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FRANCISCAN HEALTH - RENSSELAER
MEDICAL STAFF RULES AND REGULATIONS – 4/6/17

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MEDICAL STAFF RULES AND REGULATION

ARTICLE I

INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges. Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws. This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

The specific responsibilities of each individual Practitioner are to render specific professional services at the level of quality and efficiency equal to, or greater than, that generally recognized and accepted among Practitioners of the same profession, in a manner consistent with licensure, education and expertise, and in an economically efficient manner, taking into account patient needs, available Franciscan Health – Rensselaer facilities and resources, the Ethical and Religious Directives for Catholic Health Care Services, adherence to the Code of Ethics as prescribed by his/her profession, and Case Management/utilization standards in effect in Franciscan Health – Rensselaer.

ARTICLE II

ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

The hospital accepts short term patients for care and treatment provided suitable facilities are available.

a. **Admitting Privileges**: A patient may be admitted to the hospital only by an appointee to the Medical Staff with admitting privileges.

b. **Admitting Diagnosis**: Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been written in the medical record. In the case of emergency, such statement will be recorded as soon as possible.

c. **Admission Procedure**: Admissions must be scheduled with the Hospital's Admission/Registration Department. A bed will be assigned based upon the medical condition of the patient and the availability of hospital staff and services. Except in an emergency, the admitting practitioner or his designee shall contact Admission/Registration personnel to ascertain whether there is an available bed.

2.1.2 Admission Priority

Nursing unit staff will admit patients on the basis of the following order of priorities:

a. **Emergency Admission**: Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. This patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient will be admitted immediately to the first appropriate bed available.

b. **Urgent Admissions**: Urgent admission patients meet the criteria for inpatient admission; however their condition is not life-threatening. Urgent admission patients will be admitted as soon as an appropriate bed is available. Urgent admissions include admissions for observation as determined by Center for Medicare/Medicaid Services (CMS) criteria.

c. **Elective Admissions**: Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for his/her health's sake. These patients may be admitted on a first-come, first-serve basis. A waiting list will be kept and each patient will be admitted as soon as a bed becomes available.

2.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area.

2.2 UNASSIGNED EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services

routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

2.2.1 Definition of Unassigned Patient

Patients will be considered "unassigned" if the patient does not have a primary care practitioner or that practitioner is unavailable.

Patients who meet the definition of "unassigned" who present to the Emergency Department and require admission and/or treatment shall have a practitioner assigned by the Emergency Department physician.

2.2.2 Unassigned Call Service

a. **Unassigned Call Schedule**: The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Each Medical Staff Department Chair, or his/her designee, shall provide the Emergency Department and the Medical Staff Services Office with a list of physicians who are scheduled to take emergency call on a rotating basis.

b. **Response Time**: It is the responsibility of the on-call physician to respond in an appropriate time frame. The on-call physician should respond to calls from the Emergency Department within thirty (30) minutes, and must be able to arrive at the Hospital within two (2) hours or other later timeframe as specified by the Emergency Department physician. If the on-call physician does not respond to being called or paged, the Chain of Command policy will be instituted. Failure to respond in a timely manner may result in the initiation of disciplinary action.

c. **Substitute Coverage**: It is the on-call physician's responsibility to arrange for coverage and notify the Emergency Department if he/she is unavailable to take call when assigned. Failure to notify the nursing units and the ED of alternate call coverage may result in the initiation of disciplinary action.

2.2.3 Patients Not Requiring Admission

In cases where the Emergency Department consults with the unassigned call physician and no admission is deemed necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. It is the unassigned call physician's responsibility to provide one timely and appropriate follow-up evaluation for the patient following the Emergency Department visit.

2.2.4 Unassigned Patients Returning to the Hospital

Unassigned patients who present to the Emergency Department will be referred to the practitioner taking unassigned call that day unless a patient-physician relationship has been developed and the patient is no longer considered "unassigned" no matter the patient's ability to pay.

