REHOBOTH MCKINLEY CHRISTIAN HEALTHCARE SERVICES

RULES AND REGULATIONS

OF THE

MEDICAL STAFF

GALLUP, NEW MEXICO

RMCHCS
Rehoboth McKinley
Christian Health Care Services

Effective Date: 1/23/14

RMCHCS MEDICAL STAFF RULES AND REGULATIONS
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Section 1 - General Patient Management

1.1 Who May Admit Patients and General Requirements

a. Admitting Privileges - A patient may be admitted to the hospital only by physicians, dentists, and podiatrists who have been appointed to the medical staff and who have been granted privileges to admit patients. All practitioners shall be governed by appropriate admitting policies of the Hospital.

b. Provisional Diagnosis - Except in an emergency, no patient shall be admitted to the hospital unless a provisional diagnosis has been stated in the patient's medical record. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

c. Inability to Pay - In conformity with State and Federal law and regulations, no patient shall be refused treatment or care because of inability to pay.

1.2 Admitting Practitioner's Responsibilities

a. Responsibility of Admitting Physician - Each patient shall be the responsibility of a designated physician with appropriate privileges who is a member of the medical staff. Such practitioner shall be responsible for:

i. The medical care and treatment of the patient;
ii. The prompt completeness and accuracy of the medical record;
iii. Necessary special instructions; and
iv. Transmitting reports of the condition of the patient to any referring practitioner, the patient and, when appropriate to relatives/significant others.

b. Transfer of Responsibilities to Another Practitioner

i. Whenever these responsibilities are permanently transferred to another staff practitioner with appropriate privileges, a note covering the transfer of responsibility shall be entered in the patient's medical record by the transferring practitioner. The practitioner to whom the patient has been transferred shall acknowledge the transfer by documenting the acceptance of the transfer. The accepting practitioner shall be responsible for the care of that patient until the patient is discharged from the hospital.

ii. Whenever a Practitioner's responsibilities are transferred to another Medical Staff member, person-to-person contact is preferred, but if not possible, it is acceptable for the transferring Practitioner to provide the receiving Staff member with information via alternative methods such as hardcopy form, email, or fax. The communication should contain pertinent information concerning the current treatment and condition of the patient as well as information concerning any recent or anticipated changes in the status of the patient. Such transfer information should be provided in a timely manner in order to allow the receiving Staff member to review the information and request any additional information. Documentation of the transfer of patient responsibility, and exchange of the required information, should be included in the Practitioner's progress note and on the order sheet of the medical record. All EMTALA requirements must be followed during any transfer of responsibilities.

c. Information Required - The responsible practitioner shall provide the hospital with such information concerning the patient as may be necessary to protect the patient, other patients, or hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

d. Emotionally Ill and/or Suicidal/Violent Patients –

i. The Hospital does not provide inpatient psychiatric treatment; however, some patients may have symptomatic emotional illness in addition to their medical illness, or may develop such symptoms during their hospitalization. These patients are evaluated by a practitioner regarding the need for psychiatric consultation and/or treatment. Patients requiring inpatient treatment for psychiatric illness and/or chemical dependency are transferred to a facility providing those services as soon as safely permitted by the patient's medical status.

ii. Precautions shall be taken in the care of potentially **suicidal/violent** patients, and shall include the following:

1) Any patient known or suspected to be suicidal shall be referred to a facility providing those services following stabilization and/or treatment for existing emergent conditions that may exist.

2) When transfer is not possible, the patient shall be admitted to an area of the hospital with appropriate protective measures. In all cases, the nursing personnel must be informed of the nature of behavior warranting the special precautions/protective measures.

3) Any medical staff practitioner must offer any patient known or suspected to be suicidal or harmful to others a consultation by a member of the psychiatric staff. Exceptions to this will be clearly documented in the history and physical and progress notes.

4) Restraints may only be used in accordance with the organization's MEC approved ***Restraint Program Policy***.

5) The patient/family shall be made aware of community mental health resources prior to discharge from the hospital.

1.3 Alternate Coverage and Availability

a. Continuous Care - Each medical staff practitioner shall provide professional care for his or her patients in the hospital by being available or having available an alternate medical staff practitioner who has clinical privileges at the hospital sufficient to care for the patient, and with whom prior arrangements have been made. Failure to meet the requirements concerning availability may result in a professional review action and may include the loss of clinical privileges.

b. Documentation of Alternate Coverage - An attending practitioner who will be unavailable for any amount of time shall indicate, in writing on the order sheet of each patient's chart, the name of the staff practitioner who will be assuming responsibility for the care of his or her patients during the absence.

c. Availability of Alternate Coverage - "Suitable alternative coverage" means if the attending physician is absent or unavailable, that physician must arrange care for patients by another physician with comparable clinical privileges. The covering physician must be physically available within a response time defined as **45 minutes.**

1.4 Care of Unassigned Patients

a. Assignment of Patients - Any patient who presents at the hospital who has not been referred by or is not the patient of a specific medical staff practitioner, and who does not express a desire for the medical services of a particular practitioner, shall be referred to the practitioner of the medical staff on emergency call who shall arrange for appropriate care.

b. Rotation of Call - All Active Staff practitioners must take unassigned patients on a rotational basis or find suitable physician coverage for such patients. The monitoring, coordination and enforcement of participation in the call schedule shall be the responsibility of the department chair or their designees, with administrative support provided by the Medical Staff Office.

c. Patient's Rights - Nothing in this provision shall interfere with the patient's right to request his or her own physician if such a choice is expressed.

d. Failure to Respond - Failure of the assigned practitioner to respond to an emergency call may result in a professional review action, unless that practitioner presents, in writing, an acceptable reason for not attending the patient. Such written documentation shall be presented to the Chief of the applicable Service or Department Chairperson as appropriate and the Chief Executive Officer. An unexcused failure to respond to an emergency call shall be reported immediately to the MEC for appropriate action.

1.5 Emergency Medical Screening, Treatment, and Transfer

a. Presenting for Care and Medical Screening Examination

i. Any individual who comes to the hospital Emergency Department requesting examination or treatment shall be provided with an appropriate medical screening examination and care following the hospital's ***EMTALA policy)***.

ii. A medical screening examination will be provided by an appropriately credentialed physician (Emergency Department physician or another physician) or other qualified individual approved by the Medical Staff, in accordance with all EMTALA requirements. (See also **Section 10.3** of these *Rules & Regulations*, Emergency Medical Screening of Women in Labor).

b. Stabilization and Treatment beyond the Capability of the Emergency Department.

i. Except as set forth in the hospital's ***EMTALA policy***, a patient experiencing an emergent medical condition must be stabilized prior to being discharged or transferred. A patient is considered to be stabilized when the treating physician has determined, with reasonable clinical confidence, that the patient's emergent medical condition has been resolved or stabilized.

ii. An Emergency Department physician shall be responsible for the general care of all patients presenting to the Emergency Department until the patient's private physician, or an on-call physician, assumes that responsibility or the patient is discharged or transferred.

iii. A patient may request that a particular physician be contacted to provide necessary stabilizing treatment. If the physician is on the Hospital's Medical Staff, an attempt will be made to contact the physician.

iv. If the patient does not request a specific physician, or a requested physician is unavailable to come to the Hospital, or the requested physician does not respond within **30 minutes**, the physician listed on the on-call rotation schedule shall be contacted to provide the necessary consultation or treatment for the patient.

v. As soon as the on-call physician (or the physician requested by the patient) provides or directs the treatment of the patient, including giving any orders over the telephone, the patient becomes the responsibility of that physician.

vi. The patient shall remain the responsibility of the on-call physician (or the physician requested by the patient) until the episode of illness or injury that prompted the patient's assignment to that physician is satisfactorily resolved and the patient has been discharged or transferred.

vii. Patients shall be admitted for the treatment of any and all conditions and diseases for which the hospital has facilities and personnel. When the hospital does not provide the services required by a patient or for any reason the hospital cannot admit a particular patient who requires inpatient care, the hospital or the attending practitioner, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient.

viii. If the patient is to be transferred to another healthcare facility, the responsible physician shall adhere to the EMTALA policy and enter all the appropriate information on the patient's medical record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has consented to accept the patient and the patient is considered sufficiently stabilized for transport. Clinical records of sufficient content to adhere to EMTALA and insure continuity of care shall accompany the patient.

ix. All transfer priorities shall be in accordance with the hospital's ***EMTALA policy.*** No patient shall be transferred without the knowledge of the responsible physician.

1.6 On-Call Rotation Responsibilities

a. The chairperson of each department, on behalf of the Hospital, shall be responsible for developing an on-call rotation schedule that includes the name and pager number of each physician in the department who is required to fulfill on-call duties. On-call rotation schedules shall be maintained in the Emergency Department and on the Hospital's intranet.

b. Members of the Medical Staff have an obligation, but not a right, to share on-call duties. Medical Staff members who are relieved of on-call responsibilities for any reason may be assigned other duties so that all members share as equitably as possible in Medical Staff responsibilities.

c. The on-call rotation schedule may be general (e.g., medicine or surgery) or by specialty (e.g., pediatric, internal medicine, general surgery, orthopedic surgery, as determined by the Hospital and implemented by the relevant department chairpersons. The Medical MEC shall review the on-call schedule and make recommendations to the Chief Executive Officer when formal changes are to be made or when legal and/or operational issues arise.

d. The department chairperson shall consider the needs of patients and needs of the community in developing the on-call rotation, including when certain specialties will not be covered because of a lack of physicians.

e. When possible, transfer arrangements with a hospital that can provide specialty service should be made to cover the service when there is no on-call physician scheduled to provide coverage. If a patient presents needing care when a specialty is not covered, after stabilization the patient should be transferred in accordance with the hospital's ***EMTALA policy.***

f. If the scheduled on-call physician is unable to respond due to circumstances beyond the physician's control, the Emergency Department physician shall determine whether to attempt to contact another such specialist on the Medical Staff, or stabilize the patient to the best of their ability, then arrange for a transfer pursuant to this policy.

g. A physician may be on call at the Hospital and at another hospital at the same time, provided the physician has arranged for appropriate physician backup. The backup physician must be available to provide on-call coverage if the scheduled on-call physician is required to be at the other hospital.

h. A physician may perform elective surgery at the Hospital while he or she is on call, provided the physician has arranged for appropriate physician or AHP backup who is available to provide on-call coverage. The on-call physician shall inform the Emergency Department of such situation and arrangements before starting any elective surgery so the Emergency Department will know to call the backup physician or AHP if needed.

i. If there are a limited number of physicians in a given specialty, the Medical MEC may recommend, subject to Board approval, that physician backup call is not practical either when a physician is providing simultaneous call or when a physician is performing elective surgery while on call. In these situations, the on-call physician shall notify the Hospital in advance when he or she will be unavailable for call and the Hospital shall notify EMS that the service is not available.

j. Members of the Medical Staff will not be permitted to relinquish specific clinical privileges for the purpose of avoiding on-call responsibility.

k. When an on-call physician is contacted by the Emergency Department and requested to respond, the physician must:

   i. Be immediately available **(not to exceed 20 minutes**), at least by telephone, to the Emergency Department; and

   ii. Respond in person, if so requested, within a reasonable time period. Generally, response is expected within **45 minutes** of the request to respond in person. The Emergency Department physician, in consultation with the on-call physician, shall determine whether the patient's condition requires the on-call physician to see the patient immediately. The determination of the Emergency Department physician shall be controlling and shall be recorded in the medical record.

l. Physician Assistants ("PAs"), Advanced Practice Nurse Practitioners ("APNPs") and Certified Nurse Midwives ("CNM") may be used to assist the on- call physician in responding to call. Any decision to use a PA, APNP, or CNM should be made by the on-call physician, based on the individual's medical needs and the capabilities of the Hospital and must be consistent with hospital policies and/or protocols.

m. An on-call physician is responsible for the care of a patient through the episode that created the emergent medical condition, including office follow-up related to that episode. An on-call physician shall not, in the Hospital or during an office follow-up visit, require insurance information or a co-payment before assuming responsibility for care of the patient.

n. A refusal or failure of an on-call physician to timely respond shall be reported immediately to the Chief of Staff or designee and the Chief Executive Officer or designee, who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter

shall be referred to the Medical MEC for further investigation and appropriate disciplinary action. Otherwise, appropriate action may be imposed.

