MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF KAWEAH DELTA HEALTH CARE DISTRICT

MEDICAL STAFF RULES AND REGULATIONS

Adopted by the Medical Staff: September 27, 2023
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ARTICLE I

DEFINITIONS

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

(a) "Admitting Physician" means the physician who orders the admission of a given patient to the District.

(b) "Ambulatory Care" means non-emergency health care services provided to patients without hospitalization, including, but not limited to, day surgeries (with or without general anesthesia) blood transfusions, and I.V. therapy.

(c) "Ambulatory Care Location" means any department in the District or provider based site or facility where ambulatory care is provided.

(d) "Attending Physician" means the patient's primary treating physician or his or her designee(s), who shall be responsible for directing and supervising the patient's overall medical care, for completing or arranging for the completion of the medical history and physical examination after the patient is admitted or before surgery (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient's status to the patient, the referring practitioner, if any, and the patient's family.

(e) "Practitioner" means, unless otherwise expressly limited, any appropriately credentialed physician, resident, dentist, oral surgeon, podiatrist, clinical psychologist, or advanced practice provider, acting within his or her clinical privileges or scope of practice.

(f) "Responsible Practitioner" means any practitioner who is actively involved in the care of a patient at any point during the patient's treatment at the District and who has the responsibilities outlined in these Medical Staff Rules and Regulations. These responsibilities include complete and legible medical record entries related to the specific care/services he or she provides.

ARTICLE II

ADMISSIONS, ASSESSMENTS AND
CARE, TREATMENT AND SERVICES

2.1. Admissions:

(a) A patient may only be admitted to the District by order of a Medical Staff member who is granted admitting privileges. Any patient admitted from the Emergency Department must have admit orders (either verbal or written) given directly to an RN by the admitting physician. Any trauma designated patient presenting to the Emergency Department must be admitted by ACTSS or an orthopedic surgeon with medical consultation as appropriate.

(b) A patient who must be admitted on an emergency basis who does not have an appropriately privileged physician will be assigned to the on-call physician at that time in the applicable department or service.

(c) Except in an emergency, all inpatient medical records will include a provisional diagnosis on the record prior to admission. An appropriate history and physical should be documented. In the case of an emergency, the provisional diagnosis will be recorded as soon as possible.

(d) The admitting physician will provide the District with any information concerning the patient that is necessary to protect the patient, other patients or District personnel from infection, disease or other harm, and to protect the patient from self-harm.

(e) Any patient known or suspected to be suicidal in intent will be admitted to an appropriate setting to protect patient, physicians, and nurses with a prompt behavioral health evaluation.

(f) All inpatient admission and discharge orders must be signed or countersigned by a physician with admitting privileges.

2.2. Responsibilities of Attending Physician:

(a) The attending physician will be responsible for the following while in the District:

(1) the medical care and treatment of the patient while in the District, including appropriate communication among the individuals involved in the patient's care (including personal communication with other physicians where possible);

(2) daily documentation of patient contacts;

(3) the prompt and accurate completion of the portions of the medical record for which he or she is responsible;

(4) communicating with the patient's third-party payor, if needed;

(5) providing necessary patient instructions;

(6) responding to inquiries from the Case Management Committee regarding the plan of care in order to justify the need for continued hospitalization;

(7) responding to Medicare/Medicaid quality of care issues and appeal denials, when appropriate; and

(8) performing all other duties described in these Rules and Regulations.

(b) At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record. Whenever the responsibilities of the attending physician are transferred to another physician outside of his or her established call coverage, an order covering the transfer of responsibility will be entered in the patient's medical record. The attending physician will be responsible for verifying the other physician's acceptance of the transfer and updating the attending physician screen in the electronic medical record ("EMR").

(c) For admissions that are 20 days or more the attending physician (or a physician designee with knowledge of the patient) will complete the physician certification in compliance with the timing requirements in federal regulations. The physician certification includes, and is evidenced by, the following information:

(1) authentication of the admitting order;

(2) the reason for the continued hospitalization;

(3) the expected or actual length of stay of the patient; and

(4) the plans for post-hospital care, when appropriate.

2.3. Availability and Alternate Coverage:

(a) The attending physician will provide professional care for his or her patients in the District by being personally available or by making arrangements with an alternate practitioner who has appropriate clinical privileges to care for the patients.

(b) The attending physician (or his or her designee) will comply with the following patient care guidelines regarding availability:

(1) Calls/texts from the Emergency Department and other Patient Care Units –

(i) respond via phone within 30 minutes to a routine request from the Emergency Department, Intensive Care Unit ("ICU") and ICCU units, Labor and Delivery, NICU, or Operating Room, or within 15 minutes when requested to do so based on the acute nature of the patient's condition; and

(ii) respond via phone within 60 minutes to routine request from all other patient care units, or within 30 minutes when requested to do so based on the acute nature of the patient's condition;

(2) Patients Admitted from the Emergency Department – must personally see the patient within 12 hours of admission;

(3) All Other Inpatient Admissions – must personally see the patient within 24 hours of admission;

(4) ICU & ICCU Patients – must personally see the patient within 2 hours of being admitted to the ICU or ICCU, unless the patient's condition requires that the physician see him or her sooner; and

(5) Patients Subject to Restraints or Seclusion – pursuant to District Policy.

(c) All physicians (or their appropriately privileged designee) will be expected to comply with the patient care guidelines regarding consultations outlined in Article 5 of these Medical Staff Rules and Regulations.

(d) If the attending physician does not participate in an established call coverage schedule with known alternate coverage and will be unavailable to care for a patient, or knows that he or she will be unavailable for patient care responsibilities, the attending physician will document in the medical record the name of the Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability. The attending physician will be responsible for verifying the other physician's acceptance of the transfer.

(e) If the attending physician is not available, the department chair then the Chief Medical Officer or the Chief of Staff will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

2.4. Continued Acute Care Hospitalization:

(a) With respect to the continued acute care hospitalization of a patient, the attending physician will provide whatever information may be requested in accordance with the Utilization Review Plan, including:

(1) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

(2) the estimated period of time the patient will need to remain in the hospital; and

(3) plans for post-hospital care.

Such a response will be provided within 24 hours of the request. Failure to comply with this requirement will be reported to the Chief Medical Officer and Chief of Staff for appropriate action.

(b) If a case does not meet the criteria for continued acute care hospitalization under the Utilization Review Plan, written notification will be given to the District, the patient, and the attending physician. If the matter cannot be appropriately resolved, the Chief Medical Officer and Chief of Staff will be consulted.

ARTICLE III

MEDICAL RECORDS

3.1. General Requirements:

(a) Medical Record: A medical record will be prepared for every patient receiving care at the District facilities. and the Record will contain information to justify inpatient and outpatient services and continued hospitalization, support the diagnoses, and describe the patient's progress and response to medications and services. Each practitioner will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

(b) Medical Record Entries: Only authorized individuals may make entries in the medical record. Electronic entries will be entered through the electronic medical record. Legible handwritten entries will be accepted/entered into the electronic medical record ONLY in an emergent situation or during downtime procedures. Any such written or paper-based entries will be recorded in the Enlish language, scanned and incorporated into the patient's electronic medical record.

(c) Authentication: Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for electronic entries. Each practitioner who is authorized to make entries in the medical record will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with District policy. Signature stamps are not an acceptable form of authentication for written orders and other medical record entries. Written signatures must include the responsible practitioner's identification number.

(d) Forms: All forms and templates used for medical record documentation, both printed and electronic, shall be approved by the Documentation Standards or Clinical Informatics Committee. Modifications of current forms, which often result from changes in state and federal regulations, shall be handled expeditiously by these committees.

