Cumberland Medical Center

Rules and Regulations

Adopted June 23, 2008
Amended December 2009
Amended December 19, 2011
Amended October 21, 2012
Amended December 17, 2012
Amended April 22, 2013
Amended July 22, 2013
Amended September 25, 2014
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Amended January 24, 2019
Amended July 25, 2019
Amended January 23, 2020
Amended March 25, 2021
Amended September 22, 2022

RULES AND REGULATIONS

1) Deleted.

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, Courtesy Staff on duty. All Active or Courtesy 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 Chief 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) Deleted

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) The H & P may serve as the admission progress if written or entered via CPOE at time of admission / attending physician's first visit, but must be on the chart within 24 hours of 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: This rule applies to all members of the Medical Staff hold clinical privileges. It also applies to advanced practice professionals (APPs).

I. General Keeping of the Medical Record

A. Completion and Signature Requirements

1. The attending physician shall be responsible for the preparation of a complete, legible medical record for each patient.
2. All entries shall be dated, timed and authenticated by the author of the entry.
3. A medical record is defined as complete at the expiration of thirty (30) days post discharge and all required documentation and authentication are present. The medical record is then determined to be a Closed Medical Record.
4. All clinical entries shall be accurately timed, dated and authenticated by signature, identifiable initials, or computer key. A rubber stamp of a printed name may be used to clarify a signature that might otherwise be illegible.

   ***No rubber stamp bearing an actual signature may be utilized. This regulation applies to both Inpatient and Outpatient charts and orders.**
5. A list of unapproved/unacceptable abbreviations is identified below. Other abbreviations may be used. If the abbreviation is unclear, the author is to be contacted and the abbreviation clarified then documented within the record. Please refer to the Covenant Health policy on abbreviations for complete information.

   "Do Not Use" Abbreviations include:

Abbreviation	**Preferred Term**
U (for unit)	"unit"
IU (for international unit)	"international unit"
Q.D. (once daily) Q.O.D. (every other day)	"daily" and "every other day"
Trailing zero (3.0 mg) Lack of leading zero (.3 mg)	Do not use a zero by itself after a decimal point (3 mg) and always use a zero before a decimal point (0.3 mg)
MS MSO4	"morphine sulfate" or "magnesium sulfate"

B. APP Entries / Patient Care Requirements

1. APP's may perform daily rounds under the supervision of the physician. Evidence of daily communication between the supervising physician and APP is required in the medical record. A supervising physician may choose for their APP (NP or PA) to perform daily rounds. The APP will function under the direct supervision of the collaborating physician/group. The phrase "under the direct supervision of a physician" shall be construed as a periodic evaluation and clinically appropriate follow-up of the medical plan of care. Factors influencing the frequency of this evaluation include the patient's condition during the course of the medical treatment and the patient's ability to understand his/her care. The supervising physician must be readily available for in person consultation upon the request of any patient under the care of a physician-directed health care team.
2. Supervising physicians are required to co-sign the following APP entries no later than 30 days post discharge, except where noted otherwise
   a. discharge summary
   b. history and physical
   c. consults
   d. admission order
3. A physician co-signature is not required for APP orders or daily progress notes.
4. APP's are responsible for completion of their documentation and signature requirements, including their own verbal/telephone orders.

C. Documentation by Medical Students, Interns and Residents

1. Charting guidelines for these participants are as follows:

	History & Physical Examinations	**Progress Notes**	**Orders**	**Discharge Summary**
Medical Students	Documentation only in electronic student documentation form. This documentation is not part of the permanent record.	Documentation only in electronic student documentation form. This documentation is not part of the permanent record.	Medical students may not place orders.	Documentation only in electronic student documentation form or paper form.

Residents	May perform with follow-up note from attending physician within the next 24-hours	May create with the attending to co-sign on the next visit.	May place orders.	May create or dictate with co-signature required.

D. Administrative Closure of Medical Records

1. No medical staff member shall be permitted to complete a medical record on a patient unfamiliar to him/her in order to retire a record that was the responsibility of another staff member who is deceased or unavailable or other reasons.
2. HIM will make all reasonable attempts to complete every record; however, in the event a provider is no longer available, the record will be administratively closed. The appropriate Committee will be notified of all closed records.

