FRANCISCAN MEDICAL STAFF RULES AND REGULATIONS

St. Anne Hospital, St. Anthony Hospital,
St. Clare Hospital, St. Elizabeth Hospital,
St. Francis Hospital, St. Joseph Medical Center

Effective February 27, 2024

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RULES AND REGULATIONS
OF THE MEDICAL STAFF BYLAWS

DEFINITIONS

The definitions referenced in the Medical Staff Bylaws also apply in the Rules and Regulations.

CONFIDENTIALITY OF INFORMATION AND IMMUNITY FROM LIABILITY

The protections identified in Article X of the Medical Staff Bylaws shall apply to these Rules and Regulations of the Medical Staff Bylaws.

ARTICLE I. ADMISSION AND DISCHARGE

SECTION 1. ADMISSION

A. Patients shall be admitted to the Hospital only by members of the Active Medical Staff or other practitioners who have privileges to do so.

B. The Hospital's general consent for admission form must be signed by or on behalf of every patient at the time of admission to the Hospital. This signature is obtained by the Hospital admitting office staff. The admitting office shall notify the attending practitioner whenever such consent has not been obtained.

C. Hospital Inpatient Admission Order/Certification: Patients are admitted to the hospital only on the decision and certification of the attending physician who is a licensed practitioner permitted by the state to admit patients to a hospital. The attending physician certification implies that the hospital inpatient admission order is reasonable and necessary.

D. Each patient admitted to the Hospital shall have one member of the Active Medical Staff or an appropriately privileged practitioner responsible for the provision and coordination of care received while in the Hospital. This attending practitioner shall be responsible for patient care until care has been officially transferred to another practitioner. Responsibilities of the practitioner shall include the completeness and accuracy of the medical record, the communication of orders, the transmittal of reports on the condition of the patient to the referring practitioner, if applicable, and for the transmittal of reports to relatives of the patient.

E. All patients admitted to the critical care units shall be admitted according to pre-defined admission criteria. All admissions will be reviewed for appropriateness within twenty-four (24) hours by the medical director or designee of the unit to which the patient was admitted. Any questions regarding appropriateness of admission shall be resolved through consultation with the medical director of the unit.

F. The critical care Intensivist may pro-actively become involved in the care of any patient admitted to the ICU (excluding CT Surgery and Trauma) by a non-Critical Care service. All patients admitted to the critical care units must be appropriately evaluated by the attending practitioner as expeditiously as patient care needs require, but in all cases in a timely manner and within four (4) hours. Failure to do so will be brought to the attention of the practitioner and reported to the

medical director of the unit by the nurse manager of the unit. Repeated violations will be addressed by the medical director of the unit.

G. All patients admitted to a non-critical care unit must be appropriately evaluated by the attending practitioner as expeditiously as patient care needs require, but in all cases within twenty-four (24) hours of admission. Failure to do so will be reported by the nurse manager to the medical director and will be brought to the attention of the practitioner by the nurse manager. Repeated violations will be addressed by the Clinical Section Chief as outlined in the Quality and Safety Plan.

H. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been recorded in the medical record. In emergency cases provisional diagnosis shall be recorded as soon as possible.

SECTION 2. CONTINUED CARE

A. The attending practitioner is required to document the need for continued hospitalization if standard criteria for acuity of illness or intensity of care as identified by Utilization Management are not met. This documentation must contain:

1. An adequate record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient;

2. The estimated period of time the patient will need to remain in the Hospital; and

3. The plans for post-hospital care.

B. Failure of compliance with this policy will be brought to the attention of the Clinical Section Chief to which the Medical Staff member or practitioner is assigned. The Clinical Section Chief or an active staff member appointed by him/her will review the case and, if necessary, counsel and assist the attending practitioner member in order to achieve compliance with utilization standards or develop a plan for an appropriate Hospital discharge. Failure to comply with this policy will be addressed by the Clinical Section Chief according to the Quality and Safety Plan.

SECTION 3. TRANSFER OF CARE

Whenever the designation of attending practitioner is transferred, the referring practitioner shall be responsible for continued care until he/she has personally contacted another appropriately credentialed practitioner and that practitioner has agreed to assume care. No staff member shall be designated as the attending practitioner until he/she is contacted and accepts responsibility for continued care. A dated and timed note covering the transfer of responsibility shall be entered on the order sheet of the medical record and the patient shall be informed of the change by the transferring practitioner.

SECTION 4. DISCHARGE

Patients shall be discharged only by an order of an Active Medical Staff member or other credentialed practitioner. Should a patient leave the Hospital against the advice of the Medical Staff or Allied Health Staff member or, in his/her absence, the responsible Hospital staff nurse, the patient will be advised of risks/benefits and asked to sign an “against medical advice” release.

