John C. Lincoln
Deer Valley Hospital

GENERAL MEDICAL STAFF RULES AND REGULATIONS
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John C. Lincoln Deer Valley Hospital
GENERAL MEDICAL STAFF RULES AND REGULATIONS

1.0 RESPONSIBILITY

1.1 General

The overall responsibility for the quality of medical care rests with the Medical Staff. Therefore, the individual staff member is held accountable for the timing, efficiency, quality, and appropriateness of care rendered to patients. As a requirement to protect and support this commitment to optimal patient care, the attending physician is responsible to insure that appropriate arrangements are established with other members of the Medical Staff to provide medical treatment to patients in those instances in which the primary physician is unavailable.

Staff applicants and members must provide the names of covering practitioners on appointment and reappointment. Covering practitioners must be staff members with similar privileges.

1.2 Consideration for Suicidal Patients

For the protection of patients, the medical and nursing staff, and the Hospital, certain principles will be met in the care of the potentially suicidal patient. Any patient known or suspected to be suicidal in intent shall be cared for according to established suicide precautions. **(Hospital Standards Policy P-448).**

1.3 Consideration for Suspected Abuse/Neglect of Patients

Any known or suspected patient abuse/neglect shall be cared for according to established criteria. **(Hospital Standards Policy P-300 & 303)**

1.4 Transfer of Patient Care

If a physician's services are terminated by the patient or the physician, the physician will retain responsibility for the patient's care until another physician has been contacted and personally discussed the case, and both have accepted the transfer. This transfer must be documented in the patient's medical record.

If the patient is incapable of finding a new physician, the Department Chairman will be notified and will make appropriate arrangements for a physician for the patient. In the event the Chairman of the Department is the one being terminated, it will be the responsibility of the Chief of Staff or his designee.

2.0 ADMISSIONS, DISCHARGES, AND DEATHS

2.1 Admissions

Patients may be admitted to the Hospital only on authorization of members of the Medical Staff who have been granted admission privileges.

Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. Upon admission to the hospital, the provisional diagnosis will be recorded in the medical record.

Patients suffering from all types of medical problems may be admitted to the Hospital, provided proper facilities and personnel are available to handle such patients. In those instances in which transfer to another facility is warranted, the physician and administration will make appropriate arrangements.

Patients with communicable disease, identifiable or suspect, shall be treated under proper universal precautions for the protection of other patients and hospital staff.

Patients admitted to the hospital by a podiatrist or a dentist must be medically managed by a qualified member of the medical staff (DO or MD) who has been granted such privileges.

2.2 Indigent Care

All patients determined to be indigent shall be attended by members of the Medical Staff and shall be assigned to the service concerned in the treatment of the disease, which necessitated the admission. Private patients shall be attended by their own private physicians, provided such physicians have privileges at the Hospital. Patients admitted under emergency conditions that have no attending physician should be admitted and treated by the physician on-call for the Emergency Department at the time and assigned to the proper service.

2.3 CCU

Patients shall be considered appropriate for admission to the CCU when the conditions are life threatening, require advanced technological and/or pharmacological treatment modalities or intensive nursing care. Any physician on staff of the hospital may admit a patient to the CCU.

2.4 Discharges

Patients shall be discharged only on the order of attending physician or his/her designee. Should a patient leave the Hospital against medical advice, a notation of the incident shall be made in the patient's medical record.

2.5 Deaths

In the event a patient dies in the Hospital, pronouncement of death shall be made by the attending practitioner within a reasonable time. When a patient is assessed to be without signs of life, a RN may make a pronouncement of death when the following conditions are present:

1) A physician’s written order withholding all cardiopulmonary resuscitation is present in the patient’s record
2) The patient is not a known or potential organ/tissue donor (excluding corneas and skin)
3) The patient’s attending physician is willing to sign the death certificate
4) The patient does not meet any criteria for referral to the Medical Examiner

Upon receipt of the registered nurse’s assessment of the patient status, the attending physician may accept the RN’s assessment or may make arrangements for an alternate physician to pronounce the death.

Care of patients after they have expired will follow **Patient Care Standards Policy 14.17.0.71.**

In all cases in which any doubt exists regarding legal status of death, the Medical Examiner shall be notified.

It shall be the duty of all Medical Staff members to be actively interested in securing autopsies in any of the following events:

1) Unexplained death
2) Unexpected death
3) Post surgical death
4) Deaths occurring in patients who have participated in clinical trials (protocols) approved by the Institutional Review Board

In all cases, the attending physician shall offer the family the option of autopsy at their request. Requests for autopsies and/or denial shall be documented in the patients medical record. In other than Medical Examiner's cases, an autopsy may be performed only with a written consent, signed in accordance with state law. All non-Medical Examiner's case autopsies shall be performed by the Hospital pathologist. Provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours and the complete protocol should be made part of the patient's medical record within sixty (60) days. **See Patient Care Standards Policy Death/Autopsy 14.17.0.70.**

2.5.1 Universal Donors

In accordance with the Uniform Anatomical Gift Act, the attending practitioner or designee shall follow the established Medical Staff and administrative protocol to discuss with appropriate patients or their legal next-of-kin their desire to donate organs and/or tissues for transplantation.

3.0 MEDICAL RECORDS

3.1 Requirements for a Complete Medical Record:

- All entries must be signed, **timed** and dated.
- A medical record shall be maintained for each individual who is evaluated or treated in the Hospital. This includes inpatient, outpatient or emergency service patients. The attending physician shall be responsible for each patient's medical record. Only authorized individuals shall make entries in the medical record.