2.2.5 Guidelines for Departmental Policies on Unassigned Call

Pursuant to the Medical Staff Bylaws, clinical departments may adopt rules, regulations, and policies that are binding on the members of their department. The following rules should be used in developing departmental policies regarding unassigned emergency call obligations:

a. Unassigned call duties should be based on the appointee’s clinical core privileges; physicians with admitting privileges are expected to serve on the unassigned call roster regardless of their staff category.
b. Unassigned call duties shall be assigned based on performance metrics by the Department Chair in conjunction with the VPMA and approved by the MEC.
c. Unassigned call duties may be divided by department, specialty, or subspecialty.
d. A physician may request an exemption to being on the “unassigned” call roster when they reach the age of sixty (60) and have served at least ten (10) years on the call roster. Physicians should notify their department chairs one year in advance of their intentions for the exemption. The exemption request will be granted only if it does not compromise the department’s ability to fulfill the Hospital’s EMTALA obligations.
e. An impairment which is alleged to limit an appointee’s ability to provide unassigned call services shall also be grounds for limiting the appointee’s privileges for providing care to their assigned or private patients.
f. Departmental rules and regulations concerning unassigned call must be approved by the Medical Executive Committee and the Board.

2.2.6 Use of the Unassigned Call Roster

The unassigned call roster may be used as default consultation coverage when a practitioner cannot obtain consultation on his/her patient on a voluntary basis.

2.2.7 Failure to Meet Unassigned Call Obligations

All failures to meet unassigned call responsibilities shall be reported to the Department Chair and the MEC. Recurrent failure to meet call obligations may result in corrective action per the Medical Staff Bylaws.

2.3 <u>TRANSFERS</u>

2.3.1 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. All practitioners actively providing care to the patient will be notified of all transfers per the methods noted in hospital policy.

2.3.2 Transfers To Another Hospital

Patients who are transferred to another hospital must follow the Hospital policy on transfers to ensure EMTALA compliance.

2.3.3 Transfers From Another Hospital

All transfers from another hospital will be dependent on the availability of an appropriate bed and acceptance of the patient by a physician on the Medical Staff. The physician must notify the Nursing unit staff of the transfer.

2.4 <u>PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS</u>

The admitting practitioner is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Acute care admissions of suicidal patients will not be accepted except for those patients requiring medical stabilization. Once the patient’s medical condition is stabilized, the patient will be evaluated and transferred to an appropriate outpatient or inpatient psychiatric facility.

The admitting practitioner is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Acute care admission of psychiatric patients will be accepted dependent on bed capacity. Those patients requiring medical stabilization will be stabilized until an inpatient psychiatric bed becomes available externally or the patient is discharged if no longer requiring inpatient hospitalization.

2.5 PROMPT ASSESSMENT

New admissions must have a history and physical examination performed by the admitting physician or his/her designated covering privileged practitioner within 24 hours after admission. Unstable patients must be seen as soon as possible in a time period dictated by the acuity of their illness.

2.6 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician or his or her privileged designee who shall provide, or assist Hospital personnel in providing documented discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. No contingency discharge orders (i.e., OK to discharge if OK with Dr. X) are acceptable. These instructions should include, if appropriate:

a. Medication reconciliation at discharge;
b. Dietary instructions and modifications;
c. Medical equipment and supplies;
d. Instructions for pain management;
e. Any restrictions or modification of activity;
f. Follow up appointments and continuing care instructions;
g. Referrals to rehabilitation, physical therapy, and home health services; and
h. Recommended lifestyle changes, such as smoking cessation.

2.7 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the hospital against the advice of the attending physician, or without a discharge order, hospital policy shall be followed. The attending physician shall be notified that the patient has left against medical advice.

2.8 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities.

ARTICLE III

MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access to and make entries into the medical record. The attending physician is responsible for the preparation of the physician components to ensure a complete and readable medical record for each patient.

In order to practice medicine, all healthcare providers who exercise privileges in the facility are required to utilize OneChart (EPIC) in order to meet regulatory requirements and provide efficiencies in delivering healthcare to the community. The hospital will permit security access to the OneChart system only to members of the Medical Staff who have successfully completed the OneChart education and training program, or equivalent competency, assigned for their particular specialty and role. Each practitioner must have demonstrated an acceptable competency based upon the results of an OneChart exam.

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means.

