MEDICAL STAFF RULES AND REGULATIONS

MC KEE MEDICAL CENTER

Loveland, Colorado

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MCKEE MEDICAL CENTER

PART 1: ADMISSION OF PATIENTS

1.2. GENERAL ADMISSION RULES

A patient may be admitted to the hospital only by an active or consulting physician member of the medical staff permitted by state licensure and hospital privileges to admit patients. All practitioners shall be governed by the official policy of the hospital.

All diagnostic and treatment services of the hospital shall be under the direction of a staff member.

In the event a medical staff officer is unavailable to perform an assigned function, the order of medical staff officer succession to perform the function is as follows:

A. Department Chair.
B. Department Vice-chair
C. Chief of Staff
D. Chief of Staff-Elect – Secretary-Treasurer
E. Any Past Chief of Staff
F. Any member of the Medical Executive Committee

1.3. ADMITTING PREROGATIVES

1.3-1. GENERAL REQUIREMENTS

A single physician member of the medical staff or his designee shall be responsible for the medical care and treatment of each patient in the hospital, for the completeness and accuracy of the Medical Record, for necessary special instructions and for transmitting reports of 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 admitting physician shall be responsible unless otherwise specified. All patients admitted to the hospital must have written or verbal orders.

Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the cases of an emergency, such statement shall be recorded as soon as possible.

1.3-2. LIMITATION FOR DENTISTS/PODIATRISTS

The admission of a patient for dental/podiatric services is a dual responsibility involving the podiatric physician (DPM) or dentist (DDS, DMD) and MD or DO member of the medical staff with exception of graduates of a qualified oral surgery program who may admit patients without serious medical problems and may perform the history and physical examination on those patients and may assess the medical risks of the proposed surgical procedures. Dentists and allied health practitioners may complete the history and physical only if granted the privilege through the credentialing process.

The dentist and podiatrists responsibilities are:

- Provide a detailed dental or podiatric history justifying hospital admission.
- Provide a detailed description of the dental/podiatric examination, including when indicated, the initial and final diagnosis surgery and prognosis.
- A complete operative report.
- Write orders for services and medications as they relate to the dental/podiatric care rendered.
- Write progress notes and final summary as they relate to the dental/podiatric care rendered.
- Write the discharge order. When the patient is being treated for a medical condition, discharge shall be in concurrence with the MD or DO.

The MD or DO responsibilities are:

- Perform a medical history and physical examination.
- Provide for overall care of the patient's general health during the hospital stay.
- Write orders for services and medications for the general care of the patient.

1.4. ADMISSION PRIORITIES BASED ON PATIENT CONDITION

In situations when hospital beds are not available, patients will be admitted on the basis of the following priorities:

A. Emergency admissions.

B. Preoperative admissions in which the surgical procedure has been previously scheduled.

C. Routine elective admissions. This will include elective admission involving all services.

D. For admissions to the ICU/CCU, refer to the admission criteria listed in the directives of the appropriate special care unit.

E. Areas of restricted bed utilization and assignment of patients shall be as follows:

- Nursery – newborns who are born within the hospital environment.
- Postpartum – non-infective patients.

1.5. OBSERVATION STATUS POLICY

When a patient is admitted for observation services, an observation note shall be recorded reflecting that the patient is being seen and evaluated in the hospital. This note shall include the clinical rationale for the decision for observation with a pertinent history and relevant physical findings to support the observation services. If the patient is changed to inpatient status, a complete history and physical must be recorded within 24 hours of the status change if the history and physical was not completed at the time of admission to observation status.

1.6. TIMELY VISITATION AFTER PATIENT ADMITTED

Each member of the medical staff must assure timely, adequate professional care for patients who present to the Emergency Department or who have been admitted to the hospital. The medical staff member must be available or have eligible alternative physician coverage with whom prior arrangements have been made.

The on-call physician is responsible for finding alternative coverage when unable to attend to the patient. If the on-call physician cannot respond because of situations beyond the physician's control, the Emergency Department will attempt to locate another appropriate physician to care for the patient. After exhausting facility resources and stabilizing the patient within the hospital's capability, the Emergency Department will arrange for transfer to another institution.

A refusal or failure to timely respond to disputes as to coverage responsibilities shall be immediately reported to the Chief of Staff and hospital administrator, who shall address the situation. Concerns regarding on-call compliance should be reported to risk management and quality management.

