EAST MORGAN COUNTY HOSPITAL
BRUSH, COLORADO
RULES AND REGULATIONS OF THE MEDICAL STAFF

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EAST MORGAN COUNTY HOSPITAL
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## I. ADMISSION AND DISCHARGE OF PATIENTS:

A. The Hospital shall, if it deems it appropriate, accept patients presenting for care and treatment.

B. The general consent form, signed by or on behalf of every patient admitted to the Hospital**,** must be submitted at the time of admission. Admitting personnel should notify the attending Practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the Practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.

C. A patient may be admitted to the Hospital only by an appointee of the Medical Staff with admitting privileges. All Practitioners shall be responsible for the medical care and treatment of their patients in the Hospital.

D. Each patient in the Hospital will be under the care of a physician who is an appointee to the Medical Staff.

E. History and physical reports shall be dictated within twenty four (24) hours of admission date and time. Further details regarding documentation requirements are provided in Article III, Section B of these Rules and Regulations.

F. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or a reason for admission has been stated. In a case of emergency, such statement shall be noted in the medical record within twenty four (24) hours after the patient has been stabilized.

G. A patient to be admitted on any emergency basis who does not have a private Practitioner who is an appointee to the Active Medical Staff, will be assigned an appointee to the active Medical Staff on a rotation basis, where possible, from a call list to be compiled and kept current by the Chief of Medical Staff or his/her designee.

H. Each appointee to the Medical Staff who cannot attend patients in an emergency because he/she does not reside within reasonable proximity of the Hospital shall name an appointee to the Medical Staff who resides in such proximity and who will discharge such functions. A Practitioner who is unavailable will provide coverage for his/her patients by another Practitioner. If such coverage is not readily available, the Administrator or the Chief of the Medical Staff shall have the authority to call any appointee of the Active Medical Staff. In the event a staff physician is knowingly going to be absent or unavailable, he/she

will provide the name of an alternate physician who has agreed to provide coverage for his/her patients. This information shall be made available to the appropriate Hospital personnel to assure accessibility and availability of patient coverage at the Hospital.

I. The admitting Practitioner shall be held responsible for giving such information as may be necessary for the protection of the patient from self harm and for the protection of others whenever his/her patients might be a source of danger from any cause whatsoever.

J. For the protection of the patient, the Medical and Nursing Staff, and the Hospital precautions to be taken in the care of the potentially suicidal patient shall include, but not be limited to, the following:

1. Any patient known or suspected to be suicidal in intent shall be admitted to the appropriate area where proper supervision can be maintained. If there is no such area available, the patient shall be referred, if possible, to another institution where suitable facilities are available.

K. The attending Practitioner shall substantiate the need for continued hospitalization after specific periods of stay as identified by the Utilization Review Committee. Upon request from the Committee, the attending Practitioner must provide written justification of the necessity for continued acute care including an estimate of the number of additional days of stay and the reasons therefore. The report must be submitted within twenty four (24) hours of receipt of such request. The substantiation required by Article I, Section K of these Rules and Regulations shall be contained in the medical record and shall include the following:

1. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is insufficient reason.

2. The estimated period of time the patient will need to remain in the Hospital; and

3. Plans for post hospital care--discharge planning.

L. Patients shall be transferred or discharged only on a written order of the attending Practitioner. Should a patient leave the Hospital against the advice of the attending Practitioner, or without the proper discharge, the patient's signature on the appropriate REFUSAL OF TREATMENT form or LEAVING AGAINST MEDICAL ADVICE form should be obtained, if possible.

If the patient refuses to sign any forms and proceeds to leave, the RN and other appropriate staff should initiate a form documenting the event. This should have the signature of two (2)

witnesses, if possible, one signature shall be that of the RN in charge. A notation of the incident shall be made in the patient's medical record.

M. It shall be the responsibility of the attending Practitioner to discharge his/her patients, when possible, by the 1100 hour on the day of discharge. Patients awaiting special diagnostic test reports on work done the preceding day shall be discharged by the 1800 hour.

N. In the event of death of a patient, the deceased shall be pronounced dead by the attending Practitioner or charge nurse within a reasonable period of time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by the medical or nursing staff member who pronounced the death. The County Coroner or Assistant Coroner may pronounce death and document such pronouncement in the medical record. All cases of death involving unusual circumstances or criminal events shall be cause for the attending Practitioner to contact a member of the Coroner's office. The body shall be released by order of the attending Practitioner to the mortuary. The attending Practitioner shall dictate or write a death progress note relating to the events of the death. Procedures with respect to release of dead bodies shall conform with Colorado law.

## II. INFORMED CONSENT

A. A Practitioner shall furnish his/her patient with sufficient information to enable the patient to give an informed consent to medical procedures. An informed consent is that consent which a reasonably prudent person would give for a medical procedure after receiving sufficient information about the procedure. This consent shall be a part of the medical record.