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual will contact the practitioner, request an order for clarification, read back the order, and document the clarification in the medical record. This verbal order must be signed by the ordering practitioner as described in Subsection 4.4.2.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations and symbols in the medical record must be consistent with the hospital medical records policy.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

Time limits for performance of the history and physical examination are noted in the medical staff bylaws.

3.5.2 Who May Perform and Document the Admission History and Physical Examination

Who may perform the history and physical examination are noted in the medical staff bylaws. A history and physical examination performed by a non-physician must be cosigned by the admitting or attending physician.

3.5.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

A complete history and physical examination is required for all admissions, all surgeries requiring anesthesia (general, regional, MAC, or deep sedation), and all observation patients. A complete history and physical examination report must include the following information:

a. Chief complaint or reason for the admission or procedure;
b. A description of the present illness;
c. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;
d. An age-appropriate social history;
e. A pertinent family history;
f. A review of systems;
g. Relevant physical findings;
h. <u>Osteopathic Musculoskeletal Examination</u>: (Doctors of Osteopathic Medicine only) An osteopathic musculoskeletal examination is required as an integral part of the H&P performed by osteopathic physicians for their admitted patients unless contraindicated. The reason for omitting the musculoskeletal examination shall be documented in those cases where examination is contraindicated.
i. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

A focused history and physical examination report, used for outpatient procedures that require moderate sedation, should include the following information:

a. Chief complaint or reason for the admission or procedure;
b. A description of the present illness;
c. Past medical history, including current medications, allergies, and current diagnoses;
d. A review of systems relative to the procedure planned;
e. Relevant physical findings, including an evaluation of the cardiac and respiratory systems;
f. <u>Osteopathic Musculoskeletal Examination</u>: (Doctors of Osteopathic Medicine only) An osteopathic musculoskeletal examination is required as an integral part of the H&P performed by osteopathic physicians for their admitted patients unless contraindicated. The reason for omitting the musculoskeletal examination shall be documented in those cases where examination is contraindicated.
g. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

3.5.4 Admitting Physician is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the admitting physician or his/her designee. If the admitting physician does not perform the history and physical examination, then it is the responsibility of the admitting physician to do appropriate hand-off communication to the attending physician regarding the H&P. Any failures in performance of the H&P will be identified by Case Management and escalated to the department chair, President of the Medical Staff, and the Administrator-on-Call if need arises. If the admitting and attending physicians refuse to perform the H&P, the department chair (or President of the Medical Staff or VPMA) can assign the patient to another physician.

3.6 PREOPERATIVE DOCUMENTATION

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

a. all invasive procedures requiring anesthesia services or moderate sedation performed in the Hospital;

b. certain procedures performed in the Radiology Department and Cath Lab (angiography, angioplasty, myelograms, abdominal and intrathoracic biopsy or aspiration, pacemaker and defibrillator implantation, electrophysiologic studies, and ablations); and

c. certain procedures performed in other treatment areas (bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, central arterial line insertions, and elective electrical cardioversion).

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be cancelled if an H&P is not completed.

3.7 PROGRESS NOTES

The attending physician, or his/her supervised Advanced Practice Professional, will record a progress note each day, and at the time of each patient encounter on all hospitalized patients, excluding a skilled nursing patients. Progress notes must document the reason for continued hospitalization. A physician must see the patient, and document the visit, on the first day following admission, the day of discharge and at least every second day during the hospitalization. Progress notes documented by non-physicians do not need co-signature by the physician. If the documentation of the progress note is not contemporaneous to the visit, then the hospital policy on late entry of documentation should be followed.

3.8 OPERATIVE / PROCEDURE REPORTS

Operative reports will be documented immediately after the surgery/procedure is finished, and in no case later than twenty-four (24) hours after the procedure. The report is to be promptly signed by the surgeon and made a part of the patient's current medical record. Operative/procedure reports will include:

a. the name of the licensed independent practitioner(s) who performed the procedure and any assistants,

b. the name of the procedure performed,

c. a description of the procedure performed,

d. findings of the procedure,

e. any estimated blood loss,

f. any specimen(s) removed, and

g. the post-operative/procedure diagnosis.

