BANNER LASSEN MEDICAL CENTER

MEDICAL STAFF

RULES

AND

REGULATIONS

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MEDICAL STAFF RULES AND REGULATIONS

I. ADMISSIONS

A. This hospital shall accept all patients, regardless of race, creed, sex, color, age, religion, sexual orientation, physical handicapped, national origin or sources of payment for care.

B. A patient may be admitted to the hospital only by a member of the Medical Staff. All practitioners shall be governed by the admitting policy of the hospital.

C. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital; for the prompt completeness and accuracy of the medical record; for necessary special instructions and for transmitting reports on the condition of the patient to the referring practitioner and to relatives of the patient.

Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. The only exception to this would be in the case where a staff member shares call with each other on a day-by-day basis. In this instance, it is imperative that a monthly call schedule be made available that would reveal which of the physicians in that group is on call and responsible for the patient on any given day. However, if a physician outside the group is assigned responsibility, it shall be written on the order sheet of the medical record.

D. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

E. A patient admitted on an emergency basis who does not have a private practitioner available will be assigned to the back-up physician or hospitalist in accordance with the back up physician call schedule. If, for any reason, the patient absolutely refuses to be under the care of the back up call physician, he/she has the right to select any practitioner to attend him/her, provided that practitioner has clinical privileges at this hospital and he/she agrees to accept such patient.

F. Patients shall be discharged only on the order of the attending practitioner. Should the patient leave the hospital against the advice of the attending practitioner or without proper discharge, a notation shall be made by the practitioner in the patient's medical record. The patient will be asked to sign an "Against Medical Advice" form. If the patient refuses, the physician shall document this in the patient's medical record.

G. There will be no admission from the emergency department to the service of the attending physician before first contacting the attending physician and getting his/her authorization for admission.

II. DEATHS

In the event of a hospital death, the patient shall be pronounced dead by the attending practitioner or the emergency department physician. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with the respect to release of the body shall conform to state and local law. The time of death shall be recorded by the physician or his/her designee.

III. AUTOPSIES

It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed with a written consent in accordance with state law and hospital policy. All autopsies will be performed by the Shasta County Coroner's Officer. The pathologist will notify the physician of the time and place autopsy will be performed. The autopsy report will be made part of the medical record within 90 days. Refer to Autopsy policy and procedure.

IV. MEDICAL RECORD POLICIES

A. General Rules

4.1 General

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

4.1.2 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.

4.2 Purpose of the Medical Record -The purposes of the medical record are:

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

4.2.2 To document the patient's medical evaluation, treatment and change in condition during the Medical Center stay or during an ambulatory care or emergency visit,

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

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

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

4.3 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. Selectively referred to herein as EMR.

4.4 Use of EMR – All medical record documents created after the patient is admitted will be created utilizing BH approved forms or BH 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:

4.4.1 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 BH System Forms Committee. These reports must meet the time requirements and contain the data elements specified in the Medical Staff Rules and Regulations.

4.4.2 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.

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

4.5 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.

4.6 EMR Training - Practitioners who are appointed to the Medical Staff or Allied Health Staff after the EMR Enactment as of August 16, 2011 will be expected to learn the EMR system. Practitioners will be advised of the education and training offered and implemented in order to function within the EMR system. Each Practitioner will be expected to learn to function in order to practice with the new EMR system established. Exceptions will be made only when the Practitioner is functioning in areas where the new EMR system is not in effect. Any problems of involving a Practitioner who is not able to use the EMR system will be forwarded to the Medical Executive Committee for compliance.

4.7 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.

4.8 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 Medical Center only in accordance with state and federal law, a court order, or subpoena, the permission of the Medical Center'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 Medical Center or disclosure of Patient Information constitutes grounds for disciplinary action.

4.9 Passwords - All practitioners will be given access to all their patient's medical records via password. All practitioners must maintain the confidentiality of passwords and may not disclose such passwords to anyone.