B. Sufficient information includes information which will inform the patient of:

1. When applicable, the likely result(s) if the patient does not receive the proposed procedure (procedure means any diagnostic process which involves invasion or disruption of the integrity of the body or any surgical operation which is arranged or scheduled at least twelve (12) hours prior to time of performance. The term does not include venipuncture or arterial puncture;

2. When applicable, the generally accepted alternative procedures;

3. The risks associated with the proposed procedure:

4. The likelihood that death will be a proximate result of the purposed procedure;

5. Serious injuries which could result proximately from the proposed procedure and the likelihood of occurrence of each such serious injury; and

6. The likelihood that the proposed procedure will result in no improvement or worsening of the patient's condition.

C. The information listed concerning the Informed Consent shall be based upon medical knowledge generally available at the time the patient is given such information and shall be given to the patient prior to the performance of the proposed procedure unless:

1. The patient indicates that he/she does not want to be so informed;

2. Informed consent by the patient is not reasonably possible.

D. In those situations wherein the patient's life or health is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient, written informed surgical consent shall not be required prior to the operative procedure. However, these conditions should be fully explained in the medical record of the patient. If time permits, consultation in such instances may be desirable before the emergency operative procedure is undertaken.

E. SURROGATE CONSENT:
Where necessary, consent may be given by an authorized representative of the patient. "Authorized representative" refers to a parent or legal guardian in the case of a minor; otherwise, it refers to an attorney-in-fact appointed by the patient or a court appointed guardian. [These kinds of questions should be answered on a case-by-case basis.] Where the situation is not clear, standard bioethical principles regarding substitute judgment shall be applied. In the event of an impasse the Morgan County Ethics Committee may be consulted or a court order requested in an attempt to resolve issues of representation for granting consent for medical procedures and making other decisions in the place of a patient unable to make them for themselves.

F. TELEPHONE CONSENT:
Consent by telephone should be witnessed and documented in the medical record denoting the exact time and nature of the consent given. Immediate steps should then be undertaken to procure a written confirmation of consent whenever possible.

G. SECOND PROCEDURES:
Should a second procedure/operation be required during the patient's hospital stay, a second informed consent shall be obtained and evidenced on the medical record prior to the second procedure. If the original procedure was postponed/delayed but done during the same admission without greater risks or predetermined changes, the original informed consent shall be considered valid.

Medicaid sterilization consents shall be executed according to State of Colorado regulations.

H. The latest edition of the CONSENT MANUAL AND GUIDELINES FOR RELEASE

OF MEDICAL INFORMATION of the Colorado Hospital Association shall form the basis of resolving questions concerning informed consent.

## III. MEDICAL RECORDS:

### A. GENERAL RULES:

1. General

a. A medical record is established and maintained for each patient who has been treated or evaluated at the Hospital. The medical record, including electronic data, medical imaging, pathological specimens and slides, are the property of the Hospital.

b. For purposes of this Medical Records section, practitioner includes physicians, dentists, podiatrists, advanced practice nurses, physician assistants, and other credentialed practitioners to give orders, provide consultations and/or perform surgical procedures.

2. Purpose of the Medical Record.

The purposes of the medical record are:

a. To serve as a detailed data base for planning patient care by all involved practitioners, nurses and ancillary personnel.

b. To document the patient's medical evaluation, treatment and change in condition during the Hospital stay or during an ambulatory care or emergency visit,

c. To allow a determination as to what the patient's condition was at a specific time,

d. To permit review of the diagnostic and therapeutic procedures performed and the patient's response to treatment,

e. To assist in protecting the legal interest of the patient, Hospital and practitioner responsible for the patient and to provide data for use in the areas of quality and resource management, billing, education, and research.

3. Electronic Medical Record (EMR).

Banner Health is a "paper light" organization. As such, physicians need to adhere to record keeping practices that support the electronic environment. As much data as possible will be created electronically and paper-based documentation will be scanned. Records will be accessed by physicians and other users online and the

records will not be printed for internal use and selectively referred to herein as EMR.

4. Use of EMR

All medical record documents created after the patient is admitted will be created utilizing Banner Health approved forms or Banner Health electronic systems to allow for patient information to be exchanged and shared electronically among healthcare providers. This includes Operative Reports, Consultations, Discharge Summaries, and Progress Notes. The following documents are exceptions:

a. Documents from contracted/credentialed external sources that pertain to the delivery of patient care, such as radiology and telemedicine reports and select physician orders, with approval by the Banner Health System Forms Committee. These reports must meet the time requirements and contain the data elements specified in the Medical Staff Rules and Regulations.

b. Banner Health approved forms and templates that are pre-populated and maintained by the provider with physician specific information such as consents and discharge instructions. These forms will be required to meet Banner Health forms template guidelines for bar-coding/scanning purposes and should not be photocopied by the provider. This exception does not apply to pre-populated forms maintained by Standard Register.

c. Other documents that are created utilizing Banner Health unapproved forms or non-Banner Health electronic systems after the patient is admitted may be accepted only through approval of the Banner Health System Forms Committee.

