MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

OF

THE PINNACLEHEALTH HOSPITALS

CLINICAL PRACTICE
RULES AND REGULATIONS

09.01.2015
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ARTICLE 1

ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS SECTION

1.A. GENERAL ADMISSION, TRANSFER AND DISCHARGE POLICIES

1.A.1. Admission

(a) Except in emergency, no Patient shall be admitted to the Hospital unless an admitting (provisional) diagnosis has been made by a qualified Practitioner. In the case of an emergency, the admitting diagnosis shall be documented as soon after admission as possible.

(1) The attending Practitioner or his/her designee (including a resident) shall evaluate a Patient who is admitted to the hospital within a reasonable period of time given the Patient's condition, but in no event later than twelve (12) hours of the Patient's admission to a medical/surgical unit and no later than twenty-four (24) hours of the Patient's admission to the psychiatric unit.

(2) Admission orders must be documented in the Patient's record at the time of admission by the attending Practitioner or his/her designee.

(b) Attending Practitioner Evaluation of Patient Prior to Admission of Patient to Hospital from Emergency Department [See also Chapter VI. Emergency Services]

1.A.2. Transfer

(a) When the Hospital transfers a Patient from one floor to another or to a specially designated unit (i.e., isolation bed, intensive care unit, etc.), the Patient Registration Office shall notify the Patient's attending Practitioner.

(b) Patients evaluated in the Emergency Department and deemed to be critically ill will not be transferred from the Emergency Department until the attending Practitioner (designee) has made arrangements for the continuity of the Patient's care.

(c) The transfer of care for Patients waiting for admission to the critical care areas from the Emergency Department Practitioner shall be made to the attending Practitioner (designee) upon his/her arrival. This transfer of care would be completed while the Patient was still in the Emergency Department.

(d) A Patient will be transferred to the care of the surgeon upon written order to transfer the Patient to the surgeon's service.
1.A.3. Discharge

(a) Patients shall be discharged only on order of the attending Practitioner or a qualified designee. A qualified designee shall be defined as an Active Medical Staff member or a resident physician acting under the direction of the attending physician.

(b) A deceased Patient shall be pronounced dead by a Physician or an Allied Health Professional, as applicable to his or her privileges.

(1) Every effort should be made to notify a family of a death in a timely fashion.

(2) The medical staff is actively involved in the measurement, assessment, and improvement in the use of developed criteria for autopsies.

(3) No autopsy shall be performed without a legal consent.

(4) All autopsies shall be performed by a Hospital pathologist or by a Practitioner to whom he/she may delegate the duty.

1.B. INFECTION CONTROL

(1) An Infection Control Program will be established to identify and reduce the risk of acquiring and transmitting infections among Patients, Medical Staff, Allied Health Professionals, employees, volunteers and visitors. The Infection Control Program will be implemented by the Infection Control Director and Coordinators under the supervision of the Hospital Epidemiologist, with the assistance of a member of the Infection Control Committee.

(2) Infection Control Policies and Procedures will be maintained in Infection Control Policies and Procedures manuals which will be available on nursing units and in other Patient care areas.

1.C. ADMISSION, DISCHARGE AND TRIAGE POLICIES FOR CRITICAL CARE

1.C.1. General

Admission-discharge-triage policies for critical care areas are contained within Critical Care Policies and Procedures which are located in the respective units.

1.C.2. General Admission Policies/Procedures

(a) Any Practitioner may admit Patients to critical care units if Patients require interventions uniquely available in these units.

(b) Admission shall be on a priority basis, as defined under admission policies.
(c) Attending Practitioners who do not frequently care for critically ill Patients should transfer Patients to an attending Practitioner with critical care expertise.

(d) All Patients will be seen by the attending Practitioner or designee within a four (4) hour period of their admission.

(e) The admitting attending Practitioner, or resident, must have first hand knowledge of the Patient to be admitted and will be responsible for certifying the Patient's need for the special facilities.

(f) The attending Practitioner shall communicate with the appropriate resident as soon as possible.

1.C.3. Routine Transfer Policies

(a) Before a Patient may be transferred from critical care units, all orders will be rewritten by the attending Practitioner or his/her designee.

(b) Patients being transferred from critical care areas will have priority on available beds elsewhere in the Hospital.

