Cumberland Medical Center

Rules and Regulations

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Amended December 2009
Amended December 19, 2011
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Amended April 22, 2013
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Amended September 25, 2014
Amended January 28, 2016
Amended January 26, 2017
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RULES AND REGULATIONS

1) The meeting of the Medical Staff shall be held on the first Tuesday of every other month.

2) Every member of the Medical Staff is expected to be actively interested in securing autopsies. Medical Staff members should use developed criteria in requesting autopsies. No autopsy shall be performed without proper written consent. It is recommended that autopsy be requested in cases in which death is not expected in view of the diagnosis and response to prescribed therapy. All autopsies shall be performed by the hospital pathologist or by physicians delegated this responsibility. Informed consent by the appropriate medical staff member must be obtained to perform an autopsy. The attending Practitioner shall be notified when an autopsy is being performed. The hospital may allow a fee for this service.

3) Patients presenting for admission who have no attending physician shall be assigned to members of the Active, Consulting or Provisional Staff on duty. All Active or Provisional Staff members who admit patients to the hospital will be expected to participate in a call schedule unless otherwise excluded. All Medical Staff members must comply with Emergency Medical Treatment and Active Labor Act (EMTALA) Regulations and must comply with all applicable state laws. We recognize that from time to time certain medical emergencies will exist that will affect the medical staff member and/or their immediate family that would limit their ability to take call or to perform certain functions, in such instances a temporary suspension of the requirement for taking call can be granted by the Medical Executive Committee. This procedure may be granted by the CAO, or designee, upon the recommendation of the President of the Medical Staff and ratified by the Medical Executive Committee.

4) The Emergency Department physician must notify the on-call physician after the initial examination if he/she determines that the services of the on-call physician are needed. Contact with the on-call physician may be to request immediate assistance, consult to help with the disposition, schedule outpatient follow-up, or to approve a request for admission. If the Emergency Department physician requests that the on-call physician come to the department, it is not the discretion of the on-call physician whether to respond or not, but should respond within a reasonable time. For admissions from the ED, it will be the responsibility of the on-call physician to insure that the patient is seen within a period of time

as specified in the Medical Staff Bylaws, Rules and Regulations or other approved hospital policy. Violation(s) of this rule will be reported to the Medical Executive Committee.

5) When contacted to a "stat" call the on-call Allied Health Professional / Advanced Practice Professional should arrive at the hospital within 30 minutes. For a "routine" response the Allied Health Professional / Advanced Practice Professional should arrive at the hospital no later than 60 minutes.

6) Standing orders shall be in compliance with CMC's policy and procedures.

7) All orders, diagnosis and treatment shall be in legible writing; unless required to be entered via CPOE. These orders shall include those written by authorized medical staff members, individuals granted clinical privileges, and by Licensed Independent Practitioners appropriately licensed by their State licensing body.

8) Verbal orders are to be used infrequently. Verbal orders should be used only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order or enter it into a computer without delaying treatment. Verbal orders are not to be used for the convenience of the ordering practitioner (71 FR 68679). CMC 482.24(c)(1)(ii) states ALL verbal orders must be authenticated based upon Federal and State Law. Verbal orders may be accepted and written by the following appropriate hospital personnel: Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Pharmacy Technicians, Pharmacists; Registered Physical Therapist (RPT), Occupational Therapist Registered (OTR), Licensed Physical Therapist Assistant (LPTA), Certified Occupational Therapist Assistant (COTA), Speech and Language Pathologist (SPT); Registered Dietitians, Certified Respiratory Therapist (CRT), Registered Respiratory Therapist (RRT), EMT-IV, Sleep Technologist and Imaging Technologist. Such orders should be limited and pertain only to the specialized area in which the individual is employed. To assure the accuracy of the transcription of verbal orders, a read-back and verify process shall require that the individual receiving the order immediately read back the order to the physician or authorized individual, who shall immediately verify that the read-back order is correct. The verbal order must be authenticated within 48 hours unless the read-back and verifying process is followed. A verbal order shall include the date, time, and full signature and title of the person to whom the verbal order has been given and shall be authenticated within 14 days by the ordering physician or another practitioner who is responsible for the care of the patient only if such a practitioner is acting in

accordance with State law, including scope of practice laws and hospital policy. Restraint orders would be an exception to this rule and would require signature in accordance with all applicable laws and regulations. (Revised September 25, 2014)

The use of text messaging or paging to send order from physician, or other provider orders is not permitted. No telephone or verbal orders for new chemotherapy orders are permitted. (Revised September 28, 2017)

9) Mass Casualty Assignments. All Medical Staff members are expected to comply with CMC's policy and procedures in regards to emergency preparedness plans in effect.

