MEDICAL STAFF POLICIES

of

AITKIN COMMUNITY HOSPITAL, INC.

doing business as

RIVERWOOD HEALTHCARE CENTER

Patrick H. Reymann
BUCKINGHAM DOOLITTLE & BURROUGHS, LLP
50 South Main Street, P.O. Box 1500
Akron, OH 44309-1500
(330) 258-6482

Amended by Leonard, Street and Deinard, September 16, 2005; March, 2008; April, 2010; March, 2011; May 2013; April 2016

RIVERWOOD HEALTHCARE CENTER
AITKIN, MINNESOTA

GENERAL POLICY STATEMENTS

All policies in the Hospital's Administrative Manual, or any subsequent equivalent, which affect patient care or the Medical Staff will be reviewed by the Medical Executive Committee of the Medical Staff.

In addition, the policies in the Hospital's Administrative Manual must be coordinated and consistent with the policies contained in the Medical Staff Policy Manual (Medical Staff Rules and Regulations). The Medical Staff Policy Manual will be reviewed by the Hospital and the Medical Executive Committee of the Medical Staff every two years.

At minimum, the Hospital's Administrative Manual and the Medical Staff Policy Manual (Medical Staff Rules and Regulations) will be available in the Hospital's Administrative Office and the Medical Staff Library.

INDEX

Page

MEDICAL STAFF POLICIES

MSP-1. ADMISSION OF PATIENTS

1.1 Assigned and Unassigned Patients. All patients, including the medically indigent, who require treatment will be attended to by a member of the Active or Courtesy Staffs. Patients will be assigned to the member of the Active Staff on duty from the clinical service concerned in the treatment of the primary diagnosis which necessitated admission. Each patient in the Hospital is assigned a rounding practitioner. The rounding practitioner will:

(a) be responsible for total patient care
(b) be responsible for discharge of the patient
(c) be responsible in the final analysis for completion of the medical record

When a change of condition or death occurs the nursing staff will notify: the rounding practitioner, who will determine who else is to be notified. No practitioner will receive compensation for attendance in the case of any patient who is admitted to the Hospital without charge, but in the case of patients from whom the Hospital is receiving partial compensation, the rounding practitioner may charge a fee proportionate to that received by the Hospital. Being designated as a Critical Access Hospital, we may have up to 25 beds. The average length of stay of our inpatients is 96 hours.

1.2 Practitioner Responsibility. The practitioner, under whose name the patient is admitted, will be responsible for the medical care and treatment of that patient, for prompt completeness and accuracy of the medical record and for transmitting reports on the condition of the patient to relatives as appropriate. Practitioners who admit or care for patients will be held responsible for providing necessary information and making such information of record as may be necessary to assure the protection of other patients.

1.3 Basic Information to be Provided by the Admitting Practitioner. In order that patients will receive prompt attention on admission and assignment, the following information must be given to the admissions office:

(a) patient's name, address and home telephone number
(b) name of admitting Medical Staff member
(c) admission date
(d) provisional diagnosis
(e) proper service or section
(f) admission priority
(g) gender and age
(h) means of arrival

1.4 Preadmission Registration. Preadmission registration by telephone is available to all practitioners for elective admissions and is also available to patients through the Hospital's

admissions office. Receiving admission information in advance of hospitalization will greatly facilitate the process of admitting patients.

1.5 Time of Admission. Admissions, whether emergent, urgent or elective, may occur at any time.

1.6 Provisional Diagnosis. Except in an emergency, no patient will be admitted to the Hospital until assessed and a provisional diagnosis has been stated and the consent of the patient, the guardian or his appointed delegate, has been secured. In case of emergency, the provisional diagnosis will be stated as soon after admission as possible, but no longer than 24 hours after the admission of the patient.

1.7 Special Circumstances. Patients in special circumstances will be treated as follows:

(a) Physical/Mental Abnormality. The attending practitioner will inform the admissions office when he or she is admitting a patient with a potentially hazardous physical or mental condition.

(b) Alcoholism/Psychosis. When the patient's primary diagnosis is acute alcoholism or acute psychosis, he or she will be transferred to an appropriate facility unless there is a contraindication to transfer. If either is the patient's secondary diagnosis, the patient will be admitted.

(c) Infection. The admitting physician will inform the Admitting Department when a patient is admitted with a diagnosis of infection if the infection is suspected to be contagious and whether the patient should be isolated. All admissions to isolation facilities will follow current infection control protocols.

1.8 Physician Orders. Orders must be written prior to, or at the time of, every elective admission. In the care of emergency or urgent admissions, written orders will be filed at the time of admission or given verbally to the on-duty registered nurse immediately following the admission.

1.9 Dental and Podiatric Patients. Patients admitted for dental or podiatric surgery must be co-admitted by a physician member of the Medical Staff who will be responsible for the medical aspects of such hospitalization. Further, an adequate medical survey, by a physician member of the Medical Staff will be required on each patient before surgery is performed. The physician member of the Medical Staff will make recommendations for supportive therapy during the operation and will make a post-operative follow up to ascertain that the patient has suffered no systemic damage from the anesthetic or from the operation. Irrespective of the foregoing, an Active Staff member who is an Oral/Maxillofacial surgeon with the approval of the Medical Executive Committee may sign for and assume responsibility for preparation and completion of the medical record and perform the pre-operative medical survey and post-

operative follow up for his or her patients in accordance with regulations and directives promulgated by the Joint Commission in its accreditation manual for hospitals. Indicated consultation with respective members of the Medical Staff will be required in complicated cases. Complete medical and dental records will be required on each dental and podiatric patient and will be a part of the Hospital medical record. (See also MSP-4.5.)

1.10 Suicidal Patients. For the protection of patients, the Medical Staff, the Hospital and its employees, certain principles are to be adhered to in the care of the potentially suicidal patient.

(a) Suicidal Tendencies. Patients with suicidal tendencies will be transferred to a suitable facility as soon as practical.

(b) Medical Condition. If the patient's medical condition prohibits transfer to a suitable facility, the patient will be admitted to a general care area of the Hospital, if available/possible and will be offered psychiatric evaluation, and any policy established by the Hospital and the Medical Staff for suicidal patients will be followed. When the patient becomes medically stable, he or she will be transferred to a suitable facility, if deemed necessary after a psychiatric consultation, if available/possible.

(c) Suicide Precautions. If a patient with suicidal tendencies is admitted to the Hospital, a written practitioner's order will be obtained to maintain maximum suicide precautions. The continuation of suicidal close watch precautions will be reviewed by the practitioner at least every 24 hours. Implementation of suicidal precautions will be documented in the patient's medical record.

1.11 Admissions During Bed Shortage. Being a Critical Access designated hospital, patients will be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:

(a) Preoperative Admissions. This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chief of Staff may decide the urgency of any specific admission after consulting with the attending physician. Continued misuse of this category of admission, will be brought to the attention of the Medical Executive Committee for appropriate action.

(b) Emergency Admissions. This category includes patients who are in danger of loss of life or may sustain permanent serious injury if immediate medical care is not provided. Within 24 hours following an emergency admission, the attending practitioner will dictate or write a history and physical and will furnish to the Chief of Staff, if requested, signed, sufficiently complete documentation of the need for this admission.

Failure to furnish this documentation when requested to do so, or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the Medical Executive Committee for appropriate action.

(c) Observation Service. This includes patients who require periodic monitoring by nursing or other Hospital staff which are reasonable and necessary to evaluate the patient's condition and/or determine the need for possible inpatient admission. Observation time for the most part, is up to 23 hours at which time the patient is either admitted as an inpatient or discharged.

(d) Urgent Admissions. This category includes those so designated by the attending practitioner, but not as seriously ill as an Emergency Admission and will be reviewed as necessary by the Chief of Staff to determine priority when all such admissions for a specific day are not possible.

1.12 Short-Term Observation.

(a) Necessity. The admitting practitioner is to decide when it is necessary to order short-term observation and such order must be on the chart at the time of admission or as soon thereafter as is practicable.

(b) Determination. A utilization reviewer will be available to assist the practitioner in complying with any regulations of a third-party payer in determining whether the patient needs to be admitted or placed in short-term observation.

1.13 Critical Care Admissions.

(a) ICU Exams. All patients admitted to a critical care unit under critical care status must be examined by the admitting practitioner within 4 hours of admission.

1.14 Emergency Admissions.

(a) Timeliness. Patients admitted from Emergency Department must be examined by the admitting practitioner or consultant in a timely manner.