1.C.4. Admission of Patients to the Neonatal Intensive Care Unit

All Patients admitted to the Neonatal Intensive Care Unit shall become Patients of a neonatologist unless otherwise provided by written order of the neonatologist.
ARTICLE 2

MEDICAL RECORDS SECTION

2.A. GENERAL RULES AND REGULATIONS

2.A.1. Identification/Filing System

A system of identification and unit filing to insure the prompt retrieval of a Patient's medical record shall be maintained. In the case of readmission of a Patient, the Patient's medical record which includes all previous admissions and emergency service records shall be available upon request. No record shall be filed until it is complete except on written order of the Health Information Committee.

2.A.2. Access

All medical records in all Hospital departments are the property of the Hospital and shall not be removed from the Hospital except upon subpoena, court order, or statute.

(a) Access to medical records of Patients shall be afforded to Practitioners for approved study and research, consistent with preserving the confidentiality of the personal information concerning the individual Patients. Approval will be through the Practitioner's Department Chairperson.

(b) Subject to the discretion of the Senior Vice President for Medical Affairs, former Members of the Medical Staff 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.

(c) In compliance with Commonwealth and federal Regulations, and Hospital Policies and Procedures, Patients shall have access to their medical information with proper authorization.

2.A.3. Content

The medical record shall contain sufficient information to identify the Patient, support the diagnosis, justify the treatment, document the course of treatment and results accurately, and facilitate continuity of care among health care providers.

(a) The attending Practitioner shall be held responsible for the preparations of a complete medical record for each admission of each Patient.

(b) This record shall include:
(1) Identification Data (including name of any legally authorized representative when applicable)

(2) History and Physical Report including Chief Complaint; Present Illness; Past History; Family History; Physical Examination (including pelvic and rectal examination when applicable); Provisional Diagnosis (Admitting Diagnosis)

(3) Reports including Clinical Laboratory Reports; Radiology Reports; Consultations when applicable or requested; Tissue Reports

(4) Treatment [See (III)]

(5) Physician's Order [See (III)]

(6) Progress Notes [See (II)(7)(A)(3)]

(7) Principal Diagnosis

defined as the condition after study to be chiefly responsible for the admission of the Patient.

(8) Co-morbid Conditions/Complications

defined as conditions that coexist upon admission or that develop during the hospitalization that affect treatment received and/or length of stay.

(9) Principal Procedure

defined as the procedure performed for definitive treatment rather than one performed for diagnostic or exploratory purposes; the procedure most related to the principal diagnosis.

(10) Secondary Procedures

defined as additional significant procedures performed during hospitalization.

(11) Staging of a newly diagnosed cancer is required on the face sheet using the TNM Classification System.

(12) Discharge Summary

This is a recapitulation of the significant findings and events of the Patient's hospitalization and his/her condition on discharge.

(a) The Discharge Summary shall include reason for hospitalization, significant findings, treatment and/or procedures rendered, brief overview of Patient's progress throughout this hospital stay, condition
of the Patient at the time of discharge, and discharge instructions such as type of diet, medications, physical activity, and follow-up care.

(b) The person who completes the discharge summary must have integral knowledge of that Patient's hospital course and discharge plan.

(c) A dictated Discharge Summary will not be mandatory for uncomplicated patients if the hospital stay does not exceed 48 hours and the discharge diagnosis is the same as the admitting diagnosis.

(13) Discharge Instructions

At the time of discharge, the Patient's condition, diet, medications, activities, special instructions, and follow-up appointment(s) shall be documented. This may be accomplished by

(a) Use of Hospital's standard discharge instruction sheet; or,

(b) Use of the Practitioner's customized discharge instruction sheet. If a Patient is given the Practitioner's customized discharge instruction sheet, a copy must be kept in the medical record.

(14) Others

Evidence of known advance directives, Powers of attorney and Autopsy Report (when applicable).

(c) In the event of death, the Discharge Summary shall include the events leading to death.

2.A.4. Outpatient Medical Record

The outpatient medical record shall contain sufficient information to confirm the diagnosis, document services provided and treatment received.

(a) The attending Practitioner shall be responsible for the preparation of a complete outpatient medical record (or medical record entry) for each service provided to a Patient.