3.1.1 Comprehensive History & Physical

A durable, legible, original or reproduction of a comprehensive history and physical examination must be completed no more than 30 days before or 24 hours after admission and prior to surgery. This includes inpatients, observation patients or any patient undergoing an outpatient or inpatient surgical procedure or an invasive procedure. When a medical history & physical is completed within 30 days of admission, an updated medical history and physical examination is completed and documented within 24 hours of admission and prior to surgery. The documentation indicates an examination was completed to determine any changes in the patient's condition since the original medical history and physical.

3.1.2 Consultation Reports

Each consultation report shall contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and a review of the patient's medical record. Consultations must be completed at least daily, and within 12 hours if the patient is in the CCU. A qualified PA or NP may provide the preliminary consultation. The consultation note must be co-signed, dated and timed by the sponsoring physician within 24 hours.

3.1.3 Progress Notes (Clinical Observations)

Patients will be seen and a progress note to be written daily for all inpatients by the attending physician at 24-hour intervals and no less than daily. Consultants that are participating in the care of a patient need to write progress notes at 24 hour intervals unless documented otherwise in the progress note.

3.1.4 Countersigning

Countersigning by a sponsoring and/or supervising physician is required for any order or progress note written by a first year resident. Countersignature by a sponsoring and/or supervising physician is required for history & physicals, procedures and discharge summaries prepared by a resident (regardless of post-graduate level.)

3.1.5 Informed Consent

Written consents are required prior to the initiation of the procedure or therapy, except in an emergency. The consent should have documentation verifying that the physician discussed all possible alternatives and complications with the patient. The consent must be signed, dated and timed prior to the start of the procedure.

3.1.6 Verbal Orders

Licensed nurses may take verbal or telephone orders. Individuals designated and approved by the Medical Staff may take telephone and verbal orders. It is the responsibility of the ordering physician to review, date, time and sign such orders within 48 hours.

3.1.7 Operative Reports

A progress note must be completed on all patients immediately following an operative procedure. A dictated operative report must be completed within 24 hours of the procedure.

3.1.8 Pre-Anesthesia Evaluation

There will be a pre-anesthesia evaluation on each patient for whom anesthesia is contemplated.

3.1.9 Post-Anesthesia Evaluation

All patients are evaluated on admission to the post-anesthesia care unit and within 48 hours of the surgical procedure. All patients are evaluated prior to discharge from the post-anesthesia recovery area by the individual performing the post-anesthesia evaluation based on approved criteria.

3.1.10 Discharge Summary

A discharge summary shall be completed immediately or no longer than 5 days following the date of discharge. A final progress note may be substituted for the discharge summary for uncomplicated stays less than 48 hours. I the event of death, the Death Summary is also required to include the events leading to death.

3.2 The Hospital provides transcription services for inpatient, outpatient, and emergency service medical records. Use of a personal office dictation system is limited to History and Physical dictation only. All other records must be dictated utilizing the Hospitals in-house dictation system.

3.3 The inpatient record shall include the following when appropriate:

(1) Identification data
(2) Emergency care provided prior to arrival
(3) Chief medical complaint(s)

(4) Evidence of Advanced Directives
(5) Withdrawal/Withholding of Life Support
(6) Evidence of appropriate informed consent
(7) Relevant personal medical history
(8) Relevant family medical history
(9) Prenatal information in obstetrical records
(10) History of present illness
(11) Comprehensive physical examination findings/musculo-skeletal exam
(12) Diagnostic reports, medical and/or surgical treatment, pathological findings (if applicable)
(13) Pertinent progress notes and observations, regarding patient's condition and response to therapy, final diagnosis, condition on discharge or applicable autopsy report.
(14) Adequate instructions shall be given to each patient and/or family at the time of discharge, and summarized in a discharge note and/or discharge summary or included on the patient discharge instruction sheet.

3.4 Emergency Department, Observation patient, and Outpatient records shall include the following when appropriate:

(1) Patient identification
(2) Evidence of informed consent
(3) Information regarding time, means and method of transport
(4) Pertinent treatment prior to presentation
(5) Chief complaint
(6) History of illness or injury, physical exam as appropriate to present illness
(7) Clinical observations, laboratory and radiological findings
(8) Diagnostic and therapeutic orders
(9) Treatment rendered
(10) Discharge instructions
(11) Condition of patient on discharge
(12) Information concerning patient leaving "against medical advice"

3.5 Outpatient Surgery, Cath Lab and Endoscopy records will contain at least the following:

(1) Pre-operative: History of the illness or injury, including physical findings, treatment modalities, current levels of disability, and/or other indications for surgical intervention; surgical and anesthetic history, allergies and current medications; physical examination appropriate to the patient's health status; anesthetic risk, and type of procedure(s); and preoperative diagnosis.
    1. A durable, legible comprehensive history and physical examination shall be on the chart prior to surgery. A durable legible, original or reproduction of a comprehensive history and physical examination is acceptable when completed no more than thirty (30) days prior to the surgical procedure if the patient's condition has not changed.
    2. A short form History & Physical is an acceptable alternate to a comprehensive, dictated or office history and physical. Additionally the short form H&P shall be required:
        - If there is not enough time for the dictated H&P to be included on the chart;
        - An office H&P over 30 days can be included to supplement the short form H&P.

Patients admitted for podiatric surgery must have a history and physical performed by a qualified physician.

