a. **Access to Old Records:** In case of readmission of a patient, all previous records will be made available to the admitting practitioner whether the patient was attended by the same practitioner or by another practitioner.
- b. **Unauthorized Removal of Records:** Unauthorized removal of charts from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the MEC.
- c. **Access for Medical Research:** Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of the Hospital's Institutional Review Board. The written request will include: (1) the topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.
- d. **Access for Former Members:** Former members of the Medical Staff will be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital in accordance to Hospital Policy.

3.19 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Records/Utilization Review Committee.

3.19.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the following standards:

- a. An Admission History and Physical Examination or Updated History and Physical Examination must be entered in the medical record in the timeframes noted in the Bylaws, Part I, Section 2.6.8;
- b. A Preoperative History and Physical Examination or Focused Preoperative History and Physical Examination must be entered in the medical record prior to the surgery or procedure;
- c. An Admission Prenatal Record must be entered in the medical record by the attending physician or designated covering practitioner within 24 hours after an obstetrical admission
- d. An Operative Report must be entered in the medical record by the performing practitioner immediately, but in no case later than twenty-four (24) hours, following the surgery or procedure;

- e. If the Operative Report is not immediately available, a Post-Operative Note must be entered in the medical record by the performing practitioner prior to transfer of the patient to the next level of care.
- f. An Inpatient Progress Note must be recorded and authenticated by the attending physician or designee each day for each patient encounter on all hospitalized patients;
- g. An Emergency Department Record must be completed by the responsible practitioner within 24 hours of the encounter for patients admitted or placed in observation status. An Emergency Department Record must be completed by the responsible practitioner within 72 hours of outpatient discharges;
- h. A Consultation Note must be completed by the consulting physician within 24 hours of notification of the consult request;
- i. Inpatient Diagnostic Reports must be completed by the interpreting physician within 24 hours after availability of the test for review;
- j. A Discharge Summary must be entered in the medical record by the discharging physician or his or her designee preferentially within seventy-two (72) hours but in no case later than thirty (30) days after an inpatient or observation discharge, transfer, or death; and
- k. The Inpatient or Observation Medical Record must be completed within thirty (30) days of discharge, including the authentication of all progress notes, consultation notes, operative reports, verbal and written orders, final diagnoses, and discharge summary.

3.19.2 Policy on Incomplete Records

All practitioners will be held to the Hospital policy on “Medical Records Delinquency and Suspension”.

3.20 ELECTRONIC RECORDS AND SIGNATURES

“Electronic signature” means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

3.21 ORGANIZED HEALTHCARE ARRANGEMENT

- a. For the purposes of complying with provisions of the federal Health Insurance Portability and Accountability Act (“HIPAA”), the Medical Staff of Hospital are deemed to be members of, and a part of, an *Organized Health Care Arrangement* (“OHCA”) as that term is defined within HIPAA. This designation is intended to comply with the privacy regulations promulgated pursuant to HIPAA based upon the fact that the members of the OHCA operate in a "clinically integrated care setting." As such, members of Medical Staff shall, upon acceptance to membership, become part of the OHCA with Hospital and the Hospital’s Medical Staff. Except for non-compliance remedies set forth in the HIPAA regulations, no member shall be liable for any actions, inactions, or liabilities of any other member. Each member of the OHCA shall be responsible for its own HIPAA compliance requirements related to services and activities performed outside the clinical setting of the OHCA.
- b. The members hereby adopt the Hospital Notice of Privacy Practices that will be distributed by the Hospital to all patients of the Hospital, and agree to comply with all requirements contained in the Notice of Privacy Practices.
- c. The members of the Medical Staff shall have access to protected health information of the patients of other members of the OHCA for purposes of treatment, payments and healthcare operations, as those terms are defined by HIPAA and the HIPAA Privacy Regulations; provided that any member of the Medical Staff that downloads, saves or otherwise stores any protected health information, or has access to any Hospital electronic data systems, through any portal that is not solely operated by

Hospital, shall enter into an agreement, which shall require that member of the Medical Staff to observe certain requirements, and to assume responsibility for anyone who accesses any Hospital information through a portal maintained by the member.

- d. Members of the Medical Staff shall be entitled to disclose protected health information of a patient to other members of the OHCA for any health care operations of the OHCA, including peer review, mortality and morbidity meetings, cancer conference, and other similar health care operations of the OHCA, as permitted in the HIPAA Privacy Regulations.