(e) Abbreviations: Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations shall be used in the medical record. Abbreviations on the unapproved abbreviations and/or symbols list may not be used. The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file. In general, the use of abbreviations is discouraged in order to avoid misinterpretation and confusion regarding the care of the patient.

(f) Clarity, Legibility, Completeness: All entries in the medical record shall be clear, legible and complete so that other District personnel and medical professionals are able to understand the entry and the author's intentions.

(g) Corrections of Errors: The medical record shall be corrected by making a single line through the erroneous information; the author shall time, date and sign this correction in accordance with District policy. When a dictated or electronic entry requires correction, the author shall dictate or enter an electronic addendum to the initial report. Any error made while entering an order in the Computerized Provider Order Entry ("CPOE") should be corrected by writing another order.

(h) Copying and Pasting: Copying and pasting between notes is strongly discouraged. In any instance where text is copied from a prior note, it must be properly updated.

(i) Inadequate Information: When inadequate information is provided in the progress notes on a denied claim, the Case Management Committee may request the attending physician submit a written medical justification/clarification in a timely fashion.

(j) Ownership of Record: Medical records are the physical property of the District and shall not be removed from the premises except by a subpoena, court order or in accordance with federal and state law and District policy. Unauthorized removal of District patient records from the District facilities is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee.

(k) Permanent Filing of Medical Records: A medical record will not be permanently filed until it is completed by the responsible practitioner, or until it is ordered filed by the HIM Committee under the direction of the Medical Executive Committee. Except in rare circumstances, and only when approved by the Medical Executive Committee, no physician or practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.

(l) Authorized Individuals: The following individuals are authorized to document in the medical record:

(1) attending physicians, resident physicians, intern physicians and advanced practice providers;

(2) nursing providers, including registered nurses ("RNs") and licensed vocational nurses ("LVNs");

(3) physicians responding to a request for consultation when this physician has clinical privileges or is an employee or member of the House Staff at the District;

(4) other health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, and case managers;

(5) students in an approved professional education program who are involved in patient care as part of their education process (e.g., medical students, nursing students) if that documentation is reviewed and countersigned by the student's supervisor, who must also be authorized to document in the medical record; and

(6) non-clinical and administrative staff, as appropriate, pursuant to their job description.

(m) Co-Signature and Co-Documentation Requirements:

(1) Resident physicians require the following documents co-signed and co-documented by a supervising attending physician within the documentation time requirements:

(i) history and physicals: within 24 hours of admission;

(ii) discharge summaries: within five days of discharge; and

(iii) anesthesia/operative/procedure reports: within 24 hours of procedure.

Resident physicians are required to document the name of the supervising attending physician in each document.

(2) Co-documentation consists of an addendum to the original document showing involvement and participation in the management of the patient. Example: "I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note. (*add customized statement regarding the care of the patient*)."

3.2. Content and Timeliness of Medical Record Documentation:

(a) Responsibility of Attending Physician. The attending physician or his/her representative shall be responsible for the preparation of a complete medical record for each patient. The attending physician of record is ultimately responsible for completing the medical record.

(b) General Requirements. All medical records for patients receiving care in the hospital setting or at an ambulatory care location will include the information outlined in this section as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the responsible practitioners and the District:

(1) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

(2) legal status of any patient receiving behavioral health services;

(3) patient's language and communication needs, including preferred language for discussing health care;

(4) evidence of informed consent when required by District policy and, when appropriate, evidence of any known advance directives and/or "Do Not Resuscitate" ("DNR") order;

(5) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;

(6) emergency care, treatment, and services provided to the patient before his or her arrival, if any;

(7) admitting history (i.e., source and type of admission) and physical examination and conclusions or impressions drawn from the history and physical examination;

(8) allergies to foods and medicines;

(9) reason(s) for admission that justify the care, treatment, and services provided;

(10) diagnosis, diagnostic impression, or conditions;

(11) goals of the treatment and treatment plan;

(12) diagnostic and therapeutic orders, procedures, tests, and results;

(13) progress notes made by authorized individuals;

(14) medications ordered, prescribed or administered in the District (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(15) consultation reports;

(16) operative procedure reports and/or notes;

(17) any applicable anesthesia evaluations;

(18) response to care, treatment, and services provided;

(19) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;

(20) reassessments and plan of care revisions;

(21) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;

(22) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice;

(23) total charges and expected source of payment; and

(24) medications dispensed or prescribed on discharge.

(c) Progress Notes:

(1) Clinically pertinent progress notes shall be recorded at the time of observation and must be legible, dated, and timed, shall be documented with a frequency consistent with the acuity of medical problems to reflect the patient's condition and plans for management, and shall always be written in such a manner and with such clarity and frequency that another practitioner could quickly understand the patient's status if care were transferred. Each of the patient's clinical problems should be clearly identified in the progress notes along with the treatment plan for each problem. The clinical problem list and treatment plans should be clearly documented and updated daily. Any complications, hospital-acquired infections and unfavorable reactions to drugs and anesthesia must also be documented. Progress notes may also be entered by advanced practice providers as permitted by their clinical privileges or scope of practice.

(2) Progress notes shall be written per regulations with the following frequency:

(i) Acute Care: At least daily.

(ii) Long-Term Care Facility/Subacute: At least twice weekly during the first month and a minimum of at least once every week thereafter.

(iii) Skilled Nursing Facility/Transitional Care: At least every 30 days, however, based on medical necessity and/or as requested by nursing staff, the Transitional Care patient may need to be seen more often to meet the patient's needs.

(d) Medical Orders:

(1) Orders will be entered directly into the electronic medical record by the ordering practitioner utilizing CPOE. Legible handwritten orders will be accepted/entered into the electronic medical record ONLY in an emergent situation or during downtime procedures. Any such written or paper-based entries will be recorded in the Enlish language, scanned and incorporated into the patient's electronic medical record.

(2) Telephone/verbal orders are accepted only when a prescriber does not have ready access to the electronic health record and there is potential harm to the patient in delaying orders. Examples of appropriate times to take verbal or telephone orders include when the prescribing practitioner is:

(i) scrubbed in a sterile procedure;

(ii) engaged in a code situation; or

(iii) operating a motor vehicle.

(3) Telephone/verbal orders should not be accepted for routine orders or for antineoplastic (chemotherapy) agents.

(e) Medication Reconciliation: accurate and complete medication reconciliation should be completed as follows:

(1) at the time of admission, review home medication list and consider the information when writing the admission medication orders;

(2) when transferring a patient to a different level of care, review current medication orders and modify the orders based on the patient's current condition and responses to prior treatment; and

(3) when discharging a patient, review the home medication list and the current medication list when documenting and prescribing the discharge medications.

The individual performing the reconciliation will use the electronic medical record when performing the above. Any medication discrepancies are to be resolved.

(f) Informed Consent: Informed consent is required prior to surgery and prior to special diagnostic or therapeutic procedures, including blood transfusion, in accordance with District policy, except when the patient's life is in jeopardy and consent cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient for which consent cannot be immediately obtained from parents, guardians or the next of kin, such circumstances should be explained in the patient's medical record. It is the responsibility of the practitioner ordering blood or performing the procedure to discuss with the patient or responsible party the risks, benefits, and alternatives of the procedure, and document this discussion in the patient's medical record before performing any procedure that requires consent. The consent form is used to document this discussion.

(g) Vaginal Delivery Report: The delivery report will be documented by the obstetrician, family physician or nurse midwife responsible for the delivery and must be on the chart at 24 hours. If the delivery occurred without a provider in attendance, then the provider performing the inspection for lacerations and/or the delivery of the placenta shall complete the report. The delivery report will include certain elements as listed in the current MEC approved Required Elements of Delivery Report.

