

**MEDICAL STAFF
RULES AND REGULATIONS**

**SANTA ROSA
MEMORIAL HOSPITAL**

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ARTICLE 1

DEFINITIONS

Except as specifically defined below, the definitions that apply to the terms used in these Rules and Regulations are set forth in the Medical Staff Organization Manual:

- (a) “Ambulatory Care” means non-emergency health care services provided to patients without hospitalization, including, but not limited to, day surgeries (with or without general anesthesia), blood transfusions, and I.V. therapy.
- (b) “Ambulatory Care Location” means any department in the Hospital or provider-based site or facility where ambulatory care is provided.
- (c) “Attending Physician” means the patient’s primary treating physician or his or her designee(s) (e.g., an appropriately privileged Allied Health Professional), who shall be responsible for directing and supervising the patient’s overall medical care, for completing or arranging for the completion of the medical history and physical examination after the patient is admitted or before surgery (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient’s status to the patient, the referring practitioner, if any, and the patient’s family.
- (d) “Practitioner” means, unless otherwise expressly limited, any individual who has been granted clinical privileges and/or membership by the Board, including (but not limited to) members of the Medical Staff, Allied Health Professionals, and providers of telemedicine.
- (e) “Responsible Practitioner” means any practitioner who is actively involved in the care of a patient at any point during the patient’s treatment at the Hospital and who has the responsibilities outlined in these Medical Staff Rules and Regulations. These responsibilities include complete and legible medical record entries related to the specific care/services he or she provides.

ARTICLE 2

ADMISSIONS, ASSESSMENTS AND CARE, TREATMENT AND SERVICES

2.A. ADMISSIONS

- (1) Patients shall be admitted only upon the order and under the care of a member of the Medical Staff of the Hospital who is granted admitting privileges and is a licensed health care practitioner acting within the scope of his or her professional licensure.
- (2) Except in an emergency, the patient's condition and provisional diagnosis shall be established at time of admission by the member of the Medical Staff who admits the patient. In the case of an emergency, the provisional diagnosis will be recorded as soon as possible.
- (3) The admitting physician will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm. The admitting physician will recommend appropriate precautionary measures, in accordance with applicable Hospital policy, to protect the patient and others.
- (4) When a patient requires admission to the Hospital for emergency treatment, the admitting physician will (whenever possible) contact the admitting department and determine whether there is an available bed. In the event of a bed shortage, the "Admission, Transfer, and Discharge" policy (Administrative Policy and Procedure B-1) will apply. The final decision to admit a patient shall rest with the President, who is expected to consult with the admitting physician and the Chief of Staff.
- (5) Patients admitted by psychologists will be cared for collaboratively by the psychologist and a psychiatrist member of the Medical Staff. A Medical Staff member with the appropriate clinical privileges will act as the patient's attending physician. The psychologist will actively participate in the patient's treatment.

2.B. RESPONSIBILITIES OF ATTENDING PHYSICIAN

- (1) The attending physician will be responsible for the following while in the Hospital:
 - (a) the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in the patient's care (including personal communication with other physicians where possible);

- (b) the prompt and accurate completion of the portions of the medical record for which he or she is responsible;
 - (c) communicating with the patient's third-party payor, if needed;
 - (d) providing necessary patient instructions;
 - (e) responding to inquiries from Utilization Review professionals regarding the plan of care in order to justify the need for continued hospitalization;
 - (f) responding to Medicare/Medicaid quality of care issues and appeal denials, when appropriate; and
 - (g) performing all other duties described in these Rules and Regulations.
- (2) Unless other arrangements are made, the admitting physician will be considered the patient's attending physician.
- (3) At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record. Whenever the responsibilities of the attending physician are transferred to another physician outside of his or her established call coverage, an order covering the transfer of responsibility will be entered in the patient's medical record. The attending physician will be responsible for discussing the transfer with the other physician, verifying the other physician's acceptance of the transfer, and updating the attending physician screen in the electronic medical record ("EMR").
- (4) For admissions that are 20 days or more, or outlier cases, the attending physician (or a physician designee with knowledge of the patient) will complete the physician certification in compliance with the timing requirements in federal regulations. The physician certification includes, and is evidenced by, the following information:
- (a) authentication of the admitting order;
 - (b) the reason for the continued hospitalization or the special or unusual services for a cost outlier case;
 - (c) the expected or actual length of stay of the patient; and
 - (d) the plans for post-Hospital care, when appropriate.

2.C. CARE OF UNASSIGNED PATIENTS

- (1) All unassigned patients will be assigned to the appropriate on-call practitioner or to the appropriate Hospital service.
- (2) An “unassigned patient” means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Medical Center.

2.D. AVAILABILITY AND ALTERNATE COVERAGE

- (1) The attending physician will provide professional care for his or her patients in the Hospital by being personally available or by making arrangements with an alternate practitioner who has appropriate clinical privileges to care for the patients.
- (2) The attending physician (or his or her designee) will comply with the following patient care guidelines regarding availability:
 - (a) Calls/texts from the Emergency Department and/or a Patient Care Unit – must respond by telephone (or in person) within 30 minutes of being contacted and, if requested by a Medical Staff member, must personally see a patient at the Hospital within 60 minutes of the request (or more quickly based upon (i) the acute nature of the patient’s condition or (ii) as required for a particular specialty as recommended by the Medical Executive Committee and approved by the Board);
 - (b) Inpatients Admitted from the Emergency Department – must personally see the patient within 12 hours of admission;
 - (c) All Other Inpatient Admissions – must personally see the patient within 24 hours of admission;
 - (d) ICU Patients – must personally see the patient within 12 hours of being admitted to the ICU, unless the patient’s condition requires that the physician see him or her sooner; and
 - (e) Patients Subject to Restraints or Seclusion – pursuant to Article 10 of these Rules and Regulations.
- (3) All physicians (or their appropriately credentialed designee) will be expected to comply with the following patient care guidelines regarding consultations:

- (a) Routine Consults – must be completed within 24 hours of the request or within a time frame as agreed upon by the requesting and consulting physicians; and
 - (b) Critical Consults – must be completed within 12 hours of the request, unless the patient’s condition requires that the physician complete the consultation sooner (all such requests for critical care consults – e.g., “stat,” “urgent,” “today,” or similar terminology – must also include personal contact by the requesting individual to the consulting physician); and
 - (c) ICU Consults – all patients admitted to the ICU must have a mandatory critical care intensivist consultation, including a note, within 12 hours of admission to the unit.
- (4) If the attending physician does not participate in an established call coverage schedule with known alternate coverage and will be unavailable to care for a patient, or knows that he or she will be out of town for longer than 24 hours, the attending physician will document in the medical record the name of the Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability. The attending physician will be responsible for verifying the other physician’s acceptance of the transfer.
- (5) If the attending physician is not available, the Chief Medical Officer or the Chief of Staff will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

2.E. CONTINUED HOSPITALIZATION

- (1) The attending physician will provide whatever information may be requested by the Utilization Review Department with respect to the continued hospitalization of a patient, including:
- (a) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient’s diagnosis is not sufficient);
 - (b) the estimated period of time the patient will need to remain in the Hospital; and
 - (c) plans for post-Hospital care.