(b) Notification. A patient cannot be admitted from Emergency without first notifying the admitting practitioner or his or her designee.

1.15 Plan of Care. The attending practitioner/Rounder must document the need for continual hospitalization (Plan of Care) on a daily basis as identified in the Patient Care and

Evaluation Plan concurrently adopted by the Medical Staff and approved by the Governing Body.

MSP-2. PATIENT CARE/ORDERS

2.1 Attending Practitioner/Rounder And Patient Care. The attending practitioner/Rounder is responsible for the care of his or her patients from admission through discharge. In the event the attending practitioner requests the patient be cared for by another practitioner (excluding normal coverage), a transfer order must be legibly written on the medical record. The physician assuming responsibility for the patient must be notified and must accept responsibility.

2.2 Alternate Designation. Each attending practitioner/rounder must designate an alternate practitioner who has the same level of competency and training to care for the attending practitioner's patients whenever the attending practitioner cannot provide appropriate, timely and continuous care and supervision of each of his or her patients. The alternate practitioner must be a Medical Staff member with appropriate clinical privileges who will be called in the event the attending physician cannot be reached. In case of failure to name an alternate practitioner, the practitioner's clinical service area will designate an alternate practitioner. If an alternative is not appointed by the clinical service area, either the Chief of Staff, the CEO or the CEO's designee will have authority to appoint any member of the Medical Staff as an alternative practitioner should he or she consider it necessary. Coverage of a patient for another practitioner for a brief period of time does not constitute unavailability or require a transfer of coverage unless so desired and agreed upon by the attending practitioner/rounder.

2.3 Tissue Submission. The practitioner in charge of the patient's procedure will be responsible for seeing that all tissues and foreign objects removed during operations are delivered to the Hospital pathologist who will make such examination as he or she may consider necessary to arrive at a diagnosis. Exceptions to submission of specimens will be at the discretion of the Medical Executive Committee.

2.4 Written Orders. All patient care orders must be legibly written, timed and dated. Orders may be written, electronic, dictated, faxed, emailed or verbally given by any practitioner permitted by law to prescribe a patient care order and will be considered to be in writing if transcribed, signed by or dictated to a registered nurse or other appropriate allied practitioner and thereafter timely signed by the attending practitioner. Orders which are illegible or improperly written must be clarified with the ordering practitioner as soon as possible.

2.5 Designation of Written Orders. Subject to this policy, any practitioner may designate, at his or her discretion, to other members of the Medical Staff or appropriate allied practitioners the responsibility to write orders on his or her patients. Subject to this policy, the attending practitioner may also designate medical students, interns or residents to write orders.

2.6 Signatures. In all cases, orders will be signed by the practitioner who has the right to practice medicine or dentistry and who has been assigned responsibility for that patient's care.

2.7 Countersignatures. Patient orders written by medical students, interns, residents or allied practitioners must be countersigned (authenticated) by the end of the next calendar day by the attending practitioner or a resident in consultation with the attending practitioner. Exceptions may be made in the event of pre-operative orders, an emergency or in the instance of acknowledged co-management, e.g. the intensive care unit or recovery room.

2.8 Telephone, Verbal, Email Or Fax Orders. Telephone, verbal, email and fax orders may be given by a practitioner only to a registered nurse (RN), pharmacist (Rph), audiologist, respiratory therapist, occupational therapist, speech therapist, physical therapist or dietician. After confirming the identity of the caller, the order will be transcribed and signed by the RN, Rph, audiologist therapist or dietician to whom it is dictated or sent as "V.O. (verbal order), T.O. (telephone order), E.O. (email order) or F.O. (fax order) by Dr. [name of practitioner]'s" and will contain the practitioner's name, the time, the date, the order, and the RN's, Rph's, audiologist's, therapist's or dietician's signature. All telephone, verbal, email (hard copy) or fax orders must be signed, timed and dated at the earliest possible time or at the time of their next patient visit. All verbal orders received by telephone must be read back to the practitioner by the person authorized to receive them in order to verify their accuracy.

2.9 Certain Preoperative Orders. Preoperative laboratory or x-ray orders must be individually ordered for each case or as per a surgery protocol.

2.10 Post-Operative Patient. The immediate, post-operative state requires the renewing, rewriting or writing of additional patient care orders. The practitioner performing the procedure or the attending practitioner will write such orders as may be necessary to ensure appropriate and effective care of the patient post-operatively. When a patient has a procedure performed in the operating or endoscopy room, all pre-operative orders will be held post-operatively. Medications will be resumed according to protocol.

2.11 Intensive Care Units. Prior to admission to, or transfer from, the intensive care or ICU units, all medical cases and all complicated surgical cases require a review of the existing orders by the practitioner affecting the admission or transfer. Any indicated orders must be written at transfer or admission.

2.12 Advance Practice Nurses. Advance Practice Nurses may order laboratory work, x-rays, diagnostic tests, rehabilitative services and nutrition consultations without a physician co-signature.

2.13 Dentists/Podiatrists. Dentists and podiatrists who are rendering care pursuant to the requirements under the Medical Staff Bylaws and the Medical Staff Rules and Regulations are responsible for their orders within the scope of their authority to practice on a patient.

2.14 Emergency Room Orders. Emergency Room practitioners will not write orders that extend, or appear to extend, control and responsibility for the patient beyond treatment in the Emergency Room. Emergency Room practitioners may write temporary Emergency Hold orders with the consultation of the on-call practitioner.

2.15 Mid-Levels. Physician assistants and nurse practitioners may consult with their physician and may write or receive orders only within the scope of their authority in accordance with law. The supervising physician of a mid-level must co-sign any orders written by a mid-level.

2.16 Paramedic Personnel And Orders. Orders may not be received or written by paramedic personnel or others not permitted by Minnesota law to receive or write orders.

2.17 Standing Orders. Standing orders must be approved by the Medical Executive Committee and reviewed as necessary. Standing orders may only be changed with the approval of the Medical Executive Committee. Standing orders must be signed by the attending practitioner or a resident in consultation with the attending practitioner These orders will be followed insofar as proper treatment of the patient will allow and will constitute the orders for treatment until specific orders are written and signed by the attending physician.

(a) Individual Standing Orders. Each practitioner must review and revise his or her individual standing orders annually. The original of each set of standing orders must be signed, timed and dated by the practitioner and kept on file in the policy and procedure manual of the appropriate clinical service area.

(b) Medical Record. A practitioner's standing orders, when applicable to a given patient, will be reproduced in detail on the order sheet of the patient's medical record, dated and signed by the attending practitioner.

(c) Execution of Standing Orders. Individuals authorized to carry out standing orders may only act within their sphere of competence and only as specified by the standing orders.

(d) IV Oxytocic Drugs. Registered Nurses may administer IV oxytocic drugs for the induction of labor per Pitocin Induction Standing Order. The practitioner must be readily available to be present at the Hospital when such an infusion is being administered.

2.18 Preprinted Orders. Preprinted orders are orders that are on preprinted forms which are reviewed, dated, timed and signed by the attending practitioner before becoming effective. Preprinted orders must be approved by the Medical Executive Committee and reviewed as necessary.

2.19 Investigational Drug Orders. Before an investigational drug is ordered or administered, there must be evidence of informed patient consent. Informed patient consent will be evidenced by a copy of the consent form being placed in patient's chart, or entering a progress note or practitioner order stating that consent has been obtained and that the patient has signed the consent form. Physicians desiring to use investigational drugs and implantable devices must

receive prior approval and an investigational control number from the Federal Drug Administration (FDA). Following FDA approval, investigation protocols must be submitted to and approved by the Institutional Review Committee and Research Committee. The patient to whom the drug will be administered must sign a form which releases the Hospital of any responsibility for the drug.

2.20 Research Trials. In the case of investigational drugs ordered for any inpatient, outpatient, emergency patient or other participant in approved research trials, the following requirements must be observed:

(a) Drug Information. The Director of Pharmacy Services or his or her designee will provide pertinent information regarding the drug to the practitioner ordering the drug.

(b) Hospital Pharmacy. All such drugs will be stored in and issued from the Hospital pharmacy.

(c) Availability of Information. The Hospital pharmacy will be responsible for making information available to nurses prior to administration of the investigational drug.

2.21 Special Therapy Orders. Specific orders for physical, occupational, or other special therapy must be entered on the order sheet.