(h) Obstetrical Records:

(1) Medical records of obstetrical patients will contain the information outlined below:

(i) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

(ii) findings during the prenatal period;

(iii) the medical and obstetrical history;

(iv) observations and proceedings during labor, delivery and postpartum period; and

(v) laboratory and x-ray findings.

(2) The obstetrical record will also include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record provided to the District before admission. An H&P Update note

that includes pertinent additions to the history and any subsequent changes in the physical findings must be entered. The prenatal record may be substituted for the history and physical if the last prenatal visit occurred within 30 days of admission.

(3) A discharge summary is not required for a normal delivery of a term pregnancy provided that there were no complications and the infant was not in the Neonatal Intensive Care Unit. A discharge summary is required for a delivery via Cesarean Section.

(i) Newborn Records: Medical records of newborn patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the District:

(1) history of maternal health and prenatal course, including mother's HIV status, if known;

(2) description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid;

(3) time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and problems occurring from birth until transfer from the delivery room;

(4) report of a complete and detailed physical examination within 24 hours following birth; report of a physical examination within 24 hours before discharge and daily during any remaining hospital stay;

(5) physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily;

(6) documentation of infant feeding: intake, content, and amount if by formula; and

(7) clinical course during hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

(j) Diagnostic Reports: All diagnostic reports shall be included in the completed medical record. These reports may be filed in the medical record or may appear in an electronic version in the electronic medical record.

(k) Queries: A query will be sent to the physician requesting clarification if the documentation in the record is not clear or if the discharge summary is not clear

regarding the final diagnoses. The physician shall submit the reply as soon as possible or at least within 72 hours.

(l) Autopsy Report: When an autopsy is performed, a provisional anatomic diagnosis should be documented in the medical record within three days and the complete report should be made part of the medical record within 30 business days unless extenuating circumstances require additional time for toxicology studies, special pathologic procedures, etc.

(m) Ambulatory Care: For patients receiving ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. Clinical documentation should be completed, ideally on the day of the patient visit and no later than 48 hours from the visit.

Medical records of patients who have received ambulatory care services will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the practitioners and the District:

(1) identification data, including the patient's name, sex, address, date of birth, marital status, religious preference and name of authorized representative;

(2) date and time of arrival;

(3) date and time of departure;

(4) service date;

(5) known significant medical diagnoses and conditions;

(6) known significant operative and invasive procedures;

(7) known adverse and allergic drug reactions;

(8) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;

(9) principal and other diagnoses;

(10) treatment plan;

(11) procedures performed;

(12) expected source of payment;

(13) disposition of patient;

(14) medical history, including: immunization record, screening tests, allergy record, nutritional evaluation, neonatal history for pediatric patients;

(15) physical examination report;

(16) consultation reports;

(17) clinical notes, including dates and times of visits;

(18) treatments and instructions, including: notations of prescriptions written, diet instructions and applicable self-care instructions;

(19) reports of all laboratory tests performed, reports of all X-Ray examinations performed, written record of preoperative and postoperative instructions;

(20) operative report on outpatient surgery, including preoperative and postoperative diagnosis, description of findings, techniques used and tissue removed or altered, if appropriate;

(21) anesthesia record, including preoperative diagnosis, if anesthesia is administered;

(22) pathology report, if tissue or body fluid was removed;

(23) clinical data from other providers;

(24) referral information from other agencies; and

(25) all consent forms.

(n) Ambulatory Care in the Teaching Setting:

(1) The content of the medical record will contain the same elements listed above with additional requirements listed below. On medical review, the combined entries into the medical record by the teaching physician and resident constitute the documentation for the service and together must support the medical necessity of the service. Documentation by the resident/intern of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

(2) The teaching physician must personally document the following for every visit:

(i) that the teaching physician performed the service or was physically present during the critical or key portions of the service furnished by the resident/intern; and

(ii) co-sign resident/intern notes and document participation in the management of the patient. Example: "I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note (*add customized statement regarding the care of the patient*)."

(3) Timeliness Guidelines:

(i) Residents/Interns: Complete clinical documentation on the day of the patient's visit and assign to the overseeing provider, no later than 24 hours from the visit.

(ii) Faculty: Sign off on the resident's notes and lock the account on the day of patient's visit, at maximum 48 hours from the visit.

(o) Outpatient Therapeutic and Diagnostic Services: Orders for outpatient therapeutic and diagnostic services will be the responsibility of the ordering provider. All orders for outpatient services must include adequate clinical information to verify the purpose and appropriateness of the requested service. Confirmed diagnoses, symptoms, or the correct ICD code must be entered on the requisition order. "Rule out," "suspected," "probable" and "possible" will not be accepted.

(p) Emergency Care: Medical records of patients who have received emergency care will contain the information outlined in this paragraph. The emergency record shall be documented at the time of service but no later than immediately following discharge/transfer of the patient from the Emergency Department. This documentation will be the joint responsibility of the responsible practitioners and the District:

(1) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

(2) patient's language and communication needs, including preferred language for discussing health care;

(3) time and means of arrival;

(4) record of care prior to arrival;

(5) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;

(6) pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his arrival at the Emergency Department;

(7) results of the medical screening examination, including significant clinical, laboratory, and radiographic findings;

(8) treatment given, if any;

(9) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;

(10) if the patient left against medical advice; and

(11) a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.

(q) Outpatient Testing: Outpatient tests will be read by the practitioner and a report will be available in the medical record within 24 hours if it is urgent or preoperative and within 7 days if it is routine testing.

3.3. Completion and Access to Medical Records:

(a) Record Completion Not Otherwise Specified: The medical record must be complete and in compliance according to the following time frames:

(1) Inpatient and observation bed: within 7 days of discharge.

(2) Rehabilitation and Mental Health: within 7 days of discharge.

(3) Skilled Nursing Facility/Transitional Care and Long-Term Facility/ Subacute: within 7 days of discharge.

(b) Access and Retention of Record: The District will retain medical records in their original or legally reproduced form as follows:

(1) Adult and emancipated minors: 10 years following discharge or final treatment.

(2) Unemancipated minor: At least one year after the patient has attained the age of 18, but in no event less than 10 years following discharge or final treatment.

(3) Obstetrical patient: 19 years following discharge or final treatment.

(c) Release of Records:

(1) Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and District policy.

(2) A patient or his or her duly designated representative may receive copies of the patient's completed medical record, or an individual report, upon presentation of an appropriately signed authorization form in accordance with District policies, unless the attending physician documents that such a release would have an adverse effect on the patient or another person.

(d) Readmissions: In case of readmission of a patient, all previous records shall be available for use of the attending physician. This shall apply whether the patient is attended by the same physician or by another physician.

(e) Access for Study and Research: Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research consistent with District policy, applicable federal and state law, and preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Institutional Review Board (IRB).

(f) Former Members: Subject to the discretion of the Chief Executive Officer (or his or her designee), former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the District.

3.4. Delinquent Medical Records:

(a) General Requirements:

(1) It is the responsibility of any practitioner involved in the care of a hospitalized patient to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the District. If the patient care and/or discharge happened when a resident physician was covering, then the ultimate responsibility for record completion resides with the supervising physician. Non-compliance of medical record completion includes the use of unapproved abbreviations, incomplete PRN medication orders, incomplete/missing documentation, and illegible documentation.

(2) The following documents must be available in the electronic medical record (or on the paper chart when the electronic medical record is experiencing downtime), authenticated, and co-signed (if applicable) within the following time frames:

(i) History and physical: within 24 hours of admission.

(ii) Brief operative/procedure note: before patient moves to the next level of care (not needed if a full operative report is typed and ready before patient moves to the next level of care).

(iii) Full operative/procedure report: within 24 hours of procedure.

(iv) Consultation report: within 24 hours of the documented request for consultation.

