Medical Staff
Rules and Regulations 2022

Community Hospital
of the Monterey Peninsula
Montage Health

Medical Staff Rules and Regulations

V2022
Changes approved by the Medical Executive Committee October 13, 2020.
For more information, call Medical Staff Services (831) 625-4511 or e-mail medicalstaffoffice@chomp.org.

TABLE OF CONTENTS

ARTICLE 1: PREAMBLE

In accordance with the Medical Staff Bylaws, the Medical Staff has initiated and adopted these General Rules and Regulations. Adherence to these Rules and Regulations is required of all practitioners holding clinical privileges at Community Hospital of the Monterey Peninsula, including Medical Staff members, those holding temporary privileges, and where applicable allied health professional staff members working under practice prerogatives or job description, and others holding clinical privileges.

ARTICLE 2: ADMISSION OF PATIENTS

2.1 General

2.1-1 The hospital shall accept patients for diagnostic, invasive and therapeutic care. The hospital shall not accept patients who suffer from serious burns or who have virulent infectious diseases for which suitable isolation cannot be maintained. No persons shall be denied admission on the basis of sex, race, age, color, religion, ancestry, or national origin.

2.1-2 The appropriate Department Chairperson or Medical Director of Utilization Review shall contact the attending physician whenever questions arise as to whether a patient should be admitted, retained, or transferred.

2.2 Procedure

2.2-1 A patient may be admitted to the hospital only by Medical Staff members who have admitting privileges or by practitioners who have been granted temporary privileges in accordance with Medical Staff Bylaws.

2.2-2 Patients admitted to the hospital for dental, or psychological care must be given the same basic medical appraisal as patients admitted for other services. The physician Medical Staff member, identified in the medical record, shall assume overall responsibility for the patient's medical care throughout the hospital stay, including performance of the history and physical examination except that portion of the examination which relates to dentistry, or psychological evaluation.

2.3 Responsibility of the Attending Physician

2.3-1 The patient's attending physician shall be responsible for directing and supervising the patient's overall medical care, for coordinating all consultations, for completing and recording in the medical record a medical history and physical examination within twenty-four (24) hours of admission, for the prompt and accurate completion of the medical record, for necessary special instructions, and for transmitting information

regarding the patient's status to the patient, the referring physician, if any, and to the patient's family.

2.3-2 Admission laboratory and radiology testing should be tailored to the individual needs of the patient. Specific laboratory testing should be determined by such factors as patient age, clinical status, anticipated blood loss and other clinically relevant information.

2.3-3 All patients admitted to the hospital shall be seen by the attending physician or designee on a daily basis and a daily progress note shall be recorded in the medical record.

2.3-4 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In case of an emergency such statement shall be recorded as soon as possible but no later than twenty-four (24) hours after admission.

2.3-5 All patients admitted to the hospital shall be seen and evaluated by the attending physician either immediately prior to or within twelve (12) hours of admission. Patients admitted to the intensive care unit shall be evaluated and treated by attending physician either immediately prior to or within one (1) hour of admission.

2.3-6 Primary care physicians may admit directly to Behavioral Health Services. The primary care physician must obtain a psychiatrist's or psychologist's consultation at the time of admission. After the behavioral health consultation has been obtained, the primary care physician must be designated as the consultant and the psychiatrist or psychologist shall be designated as the attending.

2.3-7 Any Medical Staff member who cannot or will not assume all of the responsibilities of the attending physician may admit patients only when another Medical Staff member has assumed such responsibilities and is identified as the attending physician. If the admitting physician is not assuming responsibility as the attending physician then this fact must be clearly stated on the admitting order sheet in the medical record.

2.3-8 Whenever these responsibilities are transferred from the identified attending physician to another Medical Staff member, a note covering the transfer of responsibility shall be entered in the medical record by the current attending physician. The note shall state to whom care is being transferred and the date and time responsibility is transferred.

2.4 Hospital Admissions by Non-physician Medical Staff Members

2.4-1 Dental Admissions

A. A patient admitted for dental care is admitted with a dual responsibility of the attending dentist and a physician member of the Medical Staff.

B. The dentist's responsibility shall include:

1. A detailed dental history justifying the hospital admission including the preoperative diagnosis, if appropriate;

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

3. A completed 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;

4. Progress notes pertinent to the oral condition;

5. The dentist may write orders within his or her scope of licensure and as may be limited by the practitioner's privileges or by the Medical Staff Bylaws or these Rules and Regulations;

6. Clinical resume and discharge summary;

7. Assuring the medical history and physical examination is completed, dictated, and a summary of significant findings recorded in the medical record within twenty-four (24) hours of admission and prior to any surgical procedure.

C. The medical physician's responsibilities shall include:

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

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

3. Supervision of the patient’s general health status while hospitalized.

2.4-2 Psychology Admissions

A. A patient admitted by a clinical psychologist is admitted under the dual responsibility of the admitting psychologist and a physician member of the Medical Staff.

B. The clinical psychologist's responsibilities shall include:

1. A complete psychosocial history and mental status examination justifying the hospital admission;

2. Diagnostic formulation and development and implementation of a treatment plan;

3. Progress notes pertinent to the patient's psychological condition;

4. Assuring the medical history and physical examination is completed, dictated, and a summary of significant findings recorded in the medical record within twenty-four (24) hours of admission;

5. Arranging for a psychiatric consultation whenever psychotropic medications are indicated. The exception to this requirement is the use of medication for alcohol or drug detoxification of patients on the behavioral health service. These medications may be ordered by non-psychiatrist physicians with appropriate clinical privileges.

C. The medical physician's responsibilities shall include:

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

2. Physical examination;

3. Supervision of the patient's general health status while hospitalized including the prescribing of any medications which may be clinically indicated;

4. Assuring that psychiatric evaluation is obtained for all patients who require the use of psychotropic medications.

2.5 Admissions with Psychiatric Precautions

2.5-1 The attending physician, at the time the patient is admitted, shall inform the admitting staff and nursing staff if he or she suspects that the patient may be a danger to self or to others.

2.5-2 The attending physician shall recommend appropriate and approved precautionary measures to protect the patient and others, and shall note in the patient’s medical record the reason for his or her suspicions, and the precautions taken to protect the patient and others.

2.5-3 In the event the patient or others cannot be appropriately protected, arrangements shall be made to transfer the patient to a facility where his or her care can be appropriately managed.

2.5-4 The attending physician shall seek consultation from a psychiatrist for any patient who is a danger to self or to others.

2.6 Admissions with Infectious Disease Precautions

2.6-1 The attending physician, at the time the patient is admitted, shall inform the admitting staff and nursing staff if he or she suspects that the patient may have an infectious or contagious disease or condition.

2.6-2 All patients with infectious disease will be admitted in accordance with appropriate and approved standards articulated in the Infection Control Policies in the Environment of Care (EOC) Manual.

2.6-3 In the event the patient cannot be appropriately isolated, arrangements shall be made to transfer the patient to a facility where his or her care can be appropriately managed.

2.6-4 The attending physician shall seek consultation from an infectious disease specialist for any adult patient (age greater than fourteen (14) years) with actual or suspected bacterial meningitis.

2.7 Emergency Admissions

2.7-1 When a patient requires admission to the hospital for emergency medical treatment, the attending physician shall, whenever possible, contact the Admission Supervisor and determine whether there is an available bed.

2.7-2 In all cases involving emergency admissions, the attending physician must be able to demonstrate to the Medical Executive Committee that the admission was due to a bona fide emergency. The history and physical examination report must clearly justify the emergency nature of admission.

2.7-3 Patients who require emergency admission through the Emergency Department, and do not have an attending physician, shall be assigned an attending physician in accordance with the Policy for Use of Specialty Back-Up Coverage. If a physician on suspension due to medical record delinquencies must admit a patient in an emergent situation because the patient could not be admitted or cared for by another physician with appropriate clinical privileges then the physician on suspension must follow the procedures as identified in the current Medical Staff Policy for Delinquent Medical Records.

2.8 Admission to the Intensive Care Unit

2.8-1 All patients admitted to the Intensive Care Unit shall be evaluated and treated by the attending physician either immediately, prior to or within one (1) hour of admission.

2.8-2 All adult patients (above sixteen (16) years of age) admitted to the Intensive Care Unit shall receive a consultation by a physician with privileges in critical care medicine.

2.8-3 The triage of discharges and admissions to the Intensive Care Unit shall be the responsibility of the critical care physician.

2.8-4 All children sixteen (16) and under admitted to the Intensive Care Unit will have a mandatory pediatric consultation in accordance with the ICU Mandatory Pediatric Consultation policy.