(2) Post-operative: Immediately following surgery, a description of the techniques and findings; postoperative diagnosis; and discharge instructions.

3.6 Access to Medical Records

All physicians involved in the care of a particular patient shall have access to that patient's medical record. Records will also be available to Medical Staff members who are authorized for peer review, and other legally required reviews.

Original medical records may be removed from the Hospital only in accordance with a court order, federal or state statute, or for microfilming of patient records.

3.7 Abbreviations

Only those abbreviations approved by the Medical Staff may be used in the medical record. A list of unacceptable abbreviations is posted on each patient care unit.

3.8 Authentication

Signatures must be legible, include notation of credentials, be timed and dated.

A physician PIN number determined by the Health Information Department that uniquely identifies each physician is acceptable in lieu of a signature for signing documents electronically.

3.9 Correction of Errors

To correct an error in the medical record, the practitioner must line through the incorrect information, write "error", his/her name and date. Write in the correct information. The incorrect information should not be obliterated.

3.10 History and Physical Examination Report

A comprehensive history and physical examination must be completed no **more** than 30 days before or 24 hours after admission by a physician or qualified oral/maxillofacial surgeon. The History & Physical must be placed in the medical record within 24 hours after admission and prior to surgery. This includes inpatients, observation patients, and any patient undergoing an outpatient or inpatient surgical procedure or invasive procedure. The H&P must be filed in the patient's chart prior to any invasive or surgical procedure. In emergency situations, when a delay may constitute a danger to the health and safety of the patient, and there is inadequate time to record the history and physical examination before surgery, a progress note may be written by the attending surgeon with date given, to include the preoperative diagnosis, description of any known drug allergies and other clinical findings pertinent to the safety of the patient during surgery. When a medical history & physical is completed within 30 days of admission, an updated medical history and physical examination is completed and documented within 24 hours of admission and prior to surgery. The documentation indicates an examination was completed to determine any changes in the patient's condition since the original medical history and physical. The interval note shall include that (a) the H&P is still current; (b) an appropriate assessment was completed on admission confirming that the necessity for the procedure or care is still present; and (c) any changes to the patient's condition since the H&P was originally completed have been documented.

The attending physician of record is responsible for completion of the history and physical examination. The attending physician may accept a comprehensive H&P examination report prepared by a consultant, nurse practitioner, physician assistant or the patient's primary care physician. A history and physical examination report prepared by a consultant, nurse practitioner, physician assistant or primary care physician should either be dated and countersigned by the attending physician or a progress note written by the attending physician noting his or her acceptance. If a resident has performed a comprehensive history and physical examination, it shall be countersigned by the attending physician. If an emergency room physician has performed a comprehensive history and physical examination, it will suffice for an inpatient history and physical examination for the first twenty-four hours of a patient's stay.

3.10.1 Elements of a Comprehensive Adult History & Physical Examination

The following elements must be included:

1) Chief complaint
2) Presenting Illness: details of the present illness with relevant assessment of the patient's emotional, behavioral and social status.
3) Past History:
   Prior major illnesses and injuries;
   Prior operations;
   Prior hospitalizations;
   Age appropriate immunization status; and
   Age appropriate feeding/dietary status.
4) Current medications
5) Allergies: (e.g., drugs, food, iodine)
6) Social History: An age appropriate review of past and current activities that includes significant information about:
   Marital status and/or living arrangements;
   Current employment;
   Occupational history;
   Use of drugs, alcohol and tobacco;
   Level of education;
   Sexual history; and
   Other relevant social factors
7) Review of Systems: An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms, which the patient may be experiencing or has experienced.
   Constitutional symptoms (fever, weight loss, etc);
   Eyes, Ears, Nose, Mouth, Throat;
   Cardiovascular;
   Respiratory;
   Gastrointestinal;
   Genitourinary;
   Musculoskeletal;
   Integumentary (skin and/or breast);
   Neurological;
   Psychiatric;
   Endocrine;
   Hematologic/Lymphatic; and
   Allergic/Immunology
8) Comprehensive Physical Examination

9) Conclusion or Impression
10) Plan of action

3.10.2 Elements of a Comprehensive Pediatric History & Physical Examination

Additionally, for children and adolescents, the following is documented, as appropriate:

1) evaluation of developmental age
2) educational needs and daily activities
3) immunization status
4) family's expectations and involvement in the care of the patient

3.10.3 Interval Physical Examination Report

Readmission within thirty (30) days for the same or related diagnosis will require only an interval physical examination report, reflecting any subsequent changes, provided the original history and physical is readily available in the medical record of the patient's previous admission.

3.11 Consultation Reports

The attending practitioner is primarily responsible for calling for a consultation from a qualified member when indicated or required. Direct physician to physician communication is encouraged for all consultations. The request for consultation must include an indication and an **expectation** for the consultation.

Each consultation report shall contain a written opinion by a physician consultant that reflects, when appropriate, an actual examination of the patient and a review of the patient's medical record. Consultations must be completed within (24) hours with subsequent daily follow up by the consultant(s) or his/her designee(s) during the course of his/her specialty treatment. Exceptions will be documented in the patient's medical record. In the case of urgent or emergent consultations, the attending physician should document the extent of the verbal or written communications with the consulting physician. An emergent situation occurs when a patient requires immediate treatment and a delay may constitute a danger to the health and safety of a patient. An urgent situation occurs when a patient's condition may become significantly altered if not treated.