5. Access to the EMR

Access to patient information on the EMR will be made available to Medical Staff and Allied Staff members and their staff through Clinical Connectivity. All access to electronic records is tracked and unauthorized access to a patient's record is not tolerated.

6. EMR Training

Practitioners who are appointed to the Medical Staff or Allied Health Professional Staff after May 2011 pending Banner electronic medical record training (EMR) and who have not completed this training within six (6) months of appointment will be considered to have voluntarily resigned from the staff**.** Practitioners will be advised of the training requirement at or prior to appointment and reminded of the requirement five (5) months from the date of

appointment. Exceptions will be made on a case by case basis to be determined by the facility CEO.

7. Retention

Current and historical medical records are maintained via clinical information systems. The electronic medical record is maintained in accordance with state and federal laws regulatory guidelines and Banner Records Retention Policy.

8. Confidentiality of Patients' Medical Records

The medical records are confidential and protected by federal and state law. Medical record access to confidential materials by authorized individuals is only permissible when access is sought for patient care, payment, peer review, risk management, approved research, or other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored. In addition, Banner Health safeguards patients' records against unauthorized disclosure and/or use, loss, defacement, and tampering. Unauthorized access or disclosure of confidential patient information or tampering, loss or defacement of medical records constitutes grounds for disciplinary action.

9. Release of Patient Information

Banner Health releases patient information only on proper written authorization of the patient or as otherwise authorized by law and Banner policies. Medical Records may be removed from the Hospital only in accordance with state and federal law, a court order, or subpoena, the permission of the Hospital’s Chief Executive Officer, or in accordance with Banner Health’s policies. Unauthorized removal of an original medical record or any portion thereof from the Hospital or disclosure of Patient Information constitutes grounds for disciplinary action.

10. Passwords

All practitioners must maintain the confidentiality of passwords and may not disclose such passwords to anyone.

11. Information from Outside Sources

Health record information obtained on request from an outside source is placed in the medical record and is available to the professional staff treating the patient. This information will contain the source facility name/address. Results of examination (Laboratory and X-Ray) performed prior to admission of the patient to the Hospital and that are required for or directly related to the admission are made a part of the patient's Hospital record.

12. Abbreviations

Practitioners shall be responsible to use only approved symbols or abbreviations in the medical record. See Banner Health's policy "Medical Record Abbreviations and Symbols" List.

13. Responsibility

The attending physician is responsible for each patient's medical record. The medical record must identify who is primarily responsible for the care of the patient. Transfers of primary responsibility of the patient are not effective until documented in the clinical information system by the transferring physician and accepted on the clinical information system by the accepting physician. All clinical entries in the patient's record must be accurately dated, timed and individually authenticated by the responsible physician; group signing of documentation is not permissible. Authentication means to establish authorship by written or electronic signature and shall consist of the practitioner's name and professional title indicating the professional credential. Electronic signature authentication of medical records is the standard practice.

14. Counter-authentication (Endorsement)

a. Physician Assistants- History and Physical Reports, Operative/Procedural Notes, Consultations and Discharge Summaries must be counter-authenticated timely by the physician. Each clinical event must be documented as soon as possible after its occurrence. Requirements for countersignature of Progress Notes will be established and monitored by the supervising physician.

b. Nurse Practitioners- History and Physical Reports, Operative/Procedural Notes, Consultations and Discharge Summaries must be counter-authenticated timely by the physician. Each clinical event must be documented as soon as possible after its occurrence. Requirements for countersignature of Progress Notes will be established and monitored by the supervising physician.

c. Medical Students

i. 1st & 2nd Year- Access to view the patient chart only. May not document in the medical record.

ii. 3rd & 4th Year- Any and All documentation and orders (if permitted) must be endorsed (countersigned, counter-authenticated) timely by the physician.

d. House Staff, Resident, and Fellows- Requirements for countersignatures will be established and monitored by specific training programs. Each clinical event must be documented as soon as possible after its occurrence. The Health Information Management Services

Department does not monitor countersignatures by House Staff, Resident or Fellows. Appropriate action will be taken by the specific training programs.

15. Legibility

All practitioner entries in the record must be legible, pertinent, complete and current.

16. Copying and Pasting

Medical Staff and Allied Health Professionals may not indiscriminately copy and paste documentation from other parts of the applicable patient's medical records. If copying a template, the Practitioner shall make modifications appropriate for the patient. If copying a prior entry, the Practitioner shall make appropriate modifications based upon the patient's current status and condition. The Practitioner must reference the date of a prior note as appropriate. When copying patient data into the medical record from another provider, the Practitioner must attribute the information to the person who performed the task unless it is readily apparent, based upon the nature of the information copied, that the data was entered by another provider. If referencing a form within the record, the form must be referenced with sufficient detail to identify the source. Example: "for review of systems, see form dated 6/1/10."