2.9 Priority of Admissions and In-house Transfers

2.9-1 When the hospital's administrator on call, after consulting with the Chief of Staff, determines that bed space is not available, he/she may limit admissions to emergency cases only. In such an event, patients will be admitted using the following order of priority:

A. First Priority - Emergency Admissions. Patients who have serious medical problems and may suffer death, serious injury, or permanent disability if they are not admitted and provided treatment within four (4) hours;

B. Second Priority - Urgent Admissions. Patients who have serious medical problems who may suffer substantial injury to their health if they are not admitted and provided treatment within twenty-four (24) hours;

C. Third Priority - Preoperative Admissions. Patients who are already scheduled for surgery;

D. Fourth Priority - Routine Admissions. Patients who will be admitted on an elective basis to any service.

2.9-2 In-house Transfer Priorities. Priority shall be given for the transfer of in-house patients in the following order:

A. General care or Emergency Department to ICU bed.

B. Emergency Department to an appropriate bed.

C. Intensive Care Unit to a general care area.

D. Temporary placement in an inappropriate area for that patient to an appropriate area.

2.9-3 The appropriate Department Chairperson or Medical Staff Officer shall be consulted to help prioritize admissions and transfers. In-house transfers and transfers to other facilities will follow the Hospital Transfer Policy.

ARTICLE 3: CONSENTS

3.1 Patient's Right to Make Informed Decisions and Consent to Medical Treatment

3.1-1 Patients have the right to participate actively in decisions regarding their medical care. Physicians must give patients the information they need to make their decisions. This information includes information on the patient's medical status, diagnosis, prognosis, therapeutic interventions, admission and discharge status.

3.1-2 Complex diagnostic and therapeutic procedures may be performed only when the patient, or his or her surrogate decision maker, has been given information about the procedure and has given consent.

3.1-3 The California Hospital Association Consent Manual is used to assist medical and hospital staff in the process of obtaining and documenting informed consent.

3.2 Procedures Requiring Informed Consent

3.2-1 Complex procedures include all operations and invasive procedures, blood transfusions, and other procedures as noted below. Blood draws and IV punctures for venous access are not considered complex procedures. Informed consent is required in the following situations:

A. All operative or invasive diagnostic and/or therapeutic procedures, including all procedures performed in the main operating room, outpatient surgery center, interventional radiology and cardiac catheterization laboratory;

B. Invasive diagnostic and/or therapeutic procedures (i.e. procedures associated with a biopsy, any imaging guided needle aspiration for diagnosis or treatment) anywhere in the hospital that represents material risk to the patient based on the available clinical evidence, as informed by the responsible practitioner's clinical judgment;

C. Transfusion of blood and blood products;

D. Use of experimental, investigational, and non-FDA approved drugs, devices and protocols;

E. Radiation therapy and use of radioactive implants;

F. Electroconvulsive therapy;

G. Use of organs, tissues, or fluids for research, commercial or transplantation purposes;

H. HIV testing;

I. Use of antipsychotic medications;

J. Cardiac Stress Testing;

K. Others as mandated by statute or law.

3.3 Informed Consent Defined

3.3-1 Informed consent is a process whereby the patient, or his or her surrogate decision maker, is given information by the physician which will enable him or her to reach a meaningful, informed decision regarding whether to give consent for the complex treatment or procedure which is proposed.

3.3-2 The information provided should include a description of:

A. The nature of the operation, procedure or treatment, including the surgical site and laterality if applicable;

B. Indication for the proposed operation, procedure or treatment;

C. The material risks, benefits or effects of the operation, procedure or treatment;

1. Material risks, benefits or effects related to the operation, procedure or treatment are those that based on the available clinical evidence, as informed by the responsible practitioner's clinical judgment, represent a high severity or high likelihood for occurring and potential problems that may occur during recuperation. They also include the likelihood of achieving treatment goals.

D. Any alternative efficacious methods which may be medically viable and their associated benefits or effects, and their possible risks and complications;

E. Probable consequences of declining recommendation or alternative therapies;

F. Any independent medical research or significant interests a physician may have which may influence his/her treatment recommendations;

G. All practitioners who will conduct significant surgical tasks during the operation, procedure or treatment;

1. Significant surgical tasks include but are not limited to opening and closing, harvesting grafts, dissecting, removing or altering tissues, and implanting devices.

3.4 Who May Give Consent

Informed consent must be secured from patients with the capacity to give such consent. If a patient does not have the capacity by reason of psychiatric or medical condition then consent must be secured from a surrogate decision-maker. Surrogate decision-maker may include parents or guardians of minors, conservators, attorneys-in-fact, the patient's closest available relatives, the court or others. The persons who may lawfully give consent are identified in the California Hospital Association Consent Manual.

3.5 Responsibility for Securing Informed Consent

3.5-1 The patient's physician is legally responsible for giving the patient, or his or her surrogate decision maker, the requisite information and securing informed consent.

3.5-2 Physicians other than the patient's attending physician have a duty to secure consent, when they will provide specialized services involving complex treatments or procedures at the request of or together with the patient's attending physician.

3.6 Emergencies

3.6-1 An emergency situation occurs when treatment is immediately necessary to prevent the patient's death, severe impairment or deterioration, or to alleviate severe pain. Consent is implied in an emergency situation if there is insufficient time to obtain consent from the patient or his/her surrogate decision-maker.

3.6-2 The emergency situation exception applies only to the treatment which is immediately necessary and for which consent cannot be secured.

3.6-3 Consent shall be secured for all further, non-emergency treatment that may be necessary.

3.7 Special Consent Requirements

3.7-1 Special consents must be obtained and documented as required by law. Special consents shall be obtained for anesthesia/sedation, blood transfusions, HIV blood tests, elective sterilization procedures, hysterectomies, use of investigational drugs or devices, participation in human experimentation, reuse of hemodialysis filters, treatment for breast cancer, and use of psychotropic medications. Special consent must be secured by the attending physician in the manner specified in the law applicable to these particular procedures. When appropriate, hospital personnel shall verify that appropriate consent has been obtained. The laws related to special consents are described in the California Hospital Association Consent Manual.

3.7-2 The physician shall assure that special consent is secured in the manner required by law, and that required forms, waiting periods, and certifications have been completed.

3.8 Physician Documentation of Informed Consent

3.8-1 The physician involved in securing informed consent shall document in the patient's medical record the items in section 3.3-2 above.

3.8-2 The physician's documentation related to an emergency situation must describe:

A. the nature of the emergency;

B. the reasons consent could not be secured from the patient or a surrogate decision maker; and

C. the probable result if treatment would have been delayed or not provided.

3.9 Verification of Informed Consent for Medical and Surgical Procedures

3.9-1 Verification of informed consent will be done for all operations, procedures or treatments noted in Section 3.2-1.

3.9-2 Hospital personnel shall verify that informed consent has been obtained from the patient by asking the patient to complete the appropriate consent form.

3.9-3 The consent form must be signed and placed in the medical record prior to the operation, procedure or treatment, except in emergencies as described above.

3.9-4 Hospital personnel verify that informed consent has been given but do not provide patients or surrogate decision-makers with medical information regarding any proposed treatment. If a patient or surrogate decision-maker expresses doubt or confusion about a procedure, the physician who is responsible for securing consent or the patient's attending physician shall be contacted by Hospital personnel and asked to provide the necessary information to the patient.

3.10 Verification of Informed Consent Forms Completed Outside the Hospital

3.10-1 Hospital personnel shall verify that the informed consent form contains the elements required under Section 3.2-2. In addition, the form must designate the hospital as the location of the procedure.

3.10-2 If the form does not adequately document the informed consent, a hospital consent form will be completed as in Section 3.8.

3.10-3 If the form is deemed adequate hospital personnel will verify that informed consent was given and sign the outside consent form. The outside informed consent form will be included in the medical record.

3.11 Consent by Telephone

3.11-1 When the telephone is used to obtain consent from a surrogate decision-maker, the information normally given to secure informed consent must be provided.

3.11-2 When consent is obtained by telephone, hospital personnel should join the conversation to listen and act as a witness. The surrogate decision-maker shall be informed of all personnel listening to the discussion.

3.11-3 The physician shall note the exact time, nature and any limitations of the consent in the medical record.

3.11-4 The witness shall document the event on an appropriate consent form. If possible, a copy of the consent form should be sent to the surrogate, preferably by facsimile, for signature and returned to the Hospital medical record. At a minimum, the documents shall include the name of the person giving consent, the relationship of the surrogate to the patient, and confirm that consent was given for treatment.

ARTICLE 4: REFUSAL OF TREATMENT

4.1 Right to Refuse Treatment

4.1-1 A patient or the patient's surrogate decision-maker has the right to refuse treatment. If the patient is a minor who is not legally authorized to consent to treatment and his/her parent or guardian refuses consent, it may be desirable and possible to secure court authorization.