Specific instances in which consultations are required may be outlined in the individual Medical Staff Clinical Department Rules and Regulations. In general, a consultation may be appropriate under the following circumstances:

(1) When the patient is not a good risk for medical or surgical treatment
(2) When the diagnosis is obscure
(3) When there is doubt as to the best therapeutic measure to be utilized
(4) As required by State statute, when a patient attempts suicide, over-doses on drugs, or exhibits suicidal tendencies (behavioral consul-tation)
(5) Upon request of the attending physician, family or patient
(6) Whenever it appears that the quality of medical service may be enhanced.

A qualified Physician Assistant or Nurse Practitioner member of the Allied Health Professional Staff may provide preliminary consultation whereby the PA or NP comes in to see the patient to begin to gather data prior to the consultant seeing the patient. A complete consultation includes examination of the patient by the

consultant. The PA or NP may dictate a consultation report; provided, however, that it must be co-signed, dated and timed by the sponsoring physician within 24 hours.

3.11.1 CCU Consultations

For patients admitted to the CCU, a physician consultant must see the patient within 12 hours, unless the patient was seen in the office prior to admission. The consultant or his/her designee will see the patient daily during the course of his/her specialty treatment. Exceptions will be documented in the patient's medical record. The attending physician shall request appropriate specialist consultations on all critically ill patients and all patients in the CCU. Except in emergencies, consultations are required on critically ill patients, patients who are poor surgical risk and those who diagnoses are difficult or obscure. The physician responsible for the patient must be competent to diagnose and manage actual disease processes or immediately obtain appropriate consultations CCU Admission, Transfer, and Discharge Criteria shall be approved by the Executive Committee of the Medical Staff and shall be in accordance with **Patient Care Standards Policy #14.40.0.4.**

3.12 Clinical Observations (Progress Notes)

Patients will be seen and a progress note will be written, dated, timed and signed daily for all inpatients by the attending physician at 24-hour intervals and no less than daily. Additional progress notes will be written as frequently as the patient's condition warrants and should give a pertinent chronological report of the patient's course, reflect any change in condition, and describe the results of treatment. Progress notes are to be written only by those authorized by the Medical Staff. Progress notes by House Staff or Allied Health Staff may not substitute for a written daily note by the attending physician. All progress notes must be timed and dated.

3.13 Discharge Summary

A discharge summary shall be completed immediately or no longer than five (5) days following the date of discharge to ensure appropriate follow-up care of the patient, along with accurate and appropriate coding of the medical record sufficient for Hospital billing requirements.

The attending physician is responsible for completing a discharge summary, which concisely recapitulates the reason for hospitalization, the significant findings, the procedures performed, the treatment rendered, final diagnosis, and the condition of the patient on discharge.

Any specific instructions given to the patient and/or family will be referenced on the Patient Discharge Instruction sheet.

A final progress note, which contains the above elements, may be substituted for the discharge summary for uncomplicated stays of under 48 hours.

In the event of death, the Death Summary is also required to include the events leading to death.

A Transfer Summary will accompany all patients upon transfer regardless of the type of facility to which the patient is transferred.

3.14 Medications

3.14.1 Administration

All medications administered to Hospital patients will be supplied by the Hospitals Department of Pharmacy Services unless otherwise defined by policy or by pharmacy approval. The Department of Pharmacy Services maintains a formulary as authorized by the P&T Committee. The formulary is an established compendium of approved medications available for diagnostic, prophylactic, therapeutic or empiric treatment of patients. Medications ordered by trade name may not necessarily be filled by that name unless the physician states "do not substitute" on the order. The pharmacy will be permitted to make therapeutic substitutions of medications only within clearly defined parameters established by the P&T Committee.

Medications brought into the Hospital by patients must be specifically ordered by the attending physician and identified according to approved pharmacy policy before being administered by Hospital personnel. These medications will be kept at the nursing unit. Medications brought in by the patient which cannot be identified will not be administered to the patient by Hospital personnel and should not be taken by the patient.

3.14.2 Medication Orders

Orders for medications must be written clearly and accurately, including date, time and signature. All orders for medications must be complete including medication name, dosage form, dose, strength, route (if medications can be administered by more than one route), frequency, rate, method, and site of administration. Medications ordered as "PRN" should specify frequency and indication. The use of abbreviations should be minimized and only standard abbreviations on the Hospital's approved list can be used. Medication dosages should be expressed in the metric system and the use of unnecessary decimal points or zeros after a decimal point should be avoided. A zero should be placed in front of a leading decimal point.

Home medications are reconciled on the Admit Medication Reconciliation Order Form. The attending physician must indicate which home medications should be continued while the patient is in the Hospital. The physician may restart a patient's home medication(s) only as prescribed on the Admit Medication Reconciliation Physician Order Form or by writing a complete medication order on a physician order form – "resume home medications" is not an acceptable order. The attending physician must indicate on the Admit Medication Reconciliation Form or in the medication order the medication name, dosage form, dose, strength, route (if medications can be administered by more than one route), frequency, rate, method, and site of administration.

3.14.3 Post Operative/Post Procedure Medication Orders.

The physician must designate on the Medication Reconciliation Order Form or on a physician order which medications the patient should be continued on post operatively. "Resume pre-op medications" is not an acceptable order.

3.14.4 Medication Stop Orders

Unless the medication order indicates the exact number of doses to be administered or an exact period of time for the medication is specified, the physician will be contacted regarding the need to reorder the medications.