3.9 BRIEF OPERATIVE / PROCEDURE NOTES

If the operative/procedure report is not immediately available in the record, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. Operative/procedure notes will include:

a. the name of the licensed independent practitioner(s) who performed the procedure and any assistants,

b. the name of the procedure performed,

c. findings of the procedure,

d. any estimated blood loss,

e. any specimen(s) removed, and

f. the post-operative/procedure diagnosis.

3.10 POST-ANESTHESIA NOTES

A post-anesthesia evaluation shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving anesthesia or deep sedation. The note shall be entered by an anesthesia provider or by the physician who administered the deep sedation. This note should contain the following information:

a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
b. Cardiovascular function, including pulse rate and blood pressure;
c. Mental status;
d. Temperature;
e. Pain;
f. Nausea and vomiting; and
g. Postoperative hydration.

3.11 CONSULTATION REPORTS

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The Consultation Report should be completed and entered in the patient's chart within the time frame specified by the physician ordering the consult and no later than 24 hours after the consult is ordered. If a full consult note is not immediately available after the consultation, a note should be documented in the record containing the consultant's assessment and plan for the care of the patient. If a consultation is performed by a non-physician, the consulting physician must cosign the consultation.

If the report is not in the record within the prescribed time, an explanatory note should be recorded in the record. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

3.12 OBSTETRICAL HISTORY AND PHYSICAL EXAMINATION

The obstetrical record must include a medical history, including a complete prenatal record, and an appropriate physical examination. A copy of the practitioner's office prenatal record may serve as the history and physical for uncomplicated vaginal deliveries if it is legible and complete and the last office visit was within the thirty (30) days prior to admission. If the office prenatal record is used as the history and physical examination, an update must be performed as described in the bylaws will be documented.

3.13 FINAL DIAGNOSES

The final diagnoses will be recorded in full, without the use of symbols or abbreviations dated and signed by the discharging physician in the discharge summary, transfer note, or death summary of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the practitioner will be required to document such in the patient's record.

3.14 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries are the responsibility of the discharging physician or his/her privileged designee.

a. **Content**: A discharge summary will be completed per the Medical Records policy. The discharge summary is the responsibility of the discharging physician and will contain:
    1. Reason for hospitalization;
    2. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
    3. Condition of the patient at discharge;
    4. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
    5. Final diagnoses.

b. **Short-term Stays**: A discharge summary is not required for uncomplicated inpatient and observation hospital stays of less than 48 hours, provided the discharging physician enters a final progress note or completes a Discharge Form documenting:
    1. The condition of the patient at discharge; and
    2. Instructions given to the patient and family, including medications, referrals, and follow-up appointments.

c. **Deaths**: A discharge summary is required on all inpatients who have expired and will include:
    1. Reason for admission;
    2. Summary of hospital course; and
    3. Final diagnoses.

d. **Timing**: A Discharge Summary must be completed per Medical Records policy. A physician must sign the discharge summary if performed by a non-physician.

3.15 DIAGNOSTIC REPORTS

Diagnostic reports (including but not limited to EEGs, EKGs, echocardiograms, stress tests, Doppler studies) must be read by the physician scheduled to provide the interpretation service in a timely fashion. Failure to provide prompt interpretation of diagnostic tests may result in removal from the reading list.

3.16 ADVANCED PRACTICE PROFESSIONALS

The admitting or supervising/collaborating physician will review the History and Physical Examination and any consultations performed by the Advanced Practice Professional within one (1) calendar day. The attending or supervising/collaborating physician will cosign any Discharge Summaries performed by an Advanced Practice Professional in timeframes specified in the Medical Records policy.