4.1-2 If a patient or the patient's surrogate decision-maker refuses treatment, the attending physician shall be contacted immediately who shall explain the reason for the treatment and the possible ill effects of refusal. The attending physician shall enter a brief note in the patient's medical record regarding the initial refusal and whether the outcome was consent or continued refusal.

4.1-3 The Refusal of Treatment form should be presented to the patient or the surrogate decision-maker for signature. If the patient or the surrogate decision- maker refuses to sign, the notation "refuses to sign" shall be made at the place for the signature.

4.1-4 If treatment is ultimately refused, the event will be entered into eM2 and reviewed by the Vice President of Risk Management.

ARTICLE 5: CONSULTATIONS

5.1 Responsibility

5.1-1 The good conduct of medical practice includes proper and timely use of consultation. Judgment as to the seriousness of the illness and the resolution of doubt regarding the diagnosis or treatment rests with the physician responsible for the care of the patient. The organized Medical Staff, through its Department Chairpersons and the Medical Executive Committee, has oversight responsibility for assuring that consultants are called as needed.

5.1-2 Any qualified physician with clinical privileges in this hospital can be called for consultation within his or her area of expertise and within the limits of clinical privileges that have been granted to him or her.

5.1-3 An attending physician's responsibility for his or her patient does not end with a request for consultation, and the attending physician remains in charge of his or her patient's care unless a transfer of patient care to a different attending physician has occurred as described in these Rules and Regulations.

5.1-4 The consultation and specific diagnostic and therapeutic procedures will be done at the hospital unless specific diagnostic or therapeutic facilities are not provided within confines of the hospital. Any outside clinical sources used for inpatients must be approved by the Medical Staff and must meet appropriate accreditation standards.

5.2 Request for Consultations

Requests for consultation must be made by direct personal communication from the attending physician to the consulting physician. Hospital nurses or other hospital staff are not to be used as intermediaries. The attending physician must document the consultation request. When requested, the consultant will see the patient as soon as possible, but certainly within the same day, unless special arrangements are made with the referring physician.

5.3 Recommended Consultations

Except in an emergency, consultation is recommended in the following instances:

5.3-1 Where the diagnosis is obscure after diagnostic procedures have been completed;

5.3-2 Where there is doubt as to the choice of therapeutic measures to be used;

5.3-3 In unusually complicated situations where specific skills of other physicians may be indicated;

5.3-4 In instances where the patient on a medical/surgical unit exhibits severe psychiatric symptoms;

5.3-5 When pelvic surgery is contemplated in the presence of a confirmed pregnancy;

5.3-6 When requested by the patient or a surrogate decision-maker; and/or

5.3-7 When required by the Medical Staff or Hospital Rules and/or Policies.

5.4 Required Consultations

5.4-1 A consultation is required when the Department Chairperson or Chief of Staff determines that a patient will benefit from such consultation. Such consultation shall be required only after the Department Chairperson or Chief of Staff has discussed the situation with the patient's attending physician.

5.4-2 If a nurse has any reason to doubt or question the care provided any patient or believes that consultation is needed and has not been obtained, he or she may call this to the attention of his or her supervisor, who in turn may refer the matter to the appropriate Department Chairperson. The Department Chairperson may then, in appropriate circumstances, require a consultation, after conferring with the patient's attending physician.

5.4-3 A Medical Staff member may be required by the Medical Executive Committee to have consultations on all or some of his or her cases. In such situations, the Medical Staff member shall be responsible for informing the assigned consultants of each admission and for arranging for timely consultation.

5.4-4 The requirements for consultations in ICU are delineated in section 2.8 of these Medical Staff Rules and Regulations.

5.5 Performance of and Reporting of Consultations

5.5-1 A satisfactory consultation includes examination of the patient and the medical record. The attending physician is responsible for supplying the consultant with all available and relevant information regarding the patient and the need for the consultation.

5.5-2 The written or dictated consultant reports must contain at least the following elements:

A. Review of history and medical record;

B. Summary of pertinent physical findings;

C. Diagnostic impression; and

D. Recommendations for treatment.

5.5-3 A written or dictated opinion signed by the consultant must be included in the patient's medical record within twenty-four (24) hours or less after the consultation has been performed. A limited statement, such as "I concur," is not sufficient. When operative procedures are involved, consultations performed before surgery shall be reported before the operation except in emergency cases. Consultation reports shall be prepared in accordance with the Medical Records section of these Rules and Regulations.

ARTICLE 6: COVERAGE

6.1 Physician Responsibility for Continuous Care and Coverage of Patient

Each physician shall personally provide or otherwise arrange for continuous care and coverage for each of his or her patients who present to the Hospital for clinical care, emergency services, or who are currently hospital inpatients. If a physician is unable to provide care for his or her patients, then the physician must provide coverage through another appropriately credentialed physician. The covering physician must be available and qualified to assume responsibility for the patients during the attending physician's absence and must be aware of the status and condition of any hospital inpatient which he/she is to cover. Failure to arrange appropriate coverage shall be grounds for corrective action.

6.2 If Attending Physician is Not Available

In the event the attending physician or the attending physician's alternate is not available to address an issue regarding a Hospital inpatient, the Department Chairperson or Chief of Staff shall be contacted, and assume responsibility for caring for the patient or appoint an appropriate Medical Staff member who will assume responsibility until the attending physician can be reached.

6.3 Patients Presenting to the Emergency Department

If the patient of an active or courtesy medical staff member presents to the Emergency Department for care, it is expected that the physician or designee will be available for consultation and to admit his/her patient to the hospital if clinically indicated. It is not acceptable to refer such patients to the Emergency Department backup physician unless the Emergency Department backup physician has agreed to assume this responsibility in advance.

6.4 On Call Physician Response Time

It is expected that a physician on call will respond to pages regarding a hospital inpatient in a timely fashion and will be available to provide necessary medical evaluation and treatment. Unless extenuating circumstances prevent such a response, or the service line or division's policy require less time, the physician is required to respond to phone calls within thirty (30) minutes and present to the Hospital within sixty (60) minutes if asked to do so by requesting physician.

ARTICLE 7: EMERGENCY DEPARTMENT SPECIALTY BACK-UP CALL PANEL

7.1 Emergency Department Specialty Back-up Call Panel

7.1-1 The Emergency Department specialty back-up call panel has been established for referring unassigned patients who require Emergency Department consultation or hospital admission.

7.1-2 The Vice President of Medical Affairs is responsible for working with the Medical Staff, Medical Director of the Emergency Department, and Hospital Administration to ensure that appropriate Emergency Department specialty back-up call coverage is available and a written Emergency Department specialty back-up call panel list is developed and available.

7.1-3 If appropriate call coverage is not available in all specialties then the Medical Director of the Emergency Department shall notify the Vice President of Medical Affairs and the appropriate Division Chairperson.

7.1-4 All active, courtesy, and provisional category members of the Medical Staff, in which a specialty back-up call panel exists, are required to participate on a panel. The exact mechanism of participation shall be determined on a division or sub-specialty level with approval by the Medical Executive Committee. The Medical Executive Committee may, at its discretion, excuse members from this Emergency Department backup requirement for cause.

7.2 Conduct of Emergency Department Specialty Back-up Call Panel Member

7.2-1 Physicians on the Emergency Department specialty back-up call panel must respond to the Emergency Department by telephone and be personally available in the Emergency Department in a timely fashion. The panel physician must personally come to the Emergency Department to examine a patient if requested by the Emergency Department physician.

7.2-2 A practitioner who is unable to provide panel coverage during his or her scheduled time is responsible for arranging for coverage by an

appropriately credentialed physician who meets the criteria for panel eligibility. The practitioner shall inform the hospital of the name of the physician who will provide back-up coverage and the specific time period which will be covered by the designated physician.

7.2-3 All Emergency Department specialty back-up call panel physicians and other Medical Staff members shall comply with all current Medical Staff Emergency Medical Treatment and Active Labor Act (EMTALA) policies and procedures.

ARTICLE 8: MEDICAL RECORDS

8.1 General

8.1-1 The patient's hospital medical record serves a multitude of purposes, including those relating to primary patient care, continuity of patient care, quality management, medical research, and business documentation.

8.1-2 Although the primary purpose of the medical record is to serve the interests of the individual patient, it also serves as the basis for quality management and utilization review activities. In addition, it may be used in connection with lawsuits, and thus serves a medico-legal function.

8.1-3 Medical records must be maintained for all patients who receive treatment at the hospital, including inpatients, outpatients, and emergency patients. All medical records are property of the hospital.

8.1-4 All elements handwritten in the medical record must be legible.