II. **Content of the Medical Record**

A. The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among health care providers. Each medical record contains at least the following:

1. The patient's name, sex, address, date of birth, and the name of any legally authorized representative, allergies to foods and medicines, the patient's language and communication needs.
2. Records of communication with the patient regarding care, treatment, and services, (for example telephone calls or email) if available;
3. Patient-generated information (for example, information entered into the record over the Web or in previsit computer systems) if available;
4. The patient's legal status, for patients receiving mental health services;
5. Emergency care provided to the patient prior to arrival, if any;
6. The record and findings of the patient's assessment;
7. A statement of the conclusions or impressions drawn from the medical history and physical examination;
8. The reason(s) for admission or treatment;
9. The goals of treatment and the treatment plan; Evidence of known advance directives;

10. Evidence of informed consent for procedures and treatments for which informed consent is required by organizational policy, including explanation of risks and benefits of the procedure/treatment and of the alternatives to the procedure/treatment;
11. Diagnostic and therapeutic orders, if any;
12. All diagnostic and therapeutic procedures and tests performed and the results;
13. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
14. Progress notes made by the medical staff and other authorized individuals;
15. All reassessments, when necessary;
16. Clinical observations, including the results of therapy
17. The response to the care provided;
18. Reports of all consultations provided;
19. Every medication ordered or prescribed for an inpatient;
20. Every dose of medication administered and any adverse drug reaction;
21. Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;
22. All relevant diagnoses established during the course of care; and
23. Conclusions at termination of hospitalization
24. Any referrals/communications made to external or internal care providers and to community agencies.

B. History and Physical

1. The member of medical staff admitting a patient must assure that a complete and current medical history and a complete and current physical examination of the patient are carried out by an appropriately credentialed practitioner with privileges at this hospital.
2. The history and physical must be created no more than 30 days before the admission, or within 24 hours after admission, or registration, and in any event, prior to any surgery or procedure requiring anesthesia services.
3. H&Ps created within 30 days prior to admission must be updated by an appropriately credentialed practitioner with privileges at the hospital to include an examination for changes in the patient's

condition. This update must occur within 24 hours after the admission or registration and prior to any surgery or procedure requiring anesthesia services.

4. Please note that a History and Physical must be signed (or cosigned, as appropriate) by the physician. The physician's signature on the H&P update does not satisfy the requirement for a signature / co-signature on H & P itself. Both must be signed or cosigned by the physician. (Amended 9/22/22)
5. Documentation of the history and physical, completed and updated as required herein, must be documented in the patient's record prior to any procedure involving risk and all procedures requiring anesthesia services.
6. With the exception of emergencies, patients shall not be taken to the operating room unless a compliant history and physical examination report appears in the record. In cases of emergency surgery, a brief admission note and evidence that a history and physical examination report has been recorded.
7. The H&P must contain, at minimum, the following:
    a. chief complaint;
    b. details of the present illness;
    c. allergies and current medications, including supplements;
    d. when appropriate, assessment of the patient's emotional, behavioral, and social status;
    e. relevant past, social, and family histories;
    f. pertinent review of body systems;
    g. appropriate physical exam as dictated by patient's clinical presentation or anticipated procedure to include, at a minimum, a documented examination of the heart and lungs; and
    h. conclusions or impressions, assessment and plans for treatment.
8. Documentation of informed consent, when applicable and appropriate
9. OB Records
    a. Obstetrical medical records shall include prenatal information. A durable, legible original or reproduction of the prenatal record is acceptable for use as the H&P, provided the patient has been seen within 30 days of admission.

b. If a patient has a scheduled C-section, the H&P update process applies as outlined previously in this policy.

10. Minimally invasive procedures
    a. Procedures listed in Appendix A do not require an H&P unless anesthesia or moderate sedation is used. Moderate sedation as defined by CMS is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulations.
    b. A post procedure progress note / brief op note must be documented immediately after the procedure and must include:
        1) procedure performed
        2) pertinent findings
        3) estimated blood loss, if any
        4) specimens removed, if any
        5) complications, if any
    c. Note that if the full operative/procedure report is created, immediately available and signed immediately after the procedure, the immediate post-op note (aka Brief Op Note) is not required.
11. Recurring 'outpatient in a bed' visits for infusions, transfusions and chemotherapy on stable patients require an updated progress note at a minimum of once per year.

C. Consultation Reports
1. Contain a recorded opinion by the consultant that reflects the examination of the patient and review of the patient's medical record.