1.7 Dental Patients

a. A patient admitted for dental surgery shall receive the same basic medical appraisal as patients admitted for other services, and shall be the dual responsibility of the attending dentist and a Medical department physician staff practitioner.

b. Dentist's responsibilities shall include:

i. A detailed dental history justifying hospital admission;

ii. A detailed description of the examination of the oral cavity and pre-operative diagnosis;

iii. Documentation and completion of all elements of correct patient, correct site, correct procedure as required by the organization's ***Universal Protocol Policy****;*

iv. A complete operative report, including elements required by **Section 2.10** of these *Rules & Regulations*; in cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, with the exception of specimens listed on the exclusion list as described in **Section 8.7** of these *Rules & Regulations* shall be sent to the pathologist;

v. Progress notes pertinent to the oral condition;

vi. Clinical summary or statement; and

vii. Discharge order.

c. Attending physician's responsibilities shall include:

i. Medical history pertinent to the patient's general health;

ii. A physical examination to determine the patient's condition prior to and suitability for anesthesia and surgery;

iii. Care of any medical problem that may be present at the time of admission or that may arise during hospitalization; and

iv. Supervision of the patient's general health status while hospitalized.

1.8 Podiatric Patients

a. A patient admitted for podiatric surgery shall receive the same basic medical appraisal as patients admitted for other services, and shall be the dual responsibility of the attending podiatrist and a Medical department physician practitioner.

b. Podiatrist's responsibilities shall include:

i. a detailed history justifying hospital admission;

ii. a detailed description of the examination of the foot and pre-operative diagnosis;

iii. Documentation and completion of all elements of correct patient, correct site, correct procedure as required by the organization's ***Universal Protocol Policy****;*

iv. A complete operative report, including elements required by **Section 2.10** of these *Rules & Regulations*; All tissue, including bone and fragments, with the exception of specimens listed on the exclusion list as described in **Section 8.10** of these *Rules & Regulations* shall be sent to the pathologist;

v. Pertinent progress notes;

vi. Clinical summary or statement; and

vii. Discharge order.

c. Attending physician's responsibilities shall include:

i. Medical history pertinent to the patient's general health;

ii. A physical examination to determine the patient's condition prior to anesthesia and surgery;

iii. Care of any medical problem that may be present at the time of admission or that may arise during hospitalization; and

iv. Supervision of the patient's general health status while hospitalized.

1.9 Priorities for Admission

Patients shall be admitted based on the following order of priorities:

a. Emergency Admissions

i. Includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger. Within twenty-four (24) hours of an emergency admission, the attending practitioner shall be required to furnish complete documentation of the need for the admission. Failure to furnish this documentation, or evidence of willful or continued misutilization of this classification of admission, shall be brought to the attention of the MEC for appropriate action.

ii. Emergency admission patients who do not have a personal physician with admitting privileges shall be assigned to a Medical Staff practitioner with privileges in the specialty to which the diagnosis indicates an assignment is appropriate following procedures set forth in **Section 1.4** of these *Rules & Regulations*, Care of the Unassigned Patient.

b. ICU Admissions

i. Patients may be admitted to the ICU only by physician order. All patients, if not assessed by a physician with ICU privileges immediately prior to admission, must be seen by an ICU credentialed physician within four (4) hours after admission or sooner if warranted by the patient's condition.

ii. If any question arises regarding the validity of admission to or discharge from the ICU, a decision shall be made through consultation with the appropriately department of Medicine Chairperson or designee, and such decision shall be reviewed by the MEC Committee at its next regularly scheduled meeting.

c. Urgent Admissions – Includes non-emergency patients whose admission is considered imperative by the attending practitioner. Urgent admissions shall be given priority when beds become available over all other categories except an emergency. All urgent admissions shall be routinely reviewed, and evidence of willful or continued misuse of this classification of admission shall be brought to the attention of the MEC for appropriate action.

d. Pre-Operative Admissions – Includes patients already scheduled for surgery. If it is not possible to accommodate such admissions, the Director of Perioperative Services and Department of Surgery Chairperson or a designee will decide the priority of any pre-operative admission.

e. Routine Admissions – Includes elective admissions involving all clinical services. These patients shall be given an appropriately scheduled reservation in accordance with the hospital's applicable admission policy (ies).

1.10 Continued Hospitalization & Utilization Management

a. If any questions as to the validity of admission to or discharge/transfer from the hospital should arise, the situation shall be referred to the Department of Case Management and/or the Physician Advisor for assistance as defined in the ***Utilization Management Plan***.

In accordance with the ***Utilization Management Plan***, the attending practitioner must provide written d ocumentation for the need of continued stay. The case will then be reviewed by the Department of Case Management to determine if criteria for continued stay is being met. The Physician Advisor may be asked to review on a case-by-case basis.

b. If it has been determined that a patient's continued hospitalization is inappropriate but the attending practitioner refuses to discharge the patient, the Physician Advisor will be asked to review. If the continued stay is judged inappropriate and the Attending Physician does not agree, the case will be referred to a second Physician Advisor for opinion.

1.11 Transfer of Patients

a. Transfer of Emergency Department Patient to Another Healthcare Facility

i. If an Emergency Department patient is to be transferred to another healthcare facility, the responsible practitioner shall adhere to the EMTALA policy and enter all the appropriate information on the patient's medical record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has consented to accept the patient a n d the patient is considered sufficiently stabilized for transport. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

ii. All transfers to another healthcare facility will be pursuant to the EMTALA and applicable transfer policies of the hospital.

iii. No patient shall be transferred without the knowledge of the responsible physician.

b. Inpatient Transfers: With the following exceptions in which case the responsible physician will be notified of the internal transfer or relocation of the patient as soon as possible, transfer approval (physician order) is obtained from the responsible physician and all physicians on the case shall be notified of the patient transfer:

i. In the event of a suspected infectious patient, the Infection Control Practitioner has the authority to institute appropriate infection prevention and control measures including relocating the patient within the hospital; and

ii. In the event the patient is a potential risk to self or others, the House Supervisor may initiate appropriate relocation of the patient within the hospital.

1.12 Radiographic Over Reads - In cases in which the radiologist's interpretation of an X ray differs from that initially made by an appropriately privileged physician performing the initial read, a copy of the radiologist's report shall be made available and brought to the attention of the physician performing the initial read and the patient's private practitioner, when applicable, and the patient shall be informed of the final reading.

Section 2: Medical Records

2.1 Requirements for a Complete Medical Record

a. Definition - The term "**medical records**" includes at least written documents, computerized electronic information, radiology film and scans, laboratory reports and pathology slides, videos, audio recordings, and other forms of information regarding the condition of a patient.

b. Responsibility

i. A medical record shall be maintained for each inpatient and outpatient evaluated or treated in any part or location of the hospital. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient under his or her care. This responsibility cannot be delegated.

ii. The contents of the record shall be pertinent and current. A single attending physician shall be identified as being responsible for the patient at any given time.

2.2 Abbreviations, Symbols, Acronyms & Dose Designations

1. Only symbols, abbreviations, dose designations, and acronyms approved by the Medical Staff and hospital shall be used in the medical record.

2. No abbreviations, signs, acronyms or symbols shall be used to record a patient's final diagnoses or any unusual complications, or on the informed consent form.

3. A complete list standardized formats will be maintained on file in the HIM Department.

4. All practitioners are responsible for complying with the organization policies related to do not use abbreviations, symbols, acronyms and dose designations list and policy.

2.3 Authentication and Co-signature Requirements

a. Authorization - Only authorized individuals will make entries into the medical record.

b. Authentication of Entries

i. All entries in the record shall be dated, timed, and authenticated by the person making the entry. A single signature on the face sheet of a record shall NOT suffice to authenticate the entire record.

ii. Each entry must be individually authenticated by the legible signature or computer keys of the individual making the entry.

iii. The HIM Department will provide a method to establish the identity of the author of each entry including signatures, both written and electronic, written initials, and codes. This includes verification of the author of faxed orders/entries or computer entries. All practitioners and AHP members of the medical staff are responsible for participating in the method established for author identification.

iv. Practitioners must separately date and time his/her signature authenticating an entry, even though there may already be a date and time on the document, since the latter may not reflect when the entry was authenticated. For certain electronically generated documents, where the date and time that the practitioner reviewed the electronic transcription is automatically printed on the document, the requirements of this section would be satisfied. However, if the electronically-generated document only prints the date and time that an event occurred (e.g., EKG printouts, lab results, etc.) and does not print the date and time that the practitioner actually reviewed the document, then the practitioner must either authenticate, date, and time this document itself or incorporate an acknowledgment that the document was reviewed into another document (such as the H&P, a progress note, etc.), which would then be authenticated, dated, and timed by the practitioner.

v. Any practitioner who authenticates another practitioner's order or who cosigns a history, physical examination, or other medical record entry for another practitioner or another individual authorized to make such entry accepts the legal responsibility for the order or the information bearing his authentication.

c. Computer Keys and Signature Stamps

i. Computer key (electronic) signatures are acceptable to authenticate entries in the medical record. When a physician/AHP requests computer key for authenticating entries, the practitioner/AHP must sign a statement indicating that he/she shall be the sole user of the computer key. The original signature statement identifying them as the individual authorized for its use will be filed with the Director of Health Information Management. The authorized individual shall be the ONLY individual to use the computer key.

ii. Signature stamps are NOT acceptable.

2.4 Contents

a. The medical record will contain sufficient information to identify the patient; support the diagnosis/condition; justify care, treatment, and services; document the course and results of care, treatment, and services; and promote the continuity of care among providers. The medical record content shall be pertinent and current. In addition to content requirements described in these Rules/Regs, the HIM Department will maintain policies and procedures, which detail the medical record content requirements consistent with CMS and JC requirements. **Medical Staff and AHP's are responsible for adhering to medical record content requirements.**

b. A complete medical record shall include:

i. Demographic information, including name of legally authorized representative, legal status of any patient receiving behavioral health services and preferred language for discussing healthcare and other communication needs;

ii. Date of admission and discharge;

iii. The reason(s) for admission for care, treatment, and services;

iv. The patient's initial diagnosis, diagnostic impression(s), or condition(s);

v. Any findings of assessments and reassessments;

vi. Any allergies to food;

vii. Any allergies to medications

viii. H&P pursuant to **Section 2.5** of these *Rules/Regulations* and **Section 16.7** of the *Medical Staff Bylaws*;

ix. Any diagnoses or conditions established during the patient's course of care, treatment, and services;

x. Any consultation reports;

xi. Any observations relevant to care, treatment, and services;

xii. The patient's response to care, treatment, and services;

xiii. Any emergency care, treatment, and services provided to the patient before his or her arrival, including time and means of arrival and indication the patient left against medical advice when applicable;

xiv. Any progress notes;

xv. All orders;

xvi. Any medications ordered or prescribed;

xvii. Any medications administered, including the strength, dose, and route;

xviii. Any access site for medication, administration devices used, and rate of administration;

xix. Any adverse drug reactions;

xx. Treatment goals, plan of care, and revisions to the plan of care;

xxi. Results of diagnostic and therapeutic tests and procedures;

xxii. Any medications dispensed or prescribed on discharge;

xxiii. Discharge diagnosis;

xxiv. Discharge plan and discharge planning evaluation;

xxv. As applicable, advance directives;

xxvi. As applicable, informed consent;

xxvii. As applicable, autopsy report; and

xxviii. Other requirements as described in these *Rules & Regulations* and Hospital policies.

c. Standardization and Approval of Forms and Order Sets - All medical record forms shall be standardized, and no revision, deletion, or discontinuance of these forms shall be made without the approval of the MEC. All new forms proposed for use in the medical record shall be submitted to the Forms Committee for review. The Forms Committee shall recommend to the MEC (or reject) all forms for inclusion in the medical record. Changes approved by the MEC shall not be made until the mechanics of standardization have been accomplished.

d. Removal of Information in the Medical Record - The medical record must be maintained intact at all times. Once information has been filed in the record, it SHOULD NOT be removed for any reason.