This response will be provided to the Utilization Review Department within 24 hours of the request. Failure to comply with this requirement will be reported to the Chief Medical Officer for appropriate action.

- (2) If the Utilization Review Department determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the

Hospital, the patient, and the attending physician. If the matter cannot be appropriately resolved, the Chief Medical Officer will be consulted.

ARTICLE 3

MEDICAL RECORDS

3.A. GENERAL

- (1) The following individuals are authorized to document in the medical record:
 - (a) attending physicians and responsible practitioners;
 - (b) nursing providers, including registered nurses (“RNs”) and licensed practical nurses (“LVNs”);
 - (c) physicians responding to a request for consultation when the individual has clinical privileges or is an employee at the Hospital;
 - (d) other health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, radiological technologists, pharmacists, social workers, and case managers;
 - (e) residents, fellows, medical students, and other students in an approved professional education program who are involved in patient care as part of their education process (e.g., acting interns) if that documentation is reviewed and countersigned by the student’s supervisor, who must also be authorized to document in the medical record; and
 - (f) non-clinical and administrative staff, as appropriate, pursuant to their job description.
- (2) Entries will be made in the medical record consistent with Hospital policy. Electronic entries will be entered through the EMR. Orders will be entered using Computerized Provider Order Entry (“CPOE”). Handwritten medical record entries will be legibly recorded in blue or preferably black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents). All entries, including handwritten entries, must be timed, dated and signed.
- (3) Each practitioner will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.
- (4) Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the unapproved abbreviations

and/or symbols list may not be used. The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.

- (5) Any error made while entering an order in the CPOE should be corrected in accordance with Hospital policy. If an error is made while making a handwritten recording in the record, the error should be crossed out with a single line and initialed.

3.B. ACCESS AND RETENTION OF RECORD

- (1) The Hospital will retain medical records in their original or legally reproduced form for a period of at least 10 years from the date of discharge. In the case of unemancipated minor, who was less than 18 years old at the time he or she was last discharged, records are retained until after the patient has attained the age of 19; however, in no event, less than 10 years post discharge.
- (2) Medical records are the physical property of the Hospital. Original medical records may only be removed from the Hospital in accordance with federal or state laws.
- (3) Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and Hospital policy.
- (4) A patient or his or her duly designated representative may receive copies of the patient's completed medical record, or an individual report, upon presentation of an appropriately signed authorization form, unless the attending physician documents that such a release would have an adverse effect on the patient or another person.
- (5) Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research consistent with Hospital policy, applicable federal and state law, and preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Institutional Review Board (IRB).
- (6) Subject to the discretion of the President (or his or her designee), former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the Hospital.

3.C. CONTENT OF RECORD

- (1) For every patient treated as an inpatient, a medical record will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Medical

records will also be kept for every scheduled ambulatory care patient and for every patient receiving emergency services.

- (2) Medical record entries will be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital's policies and procedures. Stamped signatures are not permitted in the medical record.
- (3) General Requirements. All medical records for patients receiving care in the Hospital setting or at an ambulatory care location will document the information outlined in this paragraph, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:
 - (a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;
 - (b) the patient's marital status and religion;
 - (c) legal status of any patient receiving behavioral health services;
 - (d) patient's language and communication needs, including preferred language for discussing health care;
 - (e) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives;
 - (f) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;
 - (g) emergency care, treatment, and services provided to the patient before his or her arrival, if any;
 - (h) admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;
 - (i) allergies to foods and medicines;
 - (j) reason(s) for admission of care, treatment, and services;
 - (k) diagnosis, diagnostic impression, or conditions;
 - (l) goals of the treatment and treatment plan;
 - (m) diagnostic and therapeutic orders, procedures, tests, and results;

- (n) progress notes made by authorized individuals;
 - (o) medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);
 - (p) consultation reports;
 - (q) operative procedure reports and/or notes;
 - (r) any applicable anesthesia evaluations;
 - (s) response to care, treatment, and services provided;
 - (t) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;
 - (u) reassessments and plan of care revisions;
 - (v) complications, Hospital acquired infections, and unfavorable reactions to medications and/or treatments;
 - (w) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice; and
 - (x) medications dispensed or prescribed on discharge.
- (4) Emergency Care. Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:
- (a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;
 - (b) legal status of any patient receiving behavioral health services;
 - (c) patient's language and communication needs, including preferred language for discussing health care;
 - (d) time and means of arrival;
 - (e) record of care prior to arrival;

- (f) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;
 - (g) pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his/her arrival at the Emergency Department;
 - (h) results of the Medical Screening Examination;
 - (i) treatment given, if any;
 - (j) diagnostic and therapeutic orders, procedures, tests, and results;
 - (k) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;
 - (l) if the patient left against medical advice; and
 - (m) a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.
- (5) Obstetrics Records. Medical records of obstetrics patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:
- (a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;
 - (b) findings during the prenatal period;
 - (c) the medical and obstetrical history;
 - (d) observations and proceedings during labor, delivery and postpartum period; and
 - (e) laboratory and x-ray findings.

The obstetrical record will also include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission. An interval admission note that includes pertinent additions to the history and any subsequent changes in the physical findings must be entered.

- (6) Infant Records. Medical records of infant patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

- (a) history of maternal health and prenatal course, including mother's HIV status, if known;
- (b) description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid;
- (c) time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and problems occurring from birth until transfer from the delivery room;
- (d) report of a complete and detailed physical examination within 24 hours following birth; report of a physical examination within 24 hours before discharge and daily during any remaining Hospital stay;
- (e) physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily;
- (f) documentation of infant feeding: intake, content, and amount if by formula; and
- (g) clinical course during Hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

3.D. HISTORY AND PHYSICAL

The requirements for histories and physicals, including general documentation requirements and timing requirements, are contained in Article 9 of the Medical Staff Bylaws.