8.2 Organized Health Care Arrangement

8.2-1 Each member of the Medical Staff, as well as every practitioner or Allied Health professional with clinical privileges, and each practitioner with temporary privileges shall be part of the Organized Health Care Arrangement with the Hospital (OHCA).

8.2-2 This arrangement allows the hospital to share information with the practitioner and the practitioner's office to carry out treatment, payment, and healthcare operations. The patient will receive one Joint Notice of Privacy Practices during the hospital's registration or admissions process, which shall include information about the OHCA with practitioner. All parties to the OHCA will follow the terms of the Joint Notice of Privacy Practices.

8.3 Responsibility for the Medical Record

The patient's attending physician and each physician involved in the care of the patient shall be responsible for a complete medical record for each patient.

8.4 Timely Completion of the Medical Record

8.4-1 Entries should be made as soon as possible after clinical events occur, to ensure accuracy and to provide information relevant to the patient's continuing care.

8.4-2 A medical record lacking any required element or required authentication is considered incomplete.

8.4-3 Medical record entries must be completed promptly and authenticated or signed by the author within fourteen (14) days following the patient's discharge. Medical records which are incomplete for any reason fourteen (14) days after discharge are considered to be delinquent.

8.4-4 Upon the patient's discharge the Health Information Management Department shall assemble the medical record and assign deficiencies within the medical record to the responsible physician(s). If a physician has incomplete records after the patient's discharge he or she will receive a notice of the incomplete records pursuant to the current Medical Staff Policy for Delinquent Medical Records.

8.4-5 If the physician fails to complete his or her medical records within fourteen (14) days of discharge, actions including possible suspension of admitting privileges will be initiated pursuant to the current Medical Staff Delinquency and Suspension Policy.

8.4-6 When a physician accumulates over thirty (30) days of suspension in the any consecutive twelve (12) months, the Director of Health Information Management shall notify the Chief Executive Officer and the Medical Executive Committee of the number of suspension days and the nature of the deficiencies which have occurred. Further action related to the physician will then be determined by the Medical Executive Committee.

8.4-7 A medical record shall not be permanently filed until it is completed by the responsible attending physician or is ordered to be filed by the Chief of Staff. The VPMA may authorize the Director of Health Information Management to retire medical records under the following circumstances: when the physician is deceased, has moved from the area, has resigned from the Medical Staff, or is on an extended leave of absence. The VPMA must sign and date a cover letter for the medical record, stating the reason for retirement.

8.5 Use of Signature Stamp or Computer Key

8.5-1 The Medical Staff permits the use of electronic signature, per approved hospital Policy and Procedure.

8.6 Use of Symbols and Abbreviations

8.6-1 A list of symbols and abbreviations which may not be used in the medical record shall be approved by the Medical Executive Committee and made available to the Medical Staff. The list is directed by the Joint Commission and is maintained in the hospital Clinical Manual.

8.7 Correction of the Medical Record

In the event it is necessary to correct an entry in a medical record, the authorized person shall update the information in the system as necessary. The person shall note the reason for the change, the date, and sign the note. Appropriate cross-referencing shall be placed in the medical record when necessary to explain the correction. The correction shall never involve erasure or obliteration of the material that is corrected. In addition, all blanks left in dictated reports must be filled in by the dictating physician at the time the report is authenticated. Any edits should be noted as error, dated, and initialed. No medical record entry shall be removed from the medical record.

8.8 Authentication, Dating, and Timing of Entries

Each entry that is made in the medical record shall be signed by the person making the entry, dated and, when required, the time shall be noted. The date and time (if any) shall be the date and time that the entry is made, regardless of whether the contents of the note relate to a previous date or time.

8.9 Contents

8.9-1 General. Each medical record shall contain sufficient detail and be organized in a manner that will enable a subsequent treating physician or other health care provider to understand the patient's history and to provide effective care. All entries in the medical record must be legible.

8.9-2 The medical record shall include the following elements:

A. Identification Data;

B. History and physical examination report. A comprehensive and complete general history and physical examination is required on all Hospital patients. The history and physical must not be handwritten. The scope and content of the examination must be relevant to the patient's medical history and the clinical findings. Refer to the Medical Staff Bylaws Article XVI, section 16.1 for full scope of Histories and Physical Examination report requirements.

1. The complete history and physical examination report should include the following elements: chief complaint, history of present illness, past medical and surgical history, family history, social history, allergy and medication history, review of systems, physical exam and assessment with plan.

2. If a complete history and physical was performed within thirty (30) calendar days prior to the patient's admission to the hospital, a non-handwritten copy of the report may be used in the patient's medical record in lieu of the admission history and physical, provided the report was completed by a Medical Staff member or validated and authenticated by a Medical Staff member and the medical record contains an interval history and physical note completed within twenty- four (24) hours after admission but prior to a surgical or major invasive procedure which updates the original history and physical examination relevant to the patient's current clinical status.

   If, upon examination, the Medical Staff member finds no change in the patient's condition since the history and physical was completed, he/she may indicate in the patient's medical record that the history and physical was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the history and physical was completed. Any changes in the patient's condition must be documented by the Medical Staff member in the interval history and physical note and entered in the patient's medical record within twenty-four (24) hours of admission, but prior to surgery or a procedure requirement anesthesia services.

3. If the patient is readmitted to the Hospital within thirty (30) days of a previous discharge for the same or a related condition, an interval admission note within twenty-four (24) hours after admission but prior to a surgical or major invasive procedure stating the reason for re- admission and any changes in the history and physical report may be written in lieu of a complete history and physical report.

4. The history and physical report shall be prepared by the patient's attending physician, unless he/she delegates this responsibility to another physician or he or she is required by the Medical Staff Bylaws or Rules and Regulations to delegate or share this responsibility with another physician.

5. A preoperative history and physical examination must be dictated prior to surgery or a procedure requiring anesthesia services, and an interval history and physical exam note recorded within twenty-four (24) hours after admission but prior to the case.

6. A focused history and physical may be used for outpatient registrations (Emergency Department, or any surgical or invasive procedure not anticipating deep sedation or general anesthesia). The focused history and physical examination may be dictated or written and shall in all cases be of sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status.

7. The focused history and physical shall be recorded on the appropriate template approved by the Medical Executive Committee.

8. The focused history and physical shall provide at least the following: a brief account of the chief complaint and present illness, an assessment of contributing past medical history and factors, a list of current medications and allergies, a focused physical examination (the focused physical examination must address at least four systems with the following three systems included: cardiovascular; respiratory and the area being operated on), an initial diagnostic impression and a proposed initial treatment plan.

9. For obstetrical patients, the current obstetrical record shall include a complete prenatal record, if available, and may be a legible copy of the attending physician's office record transferred to the hospital before admission. In such instances, an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

C. Orders. Medications, treatment, and diet orders shall be entered on the order sheet or entered through the electronic physician order entry system. Handwritten orders may be substituted for CPOE entry only when the system is unavailable (See Drug/Medication and Treatment Orders section).

D. Progress notes. Progress notes shall be entered at least daily and more often when warranted by the patient's condition. The progress notes shall give a chronological picture of the patient's progress, and be sufficient to permit continuity of care and transferability. The progress note shall delineate the course and results of treatment. The pharmacist, dietitian, physical therapist, occupational therapist and/or speech therapist shall also make entries into the patient's progress notes as clinically indicated.

E. Pre-anesthetic assessment. The required content of the pre-anesthetic assessment include significant past medical history, previous anesthesia experience, current medications, documented physical status assessment including ASA classification, review of

relevant diagnostic studies, choice of anesthetic agents, and informed consent for the anesthesia.

F. Pre-operative checklist. A Medical Staff approved preoperative check list must be completed prior to commencing a procedure to assure that the requisite consents, preoperative assessments, resuscitation status, imaging studies, equipment, medical records, and other documents relevant to the patient's care are available and complete.

G. Operative reports. The post anesthesia report is completed by the Medical Staff member in two phases:

1. A preliminary postoperative note must be entered into the medical record prior to the patient being moved to the next level of care (i.e. from the recovery area). This note is to be completed immediately after operations and other high-risk procedures and includes pertinent information that is necessary for any care provider who will be attending the patient. This postoperative note must include at least the following elements:

    a. Pre and post-op diagnosis;

    b. Surgeon and assistant;

    c. Technical procedure performed;

    d. Surgical findings;

    e. Anesthesiologist;

    f. Estimated blood loss; and

    g. Any specimens removed.

2. The dictated operative report must be completed within twenty-four (24) hours after surgery and shall contain at least the information described above. The dictated operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. If there are co-surgeons, then both surgeons must sign the operative report.

H. Nursing and ancillary documentation. Documentation to include reports from the nursing, ancillary and support staff involved in the patient's care.