(v) Discharge/Death summary(acute care hospital): preferably on the day of discharge and no later than five days from discharge.

(vi) Discharge/Death summary(long-term care): 30 days from discharge.

(vii) Verbal/Telephone orders for medications: 48 hours

(viii) Progress Note (acute care hospital): daily before midnight

(ix) Progress Note (long-term care): every other week

(x) Ambulatory Care Documentation: 48 hours

(xi) Resident Co-Signature: 24 hours from residents signature

(xii) Pre-anesthesia evaluation: before the start of surgery

(xiii) Post-anesthesia evaluation: 48 hours or before discharge whichever is shorter

(xiv) Answering queries: 72 hours

(xv) Emergency Department documentation: immediately following discharge/transfer of the patient from the ED

(xvi) Dictated documents shall be signed within 24 hours of being available for signature

**All documentation must be in the Electronic Medical Record in the above time frames, and electronically signed within 24 hours of being available for signature

(b) Notification: If a medical record is incomplete as defined in Article 3 of Medical Staff Rules and Regulations, the HIM Department will notify the practitioner by email of the delinquency and that his or her clinical privileges are at risk of automatic suspension in accordance with the Medical Staff Bylaws and the HIM suspension policy.

(c) Enforcement: Failure to complete medical records within the timeframes specified in section 3.4.(a)(2) will trigger the process set forth in the Suspension Policy, which can result in administrative suspension and termination of Medical Staff membership and/or privileges following the issuance of the notices required by the Suspension Policy.

(d) Medical Staff Compliance:

(1) As a condition to the receipt or continued exercise of clinical or practice privileges, each practitioner shall agree, in writing, to comply with any policy, procedure or rule approved by the Board of Directors and the Medical Executive Committee relating to the confidentiality of medical records or other protected health information. This obligation includes but is not limited to compliance with the District's HIPAA Notice of Privacy Practices and Organized Health Care Arrangement agreement, together with amendments. Patient medical information shall be maintained in confidence and shall not be used or disclosed except as is expressly permitted by District policy.

(2) To assure compliance with these medical record documentation rules and regulations, the HIM Committee under the direction of the Medical Executive Committee shall, in concert with the HIM Department personnel, develop a systematic plan to evaluate individual performance. Failure to comply with the medical record documentation requirements shall result in notification in writing to the staff member or privilege holder, followed by automatic suspension of medical staff privileges as provided in the Medical Staff Bylaws.

(e) Exceptions: Any requests for special exceptions to the above requirements will be submitted by the practitioner to the HIM Department or HIM Committee and considered by the Chief of Staff.

ARTICLE IV

MEDICAL ORDERS

4.1. General:

(a) Orders will be entered directly into the electronic medical record by the ordering practitioner utilizing CPOE. Legible handwritten orders will be accepted/entered into the electronic medical record ONLY in an emergent situation or during downtime procedures. Any such written or paper-based entries will be recorded in the Enlish language, scanned and incorporated into the patient's electronic medical record.

(b) All orders (including verbal/telephone orders) must be:

(1) dated and timed when documented or initiated;

(2) authenticated by the ordering practitioner. Authentication must include the time and date of the authentication;

(3) documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider; and

(4) for patients in a skilled nursing facility, reviewed and renewed by the ordering practitioner every 45 days of the patient's stay.

(c) Orders for inpatient tests and therapies will be accepted only from:

(1) members of the Medical Staff;

(2) advanced practice providers who are granted clinical privileges by the District, to the extent permitted by their licenses and clinical privileges; and

(3) pharmacists under approved Pharmaceutical and Therapeutic Protocols or collaborative practice agreements.

(d) Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by any of the above as well as practitioners who are not affiliated with the District in accordance with District policy.

(e) The use of the summary (blanket) orders (e.g., "renew," "repeat," "resume," and "continue") to resume previous medication orders is not acceptable.

(f) Orders for "daily" tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering practitioner at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.

(g) All orders are reviewed and reconciled by the ordering practitioners (i) when a patient is transferred into or out of ICU or ICCU, (ii) when the patient has surgery (other than vascular access, PEG tube, tubal ligation, superficial biopsy, cystoscopy, or tracheostomy), (iii) after delivery of an infant, and (iv) when a patient is transferred to a different level of care (e.g., SNF).

(h) All orders for medications administered to patients will be:

(1) reviewed by the pharmacist before the initial dose of medication is dispensed (except for orders for oxygen services and in an emergency when time does not permit);

(2) reconciled at the time of admission, when the patient is transferred to a different level of care, and when the patient is discharged; and

(3) reviewed by the attending physician or his or her designee in accordance with the requirements outlined in Section 4.5 of these Rules and Regulations.

(i) All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be reentered.

(j) Advanced practice providers may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the District.

4.2. Verbal Orders:

(a) A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering practitioner or if a delay in accepting the order could adversely affect patient care. Examples of situations where it is appropriate to give a verbal order include when the ordering practitioner is

scrubbed in a sterile procedure, is engaged in a code situation, or is operating a motor vehicle. Verbal orders should not be accepted for routine orders or for antineoplastic (chemotherapy) agents.

(b) All verbal orders will include the date and time of entry into the medical record, identify the names of the individuals who gave, received, and implemented the order, and then be authenticated with date and time by the ordering practitioner or another practitioner who is responsible for the care of the patient, as authorized by District policy and state law.

(c) Authentication of medication orders will take place by the ordering practitioner within 48 hours after the order was given. Non-medication orders will be authenticated within 5 days of patient discharge for the acute care hospital and within 30 days of discharge from long-term care.

(d) For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order.

(e) Verbal orders may be received and recorded by the following, within the scope of his or her practice and licensure: registered nurses, licensed vocational nurses, pharmacists, occupational therapists, speech therapists, respiratory therapists, physical therapists, registered technologists and trained clinical dieticians.

(f) Verbal orders in a skilled nursing unit may only be given to licensed nurses, pharmacists, physician assistants (from his or her supervising physician only), and certified respiratory therapists when the orders relate specifically to respiratory care. Such orders shall be recorded immediately in the patient's medical record by the person receiving the order and will include the date and time of the order.

4.3. Standardized Procedures:

(a) The Medical Executive Committee and the District's nursing and pharmacy departments must review and approve any standardized procedures that permit treatment to be initiated by an individual (for example, a nurse) without a prior specific order from the attending physician. All standardized procedures will identify well-defined clinical scenarios for when the procedure is to be used.

(b) The Medical Executive Committee will confirm that all approved standardized procedures are consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also ensure that such standardized procedures are reviewed periodically.

(c) If the use of a standardized procedure has been approved by the Medical Executive Committee, treatment may be initiated for a patient pursuant to the standardized procedure: (1) by a nurse or other authorized individual acting

within his or her scope of practice who activates the standardized procedure; or (2) when a nurse enters documentation into the medical record that triggers the standardized procedures.

(d) When used, standardized procedures must be dated, timed, and authenticated promptly in the patient's medical record by the individual who activates the procedure or by another responsible practitioner.

(e) The attending physician must authenticate the initiation of each standardized procedure after the fact, with the exception of those for influenza and pneumococcal vaccines.

4.4. Self-Administration of Medications:

(a) Refer to Patient Care Policy PC.19-Medication: Administration for self-administration of medications

4.5. Stop Orders:

Refer to Patient Care Policy PC.19-Medication: Administration for Stop Orders.

4.6. Orders for Drugs and Biologicals:

(a) Refer to Patient Care Policy PC.19-Medication: Administration for orders for drugs and biologicals

4.7. Orders for Radiology and Diagnostic Imaging Services:

(a) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the District, or, consistent with state law, other practitioners authorized by the Medical Staff and governing body to order services.