(b) The outpatient medical record shall include

(1) Identification data

(2) History and physical report or psychiatric exam

(a) A dictated history and physical is required for all Patients who have had an outpatient procedure performed by a Practitioner unless the Outpatient History and Physical Examination form is completed.
(b) It includes past history, admission diagnosis, chief complaint and history of present illness, physical examination, and treatment plan.

(c) Any Outpatient History and Physical Examination Report performed prior to the day of procedure shall be updated to reflect Patient's current status.

(3) Reports

Laboratory reports, Radiology reports, Tissue reports, Physician's orders and progress notes and dictated operative/invasive procedure report (the only exception being x-ray procedures, provided that the x-ray report documents the same information that would be required on an operative report). Appropriate diagnoses/procedures must be listed on the face sheet.

(4) Discharge Instructions

At the time of discharge, the Patient's condition, diet, medications, physical activity and follow up care shall be documented. If a Practitioner has his/her own personalized discharge instruction sheet, a note must be documented in the record that "discharge instructions were given to the Patient." A copy of the instruction sheet will be kept in the medical record. In lieu of the above, the Hospital's discharge instruction sheet may be used.

(5) For any other requirements regarding documentation and/or timeliness on various documents in the outpatient surgery record, please refer to the appropriate section of the Medical Staff Rules and Regulations regarding that particular document.

2.A.5. Medical Record Reports

(a) The original copy of all reports shall be filed in the medical record.

(b) When pathological diagnoses are made outside of the Hospital and the Patient is admitted for treatment, either a copy of the pertinent pathology report will be filed with the Hospital's record, or the slides will be submitted to the pathologists for review.

2.A.6. Abbreviations

(a) No abbreviations are to be used on the face sheet of the medical record.

(b) For other portions of the medical record, only those abbreviations on the approved Abbreviations List shall be used.
2.B. HISTORY AND PHYSICAL EXAMINATION REPORT

2.B.1. Practitioner's History and Physical Examination Report Performed Prior to Admission

A typewritten History and Physical Examination Report performed in the Practitioner's office prior to admission can be legitimately substituted for the History and Physical required for the inpatient or outpatient Hospital's record provided that:

(a) A legible signed copy of the History and Physical is included in the Hospital record.

(b) The examination itself is no older than thirty (30) days prior to admission.

(c) The history, physical, and conclusions are still appropriate for the situation surrounding the Hospital admission.

(d) The Practitioner records an appropriate interval note as a part of his/her admission note in the Hospital record.

(e) If the History and Physical was performed outside the hospital by a Licensed Practitioners, permitted by law to perform and record a History and Physical, who is not a member of the PinnacleHealth Medical or Allied Health Staff, it must be reviewed by and updated by a member of the PinnacleHealth Medical or Allied Health Staff. If reviewed, updated to include all necessary information annotated as such and signed and dated to show that it is current, by a PinnacleHealth Practitioner, it will be considered a valid History and Physical as long as it meets the requirements outlined in this document.

(f) Any History and Physical recorded prior to admission must be updated within 24 hours of admission or prior to the performance of a procedure. It must also be compliant with the requirements outlined in this document.

2.B.2. Readmission Within One Month for Same Condition

If a Patient is readmitted within one month for the same condition, the previous history and physical examination, with an interval note, shall suffice if the previous history and physical was performed within 30 days of the readmission.

2.B.3. Completion of Medical Histories/Physical Examinations

Only the following individuals may complete medical histories and physical examinations:

(a) Appropriately credentialed Practitioners and Allied Health Professionals

(b) Residents and Fellows
2.B.4. **Special History and Physical Examination Records**

(a) Dental cases shall include both a dental and a medical history and physical examination report prepared by appropriately privileged practitioner(s).

(b) Podiatric cases shall include both a podiatric and a medical history and physical examination report prepared by appropriately privileged practitioners.

(c) The History Report of children and adolescent inpatients shall include, where feasible, an evaluation of the Patient's developmental age; consideration of educational needs and daily activities, as appropriate; the parent's report or other documentation of the Patient's immunization status; and the family's and/or guardian's expectations for, and involvement in, the assessment, treatment, and continuous care of the Patient.

