HOLLYWOOD
PRESBYTERIAN MEDICAL CENTER

# Medical Staff General Rules and Regulations

# Article I: Introduction

1.1 General Rules and Regulations shall be established to control the conduct of work of the Medical Staff as a whole. Authority for establishing and changing Rules and Regulations is stated in the Medical Staff Bylaws, Article XVIII. Establishment of such Rules and Regulations, and changes to same, shall require approval of the Medical Executive Committee and the Governing Board.

# Article II: Requirements for Staff Membership

## 2.1 Requirement for Malpractice Insurance

2.1-1 Article III, Section 3.2-2 of the Bylaws requires that all members of the Medical Staff shall carry malpractice liability insurance. Therefore, to satisfy this requirement:

A. All members of the Medical Staff shall deliver to the Medical Executive Committee, or to such person as the Medical Executive Committee shall designate at the time indicated by it, a certificate evidencing the existence of the insurance policy required above, and shall, upon request of the Medical Executive Committee, provide it with a copy of their malpractice Insurance Certificate, in the required amounts of $1 million per liability claim and $3 million per aggregate per calendar year. Should the policy be canceled or modified, the practitioner shall notify the Medical Executive Committee at least ten days prior to the effective date of any changes in the policy.

B. All members of the Medical Staff shall, prior to the expiration of their current policy of malpractice liability insurance, furnish the Medical Executive Committee with evidence of the renewal thereof or given evidence of the issuance of a policy in replacement thereof.

C. Exemptions from Malpractice Insurance

1. Members of the Medical Staff who are not privileged such as Affiliate, Honorary, Emeritus or those on Leave of Absence will be exempt from having malpractice insurance.

D. If a member of the Medical Staff fails to obtain or maintain the required amount of malpractice insurance, their membership and clinical privileges, after written warning of delinquency, shall automatically be suspended and shall remain suspended until the practitioner provides evidence of professional liability coverage in the amount required to the Medical Executive Committee.

E. The “Tail Coverage” required to be obtained by physicians with “claims made” insurance shall cover those periods when no malpractice insurance or when “claims made” insurance was in effect, and this “Tail Coverage” shall be in effect so long as other satisfactory insurance is not obtained by the physician.

## 2.2 Disclosure

2.2-1 Article III, 3.2 and 3.4, and Article IX, 9.8-1 of the Bylaws require all physicians with privileges who practice at HPMC, or who are applying for such privileges, to possess a valid, current license to practice medicine in California. Any time any action against a physician which results in suspension, limitation, revocation of the physician’s license, whether the action is civil or criminal, the physician is required to

inform the Medical Staff Office of the existence and details of such action. This notice must be given within 14 days of the date the physician became aware of the action.

### 2.3 Dues

2.3-1 In concert with Medical Staff Bylaw Article IX, 9.8-9 and Article XII, 12.4-1, dues shall be set by the Medical Executive Committee with a statement of dues mailed to each staff member in January of each year. Failure to pay dues, assessments or fines within four months of receipt of a bill for dues will be considered voluntary forfeiture of Medical Staff membership after compliance with the notice requirements set forth below. Before any such voluntary forfeiture of Medical Staff membership may occur, the member must be notified by certified mail, return receipt requested that he has 21 days to pay the dues, assessments or fines owed. Members of the Honorary, Emeritus, and Administrative Staffs shall not be required to pay dues, assessments or fines.

2.3-2 Dues Amounts

A. Active, Courtesy, Medico-Administrative, and Provisional Staff must pay $350 per year.

B. Allied Health Professional Staff must pay $100 per year.

## Article III: Admission and Discharge of Patients

### 3.1 General Guidelines

3.1-1 The hospital shall accept patients for care and treatment except those with diseases which would endanger other patients and/or the proper functioning of the hospital. Beds are not available for primary diagnosis of alcoholic, drug addiction, and psychiatric.

3.1-2 Patients must be seen on a daily basis by a physician.

3.1-3 The attending physician, at the time the patient is admitted, shall inform the admitting staff and nursing staff if they suspect that the patient may be a danger to self or to others, or has an infectious or contagious disease or condition. The admitting physician shall recommend appropriate and approved precautionary measures to protect the patient and the staff, and shall note in the patient's record the reason for their suspicions, and the precautions taken to protect the patient and others.

3.1-4 In the event the patient or others cannot be appropriately protected in the general acute care services, arrangements shall be made to transfer the patient to a facility where his or her care can be appropriately managed. When indicated, individual nursing care shall be arranged in accordance with Hospital policy.

3.1-5 The attending physician should also seek a psychiatric intervention in accordance with Hospital policy and procedure for any patient who suffers from an incapacitating emotional illness or substance abuse.