SECTION 5. DEATH

In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or another member of the Medical Staff within a reasonable time. If no other practitioner is available, the attending practitioner may request determination of death by the Hospital Supervisor. The body shall not be released until an entry indicating the time of death has been made in the deceased's medical record and has been signed by a member of the Medical Staff or upon his/her request, by the Hospital Supervisor. Policies with respect to release of bodies shall conform to local law.

SECTION 6. AUTOPSY (See Policy #15.0)

A. Deaths shall be immediately reported to the Medical Examiner's Office as required by statutory regulation. In addition, the Medical Staff, other practitioners, and/or appropriate Hospital staff shall recommend autopsies whenever:

1. Deaths within 48 hours of a surgical or invasive procedure, including radiology.
2. Death associated with a drug reaction.
3. Death associated with a preceding adverse event.
4. Deaths in emergency or outpatient settings.
5. Deaths in which the admission diagnosis suggests death was not expected, or in which extensive diagnostic procedures and consultations suggest the diagnosis was elusive.
6. There is anticipated legal liability for the Medical Staff, Allied Health Staff.

B. Compliance with this standard is monitored by the appropriate clinical section. Failure to appropriately request an autopsy shall be reported to the medical director and the Clinical Section Chief.

C. All autopsies are performed only with appropriate signed consent, as defined by Hospital policies, or as directed by legal statute.

D. It is the responsibility of the pathologist performing an autopsy to notify the appropriate practitioners when the examination is to be performed.

E. All autopsy reports are included in the patient's medical record. The provisional anatomic diagnosis shall be recorded within seventy-two (72) hours and the final report completed within sixty (60) days. Autopsy findings will be correlated with clinical diagnoses by the pathologist and reported to the practitioner with a copy to the Chief Medical Officer or designee. Such correlation data will be utilized in the quality improvement process described in the Quality and Safety Plan of the Board.

ARTICLE II. GENERAL RULES

SECTION 1. STAFF AVAILABILITY

Each member of the Medical Staff or appropriately privileged practitioner who is not available so as to allow timely response to patient care needs, including emergencies, shall name a member of the Medical

Staff who is available in the area who agrees to accept responsibility to attend his/her patients in an emergency, or until he/she arrives. Such designation of a substitute practitioner shall only include those with appropriate Clinical Privileges at the same Campu/es.

SECTION 2. MEDICATION ADMINISTRATION

All drugs and medications administered to patients shall be those listed in the latest edition of the Hospital's formulary as developed by the Pharmacy, Therapeutics and Technology Committee of the Hospital. All non-formulary drug use will be reviewed for appropriateness by the Pharmacy, Therapeutics and Technology Committee. FDA-approved drugs used for clinical investigations and all investigational drugs may be used only after approved by the Medical Research and Evaluation Committee of the Board and only 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.

SECTION 3. USE OF APPLIANCES, PROSTHETICS AND IMPLANTABLE DEVICES

The appliances, prosthetics and implantable devices utilized in the Hospital shall be those approved for such use. Non-approved items may only be used in an emergency, but such utilization of non-approved items will be reviewed by the appropriate oversight committee. All experimental appliances, prosthetics and implantable devices may be used only after approval by the Medical Research and Evaluation Committee.

SECTION 4. CONSULTATIONS

The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the serious or complex 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.

A. It is strongly recommended that consultation be obtained in the following instances:

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

   2. When the diagnosis is obscure after ordinary diagnostic procedures have been completed; or

   3. Where there is doubt as to the choice of therapeutic measures to be utilized; or

   4. In unusually complicated situations where specific skills of other practitioners may be needed; or

   5. Instances in which the patient exhibits severe psychiatric symptoms.

B. Except in an emergency, consultation is required in the following situations:

   1. In all curettage or other operations which may interrupt known or suspected pregnancy.

   2. When requested by the patient, or if the patient is not competent by his immediate family.

3. Upon admission of a female patient with known pregnancy equal or greater than 20 weeks gestation to a non-obstetrical hospital unit and/or a non-obstetrically privileged provider.

4. When a female patient with known pregnancy equal or greater than 20 weeks gestation is scheduled for an operative procedure by a non-obstetrically privileged practitioner.

C. The attending practitioner is responsible for requesting qualified consultation when indicated. Except in an emergency, he/she will provide written authorization to permit another practitioner to attend or examine his patient.

D. Any practitioner appointed to the Medical Staff of this Hospital and who has Clinical Privileges appropriate to the care of the patient, can be called for consultation. A practitioner who has been appropriately asked to see a patient in consultation has an obligation to respond personally in a timely manner or to assist in the identification of another consultant who can see the patient.

E. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. Consultants who do not come in to answer a formal consult, but make that consult by phone, are required when requested by the calling physician to dictate their consult into the CHI-FH dictation system.

F. When operative procedures are involved, the consultation note shall be recorded prior to the operation except in emergency situations so verified on the record. Appropriate authentication is required on all consultative reports.

SECTION 5. DENTAL CARE

A patient admitted to the Hospital by a dentist is a dual responsibility involving the admitting practitioner and a physician member of the Active Medical Staff. Oral surgeons who have been trained to perform history and physicals may exercise this privilege if so approved by the Board. If this privilege has not been granted, a history and physical or comprehensive consultation by a physician member of the Active Medical Staff must be performed within seven (7) days prior to the admission and in all cases, prior to any surgical or invasive diagnostic procedure. Additionally:

A. Dentist's responsibilities include the preparation of:

1. A detailed dental history justifying Hospital admission;

2. A detailed description of the examination of the oral cavity and preoperative diagnosis;

3. A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the Hospital pathologist for examination.

4. Progress notes as are pertinent to the oral condition; and

5. Clinical resume (or summary statement).

B. Physician's responsibilities:

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

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

3. Daily evaluation of the patient's general health status and provision of care, including documentation in the medical record.

C. The discharge of the patient shall be by an order of the dentist member of the Active Medical Staff with the approval of the responsible physician member of the Active Medical Staff.

SECTION 6. PODIATRIC CARE

Unless a podiatrist holds the privilege to independently admit (see paragraph C below), a patient admitted to the Hospital by a podiatrist is a dual responsibility involving the admitting practitioner and a physician member of the Active Medical Staff.

A. History and Physicals:

Podiatrists who have been trained to perform history and physicals may exercise this privilege if so approved by the Board. If this privilege has not been granted, a history and physical or comprehensive consultation is performed by a physician member of the Medical Staff according to Article III, Section 2 of the Medical Staff Rules and Regulations.

B. Podiatrist's Responsibilities: A podiatrist's responsibilities include the preparation of:

1. A detailed podiatric history justifying Hospital admission;

2. A detailed podiatric examination and pre-operative diagnosis;

3. A complete operative report, including operative findings and technique. All tissues removed shall be sent to the Hospital pathologist for examination;

4. Progress notes as are pertinent to the podiatric condition; and

5. Clinical resume (or summary statement).

C. Admitting Privileges:

1. Appropriately trained, board eligible/board certified podiatrists may apply for and be granted privileges to independently admit if so approved by the Board.

2. Podiatrists so approved may independently admit and manage uncomplicated, stable, American Society of Anesthesia Physical Status (ASA PS) Classification I & ASA PS Classification II patients for appropriate care specifically related to the patient's podiatric condition.

3. ASA PS Classification must be stated in the admission history and physical for both admission and observation patients.

4. Podiatrists are required to use the CHI-FH Podiatric Inpatient Admission Order Set.

5. Podiatrists must request a medicine consult for all patients who have an ASA PS Classification of III or greater.

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

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

   c. Daily evaluation of the patient's general health status and provision of care, including documentation in the medical record.

D. Patient Discharge:

The discharge of the patient shall be by an order of the podiatrist member of the Active Medical Staff with the approval of the responsible physician member of the Active Medical Staff for those patients requiring co-management.

SECTION 7. VIRTUAL HEALTH SERVICES

A. Virtual Health Services involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via a virtual link by appropriately credentialed practitioners. The Medical Staff shall determine which clinical services are appropriately delivered through this medium, according to commonly accepted quality standards. (See Medical Staff Bylaws, Article II, Section 6.D.)

B. If a practitioner prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at any CHI-FH facility via a virtual link, the practitioner shall be credentialed and privileged through the Medical Staff mechanisms set forth by the Medical Staff Bylaws and the Credentials Manual.

SECTION 8. RESTRAINTS AND SECLUSION

Restraint and seclusion involves significant patient-rights and patient-risk issues. Physicians and other practitioners authorized to order restraint or seclusion must have a working knowledge of hospital policy regarding the use of restraint and seclusion.

A. Restraint and seclusion orders must be time limited and comply with hospital and regulatory requirements as defined in CHI-FH Restraint and Seclusion Policy #964.00.

B. Orders to place patients into either restraints and/or seclusion are required within the time constraints established by CHI-FH Restraint and Seclusion Policy #964.00. The use of PRN orders is never acceptable.