ARTICLE IV

STANDARDS OF PRACTICE

4.1 ADMITTING/ATTENDING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an admitting physician who is an appointee of the Medical Staff with admitting privileges. The admitting physician or designee is responsible for completion of the history and physical examination. The attending physician or designee will be responsible for:

- a. the medical care and treatment of each patient in the Hospital;
- b. making daily rounds;
- c. the prompt, complete, and accurate preparation of the medical record; and
- d. necessary special instructions regarding the care of the patient.

4.1.2 Identification of Attending Physician

At all times during a patient's hospitalization, the identity of the attending physician shall be clearly documented in the medical record.

4.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending physician are transferred to another medical service, a note covering the transfer of responsibility will be entered in the medical record by the attending physician.

4.2 COVERAGE AND CALL SCHEDULES

Each physician shall provide the Medical Staff Services Office with a list of designated Medical Staff appointees (usually the members of his or her group practice who are members of the same clinical department and have equivalent clinical and procedure privileges) who shall be responsible for the care of their patients in the Hospital when the physician is not available. Each physician is responsible for providing a current and correct on-call schedule.

4.3 RESPONDING TO CALLS AND PAGES

- a. Telephonic Response: Practitioners are expected to respond within thirty (30) minutes to calls from the Hospital's patient care staff regarding their patient.
- b. Physical Response: Practitioners are expected to respond in person within sixty (60) minutes to evaluate emergent requests from the Hospital's patient care staff. An initial evaluation of a patient requiring an ICU level of care (excluding boarders for step-down beds and suicidal patients that are medically stable) shall be done timely based on the patient's condition.

4.4 ORDERS

4.4.1 General Principles

- a. All orders for treatment will be entered into the medical record.
- b. All orders must be specifically given by a practitioner who is privileged by the Medical Staff.
- c. Vague or "blanket" orders (such as "continue home medication" or "resume previous orders") will

not be accepted.

- d. Instructions should be written out in plain English. Prohibited abbreviations may not be used.
- e. All orders for treatment shall be recorded in the medical record and authenticated by the ordering practitioner with his or her legible signature, date, and time.

4.4.2 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in a computer. Verbal/telephone orders must comply with the following criteria:

- a. The order must be given to an authorized individual as defined in Hospital policy.
- b. Verbal/telephone orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal/telephone orders, like written/electronic orders, should be conveyed in plain English without the use of prohibited abbreviations.
- c. The order must be read back to the ordering practitioner by the authorized person receiving the order.
- d. All verbal/telephone orders must be signed by the ordering practitioner or another practitioner involved in the patient's care within thirty (30) days after discharge of the patient.
- e. Orders for cancer chemotherapy may not be given verbally.
- f. Verbal/telephone orders may be given only by practitioners privileged at the Hospital or working under training protocols.

4.4.3 Facsimile Orders

Orders transmitted by facsimile shall be considered properly authenticated and executable provided that:

- a. The facsimile is legible and received as it was originally transmitted by facsimile or computer;
- b. The order is legible, clear, and complete
- c. The identity of the patient is clearly documented;
- d. The facsimile contains the name of the ordering practitioner, his or her address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law;
- e. The original order, as transmitted, is signed, dated, and timed; and
- f. The facsimile, as received, is signed by the attending physician or ordering practitioner within thirty (30) days of discharge.

4.4.4 Cancellation of Orders Following Surgery or Transfer

All previous medication orders are canceled when the patient:

- a. goes to surgery,
- b. is transferred to or from a critical care area,

- c. is transferred from the Psychiatric unit or Rehabilitation unit to an acute care area, or
- d. is transferred to, and readmitted from, another hospital or health care facility.

New orders shall be specifically written following surgery or the aforementioned transfers. Instructions to “resume previous orders” will not be accepted.

4.4.5 Drugs and Medications

Orders for drugs and medications must follow Hospital Pharmacy policy.

4.5 CONSULTATION

- a. Any qualified practitioner with clinical privileges may be requested for consultation within his or her area of expertise. The attending physician is responsible for obtaining consultation whenever patients in his or her care require services that fall outside his or her scope of delineated clinical privileges. The attending physician will provide written authorization requesting the consultation, and permitting the consulting practitioner to attend or examine his or her patient. This request shall specify:
 - 1. the reason for the consultation, and
 - 2. the urgency of the consultation (emergent/urgent – within a timeframe acceptable to the referring physician based on communication with the consultant; routine – within 24 hours; delayed – within a timeframe acceptable to the referring physician as long as it does not delay the discharge planning process).
- b. All consultations will be for “consultation and treatment” unless specified otherwise.
- c. All urgent and emergent consultations should be communicated practitioner-to-practitioner. Nurse practitioners and physician assistant may initiate the consultation with the knowledge of their collaborating/supervising physician.
- d. Consultants should not order consultations with other specialties without informing the attending physician unless the need is urgent/emergent.
- e. Nurse practitioners and physician assistants may perform the consultation with the knowledge and collaboration of their collaborating/supervising physician. If the practitioner requesting the consult requests that the consulting physician perform the consultation, that request will be honored.
- f. If a nurse has any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to her manager to be addressed through the chain of command. All practitioners should be receptive to obtaining consultation when requested by patients, their families, and hospital personnel.