2.22 Medication Orders. Orders for medication must be made on the patient's chart and must be explicit. Any order for any drug which falls within the controlled substance category must be signed by a practitioner who possesses a current DEA number. All drug orders for controlled substances, sedatives, anti-coagulants, and antibiotics not specifically prescribed as to the time and number of doses will be renewed after 72 hours and discontinued after 96 hours. Practitioners are requested to use generic names for drugs and to use those drugs accepted and adopted by the Hospital Formulary. Notwithstanding the foregoing, drugs may not be discontinued without notifying the attending practitioner. If the drug order expires at night, the attending practitioner must be notified no later than the following morning.

2.23 Patient's Own Drugs and Self-Administration. Medications brought into the Hospital by a patient will not be administered unless the medication has first been inspected by a Hospital pharmacist to assure its identity and proper labeling and storage and there is a written order of the attending practitioner authorizing the use of the medication. Self administration of medications by a patient is permitted if the attending practitioner writes an order on the order sheet specifying the medications the patient may keep at the bedside and their administration.

2.24 Blood Transfusions.

(a) Request for Blood. The attending practitioner is ultimately responsible for initiating all requests for blood, plasma and other blood components by

written order on the order sheet including the product ordered, amount requested and the number of units or volume, time to be infused (when appropriate) and any special orders. Leukocyte reducedpacked red cells will be used to fill all orders for blood unless specifically ordered otherwise by the practitioner.

(b) Identification of Recipient and Blood. The practitioner or R.N. will come to the Laboratory to obtain blood products needed. Before removing the blood products from the Laboratory, the RN will double check unit #,expiration date,patient name, red BB ID number, medical record number and type and Rh with a lab staff person before removing blood products from the lab. The practitioner or R.N. compares all labels on the blood unit to make certain that the blood has been tested for compatibility with the patient who has been identified and is to be the recipient.

(c) ABO Type/Rh Factor. Any patient for which an ABO Type and Rh Factor is needed in the course of treatment must have a blood sample typed by the Hospital's Laboratory. Donor cards or typing from any other laboratory are not acceptable. Pre-op blood typing must be done within three days prior to the surgery.

(d) Unused Blood. When a type and cross match are ordered and the blood is not used within 48 hours, the blood will automatically be released unless the attending practitioner otherwise notifies the blood bank.

(e) Refusal of Blood and Blood Products. When a patient states that he or she will not accept a blood transfusion or infusion of blood products to prevent physical or mental deterioration, even to the point of death, the situation should be assessed with Hospital counsel, or an Ethics Committee consult, to determine if intervention of the court is to be sought. If a mentally competent adult patient refuses to accept blood or blood products felt necessary to prevent physical or mental deterioration, and the courts have not interceded on his or her behalf, the wishes of the patient must be honored. If the patient's wishes in this regard were not documented at the time of admission, the patient must sign a refusal for treatment form. Any refusal to sign this form should be documented in the medical record and an incident report should also be completed.

2.25 "No Code" Orders. When a practitioner's written order to the nursing staff includes instructions for "no code", or that no resuscitative measures be taken on the patient, a THE CODE STATUS OF THE PATIENT note must be made in the medical chart to this effect, and this note must be signed by the practitioner. (See also MSP-11.)

2.26 Patient Changing Practitioners. A patient's right to change practitioners will be recognized and respected. Recognized ethical procedures of the medical profession will apply.

In the event a patient decides, for whatever reason, to change attending practitioner the patient must make the appropriate arrangements to effect this change. The Hospital's only responsibility in this situation is to make a list of all suitable Medical Staff members available to the patient. If a substitute practitioner is willing to assume this care, he or she will contact the first practitioner and make arrangements for the transfer. If a substitute practitioner is not found or is not willing to accept the patient, the admitting practitioner will continue his or her care as long as the patient remains in the Hospital. Transfer of the primary care of a patient from one practitioner to another should be designated in writing on the practitioner's order sheet.

2.27 Natural Disasters. In the event of a natural or other disaster resulting in mass casualties, all members of the Medical Staff specifically agree to relinquish direction of providing care of their patients, private or charity, to the Chief of Staff. All practitioners will accept assignments in accordance with the Medical Disaster Plan.

2.28 Outpatient Diagnostic Services, Etc. A patient may receive outpatient diagnostic and therapeutic services upon the referral of any physician, provided that physician provides satisfactory evidence of a current, valid license and UPIN number. In the case of a questionable order, the ordering physician must clarify the order prior to it being acted upon by the appropriate clinical service area, i.e. Laboratory, Radiology, Therapy and so on. The results will be sent to the ordering physician only.

MSP-3. DISCHARGE OF PATIENTS

3.1 Discharge Responsibility. Patients will be discharged only on order of the rounding practitioner, his or her Medical Staff designee or a resident in consultation with the rounding practitioner. At the time of discharge, the rounding practitioner, or his or her Medical Staff designee, will see that the record is complete, document the final diagnosis and sign the record.

3.2 Timing Discharge Orders. Practitioner discharge orders must be written prior to discharge. The practitioner will see that the record is complete, state a final diagnosis, dictate the discharge summary and sign and date the record. Discharge summaries should be dictated as soon as possible after discharge. It is the practitioner's responsibility to see that the patient has received sufficient hospital care and that discharge instructions are appropriate for any follow-up care required.

3.3 Discharge Orders. Hospital discharge from an inpatient unit or day care unit to an outpatient unit or a patient's change of status from an inpatient to an outpatient will require appropriate discharge orders.

3.4 AMA Discharges. When a patient insists upon being discharged from the Hospital prematurely and such a request cannot be accommodated safely, an AMA (Against Medical Advice) discharge may be warranted. The patient will be provided with sufficient information to make an informed decision to forgo further care and treatment and leave the Hospital against advice. The patient's attending practitioner will be promptly notified of any potential AMA discharges. All AMA discharges must be documented in the patient's medical record and will include a statement about the patient's competency. Prior to discharging a patient AMA the patient will be asked to sign and date the "Release Upon Refusal of Treatment" form. If a patient refuses to sign an AMA discharge form, the nurse in charge will so indicate on the record, obtaining a witness' signature. The nurse will also complete an incident report.

3.5 Readmission. Readmission of a patient to any inpatient unit, even if within a few hours of discharge, will require new, rewritten or renewed orders by signature of the attending practitioner.

3.6 Emergency/Disaster Discharges. In case of a civil, military, natural emergency, or disaster, patients may be discharged from the Hospital, moved to other community hospitals, or moved to other facilities made available for the care and treatment of patients, by the order of the Chief of Staff, or his or her designee, in consultation with the CEO, to preserve life and health, to make room for more critically ill or injured patients sent to the Hospital from a disaster area or for the purpose of saving lives and to provide adequate medical care and treatment.

3.7 Discharge Summary. The elements of a proper discharge summary are described in MSP-4 in Section 4.14.

3.8 Discharge of Minors. A minor will be discharged only in the custody of his parent, a member of his immediate family or his legal guardian or custodian, unless such parent or guardian otherwise directs.

3.9 Interagency Referral Record. Prior to the transfer of a patient to a nursing home or other medical institution or agency, the attending practitioner must promptly complete the medical portion of a standard referral form as well as providing a discharge summary and continuing orders for treatment. If, however, the time required to complete this documentation might endanger the welfare of the patient, the patient must be transported as soon as possible and the attending practitioner must notify the receiving institution with all pertinent medical information by telephone, and as soon as possible fax otherwise have delivered all required documents.

MSP-4. MEDICAL RECORDS

4.1 Content. A complete and legible medical record must be established and maintained for every person receiving treatment as an inpatient, outpatient, or on an emergency basis in any unit of the Hospital. The content of each medical record must be pertinent and current for each patient. This record will include identification data (if none, a reason must be stated) such as: evidence of query regarding any Advance Directives; chief complaint; name, address, date of birth, family history, name of any legally authorized representative, age, appropriate psychosocial history, and history of the present illness; medical history (prenatal and obstetrical records as appropriate); physical examination; emergency care provided prior to arrival; reason for admission; record of patient assessment; legal status if receiving mental health services; impression and treatment plan; a mental status examination for psychiatric patients; diagnostic and therapeutic orders; appropriate informed consent(s); clinical observations including results of therapy, progress notes, evidence of complications, consultation, and nursing notes; laboratory and X-ray and other reports; provisional and final diagnosis; medical or surgical treatment and operative reports; every medication ordered prescribed as dispensed, the dose of the drug administered to the patient and any adverse drug reactions; pathologic findings; referrals; reports of procedures, tests, and results including operative reports; statement if patient left hospital against medical advice; discharge summary; condition on discharge (autopsy report where indicated) and instructions given for further care, such as medications, diet, limitation of activity, and date for follow-up care.