A comprehensive medical history and physical examination (H&P) must be available within twenty four (24) hours of admission, registration or operative and complex invasive procedures in either an inpatient or outpatient setting. If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record, provided that the patient is reassessed within 24 hours after admission or registration, and prior to any operative or invasive procedure.

An interval history and physical may be used to update the original history and physical.

(1) Comprehensive H&P

A comprehensive H&P is defined as an H&P that contains the following elements:

- (a) Chief Complaint
 - (b) Details of the History of Present Illness
 - (c) Pertinent past medical and surgical history
 - (d) Pertinent past psycho-social history
 - (e) Physical examination
 - (f) Statement on the conclusions or impressions drawn from the history and physical examination
 - (g) Statement on the course of action planned for the patient for the episode of care
- (2) Interval H&P

An interval H&P is a statement entered into the patient's medical record that a comprehensive H&P has been reviewed and that:

- (a) There are no significant changes to the findings contained in the comprehensive H&P since the time such H&P was performed, or
- (b) There are significant changes and such changes are subsequently documented in the patient's medical record.

3.E. PROGRESS NOTES

- (1) Progress notes will be entered by the attending physician (or his or her covering practitioner with the appropriate clinical privileges or scope of practice) at least every 24 hours for all hospitalized patients and as needed to reflect changes in the status of a patient in an ambulatory care setting.
- (2) Progress notes will be legible, dated, and timed. When appropriate, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.
- (3) Progress notes may also be entered by Allied Health Professionals as permitted by their clinical privileges.

3.F. IMMEDIATE POST PROCEDURE & OPERATIVE REPORT

Immediately after the procedure (upon completion of the operative/invasive procedure, before the patient is transferred to the next level of care), an immediate post procedure

note must be written. Post procedure & postoperative notes must be documented in the patients' records before the patient leave the recovery area.

(1) An Immediate Post-Operative/Post Procedure Note must include, at a minimum the following elements:

(2)

(a) Name(s) of the primary surgeon & assistant(s)

(b) Procedure performed

(c) Description of each procedure finding

(d) Estimated blood loss

(e) Specimen(s) removed

(f) Post-Operative diagnosis

(3) An Operative or High Risk Procedure Report must include, at a minimum the following elements:

(a) Name(s) of the primary surgeon & assistant(s)

(b) Procedure performed

(c) Description of each procedure finding

(d) Estimated blood loss

(e) Specimen(s) removed

(f) Post-Operative diagnosis

3.G. DISCHARGE SUMMARY

The attending practitioner listed on the medical record is responsible for providing the discharge summary within 24 hours of discharge, unless there is an order entered transferring the patient to another practitioner.

(1) A comprehensive Discharge Summary is defined as containing the following elements:

(a) reason for hospitalization;

(b) significant findings;

- (c) procedures performed and care, treatment, and services provided;
 - (d) condition and disposition at discharge;
 - (e) information provided to the patient and family, as appropriate;
 - (f) provisions for follow-up care; and
 - (g) discharge medication reconciliation.
- (2) If the patient was hospitalized for less than forty-eight (48) hours, a short form discharge summary may be used.
 - (3) A discharge progress note may be used to document the discharge summary for normal obstetrical deliveries, normal newborn infants, and ambulatory care patients, and for stays of less than 48 hours.
 - (4) A death summary is required in any case in which the patient dies in the Hospital, regardless of length of admission.

3.H. AUTHENTICATION

- (1) Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the CPOE. Signature stamps are never an acceptable form of authentication for written orders/entries.
- (2) The practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy.
- (3) Each practitioner with clinical privileges is responsible for authenticating each entry they make in the medical record within 24 hours, regardless of their role in the patient's care.
- (4) A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries will be individually authenticated.

3.I. CO-SIGNATURE AND CO-DOCUMENTATION REQUIREMENTS

- (1) Resident physicians, intern physicians, and Allied Health Professionals (certified midwives, nurse practitioners, and physician assistants) require the following documents to be co-signed and co-documented by a supervising attending physician within the documentation time requirements:

- (a) history and physicals: within 24 hours of admission;
- (b) discharge summaries: within seven days of discharge; and
- (c) operative/procedure reports: within 24 hours of procedure.

These practitioners are also required to document the name of the supervising attending physician at the beginning of the document.

- (2) Co-documentation consists of an addendum to the original document showing involvement and participation in the management of the patient.

3.J. INFORMED CONSENT

Informed consent will be obtained in accordance with the Hospital's Verification of Informed Consent Policy and documented in the medical record.

3.K. DELINQUENT MEDICAL RECORDS

- (1) It is the responsibility of any practitioner involved in the care of a hospitalized patient to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Hospital, regardless of the role in a patient's care.
- (2) Medical records will be completed within 14 days following the patient's discharge or they will be considered delinquent. If the record remains incomplete 14 days following discharge, the practitioner will be notified of the delinquency and that his or her clinical privileges have been automatically suspended in accordance with the Credentialing Policy. The suspension will remain in effect until all of the practitioner's records are no longer delinquent. All deficiency and delinquent notifications will be in accordance with the HIM Department process.
- (3) A suspended practitioner will not be allowed to admit new patients, consult on new patients, or schedule procedures or surgeries during the suspension period. Since the intent of this policy is to preserve continuity and quality of patient care, practitioners will still be able to care for existing patients and perform previously scheduled procedures or surgeries in the hospital.
- (4) Privileges will be reinstated within 24 hours upon completion of all past due records. If records are completed over a weekend or holiday, privileges will be reinstated by the end of the business hours on the next business day.