1.7. NEED FOR CONTINUED HOSPITALIZATION

The attending practitioner is required to document the need for continued hospitalization. This documentation shall contain:

- An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
- An estimated period of time the patient will need to remain in the hospital.
- Plans for post hospital care.

PART 2: ASSIGNMENT AND ATTENDANCE OF PATIENTS

2.1. MEDICAL SCREENING EXAMINATION

A patient presenting to the Emergency Department for evaluation/treatment will be offered a medical screening examination by the emergency department physician or qualified medical personnel (QMP) on duty. For stable patients, a physician other than the emergency department physician may evaluate/treat private patients in the emergency department as long as there is no delay in the medical screening evaluation and treatment and if selection of patients is not based on insurance coverage. If the emergency department personnel cannot contact the referring medical staff member within 15 minutes of the patient's arrival, the emergency department physician may elect to proceed with the treatment of the patient. If a patient or designated representative refuses a medical screening examination the medical staff if requested, will inform the patient of the risks and benefits of refusal. The Medical Staff will comply with the Banner Health policies: "EMTALA – Medical Screening Examination and Stabilization Treatment" and "Qualified Medical Personnel Authorized to Perform Medication Screening Examinations".

When the medical screening exam (MSE) indicates that the patient has an emergency medical condition, the Emergency Department physician or QMP, may request the services of members of the medical staff. For unassigned patients or patients for whom the attending physician is unavailable or does not have privileges, the Emergency Department physician will contact the appropriate physician on the unassigned patient call schedule. The on-call physician shall respond to the emergency department within 30 minutes and be available within a reasonable amount of time. An unassigned patient who requires admission shall be assigned to the appropriate on-call physician.

2.2. ATTENDANCE OF PATIENTS

Each member of the medical staff who cares for patients whether as an inpatient or outpatient or in the emergency room shall at all times provide continuing care for their patients.

In the attending physician's absence, he shall provide a central authority, i.e. answering service and Emergency Department, with a name or name of back-up physician coverage.

All physicians must submit a list of physicians who have agreed to provide coverage for continuing patient care in his absence or unavailability.

If a patient is being treated by more than one physician during their stay in the hospital, the admitting practitioner shall be considered the attending practitioner, unless arrangements have been made with another practitioner.

2.3. TERMINATION OF PATIENT RELATIONSHIP

In the event an inpatient terminates the physician relationship, the attending physician is responsible for continuing care of the patient until another physician assumes care.

In the event a physician requests termination of a patient relationship, the physician may relinquish care of the patient as soon as another physician is secured. In either case, the patient, with the assistance of the Care Coordination Department, will secure a new physician. If another physician cannot be secured after exhausting all options, the chair of the department wherein the attending physician has clinical privileges or the chief of staff shall be contacted for assistance.

2.4. PARTICIPATION IN THE UNASSIGNED PATIENT CALL SCHEDULE

2.4-1. GENERAL REQUIREMENTS

The Medical Staff will comply with the "Guidelines for Unassigned Patient Call". An appropriate unassigned patient call schedule will be established. All medical staff members with privileges may be assigned to such schedule, based on Department recommendations and hospital services, except for:

2.4-2. EXEMPTIONS

- Those physicians whose primary department is Emergency Medicine.
- Those excused by practitioner's department of affiliation.

2.4-3. EMERGENCY ON-CALL COVERAGE

The medical staff shall adopt a method of providing medical coverage for emergency services. This shall be in accord with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care. The Medical Executive Committee shall supervise unassigned patient call schedules through each department.

Each clinical department is required to define their on-call coverage for the emergency patient care in the departmental rules and regulations.

PART 3: GENERAL RESPONSIBILITY FOR CONDUCT OF CARE

3.1. POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE

If a nurse has reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse shall contact the attending physician to see if the matter can be rectified. If the nurse continues to have doubt, the nurse shall call this to the attention of the nurse's supervisor who in turn may refer the matter to the Chief Nursing Officer. If warranted, the Chief Nursing Officer or nurse's representative may bring the matter to the attention of the chief of the department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the chief of the department may request a consultation or take over management of the patient after attempting to notify the attending physician. If the patient or the patient's legal representative wishes a change of physician, the patient may request so according to Section 2.3.