10) Patients may only be admitted by practitioners who have been granted admitting privileges. Admitting physicians shall be held responsible for giving such information as may be necessary to assure the protection of the patient, other patients or Medical Staff personnel from infection, disease or other harm, and to protect the patient from self-harm.

11) An admission note must be written in the chart or entered via CPOE at time of admission or within one working day after admission.

12) Patients shall be discharged only on the order of the attending physician or designee. At the time of discharge the attending physician shall see that the record is complete, state his final diagnosis and sign the record in a timely manner.

13) MEDICAL RECORDS:

a) The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification date, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultation, clinical laboratory, x-ray, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; follow-up and autopsy when available. No medical record shall be filed until it is complete, except on order of the Medical Records Committee.

b) Delinquencies

i. The official Delinquency Report is generated on the **first** of each month or the first working day following the first of each month. This data is presented at the appropriate medical committees at each facility.

ii. On the **second Friday** of each month the physicians are mailed a Letter of Notification alerting them of records needing to be completed. This letter is mailed to the physician's office to the attention of the office manager in an effort to insure the physician receives the information.

iii. On the **fourth Monday** of each month, a list of delinquent records is generated, identifying each record and containing the expected completion date of the following Monday.

iv. This list is faxed directly to the physician's office with the facsimile confirmation sheet retained as proof of notice.

v. If the records have not been completed by the expected completion date, a Suspension List is generated and presented to the Leadership of each facility by e-mail notification.

vi. Without any further intervention and the records remaining delinquent, **at noon** of the day of Suspension, the list of Suspended Physicians is sent to Administration and the Directors/Managers of Admissions, Scheduling, OR Services, Emergency Room and the Medical Staff Services Office.

vii. The list of records needing completion is verified each morning. As physicians complete the required records, notice, taking the physicians off of Suspension, is sent to the grouping identified above.

c) History and Physicals – A complete history and physical shall be performed by an appropriately credentialed practitioner with privileges in the hospital. For surgical patients, the history and physical shall be performed by the physician performing the surgery or other qualified individual. H & P should be on the chart within 24 hours of admission, but always prior to surgery except in emergency cases. In the event that the H & P has been dictated but not yet transcribed, a note should be recorded in the chart to that effect. If a complete physical examination has been performed with in 30 days prior to admission, such as in the office of a physician or when appropriate, the office of a qualified oral surgeon, a durable legible copy for this report may be used in the patient's hospital medical record, provided there have been no changes prior to the original examination or the changes have been documented at the time of admission. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H & P was completed, he/she may indicate in the patient's medical record that the H & P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the

H & P was completed (71FR 68676). The entry should be dated, timed and authenticated. When the patient is readmitted within 30 days for the same or a related problem, an interval history and physical examination reflecting any changes may be used in the medical record, provided the original information is readily available. The surgeon should record and authenticate a pre-operative diagnosis prior to surgery. When such history and physical examination are not recorded or dictated and on the chart before the time stated for operation, the operation in all cases shall be postponed unless the attending surgeon states in writing that such delay would constitute a hazard to the patient and a brief note including the preoperative diagnosis and plan of treatment is written. Clarification of Hospital Admissions and Pre-surgical History and Physical Examination (H & P) requirements may be found in Medical Staff Policy and Procedure Manual.

d) History and Physical for non-inpatient procedures shall be defined as follows:
   i. If the procedure requires anesthesia or moderate sedation, then it requires a history and physical.
   ii. If a procedure is done with local or no anesthesia, then an appropriate "physician assessment" to include indications for the procedure, and anything that might be pertinent to the procedure itself (knee exam prior to arthrocentesis) and pertinent information to the procedure (primarily for coding) should be included, but a formal H & P is not required.
   iii. As defined in the Medical Staff Policy and Procedures Manual.
   iv. For outpatient surgery, the history shall include documentation of the indications and symptoms warranting the procedure, listing of the patient's current medications, any existing co-morbid conditions and previous surgeries, and social history or conditions which would have an impact on the patient's care upon discharge from the facility following the procedure.

e) All findings, conclusions, and assessment of risk are confirmed or endorsed by a qualified physician prior to major high-risk diagnostic or therapeutic interventions.

f) All records are the property of the hospital. Records may be removed from the jurisdiction and safe keeping only in accordance with court order, subpoena or statute. In cases of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient was attended by the same physician or by another.

g) Free access to all medical records of all patients shall be afforded to Staff physicians in good standing for bona fide study and research, as approved by the MEC, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the

discretion of the CAO, 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.

h) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the services provided, consistent with hospital policy and procedures.

i) Progress notes must be written at least every 24 hours, documenting the patient's progress. Penalty for not complying with this policy as follows: (1) Three offenses in one month would result in a one week suspension from the Medical Staff with all related privileges withdrawn. (2) Three suspensions in a six month period will warrant the physician's staff privileges being completely removed and the physician shall be required to proceed with all credentialing steps as outlined in the Bylaws in order to obtain Staff privileges again.