4.6 CRITICAL CARE UNITS

4.6.1 Critical Care Unit Privileges

The privilege to admit patients to, and manage patients in, critical care units shall be specifically delineated. When there are concerns regarding the continued stay within a critical care unit, consultation with the medical director of the unit will be obtained.

4.6.2 Prompt Evaluation of Critical Care Patients

Each patient admitted or transferred to a critical care unit shall be examined by a physician or designee

within two (2) hours/in a timely manner as determined by the patient's condition following admission or transfer.

4.6.3 Critical Care Services

Certain services and procedures may be provided to patients only in critical care units. The MEC shall establish policies that specify which services may be provided only in a critical care unit.

4.7 DEATH IN HOSPITAL

4.7.1 Pronouncing and Certifying the Cause of Death

In the event of a hospital death, the deceased will be pronounced as defined in Hospital policy.

4.7.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.

4.8 AUTOPSY

It is the responsibility of the attending physician to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medico-legal or educational interest. Refer to Hospital policy on autopsy.

4.9 SUPERVISION OF ADVANCED PRACTICE PROFESSIONALS

4.9.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals, which includes Advance Practice Registered Nurses (nurse midwives, CRNAs, nurse practitioners, and clinical nurse specialists providing direct patient care) and Physician Assistants, are licensed or certified health care practitioners whose license or certification does not permit and/or the Hospital does not authorize the independent exercise of clinical privileges. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical Staff Bylaws. Advanced Practice Professionals may provide patient care only under the supervision/collaboration of a physician(s) who is a member of the Medical Staff. Advanced Practice Professionals are not eligible for Medical Staff membership.

4.9.2 Guidelines for Supervising Advanced Practice Professionals

- a. The physician(s) is(are) ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, providing quality health care to patients.
- b. Health care services delivered by physicians and by Advanced Practice Professionals under their supervision/collaboration must be within the scope of each practitioner's authorized practice, as defined by state law.
- c. The physician(s) is(are) ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, assuring the quality of health care provided to patients.
- d. The physician(s) is(are) responsible for the supervision of the Advanced Practice Professional in all settings.
- e. The role of the Advanced Practice Professional in the delivery of care shall be defined through mutually agreed upon Scope of Practice Guidelines that are developed by the physician and the

Advanced Practice Professional.

- f. The physician(s) must be available for consultation with the Advanced Practice Professional at all times, either in person or through telecommunication systems or other means. A physician must be able to present to the Hospital within sixty (60) minutes when needed by the Advanced Practice Professional.
- g. The extent of the involvement by the Advanced Practice Professional in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the Advanced Practice Professional, as adjudged by the physician(s).
- h. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.
- i. The physician(s) and Advanced Practice Professional together should review all delegated patient services on a regular basis, as well as the mutually agreed upon Scope of Practice Guidelines.
- j. The physician(s) is(are) responsible for clarifying and familiarizing the Advanced Practice Professional with his or her supervising methods and style of delegating patient care.
- k. Each Advanced Practice Professional must provide documentation the identity of their supervising or collaborating physician and one or more alternate supervising physician(s) at the time of initial appointment and reappointment.

4.9.4 Collaborative Practice Agreements

Each Advanced Practice Professional must have on file in the Medical Staff Services Office written Supervision/Collaboration Agreement, if applicable, that describes all health care-related tasks which may be performed by the Advanced Practice Professional. This document must be signed by the Advanced Practice Professional, the supervising/collaborating physician, and all alternate supervising/collaborating physicians. The Supervision/Collaboration Agreement shall be submitted to the Credentials Committee and the MEC for approval before the Advanced Practice Practitioner can provide services to patients at the Hospital. The Supervision/Collaboration Agreement, if applicable, must include:

- a. the name, license number and addresses of all supervising/collaborating physicians;
- b. the name and practice address of the Advanced Practice Professional;
- c. the date the guidelines of the Supervision/Collaboration Agreement were developed and dates they were reviewed and amended;
- d. medical conditions for which therapies may be initiated, continued, or modified;
- e. treatments that may be initiated, continued, or modified;
- f. drug therapies, if any, that may be prescribed with drug-specific classifications; and
- g. situations that require direct evaluation by or immediate referral to the supervising physician.