- (5) Failure to complete the medical records that caused the automatic suspension of clinical privileges shall three months from the suspension constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.
- (6) Regardless of the role in a patient's care, every practitioner is subject to be considered delinquent, fined and/or suspended. The supervising physician for an AHP is ultimately responsible for the AHPs actions, including the timely completion of records. Fine assessments are addressed in the Medical Staff Financial Policy.
- (7) It is the responsibility of the practitioner to notify the HIM Department of any illness. Records will not age during the time a physician is ill, provided records were up to date and notification is made to HIM.
- (4) Records not available to the practitioner or assigned to an incorrect practitioner shall not be considered delinquent during the time they are inaccessible or incorrectly assigned. Unless unduly delayed, the time required for transcription of reports does not extend the delinquency period. Thus, acute care hospital reports must be dictated and signed within 14 days of discharge, inclusive of transcription time.
- (7) An incomplete medical record will not be permanently filed until it is completed by the responsible practitioner, or designee, or it is ordered filed by the HIM Department. Except in rare circumstances, and only when approved by the HIM Department, no practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.
- (8) When a practitioner is no longer a member of the Medical Staff or Allied Health Professional Staff and his or her medical records are filed as permanently inadequate, this will be recorded in the practitioner's credentials file and divulged in response to any future credentialing inquiry concerning the practitioner.
- (9) Any requests for special exceptions to the above requirements will be submitted by the practitioner and considered by the HIM Department. The Medical Executive Committee/CMO/Chief of Staff is authorized to make special exceptions if warranted by the circumstances based upon good cause or hardship due to (1) personal illness or illness of a close family member or (2) absence from the community, provided that the practitioner makes a good faith effort to complete the records prior to leaving the community.
- (10) The chart completion requirements for ambulatory care will be the same as for other medical records.

ARTICLE 4

MEDICAL ORDERS

4.A. GENERAL

- (1) Whenever possible, orders will be entered directly into the EMR by the ordering practitioner utilizing the CPOE. Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient's EMR via the CPOE in accordance with Hospital policy.
- (2) All orders (including verbal/telephone orders) must be:
 - (a) dated and timed when documented or initiated;
 - (b) authenticated by the ordering practitioner, with the exception of a verbal order which may be countersigned by another practitioner who is responsible for the care of a patient. Authentication must include the time and date of the authentication. All orders entered into the CPOE are electronically authenticated, dated, and timed, except for handwritten and paper-based orders that have already been authenticated via written signatures or initials; and
 - (c) documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.
- (3) Orders for tests and therapies will be accepted only from:
 - (a) members of the Medical Staff; and
 - (b) Allied Health Professionals who are granted clinical privileges by the Hospital, to the extent permitted by their licenses and clinical privileges.

Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by practitioners who are not affiliated with the Hospital in accordance with Hospital policy.
- (4) The use of the summary (blanket) orders (e.g., “renew,” “repeat,” “resume,” and “continue”) to resume previous medication orders is not acceptable.
- (5) Orders for “daily” tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering practitioner at the expiration of

this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.

- (6) All orders are automatically cancelled and will be completely reentered when a patient is transferred from one physician to another, when a patient is transferred from the critical care unit, and when a patient emerges from surgery.
- (7) No order will be discontinued without the knowledge of the attending physician or his or her designee, unless the circumstances causing the discontinuation constitute an emergency.
- (8) All orders for medications administered to patients will be:
 - (a) reviewed by the attending physician or his or her designee at least weekly to assure the discontinuance of all medications no longer needed;
 - (b) canceled automatically when the patient goes to surgery, is transferred to a different level of care, or when care is transferred to another clinical service; and
 - (c) reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit). In cases when the medication order is issued when the pharmacy is “closed” or the pharmacist is otherwise unavailable, the medication order will be reviewed by the nursing supervisor and then by the pharmacist as soon thereafter as possible, preferably within 24 hours.
- (9) All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be reentered. All as necessary medication orders (also known as PRN) must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.
- (10) Allied Health Professionals may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital.

4.B. VERBAL ORDERS

- (1) A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical

for such order to be entered by the ordering practitioner or if a delay in accepting the order could adversely affect patient care.

- (2) All verbal orders will include the date and time of entry into the medical record, identify the names of the individuals who gave, received, and implemented the order, and then be authenticated with date and time by the ordering practitioner or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy and state law.
- (3) Authentication will take place by ordering practitioner,
 - (h) before the ordering practitioner leaves the patient care area for face-to-face orders, and
 - (i) within 48 hours after the order was given for telephone orders. If a practitioner other than the ordering practitioner authenticates a verbal order, he or she assumes responsibility that the order is complete, accurate, and final.
- (4) For verbal orders, the complete order will be verified by having the person receiving the information record and “read-back” the complete order.
- (5) The following are the personnel authorized to receive and record verbal orders within their scope of practice and delineation of privileges:
 - (a) an LVN or RN;
 - (b) a pharmacist who may transcribe a verbal order pertaining to medications and monitoring;
 - (c) a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;
 - (d) a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;
 - (e) a radiology or imaging technologist (i.e., nuclear medicine, diagnostic medical sonographer) who may transcribe a verbal order pertaining to tests and/or therapy treatments in their specific areas of expertise;
 - (f) an occupational therapist who may transcribe a verbal order pertaining to occupational treatments;
 - (g) a speech therapist who may transcribe a verbal order pertaining to speech therapy; and

- (h) a dietician who may transcribe a telephone/verbal order pertaining to diet and nutrition.

4.C. STANDARDIZED PROCEDURES

- (1) The Medical Executive Committee and the Hospital's nursing and pharmacy departments must review and approve any standardized procedures that permit treatment to be initiated by an individual (e.g., a nurse) without a prior specific order from the attending physician. All standardized procedures will identify well-defined clinical scenarios for when the order or protocol is to be used.
- (2) The Medical Executive Committee will confirm that all approved standardized procedures are consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also ensure that standardized procedures are reviewed periodically by the Interdisciplinary Practice Committee.
- (3) If the use of a standardized procedure has been approved by the Medical Executive Committee, the standardized procedure may be initiated for a patient either by a nurse (or other authorized individual) acting within the scope of his or her practice who activated the standardized procedure, or by a nurse entering documentation into the medical record to trigger the standardized procedure.
- (4) When used, standardized procedures (or other standing orders and protocols) must be dated, timed, and authenticated promptly in the patient's medical record by the individual who activated the procedure or by another responsible practitioner.
- (5) The attending physician must also authenticate the initiation of each standardized procedure after the fact, with the exception of those for influenza and pneumococcal vaccines.

4.D. SELF-ADMINISTRATION OF MEDICATIONS

- (1) The self-administration of medications (either Hospital-issued or those brought to the Hospital by a patient) will not be permitted unless:
 - (a) the patient (or the patient's caregiver) has been deemed capable of self-administering the medications;
 - (b) a practitioner responsible for the care of the patient has issued an order permitting self-administration;
 - (c) in the case of a patient's own medications, the medications are visually evaluated by a pharmacist to ensure integrity; and insulin pump?
 - (d) the patient's first self-administration is monitored by nursing staff personnel to determine whether additional instruction is needed on the safe and

accurate administration of the medications and to document the administration in the patient's medical record.

