CHRISTUS
TRINITY MOTHER FRANCES
Health System

MEDICAL STAFF
RULES AND REGULATIONS

A. ADMISSION AND DISCHARGE OF PATIENTS

1. The hospital shall admit patients for the care and treatment of acute diseases.

2. A patient may be admitted to the hospital only by a member of the Medical Staff. A practitioner shall be governed by the official admitting policy of the hospital.

3. Patients must be seen and evaluated by a physician within twenty-four (24) hours of admission and a proper admission history and physical performed and recorded. Patients who are directly admitted from a physician's office and/or who are transferred from another facility, orders received within 1 hour and must be seen, evaluated by a physician within 4 hours of admission. Patients admitted from the Emergency Department must be seen and evaluated by the attending physician within 4 hours of admission. Members of the Medical Staff on-call for the Emergency Department must respond either by presence or telephone call within 30 minutes when called by the Emergency Department physician for consultation or emergent transfer as outlined in the Medical Staff's Transfer Policy. Patients admitted or transferred to any critical care unit must be seen and evaluated by a critical care privileged clinician within 1 hour of admission. Admission time for Emergency Department patients is defined as when the Emergency Department physician calls and the admitting physician accepts the patient as documented in the chart. Admission time for transferred patients will be defined as when the patient arrives in the critical care unit as documented in the chart.

   - Consults are to be physician to physician or with knowledge and consent of the sponsoring physician. Consults also require a consult order that is entered into EPIC. Simply entering a consult order into EPIC does not constitute a consult if physician to physician communication has not taken place.
   - Routine consults-Patient should be seen and evaluated by consultant within 24 hours
   - Urgent consults- Patient should be seen and evaluated at bedside by consultant within 6 hours
   - STAT consults- Physician to physician phone call required. Patient should be seen and evaluated at bedside by consultant as soon as possible and no more than 3 hours

For Level II Trauma, it is expected that the following specialties will respond and evaluate the patient within the time frames listed below:

- Trauma Surgery-15 mins to Level I activation within 60 mins to Level II activation within 90 minutes to a trauma consult
- Anesthesia-within 30 minutes from notification of emergent cases going to OR
- Neurosurgery-within 30 minutes to an emergent consult, within 1 hour to an urgent consult
- Orthopedic Surgery-within 30 minutes to an emergent consult, within 1 hour to an urgent consult
- Interventional Radiology-within 60 minutes from notification of emergent cases going to IR

For Level III NICU Designation, it is expected that the following specialties will respond and evaluate the patient within the time frames listed below for an urgent/STAT request:

- Pediatric Medical and Surgical Subspecialties-within 30 minutes for STAT requests
- Pediatric Echocardiography with Pediatric Cardiology interpretation and consultation-within 2 hours for STAT requests

4. A patient's general medical condition will be managed and coordinated by a physician. The attending physician shall be responsible for the care and treatment of his/her patients in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patients to the referring practitioner and to relatives of the patients.

5. All proceduralists will round at least daily on post op patients. The proceduralist will also document their post op care of the patient in the chart daily until all issues related to the procedure are stabilized and they have signed off on the case. This will not include minor procedures such as outpatient type procedures on patients that are inpatients for other reasons. Minor procedures can include but are not limited to tunnel/infusion port placement, bone marrow biopsies, skin biopsies, knee aspirations, etc.

6. 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 for communication to hospital staff. Physician to physician interactive communication will occur regarding the patient's current condition, treatment/care, and any recent or anticipated changes to provide an opportunity to ask and respond to questions.

7. 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 case of an emergency, such statement shall be recorded as soon as possible.

8. As noted above, it is the responsibility of every physician on call in their specialty to attend a patient in the Emergency Department when requested to do so by the ED physician. It is incumbent upon members of the Medical Staff involved to communicate with each other regarding patient assignment. Should a conflict arise as to which specialty should assume care for a patient which cannot be resolved by the two on call physicians discussing the case either by phone or in person, the Chief of Staff/CMO will be called to render a final decision after consulting with the emergency physician.