14) All tissue removed at operation, (excluding traumatically injured members, cataract or other benign ocular tissues, surgical appliance, foreign body [including bullets that for legal reasons are given directly in the chain of custody of law enforcement representatives], foreskin from the circumcision of a pediatric age patient, placentas that are grossly normal, teeth, provided the number, including fragments, is recorded in the medical record, finger/toenails, small bony spurs, arthroscopic shavings, products of total knee or hip arthroplasty, nasal/septal cartilage, turbinates, tonsils and/or adenoids of a pediatric age patient, and urinary stones shall be sent to the hospital pathologist who shall make such examinations they may consider necessary to arrive at a pathological diagnosis and they shall sign their report.

15) A pre-anesthesia or pre-sedation evaluation shall be documented in the medical record for all patients undergoing surgery, anesthesia, or moderate or deep sedation. The pre-anesthesia or pre-sedation physical evaluation shall be recorded in the medical record prior to the surgery or the administration of anesthesia or sedation.

16) Surgeons must be in the operating room and ready to commence the operation at the scheduled time and the operating room will not routinely be held longer than fifteen (15) minutes after the scheduled time.

17) A post-anesthesia evaluation shall be completed and documented in the medical record of all patients who have undergone surgery, anesthesia, or moderate or deep sedation by an individual qualified to administer anesthesia, no more than forty-eight (48) hours following the procedure. Post-operative documentation records the patient's vital signs and level of consciousness; medications (including intravenous fluids) and blood and blood components administered; unusual events or complications, including blood transfusion reactions; and the management of those events. It also records the patient's discharge from the post-sedation or post-anesthesia care area by the responsible practitioner or according to discharge criteria.

18) Drugs used shall meet the standards of the United States Pharmacopeia, National Formulary, New and Nonofficial Drugs, with the exception of drugs for bona fide clinical investigations. Exceptions of this rule must be well justified and documented.

21) Narcotics and sedatives that are ordered without time limitation of duration shall be automatically discontinued after five (5) days. Antibiotics that are ordered without time limitation of duration shall be automatically discontinued after seven (7) days. Drugs should not be discontinued without notifying the physician. If the order expires in the night, it should be called to the attention of the physician the following morning.

22) All drugs and biologicals must be kept in secure areas, and locked when appropriate. Schedule II, III, IV, and V drugs must be kept locked in a secure area. A "secure area" is one in which staff are actively providing patient care or preparing to receive patients. Areas restricted to authorized personnel only would generally be considered "secure" areas. Only authorized Medical Center personnel have access to locked areas. Noncontrolled drugs do not need to be locked.

23) All electrocardiograms shall have an interpreted legibly written report by a qualified credentialed physician. In the treatment of out-patients, the doctor is responsible for the care of his/her patient, and assumes full responsibility for the medical and surgical management of his/her patient, including laboratory work and other diagnostic procedures.

24) CONTINUING EDUCATION: For reappointment to the Medical Staff, each active Staff physician shall be required to maintain, for a two (2) year period, a minimum of forty (40) hours of Category I and II educational credits as defined in the AMA Guidelines for Continuing Education. There shall be no

minimum yearly requirement. Failure to comply with this rule will initially result in a three (3) month probationary period, at the end of which, if not resolved, will ultimately result in suspension from the Medical Staff. This rule will be suspended for any staff member who has completed a fellowship, residency, or Board Certification within two years of application to the Medical Staff.

25) Psychiatric and psychological consultation must be offered to all patients who have attempted suicide or are suspected to have attempted suicide and must be documented in the patient's chart. Patients who are emotionally ill, who become emotionally ill while in the hospital, or who suffer the results of alcoholism or drug abuse must be offered similar services.

26) When an order to restrain or seclude the patient becomes necessary, the order may not be a P.R.N. "as-needed" order. In the event an emergency makes immediate behavioral restraint or seclusion necessary, the physician's order must be obtained within one (1) hour. Medical Staff members will adhere to Centers for Medicare & Medicaid Services ("CMS") Regulations with regard to restraint.

27) Strongly recommend **a**ll physicians involved in direct patient care take ACLS course or become ACLS certified and/or PALS, unless otherwise noted in the Medical Staff Bylaws or Rules and Regulations. All physicians taking Medicine Call will be required to be ACLS certified**.** Each physician will have a three (3) year grace period from the date it is approved by the governing body to take the ACLS course. **(Amended June 23, 2008.)**

28) Any vote made by the Medical Staff concerning Medical Staff members should be by secret ballot.