SECTION 9. ORGAN DONATION

Per Federal and State regulations pertaining to organ donation, all Medical Staff members or appropriately privileged practitioners shall participate with management and administrative staff in the identification and referral of potential organ tissue donors to organ procurement agencies or tissue banks. All regulations regarding consent to donate and determination of brain death shall apply.

SECTION 10. CALL SCHEDULES

When deemed necessary by the Medical Staff Operating Committee at a campus, each clinical section and/or needed specialty/subspecialty group shall design a call for the provision of care to patients needing consultation or those unassigned patients needing their specialty at each Campus. For this section, "specialty group" means similarly privileged physicians, not a business group.

A. Each member of the Active Medical Staff who has designated that campus to be their Primary Campus shall serve on a designated Call roster on a fair and equitable basis at that campus with other members of the clinical section or specialty/subspecialty.

1. If needed, a formula for determining the ratio of call days covered by each physician will be calculated by dividing the number of call days covered by each physician per month by the number of days that physician was eligible for call that month. Similar call statistics for the ratio of weekend call days covered and holiday call days covered will be calculated for each physician in the specialty group for comparison.
2. The required maximal call ratio for each of the call statistics per physician will be determined by the Medical Staff Operating Committee taking into consideration the magnitude of the call ratio, the call burden, and the recommendation of the clinical section and/or specialty group.
3. The specialty group will provide a call schedule at least one (1) month in advance.
4. Members of the Medical Staff Operating Committee must recuse themselves from voting on call schedules in which they participate.
5. If approved by the Medical Staff Operating Committee, a business, specialty or subspecialty group may have an agreement with physicians in their call group to take more or less call than required.

B. When assigned to a Call roster, each designated practitioner shall have the responsibility to either take the rotation or be responsible for arranging a substitute. He/she shall notify the Medical Staff Office of the name of the substitute for the assigned Call period. Any practitioner designated as a substitute must have appropriate Clinical Privileges and attend patients at the Campus for which the Call roster exists.

C. Failure to either take the Call period or to arrange substitution for an assigned duty shall result in:

1. First failure within a two (2) year recredentialing period: Written notification of failure and immediate voluntary suspension of Medical Staff privileges for seven (7) days.

2. Second failure within a two (2) year recredentialing period: Written notification of failure and immediate voluntary suspension of Medical Staff privileges for thirty-four (34) days with reporting to appropriate agencies as required by law.

3. Third failure within a two (2) year recredentialing period: The practitioner shall be deemed to have voluntarily relinquished Hospital Medical Staff membership with reporting to appropriate agencies as required by law. Reapplication to the Medical Staff must comply with Article III of the Credentialing Manual.

4. Practitioners may be excused from the Call roster upon recommendation of their clinical section to the hospital Medical Staff Operating Committee and then to the Medical Executive Committee.

SECTION 11. DISASTER MANAGEMENT

In the event of a disaster, Emergency Management Disaster Plans and Procedures are implemented (Refer to #504.00, 504.20, 504.60 and 504.70).

The Chief Medical Officer or designee has authority for Medical Staff activities when the plan is implemented. If the emergency situation requires, this authority includes changing or overruling the orders of primary physicians, discharging patients to other facilities (or other locations) and whatever else may be medically required in his/her professional opinion.

SECTION 12. DISRUPTIVE PRACTITIONERS

It is the responsibility of all Medical Staff members to engender appropriate, professional relationships among colleagues, hospital staff, patients and families. (Reference Article I, Section 4, Medical Staff Bylaws). When any practitioner's conduct is so disruptive to operations of the hospital, that the value of the physician's clinical work is outweighed by the negative impact of his or her behavior, appropriate disciplinary action may be taken. Disruptive behavior is considered to be attacks leveled at Medical Staff which are personal and irrelevant, impertinent or inappropriate comments in medical records impugning quality of care in the hospital or attacking individual physician, nurses or policy, non-constructive criticism addressed in a manner to intimidate or undermine confidence, or behavior which, in general, compromises the effectiveness of fellow practitioners, nursing staff and other hospital personnel. See Standards of Conduct Policy #310.00 for additional information and definitions.

A. Incident Report:

An incident report shall be submitted to the appropriate supervisor and then to the Medical Staff Office to the attention of the Chief Medical Officer or Associate Chief Medical Officers. The Chief Medical Officer or Associate Chief Medical Officers shall attempt to resolve the issue with the practitioner. A copy of the complaint and the attempted resolution shall be placed in the practitioner's quality file. If the matter remains unresolved, the Chief Medical Officer or Associate Chief Medical Officers shall submit a report to the Section Chief and President of the Medical Staff. The President of the Medical Staff, the Clinical Section Chief, the Chief Medical Officer or Associate Chief Medical Officers shall evaluate the behavior and response of the practitioner and if necessary, recommend further action to the Medical Executive Committee.