3.1-6 Patients may be admitted and treated only by physicians who have membership and privileges on the Medical Staff. Treatment must be provided within the limits of the privileges granted, except in a documented emergency. All practitioners shall be governed by the admitting policies of the hospital.

3.1-7 Routine orders for non-invasive outpatient diagnostic testing and services from practitioners who are not members of the Medical Staff may be accepted for outpatient services, as well as patient referrals for hospital outpatient services.

3.1-8 Each patient shall be the responsibility of a member of the Medical Staff. The physician shall be responsible for the medical care and treatment, for the prompt completeness, pertinence and accuracy of the medical record, for necessary special instructions, and for transmitting information pertaining to the condition of the patient to the referring practitioner and to the patient and/or relatives of the patient. Whenever these responsibilities are transferred to another physician, a note covering the transfer of responsibility shall be entered as an order and be documented in the progress notes of the medical record and the transferring physician shall personally notify the receiving physician.

3.1-9 Every patient shall be admitted to the hospital with a provisional diagnosis that has been stated by the admitting physician. In the case of emergency, the provisional diagnosis shall be recorded as soon as possible.

3.1-10 In the case of an admission through the Emergency Department, patients who do not have a private practitioner may request any member of the Medical Center's Medical Staff in the department or service to which they need to be admitted, or will be assigned in rotation to members of the Staff on call in the department or service to which the illness of the patient indicates assignment in accordance with the Rules and Regulations of Emergency Services.

3.1-11 Each Member of the Medical Staff shall provide adequate professional care for their hospitalized patients either by being available or having an eligible alternate physician with whom prior arrangements have been made (per Medical Staff Bylaw Article III, 3.4-11). The alternate physician must be a member of the Medical Staff, with similar privileges. In case of failure to arrange for such coverage, the applicable Chair of the Medical Staff department, or the President of the Medical Staff, shall have authority to call any member of the Medical Staff, who is capable of providing the same type of services as the original physician.

3.1-12 The admitting practitioner shall be held responsible for giving such information to the nursing services and appropriate other practitioners involved in the case, as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his or her patients might be a source of danger from any cause whatsoever.

3.1-13 The attending practitioner is required to document the need for continued hospitalization in accordance with the Medical Staff utilization review plan.

3.1-14 Patients shall be discharged only on a written order of the attending or alternate physician. 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 by the nursing staff and the practitioner and, if possible, a signed release obtained from the patient or his or her legal guardian.

3.1-15 No patient should be transferred or discharged for the purpose of effecting transfer from the Hospital to another health facility unless arrangements have been made in advance for admission to such health facility and either the person legally responsible for the patient has been notified, or documented attempts over a 24-hour period have been made and a responsible person cannot be contacted.

3.1-16 Transfer or discharge of a patient shall not be carried out if, in the opinion of the patient's physician, such transfer or discharge would create a medical hazard.

3.1-17 Patients admitted for Podiatry services must be admitted by an allopathic or osteopathic physician staff member. Patients must be under the care of this physician, making the care of the podiatry patient the medical responsibility of this admitting physician and the Podiatrist, each limited to his or her respective field as defined (Reference Bylaw Articles 3.3-1(b) and 3.4-15(A)(6)(e).

3.1-18 A patient admitted for Dental care must have a history and physical by a physician member of the Medical Staff, who will be responsible for any medical care needed by the patient (Reference Bylaw Articles 3.3-1(a) and 3.4-15(A)(6)(e

## 3.2 Death and Autopsies

3.2-1 In the event of a Hospital death, the deceased shall be pronounced dead by a member of the Medical Staff within a reasonable time. Registered Nurses can pronounce patient death by the Standardized Procedures. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. All deaths must have a dictated death summary regardless of the patient's length of stay. Exceptions shall be made in those instances of incontrovertible and irreversible terminal diseases, wherein the patient's course has been adequately documented to within a few hours of death.

3.2-2 It shall be the duty of all staff members to secure meaningful autopsies whenever possible and in situations identified by the College of American Pathologists as follows:

A. Deaths in which autopsies may help to explain unknown and unanticipated medical complications to the attending physician.

B. All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.

C. Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death and to provide reassurance to them regarding same.

D. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.

E. Deaths of patients who have participated in clinical trials (protocols) approved by Institutional Review Boards.

F. Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.

G. Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as (a) persons dead on arrival at hospitals, (b) deaths occurring in hospitals within 24 hours of admission, and (c) deaths in which the patient sustained or apparently sustained an injury while hospitalized.

H. Deaths resulting from high-risk infectious and contagious diseases.

I. All obstetric deaths.

J. All perinatal and pediatric deaths.

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

L. Deaths known or suspected to have resulted from occupational or environmental hazards.

M. Sudden, unexpected, or unexplained deaths in the hospital that are apparently natural and not subject to a forensic medical jurisdiction.