3.17 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, the record will be made available to any member of the Medical Staff attending the patient and to members of medical staffs of other hospitals upon written consent of the patient or by the appropriate Hospital authority in an emergency situation. Medical records will otherwise be disclosed only pursuant to court order, subpoena, or statute. Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute. No person viewing the medical record is permitted to print any of the medical record.

a. **Access to Old Records**: In case of readmission of a patient, all previous records will be made available to the admitting practitioner whether the patient was attended by the same practitioner or by another practitioner.

b. **Unauthorized Removal of Records**: Unauthorized removal of paper records from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the Medical Executive Committee.

c. **Access for Medical Research**: Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of the Institutional Review Board. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.

d. **Access for Former Members**: Former members of the Medical Staff will be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

3.18 MEDICAL RECORD COMPLETION

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

3.18.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the following standards:

a. An Admission History and Physical Examination or Updated History and Physical Examination must be entered in the medical record by the admitting physician or his/her designee within 24 hour after admission;

b. A Preoperative History and Physical Examination or Focused Preoperative History and Physical Examination must be entered in the medical record prior to the surgery or procedure;

c. An Admission Prenatal Record must be entered in the medical record by the attending physician or designated covering physician within 24 hours after an obstetrical admission

d. An Operative Report must be entered in the medical record by the performing practitioner immediately following the surgery or procedure ;

e. An Inpatient Progress Note must be recorded and authenticated by the attending physician or their supervised Advanced Practice Professional at the time of each encounter, and on a daily basis ;

f. An Emergency Department Record must be completed by the responsible practitioner within 24 hours of the encounter;

g. A Consultation Note must be completed by the consulting physician within 24 hours of notification of the consult request;

h. A Diagnostic Report must be completed by the interpreting physician in a timely fashion;

i. A Discharge Summary must be entered in the medical record by the discharging physician or his/her designee within 7 days of an inpatient or observation discharge, transfer, or death; and

j. The Inpatient or Observation Medical Record must be completed within thirty (30) days of discharge, including the authentication of all progress notes, consultation notes, operative reports, verbal and written orders, final diagnoses, and discharge summary.

3.18.2 Process to Address Incomplete Records

The Hospital policy on Automatic Relinquishment Due to Delinquent Medical Records Procedure delineates responsibilities, procedure and documentation that must occur regarding the process to address incomplete records.

3.19 ELECTRONIC RECORDS AND SIGNATURES

"Electronic signature" means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

3.20 EVIDENCE-BASED ORDER SETS

The Medical Executive Committee may adopt and require the use of evidence-based order sets for use in various conditions.

3.21 ORGANIZED HEALTH CARE ARRANGEMENT

a. For the purposes of complying with provisions of the federal Health Insurance Portability and Accountability Act ("HIPAA"), the Medical Staff of [Hospital] are deemed to be members of, and a part of, an *Organized Health Care Arrangement* ("OHCA") as that term is defined within HIPAA . This designation is intended to comply with the privacy regulations promulgated pursuant to HIPAA based upon the fact that the members of the OHCA operate in a "clinically integrated care setting." As such, members of Medical Staff shall, upon acceptance to membership, become part of the OHCA with Franciscan Health - Rensselaer and the hospital's medical staff. Except for non-compliance remedies set forth in the HIPAA regulations, no member shall be liable for any actions, inactions, or liabilities of any other member. Each member of the OHCA shall be responsible for its

own HIPAA compliance requirements related to services and activities performed outside the clinical setting of the OHCA.

b. The members hereby adopt the Hospital's Notice of Privacy Practices that will be distributed by the Hospital to all patients of the Hospital, and agree to comply with all requirements contained in the joint Notice of Privacy Practices.

c. The members of the Medical Staff shall have access to protected health information of the patients of other members of the OHCA for purposes of treatment, payments and healthcare operations, as those terms are defined by HIPAA and the HIPAA Privacy Regulations; Provided that any member of the Medical Staff that downloads, saves or otherwise stores any protected health information, or has access to any Hospital electronic data systems, or Franciscan Alliance, Inc. electronic data systems, though any portal that is not solely operated by the Hospital or Franciscan Alliance, shall enter into a Franciscan Alliance Colleague Agreement, which shall require that member of the Medical Staff to observe certain requirements, and to assume responsibility for anyone who accesses any Franciscan Alliance maintained information through a portal maintained by the member.

d. Members of the Medical Staff shall be entitled to disclose protected health information of a patient to other members of the OHCA for any health care operations of the OHCA, including peer review, mortality and morbidity meetings, tumor board, and other similar health care operations of the OHCA, as permitted in the HIPAA Privacy Regulations.