2.C. **EVIDENCE OF APPROPRIATE INFORMED CONSENT**

An invasive/operative informed consent shall be obtained by the Practitioner prior to the procedure. In the case of elective sterilization for medical assistance recipients, consents must be obtained at least 30 days, but no more than 180 days, prior to the date of the procedure.

2.D. **OPERATIVE/INVASIVE PROCEDURE REPORT**

2.D.1. **Pathological Review of Specimens**

(a) All specimens removed at operation shall be sent to the Hospital pathologist with the exception of those items described on a pathological Review Exception List ("Exception List") which shall be developed and annually reviewed by the Operating Room Committee in conjunction with the Chairperson of the Department of Pathology (or his/her designee). The Exception List shall conform to all applicable laws, regulations and accreditation standards. The Exception List shall be submitted to the Medical Executive Committee of the Medical Staff on an annual basis for information and the current version of the Exception List shall be maintained in the Operating Room Rules and Regulations.

(b) The pathologist shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis, and he/she shall sign his/her written report.

2.D.2. **Dictation and Content**

(a) An operative/invasive procedure report shall be dictated immediately after the procedure and, immediately after transcription, attached to the medical record and signed by the Practitioner.
(1) The operative/invasive procedure report shall contain a description of the findings, the technical procedures used, the specimen removed, the postoperative diagnosis, and the name of the primary Practitioner and any assistants, and the estimated blood loss.

(2) An operative/invasive procedure report shall be dictated with the exception of uncomplicated obstetrical deliveries which may be handwritten on a substitute form approved by the Health Information Committee.

(b) Required Dictation

Dictated operative/invasive procedure reports are required for all procedures performed in the Operating Room, Labor and Delivery Room Suites, the G.I. Laboratory, Cystoscopy Laboratory, and Special Procedures.

(c) Exceptions for Dictated Operative/Invasive Procedure Report

The performance of all other operative/invasive procedures, in sites other than those mentioned above in subsection 2 do not require a dictated operative/invasive procedure report, but must be documented in the Patient's record.

(1) An entry in the Progress Notes is sufficient although the Practitioner may dictate an operative report if he/she should choose to do so.

(2) It is recommended that the written note or dictated report shall include the following: reason for performance of the procedure, the nature of the procedure, and the status of the Patient.

(3) The report shall be written or dictated immediately after the performance of the procedure.

2.D.3. Written Progress Note

For any surgery/invasive procedure, a written progress note is required immediately after surgery/invasive procedure including, but not limited to, the requirements outlined in this document.

2.E. DISCHARGE REGULATIONS

2.E.1. Order for Discharge

Patient shall be discharged only upon written order of the attending Practitioner.
2.E.2. Medical Record Documentation at Discharge

(a) On day of discharge, the attending Practitioner shall document his/her principal diagnosis, co-morbid conditions/complications, principal procedure, secondary procedure, sign the record and see that the discharge instructions are completed.

(b) He/She shall also sign and date the physician’s attestation statement for those appropriate financial classes.

2.E.3. Discharge Summary/Final Progress Note

(a) A discharge summary is required to be dictated on all admitted Patients with the exception of normal newborn infants and uncomplicated obstetrical deliveries which may be handwritten on a substitute form approved by the Health Information Committee.

(b) The final progress note should include any instructions given to the Patient and/or family.

(c) A dictated Discharge Summary will not be mandatory for uncomplicated patients if the hospital stay does not exceed 48 hours and the discharge diagnosis is the same as the admitting diagnosis.

2.F. AUTHENTICATION OF MEDICAL RECORDS

2.F.1. Records shall be authenticated and signed by the Practitioner [when applicable].

2.F.2. Signatures/Countersignatures

(a) All clinical entries on medical records shall be dated and signed by the author or appropriate designee.

(b) In all instances, the Practitioner should sign all clinical entries made by himself/herself.

2.G. COMPLETION OF MEDICAL RECORDS

2.G.1. Timeliness of Medical Records

(a) A complete history and physical examination shall be recorded within 24 hours after admission of the Patient. The attending Practitioner shall be responsible for a written or typed history and physical examination to be present on the chart prior to the procedure. Failure to do this will result in postponement of the procedure unless the
Practitioner states, in writing, that such delay would be detrimental to the life or health of the Patient.

(b) An operative/invasive report shall be dictated immediately after the procedure and, immediately after transcription, included in the medical record and signed by the Practitioner.