9. A practitioner who will be unavailable should, on the order sheet of the chart of each of his patients, indicate in writing the name of the practitioner who will be assuming responsibility for the care of the patient during his absence. In case of failure to name such associate, the Chief Executive Officer, Chief of Staff, Chairman of the department or CMO concerned, shall have authority to call any member of the Active Staff in such an event.

10. The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical department and approved by the Executive Committee.

11. Areas of restricted bed utilization and assignment of patients shall be as follows: Labor and Delivery and Critical Care. Patients may be admitted without regard to the above restrictions only after consultation with the service chief, or his designee, of the geographic areas to which the patient is to be admitted. It is understood that when deviations are made from assigned areas as indicated above, the admitting clerk will correct these assignments at the earliest possible moment with approval of the responsible practitioner, in keeping with transfer priorities.

12. Patient Transfers

    Transfer priorities shall be as follows:

    a. Emergency Room to appropriate patient bed.

    b. From obstetric patient care area to general care area, when medically indicated.

    c. From Intensive Care Unit to general care area.

    d. From Cardiac Care Unit to general care area.

    e. From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient. No patient will be transferred without such transfer being approved by the responsible practitioner

13. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

14. For the protection of the patients, the Medical and Nursing Staff and the hospital, certain principles are to be met in the care of the potentially suicidal patient:

    a. Any patient known or suspected to be suicidal in intent shall be admitted to the medical floor or Critical Care 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.

15. Admissions to Intensive and Cardiac Care Units - If any questions as to the validity of admissions to or discharge from the Intensive Care Unit should arise, that decision is to be made through consultation with the Critical Care Chief or Medical Director of the ICU. In similar circumstances concerning admission to or discharge from the Cardiac Unit, the appropriate designated member of the Department of Medicine is to be consulted.

16. The attending physician is required to document the need for continued hospitalization after specific periods of stay (per disease categories as defined locally) as identified by the Utilization Review Committee of this hospital and approved by the particular clinical department and the Executive Committee of the Medical Staff. This documentation must contain:

    a. An adequate written 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.
    c. Plans for post-hospital care.

    Upon request of the Utilization Review Committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized thirteen (13) days or longer, including an estimate of the number of additional days of stay and reason therefore. This report must be submitted within twenty-four (24) hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Executive Committee for action. Any patient remaining in the hospital over two (2) months must have the stay approved by the Executive Committee of the Medical Staff and by the Chief Executive Officer.

17. Patients shall be discharged only on a written order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

18. Hospital Death: Refer to policy (policy subject to periodic amendments)

19. Pediatric patients as a general rule, are defined as those patients who are 16 years or under, or those who have chronic childhood congenital diseases, with the exception of obstetrics patients. Pediatric patients will be admitted to the pediatrics floor. However, at the discretion of the admitting physician, pediatric patients may be admitted floors other than pediatrics.

B. MEDICAL RECORDS:

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data, complaint, personal history, including social history, medications, allergies and family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services, and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge notes, clinical resume, and autopsy report when performed.

2. Members of the Medical Staff with appropriate clinical privileges may perform H&Ps. A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission, but prior to any operative procedure or any procedure requiring moderate or deep sedation, general or regional anesthesia. If the history and physical exam was completed prior to admission, an updated medical record entry documenting an examination for any changes in the patient's condition must be made within 24 hours of admission or prior to operative procedures or procedures requiring moderate or deep sedation, general or regional anesthesia, whichever comes first. If the H&P contains discrepancies and/or contradicts other documentation in the patient's medical record (i.e., the informed consent or radiology reports), the discrepancies in the H&P will be resolved prior to the patient leaving the pre-procedure/holding area and before entering the procedural/operative suite. Advanced Practice Professionals may perform part or all of the H&P under the supervision of the sponsoring physician in accordance with their delineated privileges. The hospital's short stay form may be utilized if all components noted below are included. A short form H&P is required on observation visits. The history and physical shall include:

a. chief complaint,

b. details of present illness,

c. relevant past, social and family history,

d. relevant physical examination is, at a minimum, evaluation of the heart, lungs and pertinent organ systems related to the chief complaint or planned procedure,

e. conclusions or impressions drawn from the medical history and physical exam,

f. diagnosis or diagnostic impression,

g. goals of treatment and the treatment plan.

h. History and physical exams for pediatric patients must include developmental age, length or height and weight, head circumference (if appropriate) and immunization status.

i. Short forms on observation units. Cardiology OB and GI.

j. Outpatient services which require a history & physical shall be all procedures with require moderate or deep sedation, general or regional anesthesia.

3. When the history and physical examination is not recorded before an operative procedure or any procedure requiring moderate or deep sedation, general or regional anesthesia, the procedure shall be canceled, unless the attending practitioner states in writing that an emergency situation exists. Emergency procedures shall be defined as any patient admitted from the Emergency Department to the O.R., and any patient having an unplanned surgery within 12 hours of admission, or any patient with a rapid clinical deterioration.

4. The attending physician shall authenticate the history, physical examination and preoperative note within 24 hours when they have been recorded by a physician in training (resident) or Advanced Practice Professional.

5. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, 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 treatment. Progress notes shall be written at least daily on all patients, and all patients must be seen at least daily by a physician (the attending and/or consulting). There should be, in the progress notes, some form of documentation of the primary surgeon that he in some way participated in the pre- and post-operative care of the patient.

   Note: Advanced Practice Professionals may document in the medical record as delineated by the privileges and scope of practice.

6. The operative site, procedure and patient must be accurately identified and clearly communicated immediately prior to an invasive or surgical procedure.

7. A pre-sedation or pre-anesthesia assessment is conducted before the patient leaves the pre-procedure/holding area and before entering the procedural/operative suite. The patient is reevaluated immediately prior to induction. The appropriately credentialed physician plans and/or concurs with the anesthesia plan prior to sedation or anesthesia induction.

8. Operative reports shall include: patient name and hospital ID, name of the primary surgeon and assistants or other practitioners who performed surgical tasks with a description of the specific significant surgical tasks conducted by practitioners other than the primary surgery (e.g. opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues, type of anesthesia, complications, procedures performed and description of procedures, findings, specimen(s) removed, estimated blood loss

(as indicated), pre and postoperative diagnosis and prosthetic devices, grafts, transplants, or devices implanted, if applicable. Operative reports shall be written or dictated within 24 hours following surgery utilizing the hospital's approved medical records dictation system and must be authenticated as soon as possible after the procedure. The following assessments must be performed prior to surgery: history & physical, diagnostic data, pre-anesthesia assessment, consent form for blood/blood components, consent for outlining risks and benefits of procedure.

9. Immediate Post-Procedure Note (**Operative Progress Note**): Documentation of all invasive/operative procedures by the physician performing the procedure should be included in the progress notes with a brief description immediately after the procedure before the patient is moved to the next level of care. This is in addition to the dictated invasive/operative report signed by the primary physician. At a minimum, the note should include: surgeon(s) and assistants, anesthesiologist, procedure performed, findings, specimens removed, estimated blood loss, complications and pre and postop diagnoses.

10. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as, "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

11. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to history and any subsequent changes in the physical findings.

12. All clinical entries in the patient's medical record must documented in the EPIC.

13. The Medical Staff's approved abbreviation list and list of "do not use" abbreviations is available in the HIM Department. It is recommended that only those abbreviations approved by the Medical Staff be used in the medical record.

14. Final diagnoses shall be recorded in full, without the use of symbols, and dated and signed by the responsible practitioner at the time of discharge of all patients.