3.2. CONSULTATIONS

Except in an emergency, consultations with another qualified physician should be obtained according to the judgment of the attending physician for the following:

- The patient is not a good medical or surgical risk;
- The diagnosis is obscure after ordinary diagnostic procedures have been completed;
- There is doubt to the best therapeutic measures to be utilized; or
- The patient or family requests a consultation.

Medical Staff Departments may develop consultation requirements with approval of the Medical Executive Committee. Current consultants who believe the patient requires another appropriate consultation, but the attending physician is not in agreement, should contact the appropriate Department Chair or Chief of Staff. If the patient agrees, the Department Chair or Chief of Staff may request consultation.

The attending physician is responsible for requesting the consultation in writing specifying the individual physician, physician group practice or consultation specialty.

A satisfactory consultation includes examination of the patient as well as the Medical Record. When nonemergency operative procedures are involved, the consultation will be recorded prior to the operation.

3.3. PSYCHIATRIC PATIENTS

For the protection of patients, the medical and nursing staffs and the hospital, precautions to be taken for the patient with a psychiatric or substance-abuse problem includes:

- Any patient known or suspected to require psychiatric or substance-abuse services in intent shall be transferred to a mental health unit unless the patient's physical condition dictates another appropriate unit. If there are no accommodations available in this area, the patient shall be referred, if possible, to another institution where suitable facilities are available
- Any patient known to be suicidal shall have evaluation by a member of the psychiatric staff and the nursing staff should be notified by a note on the order sheet.

The admitting practitioner shall provide such information known to the practitioner as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever the practitioner's patient might be a source of danger to themselves and others.

PART 4: TRANSFERS OF PATIENTS

4.1. INTERNAL TRANSFERS

When a patient is transferred within McKee Medical Center from the hospital to the transitional care unit or rehabilitation living center, a transfer summary may be substituted for the clinical resume. The transfer summary briefly describes the patient's condition at the time of transfer and the reason for the transfer.

4.2. TRANSFER TO ANOTHER FACILITY

Transfer of an emergency department or obstetrical patient to another hospital may be considered under the following circumstances:

- The patient is stable for transfer;
- The patient or patient representative requests transfer after being informed of the hospital's obligation to provide stabilizing care and risks/benefits of transfer;
- The physician concludes and certifies the benefits of transfer outweigh the risks of transfer.

The hospital must have a person-to-person contact at the receiving facility. The transfer is affected through appropriate means consisting of the necessary qualified personnel and transportation equipment including the use of required life support measures. The transferring patient is to receive stabilizing treatment within the capability of McKee Medical Center and its medical staff. The medical

staff will assist and participate in transfer requirements including an informed patient consent to transfer, patient refusal of transfer including an explanation of the hospital obligations and risks and benefits of refusing transfer, and sending the Medical Records relating to the medical condition to the accepting facility. If the transfer results from refusal or failure of the on-call physician to come to the hospital within a reasonable period of time, the name and address of the on-call physician will be sent to the accepting facility with the patient.

The emergency department or private attending physician may transfer an unstable patient to a private office or hospital at the request of the physician on-call only if McKee Medical Center does not have access to specialized equipment to fully evaluate and treat the patient that is available in the other setting. Stable patients may be discharged and sent to an office as indicated or desired by the on-call physician.

4.3. TRANSFER FROM ANOTHER FACILITY

If McKee Medical Center has the capacity, McKee Medical Center will accept the appropriate transfer of a patient who requests or requires the specialized capabilities of the hospital regardless of financial consideration or proximity of the other hospital.

PART 5: DISCHARGE OF PATIENTS

5.1. REQUIRED ORDER

The attending practitioner determines that a patient is stable for discharge or transfer. Patients shall be discharged only on the order of the attending practitioner or designated alternate practitioner. Should a patient leave the hospital prior to a medical screening examination and/or against the advice of the attending practitioner or without proper discharge, a notation of the occurrence shall be made in the patient's Medical Record and the patient will be requested to sign the appropriate acknowledgement form.

PART 6: ORDERS

6.1. GENERAL REQUIREMENTS

All orders shall be authenticated, dated and signed as soon as possible by the prescribing practitioner. All Medical Record entries must be dated at the time of entry. An order shall be considered to be in writing if dictated to an appropriate professional (e.g. registered nurse, respiratory therapist, physical therapist, occupational therapist, medical technologist, radiology technologist, CRNA, EEG technologist, dietician, pharmacist, speech pathologist, social worker, or licensed practical nurse), recorded in the Medical Record, and signed or initialed by the prescribing practitioner. In communicating a verbal order, the prescribing

practitioner will identify him/herself and the patient, and the individual receiving the order will document the order and read back the order to the prescribing practitioner for confirmation. Verbal/telephone orders for antineoplastic agents will not be permitted under any circumstances.