4.10 Copying and Pasting: Practitioners may not indiscriminately copy and paste documentation from other parts of the applicable patient's 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."

4.11 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 Medical Center and that are required for or directly related to the admission are made a part of the patient's Medical Center record.

4.12 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.

4.13 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.

4.14 Counter-authentication (Endorsement)

4.14.1 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.

4.14.2 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.

4.14.3 Medical Students-

4.14.3.1 1st & 2nd Year- Access to view the patient chart only. May not document in the medical record.

4.14.3.2 3rd & 4th Year- Any and All documentation and orders (if permitted) must be endorsed (countersigned, counter-authenticated) timely by the physician.

4.14.4 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.

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

B. Medical Record Content

4.16 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:

4.16.1 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.

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

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

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

4.16.5 Accurate coding diagnosis in response to coding queries.

4.17 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 (see 4.16.1), or any procedure in which 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 4.18 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. The Obstetrical H&P will consist of the prenatal record, where applicable, updated in the EMR by the responsible physician or Allied Health professional.

4.17.1 Invasive Procedure – Invasive procedures which require an H&P prior to being performed, except in an emergency, include but are not limited to:

4.17.1.1 Main OR procedures
4.17.1.2 Ambulatory Surgeries
4.17.1.3 C-section deliveries/tubal ligations
4.17.1.4 Endoscopies
4.17.1.5 Interventional Cardiac Procedures – Permanent Pacemakers
4.17.1.6 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
4.17.1.7 Venograms
4.17.1.8 Transesophageal Echocardiogram (TEE)
4.17.1.9 Cardioversions
4.17.1.10 Bone Marrow Studies
4.17.1.11 Lumbar Puncture

4.18 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 responsible physician. An oral surgeon with appropriate privileges who admits a patient without medical conditions may perform the H&P, and assess the medical risks of the procedure to the patient. Dentists and podiatrists are responsible for the part of their patients' H&P that relates to dentistry or podiatry, in addition to the medical history & physical.

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

4.19.1 Medical history

4.19.2 Chief complaint

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

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

4.19.5 Review of body systems.

4.19.6 A list of current medications and dosages.

4.19.7 Any known allergies including past medication reactions and biological allergies

4.19.8 Existing co-morbid conditions

4.19.9 Physical examination: current physical assessment

4.19.10Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination

4.19.11 Initial plan: Statement of the course of action planned for the patient while in the Medical Center.

4.19.12 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.

4.19.13IV moderate sedation - For patients receiving IV moderate sedation, all of the above elements in section 4.18.1- 4.18.12, 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.

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

4.20.1 Time and means of arrival

4.20.2 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

4.20.3 Clinical observations, including results of treatment

4.20.4 Diagnostic impressions

4.20.5 Condition of the patient on discharge or transfer

4.20.6 Whether the patient left against medical advice

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

4.20 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.

4.21.1 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.

4.21 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).

4.22 Intraoperative & Post Anesthesia/Sedation Record for General, Regional or Monitored Anesthesia

4.23.1 A pre-anesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or conscious sedation within 48 hours prior to the procedure. A pre-anesthesia/ sedation evaluation of the patient must include review of the medical history, including anesthesia, drug and allergy history; review and examination of the patient; notification of anesthesia risk (per ASA classification); identification of potential anesthesia problems, particularly those that suggest potential complications or contraindications; additional pre-anesthesia as applicable; and development of the plan for anesthesia care, including type of medications for induction, maintenance, and post-operative care and discussion with the patient of risks and benefits. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before pre-operative medication has been administered. Immediately prior to the induction of anesthesia while the patient is on the procedural table, the patient's vital signs, airway and response to pre-procedure medication must be assessed and the equipment checked.