(c) A progress note must be entered on the patient's record at least once daily. For a psychiatric patient or a patient in the rehab unit, progress notes are required a minimum of five times weekly unless required more often by the patient's clinical condition.

(d) Discharge Summaries shall be dictated and filed on the medical record forty eight (48) hours after Patient discharge.

(e) At the time of discharge, the Patient's condition, diet, medications, activities and follow-up care shall be documented.

(f) All reports or records must be completed and filed within a period consistent with good medical practice and no longer than thirty (30) days following Patient's discharge.

(g) When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within three (3) days, and the complete protocol shall be made part of the record within thirty (30) days unless special studies and/or procedures are required.

2.G.2. Filing of Incomplete Medical Record

No medical record shall be filed until it is complete, except on written order of the Health Information Committee.

2.H. DELINQUENT MEDICAL RECORDS PROCEDURE FOR MEDICAL STAFF MEMBERS

2.H.1. Definition

A Medical Staff Member shall be considered having 'delinquent' medical records if:

(a) His/Her medical records have components which are outstanding beyond time limitations stipulated in this document; or,

(b) He/She has thirty (30) or more incomplete medical records.
2.H.2. Notification Process

(a) Initial Notice to Medical Staff Member of Delinquent Medical Records

The Health Information Management Department shall provide initial notification to Medical Staff Members with delinquent medical records which identifies:

(1) The medical records and specific record components which are delinquent; and

(2) The time period in which these delinquent medical records must be completed before a suspension procedure is activated.

(b) Notice of Impending Automatic Suspension of Medical Staff Member

(1) If the delinquent medical records remain outstanding, the Senior Vice President for Medical Affairs, having been notified of the continued deficiency by the Health Information Management Department, shall notify the Practitioner of impending automatic suspension of privileges.

(2) Such letter shall include the time and date of the impending suspension should these medical records remain delinquent.

(c) Automatic Suspension

If the delinquent medical records continue to be outstanding, automatic suspension of privileges will be implemented at the time and date specified in the impending suspension letter.

(1) Notification of such suspension shall be transmitted to the Patient Registration Office and to the involved Hospital departments.

(d) Notification/Suspension Schedule

<table>
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<th>MEDICAL RECORD COMPONENT</th>
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<th>FIRST NOTICE</th>
<th>IMPENDING SUSPENSION</th>
<th>SUSPENSION</th>
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<td>History and Physical Examination Report</td>
<td>24 hours post admission to hospital.</td>
<td>Allocation Date (Discovery Date)</td>
<td>Same as First Notice.</td>
<td>Following day.</td>
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<tr>
<td>Discharge Summary</td>
<td>48 hours post discharge.</td>
<td>See Delinquent Record.</td>
<td>See Delinquent Record.</td>
<td>See Delinquent Record.</td>
</tr>
<tr>
<td>Delinquent Record – Medical Staff Member (Includes Reports/Records)</td>
<td>30 days post discharge; thirty or more incomplete medical records.</td>
<td>On or about 1st of each month.</td>
<td>On or about 15th of each month.</td>
<td>7th Working day from 15th at 4PM.</td>
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(e) Exemptions; Patient Care; Chronic Offender

(1) A temporary exemption will be made for suspension letters and privilege revocation during all holidays, as well as during a Practitioner's vacation or illness. Holidays are defined to be those federally designated.

(2) All Patients who were hospitalized prior to the institution of the suspension may be cared for in the usual manner and their care shall not be affected by the suspension.

(3) Any Practitioner who remains delinquent for fourteen (14) days following the day of suspension shall be deemed to have voluntarily relinquished Membership and will be informed that he/she must reapply as per the Initial Appointment Policy.

(4) A chronic offender is defined as a Medical Staff Member who has had admission privileges suspended three times within a 180-day period. A Medical Staff Member suspended three times within a 180-day period will be deemed to have voluntarily relinquished Membership and will be informed that he/she must reapply as per the Initial Appointment Policy. A Medical Staff Member will be notified when he/she has been suspended two times within a 180-day period.

2.H.3. Restoration of Privileges of Medical Staff Member

Privileges will be restored when the Senior Vice President for Medical Affairs and the Patient Registration Office have been notified by the Health Information Management Department that the delinquent records and/or reports have been completed, except for those outlined in this document.