I. Consent forms/informed consent. Documentation of informed consent shall include:

1. Documentation in the medical record by the physician that informed consent has been obtained; and

2. Verification of the patient's consent by hospital personnel, through completion of a hospital informed consent form.

J. Discharge instructions. Discharge instructions shall be recorded and discussed with the patient and, if appropriate, family members or other care providers. Printed discharge instructions shall be given to the patient, family members or other care providers and shall include the following:

1. Activities and any activity restrictions;

2. Discharge medications (to include over-the-counter medications);

3. Diet;

4. Follow-up instructions.

K. Discharge summary. The discharge summary shall be dictated and authenticated by the responsible physician within fourteen (14) days after the patient's discharge. The discharge summary shall briefly recapitulate the significant findings and events of the patients hospitalization including the reason for hospitalization, significant findings and conclusions at the termination of hospitalization, procedures performed and treatments rendered, the condition on discharge relevant to the patients presenting symptoms or complaints, any special instructions given to the patient and/or family, and all final diagnoses. Discharge summaries must be completed within fourteen (14) days of discharge.

1. If the patient was hospitalized for less than forty-eight (48) hours for outpatient observation, or a normal newborn infant, a written clinical progress note summarizing the stay may be used in place of a dictated discharge summary.

L. Hospital Outpatient Clinic Records. Hospital outpatient clinic records shall be maintained in keeping with this section, Medical Staff and department policies.

8.10 Availability and Removal of Medical Records

8.10-1 All records are the property of the Hospital and shall not be taken from the hospital premises.

8.10-2 Medical records may be removed from the Hospital's jurisdiction and safekeeping in accordance with court order, subpoena or state statute.

8.10-3 In cases of readmission of a patient, all previous records shall be made available for the use of the attending physician, whether the patient is attended by the same physician or by another physician.

8.11 Access to Medical Records

Former members of the Medical Staff shall be permitted access to information from medical records of their patients covering all periods during which they attended such patients in the hospital.

ARTICLE 9: SURGERY AND INVASIVE PROCEDURE REQUIREMENTS

9.1 Surgical Assessment

Prior to surgery or an invasive procedure, the patient shall be assessed by the surgeon for the appropriateness of the procedure. This assessment shall include a review of the patient's history, performing an appropriate physical examination, and reviewing all laboratory, x-ray, and other diagnostic data.

9.2 Anesthesia Assessment

Prior to surgery or an invasive procedure requiring anesthesia, the patient shall be assessed by the anesthesiologist

9.3 Tissue and Foreign Bodies Handling

9.3.1 All material removed from the patient by operation or invasive procedure shall become the property of the hospital and shall remain in the hospital laboratory for a sufficient time to allow the pathologist to make a permanent record.

9.3.2 All material and tissue removed at the operation, except those excluded below, shall be sent to the hospital pathologist with a report from the surgeon or the designee indicating pertinent clinical information and the pre- and postoperative diagnosis to the extent known. All such pathological material is the property of the hospital but may be released to the patient upon written order of the attending practitioner after pathological examination is complete.

A. Specimens which require neither gross nor microscopic examination:

1. Bone chips

2. Cataract

3. Debridement
4. Fat from liposuction
5. Femoral head
6. Foreign body
7. Foreskin from circumcision of newborn
8. Ganglion
9. Grossly normal hernia sac
10. Grossly normal placenta
11. Loose bodies from joints
12. Meniscus
13. Nails (toe or fingernails)
14. Orthopedic appliances
15. Portion of rib (removed to enhance operative procedure)
16. Scars
17. Teeth (number, including fragments recorded)
18. Varicose veins
19. Therapeutic radioactive sources
20. Traumatically removed members

B. Specimens that require gross examination only:

1. Lumbar disc
2. Nasal cartilage
3. Products of conception with visible fetal parts
4. Tonsils and adenoidal tissue from children
5. Urinary tract calculi

9.3.3 Receipt by the laboratory of surgically removed specimens for examination shall be documented, and the identity of the

specimens/patient shall be assured throughout the processing and storage of the specimens. The pathologist shall make such examination as considered necessary to arrive at a tissue diagnosis. The pathologist's signed report shall become part of the medical record. Pathology reports shall be filed by diagnosis using a standard nomenclature.

9.4 Procedures Requiring History and Physical

If a procedure requires a history and physical, and/or interval history and physical examination note, then prior to commencing the procedure, the history and physical examination report and/or interval history and physical examination note must be contained in the medical record. If a history and physical examination has been dictated, but is not in the medical record for any care provider who will be involved in the care of the patient to access, the physician must enter a relevant and pertinent history and physical examination in the progress notes. In an emergency, the physician shall record a pre-operative note regarding the patient's condition and reason for emergency procedure prior to the procedure commencing.

9.4-1 When a history and physical examination and/or interval history and physical examination note is not on the medical record in dictated or written form prior to surgery or invasive procedure requiring anesthesia, including moderate or deep sedation, the procedure shall be postponed until the history and physical examination and/ interval history and physical examination note has been recorded. The procedure room staff must verify that the history and physical examination and/or interval history and physical examination note is on the medical record before admitting the patient to the procedure room.

9.4-2 No preoperative testing is required. Minimum preoperative testing requirements shall be determined by the operating physician and the anesthesiologist based on the procedure to be performed, the procedural risk and the clinical status of the patient.

9.5 NPO Status

Patients who are scheduled for procedures late in the day must adhere to the NPO guidelines for general anesthesia, monitored anesthesia care, nerve blocks, or IV sedation.

9.6-1 For procedures scheduled after 1300, clear liquids only (water, coffee, tea, clear juice) may be taken until 0700 hours, then NPO after 0700 the day of surgery.

9.6-2 Rules for pediatric patients are as follows: For children under one (1) year of age: offer formula up to eight (8) hours before surgery and clear liquids (water, apple juice) up to four (4) hours before surgery, with nothing thereafter. For children thirteen to thirty-six (13-36) months old: offer clear liquids six to eight (6-8) hours before surgery with nothing thereafter.

9.6 Previous Orders

All previous orders are suspended when patients undergo operative procedures.

9.7 Postanesthesia Evaluation

A postanesthesia evaluation must be completed and documented no later than forty-eight (48) hours from the time the patient arrived into the designated recovery area. The post anesthesia evaluation and documentation must be performed by a practitioner qualified to administer anesthesia. The postanesthesia evaluation and documentation shall note the presence or absence of any anesthetic related complications, and shall be authenticated, timed and dated. The forty-eight (48) hour timeframe begins at the point the patient is moved into the designated recovery area and no earlier. Evaluation would not be performed immediately at the point of movement of the patient from the operative area to the designated recovery area except in cases where post-operative sedation is necessary for optimal medical care of the patient.

9.9 Discharge from Recovery Area

Patients may be discharged from the recovery area to an inpatient bed following examination by a licensed independent practitioner or by a registered nursing using a standardized procedure approved by the Medical Staff.

9.10 Scheduled Operation Start Time

Surgeons must be in the operating room and ready to begin the operation at the time scheduled. In no case should the operating room be held longer than fifteen (15) minutes. At no time shall an anesthetic be administered without the operating surgeon being present in the hospital.

9.11 Surgical Site Marking Process

In compliance with Medical Staff Policy and Procedure, the surgical site must be marked and involve the patient in the marking process when appropriate. Prior to the start of any surgical or invasive procedure, a final verification process (a “time out”) to confirm the correct patient, procedure and site, using active verbal communication must occur and be documented in the medical record.

9.12 Assistant to the Surgeon

9.12-1 In any surgical procedure requiring general anesthesia there must be a qualified surgical assistant, with the exception of certain procedures where the surgical assistant is at the discretion of the surgeon. The Medical Staff policy for Surgery Assistant at Surgery identifies those surgical patients which, except in an emergency, requires an assistant.

9.12-2 Any member of the Department of Surgery holding appropriate surgical privileges shall be deemed to have “surgical assist” privileges. Members of other departments requesting surgical assisting privileges must provide evidence of current competence and appropriate professional liability coverage.

ARTICLE 10: DEATHS

10.1 Pronouncement of Deaths

A practitioner, if readily available, shall be asked to pronounce the patient dead. If not, nursing personnel will follow the Pronouncing The Death Of An Inpatient policy contained in the Nursing Services Policy Manual. The practitioner then orders the transfer of the patient to the morgue or mortuary. The practitioner is not required to come to the hospital. This order is noted on the doctor's order sheet and the practitioner signs the death certificate. The practitioner notifies the deceased patient's family.