15. A discharge clinical summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours. The discharge summary shall include: the reason for hospitalization, significant findings, procedures performed and treatment rendered, patient's condition at discharge, and instruction to the patient and family, if any. A final progress note may be substituted only for those patients with problems and interventions of a minor nature and expected results as defined by the Executive Committee of the Medical Staff and normal obstetrical deliveries and normal newborns. For these patients, the final note must include at least: condition of the patient at discharge, discharge instructions, instructions for follow up care. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.

16. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

17. All medical records are the property of the hospital and may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order for storage in a proper facility, or for transport to the HIM Shared Services Center, or other similar centralized location where the records will be properly maintained, protected, and preserved for processing by the HIM Shared Services. All records are the property of the hospital and shall not otherwise be taken away without permission of the chief executive officer. In the case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is being attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee of the Medical Staff.

18. As a general rule, no patient medical record may be accessed by a Medical Staff member unless they are directly involved in the care of that patient. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study, QI, Peer Review and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by a designated Committee of the Medical Staff before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

19. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Executive Committee.

20. 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. The usage of routine or standing orders must be approved by the Medical Staff. Departments and Sections are responsible for ensuring standing order sets are reviewed on an annual or other basis as deemed appropriate.

21. MEDICAL RECORDS**:** Refer to policies (Policies subject to periodic amendments)

22. Instances of apparent inappropriate access will be reviewed by the Chief of Staff initially following submission by HIM/Ethics Officer. Violations of information security, privacy and/or appropriate access along with recommendations for suitable discipline will be presented to the Medical Staff's Executive Committee for review and recommendation. Violations may be categorized as negligent or intentional and will be investigated and evaluated individually based on type of information accessed or disclosed, risk to facility, patient effect or possible harm, along with consideration of the Medical Staff members' quality profile. Please see the Medical Staff's Appropriate Access Policy for complete information.

C. <u>GENERAL CONDUCT OF CARE</u>:

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. Surgical operations on patients may be performed only upon the informed consent of the patient or his legal representative, except in emergencies. A separate anesthesia consent is also required if the patient is having an anesthesiologist or CRNA participate in his/her care during a surgical or other invasive procedure. A completed informed consent for a surgical/invasive procedure/anesthesia includes the signature, date, and time of the patient, witness, and surgeon/proceduralist/anesthesiologist/CRNA. The admitting officer should notify the attending practitioner whenever such consent(s) have not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital. Medical Staff members are responsible for obtaining informed consent from patients which outline potential risks, benefits, potential complications, and significant alternative treatments. Medical Staff members also must obtain informed consent for transfusion of blood or blood components, which outline the need for the blood, the risks and alternatives. It is also the obligation of a practitioner who is acting as a Supervising Physician to obtain the written consent of a patient prior to the performance of services by the Physician Assistant working under the Supervising Physician and to inform the patient the Physician Assistant is not a physician.

2. All orders for treatment shall be entered by the practitioner into the electronic medical record.

3. **Verbal orders:** refer to policy (policy subject to periodic amendments)

4. No practitioner order is required for diagnostic screening tests which do not require treatment or physician intervention. Patients may self-refer for diagnostic screening tests e.g. mammograms. Self-referred patients will be under the care of the physician performing the screening test.

5. All drugs and medications administered to the patient shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full

accordance with the State of Principles Involved in the Use of Investigational Drugs in Hospital and all regulations of the Food and Drug Investigation.

a. State of Principles Involved in the Use of Investigational Drugs in Hospitals - Procedures for the control of investigational drugs should be based on the following principles:

(1) Investigational drugs should be used only under the direct supervision of the principal investigator who should be a member of the Medical Staff and who should assume the burden of securing the necessary consent.

(2) The hospital should do all in its power to foster research consistent with adequate safeguarding of the patient.