6.2. STANDING ORDERS

Standing orders may be formulated by staff physicians and approved by the appropriate medical staff department and referred to the Medical Executive Committee for consideration. If approved by the Medical Executive Committee, standing orders shall be recommended to the administrator for implementation. The standing orders may be changed by administration only after conference with the MEC. These orders shall be followed insofar as proper treatment of the patient will allow. When specific orders are not written by the attending physician, the standing orders shall constitute the orders for treatment. All standing orders shall be authenticated by the responsible physician within twenty-four (24) hours.

A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner.

6.3. UNACCEPTABLE ORDERS

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

6.4. VERBAL/TELEPHONE ORDERS

Practitioners will comply with the hospital and medical staff policy for verbal and telephone orders. Authentication of a verbal order must occur within 48 hours after the time the order is given unless a read-back and verify process is followed. If the read-back and verify process is followed, the verbal order shall be authenticated within 30 days after the patient's discharge date.

If an emergency department patient requires injections of schedule II substances, they shall be evaluated at the time of admission by the physician ordering the narcotics, that is, personal physician or emergency department physician.

6.5. AUTOMATIC CANCELLATION OF ORDERS

All previous orders are cancelled when patients go to surgery and must be renewed.

6.6. SPECIAL ORDERS

6.6-1. DO NOT RESUSCITATE ORDERS

When indicated, a Do Not Resuscitate (DNR) order must be documented in the Medical Record as in accordance with guidelines established by the medical staff in policies and procedures reviewed by the Critical Care Committee and approved by the Medical Executive Committee.

6.6-2. RESTRAINT AND SECLUSION ORDERS

When initial use of restrains is employed, a physician's verbal or written order is obtained within one (1) hour and authenticated within twenty-four (24) hours by the ordering or covering physician. The physician's order must be time limited (how long the patient is to remain in restraints), not to exceed twenty-four (24) hours. A new order must be obtained for each new episode requiring restraints or if restraints are removed for more than sixty (60) minutes (providing patient is not under continuous observation) prior to the termination of previous time limited order. Restraint orders must be reviewed every twenty-four (24) hours or restraints will automatically be terminated.

6.6-3. CRITCAL CARE

If any questions as to the validity of admission to or discharge from the critical care unit should arise, that decision is to be made through consultation with the chair of the Critical Care Committee. In the chair's absence, the chief of medicine or chief of surgery, whichever is appropriate, shall decide.

Admission and discharge criteria for the Intensive Care Unit will be used by the Critical Care Committee for retrospective monitoring purposes when needed.

6.7. FORMULARY AND INVESTIGATIONAL DRUGS

All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Services or AMA Drug Evaluations.

Investigational drugs, properly labeled, shall be used only under the direct supervision of the principal investigator and should be approved by the Institutional Review Board and the Medical Executive Committee. Nurses who administer these drugs will be given basic pharmacologic information about the drug.

PART 7: MEDICAL RECORDS

7.1 GENERAL

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.

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.

7.2 PURPOSES OF THE MEDICAL RECORD

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

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;

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

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

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.

7.3 ELECTRONIC MEDICAL RECORDS (EMR)

Banner Health is a "paper light" organization. As such, physicians need to adhere to record keeping practices that support the electronic environment. Data will be created electronically as much as possible 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.

7.3-1 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.

7.3-2 EXCEPTIONS

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.

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.

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

7.3-3 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.

7.3-4 EMR TRAINING

Practitioners who are appointed to the Medical Staff or Allied Health Staff after April 12, 2012 pending Banner electronic Medical Record training (EMR) and who have not completed this training within six (6) months of appointment will be considered to have voluntarily resigned from the staff. Practitioners will be advised of the training requirement at or prior to appointment and reminded of the requirement five (5) months from the date of appointment. Exceptions will be made on a case-by-case basis to be determined by the facility CEO.

7.3-5 PASSWORDS

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

7.4 RETENTION OF RECORDS

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

7.5 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.

7.6 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.

7.7 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.

7.8 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.