29) An on-call physician has an obligation to provide care for an unassigned patient while the patient is in the hospital and through the episode of illness or injury that prompted the patient to present to the emergency department unless the physician terminates the physician-patient relationship as set forth below.

If an unassigned patient presents to the emergency department with an unrelated illness, the physician on-call at the time will be responsible for providing care to the patient. Upon discharge of the patient, an on-call physician can terminate the physician-patient relationship, even if the episode of illness is not resolved, by (1) documenting in the medical record a decision to release the patient, and (2) by notifying

the patient in writing that the physician will only provide care to the patient for the next 30 days, or (3) if the patient leaves with or without signing AMA

30) Medical screening exams may be performed by physicians or physicians' assistants or nurse practitioners under the direction of a physician to be responsible for the performance of patient screenings in the Emergency Department. Further, obstetrics patients may be assessed by a registered nurse trained in obstetrics or a physician of that specialty.

31) For a consultation request to be considered "having been made" the following requirements must be met.

   i. The physician requesting the consultation must ensure the physician being consulted is available for consultation and is notified of the need for the consultation. This is accomplished by direct physician to physician contact.
   ii. The physician being consulted must be given the name of the patient, room number if available, reason for the consultation, and urgency of the consultation. Reason shall be "specific" and not simply an order to "consult Dr. _____, or 'consult "specialty'". Urgency should be "stat" to mean come now, "asap" to mean within the next 90 minutes, "today" to mean with in the next 12 hours, or "at your first convenience" which would allow the physician consulted to see the patient that day or the following day.
   iii. For non-emergent consultations between 21:00 and 07:00 the physician being consulted should be called the following morning, preferably by the requesting physician.
   iv. A satisfactory consultation includes a summary of the history, examination of the patient, an appropriate summary of the medical record and a diagnosis and recommendation.

Upon requests, specialist with staff privileges shall provide consultation for their established patients admitted to hospital. Patients should be seen within 24 hours of consultation, excluding weekends, holidays, and planned absences. All unavailable dates should be provided to the medical staff office in advance.

Retain responsibility for the continuous care and supervision of each patient in the hospital for whom the practitioner is providing services, or alternatively arrange for such care and supervision by another practitioner possessing the necessary clinical privileges (such as, the hospitalist's program).

32) The Medical Staff President may approve emergency changes to the call schedule in the event of exception circumstances.

33) Conflict Resolution between the Medical Executive Committee and the organized Medical Staff.

a. When the majority of the organized medical staff plans to act or is considering acting in a manner contrary to a recommendation made by the MEC or vice versa, the Medical Staff Officers and representatives of the organized medical staff shall meet with the Board, or a designated committee of the Board and Hospital Administrative representatives (if deemed necessary), and seek to resolve the conflict through informal discussions.

b. If these informal discussions fail to resolve the conflict, a representative of the organized medical staff, the Chief of the Medical Staff, or the President of the Board may request initiation of a formal conflict resolution process.

c. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within 30 days of the initiation of the formal conflict resolution process.

d. The Joint Conference Committee may be composed of the Board, the officers of the Medical Staff, the Chief Executive Officer, and representatives of the organized medical staff.

e. The Joint Conference Committee shall make best efforts to collaborate to resolve the conflict. Any resolution arrived at during such meeting shall be subject to the approval of the Board, by the rules which are set forth in the Medical Staff Bylaws.

f. If after 90 days from the date of the initial request for the Joint Conference Committee, the organized Medical Staff and the MEC cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

g. If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take action that will remain in effect only until the conflict resolution process is completed.

34) When ordering therapeutic services, if ordering physician is not available and 100% coverage is not available and the ordering physician is not available, each physician will be required to document their covering physician with each order.

35) Physicians will verbally notify nursing staff of all STAT orders.

36) Beginning October 1, 2013, All medical staff members must use CPOE, except for verbal orders and outpatient procedures, unless excluded by:

   A. Care for less than 100 inpatients / observation patients per year,

   B. Physicians who are eligible for Senior Call status exemption, based on age and years of service at CMC,

   C. Or, unless excluded by the MEC on an individual basis after written request.

37) Director of Anesthesia Services. Anesthesia services will be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO). The director will be an active member of the medical staff with unrestricted privileges in anesthesia; of good reputation and character, including physical and mental health and emotional stability; and the ability to work harmoniously with others sufficiently so that the medical staff will be able to operate in an orderly civil manner.

38) Medical Students may only document on the 'Student Documentation Form' which is not part of the permanent medical record.