B. Investigation:

The practitioner shall be provided with a summary of the complaints and given the opportunity to respond. An additional investigation may be required and the practitioner will be informed of the results of the investigation by written note. If, after investigation and discussion, a resolution is acceptable to all parties, the matter will be considered resolved. The results of the investigation will be placed in the practitioner's quality file and considered at reappointment. If a resolution is not acceptable or if the President of the Medical Staff, the Clinical Section Chief, Chief Medical Officer and/or Associate Chief Medical Officers concur that further attention is required, formal Medical Executive Committee review will occur.

C. Medical Executive Committee Review:

The review of the matter by the Medical Executive Committee shall be conducted in executive session, with the President and the Vice Presidents, a Risk Manager, Chief Medical Officer or Associate Chief Medical Officers and the applicable Chief of Clinical Section, the Chief Executive Officer or his designee and a recording secretary present. During this session, the following will be reviewed and evaluated:

1. Facts and documentation accumulated to date.

2. Testimony from the complainant.

3. Testimony from the practitioner in question.

4. During testimony, the practitioner in question may have a member of the Medical Staff accompany him/her, and the complainant may have a peer or a representative from Administration accompany him/her. Legal counsel shall not be present for this review, for either the complainant or the practitioner.

5. The practitioner in question will be informed of the results of the investigation in writing, and a written note to inform the complainant will be sent within thirty (30) days.

6. If the Medical Executive Committee investigation results in a request for corrective action, the practitioner in question shall be notified of his/her rights to fair hearing and due process described in Articles 6 – 8 of the Medical Staff Bylaws. The procedures described in the Bylaws will be followed.

D. Action:

If the Medical Executive Committee determines the concern for disruptive behavior to be valid, the following procedures will be implemented:

1. A single incident determined after investigation to have been disruptive occurring during a two-year privileging period will be considered at the time of the practitioner's request for reappointment.

2. Two incidents determined after investigation to have been disruptive occurring during a two year privileging period will result in a request that the practitioner undertake counseling, the nature and expected outcome to be defined by the Medical Executive Committee. If the practitioner declines to participate in such counseling, a final request for corrective action may be made.

3. Three incidents determined after investigation to have been disruptive occurring during a two-year privileging period will be cause for a formal request for corrective action as specified by the Medical Staff Bylaws.

4. The above progressive discipline process notwithstanding, any single episode of disruptive behavior may be deemed significant enough by the Medical Staff or hospital administration to initiate the corrective action process.

5. All reports of behavior determined after investigation to have been disruptive, or any counseling actions/outcomes, regardless of their resolution and age, will be maintained in the practitioner's confidential quality file.

SECTION 13. UNPROFESSIONAL CONDUCT (See Policy 468.00)

The Chief Executive Officer or designee shall report to the Department of Health when the practice of a health care practitioner is restricted, suspended, limited or terminated based upon a final conviction, determinations, or finding by the hospital that the health care practitioner has committed an action defined as unprofessional under RCW 18.130.180 and specified under the hospital's Unprofessional Conduct Reporting Requirements Policy 468.00.

ARTICLE III. MEDICAL RECORDS

SECTION 1. GENERAL INFORMATION

A. The attending practitioner shall be responsible for the preparation of a complete, current and comprehensible medical record for each patient.

B. The record shall include documentation as required by the Medical Staff Rules and Regulations, licensing and accreditation bodies including the Washington State Department of Health, The Joint Commission (TJC) and Centers for Medicare and Medicaid (CMS).

C. The following shall be entered appropriately on medical records and authenticated by the responsible individuals:

1. Identification data;
2. Reason for admission
3. A history and physical examination (see Section 2B);
4. All orders including diagnostic and therapeutic;
5. Evidence of appropriate informed consent;
6. Clinical observations including the results of therapy;
7. Progress notes made by the Medical Staff and other authorized staff;
8. Consultation reports;
9. A provisional diagnosis and indication for interventions prior to an invasive diagnostic or therapeutic procedure, including surgery;
10. Reports of operative and invasive procedures, tests and their results;

11. Reports of any diagnostic and therapeutic procedures, including pathology and clinical lab examinations, radiology examinations, and nuclear medicine examinations or treatments;
12. Appropriate Data Form for Cancer Staging;
13. Records of donation and receiving transplants, when performed;
14. Final diagnosis and conclusions at the termination of hospitalization;
15. Autopsy results, when performed;
16. Clinical resumes and discharge summaries; and
17. Instructions to patient/family at the time of discharge.