7.9 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.

7.10 COUNTER-AUTHENTICATION (ENDORSEMENT)

7.10-1 PHYSICIAN ASSISTANTS

History and Physical Reports, Operative/Procedural Notes, Consultations and Discharge Summaries must be counter-authenticated timely by the physician according to individual facility medical staff policies. 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.

7.10-2 NURSE PRACTITIONERS

History and Physical Reports, Operative/Procedural Notes, Consultations and Discharge Summaries must be counter-authenticated timely by the physician according to individual facility medical staff policies. 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.

7.10-3 MEDICAL STUDENTS

First and second year students: access to view the patient chart only; may not document in the Medical Record. Third and fourth year students: any and all documentation and orders (if permitted) must be endorsed (countersigned, counter-authenticated) timely by the physician.

7.10-4 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.

7.11 LEGIBILITY

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

7.12 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:

- 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.
- A consultant to render an opinion after an examination of the patient and review of the health record.
- Another practitioner to assume care of the patient at any time.
- Retrieval of pertinent information required for utilization review and/or quality assurance activities.
- Accuracy of diagnosis/procedure coding in response to coding queries.

7.13 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 H&P's no more than 30 days prior to or 24 hours after hospital admission or registration but prior to surgery or a procedure requiring anesthesia services. The completed H&P must be on the Medical Record prior to surgery or any procedure requiring anesthesia services (regardless of whether care is being provided on an inpatient or outpatient basis) or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient. For patients admitted to a Rehabilitation Unit, the admitting rehabilitation physician must conduct an H&P that includes all required elements. A physician extender may complete the H&P but the rehabilitation physician must visit the patient and must assure that all required parts of the post-admission evaluation are completed within 24 hours of admission. A legible office H&P performed within 30 days (7 days for Nevada) prior to admission is acceptable with an updated Medical Record entry documenting an evaluation 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 H&P elements are included and the document is filed as a History and

Physical on the EMR. The Obstetrical H&P will consist of the prenatal record, where applicable, updated in the EMR by the responsible physician or Allied Health professional.

All procedures requiring anesthesia services require an H&P prior to being performed, except in an emergency, and include but are not limited to:

- Main OR procedures
- Ambulatory Surgeries
- C-section deliveries/tubal ligations
- Endoscopies
- Interventional Cardiac Procedures – Permanent Pacemakers
- 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
- Venograms
- Transesophageal Echocardiogram (TEE)
- Cardioversions
- Bone Marrow Studies
- Lumbar Punctures

7.14 RESPONSIBILITY FOR H&P

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

7.15 CONTENT OF H&P

For all inpatients, observation patients, and for those outpatients undergoing procedures requiring anesthesia services, the H&P must include the following documentation as appropriate:

- Chief complaint;
- Medical history;
- History of the current illness, including, when appropriate, assessment of emotional, behavioral, mental, and social status;

- Relevant past medical, family and/or social history appropriate to the patient's age;
- Review of body systems.
- A list of current medications and dosages.
- Any known allergies including past medication reactions and biological allergies
- Existing co-morbid conditions
- Physical examination: current physical assessment
- Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
- Initial plan: Statement of the course of action planned for the patient while in the Medical Center.
- Indications/symptoms for the procedure;
- Exam specific to the procedure performed;
- For patients receiving IV moderate sedation, all of the above elements above, plus the following:
    - Examination of the heart and lungs by auscultation;
    - American Society of Anesthesia (ASA) status;
    - Documentation that patient is appropriate candidate for IV moderate sedation.

7.16 EMERGENCY DEPARTMENT REPORTS

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

- Time and means of arrival;
- 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;
- Clinical observations, including results of treatment;
- Diagnostic impressions;
- Condition of the patient on discharge or transfer;
- Whether the patient left against medical advice;
- The conclusions at the termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment and services.

7.17 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.

7.17-1 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.

7.18 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).

7.19 PRE-OPERATIVE, INTRA-OPERATIVE & POST ANESTHESIA/SEDATION RECORD FOR GENERAL, REGIONAL OR MONITORED ANESTHESIA

7.19-1 PRE-OPERATIVE ANESTHESIA/SEDATION EVALUATION

A preanesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or conscious sedation within 48 hours prior to the procedure. A pre-anesthesia 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.

7.19-2 INTRA-OPERATIVE ANESTHESIA/SEDATION RECORD

The intra-operative 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.