(b) Orders for radiology services and diagnostic imaging services must include at minimum: (i) the patient's name and a second identifier, such as date of birth or medical record number; (ii) the name of the ordering individual and contact information so that the provider or a designee can be contacted with clarifying questions or to report critical findings; (iii) the specific procedure requested; and (iv) sufficient clinical data, including signs, symptoms, their duration and (if applicable) mechanism of injury, to justify the procedure. "rule out", "suspected", "probable", and "possible" are not acceptable. Requested procedures will not be performed in the absence of sufficient clinical history.

4.8. Orders for Oxygen Services:

Oxygen is a medicine and should be prescribed by dosage, time and method (e.g., nasal cannula 5 liters per minutes). All oxygen orders should state whether the administration of the oxygen should be continuous or intermittent. If the physician does not write "intermittent" on his or her order, such order will mean that oxygen is to be administered continuously.

ARTICLE V

CONSULTATIONS

5.1. Requesting Consultations:

(a) The attending physician shall be responsible for requesting a consultation when indicated and for contacting a qualified consultant.

(b) Requests for consultations shall be entered in the patient's medical record. In addition to documenting the reasons for the consultation request in the medical record, the attending practitioner will make reasonable attempts to personally contact the consulting practitioner to discuss the consultation request.

(c) Failure by an attending practitioner to obtain consultations as set forth in this Section will be reviewed through the professional practice evaluation policy or other applicable policy.

(d) Where a consultation is required for a patient in accordance with Section 5.3 or is otherwise determined to be in patient's best interest, the Chief Medical Officer, the Chief of Staff, or the appropriate clinical Department Chair shall have the right to call in a consultant.

5.2. Responding to Consultation Requests:

(a) Any individual with clinical privileges may be asked for consultation within his or her area of expertise. Individuals who are requested to provide a consultation are expected to respond in accordance with the following patient care guidelines:~~.~~

(1) Critical Care Consults – must be completed within 4 hours of the request, unless the patient's condition requires that the physician complete the consultation sooner (all such requests for critical care consults – e.g., "stat," "urgent," "today," or similar terminology – must also include personal contact by the requesting individual to the consulting physician); and

(2) Routine Consults – must be completed within 24 hours of the request or within a time frame as agreed upon by the requesting and consulting physicians.

(b) The physician who is asked to provide the consultation may ask an advanced practice provider with appropriate clinical privileges to see the patient, gather data, and order tests. However, such evaluation by an advanced practice provider will not relieve the consulting physician of his or her obligation to personally see the patient within the appropriate time frame, unless the physician requesting the

consultation agrees that the evaluation by the advanced practice provider is sufficient.

(c) When providing a consult, the consulting physician will review the patient's medical record, brief the patient on his or her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the consulting physician will be directly communicated to the attending physician.

(d) Failure to respond to a request for a consultation in a timely and appropriate manner will be reviewed through the applicable Medical Staff policy unless one of the following exceptions applies to the physician asked to provide a consultation:

(1) the physician has a valid justification for his or her unavailability (e.g., out of town);

(2) the patient has previously been discharged from the practice of the physician;

(3) the physician has previously been dismissed by the patient;

(4) the patient indicates a preference for another consultant; or

(5) other factors indicate that there is a conflict between the physician and the patient (i.e., the patient in question has previously initiated a lawsuit against the physician) such that the physician should not provide consultation.

To the extent possible, if the requested physician is unable to provide a consultation based on the aforementioned criteria (paragraphs (1) - (5)), then the requesting physician should find an alternate consultant. If the attending is unable to do so, then the appropriate Department Chair, the Chief of Staff, or the Chief Medical Officer can appoint an alternate consultant.

5.3. Recommended and Required Consultations – General Patient Care Situations:

(a) Consultations are recommended in the following circumstances:

(1) on elective major surgical cases in which the patient is high risk for morbidity/death;

(2) status asthmaticus/pulmonary or critical care consultation;

(3) ARDS/pulmonary or critical care consultation;

(4) chronic ventilator patients/pulmonary or critical care consultation;

(5) pneumonia requiring mechanical ventilation/pulmonary or critical care consultation;

(6) complicated myocardial infarction/cardiology or critical care consultation;

(7) bacterial endocarditis/cardiology and infectious disease;

(8) complex post-op patients/critical care or pulmonary or cardiology consultation;

(9) coma/neurology or neurosurgery consultation;

(10) diabetic keto-acidosis or Hyperosmolar coma/endocrinology or critical care consultation;

(11) acute renal failure requiring renal replacement therapy/nephrology consultation;

(12) DIC/hematology or critical care;

(13) status epilepticus/neurology;

(14) spinal cord compression/neurosurgery or neurology or orthopedic surgery consultation;

(15) GI bleeding with hemodynamic compromise, or hematochezia or hematemisis/gastroenterology or surgery consultation;

(16) SAH, ICB/neurosurgery or neurology; and

(17) hemodynamic monitoring with titration of vasoactive medications/ critical care or cardiology or pulmonary consultation.

(b) Except in emergency cases, consultations are required in all cases in which, in the judgment of the attending physician:

(1) the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(2) there is doubt as to the best therapeutic measures to be used;

(3) unusually complicated situations are present that may require specific skills of other practitioners;

(4) the patient exhibits severe symptoms of mental illness or psychosis;

(5) when the patient (or family) requests a consultation; and

(6) complex cases for which the attending physician needs additional advice.

Additional requirements for consultation may be established by the Medical Staff or District as required.

5.4. Mental Health Consultations:

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

5.5. Surgical Consultations:

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the consultant, including relevant findings and reasons, will be recorded in the patient's medical record in a timely manner.

5.6. Content of Consultation Report:

(a) Each consultation report will be completed in a timely manner and will contain a dictated or electronically documented opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," will not constitute an acceptable consultation report. The consultation report will be made a part of the patient's medical record.

(b) When non-emergency operative procedures are involved, the consultant's report will be recorded in the patient's medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.

5.7. Concerns:

(a) If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he or she shall activate the chain of command to communicate their concern.

(b) A practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation or a consultant who believes that a planned procedure is medically inappropriate may discuss the issue with the applicable Department Chair, the Chief of Staff, or the Chief Medical Officer.

ARTICLE VI

SURGICAL SERVICES

6.1. Pre-Procedure Protocol:

(a) Except in emergencies, the physician responsible for the patient's care will thoroughly document in the medical record prior to transport to the operating room: (i) the provisional diagnosis and the results of any relevant laboratory tests; (ii) a properly executed informed consent; and (iii) a complete history and physical examination (or completed short-stay form, as appropriate). In emergencies involving a minor or unconscious patient for which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, such circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.

(b) The following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs (except in an emergency situation):

(1) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

(2) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;

(3) the attending physician (i.e., surgeon) is in the Hospital; and

(4) the procedure site is marked and a "time out" is conducted immediately before starting the procedure, as described in the Operative Procedure Site Verification and Time Out Protocol.

(c) Recognizing that the safety of the patient is always paramount, a surgeon undertaking a major procedure should have a qualified first assistant. A major procedure is defined as one which may be considered a hazard to the life of the patient or in which a major body cavity is opened; this excludes cesarean sections.

(d) In the event an emergency surgery is going to cause another surgeon to be "bumped or delayed," the surgeon performing the emergency surgery is to personally speak to the surgeon whose case is being delayed or bumped to discuss the reason for the "delay/bump." In the event of an imminently life-threatening emergency, someone other than the surgeon may call the surgeon being bumped.

6.2. Post-Procedure Protocol:

(a) An operative report must be documented after an operative procedure. The operative report will include certain elements as listed in the current MEC approved Required Elements of Operative/Procedure Report.