3.2-3 An autopsy may be performed on all patients whose death does not come under the medical examiner's jurisdiction only with a written consent, signed or recorded in accordance with state law. An autopsy is a consultation and it requires consent and the concurrence of the Hospital's Pathologist that it would offer meaningful information. The attending physician should provide a brief clinical summary and delineate the questions to be answered by the autopsy.

3.2-4 All autopsies shall be performed by the Hospital Pathologist, or the medical examiner. Provisional anatomic diagnoses shall be recorded on the medical record within 72 hours and the complete report should be made a part of the medical record within 60 days.

3.2-5 Coroner's Cases

A. The law requires death to be reported to the coroner in the following circumstances:

i. Violent, sudden, or unusual deaths.

ii. Unattended deaths.

iii. Deaths wherein the deceased has not been attended by a physician in the 20 days before death.

iv. Deaths related to or following known or suspected self-induced or criminal abortions.

v. Known or suspected homicide, suicide, or accidental poisoning.

vi. Deaths known or suspected as resulting in part from or related to an accident or injury, either old or recent.

vii. Deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addition, strangulation, or aspiration.

viii. When the suspected cause of death is sudden infant death syndrome.

ix. Death in whole or in part occasioned by criminal means.

x. Deaths associated with a known or alleged rape or crime against nature.

xi. Deaths in prison or while under sentence.

xii. Deaths known or suspected as due to contagious disease and constituting a public hazard.

xiii. Deaths from occupational diseases or occupational hazards.

xiv. Deaths of patients in state mental hospitals serving the mentally disabled and operated by the State Department of Mental Health.

xv. Deaths of patients in state hospitals serving the developmentally disabled and operated by the State Department of Developmental Services.

xvi. Deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another.

3.2-6 The coroner also asks for reports of deaths due to drug addition, pneumoconiosis, and therapeutics misadventures as well as deaths during or within 24 hours after operations.

### 3.3 Alternate Physicians

3.3-1 Application for staff membership must include provision for coverage when the primary physician is not available (Reference Bylaw Articles 3.4-11 and 7.1-11).

## Article IV: Medical Records

### 4.1 General Guidelines

4.1-1 All Medical Staff Members and Allied Health Professionals are required to use the electronic medical record (EMR) system utilized by HPMC. New members of the Medical Staff must be trained within the first 30 days of membership. Exceptions may be considered by the Medical Executive Committee. Failure to use the EMR system when available and appropriate will result in referral to peer review.

4.1-2 A medical record will be created and maintained for each patient receiving services from HPMC for the purpose of:

A. Providing continuing care for the patient at HPMC and at other health care facilities and health care providers.

B. Serving as a method of communication between health care providers serving the patient.

C. Providing a historical record of tests, treatments, and interventions for the patient.

D. Medical Screening Exam (MSE): Physicians and other authorized personnel (Physician Assistant, Nurse Practitioner, Registered Nurses functioning under Standardized Procedures) are authorized to perform the MSE.

E. Reviewing the patient's response to treatments and interventions.

F. Providing details and organized information for use in case management, quality assessment, and performance improvement activities.

4.1-3 The organized Medical Staff of HPMC shall make rules and regulations regarding medical record documentation and shall be responsible for the enforcement of same.

A. These rules and regulations of the Medical Staff for the completion of medical record documentation shall be in compliance with all applicable regulatory and accreditation requirements.

B. Medical record documentation will be completed within 14 days after discharge. Records incomplete after 14 days shall be considered delinquent, unless due to missing reports or the excused absence of the responsible practitioner. The practitioner shall notify the Medical Staff in advance of time away or vacation.

C. The Medical Staff shall suspend the privileges of physicians who are delinquent in the completion of medical record documentation after due notice and warning. Suspension of privileges will include:

i. Admitting patients;

ii. Performing surgery or deliveries on patients admitted during suspension;

iii. Scheduling procedures;

iv. Accepting consults status at the request of another physician;

v. Assisting at surgery; and

vi. Participating in Emergency Department backup call.

4.1-4 The Medical Staff shall utilize ongoing review of medical record timeliness and completeness in performance improvement, quality assessment, proctoring, and re-credentialing.

4.1-5 An addendum shall suffice for corrections to the EMR.

4.1-6 The individual physician is responsible for the medical record documentation of care of the patient that they render or supervise.