B. Medical Record Content

1. Medical Record Documentation and Content – The medical record must identify the patient, support the diagnosis, justify the treatment, and document the course and results of treatment and facilitate continuity of care. The medical record is sufficiently detailed and organized to enable:

a. The responsible practitioner to provide continuing care, determine later what the patient's condition was at a specified time, and review diagnostic/therapeutic procedures performed and the patient's response to treatment.

b. A consultant to render an opinion after an examination of the patient and review of the health record.

c. Another practitioner to assume care of the patient at any time.

d. Retrieval of pertinent information required for utilization review and/or quality assurance activities.

e. Accurate coding diagnosis in response to coding queries.

2. History and Physical Examination ("H&P")

A history and physical examination in all cases shall be completed by a physician, or Allied Health Professional who is approved by the medical staff to perform admission history and physical examinations, and placed in the patient's medical record within 24 hours after admission. The completed H&P must be on the medical record prior to surgery or invasive procedure (Section Section B, Paragraph 2 below), or any procedure in which anesthesia or conscious sedation will be administered or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient. A legible office history and physical performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. If approved by the Medical Staff, the Emergency Room Report, or Consultation report may be used as the H&P as long as all the elements in Section B, Paragraph 4 below) are included and the document is filed as a History and Physical on the EMR. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services.

a. Invasive Procedure – Invasive procedures which require an

H&P prior to being performed, except in an emergency, include but are not limited to:

i. Main OR procedures and Ambulatory Surgeries

ii. Endoscopies

iii. Interventional Cardiac Procedures – Permanent Pacemakers

iv. Interventional Radiology Procedures: Percutaneous Transluminal Angioplasty (PTA), Nephrostomy Tube Insertion, Transjugular Intrahepatic Portosystemic Shunt (TIPS), CT Guided Biopsies, Thoracentesis, Paracentesis, Epidural Blocks, Nerve Root Blocks, Facet Infections, Angiograms

v. Venograms

vi. Transesophageal Echocardiogram (TEE)

vii. Cardioversions

viii. Bone Marrow Studies

ix. Lumbar Puncture

3. Responsibility for H&P

The attending medical staff member is responsible for the H&P, unless it was already performed by the admitting medical staff member. H&Ps performed prior to admission by a practitioner not on the medical staff are acceptable provided that they are updated timely by the attending physician. Dentists and podiatrists are

responsible for completing the part of their patients' H&P that relates to dental/podiatric services only. This documentation is in addition to the medical H&P completed by the attending or admitting medical staff member.

4. Contents of H&P – For all inpatients, observation patients, and for those outpatients having procedures requiring general, spinal or epidural anesthesia, the H&P must include the following documentation as appropriate:

a. Medical history

b. Chief complaint

c. History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status

d. Relevant past medical, family and/or social history appropriate to the patient's age.

e. Review of body systems.

f. A list of current medications and dosages.

g. Any known allergies including past medication reactions and biological allergies

h. Existing co-morbid conditions

i. Physical examination: current physical assessment

j. Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination

k. Initial plan: Statement of the course of action planned for the patient while in the Hospital.

l. For other outpatient (ambulatory) surgical patients, as necessary for treatment

i. Indications/symptoms for the procedure.
ii. A list of current medications and dosages.
iii. Any known allergies including past medication reactions
iv. Existing co-morbid conditions
v. Assessment of mental status
vi. Exam specific to the procedure performed.

m. IV moderate sedation - For patients receiving IV moderate sedation, all of the above elements in section 4.a-l, plus the following:

i. Examination of the heart and lungs by auscultation.

ii. American Society of Anesthesia (ASA) status

iii. Documentation that patient is appropriate candidate for IV moderate sedation.

5. Emergency Department Reports

A report is required for all Emergency Department visits. The following documentation is required:

a. Time and means of arrival

b. Pertinent history of the illness or injury, including place of occurrence and physical findings including the patient's vital signs and emergency care given to the patient prior to arrival, and those conditions present on admission

c. Clinical observations, including results of treatment

d. Diagnostic impressions

e. Condition of the patient on discharge or transfer

f. Whether the patient left against medical advice

g. The conclusions at the termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment and services

6. Progress Notes

Progress notes should be electronically created with a frequency that reflects appropriate attending involvement but at least every day. For rehabilitation admissions a physician progress note must be documented by the responsible physician a minimum of every 5 days. Exceptions may be given to an obstetrical patient that has a discharge order entered from the day before or for a patient admitted to a psychiatric unit. Progress notes should describe not only the patient's condition, but also include response to therapy.

a. Admitting Note- The responsible provider must see the patient and document an admitting note (that justifies admission and determines the plan of treatment) within 24 hours of admission.