4.2 Required Patient Identification. Each form or page of the record will be identified with patient's identification (name, birthdate, medical record number, etc.). The record of admission will become a permanent part of the record for patient demographic information.

4.3 Record Documentation. All record entries must be made in a legible manner.

(a) Emergency Room Records. All Emergency Room records must be completed, dated and timed, and signed by a physician.

(b) Additions and/or Revisions to Record. Subject to this policy, all additions or corrections to entries in a medical record must be initialed or signed and dated and timed. No original documents may be removed.

4.4 History and Physical Examination. A complete history and physical examination will, in all cases, be performed and documented in 24 hoursup by the end of the next calendar day after admission of the patient and, as determined by the Medical Staff, include all pertinent findings resulting from an assessment of all systems of the body along with a provisional diagnosis.

(a) A complete history must include the following elements:

(i) History of present illness,
(ii) History of other relevant past/present illness/surgeries,

(iii) Pertinent social history including alcohol, drug and tobacco use,
(iv) Relevant review of systems to depict potential factors that may complicate the present treatment plan,
(v) Medications and allergies,
(vi) A physical examination pertinent to the present illness.
(vii) Chief Complaint

(b) Preadmission Physical. A durable and legible copy of a report of a physical examination performed and recorded by a member of the Medical Staff within a reasonable time, but not to exceed 30 days, prior to the patient's admission to the Hospital may be used in the patient's Hospital medical record in lieu of the admission history and physical examination required by this policy. In such instance, an interval admission note that includes all additions to the history and subsequent changes of the physical findings will always be recorded.

(c) Interval History. An interval history, in lieu of a complete history and physical examination, may be performed when the patient is readmitted within 7 days of his or her prior discharge for the same medical problem or its complications.

(d) Computerized Physical. If a computerized health testing system is used, the practitioner must record the chief complaint, history of present illness, and pertinent physical findings in the admission order.

(e) Prenatal Record. All obstetrical records must include the complete prenatal record. The prenatal record may be a durable, legible reproduction of the attending practitioner's office record transferred to the Hospital before admission.

(f) Allied Practitioner, Medical Student, Etc. Any history and physical written by a medical student, allied practitioner, intern or resident must be signed by the attending Physician before the time stated for the procedure.

(g) Delinquency. A failure to satisfy history and physical requirements will result in a classification of the Medical record as delinquent.

4.5 Dental Patients. A patient admitted for dental care is a dual responsibility involving a dentist and a physician member of the Medical Staff. The dentist will have the following responsibilities:

(a) Dental History. A detailed dental history justifying hospital admission.

(b) Oral Cavity Examination. A detailed description of the examination of the oral cavity and a preoperative diagnosis.

(c) Operative Report. A complete operative report, describing the findings and technique. In cases of extraction of teeth the dentist must clearly state the number of teeth and fragments removed.

(d) Progress Notes. Progress notes as are pertinent to the oral condition.

(e) Clinical Resume. Clinical resume (or summary statement).

The physician will have the following responsibilities:

(a) Medical History. Pertinent medical history.

(b) Physical Exam. A physical examination to determine the patient's condition prior to anesthesia and surgery.

(c) Supervision. Supervision of the patient's general health status while hospitalized, discharge summary and discharge diagnosis.

4.6 Essential Data. Except in cases of life threatening emergencies, all essential data, including a clinical indication for surgery, must be completed and charted preoperatively.

4.7 Authentication. All clinical entries in the medical record must be accurately dated and timed and individually authenticated. Authenticated means to establish authorship by written signature or identifiable initials. Electronic or computer-generated signatures are acceptable as authentication, if the signature is generated by a confidential code which only the practitioner possess and uses. The following areas of the medical record require the attending practitioner's signature:

(a) Admission progress notes and orders.
(b) History and physical examination.
(c) Immediate pre-operative and post-operative progress notes.
(d) All operative or special procedure reports.
(e) Discharge summary.
(f) All other clinical entries, diagnoses, orders, reports and progress notes personally given or written by the attending practitioner.

4.8 Progress Notes.

(a) Initial Progress Note. A progress note or history and physical report must be entered into the patient's electronic health record by the attending practitioner immediately following the patient's admission. The progress note or history and physical report must include the chief complaint, the signs and symptoms of the patient occasioning admission, specific outpatient therapy prior to admission, outpatient diagnostic procedures

performed, the date the patient was last seen by the attending practitioner, the attending practitioner's rationale for admission, the working diagnosis, plan of treatment and indicated consultations.

(b) Subsequent Progress Notes.

(i) Daily Examination and Progress Note. The attending practitioner or his or her designee must examine the patient and record a progress note for every acute care inpatient at least each calendar day and/or by the end of the next calendar day after discharge. Certain patients may require more frequent notes to ensure appropriate care. Exception: Swing Bed patients and Transitional Bed patients require only weekly examination and progress notes.

(ii) All Phases. Progress notes must be recorded by the attending practitioner in all phases of the patient's Hospital stay. Other practitioners who participate in any phase of the patient's Hospital stay are also required to record progress notes regarding their participation.

(iii) Patient's Progress. Progress notes must describe in proper continuity the progress of the patient and must include, whenever applicable, a review of the chart, significant physical changes in the patient, new signs and symptoms, complications, consultations, and changes in treatment.

(iv) Dated, Etc. Each progress note must be dated, timed and signed by the attending practitioner recording the note.

4.9 Procedures: History And Physical. When a history and physical examination are not recorded before the time stated for an operation, the operation will be canceled unless the attending surgeon states, in writing, that such delay would constitute a hazard to the patient. As soon after the operation as possible, a complete history and physical examination will be recorded.

4.10 Dictation Of Operative Reports And Notes. All operative reports, for both inpatients and outpatients, are the responsibility of the operating surgeon and must be written or dictated in the medical record immediately following the surgical procedure. They must include pre and post operative diagnoses, names of surgeons and assistants, technical procedures, findings, specimens removed and estimated blood loss, if applicable. If an operative report is not completed by the end of the next calendar day after the surgery, it will be considered delinquent.

4.11 Dating Clinical Entries. All clinical entries in the patient's record must be accurately dated and authenticated. Entries should be timed when there are multiple entries on the same date by the same practitioner.

4.12 Symbols And Abbreviations. Symbols and abbreviations may be used only when they have been approved by the Medical Executive Committee. An official record of approved symbols and abbreviations will be kept on file in the Health Information Service Department.

4.13 Final Diagnoses. Final diagnoses (principal and secondary) will be recorded in full, without the use of symbols or abbreviations. These diagnoses must be signed and dated by the attending practitioner at the time of discharge. They are equally important as the actual discharge orders.

4.14 Discharge Summary. A discharge summary of each case must be dictated on all patients hospitalized. Exceptions will be identified by the Medical Executive Committee and for these a final summation progress note will be sufficient.

(a) Responsibility. The practitioner who manages the patients care will be held responsible for the preparation and authentication of the complete discharge summary.

(b) Authentication. The discharge summary will be dictated. A discharge summary may be signed by the attending practitioner, a resident in consultation with the attending practitioner or another licensed practitioner designated by the attending practitioner, provided that, when the discharge summary has been signed by a resident or another practitioner, it must be countersigned by the attending practitioner.

(c) Elements of Discharge Summary. Each discharge summary should contain the following:

(i) Provisional Diagnosis. The provisional diagnosis or reason for admission,

(ii) Principal Diagnosis The diagnosis, which is the diagnosis explaining the reason for admission,

(iii) Secondary Diagnosis. All secondary diagnoses,

(iv) Description of Stay. A description of the patient's stay (procedures performed and treatment rendered),

- significant findings,
- procedures performed and treatment rendered,

(v) Condition on Discharge. Condition on discharge,

(vi) Disposition. Disposition of the case,

(vii) Resolution of Complaint. Resolution of admission diagnosis and chief complaint,

(viii) Complications. Discussion of complications that developed during the patient's Hospital stay,

(ix) Use of Restraints. Any use of restraints or related procedures.

(x) Treatment Justification. Justification of diagnosis and treatment or inability to establish diagnosis,

(xi) Discharge Planning. A note on discharge planning including ongoing activity, diet, medications, instructions to the patient and/or the patient's family, and follow-up care, and

(xii) Blood. If blood was given, a diagnosis reflecting why blood was required.

4.15 Death Summary. In the event of death, a death summary will be added to the record and will include date, time and cause of death.