D. Operative Reports
1. Must be recorded immediately following the surgical or invasive procedure, before the patient is moved to the next treatment area.
2. Must be recorded by the person who performed the procedure.
3. Shall contain

a. the date of the procedure
b. preoperative and postoperative diagnoses
c. the procedure(s) performed
d. a description of the procedure
e. findings
f. the technical procedures used
g. specimens removed, if any
h. estimated blood loss, if any
i. complications, if any
j. prosthetic devices, grafts, tissues, transplants, or devices implanted, if any
k. the name of the primary surgeon and any assistants

4. Postoperative Progress Notes / Brief Op Note
    a. In the event the full operative report has not been recorded, a postoperative progress note / brief op note shall be recorded by the surgeon immediately following the procedure and prior to transfer to next level of care. Note that if the full operative report is created immediately after surgery using front end dictation, the postop progress note / brief op note is not needed.
    b. Required elements
        1) The procedure performed
        2) Description of the procedure
        3) Complications, if any
        4) Estimated blood loss, if any
        5) Findings
        6) Specimen(s) removed, if any
        7) Name of surgeon and any assistant(s)
        8) Postoperative diagnosis

E. Anesthesia Documentation Requirements

1. Pre-Anesthesia Evaluation

a. Must be completed and documented by an individual qualified to administer anesthesia, performed within 48 hours prior to surgery or a procedure.

b. Required elements

    1) Pre-procedural education

    2) Patient's condition immediately prior to induction of anesthesia.

2. Post Anesthesia Evaluation

    a. Shall be documented by a physician or CRNA qualified to administer anesthesia

    b. Must be performed after the patient's recovery from anesthesia and no later than 48 hours following the procedure

    c. Required elements

        1) Respiratory function, including respiratory rate, airway patency, and oxygen saturation

        2) Cardiovascular function, including pulse rate and blood pressure

        3) Mental status

        4) Temperature

        5) Pain

        6) Nausea and vomiting

        7) Postoperative hydration

F. <u>Diagnostic and Therapeutic Orders</u>

1. Must be

    a. Typewritten, computer-generated, or handwritten in ink

    b. Dated, timed and signed by the ordering provider

    c. Clear and legible

2. Verbal and telephone orders

    a. Should be used only when absolutely necessary

    b. Must be cosigned within 14 days (current law and regulation) following the 'read back and verify' process.

        1) Must be cosigned by either the ordering provider or another provider responsible for the care of the patient.

2) If the ‘read back and verify’ process is not followed, the orders must be cosigned within 48 hours.

c. Please refer to Covenant Health’s policy on Telephone and Verbal Orders for complete and detailed information.

3. Other persons listed below may take orders limited to their specific license, training and function.
   a. Physical Therapist
   b. Physical Therapy Assistant (PTA)
   c. Occupational Therapist
   d. Occupational Therapy Assistant (OTA)
   e. Psychologist
   f. Respiratory Technologist
   g. Respiratory Therapist
   h. Speech Therapist
   i. Pharmacist
   j. Radiology Technologist
   k. Ultrasonographers
   l. Nuclear Technologist
   m. Dietitian
   n. Sleep Techs
   o. Neuro Techs

G. <u>Progress Notes</u>

1. Must be recorded by an appropriately credentialed provider on a daily basis or may be documented more frequently based upon patient condition with the exception of hospice patients (see 3# below).
2. Shall denote the patient's status, detail of any changes, and the condition of the patient.
3. For inpatient hospice patients, a physician progress note must be recorded, at a minimum, once a week. If a change in plan of care is necessary, such as diagnostic testing or medication orders, this will be communicated to the primary physician for evaluation and ordering. (Amended 9/22/22)

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H. Discharge Summary

1. Required for all inpatient and observation stays. In the event of a death, a Death Summary/Record of Death serves as the discharge summary.
2. Required anytime the patient stays after midnight due to clinical condition (e.g., after day surgery when clinical condition unexpectedly changes)
3. The provider who writes the discharge order is responsible for the discharge summary.
    a. When the discharge summary is dictated by the APP, the APP must include the name of the physician who should be flagged to cosign the report.
4. Must be in the record no later than 30 days post discharge
5. Required elements
    a. Reason for admission
    b. Principal diagnosis
    c. Secondary and chronic diagnoses that are treated/monitored, and whether the condition was new or present on admission
    d. Any complications and co morbidities
    e. Operative procedures performed
    f. Pertinent lab, radiology, test results and physical findings
    g. Course of treatment
    h. Condition at discharge
    i. Disposition
    j. Instructions given at discharge
    k. Final diagnosis without abbreviations or symbols
6. A short stay discharge summary will be accepted for stays of less than 48 hours, provided the stay was uncomplicated. The following elements are required:
    a. Outcome of the hospitalization
    b. Plans for follow up care
    c. Discharge Disposition

I. Coding Queries

1. Coding queries are necessary for complete and accurate coding and core measure abstraction. Unanswered queries are treated like other chart deficiencies. Providers may be suspended if these are left unanswered as addressed under Section III of this policy.