ARTICLE IV

STANDARDS OF PRACTICE

4.1 ATTENDING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending physician who is an appointee of the Medical Staff with admitting privileges. The attending physician, or privileged designee, will be responsible for:

a. the medical care and treatment of each patient in the Hospital, and

b. the prompt, complete, and accurate preparation of the medical record.

c. a physician, or his/her supervised Advance Practice Professional, will be responsible for making daily rounds.

4.1.2 Identification of Attending Physician

At all times during a patient's hospitalization, the identity of the attending physician shall be clearly documented in the medical record.

4.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending physician are transferred to another Medical Staff appointee, a note covering the transfer of responsibility will be entered in the medical record by the attending physician.

4.2 COVERAGE AND CALL SCHEDULES

Each physician shall provide the Medical Staff Office with a list of designated Medical Staff appointees (usually the members of his/her group practice who are members of the same clinical department and have equivalent clinical and procedure privileges) who shall be responsible for the care of their patients in the Hospital when the physician is not available. Each physician is responsible for providing the Medical Staff Office with a current and correct on-call schedule.

4.3 RESPONDING TO CALLS AND PAGES

a. Telephonic Response. Practitioners are expected to respond within thirty (30) minutes to calls from the Hospital's patient care staff regarding their patient.

b. Physical Response: Practitioners are expected to respond in person within two (2) hours to evaluate urgent/emergent requests from staff, including the initial evaluation of a patient requiring an ICU level of care (excluding boarders for step-down beds and suicidal patients that are medically stable).

4.4 ORDERS

4.4.1 General Principles

a. All orders for treatment will be entered into the medical record.

b. All orders must be specifically given by a practitioner who is privileged by the Medical Staff.

c. Vague or "blanket" orders (such as "continue home medication" or "resume previous orders") will not be accepted.

d. Instructions should be written out in plain English. Prohibited abbreviations may not be used.

e. All orders for treatment shall be recorded in the medical record and authenticated by the ordering practitioner with his/her legible signature, date, and time.

4.4.2 Verbal Orders

Verbal orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in a computer. Verbal orders must comply with the following criteria:

a. The order must be given to an authorized individual as defined in hospital policy

b. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal orders, like written/electronic orders, should be conveyed in plain English without the use of prohibited abbreviations.

c. The order must be read back to the prescribing practitioner by the authorized person receiving the order.

d. All verbal orders must be signed by the ordering practitioner before the ordering practitioner leaves the area.

e. Orders for cancer chemotherapy may not be given verbally.

f. Verbal orders may be given only by practitioners privileged at the hospital or working under training protocols.

4.4.3 Telephone Orders

Telephone orders are a form of verbal order; therefore their use is discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in a computer. Orders dictated over the telephone must comply with the requirements of verbal orders as described in subsection 4.4.2 above and must be cosigned within forty-eight (48) hours unless a read back and verify process is used.

4.4.4 Facsimile Orders

Orders transmitted by facsimile shall be considered properly authenticated and executable provided that:

a. The facsimile is legible and received as it was originally transmitted by facsimile or computer;

b. The order is legible, clear, and complete

c. The identity of the patient is clearly documented;

d. The facsimile contains the name of the ordering practitioner, his address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law;

e. The original order, as transmitted, is signed, dated, and timed; and

f. The facsimile, as received, is signed by the attending physician or ordering practitioner per the Medical Records policy.

4.4.6 Cancellation of Orders Following Surgery or Transfer

All previous medication orders are canceled when the patient:

a. goes to surgery,

b. is transferred to or from a critical care area,

c. is transferred from the skilled nursing unit to an acute care area, or

d. is transferred to, and readmitted from, another hospital or health care facility.

New orders shall be specifically written following surgery or the aforementioned transfers. Instructions to "resume previous orders" will not be accepted.

4.4.7 Drugs and Medications

Orders for drugs and medications must follow Hospital Pharmacy policy.

4.5 CONSULTATION

a. Any qualified practitioner with clinical privileges may be requested for consultation within his/her area of expertise. The attending physician is responsible for obtaining consultation whenever patients in his/her care require services that fall outside his/her scope of delineated clinical privileges.

b. Practitioner to practitioner communication is required for all critical care consultations. Practitioner to practitioner communication for all other consultation requests is preferred.

c. If a nurse has any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to her manager to be addressed through the chain of command. All practitioners should be receptive to obtaining consultation when requested by patients, their families, and hospital personnel.