A. Documentation principles:

i. The medical record shall contain entries by clinical care providers including:

1. Physicians and licensed independent practitioners granted privileges by the HPMC Governing Board; or

2. Any other HPMC employee providing direct patient care.

ii. Podiatrists shall be responsible for documenting podiatric history and physical examination and an attending physician, with privileges to practice at HPMC, must complete the medical history and physical examination and be responsible for all general medical care of the patient. Regardless of training, podiatrists may not perform the general history and physical for patients undergoing surgery or admitted as an inpatient (Reference Bylaws Articles 3.3-1(b) and 3.4-15 (a)(6)(e)).

iii. Dentists shall be responsible for documenting dental history and physical examination and an attending physician with privileges to practice at HPMC must complete the

medical history and physical examination and be responsible for all general medical care of the patient (Reference Bylaws Articles 3.3-1(a) and 3.4-15 (a)(6)(e).

iv. Oral and Maxillofacial surgeons who can verify skill, training, and experience in performing general history and physical examinations and in rendering general medical care independently may provide such are within granted privileges (Reference Bylaw Article 3.4-15(a)(6)(d)).

v. Pertinent progress notes shall be recorded at the time of each daily visit for all patients, excluding all short-stay patients and outpatients, and shall be sufficient to permit continuity of care and transferability. Each of the patient's clinical problems, results of tests, and treatment shall be clearly identified in the progress notes.

vi. The written consent of the patient or legal guardian is required for release of medical information to persons not otherwise authorized to receive this information.

vii. Symbols and abbreviations may be used only when they have been approved by the Medical Executive Committee. An official record of approved abbreviations and an unacceptable abbreviations list will be kept on file in the Health Information Management Department, Pharmacy, and all nursing units.

viii. Final diagnoses shall be recorded, without the use of symbols or abbreviations, dated, and signed by the responsible practitioner at the time of discharge of all patients. The attending physician has the responsibility to establish the final diagnoses. If the final diagnoses are not on the chart within 14 days after discharge, the chart will be considered delinquent. The medical record shall not be filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee. An incomplete record will not be filed permanently if the deficiency is due to an individual who is still a member of the staff.

ix. Documentation must be through the EMR system utilized by HPMC. Documentation includes progress notes and medication reconciliation.

4.1-7 Physician Orders

A. Physician orders will be entered directly by the physician via computerized physician order entry (CPOE). When the computer order entry system is unavailable or handwritten orders are necessary, orders should be documented on the HPMC order form(s) and will be written clearly, legibly, and completely.

B. All orders will be signed, dated, and timed by the ordering physicians or by another physician who is involved in the care of the patient. Orders are automatically cancelled when patients go to surgery or go to a different level of care (e.g., ICU, Rehab, etc.).

C. Telephone orders may be taken only by qualified staff; this includes:

i. Nursing: telephone / verbal orders are taken only by registered nurses.

ii. Pharmacy: telephone / verbal orders are taken only by licensed pharmacists and are limited to medications and medication monitoring (e.g., gentamicin serum level).

iii. Respiratory: telephone / verbal orders are taken only by licensed respiratory care practitioners, and are limited to respiratory care modalities.

iv. Other practitioners: physical therapist (limited to PT orders); occupational therapist (limited to OT orders); speech pathologist (limited to ST orders); Laboratory (limited to lab orders); radiology technologists (limited to radiology orders); and dieticians (limited to nutrition-related orders).

D. Telephone orders shall be transcribed in the proper place in the medical record and shall include the date, time, name, signature of the person transcribing the order, and the name of the responsible practitioner.

E. Telephone orders for medications shall be dated, timed, and authenticated by the ordering physician or another physician involved in the patient's care, within 24 hours of being given.

F. Telephone orders for medications that are not dated, timed, and authenticated within 24 hours of being given will be considered delinquent.

G. Summary (blanket) orders to resume previous medications are prohibited.

4.1-8 Informed Consent

A. It shall be the practitioner's responsibility to obtain informed consent, from the patient or their legally constituted representative. Evidence of informed consent shall be documented in the medical record by the practitioner. When informed consent is not obtainable, the practitioner shall document the reason in the medical record. See Informed Consent policy to determine if informed consent is required.

B. Procedure specific requirements:

i. All procedures performed in the operating room.

ii. Any diagnostic procedure that requires anesthesia.

iii. All procedures performed in the GI Lab.

iv. All biopsies, including bone marrow and liver biopsies for diagnostic / laboratory purposes.

v. Blood transfusions (per Paul Gann Blood Safety Act).

vi. Hysterectomy.

vii. Implantation of cells, tissue, organs.

viii. Insertion of pacemaker and cardioversion.

ix. Medications:

1. Any investigational drug.

2. Rho (D) immune Globulin.

x. Laser procedures.

xi. Pain management procedures.

xii. Telemedicine.

xiii. Elective sterilization.

C. The consent form must state the name of the involved practitioner and/or operating surgeon and the name of the proposed procedures and/or the nature of the treatment. It is to be understood that the informed consent is delivered only when the patient has been advised in lay terminology (in their preferred language) of the calculated risk, of complications, injury or even death, from known and unknown causes and no warranty or guarantee has been made as to the result or cure. The patient must also be advised of the alternate treatment modalities and benefits of the proposed treatment.