Access to the Medical Record

1. All patient records are the property of the hospital wherein the patient is treated and shall not be removed from that hospital except by court order, subpoena, or statute and in accordance with Covenant Health's policies.
2. Free access to all medical records of all patients shall be afforded to medical staff members in good standing, their extenders and students for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. *Access must be in accordance with Covenant Health's privacy and security policies, and includes only those patients for which the provider has a legitimate treatment relationship.*

III. TIMELINESS

In all cases the medical record shall be completed within 30 days following patient discharge or the physician/provider will be subject to the suspension process. APP's who are delinquent in completing medical records will not be allowed to assist their sponsoring physician(s) in the hospital until all delinquent records have been completed.

A. Notification of Providers

1. Providers shall be notified of all incomplete medical records on a regular basis, no less than monthly. Incomplete records must be completed prior to the date of suspension in order to avoid suspension of elective admission privileges.

B. Failure to Complete Records – Automatic Suspension

A suspension for incomplete medical records is considered to be administrative in nature and is not reportable to the National Practitioner Data Bank. This type of suspension is not related to professional competence or conduct that could adversely affect the health or welfare of the patient.

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1. Failure to complete records by the suspension deadline results in an automatic administrative suspension of privileges.
2. HIM sends written notification of suspension to the physician's practice by fax or email. The notification includes the requirement for the physician to arrange for appropriate coverage for patients by another medical staff member with like privileges.
3. The automatic administrative suspension includes all admitting privileges and scheduling of any new procedures. The physician on suspension may continue to care for patients currently admitted to the physician's service for up to 15 days from the date of suspension. Admissions and procedures that have been scheduled prior to the date of suspension will be honored for up to 15 days after the date of suspension.
4. A suspended physician may continue to take emergency call and admit and care for patients in emergency situations.
5. A physician may not admit patients under the services of another physician or perform surgical or other invasive procedures when he/she is on the suspension list.
6. Reinstatement of these privileges is allowed immediately upon completion of all delinquent record(s). Suspension of these privileges cannot be based upon a minimum or maximum numbers of records to be completed. Any and all delinquent records are expected to be completed.
7. The suspension list will be distributed to the following areas/departments by Health Information Management:
    - Administration
    - Quality Care Management
    - Central Scheduling
    - Chief of Staff
    - Day Surgery
    - Emergency Department
    - Endoscopy Lab
    - Medical Staff Office
    - Outpatient Registration
    - Pre-admission Testing
    - Registration
    - Surgery

8. If a physician has been suspended for a third time in the calendar year, all clinical privileges are automatically relinquished until all delinquent medical records are completed. The automatic

relinquishment is not grounds for a fair hearing and is not reportable to the NPDB. *(Refer to Credentials Policy, 6.F AUTOMATIC RELINQUISHMENT)*

9. Reinstatement from the automatic relinquishment may be requested upon completion of all delinquent medical records. The request is to be submitted through Medical Staff Services. Payment of a fine may be required as determined by the MEC.
10. If the physician does not complete all delinquent records within 60 days after the automatic relinquishment is in effect, the matter will be referred to the MEC and may be considered an automatic resignation from the medical staff.

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APPENDIX A

I. Minimally invasive procedures that DO NOT require an H&P

A. Minimally invasive procedures as listed below do not require a history and physical. An immediate post-procedure progress note should be written to include, at minimum:

1. the name of physician performing procedure,
2. procedure performed, and
3. any other pertinent medical findings or events.