4.6 CRITICAL CARE UNITS

4.6.1 Critical Care Unit Privileges

The privilege to admit patients to, and manage patients in, closed critical care units shall be specifically delineated. Issues regarding the validity of admissions to, or discharge from, a critical care unit will be made through consultation with the medical director of the unit and with the patient's attending physician.

4.6.2 Prompt Evaluation of Critical Care Patients

Each patient admitted or transferred to a critical care unit shall be examined by a physician within two (2) hours of admission or transfer.

4.6.3 Critical Care Services

Certain services and procedures may be provided to patients only in critical care units. The Medical Executive Committee shall establish policies that specify which services may be provided only in a critical care unit.

4.7 DEATH IN HOSPITAL

4.7.1 Pronouncing and Certifying the Cause of Death

In the event of a hospital death, the deceased will be pronounced by the attending practitioner, his/her designee, or a senior nurse (nursing supervisor, charge nurse) within a reasonable time. The attending physician or his/her designee is responsible for certifying the cause of death, and completing the Death Certificate in a timely manner.

4.7.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.

4.8 AUTOPSY

It is the duty of the attending physician to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medicolegal or educational interest. For all autopsies done in the hospital, a provisional anatomic diagnosis will be recorded on the medical record within seventy-two (72) hours, and the complete autopsy report will be made part of the medical record within thirty (30) days unless an explanatory note is written. When autopsies are performed off-site, a provisional diagnosis and the complete autopsy report will be obtained as soon as possible.

4.9 SUPERVISION OF ADVANCED PRACTICE PROFESSIONALS

4.9.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals, which includes Advance Practice Registered Nurses (this includes nurse midwives, CRNAs, nurse practitioners and clinical nurse specialists providing direct patient care) and Physician Assistants, are licensed or certified health care practitioners whose license or certification may not permit and/or the hospital does not authorize the independent exercise of clinical privileges. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical Staff Bylaws. Advanced Practice Professionals may provide patient care only under the supervision/collaboration of a physician(s) who is an appointee to the Medical Staff.

4.9.2 Guidelines for Supervising Advanced Practice Professionals

a. The physician(s) is(are) responsible for managing the health care of patients in all settings.

b. Health care services delivered by physicians and by Advanced Practice Professionals under their supervision must be within the scope of each practitioner's authorized practice, as defined by state law.

c. The physician(s) is(are) ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, ensuring the quality of health care provided to patients.

d. The physician(s) is(are) responsible for the supervision of the Advanced Practice Professional in all settings.

e. The role of the Advanced Practice Professional in the delivery of care shall be defined through mutually agreed upon Scope of Practice Guidelines that is developed by the physician(s) and the Advanced Practice Professional.

f. The physician(s) must be available for consultation with the Advanced Practice Professional at all times, either in person or through telecommunication systems or other means. The physician must be able to present to the hospital within two (2) hours when needed by the Advanced Practice Professional.

g. The extent of the involvement by the Advanced Practice Professional in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the Advanced Practice Professional, as judged by the physician(s).

h. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.

i. The physician(s) and Advanced Practice Professional together should review all delegated patient services on a regular basis, as well as the mutually agreed upon Scope of Practice Guidelines.

j. The supervising physician(s) is(are) responsible for clarifying and familiarizing the Advanced Practice Professional with his or her supervising methods and style of delegating patient care.

k. Each Advanced Practice Professional must document the identity of their supervising or collaborating physician and one or more alternate supervising physicians.

4.9.4 Collaborative Practice Agreements

Each Advanced Practice Professional must have on file in the Medical Staff Services Office written Supervision/Collaboration Agreement, if applicable, that describes all health care-related tasks which may be performed by the Advanced Practice Professional. This document must be signed by the Advanced Practice Professional, the supervising/collaborating physician, and all alternate supervising/collaborating physicians. The Supervision/Collaboration Agreement shall be submitted to the Department Chair and reported to the Credentials Committee. The Supervision/Collaboration Agreement, if applicable, must include:

a. the name, license number and addresses of all supervising physicians;

b. the name and practice address of the Advanced Practice Professional;

c. the date the guidelines of the Supervision Agreement were developed and dates they were reviewed and amended; and

d. medical conditions for which therapies may be initiated, continued, or modified.