7. Consultation Reports

A satisfactory consultation includes examination of the patient as well as the medical record and should be electronically recorded or dictated within 24 hours. When operative procedures are involved, the consultation shall be recorded prior to the operation (except in an emergency).

8. Pre-Operative Anesthesia/Sedation Evaluation

A preanesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or conscious sedation within 48 hours prior to the procedure in accordance with Article V, Section C. A pre-anesthesia evaluation of the patient must include pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, American Society of Anesthesiologists patient status classification, and orders for pre-op medication. Except in cases of emergency, this evaluation should be

recorded prior to the patient's transfer to the operating area and before the pre-operative medication has been administered.

9. Intraoperative & Post Anesthesia/Sedation Record

An intraoperative anesthesia/sedation record will be maintained for each patient and include drugs/agents used, pertinent events during indications, maintenance of emergence from anesthesia/sedation, all other drugs, intravenous fluids and blood components given.

a. Documentation in the post anesthesia/sedation care unit includes the patient's level of consciousness upon entering and leaving the area, vital signs, and status of infusions, drains, tubes catheters and surgical dressing (when used), unusual events or complications and management.

b. A post anesthesia/sedation evaluation for proper recovery of anesthesia/sedation must be completed and documented by an individual qualified to administer anesthesia/sedation within 48 hours after the procedure or prior to the patient being discharged or transferred from the post anesthesia/sedation care area regardless of type or location where anesthesia/sedation is performed.

10. Operative and Procedure Reports

Operative and procedure reports must contain, as applicable, the post-operative diagnosis, a detailed account of the findings, the technical procedures used, and the specimens removed, the estimated blood loss, and the name of the primary performing practitioner and any assistants. The full report must be documented immediately, as well as the recording of a post-operative progress note to be made available in the record after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend the patient. Procedures requiring documented operative reports are identified in section 4.17.1.

11. Prior to any operative/invasive procedures, the medical record must contain an informed consent. See Article II.

12. Special Procedures: EEG's, EKG's, treadmill stress tests, echocardiograms, tissue, medical imaging and other special procedure reports will be interpreted and documented within 24 hours of notice. Notice will be a communication to the physician or agent to inform the provider of the test completion.

13. Discharge Documentation

A discharge summary must be documented at the time of discharge but no later than 7 days thereafter by the responsible practitioner on all Inpatient and Observation hospitalizations 48 hours or greater in length.

a. The discharge summary shall include:

i. Reason for hospitalization

ii. Concise summary of diagnoses including any complications or co-morbidity factors

iii. Hospital course, including significant findings

iv. Procedures performed and treatment rendered

v. Patient's condition on discharge (describing limitations)

vi. Patients/Family instructions for continued care and/or follow-up

b. The final discharge progress note should be documented immediately upon discharge for inpatient stays less than 48 hours, observations, extended recovery, normal newborns and normal vaginal delivery cases. The note shall include:

i. Final diagnosis(es)

ii. Condition of patient

iii. Discharge instructions

iv. Follow-up care required

14. Documentation of Death - A death summary is required for all deaths regardless of length of stay and must be documented at the time of death but no later than 7 days thereafter by the responsible practitioner.

15. Documentation for Inpatient Transfers to another facility– The transferring physician must dictate or electronically create a transfer summary at the time of transfer regardless of length of stay to include documentation that patient was advised of risks/benefits of transfer.

16. Amending Medical Record Entries

a. Electronic Documents (Structured, Text and Images) - Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error or omission through the EMR. The EMR will track all changes made to entries.

Once an entry has been authenticated and an error is found, the EMR will force the author to record his/her comments in the form of an electronic addendum in which the individual will document the erroneous information, authenticate the entry and the system will be date and time stamp the entry.

If information is found to be recorded on the wrong patient, regardless of the status of the entry, the EMR will not allow deletion of any entries. The entry recorded in error must be documented as such by the author, and re-enter the information on the correct patient.

b. Paper-Based Documents - Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error by drawing a single line through the erroneous entry, but not obliterating it, and initialing and dating the error.

Errors or omissions discovered at a later time shall be corrected by the individual with a new entry. The person making the change shall sign and note the date of the change and reason for the change. The new entry shall also state who was notified of the change and the date of such notification. The individual must notify the HIMS Department to permit a review of the erroneous documentation for recording in-error criteria within the EMR.

Any physician who discovers a possible error made by another individual should immediately upon discovery notify the supervisor of that clinical or ancillary area.

Upon confirmation of the error, the patient's attending physician and any other practitioners, nurses or other individuals who may have relied upon the original entry shall be notified as appropriate.

C. Timely Completion of Medical Records

1. Complete Medical Record - The Medical Record is not considered complete until all its essential elements are documented and authenticated, and all final diagnoses and any complications are recorded, consistent with these Rules. No medical record shall be considered complete without fulfilling the documentation requirements except on order of the Medical Executive Committee.