(b) If an operative report cannot be typed directly into the EMR immediately after the operation or procedure, a brief post-op note must be entered into the medical record by the attending physician before the patient is transferred to the next level of care. The brief post-op note will include certain elements as listed in the current MEC approved Required Elements of Brief Operative Note.

6.3. Tissue Specimens:

(a) All tissue specimens and foreign bodies removed at the time of surgery or invasive procedure, except those specified in the "General Rules Regarding Surgical Care," shall be sent to the Department of Pathology for examination in order to arrive at a pathological diagnosis. All specimens shall be handled in accordance with applicable Medical Staff or District policies. Unless there are extenuating circumstances, the report of this examination shall be available within 72 hours. In the event that a therapeutic intervention is planned for a patient that is based on the pathological report from another institution, the physician who is planning the therapeutic intervention shall be responsible for the review of the specimen or the report prior to commencement of the therapeutic intervention.

(b) All specimens removed at operation shall be sent to the pathologist (with the exception of those specimens listed below), who shall make such examination necessary to arrive at a pathological diagnosis. The authenticated report shall be made a part of the patient's medical record.

(c) Specimens exempt from pathological examination:

(1) specimens that, by their nature or condition, do not permit fruitful examination such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;

(2) therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

(3) traumatically injured members that have been amputated and for which examination for medical or legal reasons is not considered necessary;

(4) foreign bodies (for example, bullets) that, for legal reasons, are given directly in the chain of custody to law enforcement representatives;

(5) specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant; and

(6) placentas that are grossly normal and have been removed in the course of nonoperative obstetrics. Placentas removed at Cesarean delivery will be held for 48 hours and sent to Pathology only upon the request of the obstetrician or pediatrician.

ARTICLE VII

ANESTHESIA SERVICES

7.1. General:

(a) Anesthesia may only be administered by the following qualified practitioners:

(1) an anesthesiologist;

(2) an M.D. or D.O. (other than an anesthesiologist) with appropriate clinical privileges;

(3) a dentist, oral surgeon or podiatrist, in accordance with state law, with appropriate clinical privileges; or

(4) a Certified Registered Nurse Anesthetist ("CRNA");

(b) "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep sedation. "Anesthesia" does not include topical or local anesthesia, minimal, moderate or procedural sedation, or analgesia via epidurals/spinals for labor and delivery.

(c) Because it is not always possible to predict how an individual patient will respond to minimal, moderate or procedural sedation, a qualified practitioner with expertise in airway management and advanced life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

(d) General anesthesia for surgical procedures will not be administered outside of the operating room unless the surgical and anesthetic procedures are considered lifesaving.

7.2. Pre-Anesthesia Procedures:

(a) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia prior to an inpatient or outpatient procedure requiring anesthesia services. Documentation of the anesthesia preoperative evaluation must include date, time, and signature of anesthesia provider. Timeliness of Attending co-signature/co-documentationfor residents will adhere to the Medical Staff Rules & Regulations, section 3.1.m.

(b) The evaluation will be recorded in the medical record and will include:

(1) a review of the medical history, including anesthesia, drug and allergy history;

(2) an interview, if possible, preprocedural education, and examination of the patient;

(3) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);

(4) identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

(5) additional pre-anesthesia evaluation, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation);

(6) informed consent for anesthesia, which will be obtained through discussion with the patient and/or family regarding anesthesia options and risks.; and

(7) development of a plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care, and discussion with the patient (or the patient's representative) of the risks and benefits of the delivery of anesthesia.

Except in cases of emergency, this evaluation must be recorded prior to the patient's transfer to the operating area and before any pre-operative medication has been administered. All patients scheduled for surgery shall be examined pre-operatively by an anesthesiologist or CRNA within 24 hours prior to the scheduled surgery. If the anesthesia evaluation has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours prior to surgery/invasive procedure, and an update recorded in the medical record by an individual who has been granted clinical privileges by the district to perform Anesthesia services.

7.3. Monitoring During Procedure:

(a) The anesthesiologist or CRNA shall insert appropriate notes into the patient's medical record on approved paper or electronic forms. There must be an intraoperative anesthesia record or report for each patient who receives general, regional or monitored anesthesia. The anesthesia record shall indicate the state of consciousness of the patient on arrival in the operating room and shall include all

events occurring during the administration of the anesthetic. A paper or electronic original shall remain in the patient's medical record.

(b) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

(1) the name and District identification number of the patient;

(2) the name of the practitioner(s) who administered anesthesia;

(3) the name, dosage, route, and time of administration of drugs and all anesthetic agents;

(4) the technique(s) used and patient position(s), including the insertion/use of any intravascular or airway devices;

(5) the name and amounts of IV fluids, including blood or blood products, if applicable;

(6) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(7) any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

(c) While current practice dictates that the patient receiving moderate sedation be monitored and evaluated before, during, and after the procedure by trained practitioners, an intraoperative anesthesia report is not required because moderate sedation is not "anesthesia."

7.4. Post-Anesthesia Evaluations:

(a) A post-anesthesia evaluation will be completed and documented by an individual qualified and credentialed to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services.

(b) The calculation of the 48-hour time frame begins at the point the patient is moved into the designated recovery area. Except in cases where post-operative sedation is necessary for the optimum medical care of the patient (e.g., ICU), the evaluation generally would not be performed immediately at the point of movement from the operative area to the designated recovery area. Accepted standards of anesthesia care indicate that the evaluation may not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so

as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks, etc.

(c) The evaluation can occur in the Post-Anesthesia Care Unit ("PACU") or the ICU or other designated recovery location. The evaluation is required any time general, regional, or monitored anesthesia has been administered to the patient. Unusual post-anesthetic complications occurring in the PACU shall be recorded. The anesthesiologist or CRNA shall record his/her post-anesthetic evaluation on approved paper or electronic forms or, when necessary, in a progress note. This evaluation shall contain a note of a post-anesthetic visit after the patient has recovered from anesthesia, describing the presence or absence of anesthesia-related complications. Exceptions may be warranted on outpatients discharged prior to this evaluation.

(d) Although physicians may ordinarily delegate tasks to other qualified medical personnel, the post-anesthesia evaluation may not be performed by practitioners who are not qualified to administer anesthesia. The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:

(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; and

(7) post-operative hydrations.

Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

(e) An anesthesiologist or CRNA shall be responsible for the discharge of the patient from the PACU. Whenever anesthesia services and post-anesthesia care is provided outside the operating room, the level of care must be comparable to the care provided in the operating room suite. Any patients who have received anesthesia, other than local anesthesia, should be examined before discharge unless they meet established criteria for discharge ("discharge by criteria") and must be accompanied home by a designated person. The examination, when required, is performed by an anesthesiologist or CRNA. The anesthesiologist or

CRNA will insure that the patient is given adequate post-anesthesia recovery instructions, and will provide the patient or responsible party with a contact number for post-operative problems or questions which may arise after the patient has left the hospital.

7.5. Direction of Anesthesia Services:

Anesthesia services will be under the direction of a qualified physician with the appropriate clinical privileges and who is responsible for the following:

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

ARTICLE VIII

GENERAL RULES FOR PEDIATRIC PATIENTS

8.1. NICU Admissions:

Only properly privileged practitioners can admit to the NICU.

8.2. Pediatric Call:

The pediatrician on call to cover unassigned patients through the Emergency Department is also on call to cover C-sections for unassigned infant patients.

ARTICLE IX

PHARMACY

9.1. General Rules:

(a) Orders for drugs and biologicals are addressed in the Medical Orders Section.

(b) Adverse medication reactions and errors in administration of medications will be immediately documented in the patient's medical record and reported to the attending physician, the director of pharmaceutical services, and, if appropriate, to the District's quality assessment and performance improvement program.