- (2) The self-administration of medications will be documented in the patient's medical record as reported by the patient (or the patient's caregiver).
- (3) All self-administered medications (whether Hospital-issued or the patient's own) will be kept secure in accordance with Storage and Access provisions of these Rules and Regulations.
- (4) If the patient's own medications brought to the Hospital are not allowed to be self-administered, the patient (or the patient's caregiver) will be informed of that decision and the medications will be packaged, sealed, and returned to the patient or given to the patient's representative at the time of discharge from the Hospital.

4.E. STOP ORDERS

A practitioner is permitted to order any medication for a specific length of time so long as the length of time is clearly stated in the orders. Medications not specifically prescribed as to time or number of doses will be subject to "STOP" orders and automatically discontinued as follows:

- (1) all oxytocics after 24 hours;
- (2) narcotics (BNDD Schedule II) after 48 hours;
- (3) all soporifics and sedatives (BNDD Schedules II, III, IV), anticoagulants, corticosteroids and antibiotics after seven days;
- (4) all other medications after 14 days; and
- (5) inhalation therapy treatments after three days.

The prescribing practitioner will be notified within 12 hours before an order is automatically stopped.

4.F. ORDERS FOR DRUGS AND BIOLOGICALS

- (1) Orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.
- (2) All orders for medications and biologicals will be dated, timed and authenticated by the responsible practitioner, with the exception of influenza and pneumococcal vaccines, which may be administered per Hospital policy after an assessment for contraindications. The order shall include the name of the drug, the dosage and the frequency of administration, the route of administration, if other than oral, and the

date, time and signature of the prescriber or furnisher. Orders for drugs should be written or transmitted by the prescriber or furnisher.

- (3) Verbal orders for drugs shall be given only by a person lawfully authorized to prescribe or furnish and shall be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. Verbal or telephone orders will only be used in accordance with these Rules and Regulations and other Hospital policies.

4.G. ORDERS FOR RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES

- (1) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the Hospital, or, consistent with state law, other practitioners authorized by the Medical Staff and Board to order services.
- (2) Orders for radiology services and diagnostic imaging services must include:
 - (a) the patient's name;
 - (b) the name of the ordering individual;
 - (c) the radiological or diagnostic imaging procedure orders; and
 - (d) the reason for the procedure.

4.H. ORDERS FOR OUTPATIENT SERVICES

- (1) Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by practitioners who are not affiliated with the Hospital in accordance with Medical Staff policy.
- (2) Orders for outpatient services must be submitted on a prescription pad, letterhead, or an electronic order form and include: (i) the patient's name; (ii) the name and signature of the ordering individual; and (iii) the type, frequency, and duration of the service, as applicable.

ARTICLE 5

CONSULTATIONS

5.A. REQUESTING CONSULTATIONS

- (1) The attending physician shall be responsible for requesting a consultation when indicated and for contacting a qualified consultant.
- (2) Requests for consultations shall be entered in the patient's medical record. In addition to documenting the reasons for the consultation request in the medical record, the attending physician will make reasonable attempts to personally contact the consulting physician to discuss the consultation request. However, for critical care consults, the attending physician must personally speak with the consultant to provide the patient's clinical history and the specific reason for the consultation request.
- (3) Failure by an attending physician to obtain consultations as set forth in this Section will be reviewed through the professional practice evaluation policy or other applicable policy.
- (4) Where a consultation is required for a patient in accordance with Section 5.3 or is otherwise determined to be in patient's best interest, the Chief Medical Officer, the Chief of Staff, or the appropriate clinical Service Chair shall have the right to call in a consultant.

5.B. RESPONDING TO CONSULTATION REQUESTS

- (1) Any individual with clinical privileges can be asked for consultation within his or her area of expertise. Individuals who are requested to provide a consultation are expected to respond in a timely and appropriate manner.
- (2) For non-critical care consults, the physician who is asked to provide the consultation is expected to do so within 24 hours (as a general guideline) unless a longer time frame is specified by the individual requesting the consultation. For critical care consults, the consult must be completed within 12 hours of the request, unless the patient's condition requires that the physician complete the consultation sooner.
- (3) The physician who is asked to provide the consultation may ask an Allied Health Professional with appropriate clinical privileges to see the patient, gather data, and order tests. However, such evaluation by an Allied Health Professional will not relieve the consulting physician of his or her obligation to personally see the patient within the appropriate time frame, unless the physician requesting the consultation agrees that the evaluation by the Allied Health Professional is sufficient.

- (4) When providing a consult, the consulting physician will review the patient's medical record, brief the patient on his or her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the consulting physician will be directly communicated to the attending physician.
- (5) Failure to respond to a request for a consultation in a timely and appropriate manner will be reviewed through the Professional Practice Evaluation Policy process or other applicable policy unless one of the following exceptions applies to the physician asked to provide a consultation:
 - (a) the physician has a valid justification for his or her unavailability (e.g., out of town);
 - (b) the patient has previously been discharged from the practice of the physician;
 - (c) the physician has previously been dismissed by the patient;
 - (d) the patient indicates a preference for another consultant; or
 - (e) other factors indicate that there is a conflict between the physician and the patient (i.e., the patient in question has previously initiated a lawsuit against the physician) such that the physician should not provide consultation.

To the extent possible, if the requested physician is unable to provide a consultation based on the aforementioned criteria (paragraphs (a) – (e)), then the requesting physician should find an alternate consultant. If the attending is unable to do so, then the Chief Medical Officer, the Chief of Staff, or the appropriate clinical Service Chair can appoint an alternate consultant.

- (6) Once the consulting physician is involved in the care of the patient, the attending physician and consulting physician are expected to review each other's notes in both the electronic and paper charts on a daily basis until such time as the consultant has signed off on the case or the patient is discharged.

5.C. RECOMMENDED AND REQUIRED CONSULTATIONS – GENERAL PATIENT CARE SITUATIONS

- (1) Consultations are recommended in all non-emergency cases whenever requested by the patient, or the patient's personal representative if the patient lacks decisional capacity.
- (2) Except in emergency cases, consultations are required in all cases in which, in the judgment of the attending physician:

- (a) the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - (b) there is doubt as to the best therapeutic measures to be used;
 - (c) unusually complicated situations are present that may require specific skills of other practitioners;
 - (d) the patient exhibits severe symptoms of mental illness or psychosis; or
 - (e) the patient is not a good medical or surgical risk.
- (3) Consultations are required whenever the Chief of Staff or the relevant Service Chair determines that the patient would benefit from a consultation.
- (4) Additional requirements for consultation may be established by the Hospital as required.