10.2 Autopsies

10.2-1 It shall be the duty of all Medical Staff members to attempt to secure meaningful autopsies in all deaths that meet the following criteria, as identified by the College of American Pathologists:

A. Deaths in which an autopsy would explain unknown or unanticipated medical complications;

B. Deaths in which the cause is not known with certainty on clinical grounds;

C. Deaths in which an autopsy would allay concern or reassure the public or family regarding the death; and/or

D. Cases of unusual academic interest.

10.2-2 An autopsy may be performed only if authorized in accordance with law.

The persons who may consent to autopsies are identified in Chapter 11 of the CAHHS Consent Manual and in the Medical Staff Authorization of Autopsy policy

10.2-3 Except in coroner’s cases, all autopsies shall be performed by the hospital pathologist or his or her designee. Communication between the attending physician and the pathologist prior to performance of an autopsy is essential and it is the responsibility of the pathologist to notify the attending physician when an autopsy will be performed and when indicated, a “limited” autopsy should be considered to focus efforts on organ system questions. Autopsies of suspected infectious etiology will

be performed at the discretion of the pathologist in consultation with the attending physician. Provisional anatomic diagnoses shall be medically recorded on the medical record by the pathologist within forty-eight (48) hours after completion of the autopsy and the complete protocol should be made a part of the medical record within sixty (60) days.

10.3 Coroner's Cases

California Coroner's Statutes, as described in the Health and Safety Code 10250, and Government Code 27491, decrees that all certain deaths require the notification of the Medical Examiner Coroner. Physicians shall immediately notify the Coroner when he/she has knowledge of his/her patient's death if any of the below circumstances pertain:

10.3-1 Known or suspected homicide;

10.3-2 Known or suspected suicide;

10.3-3 Accident: Whether the primary cause or only contributory; whether the accident occurred immediately or at some remote time;

10.3-4 Injury: Whether the primary cause or only contributory; whether the injury occurred immediately or at some remote time;

10.3-5 Grounds to suspect that the death occurred in any degree from a criminal act of another;

10.3-6 No physician in attendance (no history of medical attendance);

10.3-7 Wherein the deceased has not been attended by a physician in the 20 days prior to death;

10.3-8 Wherein the physician is unable to state the cause of death (must be genuinely unable and not merely unwilling);

10.3-9 Poisoning (food, chemical, drug, therapeutic agents);

10.3-10 All deaths due to occupational disease or injury;

10.3-11 All deaths in operating rooms or following surgery or a major medical procedure;

10.3-12 All deaths where a patient has not fully recovered from an anesthetic, whether in surgery, recovery room, or elsewhere

10.3-13 All solitary deaths (unattended by physician, family member, or any other responsible person in the period preceding death);

10.3-14 All deaths in which the patient is comatose throughout the period of physician's attendance, whether in home or hospital;

10.3-15 All deaths of unidentified persons;

10.3-16 All deaths where the suspected cause of death is sudden infant death syndrome (SIDS);

10.3-17 All deaths in prisons, jails, or of persons under the control of a law enforcement agent;

10.3-18 All deaths of patients in state mental hospitals;

10.3-19 All deaths where there is no known next of kin;

10.3-20 All deaths caused by a known or suspected contagious disease constituting a public health hazard, to include AIDS;

10.3-21 All deaths due to acute alcoholism or drug addiction.

10.4 Notifying Next of Kin

The attending physician, or his/her representative, is responsible for notifying the next of kin in all cases of death.

10.5 Disposition of Remains and Contributions of Anatomical Gifts

10.5-1 The patient’s remains shall be disposed of in accordance with the instructions of the patient, the patient’s legal representative, or his/her next of kin. The order in which the next of kin shall be consulted is set forth in the CAHHS Consent Manual.

10.5-2 If the patient or his/her family indicates that the patient has or will contribute anatomical gifts, consent shall be secured in accordance with the relevant law, which is described in the CAHHS Consent Manual. The patient’s physician shall comply with hospital protocol for identifying potential organ and tissue donors, and, whenever possible, confer with the patient or family about donations.

10.6 Death Certificate

The attending physician or other physician last in attendance is responsible for signing the death certificate or ensuring its completion.

ARTICLE 11: DISCHARGE AND TRANSFER OF PATIENTS

11.1 General

11.1-1 Patients shall be discharged only on the written order of the attending physician or his/her designee. The attending physician shall see that the record is complete, state the final diagnosis and sign the medical record. Appropriate discharge instructions for care will be given to the patient or family using current hospital format and a copy is to be retained in the medical record.

11.1-2 Minors shall be discharged only to their parents or legal guardians or a person designated in writing by the parent or legal guardian, unless such parent or legal guardian shall direct otherwise in writing. This shall not preclude minors legally capable of contracting for medical care from assuming responsibility for himself/herself upon discharge. The Health Facility Minor Release Report of the CAHHS Consent Manual must be completed whenever a minor is discharged to anyone except a parent, relative by blood or marriage, or legal guardian.

11.1-3 The attending physician should inform Nursing Services of possible discharges as early as possible and enlist the aid of the Discharge Planning Coordinator when appropriate.

11.1-4 Transfer to Acute Care Facilities. Patients shall be transferred to another hospital or acute care health facility only by physician's order. The acute care transfer document shall be completed for all patients transferring from CHOMP to another hospital or acute care health facility. A completed copy of this document accompanies the patient to the receiving facility. The patient may not be transferred unless each of the requirements below is met:

A. Physician certifies that the patient has received a medical screening examination by a physician and is stabilized or, if not, that the patient has requested transfer, or that the patient has medical reason requiring transfer, and that the benefits of the transfer outweigh the risks of the transfer. The risks and benefits leading to the decision for transfer are discussed with the patient and/or responsible party and are documented;

B. The reason for the transfer is documented. Reasons for transfer include:

1. Specialized hospital services required (e.g., burns, high-risk pregnancies, neurological injuries, cardiac referrals, trauma care);

2. Absence of hospital beds;

3. Patient request (the patient must write and sign his/her reason for the request);

4. Prepaid health insurance (patient is stable and at no time has patient financial status prejudiced care at CHOMP); and/or

5. Patient without financial means (i.e., MIA status) (the patient is stable and at no time has patient financial status prejudiced care at CHOMP).

C. Patient understands reason for transfer and its risks and benefits and acknowledges and consents to transfer. If the patient cannot sign or a responsible person has not been reached after reasonable effort, the reasons for lack of consent are documented by the physician;

D. The receiving facility has available space and qualified personnel for the treatment of the patient;

E. A facility may not, based on the patient's financial status, refuse acceptance of a patient from the Emergency Department who requires emergency transfer for a higher level of care service. The patient may have health insurance which provides for medical services only in facilities authorized by the plan. When medically appropriate, the patient should be transferred to such a facility;

F. The receiving physician has agreed to accept transfer and to provide appropriate medical care;

G. The receiving facility is provided with appropriate medical records of the examination and treatment of the patient;

H. The patient has appropriate personnel, equipment, and mode of transportation.

The transferring procedure with specific guidelines is outlined in the following manuals: (a) Discharge Planning, (b) Family Birth Center/Nursery, (c) Intensive Care/Main Pavilion, and (d) Emergency Department.

11.1-5 Non-Acute Care Transfers

A. The Discharge/Transfer/Home Care document is completed for all patients to receive continuing care in a skilled nursing facility, residential care, or through a home care agency when acute level of care is no longer required. A completed copy of this document accompanies the patient to the facility or is sent to the home care agency.

B. A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital. The transfer summary shall include essential information relative to the patient's

diagnosis, hospital course, rehabilitation potential, known allergies, and treatment plan, and shall be signed by the physician

C. A copy of the transfer summary shall be given to the patient and the patient's legal representative, if any, prior to transfer to a skilled nursing unit or intermediate care facility.

11.1-6 Refusal of Treatment or Transfer

When a patient, after a medical screening examination/evaluation by a physician, refuses to be transferred to another medical facility for further treatment, the patient (or a person acting in the patient's behalf) shall be informed of the medical risks/benefits to the patient from such a transfer. If the patient (or person acting for the patient) still refuses the transfer, the informed refusal of the transfer shall be obtained in writing and placed in the medical record.

11.2 Leaving Against Medical Advice

11.2-1 If a patient indicated that he/she will leave the hospital without a discharge order from the attending physician, the nursing staff shall attempt to arrange for the patient to discuss his/her plan with the attending physician before the patient leaves.

11.2-2 Whenever possible, the attending physician shall discuss with the patient the implications of leaving the hospital against medical advice.

11.2-3 The patient who insists on leaving against medical advice shall be asked to sign the form entitled “Leaving Against Medical Advice.” If the patient cannot be located or refuses to sign the form, the nursing staff shall document in the patient’s medical record the facts surrounding the patient’s departure and a Risk Identification Report shall be submitted to the Hospital Risk Manager.