7.19-3 POST-ANESTHESIA EVALUATION

The post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia 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.

7.20 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. 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 24 hours of the procedure.

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.

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.

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.

7.21 INFORMED CONSENT

Prior to any operative/invasive procedures, the Medical Record must contain an informed consent. See Part 8.

7.22 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.

7.23 DISCHARGE DOCUMENTATION

A discharge summary must be documented at the time of discharge but no later than 24 hours thereafter 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. Any newborn patient admitted to the Special Care Unit or transported from the Newborn Nursery to a Level III Nursery will be required to have a dictated discharge summary. Exception is newborns admitted to the Special Care Nursery for observation of eight (8) hours or less. The discharge summary shall include:

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

7.24 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.

7.25 DOCUMENTATION FOR INPATIENT TRANSFER 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

7.26 AMENDING MEDICAL RECORD ENTRIES

7.26-1 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. After 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.

7.26-2 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.

7.27 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.

7.28 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 when there is a delay in the availability of the full report	
Provider Coding Query	Complete within 7 days 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 notice	
Discharge Summary Report	Documented at the time of 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	

7	discharge for all admissions less than 48hrs or for normal vaginal deliveries and normal newborns	
Death Summary 7.29 MEDICAL RECORD	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.	
Home Health (Face to Face Discharge Documentation)	Completed within 30 days of discharge.	
Transfer Summary	Documented at the time of transfer 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 Alaska = 72 hours Arizona = 72 hours California = 48 hours Colorado = 48 hours Nebraska = 48 hours Nevada = 48 hours Wyoming = 24 hours	Dated, time and authenticated within the timeframe specified by state regulation	
Psychiatric Evaluation	Documented within 24 hours of admission	

7.28-1 COPYING AND PASTING

Medical Staff members and Allied Health Professional 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 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 dates 6/1/10."

7.29 MEDICAL RECORD DEFIENCIES

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 7.28. The notice will include a due date and a list of all incomplete and delinquent Medical Records. If a vacation prevents the practitioner from completing his/her Medical Records the physician must notify the Health Information Services Department in advance of the vacation; otherwise the suspension/sanction will remain in effect until the documentation is completed. If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her Medical Records, the physician or the physician's office must notify the Health Information Management Services Department.

7.30 MEDICAL RECORD SUSPENSIONS/SANCTIONS

A Medical Record is considered eligible for suspension/sanction based on the timeframes in Section 7.28. If the delinquent records are not completed in a timely manner, providers will receive a notice and their admitting and surgical/procedure scheduling privileges will be temporarily suspended until all Medical Records are completed. A suspension/sanction list will be generated weekly and made available to the Executive Committee, Department Chairs, Administration, Medical Staff Services, Patient Registration, Patient Placement, Emergency Department, Cardiology, Inpatient and Outpatient Surgery areas. It is the responsibility of the physician to arrange coverage for the care of current patients and coverage for Emergency Department call for which the physician is scheduled.

7.30-1 RESTORATION OF PRIVILEGES

Restoration of privileges can be accomplished by completing all delinquent records assigned to the suspended physician. Health Information Management Services Department will immediately notify the appropriate departments upon completion of delinquent records so the suspension of the practitioner may be removed and appropriate departments informed.

7.31 AUTOMATIC TERMINATION OF PRIVILEGES FOR DELINQUENT MEDICAL RECORDS

Suspension of privileges or revocation of membership and privileges under this Section does not entitle a staff member to rights pursuant to the Fair Hearing Plan. Physicians may submit evidence demonstrating why the suspension/revocation is unwarranted to the Medical Executive Committee.

PART 8: CONSENTS

8.1. GENERAL

A general consent form, signed by or on behalf of every patient admitted to the hospital must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained.

8.2. INFORMED CONSENT

The surgeon is responsible for obtaining informed consent for surgery. The surgeon is responsible for discussing the planned procedure, the risks, the benefits, the potential complications and the alternatives, including the need to administer blood and blood components, with the patient and family prior to anesthesia or sedation. The surgeon is responsible for providing the documented and authenticated informed consent to the appropriate surgical area at McKee Medical Center prior to the surgery. In emergency cases in which death or serious harm would occur and informed consent for surgery cannot be immediately obtained from the patient or authorized representative, the surgeon documents the circumstances in the Medical Record.