D. Only members of the Hospital Medical Staff, properly privileged practitioners, authorized Hospital staff or scribes may place entries into the medical record.

E. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Authentication of entries into the medical record shall be performed by a process approved by the Medical Executive Committee and the Board.

Process: The provider who makes an entry into a medical record shall authenticate that entry by an original dated signature (may be electronic) placed in the medical record.

F. Entries must be recorded on a computer terminal designed for such information and must be authenticated.

G. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved and prohibited abbreviations shall be kept on file in the Health Information Management.

H. Text messages containing electronic protected health information should not be sent from or sent to an unencrypted device.

Where possible, CHI messaging should be initiated at the Electronic Health Record (EHR) system-of-record to maintain an audit trail, subject to discovery, including responses. The primary business purpose for using device to device messaging should be to alert/notify the recipient (usually providers) for a call back. The intended use is not to provide triage of a patient or for continuing conversations and discussions analogous to an email thread.

See CHI Privacy Standard No. 1, Secure Messaging of Electronic Protected Health Information (ePHI)

SECTION 2. HISTORY AND PHYSICAL EXAMINATION

A. All history and physical examinations, including office notes and copies from transferring facilities, must be recorded by a member of the Active Medical Staff and/or Allied Health Staff with privileges to perform history and physicals, and must be authenticated by the responsible practitioner and be in compliance with State regulations. The process or authentication shall be approved by the Medical Executive Committee and the Board. Refer to History and Physical Policy #20.00.

B. Content of History and Physicals: For all inpatients and observation patients, the history and physical documentation must include the following elements:

1. Medical history including chief complaint, details of present illness, relevant past, social and family histories appropriate to the age of the patient, and an inventory by body systems;

2. Known allergies (providers may refer to the Medication Reconciliation Record);

3. Current medications (providers may refer to the Medication Reconciliation Record);

4. Report of relevant physical examination;

5. A statement of the conclusions or impressions drawn from the admitting history and physical information;

6. A statement of the course of action planned, including, if applicable, the results of discussions related to the withholding of life support and/or resuscitative measures for the patient while in the Hospital.

C. The history and physical examination shall be recorded on all admissions, including short stay admissions, within twenty-four (24) hours of admission.

D. History and physical examinations completed and documented within thirty (30) days prior to the patient's admission to the Hospital may be used provided an updated examination of the patient, including any changes in the patient's condition is completed and documented within 24 hours after admission by a member of the Active Medical Staff or a practitioner so privileged and qualified by state law and hospital policy.

E. When a patient is readmitted within thirty (30) days for the same or a related problem, an interval note reflecting subsequent changes may be used in place of a history and physical. A copy of the original history and physical will be placed on the patient's readmission record if not available in the electronic medical record. The interval note can be either a dictated note or an entry in the Progress Notes.

F. Histories and physicals from transferring hospitals are acceptable if recorded by a member of the Hospital Active Medical Staff or a properly credentialed practitioner of that hospital and if there is a transfer note by the attending practitioner which indicates why the patient was transferred and a physical examination note which reflects the patient's current condition. If the attending practitioner recorded a history and physical or a consultation at the transferring facility with twenty-four (24) hours of transfer which can be made a part of the Hospital medical record, which reflects why the patient is being transferred, and which reflects the patient's current physical condition, a transfer note is not required.

G. A history and physical examination must be recorded in the medical record on all patients scheduled to undergo surgery or a procedure requiring anesthesia. Anesthesia is defined as general, regional, neuraxial or MAC (Monitored Anesthesia Care). The history and physical examination must be entered into the electronic medical record at the time the patient undergoes the procedure. An exam documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission but prior to the surgery or procedure requiring anesthesia services.

H. History and Physicals for patients with end stage renal disease (ESRD) undergoing dialysis must comply with current CMS Conditions of Participation for ESRD facilities.

I. When the history and physical examination is not recorded on the chart before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner:

1. States in writing that a history and physical has been dictated and gives findings pertinent to the immediate care of the patient; or,

2. States that emergency intervention is indicated and any delay would be detrimental to the patient.

J. Reference to an Emergency Department report in lieu of a history and physical is not acceptable.

K. A consultant's report recorded at the time of admission may be accepted in lieu of the history and physical examination only if it contains the necessary elements of: reason for admission, appropriate general history/physical examination, and diagnosis.