11.3 Refusal to Leave

Administration shall be contacted for assistance whenever a patient refuses to leave the hospital.

ARTICLE 12: WITHHOLDING OR WITHDRAWING MEDICAL CARE

12.1 General

Decisions to withhold or withdraw medical care are to be made by the patient or his/her surrogate decision-maker after discussions with the patient's attending physician. The attending physician is responsible for providing advice regarding when medical care should be withheld or withdrawn.

12.2 No CPR Orders and Partial No CPR Orders

12.2-1 A No Cardiopulmonary Resuscitation Orders (NO-CPR) means to stop the otherwise automatic initiation of cardiopulmonary resuscitation (CPR). Such an order may be proper when the patient has an underlying incurable medical condition, does not have any reasonably conceivable possibility of recovering or long-term survival, and there is no medical justification or purpose which would be achieved by applying CPR should the natural course of a patient's medical condition cause vital functions to fail.

12.2-2 CPR will be initiated when cardiac or respiratory arrest is recognized, unless a NO-CPR Order is given. No resuscitative measures will be taken if the Physician orders "NO-CPR," "No Code," "Do Not Resuscitate (or DNR)" or "Do Not Attempt Resuscitation (or DNAR)."

12.2-3 A partial NO-CPR or partial do not resuscitate order may be warranted. If a partial NO-CPR order is issued, the physician must specify precisely which modalities shall be used and which shall not.

12.3 Issuing the Order

All orders to withhold, limit, or withdraw life-sustaining treatment must be entered electronically or written and signed by a physician in the patient's medical record. If the order is a telephone order, two nurses must hear the order and document accordingly. Orders not to resuscitate should be reviewed whenever there is a significant change in the patient's clinical condition to assure the orders remain consistent with the patient's condition and desire.

ARTICLE 13: ORDERS FOR DRUGS, TREATMENT, AND DIAGNOSTIC TESTING

13.1 General

13.1-1 Drug orders may be given only by a person lawfully authorized and credentialed to prescribe the particular drug being ordered.

13.1-2 Drugs, treatment, and diagnostic testing orders may only be accepted from a licensed practitioner and the order the licensed practitioner gives must be within the licensed practitioner's scope of practice as defined by state law and within the scope of the practitioner's clinical privileges.

13.2 Drug Formulary

13.2-1 The hospital maintains a drug formulary and, to the extent possible, all drugs ordered for patients should be those listed in the formulary.

13.2-2 Drugs not contained in the drug formulary can be obtained by completing a non-formulary drug request. All non-formulary drug requests are reviewed in accordance with Pharmacy and Therapeutics Committee policy.

13.2-3 Any Medical Staff member may request a medication be added to the drug formulary by contacting the Director of Pharmacy or the Chairperson of the Pharmacy and Therapeutics Committee, who will initiate the evaluation process as outlined in the Drug Formulary System Work Group Policy.

13.3 Experimental or Investigational Drugs

13.3-1 Drugs under experimental or clinical investigation may be used within the hospital under the following circumstances:

A. Experimental or investigational drugs shall be used only under the direct supervision of the Principal Investigator, who shall be a member of the Medical Staff;

B. The written protocol, all written materials presented to the patient, and the informed consent for the experimental or investigational drug shall be reviewed and approved by the Institutional Review Board (IRB) prior to the drug being administered within the hospital;

C. Emergency use of an experimental or investigation drug or device may be approved for single patient use in accordance with Medical Staff Institutional Review Board policy. Federal regulations require the conditions for emergency use be met. These conditions include: the emergency is life threatening, no standard acceptable treatment is available, there is not sufficient time to obtain full IRB approval and the drug or device must have a FDA approved IND for the condition. The IRB Chairperson must be contacted and approve the emergency use of a non-approved drug or device.

13.4 Acceptable Medication Orders

13.4-1 All orders for drugs, treatment and diagnostic testing orders shall be entered electronically or in writing on the patient’s order sheet, signed and dated by the physician. Drugs/medication orders shall also be timed.

13.4-2 A complete medication order will include: patient name, drug name, dosage form, strength, and concentration (if applicable), dose, frequency, route and duration (if applicable).

13.4-3 When medications are to be given on an as needed or PRN basis, the medication order must specify why, and when the medication is to be administered based on the specific clinical findings of the patient.

Example: PRN analgesics must specify if they are being prescribed for fever (temp greater than 100) or pain (mild, moderate or severe).

13.4-4 Medication orders will contain only one variable in the route or dosage portion of the order. Variable dosage strengths will not exceed a two-fold range. (Example of an acceptable order: Morphine Sulfate 2-4 mg IV every 4 hours as needed for severe pain). For variable orders, the healthcare provider for the patient will determine the dose or frequency of administration based on the current clinical condition of the patient.

13.4-5 Orders to place a medication on hold can only be done within a specified timeframe (e.g. 6 P.M. dose, today's dose). An unspecified time hold order will be considered discontinued; it must be re-ordered to be re- started.

13.4-6 Medication orders that are unclear, illegible, or incomplete will not be carried out until re-written and understood by administering practitioner.

13.5 Review of Drugs and Automatic Stop Orders

13.5-1 Each physician is expected to review all medications for all patients regularly to ensure discontinuation of all orders that are no longer needed.

13.5-2 The Pharmacy and Therapeutics Committee shall establish a list of medications eligible for automatic stop orders and for the duration of administration. All other medications shall have an automatic stop order at thirty-two (32) days. The practitioner shall be notified before the stop order becomes effective. Medications must be reordered to be renewed. "Resume medications" is not an acceptable order.

13.5-3 An automatic stop order does not apply when the prescriber specifies the number of doses or an exact and reasonable period of time.

13.5-4 Orders for medications and treatments that were active prior to surgery must be reconciled post-operatively. Orders that are deemed appropriate by treating physician remain active.

13.6 Procurement of Drugs

13.6-1 All drugs shall be procured from the hospital pharmacy except as specified in this section.

13.6-2. Admitted patients may not use their own medications during their hospital stay. All drugs and medications brought to the hospital by patients will be turned over for safekeeping, in accordance with hospital policy, to the pharmacy staff.

13.6-2 In the event the Pharmacy Department cannot provide a particular medication, the patient's own medication may be used if all of the following conditions are met:

A. The drugs have been ordered by a practitioner legally authorized to do so and the order has been entered into the patient's record;

B. The medication containers are clearly and properly labeled; and

C. The contents of the containers have been examined, positively identified, and integrity confirmed after the patient's arrival at the hospital, by the pharmacist.

13.6-3 Practitioners may order medications to be left at the patient's bedside for self-administration. These drugs are limited to antacids, topicals, ophthalmic preparations and inhalants. Use of these medications must be reported to the nurse and documented in the medical record.

13.7 Substitution of Generic Drugs

Generic drugs may be dispensed unless ordered otherwise.

13.8 Verbal Orders

13.8-1 Verbal orders for patient care are defined as those orders that are oral, spoken communications, transmitted face-to-face, by telephone or by other auditory device.

13.8-2 Verbal orders can be given in emergency situations or situations when the physician is physically unable to write or electronically enter the orders.

13.8-3 A verbal order shall be entered electronically or considered to be in writing if dictated to a Registered Nurse, Licensed Vocational Nurse, Respiratory Therapist, Occupational Therapist, Physical Therapist, Speech Therapist, Registered Dietitian, Registered Pharmacist, Licensed Psychiatric Technician, Laboratory Technician, Phlebotomist (for outpatients only), Sonographer, or Licensed X-ray Technician functioning within the practitioner's scope of licensure and competence. All verbal orders or orders dictated over the telephone shall be electronically or manually signed, timed and dated by the appropriate authorized person to whom the order was given. The name of the practitioner from whom the order was taken shall also be recorded in the record.

Verbal medication orders can only be given to a Registered Nurse, Registered Pharmacist, Licensed Vocational Nurse, Respiratory Therapist and Licensed Psychiatric Technician within the scope of their practice.

13.8-4 All verbal orders and telephone orders must be dated, timed, and authenticated within forty-eight (48) hours of the order by the practitioner who has given the order or who has responsibility for evaluating the patient's care.

13.8-5 All verbal orders and critical test results shall be verified by "read-back" to assure accurate communication.

13.8-6 Verbal orders will not be accepted for antineoplastic agents or investigational drugs.

13.9 Pre-Printed Orders

13.9-1 Pre-printed orders may be used for specified patients when authorized by a person licensed to prescribe. A copy of pre-printed orders for a specific patient must be promptly signed, dated and timed by the prescriber, and included in the patient's medical record. These pre-printed orders must:

A. Contain acceptable medication orders as per Section 13.2;

B. Specify the types of the medical conditions to which the standing orders are intended to apply;

C. Be initially approved and reviewed periodically by the appropriate Medical Staff Committee(s); and

D. Take into consideration the unique clinical situation of the individual patient for whom the standing orders are written.