2. Timely Completion of Medical Record Documents - All medical record documents shall be completed within time frames defined below:

| Documentation Requirement | Timeframe | Exclusions |
|---|---|---|
| Emergency Room Report | Documented within 24 hours of discharge/disposition from the ED | |
| Admitting Progress Note | Documented within 24 hours of admission | |
| History & Physical | Documented within 24 hours of admission and before invasive procedure | |
| Consultation Reports | Documented within 24 hours of consultation | |

| | | |
|---|---|---|
| Post op Progress Note | Documented immediately post-op | |
| Provider Coding Query | Documented response no later than 7 days post notification to the provider | |
| Operative Report | Immediately after procedure | |
| Special Procedures Report | Documented within 24 hours of completion of procedure | |
| Discharge Summary Report | Documented at the time of discharge/disposition but no later than 7 days post discharge | Not required on all admissions less than 48hrs, or for Normal vaginal deliveries and normal newborns |
| Discharge Progress Note | Documented at the time of discharge/disposition but no later than 7 days post discharge for all admissions less than 48hrs or for normal vaginal deliveries and normal newborns | |
| Death Summary | Documented at the time of death/disposition but no later than 7 days post discharge | |
| Transfer Summary | Documented at the time of transfer | |
| Signatures | Authentication of transcribed or scanned reports and progress notes, within 15 days from the date of discharge | |
| Verbal Orders | Dated, time and authenticated within 48 hours from order | |

3. Medical Record Deficiencies – Physicians are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians, by fax, mail or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has reached 22 days from the date the deficiency is assigned (allocation date). The notice will include a due date and a list of all incomplete and delinquent medical records. No additional notification is given,

If a vacation prevents the practitioner from completing his/her medical records the physician must notify the Health Information Services Department in advance of the vacation; otherwise the suspension/sanction will remain in effect until the documentation is completed.

If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the physician or the physician's office must notify the Health Information Management Services Department.

4. Medical Record Suspensions/Sanctions - A medical record is considered eligible for suspension/sanction 22 days from the date the deficiency is assigned (allocation date). If the delinquent records are not completed timely, providers will receive a notice and their admitting and surgical/procedure scheduling privileges will be temporarily suspended until all medical records are completed as provided for in the Medical Staff Bylaws, Article VII, Section 5.

a. First contact with the physician will be a phone call or verbal contact as notification of lack of compliance.

b. Second contact is documented by Notice of Incomplete Records sent to the physician.

c. Third contact will be handled with a Formal Letter which is issued through the administrator and denies the practitioner's admitting privileges until such time as he/she meets the requirements of these Rules and Regulations. A copy of this letter is placed in the practitioner's profile folder.

d. THREE such denials of admitting privileges within one year invokes a non-reversible 2 week suspension of the Practitioner's clinical privileges and requires personal appearance before the Medical Executive Committee for review of physician privileges.

e. All documentation of the monitoring in the form of verbal and/or phone contacts as well as letters to the practitioner shall become a part of the physicians' yearly profile folder which will be utilized during re-credentialing.

## IV. GENERAL CONDUCT OF CARE

A. Medications and treatment shall be given only on order of Practitioners appointed to the Medical Staff of the Hospital, including appropriately applied care protocols which have been approved by the Medical Staff.

B. All drugs and medications administered to the patient shall be those listed in the latest

edition UNITED STATE PHARMACOPEIA, NATIONAL FORMULARY, AMERICAN HOSPITAL FORMULARY SERVICE, or A.M.A. DRUG EVALUATIONS. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the statements of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration. Traditional, folk and complementary remedies, upon determination that they will not interfere with the standard medical care being delivered, may, at the request of patient, family or friend, be allowed at the discretion of the Practitioner.

C. Narcotics, antibiotics, steroids, and anticoagulant drugs that are ordered without time limitations of dosage shall automatically be discontinued after seventy-two (72) hours for narcotics and after five (5) days for antibiotics, steroids and anticoagulants. Drugs should not be discontinued without notifying the Practitioner. If the order expires in the night, it should be called to the attention of the Practitioner the following morning.

D. Only Practitioners who are so authorized under state and federal law shall prescribe narcotics. In case of recurring shortages or loss of significant quantities of narcotics, a copy of report of investigation shall be reported to the appropriate authorities.

E. Investigational drugs shall be used only under direct supervision of the principal investigator and with recorded evidence of full knowledge of an approval of the Executive Committee and the hospital administration. The principal investigator shall be appointed to the Medical Staff and shall assume responsibility for securing the necessary consent of the patient prior to administration of the drug.

F. When nurses or other authorized professional staff administers investigational drugs, they shall have documented basic information available concerning such drugs, including dosage forms, strengths available, actions and uses, side effects including methods to combat them, symptoms of toxicity, and contraindications for use. It is the responsibility of the investigator to provide this information.