4.16 Complete Medical Record Responsibility. The attending practitioner will be held responsible for the preparation of a complete, accurate and scientific medical record for each patient. This record will include identification data, admitting complaint(s), family history (where applicable), personal history, present drug allergies or lack thereof, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical or surgical treatment, pathological findings, progress notes, principal diagnosis, associate diagnoses, final diagnosis, condition on discharge (including notes regarding infections or other complications), disposition, autopsy report when available, and an adequate discharge summary.

(a) Time Limit. The Discharge Summary will be dictated or written within 14 days and signed within 30 days.

(b) Filing of Medical Record. No inactive medical record will be filed until it is complete, except on the order of the Medical Executive Committee or a Medical Director with approval from the Medical Executive Committee.

(c) Medical Records Dictation. Any material dictated by the practitioner on a patient does not become a legal part of the record until the document is signed and placed on the chart. After that time, any changes made to the document must be done as an addendum.

4.17 Countersignature Time Frame. Except as otherwise provided for herein, the attending practitioner must countersign the history, physical examination, pre-operative note, operative reports written by house staff (interns and residents), and discharge summaries by the end of the next calendar day when they have been recorded by an allied practitioner.

4.18 Access To Medical Record. Each Medical Staff member has access to all of the medical records of his or her patients; and upon the approval of the chairman of the Medical Executive Committee, access to all medical records of all patients will be afforded to Medical Staff members in good standing for study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All information regarding a patient is strictly confidential and must be restricted except when released in the normal course of duty and scope of employment or in accordance with state and federal law.

4.19 Medical Record And Former Practitioners. By direction of the CEO, former members of the Medical Staff will be permitted access to information from the medical records of patients they admitted to the Hospital during their staff tenure.

4.20 Readmission And Previous Medical Record. In case of readmission of a patient, all previous records will be available for the use by the attending practitioner. This will apply in all cases whether the patient was attended to by the same practitioner or by another practitioner.

4.21 Property of Hospital. Except as allowed in this policy, all medical records and films are the property of the Hospital and may not be removed without proper authorization. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. Unauthorized removal of medical records is grounds for suspension of Medical Staff membership, and/or clinical privileges under the Medical Staff Bylaws.

4.22 Patient Consent. Written consent of the patient will be required to release medical information to persons not otherwise authorized to receive such information. Upon request by a patient, the Hospital will permit the patient to examine or will provide a copy of the medical record in accordance with the request except that, if a practitioner who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, the Hospital will instead provide the record to a practitioner designated by the patient.

4.23 Adverse Drug Reactions. Adverse drug reactions will be documented in the patient's medical record.

4.24 Patient Instructions. All instruction sheets, pamphlets or educational materials relating to patient care and given to patients must be approved by the Medical Executive Committee.

4.25 Emergency Room Medical Record. The attending practitioner or the emergency room physician will be responsible for the preparation of a complete emergency patient record

on each patient at time of treatment. The emergency room record will include: patient identification, time of arrival, method of transport (and by whom), record of any treatment patient received prior to arrival, history of disease or injury, chief complaint and physical findings, diagnosis, diagnostic findings, laboratory and x-ray reports (if applicable), treatment, prescriptions, final disposition and condition of patient upon discharge from or admission to the Hospital, the name of the practitioner who saw the patient in the emergency room and instructions given to patient and/or his family pertaining to follow-up care. It will also include reports of all consultations and of all diagnostic and therapeutic procedures. Emergency patient records not completed at the time of treatment will be forwarded to the Medical Record Department for completion. Any emergency patient record not completed by the attending or emergency room practitioner within 30 days of discharge from the emergency room will be counted as a delinquent patient chart.

4.26 Delinquent Medical Records.

(a) Delinquent Standard. A Medical Staff member is delinquent if medical records are not completed 30 days after a patient's discharge.

(b) Extensions. Extensions will be given for:

(i) vacation, illness or other circumstances beyond the practitioner's control and resulting in unavailability of the attending practitioner or another individual contributing to the medical record;

(ii) reports dictated and awaiting transcription by Hospital personnel; or

(iii) final laboratory or other essential reports for the determination of the final diagnosis.

(c) Loss of Admitting Privileges, Etc. On the thirtieth day after discharge at 12:00 noon, a delinquent list is posted and the Medical Staff member automatically loses admitting, surgical and outpatient privileges:

(i) Admissions. The delinquent Medical Staff member may not admit patients or write admitting, surgical and outpatient orders.

(ii) Write Orders. The delinquent Medical Staff member may continue to see patients and write orders.

(iii) Call Roster. The delinquent Medical Staff member continues to be listed on the Emergency Room Call Roster.

(d) Final Ten Days. The delinquent Medical Staff member has ten additional days to complete records (or up to 40 days after discharge before suspension of all Medical Staff privileges).

(e) Notice. On day 35, a notice of impending suspension is sent by certified mail to the Medical Staff member.

(f) Suspension. The delinquent Medical Staff member is suspended on day 40. If the fortieth day is a weekend day, or hospital-recognized holiday, the Medical Staff member is suspended on the next working day.

(i) No Admitting Privileges, Etc. The suspended Medical Staff member has no admitting, surgical or outpatient privileges, except in life-threatening situations.

(ii) No Privilege to Write Orders. The suspended Medical Staff member may not write orders or see patients in the Hospital.

(aa) Violation of Prohibition on Writing Orders. If a suspended Medical Staff member writes orders, the Nursing Staff will contact the covering Medical Staff member to cover these orders. If the covering Medical Staff member cannot be reached, the Nursing Staff will contact the Chief of Staff to cover the orders.

(bb) Transfer of Patients. In-house patients will either be transferred to another facility or to another Medical Staff member.

(iii) No Privilege to Take Call. The suspended Medical Staff member may not take call under any circumstances.

(iv) No On-Call Roster Listing. The suspended Medical Staff member will not be placed on the Emergency Room Call Roster.

(v) No Consultations. The suspended Medical Staff member may not provide any consultation.

(g) Reinstatement. The suspended Medical Staff member may be reinstated with full privileges by the Chief of Staff or at the discretion of and the Chief Executive Officer (or their designees) only after completion of all delinquent records.

4.27 Correction/Alterations of the Medical Record. In a circumstance whereby any portion of a medical record must be altered or corrected due to an errant or incomplete entry, the following rules apply:

(a) Who May Alter. The alteration may be made only by the person who made the original (errant) entry.

(b) Crossed Out. The error should be crossed out with a single line (not erased or obscured) and initialed and dated by the author.

(c) Note of Explanation. A marginal note should be entered into the record explaining the reason for the alteration of the record and/or a reference to an addendum may be documented.

(d) Misspellings, Etc. Spelling or typographical mistakes will be lined out, corrected and marked as "errors".

(e) Chronological. A corrected entry or addendum should be made in chronological order.

(f) Patient Request. If the patient requests the alteration and the attending practitioner agrees, the record may be modified in the prescribed manner and noted that it was altered at the request of the patient, or the patient may initial and date the altered notation or add a personal signed and dated addendum sheet to the record. If the attending practitioner does not agree, the matter will be referred to the Chief of the Medical Staff.

4.28 Incomplete Medical Records. No medical record may be filed until it is complete or closed out administratively by the Health Information Management Department Manager. If a member of the Medical Staff should die or resign from the Medical Staff and leaves incomplete charts, the following procedure will apply: A list of the charts will be submitted to the Medical Executive Committee and, with the approval of the Medical Executive Committee, these charts will be signed as incomplete, and a memo filed on the record to that fact.

4.29 Ambulatory Care Services. For patients receiving continuing ambulatory care services, the medical record contains a summary list of known significant diagnoses, conditions, procedures, drug allergies and medications. This list is initiated for each patient by the third visit and maintained thereafter.

4.30 Rehabilitation Plans. An interdisciplinary rehabilitation plan and goals, developed by qualified professionals, in conjunction with the patient and/or his or her family social network, or support system, and based on a functional assessment of patient needs, will guide the provision of rehabilitation services, appropriate to the patient's needs and environment. Discharge planning from rehabilitation services is integrated into the functional rehabilitation assessment.

4.31 Retention. Medical records must be retained in their original or legally reproduced form for a period of at least 6 years.

4.32 Photographs. Photographs may be taken of a patient only in accordance with Hospital policy.

4.33 Organ Retrieval. The medical records requirements for organ retrieval will be in accordance with the required documentation and acceptable procedures of the organ retrieval program. (See also MSP-10.9 and MSP-10.10.)