13.10 Legibility

The practitioner's orders must be written clearly, legibly, and completely. Orders that are unclear, illegible or incomplete will not be carried out until rewritten or understood by the nurses.

ARTICLE 14: PROCTORING

14.1 All Medical Staff members and practitioners initially granted privileges or practice prerogatives shall complete a period of proctoring. Physicians granted temporary privileges and members requesting new or additional privileges may also be proctored at the discretion of the Chief of Staff and/or Medical Executive Committee. Proctoring requirements may also be imposed whenever the Medical Executive Committee determines that additional information is needed to assess a practitioner's performance.

14.2 Proctoring shall be carried out according to the current Medical Staff Bylaws, Proctoring Policies and Procedures and in compliance with accreditation, Federal and State law.

14.3 Failure of a practitioner to satisfy proctoring requirements based solely on the failure to perform the required number of proctored cases is considered a failure to meet a predetermined quantitative standard established by the Medical Staff which the practitioner has voluntarily agreed to meet as a condition of clinical privilege and/or Medical Staff membership. In this circumstance, the loss of privilege and/or the loss of Medical Staff membership shall not be considered an adverse action based on the medical disciplinary cause or reason and shall not be reportable under state or federal regulations, and the practitioner so affected shall have no right to a hearing.

ARTICLE 15: PROFESSIONAL LIABILITY INSURANCE

15.1 Each Medical Staff member is required, as a condition of membership, to obtain and maintain professional liability insurance in the minimum amounts of coverage of $1,000,000 per occurrence and $3,000,000 aggregate unless exception is made by the Medical Executive Committee upon written request of the physician.

15.2 Failure to maintain the minimum level of professional liability insurance is deemed voluntary resignation of the Medical Staff. A practitioner whose membership is terminated by reason of failure to maintain professional liability insurance will not have the rights of appeal.

15.3 The insurance will be with an insurance carrier admitted to market insurance in the State of California, or a physician mutual cooperative trust, operated in compliance with California law as outlined in the Medical Staff Bylaws.

15.4 The insurance must apply to all patients the physician treats and to all procedures the physician has privileges to perform in the hospital.

ARTICLE 16: MEDICAL STAFF ROLE IN DISASTER PREPAREDNESS

16.1 The plan for care of mass casualties shall be rehearsed at least semi-annually by key Medical Staff and hospital personnel.

16.2 It shall be the responsibility of the Safety and Risk Management Committee of the Medical Staff to prepare and keep updated plans for disasters within and outside of the hospital. In the event of such a disaster or preparatory drill, all Medical Staff members shall report to their assigned stations. No Medical Staff member shall perform any duties other than those assigned. The Incident Commander, as assigned by Hospital Emergency Incident Command System (HEICS) protocol, coordinates the disaster response. During a disaster, all Medical Staff members specifically agree to relinquish direction of the professional care of their patients, as it relates to triage and resource utilization, to the Medical Care and Medical Staff Director of the incident command structure.

ARTICLE 17: OTHER REQUIREMENTS

17.1 Clinical Privileges

The Medical Staff Services Department shall provide a current electronic file of all medical staff members' clinical privileges. This file shall be available for review by hospital staff to assure practitioners are appropriately exercising their clinical privileges.

17.2 California Health & Safety Code Requirement for Radiology

All practitioners actuating an X-ray generator or influencing radiating dose to patients while participating in the use of fluoroscopy, i.e., conventional unit or C-arm, are required to become certified by the California Department of Health Services as an X-ray supervisor and operator. The State of California requires that a current copy of the license be kept in the practitioner's credential file. Failure to maintain a licensure as a supervisor and operator is deemed a voluntary resignation of the privilege to operate an X-Ray generator. A practitioner whose privilege is terminated by reason of failure to maintain licensure as a supervisor and operator will not have the rights of appeal.

17.3 Services Performed by Sources Outside the Hospital

Sources outside the hospital that perform diagnostic tests for the hospital must be approved by the Medical Staff and meet the Joint Commission, CMS, and hospital standards. Diagnostic test results obtained from sources outside the hospital will be included in the hospital records. An outside ECG is acceptable in lieu of in-house ECG if the quality is good, it is within time guidelines, and it is properly identified and read by an interpreter who is a practitioner privileged by the Medical Staff to read ECGs.

17.4 Review of Medical Staff Credential Files by the Hospital's Insurance Carrier

The purpose of the review by the hospital's insurance carrier is according to the requirements set forth by state and federal agencies and the Joint Commission. Requests to examine any Medical Staff credential file by the hospital's insurance carrier may be granted contingent upon the review being done in the presence of the Vice President Medical Affairs or any other member of the Medical Staff appointed by the Chief of Staff. Inspection of credential files is limited to licensure, liability insurance, and privileges. The reviewer shall not be informed of the identity of the practitioner whose file is reviewed. Copies may not be made nor may notes regarding these files be taken.

17.5 Board Eligible Periods and Transition Dates for ABMS Member Boards

See Addendum 1.

ADDENDUM 1: BOARD ELIGIBLE PERIODS AND TRANSITION DATES

American Board of Medical Specialties
Higher standards. Better care.®

American Board of Medical Specialties
Chicago, IL
(312) 436-2600 abms.org

BOARD ELIGIBLE PERIODS AND TRANSITION DATES				
American Board of	SPECIALTIES		SUBSPECIALTIES	
	Board Eligible Period *(+practice requirement)*	Transition Date	Board Eligible Period *(+practice requirement)*	Transition Date
Allergy and Immunology	5 years	*	*No subspecialties*	
Anesthesiology	7 years	*	7 years	*
Colon and Rectal Surgery	7 years[1]	12/31/2023	*No subspecialties*	
Dermatology	5 years	*	5 years	*
Emergency Medicine	5 years	12/31/2019	7 years	*
Family Medicine	7 years	*	7 years	*
Internal Medicine	7 years	12/31/2019	7 years	*
Medical Genetics and Genomics	7 years	*	7 years	*
Neurological Surgery	6-7 years[2]	*		1/1/2025
Nuclear Medicine	7 years	*	*No subspecialties*	
Obstetrics and Gynecology	7 (+1) years	*	8 years	1/1/2020
Ophthalmology	7 years	*	*No subspecialties*	
Orthopaedic Surgery	5 years[3]	*	7 (+2) years[4]	*
Otolaryngology – Head and Neck Surgery	5 years	*		1/1/2025
Pathology	5 years	*	7 years[5]	*
Pediatrics	7 years[6]	*	7 years	*
Physical Medicine and Rehabilitation	7 years	12/31/2019	7 years	12/31/2020
Plastic Surgery	7 (+1) years	*	7 (+2) years[7]	*
Preventive Medicine	7 years	*	7 years	*
Psychiatry and Neurology	7 years	*	7 years	*
Radiology	6 years	*	10 years	1/1/2025
Surgery	7 years	7/1/2022		1/1/2025
Thoracic Surgery	7 years[8]	*	7 years[9]	*
Urology	6 years	*	6 years[10]	*

*The Member Board either had a policy in place prior to the effective date of the ABMS policy, or the transition date has passed.

[1] Colon and Rectal Surgery requires candidates to pass the written examination given by the American Board of Surgery. Candidates have 7 years to complete both the traditional and oral examinations after application approval.

[2] Neurological Surgery candidates completing residency training on or after 6/30/2011, but before 6/30/2017 must submit a completed application no later than 4 years after completing residency training. Those completing training on or after 6/30/2017 must submit no later than 3 years.

[3] Orthopaedic Surgery candidates have 5 years to achieve certification after passing the traditional examination.

[4] Orthopaedic Surgery allows a maximum of 9 years to complete certification in Surgery of the Hand. This policy also applies to Sports Medicine, pending review by the board.

[5] Pathology eligibility period starts from the completion of subspecialty training or primary certification, whichever is later.

[6] The board eligible period for Pediatrics is 7 years for those completing training in 2007 or later. For those completing training before 2017, the transition period ended on 12/31/2013.

[7] Plastic Surgery allows a maximum of 7 years to complete certification after application, except for Surgery of the Hand which is 9 years.

[8] Thoracic Surgery will accept a Vascular Surgery residency in lieu of a General Surgery residency as along as the Vascular Surgery training leads to primary certification by the American Board of Surgery.

[9] Thoracic Surgery requires diplomates to apply within 1 year of completing training.

[10] Urology allows a maximum of 3 years to complete certification after application.

Questions? Contact Gina Parentino, ABMS Business Development Support Manager, at (312) 436-2687 or gparentino@abms.org