(c) The pharmacist shall be able to write orders for therapeutic substitutions or interchanges for pharmacokinetic drug therapy/lab order as approved by the Pharmacy and Therapeutics Committee and shall sign the order with his or her name and note "per protocol."

(d) Except for investigational or experimental drugs in a clinical investigation, all drugs and biologicals administered will be listed in the latest edition of: United States Pharmacopeia, National Formulary, the American Hospital Formulary Service, or AMA Drug Evaluations.

(e) The use of investigational or experimental drugs in clinical investigations will be subject to the rules established by the Medical Executive Committee and the Institutional Review Board.

(f) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to members of the Medical Staff, other practitioners and District staff.

9.2. Storage and Access:

(a) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with District policy, consistent with federal and state law.

(1) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.

(2) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.

(3) Only authorized personnel may have access to locked or secure areas.

(b) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, to the Chief Executive Officer, and others per medical staff policy.

ARTICLE X

RESTRAINTS AND SECLUSION

Restraints and seclusion will be governed by applicable District Policy.

ARTICLE XI

EMERGENCY SERVICES

11.1. General:

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

11.2. Medical Screening Examinations:

(a) Emergency Department. Medical screening examinations, within the capability of the District, will be performed on all individuals who come to the District requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations within applicable District policies and procedures are defined as:

(1) members of the Medical Staff;

(2) residents under the supervision of an appropriately credentialed Emergency Medicine attending physician;

(3) appropriately credentialed advanced practice providers upon completion of specific department orientation; and

The County Crisis team, comprised of licensed social workers, licensed marriage and family therapists, and RNs will provide appropriate mental health screenings for psychiatric patients.

(b) Labor and Delivery. Obstetrical medical screening exams, within the capability of the District, will be performed on all individuals who come to the District requesting examination or treatment to determine the presence of an emergency obstetrical condition. Qualified medical personnel who can perform medical screening examinations within applicable District policies and procedures are defined as:

(1) members of the Medical Staff with OB/GYN privileges;

(2) residents under the supervision of an OB/GYN or an appropriately credentialed Family Medicine attending physician;

(3) Certified Nurse Midwives with OB privileges; and

(4) Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment.

(c) Pediatric Patients. When pediatric patients present to the Emergency Department, if the diagnosis is clearly a surgical one, the Emergency Department physician will call the on-call general surgeon directly to admit the patient. If the Emergency Department physician is uncertain of the medical or surgical diagnosis, the Emergency Department physician will directly call the on-call pediatrician to evaluate the patient. The pediatrician will consult with a surgeon, as necessary.

(d) The results of the medical screening examination must be documented within 48 hours of the conclusion of an Emergency Department visit.

11.3. On-Call Responsibilities:

(a) At a minimum, participants in the on-call roster are expected to follow all applicable laws and regulations, including EMTALA, and respond in accordance with the time frames outlined in Section 2.3(b) of these Rules and Regulations.

(b) A determination as to whether the on-call physician must physically assess the patient, and the expected time frame for doing so should be mutually agreed to by the emergency department and on-call attending physician. In the event a mutually agreeable determination cannot be reached the on-call physician must physically see the patient in the Emergency Department And document evaluation and plan of care of the patient.

(c) If the on-call physician is asked by the Emergency Department physician to evaluate or assist with the care of a patient, and it is mutually agreed, after appropriate medical screening examination and stabilization have been accomplished, that evaluation/treatment will be provided by the on-call physician in an office setting, the on-call physician shall provide the agreed upon evaluation/treatment without regard to the patient's payment source, insurance status, economic status or ability to pay. The on-call physician may, if necessary and appropriate, make timely and appropriate arrangements to transfer responsibility for that evaluation/treatment to another qualified and willing practitioner. The responsibility for evaluation/treatment is limited to that medical care for the condition for which the patient presented at the Emergency Department.

(d) In addition, the on-call physician is expected to provide care to emergency patients without discrimination based on race, ethnicity, religion, national origin, citizenship, age, sex, sexual orientation, or pre-existing medical condition, except to the extent such circumstances are medically significant to the provision of appropriate care.

(e) All members of the Medical Staff are responsible for the emergency care of their own patients who come to the Emergency Department. If a physician is not personally available, he or she is responsible to provide back-up coverage by another member of the Medical Staff with admitting privileges.

11.4. Unavailability of Emergency Department On-Call Physician While On Call:

(a) In the event of potential unavailability of an on-call physician in a particular specialty due to being overwhelmed with cases, tied-up in the operating room or the ICU with lengthy/difficult cases, extreme fatigue or illness, the on-call physician must contact and discuss the situation with his or her Department Chair or, in the absence of the Department Chair, the Vice-Chair in order to decide if the individual can be removed from call. Should the on-call physician and Department Chair (or Vice-Chair) be unable to resolve the on-call issues, then the Department Chair must contact the Chief of Staff.

(b) The on-call physician is obliged to remain on call and provide services unless:

(1) an alternative for coverage has been arranged; or

(2) the Department Chair or the Chief of Staff has approved taking the on-call physician off call and has notified the Emergency Department of the duration of any approved removal from Emergency Department on-call responsibility.

ARTICLE XII

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

12.1. Who May Discharge:

(a) Patients will be discharged only upon the order of the appropriately credentialed practitioner.

(b) At the time of discharge, the appropriately credentialed practitioner will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.

(c) If a patient insists on leaving the District against medical advice, or without proper discharge, a notation of the incident will be made in the patient's medical record.

12.2. Identification of Patients in Need of Discharge Planning:

(a) All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will be identified at an early stage of hospitalization. The District should reevaluate the needs of the patients on an ongoing basis, and prior to discharge, as they may change based on the individual's status.

12.3. Discharge Planning:

(a) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The responsible practitioner is expected to participate in the discharge planning process.

(b) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

12.4. Discharge Summary:

(a) A concise, typed discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made with another practitioner who agrees to assume this responsibility. All discharge summaries will follow the current MEC-approved Require Elements of Discharge Summaries.

(b) A discharge progress note may be used to document the discharge summary for outpatient ambulatory surgery patients observed on a medical/surgical floor for less that 24 hours, normal obstetrical deliveries, and normal newborn infants.

(c) A discharge/death summary is required in any case in which the patient dies while admitted to the District's inpatient facilities (acute care hospital, mental health ospital, or skilled nursing facility), regardless of the length of admission.

(d) For long-term care patients, the discharge summary must be completed within 30 days.

12.5. Discharge of Minors and Incompetent Patients:

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

12.6. Discharge Instructions:

(a) Upon discharge, the responsible practitioner, along with the District staff, will provide the patient with information regarding why he or she is being discharged and educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.

(b) Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or representative will be provided appropriate language resources to permit him or her to understand. If the patient's primary language is not English, discharge instructions will be translated and provided verbally and in writing in accordance with the applicable District policy.

(c) The responsible practitioner, along with the District staff, will also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.

(d) When the District determines the patient's transfer or discharge needs, the responsible practitioner, along with the District staff, promptly will provide appropriate information to the patient and the patient's family when it is involved in decision-making and ongoing care.

(e) When continuing care is needed after discharge, the responsible practitioner, along with the District staff, will provide appropriate information to the other health care providers, including:

(1) the reason for discharge;

(2) the patient's physical and psychosocial status;

(3) a summary of care provided and progress toward goals;

(4) community resources or referrals provided to the patient; and

(5) discharge medications.

ARTICLE XIII

TRANSFERS TO AND FROM OTHER FACILITIES

13.1. EMTALA Transfers:

(a) The transfer of a patient with an emergency medical condition from the Emergency Department to another hospital will be made in accordance with the District's applicable policy and in compliance with all applicable state and federal laws, such as EMTALA.