A general consent form, signed by, or on behalf of, the patient admitted to the hospital, must be obtained from every patient at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not be obtained.

PART 9: SPECIAL SERVICES UNITS AND PROGRAMS

9.1. SPECIAL CARE UNITS

Admission to any special care unit is not restricted to any physician. Physician privileges are delineated by diagnoses, procedure or severity of illness. Any physician having privileges to treat specific categories or patients may admit to units designed for specialty care.

9.2. SURGICAL SERVICES

9.2-1. EMERGENCY AND SCHEDULED CASES

Emergency cases shall take precedence over scheduled surgical cases. The Surgery Department has responsibility for guidelines and determining emergency cases requiring interruption of the scheduled surgical cases. The Surgical Services Department Manager, the Medical Director of Surgical Services, or the Anesthesiologist in charge will be consulted to assist with the decision to schedule procedures on week-ends and holidays.

9.2-2. PRESENCE IN THE OPERATING ROOM

The primary surgeon will be immediately available at the beginning of a surgical procedure for induction of anesthesia. Surgical assistants (excepting physicians) may perform the incision and wound exposure only if granted privilege by the credentialing process and the primary surgeon is scrubbed and is present.

Only authorized personnel will be allowed in surgery or in the delivery room according to the hospital policy on visitors observing in a surgical suite or procedure area.

9.2-3. TISSUE REPORTS/POSSIBLE EXEMPTED CASES

The Pathology Department, in consultation with the Surgery Department and subject to the approval of the Medical Executive Committee, will recommend the guidelines to determine specimens that do not require pathology examination or require only gross examination as specified in the "Policy for Tissues Submitted to Pathology."

The surgeon may have discretion to decide which tissues may require histological examination.

The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include:

- Specimens that by their nature do not permit fruitful examination;
- Therapeutic radioactive sources, the removal of which may be guided by radiation safety monitoring requirements;
- Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;

- Foreign bodies that for legal reasons are given directly in the chain of custody to law enforcement representatives;
- Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics and recorded in the Medical Record; and
- Teeth, provided the number, including fragments, is recorded in the Medical Record.

PART 10: HOSPITAL DEATHS AND AUTOPSIES

10.1. PRONOUNCEMENT

In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or the practitioner's designee within a reasonable time.

10.2. RELEASE OF BODY

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 prior to death.

10.3. AUTOPSIES

Every staff member shall be actively interested in obtaining autopsies whenever appropriate. Permission for autopsy shall be obtained in accordance with legal requirements. All autopsies shall be performed by the hospital pathologist or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the Medical Record within 72 hours and the complete protocol should be made a part of the record within sixty (60) days. Pathologists must date necropsy reports when completed.

PART 11: DISASTER EMERGENCY PLAN

11.1. GENERAL

There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community.

11.2. DISASTER EMERGENCY ASSIGNMENTS

In a disaster, all physicians shall be assigned to posts as needed and it is their responsibility to report to their assigned stations. The chairs of the clinical departments in the hospital will work as a team to coordinate activities and

directions. In cases of evacuation of patients from one section of the hospital to another or evacuation from the hospital premises, the chair of the clinical departments during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the department chairs and the chief executive officer of the hospital. In their absence, the vice-chairs and alternate in administration are next in line of authority respectively.

The disaster plan should be rehearsed at least twice a year or as required by state law or regulations, preferably as a part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the medical staff as well as administrative, nursing and other hospital personnel. Actual evaluation of patients during drills shall be made.

PART 12: PROCEDURE FOR RELEASE OF PATIENT INFORMATION

A written consent for the patient is required for release of medical information to persons not otherwise authorized to receive this information except as allowed by applicable statutes.

PART 13: PRACTITIONER CLINICAL PRIVILEGES

The Credentials Committee shall furnish the Surgical Services Department the approved practitioner's privileges after initial appointment and reappointment.

All medical images taken in the hospital will be read by board-eligible or board-certified radiologists or by physicians approved by the Credentials Committee.

PART 14: CLINICAL DEPARTMENT RULES AND REGULATIONS

Each clinical department may establish regulations and procedural rules governing their section.

PART 15: ADOPTION AND APPROVAL

MEDICAL STAFF: The Medical Staff Rules and Regulations was adopted and recommended to the Governing Board by the Medical Executive Committee.

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Chief of Staff, MC KEE MEDICAL CENTER

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DATE