2.5 Histories and Physicals (H&Ps)

a. Timeframes for Completion, Update Requirements, Responsibilities, and Authorization for Completing – These requirements are pursuant to **Section 16.7** of the *Medical Staff Bylaws.*

b. Cancelation/Delay of Procedures - Elective inpatient or outpatient surgery/invasive procedures will be canceled or delayed until a complete and current history and physical examination is recorded in the medical record.

c. Emergency Situations - If an emergency situation exists and the H&P, pertinent laboratory, x-ray and EKG reports are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure for which an H&P is required, the surgeon or proceduralist shall write a note describing the patient's condition prior to the induction of anesthesia and the start of surgery/procedure.

d. Content Requirements - The content of the H&P may vary depending on the level of care, treatment, or services provided. Therefore, the medical staff has defined the minimum content requirements as follows:

i. **All Inpatients And Outpatients Undergoing Procedures Requiring General Anesthesia** - The complete history and physical shall be obtained for all inpatients and outpatients undergoing procedures requiring general anesthesia, and include:

1) HISTORY:

a) Chief complaint
b) Details of present illness or condition (onset, history, indications) including, when appropriate, assessment of emotional, behavioral, and social status
c) Relevant past medical, family and social history, appropriate to age of patient, including pertinent co-morbidities)
d) Allergies;
e) Medications
f) Appropriate menstrual and obstetrical history in females
g) In the case of children and adolescents, the history should also include:
- An evaluation of the patient's developmental age
- Consideration of educational need and daily activities, as appropriate;
- The families and/or guardian's expectations for, and involvement in the assessment, treatment and continuous care of the patient.

h) Inventory by body system

2) PHYSICAL:

a) Vital signs
b) Mental Status
c) Skin

d) HEENT
e) Heart
f) Lungs
g) Breast, genitalia, rectal, pelvic exams (as appropriate to the age of patient) may be deferred. If deferred, the reason for deferral should be documented.
h) Abdomen
i) Extremities
j) Neurologic or contraindications for such exam or valid reasons why the exam was not performed should be documented.
k) Laboratory data, if available.

3) Statement of conclusions/impressions

4) Statement of course of action planned

ii. **Outpatients/ED Patients Requiring Procedural Sedation (Moderate or Deep)** – For non-inpatients undergoing procedural sedation, at a minimum the H&P should include:

1) Chief complaint/indication for procedure (including pre-procedure diagnosis)
2) Pertinent and relevant history, including social and family history as applicable;
3) Review of patient's current medications;
4) Known allergies;
5) Patient's previous reactions to sedation/anesthesia
6) Mental status; and
7) Review of cardiac, respiratory systems and other systems relevant to the procedure.

iii. **Outpatients/ED Patients Undergoing Minimally Invasive Noncomplex Procedures Requiring Local Anesthetic** – For non-inpatients requiring minimally invasive procedures which generally use of local anesthetics, at a minimum the following documentation is required:

1) Chief complaint/indication for procedure (including pre-procedure diagnosis)
2) Assessment of mental status
3) An examination pertinent to the procedure proposed to be performed and any co-morbid conditions

iv. **Prenatal Record as the H&P** - It is recognized that the prenatal patient is a special situation in that, in and of itself, the prenatal course of care is a planned, systematic updating of the history and physical performed at the first visit and throughout the pregnancy, as such, with the exception of scheduled C-sections, the entire prenatal record may be utilized as the H&P, provided an update is performed including pertinent additions to the history and any subsequent changes in the physical findings accompanying the prenatal record if the last prenatal visit occurred 30 days prior to admission or procedure whichever occurs first. If the last prenatal visit occurred greater than 30 days prior to admission or procedure, a complete H&P with content as described for inpatients is required. In the case of scheduled C-sections, an H&P meeting the content requirements for inpatients is required (see **Section 2.5 d i**).

v. Anesthesia/Sedation Combinations – Anesthesia/Sedation combinations require a history and physical relevant to the highest level of anesthesia/sedation provided.

vi. Newborn - Completion of the newborn record shall constitute a medical history and physical assessment for newborns. The newborn record may be handwritten or dictated.

vii. Clinics - For patients with scheduled surgical procedures performed at the hospital, a complete H&P as required in **Section 2.5 d i** for inpatients is required.

e. Monitoring Quality of H&Ps – The medical staff will monitor the quality of H&Ps through the performance improvement processes of the hospital.

2.6 Standardized Order Sets

a. Approval and Review of Standardized Order Sets

i. Standardized order sets are not acceptable unless approved by appropriate Section Chief or Department Chairperson and the Forms Committee. In addition, the P&T Committee must approve all order sets containing medications.

ii. Practitioners wishing to use their own orders sets must have them approved as indicated above.

iii. Pre-printed orders sets will be reviewed by responsible practitioner, appropriate committee and the Forms Committee at least **every two (2) year(s).**

iv. Order sets should include appropriate parameters to guide or limit use as appropriate to patient specific needs/assessment.

b. Authentication of Pre-Printed Orders Sets Containing Multiple Pages

i. Last page: Sign, date, and time the last page of the orders, with the last page also identifying the total number of pages in the order set.

ii. Pages with Internal Selections: Sign or initial any other (internal) pages of the order set where selections or changes have been made.
   1) The practitioner should initial/sign the top or bottom of the pertinent page(s);and
   2) The practitioner should also initial each place in the preprinted order set where changes, such as additions, deletions, or strikeouts of components that do not apply, have been made.

iii. It is not necessary to initial every preprinted box that is checked to indicate selection of an order option, so long as there are no changes made to the option(s) selected.

iv. In the case of a pre-established electronic order set, the same principles would apply, so that the practitioner would date, time, and authenticate the final order that resulted from the electronic selection/annotation process, with the exception that pages with internal changes would not need to be initialed or signed if they are part of an integrated single electronic document.

c. Orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, and shall be dated, timed and signed by the prescriber.

2.7 Summary List

a. Patients receiving continuing ambulatory care services will have a medical record which contains a Summary List (aka Problem List).

b. The Summary List will:

i. Be initiated by the third visit and be maintained thereafter;

ii. Be stored in the same location in all charts to assist practitioners and staff in accessing needed information easily and quickly;

iii. Be on the Forms Committee approved form/format; and

iv. Contain the following elements:

1) Any significant medical diagnosis or conditions;
2) Any significant operative and invasive procedures;
3) Any adverse and allergic drug reactions; and
4) Any current medications, over-the-counter medications, and herbal preparations.

c. A Summary List is required in all RMCHCS Clinics and where continuing ambulatory services are provided to a patient.

2.8 Progress Notes

a. Progress notes shall provide a pertinent chronological report of the patient's course of care in the hospital. Progress notes can be written by Medical Staff practitioners and allied health professionals as permitted by their clinical privileges or scope of practice, and shall be legible, document the date and time of observation, and contain sufficient information to insure continuity of care at this hospital or other health care facility to which the patient might later be transferred. Where possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

b. Progress notes for all patients must be written as frequently as indicated by the patient's clinical condition, but at least daily for all acute care patients.

c. Progress note documentation shall include, but need not be limited to the following:
   i. Comments that describe the current status of the patient, including the patient's response to the treatment regimen;
   ii. Any complications, new symptoms or additional diagnoses for which the patient is to be evaluated or treated;
   iii. Plans for additional workups, consultations, or definitive treatment(s); and
   iv. Discharge planning.

d. If the patient's condition is stable and unchanged, a statement documenting such shall be adequate.

2.9 Surgical Records

a. Except in emergencies, the following data shall be recorded in the patient's medical record prior to surgery, or the operation shall be automatically canceled:

   i. Verification of patient identity and all required elements of the RMCHCS ***Universal Protocol Policy;***

   ii. Medical history and physical per **Section 2.5** of these *Rules/Regulations* and **Section 16.7** of the *Medical Staff Bylaws.*

   iii. Pre-anesthesia Assessment per **Section 9.5** of these *Rules/Regulations*;

   iv. Provisional diagnosis;

   v. Laboratory test results;

   vi. Consultation reports;

   vii. Informed consent pursuant to the RMCHCS ***Informed Consent Policy***; including, voluntary consent form signed by the patient or the patient's legal representative verifying that the physician has explained the procedure and its risks, benefits and alternatives, and an anesthesia consent form signed by the patient or the patient's legal representative. A member of the hospital staff shall serve as a witness to the voluntary consent of the patient;

   viii. Radiology reports, if applicable; and

   ix. Other ancillary reports, if applicable.

b. Except in the case of an emergency, the patient should not leave for the operating room until the chart is complete or the operating room has received a telephone message that the tests are done but no report received.

c. All operations performed shall be fully described by the operating surgeon who shall record information immediately after the procedure consistent with that required in **Section 2.10** of these *Rules/Regulations*, Operative/Post Procedure Reports.

2.10 Operative / Post Procedure Reports

a. Operative/post procedure reports are required for all invasive surgical procedures, invasive procedures requiring an-

esthesia, deep sedation or moderate sedation, circumcisions and other procedures as may be required by the MEC.

b. Operative/ post procedure reports must be written immediately after procedure. Immediately is defined as a "upon completion of the procedure and before the patient is transferred to the next level of care". If the surgeon/physician performing the procedure accompanies the patient from the procedure setting to the next unit or area of care, the post procedure report may be written in that unit or care area. NOTE: Documenting in the medical records, *"See Dictated Report",* DOES NOT meet the intent of this requirement.

c. A brief operative/post procedure report shall be handwritten in the medical record immediately after surgery/procedure and shall contain:

i. Name and hospital identification number of the patient;

ii. Date and time of the procedure;

iii. Name(s) of the physician (s) and assistants or other practitioners who performed the procedure and procedural tasks (even when performing those tasks under supervision), including names of physicians or practitioners name(s) and a description of the specific significant procedural tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);

iv. Pre-operative diagnosis;

v. Post-operative diagnosis;

vi. Name of the specific procedure(s) performed;

vii. A description of techniques, including procedural technique and related findings;

viii. Type of anesthesia administered;

ix. Complications, if any;

x. Estimated blood loss;

xi. Tissues and specimens removed or altered; and

xii. Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

xiii. Gross pathology observed visually or by palpation;

d. A detailed operative report, containing the elements described above, shall be dictated within twenty four (24) hours following surgery/procedure, and the completed operative report shall be authenticated (including signature, date and time) by the surgeon/proceduralist and filed in the patient's medical record as soon as possible after surgery/procedure. When the operative report is not placed in the medical record immediately after surgery, a progress note shall be entered immediately.

2.11 Anesthesia, Deep Sedation and Moderate Sedation Documentation Requirements

a. Anesthesia – Anesthesia requirements are as defined in **Section 9** of these *Rules/Regulations*, Anesthesia Rules and Records.

b. Deep Sedation – All requirements for Anesthesia as noted **Section 9** of these *Rules/Regulations*, Anesthesia Rules and Records apply to deep sedation.

c. Moderate Sedation

i. Prior to administration of moderate sedation the following must be completed and documented:

1) Provisional diagnosis;

2) History and Physical as defined in **Section 2.5** of these *Rules/Regulations* and **Section 16.7** of the *Medical Staff Bylaws*;

3) Informed consent for procedure per the ***Informed Consent Policy*** and informed consent for sedation;

4) A pre-sedation evaluation must be documented in the medical record by a practitioner with appropriate privileges. The pre-sedation evaluation will include ASA Level, airway assessment and any other elements as may be required by the organization's MEC approved ***Moderate Sedation Policy.***

5) All applicable Universal Protocol requirements, including "time-out";

6) Plan for sedation or concurrence with plan; and

7) The reassessment immediately prior to induction/administration.

ii. The following requirements will be completed and documented in accordance with the MEC approved ***Moderate Sedation Policy***:

1) Intra-procedure monitoring;

2) Post procedure monitoring; and

3) Discharge from the post-procedure area.

iii. A post procedure note will be documented in accordance with **Section 2.10** of these *Rules & Regulations,* Operative/Post Procedure Reports.