L. Unless otherwise defined, the medical staff defines in writing the requirements for initial assessment and reassessment of relevant hospital sponsored outpatient/ambulatory services. (See History and Physical Policy #20.00)

M. The history and physical portion of the New Born Exam Record does not need to be completed for a non-viable fetus.

SECTION 3. ORDERS FOR TREATMENT (See Physician Order Policy #954.25)

A. All orders for treatment shall be entered into the Computerized Provider Order Entry system as per Policy #954.25. Verbal and telephone orders from credentialed and privileged members of the Medical Staff may be accepted by a registered nurse, physician assistant, licensed practical nurse, pharmacist, respiratory therapist, physical therapist, occupational therapist, speech therapist, dietician, utilization management specialist, radiation technologist, sonographers or social work staff. The authorization of this regulation, which allows respiratory therapists, pharmacists, physical therapists, occupational therapists, speech therapists, dieticians, utilization management specialists, radiation technologists, sonographers or social work staff to accept verbal and telephone orders, shall only apply to those orders directly related to their areas of expertise. Verbal and telephone orders must identify the provider giving the order and be signed, dated and timed by the individual authorized to accept such orders.

1. In order to ensure the safe transcription of verbal and telephone orders, the ordering provider should request and expect the individual accepting the order to read the order back verbatim as transcribed. Verbal orders-(face-to-face) are to be used infrequently, and should only be used to meet the urgent needs of the patient when it is not feasible for the ordering provider to immediately communicate the order either in writing or electronically.

2. Verbal orders or telephone orders shall be authenticated by an appropriately privileged provider as soon as reasonably possible but in no case longer than forty eight (48) hours after they are received. On-call or covering providers rounding on the units shall date, time and

authenticate telephone/verbal order of providers for whom they are on-call or sharing coverage.

3. However, neither telephone nor verbal orders will ever be accepted for chemotherapeutic agents, investigational new drugs (IND's) or other high risk medications that may be added to this list in the future by the Medical Staff.

B. For those exceptional circumstances where a written order may be justified, the practitioner's order must be written legibly and completely with sufficient content to clearly convey the practitioner's intent. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse or hospital staff responsible for implementation.

C. Electronic Provider Order Sets shall be created and approved by the appropriate Health System Interdisciplinary Team or Leadership Team. Practitioners are expected to utilize standard order sets whenever applicable.

D. All pre-op orders, not intended to continue intraoperatively, are suspended upon entry to the surgical suite. All post-op orders for care and treatment must be reviewed and electronically continued, discontinued or modified after surgery. Code Status Orders (#515) prior to a surgical procedure will be reviewed to ascertain that the patient or guardian reasonably understood the risk inherent in surgery and anesthesia, any underlying instability and identify the patient's desires regarding management of life threatening complications. The practitioner counseling the patient has the responsibility to obtain Informed Consent. The wishes of the patient will be respected. If the patient's wishes make the practitioner unwilling to proceed with the procedure under the Code Status Orders request, he/she will assist the patient in finding another appropriately privileged practitioner acceptable to the patient so as not to delay needed care. If the patient is, for any reason, unable to participate in the Informed Consent, the appropriate next of kin or guardian will be asked to assist and act. Emergency situations will be documented and the practitioner may proceed using his/her best clinical judgment.

SECTION 4. OBSTETRICAL RECORDS

Obstetrical records shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital before admission. If a complete prenatal record is not on file or available upon admission, the attending practitioner shall complete a standard prenatal history and physical form or dictate a complete history and physical. Upon admission, an interval admission note must be entered by the attending practitioner that includes pertinent additions to the history and any subsequent changes in the physical findings. A completed prenatal history and physical and interval admission note shall constitute an admission history and physical.

For any procedure other than normal/routine delivery with appropriate anesthesia, the indications for that procedure shall be identified in the medical record.

Documentation of appropriate informed consent shall also be noted in the medical record.

SECTION 5. PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care. Whenever possible, each of the patient's clinical problems, as well as results of tests and treatment, should be clearly identified in the patient record and correlated with specific orders. The attending

practitioner shall ensure that progress notes are entered at least daily on all inpatients; however, patients may be discharged from the hospital within 24 hours of the attending practitioner last rounding as long as an appropriate discharge order is entered into the record.

SECTION 6. OPERATIVE REPORTS

Full operative reports (dictated or electronically recorded) should be entered into the chart as soon as possible after surgery or high risk interventional procedure or high risk invasive diagnostic procedure, but prior to the patient leaving recovery and moving to the next phase of care. The operative report includes the name of the primary surgeon/proceduralist(s) who performed the procedure and his or her assistants, pre-operative diagnosis, name of the procedure, description of the procedure, findings of the procedure, any estimated blood loss (only if applicable), any specimens removed (only if allocable) and postoperative diagnosis.

When the full operative report is not placed in the electronic medical record immediately (when it is dictated, but not transcribed), a progress note is entered immediately before the patient is transferred to the next phase of care. The note must include at a minimum: the name of the primary surgeon(s) and assistant(s), procedure performed and descriptions of each procedure finding, estimated blood loss, specimens removed and postoperative diagnosis.