4.1-9 Restraints

A. Refer to Hospital policy and procedure.

B. Non-Violent / Non-Behavioral / Non-Self-Destructive Patient

i. Physician Assessment and Orders

1. Physician assessment must occur within 24 hours of initial restraint application. A restraint order is required for renewal every calendar day. Renewal orders for restraints must be done by physician in person and upon patient assessment.

2. The Physician Order Restraints form must include:

a. Indication for restraints based on assessment.

b. Type of restraint required, beginning with the least restrictive method that is clinically feasible.

c. Criteria for early release.

3. If restraints are discontinued, then later determined to be necessary, a new order will be obtained.

4. PRN orders are not permitted under any circumstances.

5. Chemical intervention orders include medication name, dose, route, and whether a stat or now order.

C. The Violent / Self-Destructive / Behavioral Patient

i. Physician Assessment and Orders

1. Perform a face-to-face assessment of the patient within one hour of ordering the emergency application of restraint, and document these findings in the physician progress notes. The in-person evaluation includes the following:

    a. An evaluation of the patient's immediate situation.

    b. The patient's reaction to the situation.

    c. The patient's medical and behavioral condition.

    d. The need to continue or terminate the restraint.

2. Assist staff in identifying ways to help the patient regain control of their violent / self-destructive behavior.

3. Complete order form for violent / self-destructive behavior.

4. The physician must reassess the patient face-to-face at least every 24 hours if the patient's behavior continues to be violent / self-destructive. Additional face-to-face assessments will be at the discretion of the physician during the patient's first 24 hours in restraint.

5. The physician's order must include:

    a. Date and time restraints initiated.

    b. Indications for restraint use.

    c. Type of restraint required.

    d. Behavioral criteria for release of restraint.

6. PRN orders are not permitted under any circumstances.

7. Order renewals for violent patients:

    a. Adults renew order every four hours or more often per unit schedule.

    b. Ages 9-17 years old renew order every two hours or more often.

    c. Less than 9 years of age renew order every hour.

    d. Order may be renewed according to above time limits for a maximum of 24 consecutive hours.

## 4.1-10 Delinquency, Suspension, and Fines

### A. HIM Delinquency

i. All patient medical records shall be completed at the time of discharge. Where it is not possible because of laboratory or other essential reports, the patient's record will be available in Health Information Management (HIM) until complete.

ii. A medical record is considered delinquent if it remains incomplete 14 days following a patient's discharge.

iii. Any operative report / procedure report is considered "delinquent" if not dictated immediately after the surgery / procedure. For monitoring purposes, a procedure / operative report that is not dictated the day after the procedure was performed will be subject to the suspension process. It is the responsibility of the physician to dictate the operative / procedure report immediately after the surgery / procedure. Notification will be provided for suspensions due to incomplete operative / procedure reports.

iv. Any history and physical report is considered "delinquent" if not completed within 24 hours of admission or prior to surgery or a procedure requiring anesthesia services.

v. A medical record holding for the completion of a physician query form or a Cancer Staging form will be considered delinquent if not completed within 14 days from the date of discharge.

vi. The physician query form is a request to the attending physician, surgeon, or consultant, to answer and/or clarify detailed questions posed by HIM coding staff concerning the patient's diagnosis or surgery. The response(s) are needed to complete coding according to established coding guidelines. The response to the query must be written in the patient's record.

vii. The surgeon will complete the Cancer Staging form for surgical cases. The attending Oncologist will complete Staging forms for medical cancer cases. If there is no Oncologist on a medical cancer case, the attending physician will be responsible for completion of the form.

B. HIM Suspension Process

i. HIM will notify physicians of record deficiencies.

1. HIM will mail a courtesy letter to physicians weekly identifying all of their incomplete records (includes deficiencies and delinquencies).

2. HIM staff will fax a copy of the pending suspension letter to the physicians' office two days before the effective suspension date.

3. HIM staff will call the physicians' office advising the physician of his or her office staff of the impending suspension one day before the effective suspension date.

4. HIM will document the date of the call and who in the physician's office HIM staff spoke with. The most up-to-date listing of accounts pending suspension can be access via the Paragon web station for physicians (WSP).

C. Fines for Delinquent Medical Records

i. On suspension days 1-30, a $5 per day fine will be assessed.

1. Physicians will lost parking access on consecutive suspension day 11. The suspended physician will be responsible for all parking expenses.

2. Physicians will lost cafeteria access on consecutive suspension day 21.

ii. Physicians who accumulate 30 or more consecutive suspension days will be considered to have voluntarily resigned.

iii. To be released from suspension, a physician must complete his or her delinquent records and then pay all accumulated fines.