3.14.5 Authorization to Administer Medications

Only appropriately licensed personnel or approved personnel working under the direction of a licensed practitioner may be allowed to administer medications. (Administration of medications will be in response to an order by an authorized individual, as set forth above) The following categories of personnel may administer medications at the Hospital under the order of a qualified practitioner:

1) Physician, House Staff, Physician Assistants
2) Registered Nurses, Licensed Practical Nurses, Nurse Practitioners, Certified Registered Nurse Anesthetists and Clinical Perfusionists. Administration of chemotherapeutic agents can only be performed by nurses trained in chemotherapy
3) Respiratory Care Practitioners (medications related to respiratory therapy treatments only)
4) Licensed Imaging Technologists (medications related to radiology/nuclear procedures only)
5) Physical Therapists (topical medications only)
6) Student nurse, under supervision of an RN or a licensed medical practitioner
7) Medical students under supervision of a licensed medical practitioner

3.15 Orders

3.15.1 General Requirements

All orders must be written only within the authority of clinical privileges granted to the practitioner giving the orders. All orders must be legible, dated and timed. Orders for diagnostic and therapeutic tests must include sufficient detail to facilitate interpreters review.

3.15.2 Outpatient Orders

All orders for diagnostic and therapeutic tests on outpatients shall be carried out only upon receipt of an order from a physician or a qualified Allied Health Professional with the designation of a sponsoring physician to whom the results will be sent.

At the discretion of the Hospital radiologist, orders for procedures which require invasive methods will be accepted from non-staff physicians who have made special arrangements with the Hospital's physician staff who has agreed to be responsible for dealing with any complications that may occur during or after the procedure. Examinations that are non-invasive may be ordered by chiropractic physicians at the discretion of the Hospital's radiologist.

3.15.3 Verbal Orders

Licensed nurses may take telephone and verbal orders. Registered Pharmacists, Licensed Physical Therapists, Respiratory Care Practitioners, Occupational Therapists, Speech Therapists, Clinical Dieticians, Licensed Imaging Technologist or other individuals designated and approved by the Medical Staff may take telephone and verbal orders in their areas of specialty. It is the responsibility of the ordering physician to review and sign such orders within 48 hours. Verification of all telephone and verbal orders must be done by the qualified person taking the order repeating the order back to the physician. The traditional abbreviations of TO or VO for Telephone Order or Verbal Orders, will be change to “RVO” for “repeated verified order.” This will be reflected on the physician order sheet.

If the order is from a physician’s office, the documentation will include the office personnel name in addition to the ordering physician’s name and the name of the qualified person who took the order. Faxed orders will be verified if they fail to indicate date, time, ordering physician or are illegible and will be documented the same as a telephone or verbal order.

3.15.4 Special Treatment Orders

3.15.4.1 Restraints

Restraint orders will be documented to include type of restraint, justification and time limits, NOT TO EXCEED 24 HOURS. Subsequent restraint orders must be written by the physician every day of continuation of the restraint. Standing and PRN restraint orders are not permitted.

When a patient is placed in restraints for behavioral reasons, new orders are required every four (4) hours for adults, two (2) hours for patients who are 9-17 years of age, and every one (1) hour for patients under the age of 9 years. **(Patient Care Standards Policy 14.37.06)**

3.15.4.2 Cardiopulmonary Resuscitation Withholding – No Code Arrest Orders

“No Code” order means that there shall be no extraordinary intervention in a potentially terminal event. The No Code order shall be entered in the medical record by the admitting physician or his/her designee and the rationale for this order will be documented in writing in the medical record. It is recommended that a copy of the patient’s living will and advance directives, if available, and a record of the discussion with the patient/agent/”statutory surrogate” be included in the medical record. The appropriateness of withholding CPR shall be determined by the attending physician based on his/her knowledge of the patient. **(Patient Care Policy P-754)**

3.15.5 Standing Orders

Standing orders may be developed by physicians and approved by the Medical Staff and the Administration. Such orders may be changed only by mutual consent of the Medical Staff (as represented by the Executive Committee) and Administration with appropriate notification given to all personnel concerned when standing orders are changed.

Standing orders, once established, shall constitute the orders for the treatment and shall be followed insofar as proper treatment of the patient will allow unless they are

specifically changed by a physician for a specific patient. In all cases, routine orders may be modified as necessary by the attending physician to reflect the individual needs of the patient. These orders, where necessary, shall include automatic stop orders and shall be signed by the attending physician.

3.15.6 Automatic Cancellation of Orders

All previous orders are automatically discontinued when the patient goes to surgery or is transferred to a higher level of services.

3.15.7Countersigning

Countersignature by a sponsoring and/or supervising physician is required for any order or progress note written by a first year resident, an intern or a physician assistant. Countersignature by a sponsoring and/or supervising physician is required for history & physicals, procedures and discharge summaries prepared by a resident (regardless of post-graduate level) or a physician assistant.

Note: Emergency Department PA's may write Treat and Release Orders without a Physician Countersignature.

Pursuant to Arizona Department of Health Service regulatory requirements, countersignature by a sponsoring and/or collaborating physician is required for history & physicals performed and dictated by a nurse practitioner.

3.16 Informed Consent

Written consents are required prior to the initiation of the procedure or therapy, except in an emergency, for at least the following:

(1) All inpatient and outpatient surgical and invasive procedures
(2) All procedures where anesthesia of any type is administered
(3) All endoscopic procedures
(4) All administration of blood products including consideration to be given to options if they exist and the need for and risk of blood transfusion and available alternatives
(5) All HIV testing
(6) All administration of investigational drugs or devices

It shall be the responsibility of the physician to inform the patient about any and all proposed procedures and therapies and to secure the patient's informed consent prior to the initiation of any procedure.