5.D. HOSPICE & PALLIATIVE CARE CONSULTATIONS

In addition to physicians in the specialty of Hospice and Palliative Care, Nurse Practitioners who have been granted privileges to do so may provide Hospice & Palliative Care consults as requested.

5.D. MENTAL HEALTH CONSULTATIONS

A mental health consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose) or who are determined to be a potential danger to others. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient's medical record.

5.E. SURGICAL CONSULTATIONS

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the consultant, including relevant findings and reasons, appears in the patient's medical record. If a relevant consultation has not been communicated, surgery and anesthesia will not proceed, unless the attending physician states in writing that an emergency situation exists.

5.F. CONTENT OF CONSULTATION REPORT

- (1) Each consultation report will be completed in a timely manner and will contain a dictated or legible written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," will not constitute an acceptable consultation report. The consultation report will be made a part of the patient's medical record.
- (2) When non-emergency operative procedures are involved, the consultant's report will be recorded in the patient's medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.

5.G. CONCERNS

- (1) If a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that an appropriate consultation is needed and has not been obtained, after having a conversation with the attending physician that nurse will notify the nursing supervisor who, in turn, will contact the attending physician. If a consultation is not thereafter ordered by the attending physician, the nursing supervisor may then bring the matter to the attention of the Service Chair in which the member in question has clinical privileges. Thereafter, the Service Chair or Chief Medical Officer may request a consultation after discussion with the attending physician.
- (2) A practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation should utilize the Chain of Command Escalation for the concern and may discuss the issue with the applicable Service Chair, the Chief of Staff, or the Chief Medical Officer.

ARTICLE 6

SURGICAL SERVICES

6.A. PATHOLOGICAL SLIDES

It is recommended that all preoperative biopsies performed at another institution should be reviewed by a pathologist at the Hospital before the patient undergoes a disfiguring or disabling surgery for malignancy. This would include procedures such as amputations, facial surgery, genital surgery, radical mastectomy, radical neck surgery, and radical prostatectomy.

6.B. PRE-PROCEDURE PROTOCOL

- (1) The physician responsible for the patient's care will thoroughly document in the medical record: (i) the provisional diagnosis and the results of any relevant diagnostic tests; (ii) a properly executed informed consent; and (iii) a complete history and physical examination prior to transport to the operating room, except in emergencies.
- (2) Except in an emergency situation, the following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:
 - (a) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;
 - (b) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;
 - (c) the attending physician (i.e., surgeon) is in the Hospital; and
 - (d) the procedure site is marked and a "time out" is conducted immediately before starting the procedure, as described in the Operative Procedure Site Verification and Time Out Protocol.

6.C. POST-PROCEDURE PROTOCOL

- (1) An operative procedure report must be dictated immediately after an operative procedure and entered into the record. The operative procedure report shall include:
 - (a) the patient's name and Hospital identification number;
 - (b) pre- and post-operative diagnoses;
 - (c) date and time of the procedure;

- (d) the name of the attending physician(s) and assistant surgeon(s) responsible for the patient's operation;
- (e) procedure(s) performed and description of the procedure(s);
- (f) description of the specific surgical tasks that were conducted by practitioners other than the attending physician;
- (g) findings, where appropriate, given the nature of the procedure;
- (h) estimated blood loss;
- (i) any unusual events or any complications, including blood transfusion reactions and the management of those events;
- (j) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;
- (k) specimen(s) removed, if any;
- (l) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any);
and
- (m) the signature of the attending physician.

ARTICLE 7

ANESTHESIA SERVICES

7.A. GENERAL

- (1) Anesthesia may only be administered by the following qualified practitioners:
 - (a) an anesthesiologist;
 - (b) an M.D. or D.O. (other than an anesthesiologist) with appropriate clinical privileges;
 - (c) a dentist, oral surgeon or podiatrist, in accordance with state law;
- (3) “Anesthesia” means general or regional anesthesia, monitored anesthesia care or deep sedation. “Anesthesia” does not include topical or local anesthesia, minimal, moderate or conscious sedation, or analgesia via epidurals/spinals for labor and delivery.
- (4) Because it is not always possible to predict how an individual patient will respond to minimal, moderate or conscious sedation, a qualified practitioner with expertise in airway management and advanced life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.
- (5) General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

7.B. PRE-ANESTHESIA PROCEDURES

- (1) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services.
- (2) The evaluation will be recorded in the medical record and will include:
 - (a) a review of the medical history, including anesthesia, drug and allergy history;
 - (b) an interview, if possible, preprocedural education, and examination of the patient;

- (c) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);
- (d) identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);
- (e) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and
- (f) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The elements of the pre-anesthesia evaluation in (a) and (b) must be performed within the 48-hour time frame. The elements in (c) through (f) must be reviewed and updated as necessary within 48 hours, but may be performed during or within 30 days prior to the 48-hour time period.

- (3) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

7.C. MONITORING DURING PROCEDURE

- (1) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.
- (2) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:
 - (a) the name and Hospital identification number of the patient;
 - (b) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;
 - (c) the name, dosage, route time, and duration of all anesthetic agents;
 - (d) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;
 - (e) the name and amounts of IV fluids, including blood or blood products, if applicable;

- (f) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and
- (g) 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, and the patient's status upon leaving the operating room.

7.D. POST-ANESTHESIA EVALUATIONS

- (1) In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.
- (2) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient's inability to participate will be made in the medical record (e.g., intubated patient).
- (3) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:
 - (a) respiratory function, including respiratory rate, airway patency, and oxygen saturation;
 - (b) cardiovascular function, including pulse rate and blood pressure;
 - (c) mental status;
 - (d) temperature;
 - (e) pain;
 - (f) nausea and vomiting; and
 - (g) post-operative hydrations.
- (4) Patients will be discharged from the recovery area by a qualified practitioner according to criteria approved by the American Society of Anesthesiologists ("ASA"), using a post-anesthesia recovery scoring system. Post-operative documentation will record the patient's discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

- (5) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.
- (6) When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

7.E. MINIMAL, MODERATE OR CONSCIOUS SEDATION

All patients receiving minimal, moderate or conscious sedation will be monitored and evaluated before, during, and after the procedure by a trained practitioner. However, no pre-anesthesia evaluations, intraoperative anesthesia reports or post-anesthesia evaluations are required.