MSP-5. INFORMED CONSENT

5.1 Admission Consent. Except in an emergency, a general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting person or charge nurse will notify the attending practitioner whenever such consent has not been obtained.

5.2 Specific Consent. In addition to obtaining the patients informed consent for treatment, the attending practitioner will be responsible for obtaining a specific, written consent that informed the patient of the nature and risk inherent in any surgical or other procedure. The written consent form will be part of the patient's record.

5.3 Informed Consent. It is the practitioner's right and duty to participate in the decision-making process with the patient or patient's surrogate and clearly explain the risks and benefits of such procedures. Diagnostic and therapeutic interventions which are considered unnecessary from a medical standpoint cannot be mandated by the patient or the patient's surrogate if, in the best medical judgment, such interventions would not be expected to alter the prognosis or outcome. It is the practitioner's responsibility to determine the medical necessity of those interventions for patients. The responsible practitioner should write a short statement in the progress note indicating that a patient has been duly informed and has consented to the procedure or treatment. Surgical operations or other invasive or hazardous procedures will be performed only upon obtaining informed consent from the patient or from a qualified representative. Informed consent, as evidenced by a signed form, will only be valid for 90 days from its date.

5.4 Surrogate Consent. When consent is unobtainable from the patient, the attending practitioner will enter the reason into the medical record and will identify in the patient's chart the party making the consent or decision for the patient.

5.5 Standard Forms. Subject to this policy, standard Hospital consent forms, in addition to any form developed by a practitioner, will be available for evidencing a patient's consent. Consent forms may be processed by Hospital employees, and made a part of the patient's record, only after the responsible practitioner has obtained the patient's informed consent.

5.6 Elements of Informed Consent. The elements of an acceptable informed consent form:

(a) General Nature. It sets forth in general terms the nature and purpose of the intended operation or procedure, the various alternatives, and what they are expected to accomplish, together with the benefits and the reasonably known risks, and except in emergency situations, sets forth the names of the practitioners who will perform the intended procedures. Such disclosures will include anesthesia.

(b) Patient Acknowledgment. The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the operation or procedure have been answered in a satisfactory manner.

(c) Patient Signatures. The consent form is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, infancy, or the fact that at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such person in such circumstances.

(d) Practitioner Signature. The practitioner performing the surgery or procedure must sign the form, and the form must be dated.

5.7 Emergencies. When a patient is unable to execute an informed consent form, by reason of minority or mental or physical condition, and no acceptable surrogate is available, and such patient requires emergency medical care, the attending practitioner will make an appropriate entry on the patient's medical record that an emergency situation exists and that, for the reasons stated, a proper consent could not be obtained.

MSP-6. PATIENT TRANSFER

All patient transfers will be conducted in accordance with the Emergency Medical Treatment and Active Labor Act ("EMTALA"). For additional guidance, see Hospital Policy 35-81, Screening Stabilization and Transfer of Individuals with Emergency Medical Conditions.

6.1 Medical Service Transfers. When a patient is transferred from one attending practitioner's medical service to another practitioner's medical service, responsibility for that patient is transferred to the new practitioner. Transfer of medical service will only be completed when the practitioner transferring the patient executes a written order stating "patient is to be transferred to Dr. [name of practitioner]'s medical service" and the receiving practitioner has been notified.

(a) Nursing Unit. A patient whose medical service is changed may physically remain in the same nursing unit or may change nursing service.

(b) From Emergency Room. Admission of a patient from the Emergency Room to the Hospital as an inpatient will be considered a "transfer of medical service."

6.2 New Orders. The attending practitioner will renew, rewrite or write new orders on a transferred patient as necessary. Orders that are renewed or rewritten before or at the time of transfer will become effective immediately. Existing orders on a patient being transferred from one medical service to another will remain effective until the transfer is considered complete. If new orders are unavailable upon transfer of a patient's medical service, the nurse may, at his or her discretion, continue previous orders, but must immediately notify the responsible practitioner.

6.3 Nursing Unit Transfers. All patient transfers between nursing units will only be initiated upon order by the attending practitioner or by administration for space allocation needs and only after obtaining concurrence by the attending practitioner. If new orders are unavailable upon transfer of a patient's nursing service, the nurse may, at his or her discretion, continue previous orders, but must immediately notify the attending practitioner.

6.4 Critical Care Unit Transfers.

(a) Order Required. A transfer to, or the discharge of a patient from, the Intensive Care Unit requires a verbal or written order from the attending practitioner or a resident acting in consultation with the attending practitioner.

(b) Filled to Capacity. When the unit is filled to capacity and bed space is required for an acutely ill new admission, the charge nurse will call the attending practitioners of those patients who may be candidates for transfer out of the unit. If no practitioner is willing to transfer his or her

patient, the charge nurse will then place a call to the unit's director who will confer with the involved practitioners and decide which patient or patients will be transferred out of the unit, if any.

6.5 Appropriate Patient Transfer. If the patient has an emergency medical condition that has not been stabilized, or is in active labor, the Hospital will not carry out a transfer unless:

(a) Transfer Request. The patient, or a legally-responsible person acting on the patient's behalf, after having been informed of the Hospital's obligations under EMTALA and the risks of transfer, requests the transfer. The request by the patient or his representative must be put in writing and indicate the reasons for the request as well as indicate that the patient is aware of the risks and benefits of the transfer; or

(b) Certification. A physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the transfer outweigh the increased risk to the patient and, in the case of labor, to the unborn child from effecting the transfer; and

(c) Receiving Facility. Prior to the transfer, the Hospital has ensured that the receiving facility has available space and qualified personnel for the treatment of the patient, and has agreed to accept transfer of the patient and to provide appropriate medical treatment; and

(d) Medical Records. The Hospital will provide the receiving facility with appropriate medical records, or copies thereof, of the examination and treatment provided by Hospital.

6.6 Patient Refuses Transfer. If a transfer is appropriate and the Hospital offers to transfer the patient and informs the patient (or person acting on the patient's behalf) of the risks and benefits to the patient of the transfer, but the patient or his representative refuses, the Hospital must take reasonable steps to secure the refusal in writing. The writing must indicate that the patient or his representative has been informed of the risks and benefits of the transfer and the reasons for the patient's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the patient.

6.7 Patient Requests External Transfer. For cases in which the patient or family members demand transfer to another facility, the attending practitioner (Emergency Room and/or other relevant specialty) should be involved in the external transfer decision.

6.8 Practitioner Refuses External Transfer. If the patient's attending practitioner refuses to effect an external transfer requested by the patient, the patient may leave the Hospital Against Medical Advice (AMA) subsequent to signing an AMA statement. This statement may

be signed by either the patient or another responsible person. AMA transfers will not utilize Hospital personnel. If the patient refuses to sign the statement, he or she must still be released and details of the incident must be thoroughly described in the medical record by the attending practitioner or a resident in consultation with the attending practitioner. Entries in the record should be witnessed by other personnel familiar with the situation. An incident report should also be completed.

6.9 Transfers from Another Facility. A request for the transfer of a patient to the Hospital will be accepted without regard to the patient's ability to pay, if the patient fits into a category of the definition of "emergency medical condition" as defined by EMTALA and the Hospital has the capability, space and qualified personnel to provide treatment.

MSP-7. CONSULTATIONS

7.1 Consultant. A consultant is defined as a practitioner who is qualified both by experience and training in a particular specialty to give an opinion on the condition in question. Any qualified member of the Medical Staff may consult within his or her area of expertise and clinical privileges.

7.2 Consultation Situations. Except in an emergency, consultation is urged in the following instances:

(a) Patient Not a Good Risk. When the patient is not a good medical or surgical risk.

(b) Obscure Diagnosis. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.

(c) Doubt. Where there is doubt as to the best choice of therapeutic measures to be utilized.

(d) Complicated Situations. In unusually complicated situations where specific skills of other practitioners may be needed.

(e) Pregnancies. Consultation is required for all TAB (threatened abortion), curettages or other procedures by which a normal pregnancy may be interrupted.

(f) Technical Procedures. In the performance of technical procedures such as Swan Ganz catheters, and assistance in patient management, such as ventilator management or antibiotic therapy.

(g) Psychiatric Symptoms. The attending practitioner must request a psychiatric evaluation on any patient deemed a potential danger to himself or others.

(i) Nursing Staff Concerns. In situations where the nursing staff becomes first aware and concerned with such a patient, the nurse will inform the attending practitioner of her or his concern, and it will be the responsibility of the attending practitioner to request such a psychiatric consultation if deemed necessary and see that the consultation is obtained and adequately documented.