4.23.2 The intraoperative anesthesia/sedation record will also include the name of the practitioner who administered anesthesia and the name of the supervising anesthesiologist or operating practitioner; techniques used and patient position(s), including the insertion/use of any intravascular or airway devices;

name and amounts of IV fluids, including blood or blood products if applicable; time-based documentation of vital signs as well as oxygenation and ventilation parameters; and any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

4.23.3 The post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia or conscious sedation no later than 48 hours after surgery or a procedure requiring anesthesia services and, for outpatients, prior to discharge. The record must include respiratory function, including respiratory rate, airway patency and oxygen saturation; cardiovascular function, including pulse rate and blood pressure; mental status; temperature, pain; nausea and vomiting; and postoperative hydration.

4.23 Operative and Procedure Reports - An operative or other high-risk procedure report is documented upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.

4.23.1 The exception to this requirement occurs when an operative or other high-risk procedure progress note is documented immediately after the procedure, in which case the full report can be documented within a time frame defined by the hospital.

4.24.2 If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be documented in the new unit or area of care.

4.24.3 The operative or other high-risk procedure report includes the following information:

- The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
- The name of the procedure performed
- A description of the procedure
- Findings of the procedure
- Any estimated blood loss
- Any specimen(s) removed
- The postoperative diagnosis

4.24 When a full operative or other high-risk procedure report cannot be documented immediately into the patient's medical record after the operation or procedure, a progress note is documented in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and assistant(s), procedures performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

4.25 Prior to any operative/invasive procedures, the medical record must contain an informed consent. See General Rules Regarding Surgical Care Section IV.

4.26 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.

4.27 Discharge Documentation - A discharge summary must be documented at the time of discharge but no later than 24 hours after by the responsible practitioner on all Inpatient and Observation hospitalizations 48 hours or greater in length. Normal newborns and normal vaginal deliveries do not require a discharge summary regardless of the length of stay.

The discharge summary shall include:

4.28.1 Reason for hospitalization
4.28.2 Concise summary of diagnoses including any complications or co-morbidity factors
4.28.3 Hospital course, including significant findings
4.28.4 Procedures performed and treatment rendered
4.28.5 Patient's condition on discharge (describing limitations)
4.28.6 Patients/Family instructions for continued care and/or follow-up
4.28.7 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:

- Final diagnosis(es)
- Condition of patient
- Discharge instructions
- Follow-up care required

4.29 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 24 hours thereafter by the responsible practitioner. In the case of the death of a pre-term newborn infant less than 3 hours after birth, a final discharge progress note will be documented by the physician who pronounced the death.

4.30 Documentation for Inpatient Transfers to another facility– The transferring physician must dictate or electronically create a transfer summary regardless of length of stay to include documentation that patient was advised of risks/benefits of transfer at the time of transfer but no later than 24 hours thereafter.

4.31 Amending Medical Record Entries

4.31.1 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.

4.31.2 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

4.32 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.

4.33 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 Clarification	Documented within 24 hours of notice	
Operative Report	Documented immediately post-op and no later than 24 hours after the procedure.	
Special Procedures Report	Documented within 24 hours of completion of procedure	
Discharge Summary Report	Documented at the time of the discharge but no later than 24 hours after 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 but no later than 24 hours after discharge 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 within 24 hours after death	
Death Pronouncement Note	Completed at the time the patient is pronounced within 24 hours	
Transfer Summary	Documented at the time of transfer (to another facility including the rest home) but no later than 24 hours	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 7 days from the date of notice	
Verbal Orders	Dated, time and authenticated within 48 hours from order	
Psychiatric Evaluation	Documented within 24 hours of admission	

4.34 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 met or exceeded the timeframes in section 4.32. The notice will include a due date and a list of all incomplete and delinquent medical records.

4.34.1 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.

4.34.2 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.

4.35 Medical Record Suspensions/Sanctions - A medical record is considered eligible for suspension/sanction d based on the timeframes in section 4.32. A limited suspension, in the form of withdrawal of admitting and other related Clinical Privileges until medical records are completed, shall be imposed by the Chief of Staff, or the Chief of Staff's designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section 4.34 "related Clinical Privileges" means scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the Medical Center for future patients. Bona fide vacation or illness may constitute an excuse, subject to approval by the Medical Executive Committee. Practitioners whose admitting and other related Clinical Privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or the Chief of Staff's designee.