7.F. DIRECTION OF ANESTHESIA SERVICES

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE 8

PROCEDURES FOR OBSTETRICAL CARE

8.A. ADMISSION

- (1) Obstetrical patients may be admitted on a 24-hour basis via the emergency department or admitting office. Nursing personnel shall notify the attending physician when the patient is admitted.
- (2) In the event a pregnant patient is admitted to a department other than the Department of Obstetrics and Gynecology, a consultation is required with a member of the Department of Obstetrics and Gynecology unless the responsible practitioner has obstetrics privileges.

8.B. REQUIRED LABORATORY PROCEDURES

A standard OB panel, including HIV, should be performed prior to admission of the obstetrical patient and recorded on the prenatal record. If not performed prior to admission, then such laboratory procedures must be performed upon admission. Cord bloods shall be sent to the laboratory for all deliveries to determine potential incompatibility when indicated based on maternal blood type.

8.C. VAGINAL EXAMINATIONS

Vaginal examinations shall be performed on obstetrical patients as may be set forth in Hospital policy or as is recognized by ACOG.

8.D. MEDICAL RECORD AND BIRTH CERTIFICATE

- (1) An obstetrical patient's medical record shall include findings during the prenatal period, which shall be available in the obstetrics department prior to the patient's admission and shall include the medical and obstetrical history, observations and proceedings during labor, delivery and postpartum period, and laboratory and x-ray findings.
- (2) Birth certificates are the joint responsibility of the Hospital and the delivering physician (or other member of the health care team), who must provide the medical information required by the certificate within 48 hours after the birth occurs.

8.E. IDENTIFICATION

The Hospital means of patient identification shall be attached to the mother and newborn infant before they are removed from the delivery room, or operating room in the case of a caesarean section.

8.F. RECOVERY ROOM

The attending practitioner shall remain in the delivery room or operating room area until the patient is stable and admitted to her room or the recovery room. The attending practitioner shall subsequently examine the patient and issue appropriate orders. If the patient has been admitted to the recovery room, the attending practitioner shall examine the patient and issue appropriate orders to discharge the patient from the recovery room. In cases of caesarean section, the anesthesiologist is authorized to act on behalf of the attending physician in issuing orders to discharge the patient from the recovery room. If postpartum hemorrhage is observed during recovery, the attending practitioner shall be notified immediately and shall return to reexamine the patient and to determine the appropriate therapy.

8.G. ATTIRE

Anyone entering the delivery room suite must be properly attired according to hospital policy.

ARTICLE 9

PHARMACY

9.A. GENERAL RULES

- (1) Orders for drugs and biologicals are addressed in the Medical Orders Article 4.
- (2) Blood transfusions and intravenous medications will be administered in accordance with state law and approved policies and procedures.
- (3) Adverse medication reactions, transfusion reactions, and errors in administration of medications will be immediately documented in the patient's medical record and reported to the attending physician, the director of pharmaceutical services, and, if appropriate, to the Hospital's quality assessment and performance improvement program.
- (4) The pharmacy may substitute an alternative equivalent product for a prescribed brand name as approved by the Pharmacy and Therapeutics Committee.
- (5) Except for investigational or experimental drugs in a clinical investigation, all drugs and biologicals administered will be listed in the latest edition of: United States Pharmacopeia, National Formulary, or the American Hospital Formulary Service.
- (6) The use of investigational or experimental drugs in clinical investigations will be subject to the rules established by the Medical Executive Committee and the Institutional Review Board.
- (7) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to members of the Medical Staff, other practitioners and Hospital staff.

9.B. STORAGE AND ACCESS

- (1) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, consistent with federal and state law.
 - (a) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.
 - (b) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.

- (c) Only authorized personnel may have access to locked or secure areas.
- (2) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the President.

ARTICLE 10

RESTRAINTS, SECLUSION, AND BEHAVIOR MANAGEMENT PROGRAMS

Restraints, seclusion, and behavior management programs will be governed by the Medical Staff policy entitled "Patient Restraints."

ARTICLE 11

EMERGENCY SERVICES

11.A. GENERAL

Emergency services and care will be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care will be provided without regard to the patient's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, sexual orientation or ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

11.B. MEDICAL SCREENING EXAMINATIONS

- (1) Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:
 - (a) Emergency Department:
 - (i) members of the Medical Staff with clinical privileges in Emergency Medicine;
 - (ii) other Active Staff members;
 - (iii) Residents; and
 - (iv) appropriately credentialed Allied Health Professionals acting in accordance with Hospital policy and procedure.
 - (b) Labor and Delivery:
 - (i) members of the Medical Staff with OB/GYN privileges;
 - (ii) Residents;
 - (iii) physician assistants and nurse practitioners with appropriate privileges;
 - (iv) Certified Nurse Midwives with appropriate privileges; and

- (v) Registered Nurses who have achieved competency in Labor and Delivery, who have validated skills to provide fetal monitoring and labor assessment, and who are operating under standardized procedures.
- (2) The results of the medical screening examination must be documented within 48 hours of the conclusion of an Emergency Department visit.

11.C. ON-CALL RESPONSIBILITIES

It is the responsibility of the scheduled on-call physician to respond to calls from the Emergency Department in accordance with Medical Staff and Hospital policies and procedures.

ARTICLE 12

DISCHARGE PLANNING

12.A. WHO MAY DISCHARGE

- (1) Patients will be discharged only upon the order of a responsible Practitioner.
- (2) At the time of discharge, the discharging practitioner will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.
- (3) If a patient insists on leaving the Hospital against medical advice, or without proper discharge, a notation of the incident will be made in the patient's medical record, and the patient will be asked to sign the Hospital's release form.

12.B. IDENTIFICATION OF PATIENTS IN NEED OF DISCHARGE PLANNING

- (1) All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will be identified at an early stage of hospitalization. The Hospital should reevaluate the needs of the patients on an ongoing basis, and prior to discharge, as they may change based on the individual's status.
- (2) Criteria to be used in making this evaluation include:
 - (a) functional status;
 - (b) cognitive ability of the patient; and
 - (c) family support.

12.C. DISCHARGE PLANNING

- (1) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The responsible practitioner is expected to participate in the discharge planning process.
- (2) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

12.D. DISCHARGE OF MINORS AND INCOMPETENT PATIENTS

Any individual who cannot legally consent to his or her own care will be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual will so state in writing and the statement will become a part of the permanent medical record of the patient.