(ii) Disagreement. In cases where there may be disagreement between nursing staff and the attending practitioner regarding the need for psychiatric consult, the nursing staff will have the responsibility of communicating with Nursing Administration, who in turn will

contact the appropriate Medical Director, who will then have the responsibility of clarifying the issue of need for the consultation.

(h) No Clinical Privileges. A consultation or management by a practitioner, or other qualified licensed independent practitioner is required when the patient's treatment requirements exceeds the treating practitioner(s) privileges.

(i) Patient or Family Request. A consultation is required when requested by the patient or family.

(j) Another Medical Staff Member. If a member of the Medical Staff has any reason to question the care provided to any patient or believes that a consultation is needed, it is his or her obligation to call the matter to the attention of the attending practitioner. If not resolved, a consultation may be requested by the Chief of Staff.

(k) All Other Situations. When deemed necessary by the attending practitioner.

The Chief of Staff may request a consultation on any patient where the attending practitioner's care appears to deviate markedly from acceptable standards.

7.3 Consultation Requests. The attending practitioner is responsible for requesting consultation. Requests for practitioner consultations must be initiated by a patient care order signed by the requesting attending practitioner. The order should include the following information:

(a) Name. Name of the Medical Staff practitioner consulted.

(b) Response Time. Response time requested, including stat, urgent or routine. Notification of an urgent consultation is the responsibility of the requesting practitioner.

(c) Clinical Indications. Specific clinical indication (known or suspected diagnosis) for consultation.

(d) Level of Patient Care. Level of patient care requested and continuing responsibility, if any.

7.4 Consultant's Response. Consulting practitioners must respond to patient consultation requests in a timely manner (see patient within 24 hours of the request) and in concert with the needs of the clinical situation. Responses must be documented and will include the following information:

(a) Documentation. Documentation of patient contact, evaluation and date.

(b) Diagnosis. Actual or presumptive diagnosis.

(c) Recommendations. Management and therapeutic recommendations.

(d) Follow-Up. Follow-up recommendations, as required.

(e) Signature. Consultant's signature.

7.5 Types of Consultation Orders. Orders for consultation may be any of the following:

(a) Consultation Only. This order leaves the management in the hands of the attending practitioner and prohibits the consultant from writing orders on the medical record.

(b) Specific Problem. In this case, the consultant may write orders to manage a specific problem, diagnosis or procedure, but the overall responsibility for the case remains with the attending practitioner.

(c) Full Responsibility. In this case, the consultant assumes full responsibility for writing orders and for the management of the patient and this order prohibits the attending practitioner from writing any further orders.

7.6 Content of Consultation Order. An order for consultation will specify the name of the consultant and indicate whether the consultation is routine, urgent or emergency. The order must be dated and signed by the ordering practitioner.

(a) Critical Care Units. When an order for consultation is written in the Critical Care Unit, the consultation will be assumed to be an emergency unless otherwise indicated.

(b) Group Practitioner Request. When ordering consultation from a member of a group practice, the practitioner may write the names of certain members of the group or simply the name of the group.

(c) Documentation. When any consultation order has been given in an emergency situation and the order is written on the chart at a later date, the order must specify the date on which it was actually given.

(d) Not a History and Physical. A consultant's report should not be used as the history and physical. The attending practitioner should complete the history and physical unless he expressly requests the consultant to do this and it is understood by both practitioners.

7.7 Medical Record. A consultation requires an examination of the patient and the patient's record and must be included in the medical record. A consultation is not complete or satisfactory unless it indicates pertinent history and physical findings related to the requested consultation, evidence of chart review, conclusions, recommendations, date and the consultant's signature.

(a) On the Chart. The consultant's report is expected to be on the chart at the time of completion. If the consultant dictates the report, the consultant must make an initial written progress note at the time of consultation indicating impressions and recommendations.

(b) Not Consultations. Procedures such as x-rays, electrocardiograms, tissue examinations, pap smear, proctoscopies, and cystoscopies are not considered consultations.

(c) Surgical Procedure. When an operative procedure is involved, a consultation note must be recorded before the operation is performed, except in an emergency.

7.8 Transfer of Patient Management. An attending practitioner may write orders to transfer the management of a patient. In this case, the management is transferred to another named practitioner and the admitting practitioner may no longer write orders for the patient.

7.9 Disagreement. If the attending practitioner and consultant disagree on the management of a patient, a second consultation may be ordered by the attending practitioner.

7.10 Refusal to Consult. Should a consultant refuse to provide a consult or refuse to continue to provide consultant care, or should a consultant be requested by a patient or family to discontinue consultant care, the following procedures will be followed in the order listed:

(a) Consultant is Not On-Call Practitioner. The ordering practitioner will consult another Medical Staff member or the Medical Staff member who is on Emergency Call at that time, provided the consultant who is refusing or withdrawing is not the Medical Staff member on Emergency Call.

(b) Consultant is On-Call Practitioner. If the consultant refusing or withdrawing is the Medical Staff member on Emergency Call, the ordering practitioner will contact the appropriate Medical Director who will assign a consultant.

(c) Unavailability of Medical Director. If the Medical Director is not available or happens to be the consultant who is refusing or withdrawing, the ordering practitioner will contact the Chief of Staff who will assign a consultant.

7.11 Surgery. When operating procedures are involved, the consultation report must be recorded prior to surgery, except in the case of an emergency as verified in the medical record.

7.12 Outside Resources. All communications by phone, email (hard copy) or otherwise with outside resources or supervising practitioners must be recorded in the medical record.

MSP-8. PHARMACEUTICALS

8.1 Formulary. Medications will be listed in the Hospital formulary, with the exception of medications for bona fide clinical investigations. The Hospital formulary is a continually revised compilation of therapeutics and pharmaceuticals that reflect the current clinical judgment of the Medical Staff. The formulary system is a method whereby the Medical Staff evaluates, appraises and selects those drug products that are considered most useful in patient care. Only those so selected are routinely available from the Hospital pharmacy. The formulary system provides for the procuring, prescribing, dispensing and administering of drugs under either their nonproprietary or proprietary names. All drugs and medications administered to patients must be listed in the latest edition of the United States Pharmacopoeia National Formulary, American Hospital Drug Information Service or AMA Drug Information Service or AMA Drug Evaluations; drugs for approved clinical investigations may be excepted.

8.2 Drug Investigations. The Medical Executive Committee or its designee will review and approve all clinical drug investigations. In an emergency, the chairman of the Medical Executive Committee may authorize exemption from the formal review procedure. Practitioners desiring to use investigational drugs and implantable devices must receive prior approval and an investigational control number from the Federal Drug Administration (FDA). Following FDA approval, investigation protocols must be submitted to and approved by the Medical Executive Committee, or its designee. The patient to whom the drug will be administered must sign a form which releases the Hospital of any responsibility for the drug.

8.3 Adverse Drug Reactions. The Medical Staff in cooperation with the Hospital pharmacy and the Nursing Department is responsible for notification and reporting any adverse drug reaction that occurs in the Hospital. A registered nurse must record in the nurse's notes any observations suggesting an adverse drug reaction and immediately communicate the same to the practitioner and pharmacist for investigation and any necessary corrective action. The attending practitioner will review the suspected adverse drug reaction and record the reaction and implicated drug in the patient's medical record.

8.4 Medication Allergies. The attending practitioner who determines a patient has a medication allergy will record the name of the medication on the physician order form. Nursing Department personnel will send the order to the Hospital pharmacy for inclusion in the patient's medication profile.

8.5 Stop Dates for Medications. The Medical Executive Committee may establish stop dates for any drugs. Implementation of automatic stop orders must be documented in the patient medical records.

8.6 Drug Substitution. Substitution of drugs by the pharmacist is not permitted unless the specific drug substitution has been approved by the Medical Executive Committee and the Administration. Notwithstanding the foregoing, no drug substitution is permitted when the attending practitioner requests a specific drug for patient care purposes. Provider must write

"dispense as written" or "do not substitute" if a generic is not to be dispensed for the brand name drug.

8.7 Order Sheets. The signed, dated, and timed practitioner's order sheets must have a copy sent directly to the pharmacist for the interpretation and implementation.

8.8 Patient's Own Drugs and Self Administration. See MSP-2 at Section 2.23.

MSP-9. RESTRAINTS

9.1 Nursing Manual. Restraints or seclusion will be used in accordance with the Hospital's Administrative Manual, some principles of which are listed below.