4.36 The Medical Executive Committee may choose not to take action regarding delinquent medical records during the initial phase of implementation.

V. GENERAL CODE OF CONDUCT

A. All orders for treatment shall be in writing. A verbal or telephone order shall be considered to be in writing if dictated to a registered nurse (RN) or licensed vocational nurse (LVN) (within the guidelines of the Nursing Practice Act), respiratory therapist (RT), (within scope of their practice) and a pharmacist (when dispensing drugs from emergency department and functioning within his/her sphere of competence), dietitian and signed by the responsible practitioner within 48 hours. (with the exception for restraint orders which will be reviewed/renewed by the physician every 24 hours) All verbal orders shall be repeated to the physician after they have been written. All orders dictated over the telephone or in person shall be signed by the RN, LVN, RT or pharmacist to whom they were dictated with the name of the practitioner per his/her own name with the date and time noted. The responsible practitioner shall authenticate such orders within 48 hours. (with the exception for restraint orders which will be

reviewed/renewed by the physician every 24 hours) Pre-printed orders may be used in the practice of medicine in this hospital on approval of the Medical Staff.

B. The practitioner's orders must be written clearly, legibly and completely with date and time. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

C. All previous orders are canceled when the patient goes to surgery. Orders will be rewritten upon transfer from surgery to acute.

D. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, Physician Desk Reference, or American Medical Association Drug Evaluations. All drugs in the three categories listed below, ordered for patients in the hospital without specific limitations as to dosage and time, shall be called to attention of the attending physician by the nursing staff or Pharmacy Staff pursuant to the hospital's Automatic Stop Order policy and procedure. The attending physician will reorder the drug, change the order or discontinue the order. It is not considered necessary to awaken the physician in the middle of the night if expiration of order occurs but it should be called to his/her attention when he/she visits the patient the following morning. The three (3) categories are:

1. Narcotics
2. Sedatives, hypnotics, soporifics and tranquilizers
3. Antibiotics and cortisone products

Anticoagulants and ergots, because of their extreme danger and toxicity, shall be ordered specifically as to dosage and time. Self medication by patients shall not be allowed unless specifically ordered by the attending physician. Nurses admitting the patient shall ask if he/she has any medication with him/her and request these be stored for them until the time of discharge.

Preprinted Orders for drugs may be used for specified patients when authorized by a person licensed to prescribe. A copy of the orders for a patient shall be dated, timed and promptly signed by the prescriber and included in the patient's medical record. These preprinted orders shall:

1. Specify the circumstances under which the drug is to be administered.

2. Specify the types of medical conditions of patients for whom the orders are intended.

3. Be reviewed and approved periodically by the Medical Staff.

4. Be specific as to the drug, dosage, route and frequency of administration.

E. Any qualified practitioner with clinical privileges in this hospital can be contacted for consultation within his/her area of expertise. Except in an emergency, a consultation is required in cases in which, according to the judgment of the physician:

1. The patient is not a good risk for an operation or treatment.

2. The diagnosis is obscure after ordinary diagnostic procedures have been completed.

3. There is doubt as to the choice of therapeutic measures to be utilized.

4. In unusually complicated situations where specific skills of other practitioners may be needed.

5. In instances in which a patient exhibits severe psychotic symptoms.

The attending physician is primarily responsible for requesting a consultation when indicated. He/she will provide written authorization to permit another attending practitioner to attend or examine his/her patient, except in an emergency. It is the duty of the Chief of Staff or his/her designee to make certain that members of the Medical Staff do not fail in the matter of calling for consultations when needed.