SECTION 7. DISCHARGE DIAGNOSIS AND CLINICAL SUMMARY

A. A discharge diagnosis shall be recorded in the patient record no more than 24 hours prior to discharge for all patients.

B. A discharge summary shall be dictated on all medical records of patients hospitalized over forty-eight (48) hours except for normal obstetrical deliveries and normal newborn infants. Medical records of women who undergo cesarean section deliveries must have a dictated discharge summary.

C. An adequate discharge summary must contain the following elements:

1. Final diagnosis or diagnoses including secondary diagnoses and complications;
2. Reason for hospitalization;
3. Significant findings and events during hospitalization;
4. Procedures performed and treatment rendered;
5. Condition of the patient on discharge; and
6. Specific instructions, including the plan for continued care, given to the patient and/or family.

SECTION 8. RELEASE OF INFORMATION AND ACCESS TO MEDICAL RECORDS

A. Written consent of the patient is required for release of medical information to persons not authorized to receive this information.

C. Original records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. This includes electrocardiograms and X-ray films. All original records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer.

C. Unauthorized removal of records from the Hospital by Medical Staff or other practitioners is grounds for suspension of privileges until such records are returned to the Hospital (see Article VI, Section 3, E of the Medical Staff Bylaws).

D. In case of readmission of a patient, all previous records maintained in the Hospital shall be available for the use of the attending practitioner. This shall apply whether the patient is to be attended by the same practitioner or by another.

SECTION 9. COMPLETION AND FILING OF MEDICAL RECORDS

A. The patient's medical record shall be complete at time of discharge, including progress notes, Operative Reports as applicable, discharge diagnosis and dictated discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's record will be available for completion through the electronic health record system.

B. A medical record which has not been completed thirty (30) days after discharge is considered delinquent. However, those records missing History and Physician and/or Operative Reports (on surgical charts) will be considered delinquent three (3) business days after discharge. Practitioners who are responsible for completion of the delinquent medical record will have practice privileges suspended such that they may not admit new patients or schedule new procedures until records are completed in accordance with the Medical Staff Bylaws, Article VI, Section 4, 3A. However, in order to provide for continuity of care, providers will maintain call responsibilities and continue to treat patients already in the hospital.

C. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered to be filed by the Medical Executive Committee.

SECTION 10. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) / PATIENT TRANSFERS

A. All privileged medical staff must have a working knowledge of the CHI-FH Policy # 345.00 *EMTALA-How to Comply with the Law*.

B. Any individual who presents to a CHI-FH dedicated Emergency Department will receive a Medical Screening Examination to rule out an Emergency Medical Condition (EMC) according to Federal and State (EMTALA) regulations and CHI-FH policy.

C. The Medical Staff have determined the following to be qualified to perform a medical screening exam: Physicians, Physician Assistants (PA-C), Advanced Registered Nurse Practitioners (ARNP), Neonatal Nurse Practitioners, Certified Nurse Midwives and OB Registered Nurses with documented screening and competency.

D. The hospital must provide stabilizing treatment within the capabilities of the staff and services available according to Federal and State (EMTALA) regulations and CHI-FH policy.

E. All hospitals with specialized capabilities, including physician specialties, have a responsibility to accept a transfer when such transfer is necessary to stabilize an EMC. On-Call physician who, as part of their routine responsibilities, are charged with the duty to accept patients transferred from other facilities may not refuse any unstable transfer as long as their hospital has the capability and capacity to provide treatment.

F. Transfers between facilities, either within or outside the Health System, will be managed according to Federal and State regulations.

G. Transfer of newborn infants. In the case of an emergency, if a physician is not available to evaluate an infant prior to transfer to another facility providing a higher level of care, a Neonatal Nurse Practitioner (AARP/NNP) who is a member of the Allied Health Staff may, in consultation with a physician on the Health System Medical Staff, provide the necessary stabilization and evaluation prior to transfer.

Transfer documents must be signed with twenty-four (24) hours by the consulting physician.

ARTICLE IV. AMENDMENTS

An amendment to these Rules and Regulations may be made under provisions of Article XII, Section 2, of the Medical Staff Bylaws.

ARTICLE V. ADOPTION

After adoption by the Active Medical Staff as an amendment to the Medical Staff Bylaws last revised in 1996, these Rules and Regulations, together with the appended Bylaws, Credentialing Manual, and Organization Manual, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Board.

ADOPTED by the Active Medical Staff on February 8, 2024

APPROVED by the Board of Directors on February 27, 2024