4.9.5 Supervising/Collaborating Physician

An Advanced Practice Professional may not provide services to patients if the supervising physician is more than two (2) hours travel time from the Hospital. A physician may not supervise more Advanced Practice Professionals than allowed by state law.

A Medical Staff appointee who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of or collaboration with of an Advanced Practice Professional or other dependent health care professional shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.9.6 Medical Record Documentation

Advanced Practice Professionals may enter notes and orders within the scope of their written Supervision/Collaboration Agreement. Advanced Practice Professionals should discuss consultations with their supervising/collaborating physician as soon as possible after the completion of the consultation. When performed by an APP, history and physical examinations and consultations require co-signature within twenty-four (24) hours.

4.9.7 Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional may not:

a. provide a service which is not listed and approved in the Supervision Agreement on file in the Medical Staff Services Office;
b. prescribe drugs, medication, or devices not specifically authorized by the supervising physician and documented in the Supervision Agreement; and
c. provide a medical service that exceeds the clinical privileges granted to the supervising physician.

4.10 INFECTION CONTROL

All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties.

4.11 CLINICAL PRACTICE GUIDELINES

Evidence-based order sets provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Evidence-based order sets assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. The Medical Executive Committee may adopt evidenced-based order sets upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

ARTICLE V

PATIENT RIGHTS

5.1 <u>PATIENT RIGHTS</u>

All practitioners shall respect the patient rights as delineated in Hospital policy.

5.2 <u>INFORMED CONSENT</u>

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner performing the procedure that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow Hospital policy.

5.3 <u>WITHDRAWING AND WITHHOLDING LIFE SUSTAINING TREATMENT</u>

Hospital policies on withdrawing and withholding life sustaining medical treatment delineate the responsibilities, procedure, and documentation that must occur when withdrawing or withholding life-sustaining treatment.

5.4 <u>DO-NOT-RESUSCITATE ORDERS</u>

The Hospital policy on 'Do Not Resuscitate' delineates the responsibilities, procedure, and documentation that must occur when initiating or cancelling a Do Not Resuscitate order.

5.5 <u>DISCLOSURE OF UNANTICIPATED OUTCOMES</u>

The Hospital policy on 'Disclosure of Unanticipated Outcomes' delineates the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur.

5.6 <u>RESTRAINTS AND SECLUSION</u>

The Hospital policy on restraints and seclusion delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.7 <u>ADVANCE DIRECTIVES</u>

The Hospital policy on advance directives delineates the responsibilities, procedure, and documentation that must occur regarding Advance Directives.

5.8 <u>INVESTIGATIONAL STUDIES</u>

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy should be followed.

ARTICLE VI

SURGICAL CARE

6.1 SURGICAL PRIVILEGES

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Services Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

6.2 SURGICAL POLICIES AND PROCEDURES

All practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures will cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 ANESTHESIA

Moderate or deep sedation and anesthesia may only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The anesthesiologist/anesthetist will maintain a complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition for each patient receiving deep sedation and anesthesia. The practitioner responsible for the ordering the administration of moderate sedation will document a pre-sedation evaluation and post-sedation follow-up examination. Deep sedation shall be administered following the Franciscan Alliance deep sedation protocol.

6.4 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens, as defined in pathology policy, are exempt from pathology examination. The pathologist's report will be made a part of the patient's medical record.

6.5 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID wrist band with the patient's name and a second identifier as chosen by the hospital. The Hospital policy on 'Universal Protocol' shall be followed.

ARTICLE VII

RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

The Hospital policy on Medical Staff Code of Conduct delineates the examples of inappropriate conduct, principles, reporting inappropriate conduct and procedure.

7.2 REPORTING IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall be referred to the Practitioner Assistance Committee for consideration in accordance with guidelines set forth in Organization and Functions 1.3.12 and 2.7.