G. Except in an emergency, consultations with other Practitioners are required in the following situations:

1. When the patient is not a good risk for surgery or for treatment;

2. When the diagnosis is obscure after ordinary diagnostic procedures have been completed and further diagnostic and therapeutic measures are deemed appropriate (e.g. not futile);

3. Where there is doubt as to the choice of therapeutic measures to be utilized;

4. In unusually complicated situations where special skills of other Practitioners

may be needed;

5. In instances in which the patient exhibits unanticipated or intractable psychiatric symptoms;

6. When requested by the patient or his/her family;

7. Hysterectomy or bilateral oophorectomy on a woman of child-bearing age.

H. The attending Practitioner shall request consultation when indicated.

I. The opinion of the consultant shall be noted in the medical record as required by Article III, Section B of these Rules and Regulations.

J. If a nurse or other professional staff member has any reason to doubt or question the care provided to any patient or believes that consultation is needed and has not been obtained, he/she is encouraged to discuss the matter directly with the provider. If this is not possible or the patient care issue remains unresolved the staff member shall call this to the attention of his/her superior who in turn may refer the matter to the Director of Nursing, or if the Director of Nursing is not available, to the Chief of the Medical Staff or his/her designate. Where circumstances are such as to justify such action, the Chief of the Medical Staff may himself/herself request a consultation.

K. In the event a patient is being treated by more than one physician during the course of hospital stay, the admitting practitioner is responsible for the admission orders and provisional diagnosis as well as the completion of the History and Physical report within twenty four (24) hours of admission or prior to surgical procedures whichever occurs first. When a patient becomes a surgical patient and the procedure is a Class I or II procedure, the surgeon ultimately becomes responsible for completion of the record with discharge orders, final diagnosis(es) and completion of the discharge summary. Where the admitting and attending practitioner are not the same, it shall be the responsibility of the attending to complete the discharge summary. If there is a dispute as to which physician is responsible to do a particular summary, the record shall be referred to the Chief of Staff or designee to determine which practitioner was most responsible for the patient during the hospital stay. This person will then be obligated to complete the summary.

L. Dilatation and curettage will be performed only in the operating room.

V. GENERAL RULES REGARDING SURGICAL CARE:

A. Admission - The patient for elective surgery shall be admitted according to East Morgan County Hospital's admitting policies and procedures.

B. Scheduling of surgery:

1. Scheduling shall be on a first come first served basis. Conflicts shall be resolved by the Chief of the Medical Staff or designee.

2. Emergencies have priority over elective operations and may be performed in the first operating room available.

3. The scheduling of elective and emergency surgery is to be done by the operating room supervisor or delegate.

4. The surgeon and anesthesiologist or anesthetist, if any, must be in the operating room at the time scheduled and ready to start the surgical procedure. At the discretion of the operating room supervisor, a delay of twenty minutes shall be adequate reason for cancellation of the surgical procedure and scheduling it to follow later in the day.

C. Requirements prior to Anesthesia and Surgery:

1. Identification for the patient will be made through the wristlet that is on each individual patient.

2. Pre-operative evaluation, intra-operative and operative documentation requirements are set forth in Article III, Section B, Paragraphs 8-10.

D. The care of the post-surgical patient in the recovery area is a joint responsibility of the anesthetist and the surgeon. The anesthetist or surgeon must discharge the patient from the recovery room by a written order, after the patient meets pre-established criteria.

E. All tissue removed at the operation shall be sent to the Hospital pathologist with the exceptions per criteria of the Tissue Committee. The pathologist shall examine tissue as necessary to arrive at tissue diagnosis. His/her authenticated report shall be made a part of the patient's medical record.

F. Patients who pose a risk of contaminating other patients may be sent directly to a private room as indicated, for recovery.

G. The admission of a patient for dental/podiatric services is a dual responsibility involving the podiatric physician (DPM) or dentist (DDS, DMD) and MD or DO member of the medical staff with exception of graduates of a qualified oral surgery program who may admit patients without serious medical problems and may perform the history and physical examination on those patients and may assess the medical risks of the proposed surgical procedures. Dentists and Podiatrists may complete the part of their patients'

H&P that relates to dental/podiatric services only.

1. The dentist and podiatrists responsibilities are:

   a. Provide a detailed dental or podiatric history justifying hospital admission.

   b. Provide a detailed description of the dental/podiatric examination, including when indicated, the initial and final diagnosis surgery and prognosis.

   c. A complete operative report.

   d. Write orders for services and medications as they relate to the dental/podiatric care rendered.

   e. Write progress notes and final summary as they relate to the dental/podiatric care rendered.

   f. Write the discharge order. When the patient is being treated for a medical condition, discharge shall be in concurrence with the MD or DO.