2.H.4. Delinquent Medical Records Procedure for Residents

See Policy for Resident Completion of Medical Records.
ARTICLE 3

TREATMENT AND ORDERS SECTION

3.A. TREATMENT

3.A.1. Practitioner Care Designation

In case of the inability to locate a designated Practitioner, the Department Chairperson or designee may authorize any qualified Member of the Medical Staff to provide care should such be necessary.

3.A.2. Surgical Care

Refer to Operating Room Policies and Procedures

3.A.3. Levels of Care

Refer to Hospital Policies and Procedures on Level of Care

3.A.4. Invasive or Similar Procedures on Family Members

(a) As a general rule, a Medical Staff Member is discouraged from performing invasive or similar procedures on family members, provided, however, that the Medical Staff also recognizes, in particular situations, performing such procedures may be appropriate.

(b) Any staff Member who wishes to perform such a procedure, except in an emergency, should discuss the matter with the Senior Vice President for Medical Affairs prior to performing it.

(c) If an emergency procedure is necessary, the Senior Vice President for Medical Affairs should be notified following its performance.

3.A.5. Clinically Significant Allergies

The documentation of clinically significant allergies should be recorded with the Patient's admission orders.

(a) If the Patient has no known allergies, "NKA" (No Known Allergies) must be documented.

(b) The record shall display in a prominent manner a notice of any clinically significant allergies.
3.B. ORDERS

3.B.1. General Regulations

(a) All orders for treatment shall be in writing, or electronically as available.

(b) An order for a medication or a drug requiring a DEA (Drug Enforcement Agency) number must be either signed or countersigned by a Practitioner holding a DEA Number.

(c) The attending Practitioner shall be responsible for clarifying any question regarding the Patient's orders when the signature of another Practitioner issuing orders cannot be read.

3.B.2. Verbal Orders

(a) A verbal order shall be authorized if dictated, or transmitted by a facsimile machine with the signature of the Practitioner, to the following individuals:

(1) Registered nurse (including CNM) for any patient intervention,

(2) Medical or osteopathic doctor for any patient intervention,

(3) Resident or Fellow for any patient intervention,

(4) Physician Assistant for any patient intervention,

(5) Certified Registered Nurse Practitioner for any patient intervention,

(6) Registered Pharmacist for pharmaceuticals,

(7) Physical therapists, occupational therapists, and speech therapists for rehabilitative interventions,

(8) Respiratory therapists for respiratory interventions, and

(9) Paramedics employed by the Hospitals for treatment of patients in emergency situations only in the Emergency Department.

(b) Orders dictated over the telephone shall be signed by the person to whom dictated with the name of the Practitioner per his or her own name.

(c) The responsible Practitioner or designee shall authenticate orders within 24 hours.

(d) Verbal orders for medication or treatment shall be accepted only under urgent circumstances when it is impractical for the orders to be given in written manner by the responsible practitioner. “Urgent” is defined as based on the patient’s perspective of having pain, discomfort or heightened concern regarding his/her condition. “Impractical” is defined as practitioner is off site, involved in an invasive procedure or
unavailable due to sleeping hours. Unless immediate patient safety is jeopardized or extreme circumstances do not allow the use of electronic orders, verbal orders should never be used for patient admission orders.

3.B.3. Orders must be reviewed:

(a) When a Patient has major surgery; and,

(b) When a Patient is transferred to and from an intensive/critical care unit.

3.B.4. Automatic Stop Orders

(a) The Medical Staff through the Pharmacy and Therapeutics Committee, establishes and promulgates written policies concerning the use of Automatic Stop Orders for selected medications (see Department of Pharmacy Policy MG-24).

3.B.5. Tissue/Cytology Requests

The Practitioner or his/her designee must include appropriate history on all tissue/cytology request slips and must also ensure that the surgical specimen(s) is/are appropriately identified.

3.B.6. Use of Restraints

Refer to Hospital Policies and Procedures
4.A. CONSULTATION REQUESTS

Any Practitioner on the Staff may request a consultation with the approval of his/her Patient with any other licensed Practitioner. If the consultant requested is not a Member, the requesting Practitioner must request permission from the Senior Vice President for Medical Affairs, or his/her designee, for the consultant to answer the consult.