B. Minimally invasive procedures are defined as all:

1. Epidural steroid injections or diagnostic injections
2. Nerve root blocks, sympathetic blocks, IV regional blocks
3. Image guided biopsy, image guided drainage, image guided aspiration
4. Myelograms, lumbar punctures
5. Arthrocentesis, joint injections, arthrograms
6. Central venous line, Q Port flush
7. Newborn circumcisions
8. EEG
9. Esophageal motility studies, rectal motility studies
10. Labor checks
11. Manometry
12. Tilt table test
13. Breast biopsy if no sedation
14. Apheresis
15. Aspiration
16. Biliary tube change
17. Blood patch
18. Coronary CTA
19. PFT
20. Fistulogram
21. Gastrotomy tube replacement

22. Nephrostogram
23. Paracentesis, thoracentesis
24. PEG tube replacement
25. Perma cath removal
26. Percutaneous transhepatic choangiogram
27. Pill cam
28. PICC line placement
29. Spirometry
30. Stress test
31. Ureteral stent placement
32. Venogram
33. pH study
34. Bone marrow biopsy
35. Skin Lesions if using local

II. **Procedures that DO require H&Ps include, but are not limited to:**

A. Any procedure involving sedation requires an H&P (including radiology).
B. Angiogram
C. Device implants (e.g., pH probe)
D. Heart catheterization
E. Chemotherapy, blood transfusions and drug infusions
   1. Stable patients receiving any of the above on a regular basis require an H&P or updated progress note once a year.

14) All tissue removed at operation, (excluding traumatically injured digits, 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], fingernails/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, hernia sacs, debridement material, skin or mucosal trimming, and urinary stones),shall be sent to the hospital pathologist who shall make such examinations he/she may consider necessary to arrive at a pathological diagnosis and including a signed 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.

19) 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.

20) 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.

21) 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.

22) 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.

23) Deleted.

24) 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.

25) 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.)**

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

27) 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

28) 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.

29) Consultations: Consultation with other members of the medical staff shall be sought liberally and consistently with good medical practice. The Physician being consulted by an APP Staff Member may request to speak with the Supervising Physician directly. Additionally the following consultation guidelines should be followed:

a. A psychiatric consult must be requested for and offered to all patients admitted subsequent to an attempted suicide or chemical overdose, and this must be documented in the medical record.

b. All requests for consultations shall state the reason(s) for the consultation and pertinent patient information that will be meaningful for the consulting provider. Documentation of meaningful history and physical findings that support the need for consultation should be included in the patient's clinical record.

c. If circumstances are such that the consulting physician determines that the consultation is not required for patient care, the consultation shall not be performed and the reason shall be promptly documented in the progress notes of the patient's clinical record. It is recommended such decision be discussed with the provider requesting the consultations.

d. All requests for consultation shall state the time frame within which the consult should be accomplished. There are three (3) established time frames for providers to respond to requested consultations.

i. **STAT** – responds to clinical situations within 3 hours of being called. Given the urgency of STAT consultations, the requesting provider will make direct contact with the consulting provider to discuss the patient's clinical situation and urgency for the consultation. It is expected STAT consults will be seen within three (3) hours unless a different timeline is determined through Provider to Provider communication.

ii. **ASAP** – responds within the mutually agreed upon timeline, not to exceed 24 hours. Given the urgency of ASAP consultations, the requesting provider will make direct contact with the consulting provider to discuss the patient's clinical situation and urgency for the consultation. It is expected that ASAP consults will be seen within the mutually agreed upon timeline.

iii. **Routine** – responds within 24 hours of consult being called. The requesting provider will make direct contact with the consulting provider to discuss the patient's clinical situation and urgency for the consultation. For non-emergent consultations between 21:00 - 07:00, the physician being consulted should be called the following morning, preferably by the requesting physician.

iv. **As an outpatient**

e. The ED Call Schedule will be utilized for ED call and in-house unattached patients, unless a specific physician is requested. All unavailable dates should be provided to the medical staff office in advance.

f. Failure to follow these Rules and Regulations may result in a referral to the PQPR Committee (Professional Quality and Peer Review Committee).

30) The Chief of Staff may approve emergency changes to the call schedule in the event of exception circumstances.

31) 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.

32) 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.

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

34) All Medical Staff Members must use CPOE; exceptions would be for verbal orders, pre-op orders and all non-surgical outpatient procedures.

35) MEDICAL SERVICES DIRECTORS

A. 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 or surgery; 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 and civil manner.

B. Director of Emergency Services -
Emergency 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; 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 and civil manner.

C. Director of Nuclear Medicine Services -
Nuclear Medicine 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 radiology with nuclear medicine privileges; 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 and civil manner.

D. Director of Respiratory Care / Critical Care Services -
Respiratory/Critical Care 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 with critical care training, or pulmonary medicine; 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 and civil manner.