It shall be the responsibility of the physician to inform the patient (or the patient's legal agent or "statutory surrogate") about the risks, benefits and alternatives of proposed procedures and therapies, to secure the patient's consent prior to the initiation of the procedure and to document the explanation in the chart. Exceptions are as in accordance with **Nursing Policy 14.11.0.11** and **Network Standards Policy (Q-605)**

3.17 Surgery Requirements

3.17.1 Preoperative Diagnosis

The individual who is responsible for the patient records a preoperative diagnosis prior to surgery.

3.17.2 Pre-Anesthesia

There will be a pre-anesthesia evaluation on each patient for whom anesthesia is contemplated. The evaluation will be performed by a practitioner with appropriate clinical privileges.

3.17.3 Post-Anesthesia

All patients are evaluated on admission to the post-anesthesia care unit by the physician who administers the anesthesia. Within 48 hours of the surgical procedure, a follow up report must be written by the individual who administered the anesthesia or by a physician delegated the post anesthesia assessment who is qualified to administer anesthesia. All patients are evaluated prior to discharge from the post-anesthesia recovery area by the individual performing the post-anesthesia evaluation based on approved discharge criteria.

All patients receiving anesthesia, regardless of the location, must be re-assessed within 48 hours of the procedure.

3.17.4 Tissue

All tissue and foreign objects removed during any operation except those described below shall be sent to the Hospital pathologist who shall make such examination as he or she may consider necessary to arrive at a pathological diagnosis and he shall make a written report. All tissue obtained in this manner shall remain the property of the Hospital. If an outside pathology consult is requested, the staff pathologist will coordinate this consult. Tissue exceptions are as follows:

1) Newborn circumcisions
2) Certain foreign bodies, particularly those without medicolegal implications
3) Cataracts
4) Placenta from uncomplicated, normal single birth deliveries, discarded after the first 24 hours
5) Teeth
6) Fingernails and toenails removed for acute trauma debridement
7) Arthroscopy shavings
8) Bone fragments

All tissues and foreign bodies not submitted for pathologic review shall be described and recorded in the medical record by the operating surgeon or physician removing the tissue or foreign body.

3.17.5 Frozen Section Consults

The staff pathologist will perform all intraoperative frozen section consults. If an outside pathology consult is requested, the staff pathologist will coordinate this consult.

3.17.6 Operative Reports

Operative reports shall be dictated or written immediately following operative procedure. (Operative procedure includes cardiac catheterizations and endoscopy procedures.) Each report shall contain a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, the estimated blood loss, and the name of the primary surgeon and

any assistants. In addition to the dictated report a comprehensive post-operative progress note shall be entered in the medical record immediately after surgery to provide pertinent information for use by any individual who is required to attend to the patient. The note should contain the date, surgeon, assistant surgeon, preoperative diagnosis, postoperative diagnosis, procedure, findings, complications, specimens and estimated blood loss.

4.0 Delinquency and Termination Policies for Incomplete Medical Records

4.1 Medical Record Delinquent Days

The Medical Records Department will notify physicians about incomplete records weekly by mail or fax, informing them of those records that must be completed within fifteen (15) days following discharge. Once records remain incomplete **for** thirty (30) days following discharge, delinquent days shall begin to accumulate. No more than sixty (60) days of delinquency may be accumulated in a calendar year. The Medical Records Department shall notify a physician by certified mail, after thirty (30) days of incomplete records that the counting of delinquent days is underway.

Medical and surgical care of patients shall not be disrupted during the accumulation of delinquent days or while a physician's medical records remain incomplete during this delinquency. However, termination of membership and privileges will become automatic if greater than 60 days of delinquency are accumulated in a calendar.

4.2 Termination for Incomplete Records

A physician shall be allowed no more than sixty (60) delinquent days per calendar year. A staff member who accumulates more than 60 delinquent days shall be notified by the Chief Executive Officer (or his designee), as the agent of the Board of Directors, of the termination of his/her staff appointment.

Pursuant to Arizona Revised Statutes, the Hospital shall report the physician to his/her appropriate licensing board.

In order to obtain staff privileges following such action, the physician shall follow the required process:

First Occurrence:

(1) Wait a minimum of thirty (30) days after receipt of notification by the Chief Executive Officer (or his designee), or thirty (30) days after completion of all incomplete medical records, whichever date occurs later, before requesting an application for reinstatement; and
(2) Remit a reinstatement fee of $500.

Subsequent Occurrence:

(1) Wait a minimum of six (6) months after receipt of notification by the Chief Executive Officer (or his designee) or **six** 6 months after completion of all incomplete medical records, whichever date occurs later, before requesting an application for reinstatement; and

(2) Remit a reinstatement fee of $1,000.

The application for reinstatement shall require processing and verification of information since the physician's last reappointment to the Medical Staff. Review and approval of the completed application for reinstatement shall be required by the respective clinical department, Credentials Committee, the Medical Executive Committee and the Board of Directors. There shall be no expedited process to reinstate a physician following revocation of membership and privileges for incomplete medical records.