2.12 Obstetrical Records

a. The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office prenatal record transferred to the hospital before admission but an update note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings pursuant to **Section 2.5** of these *Rules & Regulations*, History and Physicals and **Section 16.7** of the *Medical Staff Bylaws*.

b. In addition, OB records are subject to any additional requirements pursuant to **Section 10** of these *Rules & Regulations*, General Rules Regarding Obstetrical Care.

2.13 Discharge Summaries

a. All relevant diagnoses established by the time of discharge, as well as all operative procedures performed and any complications experienced, shall be recorded on the Discharge Summary, using acceptable disease and operative terminology that includes topography and etiology as appropriate ("Standard Nomenclature of Diseases and Operations").

b. The Discharge Summary shall be authenticated (dated, timed, and signed) by the attending practitioner.

c. The patient's medical record shall be complete at the time of discharge when possible, including discharge summary. The written or dictated discharge summary shall be completed preferably within **fourteen (14) days but no more than thirty (30) days** of discharge or outpatient care.

d. A discharge summary shall be written or entered on inpatients and outpatient stays greater than **forty eight (48) hours**, with the exception of:

i. When a patient is transferred to a different level of care within the organization and:

1) The caregivers change; a transfer note may be substituted for a discharge summary.

2) The caregivers remain the same; a progress note may be substituted for a discharge summary.

ii. Normal newborn infants – A final progress note may be substituted for a discharge summary.

iii. Minor interventions or problems, such as presentation for diagnostic studies only and others as may be specified by the MEC.

For the above exceptions to a discharge summary, a transfer note or final progress note may suffice. However, for discharged patients, the final progress note must contain the outcome of hospitalization, the case disposition, and any provisions for follow-up care including any pertinent instructions to the patient/family.

e. A clinical discharge summary shall be included in the medical records of all patients (inpatient and outpatient).

f. The discharge summary shall include:
   i. The reason for hospitalization;
   ii. Final diagnosis;
   iii. Care, treatment and services provided;
   iv. Significant findings;
   v. Any complications;
   vi. Procedures performed and treatment rendered;
   vii. Condition and disposition of the patient on discharge;
   viii. Any specific, pertinent instructions given to the patient or the patient's representative, including instructions relating to physical activity, medication, diet, and follow-up care; and
   ix. Provisions for follow-up care.

g. The condition of the patient at discharge should be stated in terms that permit a specific measurable comparison with the patient's condition at admission.

h. When preprinted instructions are given to the patient or the patient's representative, a copy will be placed in the patient's medical record.

i. In the event of patient death, a dictated death summary indicating the reason for admission, the findings and course in the hospital, and events leading to death shall be added to the record.

2.14 Delinquent Medical Records

a. Completion Timeframe - Each medical record shall be completed preferably within **fourteen (14) days but no more than thirty (30) days** following discharge. A practitioner who has not completed his or her medical records within **thirty (30) days** after discharge shall be considered delinquent.

b. Automatic Suspension for Delinquent Records

   i. A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever he or she fails to complete medical records within required time frame. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. Notice of automatic suspension for medical records completion requirements shall be from the Medical Staff Office in collaboration with the HIM Department. The relinquished privileges will be automatically restored when the medical records are completed in compliance with medical records policies. Both inpatient and outpatient medical records will be considered delinquent for purposes of an automatic suspension. Patients admitted prior to the practitioner's suspension may be followed by the practitioner until discharged.

   ii. All relinquishments shall be reported to the MEC. Repeated failures to meet appointed deadlines can result in suspension and termination of medical staff appointment.

c. Responsibility for Completing Records and Providing Coverage if Suspended

   i. No medical staff practitioner or other individual shall be permitted to complete a medical record on an unfamiliar patient in order to retire that record.

   ii. A suspended staff member is obligated to provide the name of another physician with appropriate

privileges who will take his/her call, emergency room coverage, consultations and any other services provided by the suspended practitioner.

d. Exceptions - The Chief of Staff may exempt a practitioner from these requirements in case of illness, prolonged absence or other emergency.

e. Vacations - A practitioner will not be placed on non-admit status while on vacation. However, the practitioner must complete his or her delinquent records within **72 hours** of return. **It is the practitioner's responsibility to notify the HIM Department of vacation plans.**

f. Notification of Departments/Services - All clinical and appropriate administrative hospital departments shall be notified of a suspension to enable the enforcement of the suspension.

g. Resignation - When a practitioner resigns from the Medical Staff, a printout of the practitioner's incomplete medical records will be presented to the Department Chairman by the HIM Department. The practitioner will be required to complete the outstanding records. If the records are not completed within **sixty (60) days** post notification, the records will be filed as incomplete, and the Chairman will sign off as such. Any practitioner who is removed from the medical staff, per the Bylaws, for delinquent records, or who resigns from the medical staff without adequately completing all medical records, will not be allowed to return or reapply for staff membership until such records are satisfactorily completed.

2.15 Possession, Access and Release of Medical Records, Radiographs and Slides

a. Only authorized individuals are permitted access to medical records. Medical records or other confidential patient information are released only to authorized individuals for patient care, evaluation, utilization review, treatment, quality assurance programs, in-house educational purposes, and in accordance with Federal and State Law, court orders or subpoenas. No patient record shall be removed from the HIM Department except for these purposes and/or as needed by the HIM Director or a designee.

b. The disclosure of information from the medical records to any individual other than a physician or others authorized individual with medical reasons for reviewing the chart shall be limited to those who fully comply with the laws of the state of New Mexico and all applicable Federal laws in this matter. The patient's written consent, or that of his guardian, must accompany each request for information.

c. All medical records are the physical property of the hospital and shall not be taken from the confines of the hospital, except in specific situations, and only with the permission of the HIM Director, and then only when accompanied by a person designated by the HIM Director. Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, or statute. When such a removal is mandated, every reasonable attempt shall be made to notify the attending practitioner. Unauthorized removal of a medical record from the hospital by a practitioner shall constitute ground for a professional review action by the MEC.

d. In cases of readmission of a patient, all previous records shall be available for the attending practitioner's use. This shall apply whether the patient is attended by the same practitioner or another practitioner.

e. Any record taken out of the HIM Department for the purpose of patient readmission shall be returned with the current record upon discharge of the patient.

f. In accordance with the ***Medical Research Policy***, upon written approval of the Medical Staff and an Institutional Review Board (IRB), access to the medical records of all patients shall be afforded to Medical Staff practitioners in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients.

g. Subject to the discretion of the HIM Director, former Medical Staff practitioners shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital for continuing care purposes or a threat of malpractice.

h. Radiographs and pathology slides are the property of the hospital and may be lent to other hospitals, practitioners, or research institutions for valid reasons and only with the written permission of the patient, the chair of the appropriate department/service involved, and the HIM Director. Radiographs shall be copied only with the approval of the Radiology Department Service Chief, the Emergency Department physician (when appropriate), or the HIM Director.

In the event a patient picks up his or her own radiographs or slides, a signed authorization is still required.

2.16 Medical Information from Other Hospitals or Health Care Facilities

Upon written authorization of the patient, the HIM Department shall transmit information to other hospitals or healthcare facilities requesting data concerning the patient's previous admissions, record name, birthdate, and dates of previous hospitalization. Similarly, the HIM Department, upon written authorization of the patient, may request information from other hospitals or health care facilities concerning the patient. Information received in response to said request shall not become part of the patient's medical record at his hospital unless authenticated by the attending practitioner as part of the current medical record.

2.17 Filing of Medical Records

A medical record shall not be permanently filed until it is completed by the attending practitioner or is ordered filed by the MEC.

2.18 Alterations And Corrections Of Medical Record Entries

a. Only the original author of a medical record entry is authorized to correct or amend an entry.

b. Any correction must be dated, timed, and authenticated by the person making the correction.

c. Medical record entries may not be erased or otherwise obliterated, including the use of "white-out".

d. To correct or amend an entry, the author should cross out the original entry with a single line, ensuring that it is still readable, write the word "error", enter the correct information, sign, and enter the date and time the correction was made.

e. Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, timed, authenticated and identified as such.

Section 3 Orders

3.1 General Requirements

a. Orders must be entered clearly, legibly, and completely. Orders that are illegible, incomplete, or improperly entered shall not be carried out until they are clarified by the ordering practitioner and are understood by the nurse or other qualified, authorized staff. If the prescriber cannot be reached, the individual receiving the order is to follow chain of command by notifying their immediate supervisor/manager. The supervisor/manager is responsible for notifying the Chief Nursing Officer and the Chief of Staff.

d. With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders to do so at the hospital and in accordance with State law, and who is responsible for the care of the patient.

e. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary, patients name, service/test ordered, date and time order written and physician authentication of the order.

f. The use of the terms "renew", "repeat", and "continue" standing alone on orders is not acceptable.

g. All previous orders shall be canceled when patients go to surgery.

h. Orders shall be rewritten for patients transferred to a lesser or higher level of care, e.g., from a special care unit to a medical-surgical nursing unit or vice versa, or from outpatient to inpatient status.

i. Orders for "daily" tests shall state the number of days and shall be reviewed by the attending physician at the end of the expiration of said days unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued must be rewritten in the same format that it was originally recorded if it is to be continued.

j. Orders for all mediations and treatments for all patients shall be under the supervision of the attending practitioner and shall be reviewed by the attending practitioner in a timely manner to assure discontinuance when no longer needed.

k. All orders must be reviewed by the attending practitioner when a patient is transferred from one service to another (from one practitioner to another).

l. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped must be rewritten.

m. No order shall be discontinued without the knowledge of the attending physician, unless the circumstances causing the discontinuation constitute an emergency.

n. All requirements described in **Section 2.2** of these *Rules/Regulations,* Abbreviations, Acronyms, Symbols and Dose Designations must be strictly adhered to when writing orders.

3.2 Who May Enter Orders

a. Medical staff practitioners and allied health professionals shall have the authority to enter orders only as permitted by their licenses and clinical privileges or by their scope of practice.

b. All orders must be entered in the patient's record, dated, timed, and signed by the responsible practitioner.

c. During daily rounds of hospitalized patients, the attending/rounding physician will review the treatment plan and all active medication orders. The physician will sign, date, and time any unsigned orders, thus indicating a review of the order for appropriateness. The attending/rounding physician is correspondingly responsible for making necessary adjustments in the medical regime, including changes made through verbal orders.

3.3 Verbal/Telephone Orders

a. Definition - Per CMS verbal orders are orders for medications, treatments, interventions or other patient care that are transmitted as oral, spoken communications between senders and receivers, delivered either face-to-face or via telephone.

b. Restrictions

i. Verbal orders are not to be used for the convenience of the practitioner.

ii. A verbal order (either in person or via telephone) shall be accepted only under circumstances when it is impractical for such order to be directly entered into the computerized practitioner order entry system. Impractical circumstances are considered emergent situations (such as a Code Blue) or during procedural situations when patient care would be impeded if verbal orders were not used. In all other situations, when the prescriber is physically present, he/she is responsible for entering in the order.

iii. Verbal/telephone orders for chemotherapy, investigational drug, and device or procedure protocols may be given and accepted only by an appropriate staff member over the telephone in the following circumstance: two (2) nurses must witness and countersign the order(s).

iv. Verbal/telephone orders are not accepted for DNR or withdrawing of life support. Withdrawing life support and DNR will be implemented only with an order written and authenticated by the prescribing practitioner, AND in accordance with applicable hospital policies.

c. Authorization to Receive Verbal Orders - A verbal order shall be given only to authorized qualified personnel who shall transcribe the verbal order in the proper place in the medical record of the patient. The following staff members can accept and transcribe verbal/telephone orders for within the scope of their professional practice:

i. Medical Staff/AHPs (including CRNAs and NPs) with clinical privileges at this hospital
ii. Registered Nurse
iii. Licensed Practical Nurse
iv. Respiratory Therapist pertaining to respiratory therapy treatments
v. Licensed Physical Therapist, pertaining to physical therapy treatments

vi. Registered Pharmacist, pertaining to medications
vii. Registered Dietician, pertaining to nutritional needs
viii. Registered Radiological Technician, pertaining to radiological tests and/or treatments
ix. Licensed Speech/Occupational Therapist, pertaining to their scope of practice
x. Licensed Clinical Social Worker, pertaining to their scope of practice
xi. Registered Medical Technologist, pertaining to laboratory services
xii. Designated electro-diagnostics personnel, pertaining to electro-diagnostics services.

d. Read-back and Confirmation by Recipient - The clinical staff member receiving the verbal order will write down and read back the order to the prescribing practitioner. The prescriber is responsible for providing confirmation that the read back was correct. Clinical staff will not accept an order that is not clear. A verbal order shall include the date, time, and full signature and title of the person to whom the verbal order has been given.

e. Authentication

i. The prescriber shall authenticate the verbal order within forty-eight **(48) hours** unless a specific hospital policy for a specific type of order requires a short time (for example the ***Restraint Program Policy***).

ii. The authentication of the order shall include the signature, date and time the prescriber authenticated the order.

iii. The failure to authenticate a verbal order appropriately shall be brought to the attention of the MEC for appropriate action.