4.B. CONSULTANT

A consultant must be well qualified to give an opinion in the field in which his/her opinion is sought.

4.C. ESSENTIALS OF A CONSULTATION

(1) A satisfactory consultation includes examination of the Patient and the record.

(2) A written opinion signed by the consultant must be included in the medical record with the date and time.

(3) Consultations must be answered within 48 hours of request unless otherwise specified. If the consultation needs to be answered more expeditiously, it is the responsibility of the requesting Practitioner to personally contact the consultant.

4.D. DOCUMENTATION OF CONSULTATION REQUESTS

The attending Practitioner is responsible for requesting consultation, when indicated, including documentation of the reason, extent (consult and treat unless otherwise specified), and date and time.

4.E. CONSULTATION REQUESTS FOR ANCILLARY HEALTH PROFESSIONALS

Other ancillary health professionals (e.g., nutritionist, physical therapist, etc.) employed by the Hospital may be consulted.
ARTICLE 5

UTILIZATION SECTION

5.A. ADMISSION REVIEW

(1) The Nurse Case Manager will review records of all categories of Patients within one working day of admission to determine the need for the services of the Hospital.

(2) If, in the opinion of the Nurse Case Manager, a diagnostic admission, preoperative overstay or other type of inappropriate utilization exists, the Nurse Case Manager will contact the admitting Practitioner for more information.

(3) If misutilization still appears likely, the physician advisor engaged by the Outcomes Management Department will be notified.

5.B. THIRD PARTY PAYOR ACTIONS

In those cases where the Hospital has incurred or may incur loss through denial of payment or disapproval of days by any third party payor, the attending Practitioner shall reasonably cooperate by providing information to the Hospital.

5.C. MEDICAL EXECUTIVE COMMITTEE REVIEW

Practitioners who fail to cooperate in providing information to the Hospital as provided in this Section, or who otherwise exhibit a pattern of inappropriate utilization, may be required to appear before the Medical Executive Committee in accordance with the Medical Staff Bylaws.
ARTICLE 6

EMERGENCY SERVICES SECTION

6.A. PROVISION OF EMERGENCY MEDICAL SERVICES

The Hospital and its Medical Staff have assumed the responsibility for providing emergency medical services to the residents of its service area as part of a regional emergency medical services system.

6.B. PRACTITIONER STAFFING

Because of the broad nature of clinical problems that are seen and treated in an Emergency Department setting, it is necessary for the Hospital and individual Members of the Medical Staff to share in the responsibility for providing the necessary and appropriate Practitioner staffing. The responsibility for staffing shall be delegated as follows:

1. The Hospital will arrange for twenty-four (24) hour coverage in the Emergency Department by Practitioners with special training and/or expertise in Emergency Medicine. Said staffing shall be sufficient to handle the normal case load in a reasonable and cost efficient manner.

2. The Medical Staff through its clinical departments/sections shall provide specialty and subspecialty coverage as needed, on an "on-call" basis. Each department or section shall develop an "on-call" schedule which will provide adequate Emergency Department coverage.

3. A Departmental schedule designating Emergency Department coverage shall be developed on an equitable basis and shall not exclude any qualified Practitioner who desires to provide coverage.

4. Any conflicts or disputes related to on call coverage, may be forwarded to the Medical Executive Committee for resolution.

6.C. GENERAL RULES REGARDING EMERGENCY CARE

The duties and responsibilities of all Practitioners and personnel serving Patients within the Emergency Department shall be defined in an Emergency Department Policies and Procedures Manual.
6.D. TIME LIMITS TO BE OBSERVED IN ATTENDING PRIVATE PATIENTS IN THE EMERGENCY DEPARTMENT

The Psychiatric Department is excluded.

(1) If the attending Practitioner or his/her designee has not seen the (non-emergency) Patient within a reasonable time of Patient's arrival in the Emergency Department, the Patient may be seen by the Emergency Department Practitioner. A qualified designee shall be defined as an Active Medical Staff Member or a resident physician acting under the direction of the attending physician.

(2) If a Patient is seen and/or treated by a resident on behalf of an attending Practitioner in the Emergency Department, the attending Practitioner shall countersign the Emergency Department record. If a Patient is seen and/or treated by a resident on behalf of an Emergency Department Practitioner in the Emergency Department, the Emergency Department Practitioner shall countersign the Emergency Department record.