12.E. DISCHARGE INSTRUCTIONS

- (1) Upon discharge, the responsible practitioner, along with the Hospital staff, will provide the patient with information regarding why he or she is being discharged and educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.
- (2) Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or representative will be provided appropriate language resources to permit him or her to understand.
- (3) The responsible practitioner, along with the Hospital staff, will also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.
- (4) When the Hospital determines the patient's transfer or discharge needs, the responsible practitioner, along with the Hospital staff, promptly will provide appropriate information to the patient and the patient's family when it is involved in decision-making and ongoing care.
- (5) When continuing care is needed after discharge, the responsible practitioner, along with the Hospital staff, will provide appropriate information to the other health care providers, including:
 - (a) the reason for discharge;
 - (b) the patient's physical and psychosocial status;
 - (c) a summary of care provided and progress toward goals;
 - (d) community resources or referrals provided to the patient; and
 - (e) discharge medications.

ARTICLE 13

TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

13.A. TRANSFER

The process for providing appropriate care for a patient, during and after transfer from the Hospital to another facility, includes:

- (1) assessing the reason(s) for transfer;
- (2) establishing the conditions under which transfer can occur;
- (3) evaluating the mode of transfer/transport to assure the patient's safety; and
- (4) ensuring that the organization receiving the patient also receives necessary medical information and assumes responsibility for the patient's care after arrival at that facility.

13.B. PROCEDURES

- (1) Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The responsible practitioner will take the following steps as appropriate under the circumstances:
 - (a) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;
 - (b) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;
 - (c) involve the patient and all appropriate practitioners, Hospital staff, and family members involved in the patient's care, treatment, and services in the planning for transfer; and
 - (d) provide the following information to the patient whenever the patient is transferred:
 - (i) the reason for the transfer;
 - (ii) the risks and benefits of the transfer; and
 - (iii) available alternatives to the transfer.

- (2) When patients are transferred, the responsible practitioner will provide appropriate information to the accepting practitioner/facility, including:
 - (a) reason for transfer;
 - (b) significant findings;
 - (c) a summary of the procedures performed and care, treatment and services provided;
 - (d) condition at discharge;
 - (e) information provided to the patient and family, as appropriate; and
 - (f) working diagnosis.

- (3) When a patient requests a transfer to another facility, the responsible practitioner will:
 - (a) explain to the patient his or her medical condition;
 - (b) inform the patient of the benefits of additional medical examination and treatment;
 - (c) inform the patient of the reasonable risks of transfer;
 - (d) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and
 - (e) provide the receiving facility with the same information outlined in paragraph (2) above.

13.C. EMTALA TRANSFERS

The transfer of a patient with an emergency medical condition from the Emergency Department to another hospital will be made in accordance with the Hospital's applicable EMTALA policy.

ARTICLE 14

HOSPITAL DEATHS AND AUTOPSIES

14.A. DEATH AND DEATH CERTIFICATES

- (1) In the event of a patient death in the Hospital, the deceased will be pronounced dead by the attending physician, his or her designee, or the Emergency Department physician, within a reasonable time frame.
- (2) The medical certification of the cause of death within the death certificate will be completed by the attending physician (or his or her designee) within 24 hours of when the certificate is made available.
- (3) The attending physician will collaborate with Hospital personnel to ensure that the Coroner Unit of the Sonoma County Sheriff's Office is notified of any cases that come under coroner jurisdiction.

14.B. RELEASE OF THE BODY

- (1) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made in the deceased patient's medical record by the attending physician (or his or her designee) or other designated member of the Medical Staff.
- (2) It is the responsibility of the attending physician (or his or her designee) to notify the coroner/medical examiner of any cases considered by law a coroner/medical examiner's case.

14.C. ORGAN AND TISSUE PROCUREMENT

All suitable organ or tissue donors will routinely be afforded the opportunity to consent to donation in accordance with Hospital policy.

14.D. AUTOPSIES

Autopsies will be addressed under the Medical Staff Autopsy Criteria Policy.

14.E. DO NOT RESUSCITATE ("DNR") POLICY

The Medical Staff will administer care in accordance with Hospital policy, for those competent adult patients or the parent of an infant, neonate or minor child who knowingly chooses to forgo treatment.

ARTICLE 15

MISCELLANEOUS

15.A. HIPAA REQUIREMENTS

All members of the Medical Staff and Allied Health Professional Staff will adhere to the security and privacy requirements of HIPAA, meaning that only a responsible practitioner may access, utilize, or disclose protected health information.

15.B. SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS

- (1) Members of the Medical Staff are strongly discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.
- (2) A member of the Medical Staff should not admit or perform an invasive procedure on a member of his or her immediate family, including spouse, parent, child, or sibling, except in the following circumstances:
 - (a) no viable alternative treatment is available, as confirmed through discussions with the Chief of Staff or the President;
 - (b) the patient's disease is rare or exceptional and the physician is considered an expert in the field;
 - (c) in the Emergency Department where the Medical Staff member is the attending physician or is on call; or
 - (d) in an emergency where no other Medical Staff member is readily available to care for the family member.

This prohibition is not applicable to in-laws or other relatives.

15.C. ORIENTATION AND TRAINING FOR NEW PRACTITIONERS

Each new practitioners will be provided with an orientation to the Medical Staff, the Hospital and its operations. This is designed to ensure that new staff members are assisted in the performance of their duties.

All new applicants seeking clinical privileges will be advised that they must complete any required training within ninety (90) days of approval of their applications. Any practitioner not completing the required training during this period will be automatically suspended until such

time training is completed.

Practitioners are required to complete New Member Orientation, Crew Training, and EMR Training. Those practitioners who have completed CREW or Team Steps training at another hospital may submit evidence of completion in lieu of completing this training.

The Chief of Staff is authorized to make an exception to this policy on an emergent basis which involves an important patient care need.

Failure to complete the required training that caused the automatic suspension of clinical privileges shall constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges at the time of reappointment.

15.D. EDUCATION & TRAINING FOR ALL PRACTITIONERS

Annually, Practitioners will receive an education packet to review for current information on Hospital and regulatory requirements and policies.

The Medical Executive Committee may also mandate other training as necessary for education and compliance concerns. If required to be completed, a date for compliance will be set. Any practitioner not completing the required training during this period will be automatically suspended until such time training is completed.

The Chief of Staff is authorized to make an exception to this policy on an emergent basis which involves an important patient care need.

Failure to complete any required training shall constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges at the time of reappointment.

ARTICLE 16

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 9 of the Medical Staff Bylaws.

ARTICLE 17

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations, policies, manuals of the Medical Staff, or the Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on: June 12, 2018

Approved by the Board on: June 26, 2018