3.4 Orders for Specific Procedures

a. All requests for radiological or other special examinations and services shall contain a pertinent clinical statement or specific diagnosis of the reason for the examination. An order for a serial diagnostic or laboratory testing must specify both the desired frequency and the duration of the series.

b. All orders for therapy shall be entered in the patient's record, dated and timed, and signed or countersigned by the ordering practitioner.

c. Therapeutic diets shall be prescribed by the attending practitioner in orders on the patient's chart.

d. All "NO CODE" orders shall be written physician orders pursuant to the hospital's ***Withholding or Withdrawal of Life Support and DNR Policies***.

Section 4 Consultations

4.1 General

a. The attending practitioner shall be responsible for requesting consultation when indicated and for calling a qualified consultant. It is the responsibility of the medical staff through its department chairs and the MEC to assure that practitioners to the staff seek consultation as appropriate. It is the responsibility of the individual practitioner requesting the consult to review the consultation report. The review of the consultation report should be documented.

b. Requests for a consultation shall be entered into the order sheet in the patient's medical record. If the history and physical are not part of the patient's medical record, it shall be the responsibility of the practitioner requesting the consultation to provide this information to the consultant.

c. If a registered nurse employed by the hospital 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, that nurse shall notify the department director or hospital supervisor who, in turn, may refer the matter to the Chief Medical Officer, Chief Nursing Officer or designee. The /CNO may, if warranted, bring the matter to the attention of the medical staff Department Chairperson or Section Chief of the clinical service in which the practitioner in question has clinical privileges. Thereafter, the Department Chairperson may request a consultation after discussion with the attending practitioner.

4.2 Who May Provide Consultations

a. Any Medical Staff practitioner with clinical privileges at this hospital can be asked for consultation within his or her area of expertise. In circumstances of grave urgency, or where consultation is required by these *Rules & Regulations* or imposed by the Credentials or MEC, the Chief of Staff, the appropriate Department Chairperson or Section Chief, the CEO or the Board, shall at all times have the right to call in a consultant or consultants.

b. When the required consultative expertise is not available through the existing medical staff membership and the patient cannot be transported elsewhere safely, consultation may be obtained by granting temporary privileges for a specific patient care need to a qualified practitioner who is not currently a staff member as provided in the *Medical Staff Bylaws.*

4.3 Recommended Consultations

a. Consultations are recommended in all non-emergency cases whenever requested by the patient or the patient's personal representative if the patient is incompetent.

b. Consultations are also recommended in all cases which, in the judgment of the attending practitioner or AHP:

i. The diagnosis is obscure after ordinary diagnostic procedures have been completed;

ii. There is doubt as to the best therapeutic measures to be used;

iii. Unusually complicated situations are present that may require specific skills of other practitioners;

iv. The patient exhibits severe symptoms of mental illness or psychosis (also see **Section 4.4, *Psychiatric Consultations***);

v. The patient is not a good medical or surgical risk; or

vi. There is a question as to whether the patient's condition may be the result of criminal conduct on the part of the patient or others, e.g. gunshot wound, knife wound, battered spouse or child activity.

c. Consultations shall also be required when clinical services, including department or section rules and regulations, so require.

d. Additional requirements for consultation may be established by the MEC and/or hospital as required.

4.4 Psychiatric Consultations

Psychiatric consultation and treatment shall be requested for and offered to all patients who present self-destructive behavior, i.e., attempted suicide, chemical overdose, etc. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made must be documented in the patient's medical record.

4.5 Surgical Consultations

Whenever a consultation (medical or surgical) is requested prior to surgery, the anesthesiologist shall ascertain that an adequate notation of the consultation, including relevant findings and reasons, appears in the patient's medical record. If it does not so appear, surgery and anesthesia shall not proceed.

4.6 Obstetrical Consultations

Midwifes should seek consultation in those situations recommended in **Section 4.3**, **Recommended Consultations**, and when the patient's response to care is not as anticipated. Midwifes are required to seek consultation for therapeutic abortions.

4.7 Mandatory Consultations

a. When a consultation requirement is imposed by the Credentials, MEC, or by the Board, the required consultation shall not be rendered by an associate or partner of the affected practitioner if possible.

b. Failure to obtain required consultations may constitute grounds for a professional review.

4.8 Timeliness and Contents of Consultation Report

a. All consultations and consultation reports shall contain the date and time of the consultation and shall be documented on the patient's chart within **twenty-four (24) hours** of the consultation request.

b. Each consultation report shall contain a written opinion and recommendations by the consultant that reflect an actual examination of the patient and the patient's medical record. A statement, such as "I concur" shall not constitute an acceptable consultation report. The consultation report shall be made a part of the patient's medical record.

c. Where non-emergency operative procedures are involved, the consultant's report must be recorded in the patient's medical record prior to the operation. The consultation report shall contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the signature of the consultant.

d. It is the responsibility of the consult to communicate the findings of the consult with the practitioner ordering the consult

Section 5 Informed Consent

5.1 In addition to a general consent to treat obtained by the Hospital at the time of the patient's admission/registration, specific informed consent must be obtained as required by law and regulation prior to diagnostic or therapeutic interventions and other procedures as required by the organization's MEC approved ***Informed Consent Policy***.

5.2 The attending and/or treating practitioner is responsible for documenting in the medical record the information provided to the patient relative to the intervention anticipated as required by the organization's MEC approved ***Informed Consent Policy***. Exceptions to obtaining the patient's timely consent are limited to emergency and other situations defined in the hospital's ***Informed Consent Policy***.

Section 6 Medication Management

6.1 General Requirements

a. Formulary, Preparation And Administration

i. Drugs and biologicals must be prepared and administered in accordance with Federal and State laws by orders of the practitioner or practitioners responsible for the patient's care and accepted standards of practice.

ii. Medications may only be administered by individuals functioning within the scope of their license and current competence and in accordance with applicable organization policy (ies).

iii. The P&T Committee will maintain and approve the hospital's formulary. The P&T Committee may restrict the use of a specific drug or class of drugs, either entirely.

iv. All medications administered to patients shall be:

1) Listed in the latest edition of "United States Pharmacopoeia"", National Formulary"", American Hospital Formulary Service", "A.M.A. Drug Evaluations", or "New and Nonofficial Drugs". Drugs for bona fide clinical investigations whose use is in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals", the regulations of the New Mexico State Board of Pharmacy, federal Food and Drug Administration, and approved by the Pharmacy and Therapeutics Committee and/or Institutional Review Board shall be excepted;

2) Reviewed and reordered by the attending practitioner as follows:

a) All controlled substances in Schedule II are to be re-ordered after **72 hours (3 days).**

b) All Schedule III-V controlled substances and antibiotics are to be re-ordered after **seven (7) days**.

c) Anticoagulants new to the patient are to be ordered daily and in accordance with applicable hospital protocols until patient is therapeutically stable unless the patient is on a pre-established maintenance dose.

d) The ordering physician will be notified on the patient's chart that a drug has reached the stop time. A **24-hour** "grace" period will be granted to the order during which time an effort will be made to contact the physician during the normal working day before actual stoppage of the medication.

3) Cancelled automatically when the patient goes to surgery; and

4) Reviewed by the pharmacist before the initial dose of medication is dispensed unless a licensed independent practitioner controls the ordering, preparation, and administration (such as in a procedural situation) or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's condition, in accordance with applicable law, regulation and hospital policy. In cases when the medication order is written when the pharmacy is "closed" or the pharmacist is otherwise unavailable, the medication order shall be reviewed by the pharmacist as soon thereafter as possible, within twenty four (24) hours and in accordance with hospital policy.

b. Preparation – In accordance with New Mexico State Board of Pharmacy and federal guidelines, a pharmacist may prepare intravenous solutions with additives, dilute, dried or concentrated injectables, or prepare unit dose medications for administration by an appropriately licensed individual. Each drug dose shall be recorded in the patient's medical record noting date and time, and properly signed after the drugs have been administered.

c. Medical Staff Oversight - The P&T Committee is responsible for approving policies related to selection and procurement, storage, orders, preparing and dispensing, administration, monitoring and evaluation of medications. This includes developing policies and procedures that minimize drug errors.

6.2 Orders

a. Elements of a Complete Medication Order - The following are the minimum required elements for orders for drugs and biologicals:

i. Name of patient (present on order sheet);

ii. Age and weight of patient,

iii. Date and time of the order;

iv. Drug name;

v. Strength or concentration,

vi. Dose; (*Note: dose designations MUST be ordered with a with a zero (0) written preceding a decimal point for drug dosages which have no other value to the left of the decimal point (example digoxin 0.25mg), AND MUST not have a trailing zero (0) written after the decimal point for drug dosages which have no other value after the decimal point.*

vii. Frequency;

viii. Route;

ix. Quantity and/or duration, when applicable;

x. Specific instructions for use, when applicable; and

xi. Name of prescriber

b. Orders for Antibiotics - All orders for antibiotics must have supporting evidence for administration thereof i.e. written documentation.

c. Range Orders - All medication orders must clearly state the administration times or the time interval between doses. Range orders are not acceptable and if written must be clarified by staff prior to implementation.

d. Abbreviations, Acronyms, Symbols, and Dose Designations - Orders involving abbreviations and chemical symbols should be carried out only if the abbreviations and symbols appear on a standard list approved by the medical staff and in accordance with all applicable organization policies related to do not use abbreviations, symbols, acronyms and dose designations list and policy.

e. Unacceptable Orders – Unacceptable orders include, but may not be limited to:

i. *"Continue home medications"* is not an acceptable order; and

ii. The terms *"renew", "repeat, resume"* and *"continue"* in reference to previous orders are not acceptable.

f. PRN orders - Orders for "as needed" or "PRN" medications shall specify the indication(s) for use and be specific for dose and dosage frequency. "PRN" orders will include qualification with regards to dosage interval (i.e., every 4 hours PRN) and indications when appropriate (i.e., for severe pain, temperature, etc.). "PRN" medications shall specify the indication(s) for use and be specific for dose and dosage frequency.

6.3 Self -Administration - Self-medication by patients shall not be permitted. All Medication administration must be under the direct control of a Licensed Independent Practitioner, medication nurse, or Respiratory Therapist.

6.4 Medications Brought from Home / Patient's Own Medications - If patients bring their own medications to the hospital, these drugs shall not be administered to the patient until Pharmacy has inspected and approved the medication for use and an order including name of drug, dose frequency of administration and route has been entered for "Patient May Use Own Medication" has been made by a Licensed Independent Practitioner. All efforts will be made to provide hospital medications and not use "Patient Own Medications". Patient medications will not stay in the possession of the patient. Efforts will be made to give the medication to a patient representative for return of the medications to home. If this is not possible, the medication(s) will be inventoried by nursing and sent to the Pharmacy for storage until the patient is discharged.*

- Patients who are connected to automatic dispensing devices i.e. insulin pumps, will continue to receive the medication until if and when the patient's physician decides to alter or stop the automatically dispensed medication.

Vitamins, herbal, and nutritional supplements that are not listed in the "American Hospital Formulary Service" Drug Information Reference Book will not be allowed for administration.