(3) If a Practitioner cannot be contacted within one hour in order to discuss the Patient's problem,

   (a) Where the Patient is able to be discharged, the Emergency Department Practitioner will discharge him/her with follow-up care by his private Practitioner.

   (b) Where a Patient needs to be admitted and the attending Practitioner is not available within one hour, the Emergency Department Practitioner will call the following order of Practitioners to determine who will admit the Patient:

      (1) On call Practitioner

      (2) Hospitalist

      (3) Chief of Section

      (4) Chairperson of Department

      (5) Senior Vice President for Medical Affairs

6.E. ON CALL SERVICES

The duties and responsibility of a Medical Staff Member who is providing specialty and sub-specialty on-call services shall, at a minimum, include the following:

(1) When the on-call specialist or sub-specialist is specifically requested by a physician to see a patient in the Emergency Department, the on-call specialist or sub-specialists shall respond in person (or by approved telemedicine link) and in a timely manner.
(2) The on-call specialist or sub-specialist must provide services, when requested, without regard to the patient’s ability to pay for the services rendered.

(3) After an appropriate medical screening, when a patient with an emergency medical condition requires the services of an on-call specialist or sub-specialist to examine and stabilize the patient, those services must be rendered in the Emergency Department.

(a) An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions (d) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (e) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(4) The current month’s on-call physician list is maintained in the Emergency Department.

6.F. MEDICAL SCREENING FOR PATIENTS PRESENTING TO THE HOSPITALS

(1) All patients coming to the Hospitals requesting emergency services will receive an appropriate medical screening examination as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C.§1395dd.

(2) Health care personnel approved to perform a medical screening examination includes physicians, physician assistants, certified registered nurse practitioners and registered nurses.

(a) A triage assessment does not constitute a medical screening examination.
ARTICLE 7

MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR ACT REQUIREMENTS

7.A. REPORT OF A SERIOUS EVENT OR INCIDENT

A Practitioner who reasonably believes that a serious event or incident has occurred shall report the serious event or incident to the Patient Safety Officer of the Hospital. The report shall be made immediately or as soon thereafter as is reasonably practicable, but no later than twenty-four (24) hours after the occurrence or discovery of the serious event or incident.

7.B. DISCLOSURE OF A SERIOUS EVENT OR INCIDENT

The attending Practitioner should be central to the notification and discussion of serious events and incidents with patients and, as appropriate, family members. If the attending Practitioner does not feel capable of the responsibility, the attending Practitioner should immediately contact the Senior Vice President of Medical Affairs or the Patient Safety Officer of the Hospital to pursue the initial discussion.
ARTICLE 8

IMPAIRED MEDICAL & ALLIED HEALTH STAFF MEMBER SECTION

8.A. SELF-REFERRAL

A member of the Medical Staff or the Allied Health Staff may refer himself or herself for treatment of a physical illness, psychiatric or emotional illness, or for drug and alcohol abuse. A self-referral may be made by contacting the Senior Vice President of Medical Affairs or the President of the Medical Staff who shall provide the member with a referral to sources for diagnosis, treatment and rehabilitation.

8.B. REPORT OF IMPAIRMENT BY STAFF

An employee of the Hospital or member of the Medical Staff or Allied Health Staff may report suspected impairment due to physical illness, psychiatric or emotional illness, or drugs or alcohol by contacting the Senior Vice President of Medical Affairs or the President of the Medical Staff.

If the Senior Vice President of Medical Affairs or the President of the Medical Staff believes that there exists sufficient grounds to investigate the report he or she shall meet with the Medical Staff or Allied Health Staff member about whom the report is made to review the report and the circumstances giving rise to the report. When impairment is found an appropriate referral shall be made in accordance with this document.

Nothing in this document shall be deemed to suspend or in any way interfere with the provisions of the Medical Staff Bylaws and other Governing Documents regarding the imposition of a precautionary suspension or corrective action should circumstances warrant the same.

Nothing in this document shall be deemed to suspend or in any way interfere with the Hospital’s policies and procedures regarding employee impairment as they pertain to Medical Staff and Allied Health Staff members who are employed by the Hospitals or by subsidiaries of the PinnacleHealth System.