4.9.5 Supervising/Collaborating Physician

An Advanced Practice Professional may not provide services to patients if they do not have a supervising/collaborating physician who is at least sixty (60) minutes travel time from the Hospital. A physician may not supervise more Advanced Practice Professionals than allowed by State law.

A Medical Staff member who fails to fulfill the responsibilities defined in this section and/or in a Supervision/Collaboration Agreement for the supervision of or collaboration with an Advanced Practice

Professional or other dependent health care professionals shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.9.6 Medical Record Documentation

Advanced Practice Professionals may enter notes and orders within the scope of their written Supervision/Collaboration Agreement. Advanced Practice Professionals should discuss consultations with their supervising/collaborating physician as soon as possible after the completion of the consultation. When performed by an APP, consultations and discharge summaries require co-signature by a physician. Either the history and physical performed by an Advanced Practice Professional or the addendum written by the physician, must be signed by the physician.

4.9.7 Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional may not:

- a. provide a service which is not listed and approved in the Supervision/Collaboration Agreement on file in the Medical Staff Services Office;
- b. prescribe drugs, medication, or devices not specifically authorized by the supervising/collaborating physician and documented in the Supervision/Collaboration Agreement; and
- c. provide a medical service that exceeds the clinical privileges granted to the supervising/collaborating physician.

4.10 INFECTION CONTROL

All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties.

4.11 EVIDENCE-BASED ORDERSETS

Evidence-based order sets provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Evidence-based order sets assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. The MEC may adopt evidenced-based order sets upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, Hospital senior administrative personnel, and those health care providers who are expected to implement the guidelines.

4.12 TREATMENT OF FAMILY MEMBERS

The following is based on the *AMA Code of Medical Ethics'* Opinion on Physicians Treating Family Members. In general, practitioners should not treat themselves or their family members. Family members are defined as: 1) first degree relative based on consanguinity or adoption (i.e., parents, siblings, children), 2) spouse or ex-spouse, or 3) domestic partner or ex-domestic partner.

In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

4.13 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall follow the Hospital policy regarding access to medical records of themselves or family members.

ARTICLE V

PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in Hospital policy.

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow Hospital policy.

5.3 WITHDRAWING AND WITHHOLDING LIFE SUSTAINING TREATMENT

Hospital policies on withdrawing and withholding life sustaining medical treatment delineate the responsibilities, procedure, and documentation that must occur when withdrawing or withholding life-sustaining treatment.

5.4 DO-NOT-RESUSCITATE ORDERS

The Hospital policy on 'Do Not Resuscitate' delineates the responsibilities, procedure, and documentation that must occur when initiating or cancelling a Do Not Resuscitate order.

5.5 DISCLOSURE OF UNANTICIPATED OUTCOMES

The Hospital policy on 'Disclosure of Unanticipated Outcomes' delineates the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur.

5.6 RESTRAINTS AND SECLUSION

The Hospital policy on restraints and seclusion delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.7 ADVANCE DIRECTIVES

The Hospital policy on advance directives delineates the responsibilities, procedure, and documentation that must occur regarding Advance Directives.

5.8 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Hospital Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy should be followed.

ARTICLE VI

SURGICAL CARE

6.1 SURGICAL PRIVILEGES

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the MEC. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Services Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

6.2 SURGICAL POLICIES AND PROCEDURES

All practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures will cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 ANESTHESIA

Moderate or deep sedation and anesthesia may only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The anesthesiologist/anesthetist will maintain a complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition for each patient receiving deep sedation and anesthesia. The practitioner responsible for the ordering the administration of moderate sedation will document a pre-sedation evaluation and post-sedation follow-up examination. Deep sedation shall be administered following the Hospital's deep sedation protocol.

6.4 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens, as defined in pathology policy, are exempt from pathology examination. The pathologist's report will be made a part of the patient's medical record.

6.5 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by the Hospital. Hospital policies related universal protocol shall be followed.

ARTICLE VII

RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. The Hospital policy on 'Professional Conduct (Medical Staff)' shall be followed.

7.2 REPORTING IMPAIRED PRACTITIONERS

Reports and self referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the Hospital policy 'Impaired Provider (Medical Staff)'.