6.5 Bedside Medications – Medications shall not be kept in a patient's room.

6.6 Automatic Substitutions - The pharmacist may dispense the generic equivalent drug, which has been accepted for the formulary by the P&T Committee when a trade drug name is prescribed, but is not in the hospital formulary. A practitioner may object to the use of the generic equivalent for a particular patient and may request the specific product by underlining the drug's trade name or noting the name of the manufacturer. Any practitioner must be notified by the hospital pharmacy prior to the substitution of any equivalent generic drug for a specific trade name drug.

6.7 Sample Medications - Sample drugs may only be used in accordance with the P&T approved ***Sample Medication Policy***. Practitioners are responsible for following all storage, security, and documentation requirements required by the policy. Sample medications will not be provided by the Hospital for patient use.

6.8 Medication Reconciliation – Practitioners are responsible for following the organization's ***Medication Reconciliation Policy.***

6.9 Off – Label Use of Medications

a. When the Director of the Pharmacy and the Chairperson of the Pharmacy and Therapeutics Committee are made aware of drugs prescribed for non-FDA-approved uses, they consider the matter.

b. If the use is generally recognized by evidenced-based practice by physicians in the relevant clinical specialty, no approval by the Pharmacy and Therapeutics Committee shall be required.

c. If the use is not commonly recognized, the prescribing physician must present references from the medical literature to the Pharmacy and Therapeutics Committee to substantiate the prescribing practice.

d. The Pharmacy and Therapeutics Committee may approve or disapprove the practice or may require the physician to obtain informed consent prior to initiating therapy.

e. Nurses may administer these drugs only after they have been given basic pharmacological information about the drug. These drugs shall be stored, dispensed, and packaged in the pharmacy with a pharmacist responsible for maintaining information on the drugs.

6.10 Medication Errors & Adverse Reactions

a. Any medication error or apparent drug reaction shall be reported immediately to the practitioner who ordered the drug and nursing supervisor on the floor/unit. Any medication given in error or the apparent drug reaction, or both, shall also be recorded in the patient's medical record.

b. Any adverse drug reaction shall be immediately noted on the medical record of the patient in the most conspicuous manner possible in order to notify everyone treating the patient, throughout the duration of hospitalization, of this drug sensitivity, and to prevent a recurrent of an adverse reaction. Notification of all drug sensitivities, including any apparent adverse reaction, shall be sent to the practitioner and to the Director of Pharmacy. Unexpected or significant adverse reactions shall also be reported promptly to the Food and Drug Administration (FDA), New Mexico State Board of Pharmacy and to the drug manufacturer as required.

Section 7 Infection Prevention and Control

7.1 Isolation Precautions

a. All patient care areas shall follow the standard procedure for isolation as outlined in the Infection Control Manual which is based on the Center for Disease Control's Guidelines for Isolation Precautions in Hospitals (CDC Guidelines).

b. Any patient with a known or suspected communicable disease or infection shall be isolated as required by the Infection Control Manual. The attending physician will be notified. The Infection Control Practitioner shall be empowered to order appropriate isolation procedures or epidemiologic investigations as required.

7.2 Cultures - The nurse director of a unit and the Infection Control Practitioner of a unit may initiate the order for culture of a draining wound. The order must be validated by the attending practitioner. Cultures of draining wounds and stool cultures on patients with unexplained diarrhea may be requested by a department and/or section chairperson in consultation with the Chairperson of the Infection Control Committee or the Infection Control Practitioner.

7.3 Restrictions of Practitioners and Others with Communicable Diseases - Practitioners, employees, and other health care personnel with communicable disease processes shall be restricted from patient contact in accordance with CDC Guidelines.

7.4 Hand Hygiene – All practitioners are responsible for adhering to the organization's hand hygiene policies as approved by the Infection Control Committee.

7.5 Clusters - When a cluster of Nosocomial infections, including post-operative infections, occur, the Chairperson of the Infection Control Committee shall initiate procedures necessary to investigate and prevent further spread of infection.

7.6 Tuberculosis (TB) – Patients will be screened for TB in accordance with the organization's ***TB Exposure Control Plan.*** Patients with active TB will be isolated in accordance with this plan.

Section 8 General Rules Regarding Surgical Care

8.1 General Requirements

a. Enforcement of the rules and regulations pertaining to the operating room procedures shall be the responsibility of the Chairperson of the Department of Surgery and, where appropriate, his/her designee, the Director of Perioperative Services. The Director of Perioperative Services or his/her designee shall have the responsibility of administrative supervision of the operating room and shall be the authority to plan and execute the daily operative schedule.

b. The operating room schedule shall begin promptly each day. The scheduled start time documented for each operation shall be defined as the time of the patient in room time. The documented surgery start time is the incision time.

c. The Director of Perioperative services in conjunction with the department of surgery shall have the responsibility for designing a schedule based on the maximum efficient use of the operating room and the Anesthesia Service.

d. Any personnel with an open infected skin area shall not be permitted to enter the operating room suite.

e. A roster of practitioners currently possessing surgical and anesthesia privileges, with a delineation of the privileges of each, shall be maintained in the surgical suite and be available to the Director of Perioperative Services. There shall be an on-call schedule of surgeons and qualified anesthesia providers established and posted at each patient unit or other area where surgical patients are admitted, or at the communications center of the hospital to ensure that there is **twenty-four (24) hour** emergency care or post-operative follow-up care, or both, available.

f. The Director of Perioperative Services shall be responsible for and authorized to carry out all orders, which will ensure optimal technical procedures. Disputed matters shall be referred to the Chairperson of the Department of Surgery. Nursing concerns may be referred through nursing chain of command.

8.2 Universal Protocol - All practitioners, regardless of assigned Department or location a procedure is being performed are required to adhere to the organization's MEC approved ***Universal Protocol Policy*** related to identification of correct patient, correct site, correct procedure and other requirements of the current ***Universal Protocol Policy***.

8.3 Test/Report Availability Prior to Procedure - All required or ordered test reports/results (laboratory, radiological, ECG, etc.) appropriate to the patient's medical condition and supported by the patient's medical diagnosis shall be recorded in the medical record prior to the performance of any elective surgical procedure.

8.4 Operating Room Procedures

a. Surgeons shall be in the operating room and ready to commence operating at the scheduled time and must be in the suite when the patient is delivered to the operating room. Should an unexpected delay prevent the appearance of the principle surgeon at the appointed time, and if the delay is in excess of **twenty (20) minutes**, rescheduling of the procedure for a later time may be invoked should this delay encroach upon the time of subsequent procedures and their designated surgeons.

b. An emergency case shall take precedence over an elective surgical case not in progress.

c. Surgery shall be performed by a surgeon-practitioner according to the surgical privileges granted by the Board. If a surgeon attempts to schedule a procedure for which no privileges have been granted, the Director of Perioperative Services or designee shall inform that surgeon of the lack of such privileges and immediately notify the Chairperson of the Department of Surgery and the CEO/designee of the matter. No practitioner may perform a procedure for which he/she does not have current privileges approved by the Board. This requirement also applies to anesthesia providers.

8.5 Recovery Room

a. The surgeon shall remain in the surgical area until the patient is admitted to the recovery room. Post-operative orders must be written by the surgeon or a qualified designee before the patient leaves the post-anesthesia recovery room suite. The anesthesiologist, or, if appropriate, the designated nurse anesthetist shall subsequently examine the patient and write orders to discharge the patient from the recovery room.

b. At least **two (2)** professional registered nurses shall be on duty in the recovery room and immediate area whenever the room is occupied. Additional personnel shall be provided to meet the needs of each patient.

c. Any recovery outside of the PACU must be performed by staff with equivalent PACU competencies.

d. Discharge of patients from post anesthesia care in any area of the facility is the responsibility of a privileged provider. Registered Nurses in areas of the facility where patients are being recovered from anesthesia may use discharge criteria, which have been approved by the Medical Staff. If there are any questions as to the patient's attainment of these discharge criteria, the Registered Nurse will contact the surgeon/anesthesiologist for a discharge determination.

e. Patients may be discharge from PACU order by the authorized anesthesia provider order or when discharge criteria as approved by the Anesthesia Services and the medical staff has been met.

f. If the patient goes directly to Intensive Care Unit from the operating room, the patient will be discharged to the surgeon and if appropriate, the Hospitalist.

8.6 Operating Room Records

a. Operating Room Register - An operating room register shall be provided and maintained on a current basis. The operating room log or register shall contain:

i. Patient's name;

ii. Patient's hospital identification number;

iii. Date of the operation;

iv. Inclusive or total time of the operation;

v. Name of the surgeon and any assistant(s);

vi. Name of nursing personnel (scrub and circulating);

vii. Type of anesthesia used and name of person administering it;

viii. Operation performed;

ix. Pre and post-op diagnosis; and

x. Date of birth.

b. Medical Record Documentation Requirements – All requirements as described in **Section 2,** Medical Records, and other applicable sections of these Rules/Regulation must be adhered to, including but not limited to history and physical prior to procedure, documentation of pre-operative diagnosis prior to procedure, informed consent, universal protocol, operative reports, and all anesthesia related requirements.

8.7 Specimens and Documentation of Pathology Reports

a. All appropriate specimens removed during a surgical procedure shall be properly labeled, packaged in preservative as designated, identified in the operating room or operating suite as to patient and source, and sent to the laboratory for examination by or under the supervision of a pathologist. The specimen must be accompanied by pertinent clinical information, including the pre-operative and post-operative surgical diagnosis.

b. All specimens except for those identified in the ***Tissue Specimens Excluded from Routine Submission to the Pathology Department #24.429 Policy*** will be sent to the laboratory for examination.

c. The pathologist shall document the receipt of all surgically removed specimens and shall sign the pathology report which shall become part of the patient's medical record. Results of any intra-operative consultation by a pathologist, including frozen section interpretations, shall be documented in the medical record by the pathologist. The pathology report shall be filed in the medical record within **twenty-four (24) hours** of completion, if possible.

d. Frozen section interpretations will be called immediately to the operating surgeon.

e. The pathologist will conduct macroscopic and microscopic examinations on specimens pursuant to the ***Tissue Specimens Excluded from Routine Submission to the Pathology Department #24.429 Policy.***

f. The disposition of surgical specimens, whether discarded or submitted to pathology, shall be recorded in the operative record.

8.8 Counts - If, at the end of a procedure, the sponge, sharps, or instrument count is incorrect, the patient must be x-rayed and the film read prior to moving the patient out of the operating room, unless the patient's condition dictates otherwise. Any unintended retention of a foreign object in a patient after surgery or other procedure is considered a Sentinel Event and the organization's MEC approved ***Sentinel Event Policy*** applies.

Section 9 General Rules Regarding Anesthesia Services

9.1 Definitions

a. Anesthesia: involves the administration of a medication to produce a blunting or loss of pain perception (analgesia), voluntary and involuntary movements; autonomic function; and memory and/or consciousness, depending on where along the central neuraxial site (brain or spinal cord) the medication is delivered.

b. Analgesia: involves the use of a medication to provide relief of pain through the blocking of pain receptors in the peripheral and/or central nervous system. The patient does not lose consciousness, but does not perceive pain to the extent that may otherwise prevail.

c. General anesthesia: a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory support is often impaired. Patients often require assistance in maintaining a patent airway and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. For example, a patient undergoing major abdominal surgery involving the removal of a portion or all of an organ would require general anesthesia in order to tolerate such an extensive surgical procedure. General anesthesia is used for those procedures when loss of consciousness is required for the safe and effective delivery of surgical services.

d. Regional anesthesia: the delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves. Regional anesthesia includes epidurals, spinals, and other central neuraxial nerve blocks, and is used when loss of consciousness is not desired but sufficient analgesia and loss of voluntary and involuntary movement is required. Given the potential for the conversion and extension of regional to general anesthesia in certain procedures, it is necessary that the administration of regional and general anesthesia be delivered or supervised by a practitioner as specified in 42 CFR 482.52(a).

e. Monitored anesthesia care (MAC): anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia as defined by the regulations at §482.52(a). Indications for MAC depend on the nature of the procedure, the patient's clinical condition, and/or the potential need to convert to a general or regional anesthetic. Deep sedation/analgesia is included in MAC.

f. Deep sedation/analgesia: a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Because of the potential for the inadvertent progression to general anesthesia in certain procedures, it is necessary that the administration of deep sedation/analgesia be delivered or supervised by a practitioner as specified in 42 CFR 482.52(a).

g. Moderate sedation/analgesia: ("Conscious Sedation"): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. CMS, consistent with ASA guidelines, does not define moderate or conscious sedation as an anesthesia procedure, therefore only requirements of the ***Moderate Sedation Policy 2-35*** apply and requirements of anesthesia and deep sedation policies do not apply. (71FR 68690-1).

h. Minimal sedation: a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected. This is also not considered anesthesia.

i. Topical or local anesthesia; the application or injection of a drug or combination of drugs to stop or prevent a painful sensation to a circumscribed area of the body where a painful procedure is to be performed. There are generally no systemic effects of these medications. Topical and local anesthesia, despite the name, are not considered anesthesia.