1. Payment will only be accepted by Medical Staff Services personnel, during operating hours, via check.

2. Access to parking and cafeteria will be reactivated 24 business hours after release from suspension.

4.1-11 Treatments and Interventions

A. The responsible surgeon is required to place in the patient's record prior to surgery a note showing examination of the patient and diagnosis of the patient's surgical problem before the operation.

B. Operative reports shall contain a description of the findings, procedures used, specimen removed, postoperative diagnosis and name(s) of the surgeon(s). Operative reports shall be dictated immediately after surgery.

C. Pending completion of the transcription of the dictated operating procedure report, a handwritten postoperative note shall be documented as a procedure summary on the progress notes at the conclusion of the procedure and before the patient is transferred to the Post-Anesthesia Care Unit or designated recovery area. The report shall contain:

i. Preoperative diagnosis.

ii. Postoperative diagnosis.

iii. Name of the primary surgeon, co-surgeon, and assistants, as applicable.

iv. Name of the anesthesiologist, if applicable.

v. Type of anesthesia.

vi. Procedure(s) performed.

vii. Findings.

viii. Estimated blood loss.

ix. Complications.

x. Specimens.

D. Dictation of an operative report is required for all procedures taking place in an operating room, GI lab, Cardiac lab, and any procedure performed at the bedside requiring moderate sedation. A physician may, at his or her discretion, dictate an operative report on any procedure, including minor procedures requiring local anesthetic or no anesthesia performed outside an operating room.

E. Podiatrists and Dentists are responsible for the completion of all operative documentation of the procedure which they performed (reference Bylaws sections 3.3-1(b) and 3.4-15 (a)(6)(e).

4.1-12 Discharge, Transfer, or Death

A. The attending physician is responsible for dictating a discharge summary on all patients discharged except for those patients hospitalized less than 48 hours, obstetrical cases, and normal newborns. A short form discharge summary will be completed for patients discharged within 48 hours, normal obstetrical deliveries, and normal newborns.

B. The dictation shall be completed within 14 days of the discharge. The summary shall contain:

i. Provisional diagnosis or reason for hospitalization.

ii. Principal and additional associated diagnoses.

iii. Significant findings.

iv. Procedures performed and treatment rendered.

v. Condition of the patient on discharge.

vi. Specific instructions given to the patient and/or family (particularly in relation to physical activity, medications, diet, and follow-up care) should be dictated in the discharge summary and identified on the physician discharge order form.

C. The condition of the patient on discharge should be stated in terms that permit measurable comparison with the condition on admission, avoiding the use of vague relative terminology.

D. A death summary must be dictated for any patient who expires, regardless of hospitalization time.

E. For the Chalet, the attending physician is responsible for writing and completing a discharge / death summary on all patients discharged from the Chalet within 14 days of discharge / death. The summary shall contain:

i. Date of admission and discharge.

ii. Diagnosis on admission.

iii. Diagnosis on discharge / death.

iv. Conditions on discharge.

v. Prognosis.

vi. Reason for discharge.

1. Lower level of care.

2. Higher level of care.

3. Same level of care, i.e. other facility.

vii. Summary of the care / stay at the Chalet.

viii. Cause of death (if applicable).

4.1-13 Outpatient and Emergency Department Medical Records

A. A medical record will be maintained for each patient receiving outpatient services or emergency care.

B. All patients seen in the Emergency Department shall have a brief written note describing essential findings and treatments, even though a comprehensive note has been dictated.

C. Emergency Room records shall include:

i. Concise history of illness.

ii. Accurate description of positive findings on examination.

iii. X-ray and lab tests and their results.

iv. Condition on discharge.

v. Instructions to the patient for follow-up care.

4.1-14 Access to Medical Records

A. All medical records shall remain the property of HPMC. No medical records, original reports, images or electronic recordings may be removed from the facility except as required by law, statute, court order, or subpoena. Unauthorized removal of medical records shall be a cause for corrective action by the Medical Executive Committee or the Governing Board.

B. Physicians may have access to the records of their own patients for purposes of provision of ongoing care or for the personal review of practice.

C. Duly authorized members of the Medical and Allied Health Professional staffs of HPMC may have access to patient records, without restriction , for purposes of ongoing professional practice evaluation (OPPE), focused professional practice evaluation (FPPE), performance improvement, risk management, the ongoing evaluation and enhancement of all hospital services, the preparation of necessary statistical; reports, and surveys.

4.1-15 Resident / Fellow Staff Activities / Documentation

A. Resident Staff (as defined in the Medical Staff Bylaws, Article VI) may document histories, physical examinations, orders (except those for DNR; note that restraint / seclusion orders can be written by postgraduate year [PGY] PGY 2 and above), transfer summaries, discharge summaries, progress notes, and operative reports for procedures performed, consistent with their approved scope of activities pursuant to the training protocols. All entries by Resident / Fellow Staff shall designate title (i.e., Resident, Fellow) and practice level. The attending physician is ultimately responsible for the adequacy and completion of the medical record. The supervision of Residents shall be documented in the medical record, evidenced by: countersigning orders, history and physical exam reports, consultation reports, prescriptions, delivery notes, fetal monitoring interpretation, consent; preoperative reports, operative reports, transfer summaries, discharge summaries, and physician orders.