2. Physician's responsibilities:

   a. Admission, history and physical;

   b. Supervision of the patient's general health status while hospitalized; and

   c. The admitting physician or qualified alternate shall be available for emergencies when general anesthetic is administered to dental patients.

H. A patient admitted for care by an Allied Health Professional (AHP) shall be the dual responsibility of the AHP and Physician. Further details regarding the requirements and responsibilities of Allied Health Professionals are set for the in the Allied Health Personnel Policy.

VI. EMERGENCY SERVICES:

A. Emergency care shall be available twenty four (24) hours a day, seven (7) days a week.

B. For purposes of compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA), the Board has designated the following as qualified medical personnel to perform an initial medical screening examination: Physician's Assistant (PA), Certified Nurse Practitioner (CNP), Physician. A medical screening exam includes at a minimum, but is not limited to, a complaint, specific history and physical, relevant past medical history, allergies, relevant medication history, treatments and response to

treatments and ancillary diagnostic tests as indicated. Refer to the EMTALA Guideline: Qualified Medical Personnel Authorized to Perform Medical Screening Examinations policy.

C. Where time is of the essence, the emergency room practitioner shall have the authority, within the scope of his or her license, to initiate further treatment or modify treatment until consultation and/or the surgeons are physically present. As specified in the "EMCH ER Services" policy, an RN shall contact the physician, PA or CNP as appropriate to conduct the medical screening examination. If the RN, PA or CNP determines that the presence of a physician is necessary to assist in the determination of whether a patient has an emergency medical condition or to initiate stabilizing treatment, such professional will contact the on call physician, provided that there is no physician present in the emergency room or elsewhere in the hospital who is available and willing to examine and treat the patient. Further details are provided in the "EMCH ER Services" policy.

1. An emergency medical condition is now defined in the regulations as:
   a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could be reasonably expected to result in-
      i. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
      ii. Serious impairment to bodily functions; or
      iii. Serious dysfunction of any bodily organ or part; or

   b. With respect to a pregnant woman who is having contractions *(true labor is presumed unless the physician, after a period of observation certifies the presence of false labor)-*
      i. That there is inadequate time to effect a safe transfer to another hospital before delivery; or That transfer may pose a threat to the health or safety of the woman or the unborn child.

D. Active medical staff shall serve on a rotation schedule for coverage of the emergency room at East Morgan County Hospital. According to the schedule and duty roster the physician member shall be available and willing to serve his/her calls.

E. When taking call practitioners must be able to respond appropriately within 30 minutes or less. Under some clinical circumstances, the term “appropriate” implies physical presence as soon as reasonably possible within 30 minutes. Requirements according to state and federal law, accreditation standards, or specific hospital and system policies are applicable.

F. The Disaster plan, established in coordination with the City of Brush, required by the Medical Staff Bylaws shall include the following:

1. Availability of adequate basic utilities and supplies, including, food, water and essential medical and supportive materials;

2. An efficient system for notifying and assigning personnel;

3. Unified medical command under the direction of a designated physician as outlined in the facility disaster plan;

4. Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care;

5. Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care;

6. A special disaster medical record, such as an appropriate designed tag, that accompanies the casualty when he/she is moved;

7. Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy;

8. Maintaining security in order to keep relatives and curious persons out of the triage area; and

9. Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with the emergency communications system will help to provide organized dissemination of information.

## VII. REPORTS REQUIRED OF THE HOSPITAL:

A. Incidents of child abuse shall be reported to the local Department of Social Services or the local law enforcement agency.

B. Incidents of diseases which require mandatory reports to the Colorado State Health Department shall be made consistent with the State's current regulations. A current list of reportable diseases is available within the Hospital.

C. Practitioners caring for patients with suspected conditions which are not in the realm of normal conditions, such as animal bites, gunshot wounds etc**.** shall report as required to local law enforcement officials.

D. Reports of disciplinary action or voluntary relinquishment of Medical Staff appointment and/or clinical privileges in lieu of disciplinary action should be forwarded to the State Board of Medical Examiners in accordance with state law and the Healthcare Quality Improvement Act of 1986.

VIII. PATIENT CARE PROVISION FOR PATIENTS SUFFERING FROM CONDITIONS OR CIRCUMSTANCES WHICH ARE NOT WITHIN THE NORMAL PATIENT REALM:

A. the Hospital may admit patients suffering from uncontrollable mental, alcoholic or chemical related condition. A special attendant shall be provided by the responsible party. When adequate facilities and/or procedures are not available for the proper evaluation, the patient shall be promptly transferred by order of the attending practitioner to an appropriate facility.

B. Patients requiring hospitalization who are incarcerated at law enforcement facilities may be admitted with a special attendant provided by the responsible party as East Morgan County Hospital does not have a lock ward to provide this sort of security to this type of patient.

ADOPTED BY THE MEDICAL STAFF:

CHIEF OF THE MEDICAL STAFF: _____

APPROVED BY THE GOVERNING BOARD: November 14, 2013