9.2 Structure, Policies and Procedures, Supervision and Performance Improvement

a. Integration with Department of Surgery - Anesthesia Services shall be within the Department of Surgery; therefore all requirements of the General Rules Regarding Surgical Care apply to Anesthesia Services.

b. Oversight by Chief of Anesthesia Services

i. Anesthesia services throughout the hospital (including all departments in all campuses and off-site locations where anesthesia services are provided) must be organized into one anesthesia service. Therefore, any policies, procedures, or processes related to anesthesia services must be reviewed and approved by the Chief of Anesthesia Services.

ii. The Chief of Anesthesia Services is responsible for oversight of anesthesia services provided in any location within the organization.

c. Qualifications and Responsibilities of the Chief of Anesthesia Services – The Chief of Anesthesia Services must:

i. Meet all qualification requirements for Service Chiefs described in the *Medical Staff Bylaws;* In addition the following requirements must be met:

1) The qualifications must be consistent with State laws and acceptable standards of practice; and

2) The Service Chief must be a qualified MD or DO.

ii. Fulfill the responsibilities of Service Chiefs as described in the *Medical Staff Bylaws* and:

1) Provide oversight of policies, procedures and practices related to anesthesia, deep sedation or moderate sedation regardless of where performed in the organization;

2) Plan, direct and supervise all activities of the Anesthesia Service;

3) Evaluate the quality and appropriateness of Anesthesia Services provided to patients throughout the organization;

4) Developing qualification for privileges when appropriate.

d. Qualifications of CRNA Supervising Physicians and Supervision Requirements for CRNAs - The qualifications of practitioners authorized to supervise CRNAS and the supervision requirements are as defined in **Section 5.2.a.ii.3.c** of the Medical Staff Bylaws, *Special Provisions* for Nurse Anesthetists.

e. Review of Anesthesia Services Policies and Procedures- Anesthesia policies/procedures, including Deep Sedation and Moderate Sedation policies/procedures shall be reviewed as needed, at least **every three years**. The review will be under the direction of the Chief of Anesthesia Services and conducted in collaboration with Nursing, Pharmacy, Emergency Department physicians and other physicians and specialties as appropriate.

f. Performance Improvement - Quality indicators will be established, monitored, and acted upon for Anesthesia Services, including moderate sedation.

9.3 Anesthesia Patient Attendance Requirements - The responsible qualified anesthesia provider shall be in constant attendance during the entire procedure. Following the procedure, the anesthesia provider shall remain with the patient as long as required by the patient's condition relative to anesthesia status and until responsibility for proper patient care has been assumed by another qualified individual.

9.4 Availability of Anesthesia Services - Anesthesia services must be available within **thirty (30) minutes** after obstetric anesthesia is deemed necessary. Thus, the response time for arrival of the CRNA and/or anesthesiologist must not exceed **twenty (20) minutes**.

9.5 Assessment and Documentation Requirements for Anesthesia and Deep Sedation

a. **Anesthesia**

i. Qualified Anesthesia Provider – Only qualified anesthesia providers may administer and document administration of anesthesia (general, regional, monitored anesthesia care) addressed in this section and as otherwise noted in MEC approved hospital policies and procedures. A qualified anesthesia provider is any individual qualified to administer anesthesia per State law and granted current anesthesia privileges do so at RMCHCS (CRNA or Anesthesiologist).

ii. Informed Consent – The anesthesia provider is responsible for obtaining and documenting informed consent for anesthesia.

iii. Pre-Anesthesia Evaluation

1) A pre-anesthesia evaluation must be completed and documented within **forty-eight (48)** hours prior to procedure requiring anesthesia services. The delivery of the first dose of medication(s) for the purpose of inducing anesthesia marks the end of the **forty-eight (48)** hour time frame.

2) The evaluation must be completed by an individual qualified anesthesia provider with anesthesia privileges.

3) At a minimum, the pre- anesthetic evaluation of the patient will include:

a) Review of the medical history, including anesthesia, drug and allergy history;

b) Interview, *if possible given the patient's condition,* and examination of the patient*;*

c) Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk);

d) 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);

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

f) Development of the 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 patient's representative) of the risks and benefits of the delivery of anesthesia.

iv. Reassessment Immediately Prior to Induction - A reassessment immediately prior to induction must be documented. At a minimum Blood Pressure, Pulse, Respiratory Rate, O_2 Sats and LOC should be included in this reevaluation. At the conclusion of the reassessment, the anesthesia provider should determine if patient continues to be an appropriate candidate for the type of anesthesia planned or if the original plan should be changed.

v. Intra Procedure Documentation- At a minimum the intra procedure documentation should include:

1) Name and hospital identification number of the patient;

2) Name of practitioner who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist;

3) Name, dosage, route and time of administration of drugs and anesthesia agents;

4) IV fluids administered;

5) Blood or blood products, if applicable;

6) Oxygenation (continuously monitored);

7) Ventilation (continuously monitored);

8) Circulation (continuously monitored);

9) Unusual events during the anesthesia period; and

10) Status of the patient at the conclusion of anesthesia.

vi. Post-Anesthesia Evaluation

1) A post-anesthesia evaluation must be completed and documented no later than **forty-eight (48)** hours after surgery or a procedure requiring anesthesia services by a qualified anesthesia provider. The evaluation is required any time general, regional, or monitored anesthesia care has been administered to the patient.

2) The evaluation should not begin until the patient is sufficiently recovered from the acute administration of the anesthesia to participate in the evaluation, e.g., answer questions appropriately, perform, simple tasks, etc. Individual patient risk factors may dictate that the evaluation be completed and documented sooner than the **forty-eight (48) hours**.

3) For those patients who are unable to participate in the post anesthesia evaluation (e.g., post-operative sedation, mechanical ventilation, etc.), the evaluation should be completed and documented within **forty-eight (48) hours** with a notation that the patient was unable to participate, including the reason for the patient's inability to participate as well as expectations for recovery time, if applicable.

4) At a minimum, the post-anesthesia evaluation should include evaluation of:

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

b) Cardiovascular function, including pulse rate and blood pressure;

c) Mental status;

d) Temperature;

e) Pain;

f) Nausea and vomiting;

g) Postoperative hydration; and

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

b. **Deep Sedation** – All requirements for Anesthesia noted above are required with the exception that a qualified anesthesia provider may also be a physician who is Board Certified in Emergency Medicine, is fully privileged at RMCHCS in emergency medicine privileges, has been granted deep sedation privileges, and meets other requirements as defined by the organization's ***Deep Sedation/Analgesia Administration by Non-Anesthesia Personnel for Patients Undergoing Procedural Sedation Policy***.

c. **General Anesthesia in the Emergency Department** - General anesthesia for surgical procedures shall not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

9.6 Outpatient Discharge Instructions

a. When surgical or anesthesia services are performed on an ambulatory basis, the patient shall be provided with written instructions for follow-up care that includes information about how to obtain assistance in the event of post-operative problems. The instructions shall be reviewed with the patient or the individual responsible for the patient.

b. The patient may only be discharged in the company of a responsible adult.

Section 10 General Rules Regarding Obstetrical Care

10.1 General Requirements

a. For patients who have received prenatal care, a prenatal record shall be available on the obstetrical floor for each patient upon admission.

b. Inhalation anesthesia for delivery will be administered by a qualified anesthesia provider.

c. Patients will be kept in the recovery area until responding from inhalation anesthesia or until the vital signs are stabilized following conduction anesthesia.

d. Cesarean sections will be performed only in the general surgical suite except in immediate life-threatening emergencies.

e. The individual identified by the laboring patient may be permitted in the delivery room/operating room with the consent of the attending practitioner and the patient, providing no inhalation anesthetic is being given.

f. Other observers may be permitted in the delivery room with the consent of the attending practitioner and the patient.

g. OB practices will be in accordance with ACOG guidelines.

10.2 High-Risk Infant Care -Only those physicians who have training in high-risk infant resuscitation and care will provide pediatric care for newborns at high risk for complications. High risk for these purposes will be defined as:

a. All cesarean sections;

b. Premature infants less than thirty-five (35) weeks gestation, with or without complications;

c. Premature infants less than four (4) pounds eight (8) ounces, with or without complications;

d. All premature infants with complications; and

e. Full term infants with complications requiring invasive intervention.

10.3 Emergency Medical Screening Of Women In Labor - When a pregnant female presents to the Emergency Department, she will be assessed and screened by a qualified trained triage RN, APNP, or Physician's Assistant to determine whether the presenting complaint is onset of labor or a general other complaint, not of onset of labor. Patients determined to be complaining of labor onset will be transported to the Obstetrical Department with qualified medical personnel. In the Obstetrical Department, an RN qualified to conduct an obstetric medical screening evaluation will initiate the orders of the obstetrician or CNM of record, or in the case of a patient presenting with no prenatal care or care by a physician who is not a member of this Medical Staff, the orders of the physician or CNM on-call for obstetrics. In the case of a patient who is determined not to be in active labor (false labor), she may be discharged home by telephone order if the obstetrician or CNM certifies the diagnosis **and** the patient has had prenatal care under that physician, CNM, or physician/CNM's practice. In cases where the patient has had no prenatal care and/or is unknown to the physician or CNM's practice, the on-call physician or CNM shall examine the patient prior to a discharge decision and order. Documentation in the medical record must include all requirements of the ***EMTALA Policy***.

10.4 Labor Induction and Augmentation

Labor induction and augmentation will be in accordance with ACOG guidelines.

10.5 Gynecological Surgery

a. Surgery on gynecological patients shall be performed in the surgical suite, not in the delivery suite.

b. Surgery scheduling, operating room procedures, preoperative anesthesia requirements, and postoperative procedures as required by the Department of Surgery shall apply for gynecological surgery procedures.

Section 11 General Rules Regarding Emergency Care Services

11.1 General Requirements

a. The Medical Staff shall adopt a method for providing medical coverage in the emergency services area. Such method shall be consistent with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges or scope of practice for all health professionals who are authorized to render emergency care.

a. The medical director of Emergency Department, in collaboration with appropriate hospital personnel, is responsible for integrating emergency services with all other departments of the hospital, ensuring current policies and procedures governing the medical care provided in emergencies are established and implemented, ensuring the medical staff has approved policies and procedures for offsite locations of the hospital providing patient care, treatment and services for appraisal of emergencies and referral when appropriate.

b. Other general rules and policies regarding emergency services shall be defined by the Emergency Medicine Services, and approved by the MEC and the Board, including but not limited to ***EMTALA Policy.***

11.2 Triage - There shall be a triage system to identify patients requiring urgent care.

11.3 Disposition - The disposition of each patient shall be a physician's responsibility.

11.4 Procedures and Visits

a. The established list of procedures permitted to be performed in the emergency department shall not be exceeded except in a bona fide emergency.

b. Procedures requiring general or regional anesthesia shall not be performed in the Emergency Department, unless the situation is truly life threatening.

11.5 Discharge Instructions - A patient and/or responsible other, on leaving the Emergency Department following evaluation and/or treatment, shall be given written follow-up instructions, to be authenticated by the patient or responsible other, indicating he/she has received and understands the instructions. The written follow up instructions shall also be signed by the responsible practitioner or RN, stating that the patient or the responsible other has received the instructions. Any language barrier will be compensated for through use of an interpreter, by instructions written in the patient's language, or by another acceptable system and this will be noted on the instruction sheet.