(b) Before any such transfer occurs, a physician must see the patient and enter a certification in the patient's medical record indicating that the medical benefits to be received at another medical facility outweigh the risk to the patient of being transferred (including, in the case of a woman in labor, the risks to the unborn child).

13.2. All Other Patient Transfers:

(a) ***General.*** The process for providing appropriate care for a patient for all other transfers from the District to another facility, includes:

(1) assessing the reason(s) for transfer;

(2) establishing the conditions under which transfer can occur;

(3) evaluating the mode of transfer/transport to assure the patient's safety; and

(4) ensuring that the organization receiving the patient also receives necessary medical information and assumes responsibility for the patient's care after arrival at that facility.

(b) ***Procedures*** Patients will be transferred to another hospital or facility based on the patient's needs and the District's capabilities. The responsible practitioner will take the following steps as appropriate under the circumstances:

(1) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;

(2) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;

(3) involve the patient and all appropriate practitioners, District staff, and family members involved in the patient's care, treatment, and services in the planning for transfer; and

(4) provide the following information to the patient whenever the patient is transferred:

(i) the reason for the transfer;

(ii) the risks and benefits of the transfer; and

(iii) available alternatives to the transfer.

(c) ***Provision of Information.*** When patients are transferred, the responsible practitioner will provide appropriate information to the accepting practitioner/facility, including:

(1) reason for transfer;

(2) significant findings;

(3) a summary of the procedures performed and care, treatment and services provided;

(4) condition at discharge;

(5) information provided to the patient and family, as appropriate; and

(6) working diagnosis.

(d) ***Patient Requests.*** When a patient requests a transfer to another facility, the responsible practitioner will:

(1) explain to the patient his or her medical condition;

(2) inform the patient of the benefits of additional medical examination and treatment;

(3) inform the patient of the reasonable risks of transfer;

(4) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and

(5) provide the receiving facility with the same information outlined in paragraph (c) above.

ARTICLE XIV

HOSPITAL DEATHS AND AUTOPSIES

14.1. Death and Death Certificates:

(a) In the event of a patient death in the District, the deceased will be pronounced dead by a physician or RN, within a reasonable time frame.

(b) Per Health and Safety Code Sections 102800 and 102975 the medical certification of the cause of death within the death certificate will be completed by the attending physician (or his or her designee) within 15 hours of the time of death.

14.2. Release of the Body:

(a) The body of a deceased patient can be released only with appropriate consent, consistent with all applicable state law.

14.3. Organ and Tissue Procurement:

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

14.4. Autopsies:

(a) Autopsies should be considered in cases of unusual death or of particular medical-legal or educational interest and in the following circumstances:

(1) deaths in which an autopsy may help to explain unknown or unanticipated medical complications;

(2) deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards; and

(3) deaths at any age in which it is believed that an autopsy would disclose a known or suspected illness that also may have a bearing on survivors or recipients of transplant organs.

(b) Unless otherwise required by the County Coroner, an autopsy will only be performed after permission is obtained from the patient's or legally authorized agent and documented in the medical record, along with any applicable permission to donate organs or tissue. The attending physician (or his or her designee) must be notified when an autopsy is to be performed.

(c) Except for Coroner cases or family requests, all autopsies will be performed by the District's Pathology Department. In the event of a family request, it is the family's responsibility for all arrangements and fees. The Pathology Department will be provided notification whenever permission to perform an autopsy has been granted. In addition, if not otherwise attainable from the patient's medical record, the Pathology Department will discuss the case with the attending physician (or his or her designee) prior to starting of the autopsy, so that the clinical diagnosis and any concerns, including any infection hazards, can be provided to the pathology staff.

(d) The Pathology Department reserves the right to refuse autopsy services on a patient that meets criteria for forensic medical examination by the County Coroner. In addition, the pathology staff reserves the right to require notification of the County Coroner prior to performing an autopsy.

(e) If autopsy is performed on-site, it is expected that a copy of the preliminary autopsy diagnoses will be completed within four working days and that the entire autopsy will be completed within 30 days, unless extenuating circumstances, such as special toxicological studies, special pathologic procedures, etc., pertain. As part of the performance improvement program, a copy of the autopsy results will be sent to the patient's clinical service, and findings from autopsies may be used as a source of clinical information in seeking to continue to improve patient care.

ARTICLE XV

MISCELLANEOUS

15.1. Adverse Events:

Reportable adverse events will be handled in accordance with district policies. (See Administrative Policies AP.10 – Occurrence Reporting Process and AP.87 – Sentinel Event and Adverse Response and Report for a list or reportable events and further information.)

15.2. Decisions for Unrepresented Patients:

Upon determination that a patient lacks the capacity to make health care decisions, the Health Care Decisions for Unrepresented Patients (as referenced in KDHCD administrative policy AP.145) will be consulted.

15.3. Self-Treatment and Treatment of Family Members:

(a) Members of the Medical Staff are discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.

(b) A member of the Medical Staff shall not admit or perform an invasive procedure on a member of his or her immediate family, including spouse, parent, child, or sibling, except in the following circumstances:

(1) no viable alternative treatment is available, as confirmed through discussions with the Chief of Staff or the Chief Executive Officer;

(2) the patient's disease is so rare or exceptional and the physician is considered an expert in the field;

(3) in the Emergency Department where the Medical Staff member is the attending physician or is on call; or

(4) in an emergency where no other Medical Staff member is readily available to care for the family member.

15.4. Orientation of New Physicians:

Each new physician will be provided an overview of the District and its operations.

15.5. HIPAA Requirements:

All members of the Medical Staff and advanced practice providers will adhere to the security and privacy requirements of HIPAA.

ARTICLE XVI

AMENDMENTS

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

ARTICLE XVII

ADOPTION

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

Adopted by the Medical Staff: September 27, 2023

Approved by the Board: September 27, 2023

APPENDIX A

LIST OF SERIOUS REPORTABLE EVENTS

Surgical events, including:

1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent.

2. Surgery performed on the wrong patient.

3. The wrong surgical procedures performed on a patient that is inconsistent with the documented informed consent.

4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or device events, including:

1. Patient death or serious disability associated with the use of a contaminated drug, device or biologic provided by the hospital when the contamination is the result of generally detectable contaminants in the drug, device, or biochemical, regardless of the source of the contamination or the product.

2. Patient death or serious disability associated with the use of function of a device in patient care in which the device is used or functions other than as intended.

3. Device includes, but is not limited to, a catheter, drain or other specialized tube, infusion pump or ventilator.

4. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular embolism.

Patient protection events, including:

1. An infant discharged to the wrong person.

2. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capability.

3. A patient suicide or suicide attempt resulting in serious disability while being cared for in any of the District facilities due to patient actions after admission, excluding deaths resulting from self-inflicted injuries that were the reason for the admission to the hospital.

Care management issues, including:

1. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on selected doses.

2. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

3. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the District, including events that occur within 42 days, excluding post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy.

4. Patient death or serious disability directly related to hypoglycemia reaction due to the administration of ABO-incompatible blood or blood products.

5. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

6. A Stage 3 or 4 ulcer, acquired after admission to the District facilities, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

7. A patient death or serious disability due to spinal manipulative therapy performed at the District.

Environmental events, including:

1. A patient death or serious disability associated with an electric shock while being cared for in the District, excluding events involving planned treatments such as electric counter shock.

2. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

3. A patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.

4. A patient death associated with a fall while being cared for in any of the District facilities.

5. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.

Criminal events, including:

1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

2. The abduction of a patient at any age.

3. The sexual assault of a patient within or on the grounds of any District facilities.

4. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of the District.

"Serious Disability" – a physical or mental impairment that substantially limits one or more of the major life activities of an individual or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.