The following steps shall be taken in accordance with the above provision:

1) A physician shall be notified by mail that medical records are to be completed fifteen (15) days following discharge;
2) After thirty (30) days of incomplete medical records, a physician shall be notified by certified mail that the counting of delinquent days is underway;
3) If greater than sixty (60) delinquent days are accumulated in a calendar year, the Chief Executive Officer (or his designee) shall notify the physician, by certified mail, that his/her Medical Staff membership and privileges have been terminated.
4) Pursuant to Arizona Revised Statutes, the Hospital shall, in accordance with law, file a report with the appropriate State licensing board.

5.0 EMERGENCY DEPARTMENT

Any individual who presents for examination or treatment in the Emergency Department shall be appropriately screened and examined, to include ancillary service testing to determine whether or not an emergency medical condition exists. The emergency medical condition shall be stabilized to the extent possible prior to a patient's transfer if definitive treatment is beyond the capabilities of the Hospital.

Each Medical Staff Clinical Department is responsible for establishing its Emergency Department call requirements.

A physician serving on the Emergency Department "on-call physician" call rotation must accept any patient who has been referred from the Emergency Department for one office visit or until the patient can be safely and legally discharged to the care of another source regardless of the patient's financial status.

An on-call physician must be available and accessible by telephone during time on-call and must respond to all calls. The on-call physician must respond in person, if requested to do so by the Emergency Department physician.

An on-call physician who refuses to come in and see a patient, necessitating a transfer of the patient to another facility, shall be reported to the appropriate regulatory authority. Pursuant to State Statute, documentation of the refusal must be recorded in the patient record.

If a patient is admitted through the Emergency Department within thirty days following discharge from the Hospital, the initial physician assigned is responsible as well as his/her covering physician. If after the thirty-day period the patient fails to follow-up with the physician as recommended, the physician has the right of first refusal.

Discussion of treatment plan by the Emergency physician with the attending physician is recommended. The attending physician assumes and is responsible for all further medical direction, including orders written by the Emergency Department physician.

A patient admitted through the Emergency Department to a special care unit must be seen by the attending or consulting physician within twelve (12) hours of admission to the unit unless the patient's condition dictates otherwise.

A patient admitted through the Emergency Department to a general medical/surgical floor must be seen by the attending or consulting physician within twenty-four (24) hours of admission to the floor unless the patient's condition dictates otherwise. The attending physician, however, is ultimately responsible for patient care**. (Patient Care Standards Policy Q-185)**

Standards for emergencies that occur in off campus departments are defined in the Emergency Department Unit Standards.

6.0 CONTINUING EDUCATION

Each individual with delineated clinical privileges is expected to participate in continuing educational activities that relate to privileges granted.

7.0 PEER REVIEW

The responsibility of the Medical Staff through its clinical departments is to participate in peer review activities for the purpose of reducing morbidity and mortality and for the improvement of care of patients provided in the Hospital. Such review shall include the nature, quality and necessity of the care provided and the preventability of complications and deaths occurring in the Hospital.

Peer review is the process by which medical decision-making or other medical activities of a physician or other medical staff member are reviewed and critiqued by other physicians/members in the same or similar specialties. Peer review is based on the applicable standard of care.

7.1 Process

Whenever a practitioner's clinical course of treatment is identified as being outside the normal range of established criteria, a practitioner reviewer, within the practitioner's Clinical Department, shall evaluate the reason the case(s) was referred for review for all, or, if appropriate, selected aspects of the care provided. The Chairman of the Clinical Department shall be notified when a practitioner reviewer suggests aberrant clinical behavior involving a practitioner. The Chairman shall evaluate the outcome of a pattern/trend/analysis, and the recommendation of the practitioner reviewer. Action proposed may include

a) department review of the case(s) with the practitioner reviewer and practitioner being invited for discussion of the case. If either or both practitioners are unable to attend, peer review may proceed without them
b) an educational letter without required response
c) a letter noting an opportunity for improvement in management of care and documentation

d) a request for further professional review or corrective action pursuant to Article 6 of the Medical Staff Bylaws

7.2 Timeframe to Conduct Peer Review

The normal course for the conduct of departmental peer review involving an individual practitioner, and excluding the corrective action process, shall occur as expeditiously as possible, and ideally within 120 days from the date of discharge or the date identified, whichever is later. Thoroughness and credibility of the process are more important than the speed of completion. The affected practitioner shall be notified of the departmental peer review process, and given an opportunity to participate in the process.

8.0 IMPROVING ORGANIZATIONAL PERFORMANCE

As a component of the Hospital's ongoing process for the assessment and improvement of organizational performance, each medical staff member shall participate in the ongoing monitoring and evaluation of patient care activities.

9.0 INVESTIGATIONAL RESEARCH INVOLVING HUMAN SUBJECTS

Prior to their use, all investigational devices, drugs, isotopes, or drug therapy administered to Hospital patients must be approved by an Investigational Review Board.

Investigational drugs and devices shall be used only under the direct supervision of the Principal Investigator, who shall be a member of the medical staff and who will provide to the Pharmacy, necessary committees and the nursing staff, all information concerning such drugs or devices. This includes dosage, strengths available, actions and use, side effects, symptoms of toxicity, and any other pertinent information.

10.0 INFECTION CONTROL

Standard precautions shall be implemented for all patients pursuant to Hospital Infection Control policies and procedures.

Physicians with potential occupational exposure to contaminated bodily fluids through needle puncture, wound, scalpel cut, or other broken skin or mucous membrane exposure should immediately follow procedures set forth in the Infection Control policies and procedures and contact the Infection Control Department.

Infectious waste shall be handled pursuant to infectious waste policies and procedures as set forth in the Hospital Infection Control Policy.