11.6 Emergency Patient Records

a. An appropriate medical record shall be maintained for every patient receiving emergency services and shall be incorporated into the patient's hospital record.

b. Each patient's medical record shall be authenticated by the practitioner in attendance that is responsible for its clinical accuracy.

c. Emergency patient records shall be reviewed regularly by the Emergency Medicine Services and by appropriate clinical services to evaluate the quality of emergency medical care provided at this hospital.

d. In addition to pertinent history, pertinent physical exam, details of first aid or emergency care given prior to arrival at the hospital, pertinent laboratory and radiological data, related to evaluation, treatment, and disposition of the patient, the emergency medical record shall include:

i. The time and means of the patient's arrival;

ii. Indication that the patient left against medical advice, when applicable;

iii. Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment and services;

iv. Copy of any information made available to the practitioner or medical organization providing follow-up care, treatment and services;

v. If applicable to the patient visit, all documentation requirements set forth for use of moderate and/or deep sedation; and

vi. All applicable requirements of **Section 2,** Medical Records Content.

Section 12 Discharge

12.1 Who May Discharge

a. Patients shall be discharged only on a written order of the attending practitioner. The attending practitioner is responsible for examining the patient to determine suitability for discharge.

b. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the hospital's release form indicating that he or she has been informed/advised by the attending practitioner to remain a hospitalized patient, but that the patient has decided to leave the hospital against that advice, and thus relieves the attending practitioner and the hospital of any further responsibility for his or her care. Should the patient refuse to sign the waiver, such refusal shall be documented in the patient's medical record by the attending practitioner or the nurse on duty, and the act of refusal shall be attested to by at least one (1) other hospital staff member. If the nurse on duty makes the notation in the patient's medical record, he or she shall promptly notify the attending practitioner.

12.2 Discharge Planning

a. Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, including an assessment of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's medical record. When hospital personnel determine that no discharge planning is necessary in a particular case, that conclusion shall be documented in the medical record of the patient.

b. Discharge planning shall include, but need not be limited to, the following:

i. Appropriate referral and transfer plans;

ii. Methods to facilitate the provision of follow-up care; and

iii. Information to be given to the patient or the patient's family or other persons involved in caring for the patient on matters such as the patient's condition, health care needs, and the amount of activity the patient should engage in and any necessary medical regiments including drugs, diet, or other forms of therapy. Sources of additional help from other agencies and procedures to follow in case of complications should also be part of the discharge plan. All such information should be provided by the attending practitioner or designee.

12.3 Discharge of Minors and Incompetent Patients

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing *in loco parentis*, 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 shall so state in writing and the statement shall become a part of the permanent medical record of the patient.

Section 13 Pronouncement of Death and Autopsies

13.1 Pronouncement of Death and Disposition of Bodies

a. The remains of any deceased patient, including a fetal or neonatal death, shall not be subjected to disposition until death has been officially pronounced by a physician and the event adequately documented in the patient's medical record within a reasonable period by the attending practitioner or another designated Medical Staff practitioner.

b. The body of a deceased patient can be subjected to disposition only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made and signed in the deceased patient's medical record by the attending physician or a designee. Death certificates are the responsibility of the attending practitioner and must be completed within **forty-eight (48) hours** of death or birth in the case of fetal death. Policies with respect to the release of a corpse shall conform to applicable law(s).

13.2 Autopsies

a. Permission To Perform An Autopsy - An autopsy may be performed with a written consent signed in accordance with state law. The mechanism to secure permission to perform autopsies, and the mechanism for documenting permission to perform an autopsy is defined in the MEC approved ***Autopsy Policy***.

b. Criteria For Securing An Autopsy - The medical staff should attempt to secure autopsies in those instances described in the MEC approved ***Autopsy Policy***. Autopsies are mandatory when required by appropriate legal authorities. It is the responsibility of the attending practitioner or designee to notify the coroner of any case considered a coroner's case.

c. Performance of Autopsies – Autopsies shall be performed by the hospital designee.

d. Documentation of Autopsy – The autopsy results will be recorded in the medical record in accordance with State law and hospital policy and procedure.

e. Autopsy Notification & Performance Improvement

i. The attending practitioner will be notified when an autopsy is performed.

ii. As a component of the Medical Staff performance improvement initiatives, the pertinent medical staff committee and/or Medical Staff Department will review autopsy results, as applicable, for educational and quality purposes.

Section 14 Disasters (Emergency Operations Plan)

14.1 Planning and Preparation

a. Designated medical staff members will actively participate in the organization's disaster planning and preparation processes. The responsible oversight committee is responsible for assuring the organization's Emergency Operations Plan (EOP) is current with regulatory guidelines and tested at timeframes defined in the in the EOP. The MEC will be responsible for assigning physicians responsible for planning and preparation of the EOP. The planning and preparation shall be in collaboration with appropriate hospital staff.

b. All practitioners are responsible for knowing their assignment (station) in the event of a disaster and shall report accordingly.

c. Practitioners shall be informed of the rules regarding patient discharge and other controls to be invoked during a disaster and informed of their roles in a disaster.

14.2 **Privileges** – Disaster privileges for volunteers will be granted in accordance with the Section 7.8 of the *Medical Staff Bylaws* and the hospitals' Emergency Operation Plan.

14.3 **Drills** - Participation in Emergency Management (Disaster) drills is required.

Section 15 Restraint Use

15.1 Restraint will only be utilized when the patients behavior warrants in accordance with the MEC approved ***Restraint Policy***.

15.2 All practitioners are responsible for strictly adhering to the MEC approved ***Restraint Policy***.

Section 16 Core Measures, Patient Safety Initiatives and Performance Improvement (PI)

16.1 **Core Measures** – The medical staff is responsible for supporting and implementing Core Measures processes.

16.2 **National Patient Safety Goals & PI** - The organized medical staff is responsible for supporting and implementing the organization's patient safety and performance improvement initiatives. All practitioners are responsible for adhering to and implementation of the National Patient Safety Goals, other patient safety, and performance improvement initiatives of the Hospital. This includes, but may not be limited to policies/processes relate to the following:

a. Improving Accuracy of Patient Identification;

b. Communication of Critical Results;

c. Labeling of Medications and Solutions On/Off the Sterile Field;

d. Anticoagulation Therapy;

e. Hand Hygiene;

f. Management and Prevention of MDROs;

g. Management and Prevention of Central-Line Associated Blood Stream Infections;

h. Management and Prevention of Catheter Associated Urinary Tract Infections (CAUTI);

i. Prevention of Surgical Site Infections;

j. Medication Reconciliation;

k. Suicide Risk Assessment and Prevention; and

l. Universal Protocol

16.3 **Compliance –** Any member who fails to comply with the policies and processes identified in Sections 16.1 and 16.2 may be referred to collegial interventions by the Chief Quality Officer and/or the Chief Medical Officer. Further noncompliance may subject the member to Provider Quality Peer Review and /or Focused Professional Practice Evaluation as outlined in Sections VII of these Rules and Regulations.

Section 17 HIPAA and Confidentiality

17.1 **HIPAA** - Under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, a clinically integrated setting such as a hospital and its medical staff is an organized health care arrangement. RMCHCS Medical Staff Members and Allied Health agree as a condition of their medical staff membership to participate in the organized health care arrangement and to comply with the Hospital's Privacy Policies and Procedures with regard to all patients admitted or treated by the Member in the Hospital or its outpatient clinics. All patients admitted to the Hospital or treated in a Hospital-owned facility will receive the Hospital's Notice of Privacy Practices, which shall be considered a joint notice of privacy practices of the Member and the Hospital.

17.2 Confidentiality and Meeting Minutes/Records

a. Medical Staff practitioners shall not discuss with any other individuals the transacted business or discussions that occur within the confines of any official staff meetings or any meetings of committees, panels, sections, or services.

b. Medical Staff practitioners shall not record or otherwise transcribe the proceedings of any meeting without the unanimous consent of all those in attendance.

c. Written attendance records shall be maintained for all meetings of the Medical Staff, clinical services and sections, panels and committees. This responsibility shall be discharged by the presiding officer of the meeting or a designee. Minutes of meetings shall reflect the educational programs and, if applicable, clinical reviews conducted at each meeting.

Section 18 Reporting of Situations Potentially Detrimental to Patients or Hospital

18.1 It shall be the responsibility of each practitioner to report, to the Chief of Staff or the CEO/ designee any conduct, acts or omissions or commission by Medical Staff practitioners which are believed to be detrimental to the health or safety of patients or to the proper functioning of the hospital, or which violate professional ethics.

Section 19 Orientation of New Medical Staff Practitioners

19.1 The Medical Staff Office will maintain a current orientation program that addresses key policies procedures as noted throughout the *Bylaws* and *Rules/Regulations* and other priority policies and procedures.

19.2 Each new Medical Staff practitioner shall be assigned by the Chief of Staff, Department Chairperson or Service Chief an Active Staff practitioner for purposes of orientation to the hospital and its environment. In addition, each new Medical Staff practitioner may be introduced to the various hospital departments by the CEO or a designee.

Section 20 Students (Medical, Physician Assistants, etc.)

20.1 Status

a. Medical students and other students have no legal status as a provider of health care services.

b. Students shall **not** hold appointment to the Medical Staff and shall not be granted specific clinical privileges.

20.2 Limitations - To provide appropriate care for patients while at the same time providing educational experience for the beginning health care practitioner, these individuals may provide limited care, treatment, and services in any patient care areas of the hospital under the supervision of a school preceptor or member of the medical staff. The care, treatment, and services shall be limited in scope, limited by the scope of the educational experience outlined in the contractual relationship with the affiliated school and the limited scope of privileges of the supervising /sponsoring /preceptor physician(s). However, regardless of the scope of privileges of the supervising/sponsoring/preceptor physicians, students may on perform the care, treatment and services as limited in the contractual arrangement with the affiliated school

20.3 Requirements - These individuals:

a. Must be students must be participating in a formal, contractual clinical experience at school the hospital has a current contract affiliation;

b. May observe or interact with the patient but may not participate in any unauthorized activities;

c. Must have patient's/families permission to participate;

d. Must undergo the appropriate orientation by the hospital's education department and sign any necessary compliance or confidentiality forms;

e. Are permitted to perform an evaluation of patients and write progress notes, which must be countersigned by the supervising physician. *Note: Medical students and PA students are not authorized to complete a patient's History and Physical which will then be accepted as the complete H&P as defined previously in these Rules/Regulations;*

f. Are allowed to provide care, treatment and services under the DIRECT supervision of the attending physician or authorized proctor and as limited by the scope of care, treatment and services described in the affiliation agreement with the school;

g. Must wear the appropriate identification badge;

h. Must wear professional attire while in the hospital as required by the hospital; and

i. Must adhere to the organization Code of Ethics and other hospital and medical staff policies, procedures, and rules at all times.

20.4 Responsibility for Oversight - The supervising/sponsoring/preceptor physician(s) are, at all times, directly accountable for all activities of these individuals. Additionally, the supervising/sponsoring/preceptor physician(s) are directly responsible for the actions of these individuals while in the hospital.

Section 21 Residents & Fellows in Training

Residents and Fellows in training will be subject to all requirements as specified in **Section 16.9** of the *Medical Staff Bylaws*, Special Considerations for Residents and Fellows in Training and applicable MEC approved policies.

CERTIFICATION OF ADOPTION AND APPROVAL

(Original signatures on file in the medical staff office)

APPROVED BY:

_____

Chief of Staff Date of Action

_____

Board Chairperson Date of Action

REVIEWED BY:

_____

CEO Date of Action

Date	Brief Summary of Revision(s) Made, When Applicable
1986	Original approved
1991	Retyped
May 1994	Revised
May 1996	Revised
October 1997	Revised
October 1998	Revised
January 1999	Revised
April 2001	Revised
August 2001	Revised
August 2002	Revised
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February 2005	Revised
November 2006	Revised
November 2009	Revised
April 2010	Revised
August 2011	Comprehensive review, update, and revisions to all sections.
December 2013	Comprehensive review, update, and revisions.
January 2014	Review and Revision