# Article V: Conduct of Care

## 5.1 General Guidelines

5.1-1 The Hospital shall not permit any Resident, Intern, or Student to perform any service for which a license, certification or registration, or other form of approval is required, unless such person is licensed, registered, approved, or is exempted there from under the provisions of the State Medical Practice Act or State Dental Act; and further, unless such services are performed under the direct supervision of a licensed practitioner whenever so required.

5.1-2 A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. “Informed” consent shall be the responsibility of the attending practitioner. Consent forms for treatment shall be prepared by the Hospital as appropriate based on the advice of counsel.

5.1-3 Treatment of a patient under emergency conditions without written consent is authorized under the doctrine of implied consent; that is to say, if the patient was able or his legal representative was present, such consent would be given ordinarily. In such instances the attending physician should designate that an emergency exists and secure appropriate medical consultation confirming this. Should delay in securing written consent be hazardous to the patient, proper notations on the chart should be made and signed by the attending physician and consulting practitioners.

5.1-4 All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia; National Formulary; American Hospital Formulary Service; or AMA Drug Evaluations. Drugs for bona fide clinical investigations are subject to approval by the Institutional Review Board. These shall be used in full accordance with the statement of principles involved in the use of investigational drugs in hospitals and all regulations of the Federal Drug Administration.

5.1-5 Patients are not allowed to use their own medications brought into the Medical Center unless the following conditions have been met:

A. The medication is not available at HPMC.

B. The physician must order the medication in the patient’s chart and clearly state that the patient may use medications from home.

C. The medication must be identified by a Pharmacist, and attach a HPMC label.

D. The medication will be kept in the medication room or designated secure storage area and entered on the Medication Administration Record.

5.1-6 Medications shall not be left at the bedside unless the attending physician so orders in writing, and only when such patient is competent and capable of self-medications. This practice is discouraged and only to be used when absolutely necessary for patient care.

A. Controlled substances shall not be left at the bedside.

5.1-7 Medications in the categories listed below that are ordered without time limitation shall automatically be discontinued after the indicated time has elapsed. Pharmacy / Nursing Staff will give 48 hour notice to the physician if possible. A medication should not be discontinued before a reasonable attempt to contact the physician has been made. The physician will either discontinue, change, or reorder the medication.

A. Medications under stop order policy are as follows, except those noted as “exceptions”:

i. 24 hours.

1. Albumin.

2. Antineoplastic agents.

ii. 7 days.

1. Antibiotics used for treatment.

a. Prescribers must document in the medical record (ex Progress Notes) or during order entry, a duration and indication for all antibiotic prescriptions, in addition to other requirements such as drug name, dose, route, etc.

2. Schedule II, III, IV, and V Controlled Substances.

iii. 14 days.

1. Steroids.

iv. 30 days.

1. All other drugs and nutritional products unless otherwise specified.

v. Exceptions:

1. Specific number of doses specified by written physician’s order.

2. Exact time period specified, i.e., number of days (steroids, chemotherapy).

3. The physician reorders the medication.

4. The Pharmacist reorders the medication based on information in the progress notes.

5. Anticoagulants (Warfarin) on the Rehabilitation Unit (3R) need renewal every 14 days.

vi. Automatic cancellation of all orders:

1. Surgery.

2. Delivery.

3. Transfer to or from special care units, or to a different "level" of care (e.g. from ICU to the regular floor).

vii. Reorder for medication required:

1. Surgery.

2. Delivery.

3. Transfer to or from special care units, or to a different "level" of care (e.g. from ICU to the regular floor).

5.1-8 Anticoagulants and oxytoxins shall be ordered specifically as to dosage and time (see Rules and Regulations for Departments of Obstetrics and Gynecology, and Pediatrics).

5.1-9 Intravenous policies as approved by the Pharmacy and Therapeutics Committee and the Medical Executive Committee shall be followed. Such policies are available on each nursing unit. They cover who may start and administer IV fluids, blood, and its derivatives, and when IV fluids may be administered, including a Pharmacy Department IV manual, containing maximum dosages, etc.

5.1-10 Protocols or Standardized Procedures may be used in order to routinize the conduct of certain procedures in a department or service. They shall be formulated by the head of the appropriate clinical department, service, or committee in consultation with other physicians, nurses, administrative staff as indicated, and after appropriate liaison with those heads of other departments, services and/or committees whose conduct or work may be affected by the order. Protocols and Standardized Procedures shall be approved by the Interdisciplinary Practices Committee, the Medical Executive Committee, and the Governing Board triennially.