11.0 DISASTER PLAN

The Hospital shall have a plan for the care of mass casualties at the time of any major disaster, based on the Hospital's capabilities in conjunction with other emergency facilities in the community.

The Disaster Plan shall make provisions for:

(1) Authorization to the Chief Executive Officer and/or the Chief of Staff or their respective designees, pursuant to Article 5.5 of the Bylaws, to grant privileges as necessary to accommodate patient population during emergency situations
(2) Availability of adequate basic utilities and supplies including gas, water, food and essential medical supportive materials
(3) An efficient system of notifying and assisting personnel
(4) Unified medical command under the direction of the Emergency Depart-ment physician(s) on duty
(5) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care
(6) A special disaster medical record, such as an appropriately designated tag that accompanies the casualty at all times and contains specific required information
(7) Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy
(8) Maintaining security in order to keep relatives and unauthorized personnel out of the triage area
(9) Establishment of a centralized public information center with designated spokesman
(10) A pre-established radio communication system for use when telephone communications are unavailable
(11) Assignment of all available physicians to posts, either in the Hospital or in satellite casualty stations. The Emergency Department physician(s) on duty at the time of the disaster will be in charge of all matters relating to direct pertinent care until such time as is relieved by the Medical Director of Emergency Services or the Chief of the Medical Staff. The command physician will work with the Administration to coordinate all activities and support services
(12) The Disaster Plan will be reviewed in accordance with the Hospital's Disaster Plan Policies and Procedures

12.0 NEW PROCEDURES

Requests for clinical privileges to perform a procedure or service not currently being performed at the Hospital, or a new technique to perform an existing procedure will not be processed until: (1) a determination has been made that the procedure will be offered by the Hospital; and (2) minimum criteria for granting such procedure has been established.

Whenever the Medical Staff Services Department is requested to establish credentialing criteria for a New Procedure, information regarding the New Procedure, per specialty, shall be submitted to the Chief of Staff and or applicable Clinical Department Chairman who shall assist Medical Staff Services personnel in determining if the New Procedure warrants further investigation or specific credentialing criteria. This decision may be made with the assistance of appropriate experts who may be members of the Medical Staff including members who are requesting to perform the New Procedure.

The applicable clinical department ("department") and the Medical Staff Executive Committee ("MEC") shall make a recommendation as to whether the New Procedure should be offered taking into consideration whether the Hospital has the capabilities, including support services, to perform the New Procedure.

After receiving the recommendations from the department and the MEC, the Board of Directors shall determine whether the New Procedure will be offered. If the Department recommends approval of the Procedure part of the recommendation shall include

privileging criteria for the New Procedure. The Department shall develop recommendations regarding: (1) the minimum education, training and experience necessary to perform the New Procedure; and (2) the monitoring and observation requirements that may be warranted when privileges are granted.

Once the minimum threshold qualifications are approved by the Executive Committee and the Board of Directors, specific requests from eligible applicants may be processed.

13.0 HIPAA (Health Insurance Portability and Accountability Act)

All members of the Medial Staff are participants in the John C. Lincoln Hospitals Organized Healthcare Arrangement (OHCA). All members of the Medical Staff are required to follow the John C. Lincoln Health Network's ("Network") Notice as to Protected Health Information (PHI) whenever they generate or receive PHI from the Network's facilities.

The Notice will serve as the Notice of Privacy Practices at the Hospital for all Medical Staff Members. This Notice governs the handling of all PHI generated at or received from the Hospital by Medical Staff members. Each Medical Staff member will abide by the provisions of this Notice for all such PHI. Failure to abide by the Notice may result in discipline or corrective action, pursuant to the Medical Staff Bylaws and the Rules and Regulations.

The Health Insurance Portability and Accountability Act (HIPAA) requires each Medical Staff member to provide a separate Notice of Privacy Practices in his or her private office setting. The Medical Staff member's own Notice of Privacy Practice will not, however, apply to PHI the Medical Staff member generates at or receives from the Hospital. Medical staff members therefore will not provide their own Notice of Privacy Practices developed for their office to patients while they are being treated at a Network facility.

14.0 Whenever in these Rules and Regulations action is required to be taken by the Chairman of the Board of Directors, the Chief Executive Officer, the Chief of Staff or the Chairman of a clinical department, such action may be taken by such person's designee in such person's absence.

15.0 AMENDMENT

These General Rules and Regulations of the Medical Staff may be amended or repealed, in whole or part, by a resolution of the Executive Committee recommended to and adopted by the Board.

16.0 ADOPTION

16.1 Medical Staff

The Executive Committee shall be responsible for the development and biennial review of these General Rules and Regulations of the Medical Staff, which shall be consistent with Hospital policies, the Network's Bylaws and applicable laws.

These General Rules and Regulations of the Medical Staff, as amended, were approved be the Executive Committee on July 16, 2007

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Richard Wright III, D.O., Chief of Staff of Staff

16.2 Board of Directors

These General Rules and Regulations of the Medical Staff, as amended**,** were approved and adopted by resolution of the John C. Lincoln Health Network Board of Directors on September 6, 2007 upon the recommendation of the Executive Committee.

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Joel Kramer, Secretary/Treasurer, Board of Directors

Revised: 07/99,08/98, 09/99, 04/00, 09/00, 12/00, 03/01, 04/01, 12/01, 01/02, 10/03, 08/04, 6/05, 10/05, 8/06, 10/06, 2/07, 9/07