(3) When nurses are called upon to administer investigational drugs, they should have available to them basic information concerning such drugs - including dosage forms, strengths available, actions and uses, side effects, and symptoms of toxicity, etc.

(4) The hospital should establish, preferably through the Pharmacy and Therapeutics Committee, a central unit where essential information on investigational drugs is maintained and whence it may be available to authorized personnel.

(5) The pharmacy department is the appropriate area for the storage of investigational drugs, as it is for all other drugs. This will also provide for the proper labeling and dispensing in accord with the investigator's written orders.

6. The attending practitioner is responsible for requesting consultation when indicated and for notification to a qualified consultant. He will provide written authorization to permit another attending practitioner to attend or examine his patient, except in an emergency.

7. If any member of the care team, in good faith, has any reason to doubt or question the care provided to any patient, he/she has the authority to stop the care process when it appears that there is an imminent and significant issue regarding patient safety. The care team member shall call this to the attention of the practitioner and/or his/her superior. The care concern may be referred to the Chief Nursing Officer (CNO) or Chief Medical Officer (CMO). If warranted, they may bring the matter to the attention of the hospital administration.

8. No laboratory tests will be routine on admissions, it shall be at the discretion of the attending physician.

9. Pre-Admission Studies and Outpatient Lab Work:

(a) When pre-admission outpatient lab work is performed in lieu of inpatient admission lab work, then the outpatient lab work must meet the following criteria. The original or a photocopy of the original lab report must be filed on the chart. Handwritten transcriptions of the lab work are not acceptable. The lab report must contain the name of the laboratory performing the test, the patient's name, the test results to include the units of concentration or activity, the date the test was performed and the reference normal values of the lab performing the test.
(b) When preadmission studies (e.g. radiology reports, tissue biopsies, cardiopulmonary reports) which are used as a basis for treatment, are performed in lieu of inpatient admission studies then an original or copy of the original outside report must be included on the chart prior to the procedure or treatment.

10. **Tissue Removal**- Refer to policy (Policy subject to periodic amendments)

11. The primary surgeon's name must be placed on the operative permit.

12. **Autopsies**- Refer to policy (policy subject to periodic amendments)

13. **Restraints**- Refer to policy (Policy subject to periodic amendments)

14. Licensed practitioners without Medical Staff membership and privileges may be permitted to order out-patient testing and therapy not requiring physician supervision (e.g., diagnostic imaging studies, physical therapy, etc.) providing the following requirements are met:

    a. The hospital shall ensure that the practitioner is eligible to participate in federal and state health programs by checking the OIG/GSA Sanction Report, and OIE List at the time of ordering tests or services and every six months thereafter. If the applicant is excluded from participation, the outpatient testing may not proceed.

    b. The hospital shall verify the practitioner's current license at the time of initial ordering and at license expiration thereafter.

    c. Excludes interventional radiology procedures

15. **Medical Staff Treating Family Members:** Refer to policy (Policy subject to periodic amendments)

16. All obstetrical medical and surgical patients admitted for other conditions must have an obstetrician of record with privileges at the hospital. The obstetrician of record must provide a consultation on surgical patients to obtain necessary documentation to support monitoring decisions. Obstetrical patients presenting through the Emergency Department with no obstetrician will be seen by the immediate on-call obstetrician.

17. The Section Chief of Anesthesiology directs, plans and supervises the Medical Staff's anesthesia service and is responsible for anesthesia administration in the hospital. The Section Chief is responsible for reviewing and approving all anesthesia privileges for both anesthesiologists and non-anesthesiologists on the Medical Staff and Advanced Practice Professional Staff. The Section Chief evaluates the quality and appropriateness of anesthesia patient care. The Section Chief insures staffing for emergency anesthesia care through the daily call schedule. Individual anesthesiologists are responsible to their attending surgeons for scheduling/staffing their cases in procedural areas.

18. **Time outs:** Refer to policy (Policy subject to periodic amendments)