F. The following types of Allied Health Professionals who are actively admitting and/or caring for at least an average of one (1) patient per month, as determined on an annual basis, may participate in Medical Staff committee meetings as assigned by the Chief of Staff: Nurse Practitioners, Physician Assistants, and Nurse Midwives. Such Allied Health Professionals may also attend general Medical Staff meetings, but without the right to vote, as they are not members of the Medical Staff. Any such Allied Health Professional who is assigned to a Medical Staff committee will be a non-voting member of such committee and will not participate in physician peer review. Only one (1) member at a time of any Medical Staff committee may be an Allied Health Professional; provided, however, that other Allied Health Professionals may still attend Medical Staff Committee meetings solely as employees of the Hospital.

G. Orders from Physician Assistants (PAs) or Advanced Practice Registered Nurses (APRNs) for diagnostic tests such as laboratory tests, EKGS and imaging studies do not require co-signature by a physician in either inpatient or outpatient settings.

VI. GENERAL RULES REGARDING SURGICAL CARE

A. History/Physical and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and beginning of surgery. A patient admitted for dental or podiatry care is a dual responsibility involving the dentist and physician member of the Medical Staff.

VII. DENTAL SURGERY

A. The surgical nurse is to be contacted for surgery time.

B. The dental surgeon is to request from the attending physician a written history and physical to be placed on the patient's medical record prior to surgery.

C. Any extra blood tests required (PTT, bleeding time, etc.) shall be requested by the dental surgeon.

D. The attending physician shall prescribe preoperative medications and approve the patient for receiving general anesthesia.

E. General orders are written by either the dental surgeon or attending physician as long as both physician and dental surgeon are in concurrence.

F. Operative dentistry requires a minimum of one dental assistant.

G. Oral surgery or periodontal surgery may require the use of a nurse assistant to assist suctioning.

1. Dentist's Responsibilities:

    a. A detailed dental history must be recorded on the patient's medical record prior to surgery.

    b. A detailed description of the examination of the oral cavity and a preoperative diagnosis recorded on the patient's medical record.

    c. A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the pathologist for examination.

2. Physician's Responsibilities:

    a. Medical history pertinent to the patient's general health.

    b. Physical examination to determine the patient's condition prior to anesthesia and surgery.

    c. Supervision of the patient's general health status while in the hospital.

d. The discharge of the patient shall be on a written order of the dentist or physician member of the Medical Staff.

Dental assistants shall be approved through the hospital Administrator and Chief of Staff in order to assist in the operating room.

VIII. PODIATRY SERVICES

A physician member of the Medical Staff shall be responsible for the care of any medical problem arising during the hospitalization of podiatry patients.

A. Podiatrist's Responsibilities:

1. Recording of all podiatry services provided to the patient which shall be part of the patient's medical record.

2. Detailed podiatry history must be recorded on the he patient's medical record.

3. A detailed description of the examination by the podiatrist and the preoperative diagnosis must be on the patient's medical record.

4. The complete operative report describing the findings and technique shall be completed. All tissue shall be sent to the pathologist for examination.

B. Physician's Responsibilities:

1. Medical history pertinent to the patient's general health.

2. Physical examination to determine the patient's condition prior to anesthesia and surgery.

3. Supervision of the patient's general health status while in the hospital.

Discharge of the podiatry patient shall be on written order of the podiatrist or physician member.

IX. GENERAL RULES

A. Written, signed informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. It shall be the physician's responsibility to explain the surgical procedure prior to the consent being obtained. In emergencies involving a minor or unconscious patient in which consent for the surgery cannot be immediately obtained from the parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such circumstances shall be made before the emergency operative procedure is undertaken, if time permits.

B. All consents will be in medical and layman's terminology.

C. Should additional operations be required during the patient's hospital stay, a second consent specifically worded should be obtained. If two or more specific procedures are to be performed simultaneously and this is known in advance, they may all be described and consented to on the same form.

D. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic follow up of the patient's condition. The pre-anesthesia record entry shall include the patient's previous drug history, other anesthetic experiences, any potential anesthetic problems and plan of type of anesthesia to be used. Following the procedure for which anesthesia is administered; the anesthetist or his/her qualified designee shall remain with the patient as long as required by the patient's condition relative to his anesthesia status and until other qualified individuals have assumed responsibility for proper patient care. Personnel responsible for post-anesthesia care should be advised of specific problems presented by the patient's condition.

E. Release of a patient from the post-anesthesia care unit shall be made only by a physician, or in the case of an oral surgeon or podiatrist, by that oral surgeon or podiatrist and not by nursing service.

F. In all major surgical procedures, there must be a qualified assistant; either a staff physician or appropriately privileged Allied Health Practitioner. (See attached list).

G. Those specimens removed during operation (s) which require review shall be sent to the contracted pathology/laboratory services of the hospital who shall make such examinations as considered necessary to arrive at a diagnosis. The authenticated pathology report shall be made part of the patient's medical record.

X. OBSTETRICS/GYNECOLOGICAL GUIDELINES

A. Those patients presenting with conditions as listed below will have a consultation or be referred if the condition is found during the normal prenatal workup. However, patients presenting at the hospital with these conditions in active labor may not be transferred if it will jeopardize the health and safety of the mother and/or infant. In this case, transfer would occur only when the patient is stable.

1. Active gynecological malignancy.

2. Pregnancies complicated by significant medical disease.

3. Premature delivery from 24-34 weeks gestation.

4. Polyhydramnios.

5. Maternal diabetes, uncontrolled.

6. All cases where neonatal transfer is expected.

B. Induction and/or stimulation or labor with IV oxytocin drugs will be initiated with the attending physician immediately available. The physician or his/her designee will remain available the entire time such a drug is being administered. All inductions shall be performed for medical reasons with documentation supplied in the progress note to show medical indications for performing an induction.

XI. NEWBORNS

If oxygen is used for newborns, the amount will be determined by the attending physician and ordered by percentage of concentration, not by liters.

XII. TRANSFER OF PATIENTS

A. Administrative or Management Issues:

1. When it is determined by the Administrator or his/her designee that the hospital is unable to adequately care for a patient, either because of lack of services or staff, the Administrator or his/her designee will contact the attending physician and discuss the situation.

2. If there is disagreement between the Administrator or his/her designee and the attending physician upon the concurrence of the Chief of Staff the Administrator's decision is final if it involves an administrative or management issue.

B. Medical judgment:

If there is a disagreement that involves a medical judgment, the attending physician and the Administrator will meet with at least two members of the Executive Committee for resolution of the issue.

C. In any event, all transfers will comply with current legal requirements.

XIII. MEDICAL SCREENING EXAMINATIONS

A. Medical Screening Examinations (MSE)

Definition: State law defines "emergency services and care" as " medical screening examination and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility."

Non-physician personnel who are authorized to perform medical screening examinations include:

-Certified Nurse Midwives (CNM)
-Authorized Registered Nurses in OB
-Authorized Registered Nurses who administer outpatient medications

B. Surgery Department

Qualified Assistant will be needed at the discretion of the Operating Surgeon On These Procedures

1. Cesarean Section
2. Exploratory Laparotomy
3. Hysterectomy
4. Thyroidectomy
5. Vagotomy, Pyloroplasty
6 Open Reduction-Hips
7. Bowel Resection
8. Gastric Resection
9. Radical Mastectomy
10. Total Joint Replacement

Revised: 9/86, 5/91, 4/93, 3/96, 3/97, 8/00, 7/07, 10/07, 5/08, 9/09, 11/09, 8/11, 4/12, 8/14, 2/15

RULES & REGULATIONS

ADOPTED BY THE MEDICAL STAFF ON

____________________, ____________

Date

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Chief of Staff

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Secretary

Approved by the Board of Directors on

____________________, ____________

Date

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Chair

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Secretary