5.1-11 Ongoing monitoring and evaluation activities of patient safety will be conducted by the Quality Management Committee, and Medical Executive Committee as defined in the Patient Safety Plan.

5.1-12 HPMC is a tobacco0free facility.

## 5.2 Request for Radiological Services

5.2-1 As per The Joint Commission Accreditation Manual of Hospitals, "All requests for radiological services shall contain the reasons for the examination. The requesting Medical Staff members, house staff

member, or other practitioner authorized to request radiological services is responsible for providing this information."

5.2-2 Any potentially hazardous diagnostic procedures, such as an angiography, non-vascular special procedures, interventional radiological procedures, shall be postponed until physical and history are recorded or the requesting physician states, in writing, that such a delay would be detrimental to the patient.

### 5.3 Utilization Review System

5.3-1 The Utilization Management Committee is responsible for the development and periodic review of the Utilization Review System. The Utilization Review System will be implemented or revised based upon the recommendation of the Utilization Management Committee with approval of the Medical Executive Committee and the Governing Board.

5.3-2 The Utilization and Case Management Plan is attached to these General Medical Staff Rules and Regulations.

## Article VI: Consultations

### 6.1 General Guidelines

6.1-1 The good conduct of medical practice includes the proper and timely use of consultations. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rests with the practitioner responsible for the care of the patient. On the other hand, it is the duty of the organized Medical Staff through its Department Chairs and Medical Executive Committee to see that those with clinical privileges do not fail in the matter of calling consultants as needed.

6.1-2 Except in an emergency situation, consultation is recommended in the following situations:

A. When the patient is not a good risk for operation or treatment.

B. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.

C. Where there is doubt as to the choice of therapeutic measures to be utilized.

D. In unusually complicated situations where specific skills of other practitioners may be needed.

E. In instances in which the patient exhibits severe psychiatric symptoms.

F. When requested by the patient or his or her family.

G. When the patient's admitting physician does not have the privileges requested for subsequently scheduled surgery. In such cases, the record shall include documented evidence that the consulting surgeon supervising the postoperative care of the patient.

H. As specified in the Department Rules.

6.1-3 Any qualified practitioner, having full privileges in a specialty field in this Medical Center, may be called for consultation in that field.

6.1-4 The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant, by direct communication if possible. He will provide written authorization to permit another practitioner to attend or examine his patient except in an emergency. The reason for the consultation and the name of the consultant shall be indicated by the physician when writing the order for consultant. Over utilization of consultants shall be subject to review through Medical Staff Committees.

6.1-5 If a nurse has any reason to doubt or question the care provided to any patient or feels that appropriate consultation is needed and has not been obtained, he or she shall call this to the attention of his or her supervisor who in turn may refer the matter to the Director of Nursing. If warranted, the Director of Nursing will bring the matter to the attention of the Chair of the Department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the Chair of the Department may him or herself request a consultation.

6.1-6 A satisfactory consultation shall show evidence of review of the patient's record by the consultant, pertinent findings on examining the record of the patient, and the consultant's opinion and recommendations. Consultation shall include the date and time, the express indication of where and when the patient was interviewed and/or examined by the consultant; and the consultant's findings and diagnosis and basis for arriving at that conclusion. A written opinion signed by the consultant must be included in the medical record. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

6.1-7 When a physician considers a patient's end of life decisions, withholding, withdrawing, or foregoing life sustaining treatment, and/or needs to determine a patient is brain dead, the following Hospital policies and procedures should be referenced:

A. Brain Death Determination and Accommodation of Family.

B. End of Life Care Decision Report.

C. Medical Bioethics Committee: Purpose; Composition; Process.

D. Withholding, Withdrawing, or Foregoing Life Sustaining Treatment.

6.1-8 Consultations with a medical physician staff member shall be required when medical or surgical complications are present for Podiatry patients.

6.1-9 All suicidal or mentally disturbed patients shall have consultation by a psychiatrist member of the Medical Staff.

# Article VII: Response Times

## 7.1 Emergency Response Times for On Call Panel Physicians

7.1-1 Physicians on an Emergency Room Call Panel will respond within 30 minutes to emergency telephone calls. The first call is made to the number listed in the Medical Staff roster. If the physician has not responded within the first 30 minutes, a second call is made. If the physician has provided a cell phone or pager number, the second and all subsequent calls will be made to that number. If specifically

requested by an Emergency Room physician, an on call physician will be present within 60 minutes of receiving the request.

## 7.2 Inpatient Response Times

7.2-1 A patient admitted to the ICU must be seen within four hours by a physician; patients admitted to DOU or Telemetry floors will be seen within eight hours; and all other floors, patients will be seen within 12 hours by a physician.