9.2 Restraints or Seclusion Requirements. The use of restraints or seclusion requires:

(a) Time-Limited Order. A written time-limited order from the attending practitioner.

(b) Justification. Written documentation on the order sheet of the justification for use.

(c) Frequent Observation. Observation by nursing staff.

(d) Patient Needs. There is documentation that the needs of the patient are regularly attended to, especially in regard to meals, bathing and the use of the toilet.

9.3 Least Restrictive Device. Whenever a patient is assessed to require application of any restraint or seclusion, the least restrictive device will be used. The initial order for restraint or seclusion may be a written or verbal order.

9.4 Limitations. A complete order for restraint or seclusion must include a time limit as defined above, be specific as to the device used and body part to be restrained, and document the date and time when the order is written or given.

9.5 Special Treatment Procedures. Special treatment procedures such as restraints, seclusion, electroconvulsive therapy, or other forms of convulsive therapy, psychosurgery, or other similar procedures and behavior modifications procedures that use aversive conditioning require special justification and documentation in the medical record.

MSP-10. DEATH AND AUTOPSIES

10.1 Autopsies. Every member of the Medical Staff is expected to be interested in securing autopsies whenever indicated. Coroner cases are decided at the discretion of the Coroner/Medical Examiner's office. If the case is released from jurisdiction, and an autopsy is desired, then the attending physician and patient's legal next of kin must authorize the Hospital ordered autopsy with an autopsy permit. Hospital is responsible for arranging transportation of the body to and from the Ramsey County pathologist for autopsy (transportation restricted through MN statues to licensed funeral directors outside of Coroner cases). Autopsies are performed by the Ramsey County pathologist. The Ramsey County pathologist is responsible for notifying the attending practitioner of the results of the autopsy.

10.2 Pronouncement of Death. In the event of a Hospital death, the deceased will be pronounced dead by the attending practitioner or his or her designee within a reasonable period of time. Exceptions may be made in those instances of incontrovertible and irreversible terminal disease where the patient's course has been adequately documented to within a few hours of death. In such cases, a nurse may pronounce the patient dead using approved assessment criteria in accordance with Hospital policy. If a patient dies in the Emergency Room, and has no attending practitioner, the Emergency Room physician will be responsible for this pronouncement. The attending practitioner is responsible for the terminal note in the medical record. Reporting of deaths to the Coroner's Office will be carried out when required by and in conformance with local law. The death certificate must be signed and an entry made on the medical record by the attending practitioner unless the death is a Coroner's case, in which event the death certificate may be issued only by the Coroner.

10.3 Authorization for Autopsy or Post Mortem Examination. No post mortem examination or autopsy will be performed without the express written consent of one of the following persons of sound mind and 18 years of age or older in the order named:

(a) the deceased person in his lifetime
(b) the deceased's spouse
(c) children
(d) parents
(e) brothers or sisters
(f) any other relative
(g) person who assumes custody of the body for burial.

Consent of a person in one of the above categories must give way to a refusal to consent by a person in the same or higher category. The consent must be properly witnessed. Any limitations on the scope of the post mortem examination as stated in the written consent must be respected. If a family member is unwilling to consent to a complete autopsy, a limited autopsy should be suggested. A family's wishes regarding an autopsy must be respected except in Coroner's cases. In difficult cases, Hospital counsel should be consulted.

10.4 Securing Autopsies. Autopsies should be sought when there is:

(a) Unanticipated. Unanticipated death.

(b) Therapeutic Trial Regimen. Death occurs while the patient is being treated under a new therapeutic trial regimen.

(c) Medical Education. A death that has potential to contribute to medical education.

(d) Obstetric. All obstetrical deaths.

(e) Neonatal. All neonatal and pediatric deaths.

(f) Occupational. Deaths known or suspected to have resulted from occupational hazards or environmental hazards in the workplace.

(g) Unexpected. Unexpected or unexplained death occurring during, or following any dental, medical, surgical, diagnostic or therapeutic procedure.

(h) Unusual Circumstance. Natural deaths that are ordinarily subject to forensic jurisdiction, such as following:

(i) DOA. Persons dead on arrival at the Hospital,

(ii) After Admission. Deaths occurring in the Hospital within 24 hours of admission,

(iii) Injury While Hospitalized. Death of a patient who sustained an injury while hospitalized.

(i) Infections. Deaths resulting from high-risk infections or contagious disease.

(j) Obscure Cause. Death occurs where there is no clear cause or where the cause is sufficiently obscured to delay completion of the death certificate.

10.5 Reportable Deaths. Deaths of the following nature must be reported immediately to the Coroner before the body is released:

(a) Accident, Suicide, Etc.. A death resulting directly or indirectly from accident, homicide, manslaughter, suicide, or if there is reasonable suspicion that the death was due to accident, homicide or suicide exists. This applies irrespective of the duration of survival of the individual.

(b) Sudden or Suspicious Death. A sudden unexpected death due to apparent natural causes wherein the attending practitioner cannot reasonably establish the cause of death as due to a natural disease process or a sudden death with a suspicion of crime or foul play.

(c) Within 24 Hours of Admission. Any unexpected death that occurs within twenty-four hours of admission to the Hospital, any intraoperative death or suspected therapeutic misadventure.

(d) Public Health Threat. A natural death wherein there is reasonable suspicion that an undiagnosed serious contagious disease exists representing a threat to public health.

(e) Occupational Deaths. Instances in which the environment of present or past employment may have caused or contributed to death by trauma or disease. Deaths in this classification include caisson disease (bends), industrial infections, pneumoconiosis, present or past exposure to toxic waste or product (including nuclear products, asbestos or coal dust), fractures, burns or any other injury received during employment or as a result of past employment, which may have contributed to death.

(f) Under Age of Two. Any child under the age of two years who dies suddenly when in apparent good health.

(g) Anesthetic. A death occurring while the patient is under the influence of any anesthetic, whether in an operating room, recovery room, patient room, Emergency Department or Radiology.

(h) Drugs and Vaccines. Death due to the administration of a drug, serum, vaccine or any other substance for any diagnostic, therapeutic or immunological purpose.

(i) Abortion. Any criminal abortions.

(j) Accidents. Any death resulting directly or indirectly from an accident such as gunshot or stab wounds, poisoning, fires, explosions, burns, scalds and automobile accidents.

(k) Tetanus. Any death from tetanus.

(l) Alcoholism. Any death from alcoholism.

(m) Drowning. Any death by drowning.

(n) Injury. Any death occurring in the Hospital as the result of an injury. For example, if a patient died after being admitted for a fracture, it is a Coroner's case regardless of the length of time the patient is hospitalized or the cause of death.

(o) Surgical Procedure. Any death occurring during a surgical procedure, unless the death is the result of a natural disease.

10.6 Timeframes. Pathology will initiate an autopsy examination within 24 hours after receiving the proper authorization. When an autopsy is performed, provisional anatomic diagnoses should be recorded in the medical record within three working days and the complete pathology report must be made a part of the record within 30 days for a routine autopsy and within 90 days for a complex autopsy. A routine autopsy is one without clinical-pathological discrepancies or one not requiring special studies, e.g. EM, Immuno, outside consultations and so on. A complex autopsy is one involving medical-legal questions, complex surgery with complications, or one with clinical-pathological discrepancies or involving special studies or consultations.

10.7 Records. If an autopsy is performed, a full record or report of the facts developed by the autopsy in the findings of the person making such autopsy will be made and filed in the office of the county medical examiner or the board of supervisors.

10.8 Autopsy Costs. The Hospital offers post mortem examinations at no charge if, at death, the deceased was at the Hospital:

(a) Inpatient. As an in-patient; or

(b) Outpatient. As an out-patient undergoing in-hospital test or procedure; or

(c) Previously Hospitalized. Previously hospitalized within one month of death, and whose death would have appeared to be related to conditions of the hospitalization, and provided that those patients are not a reportable Medical Examiner's case under Minnesota law.

For all other deceased patients, including, those seen only in the Emergency Room, and who may or may not fall under Medical Examiner's jurisdiction under Minnesota Law, an autopsy may be performed, but only after arrangements have been discussed and confirmed by a Medical Staff pathologist, since a professional fee for such an examination may be charged.

10.9 Organ Donation. Following the death of a hospitalized patient, a decision will be made as to the suitability of the deceased's organs for transplant. The attending practitioner will then inform the next of kin of the need for specified body organs for the purpose of transplantation to living donees. If the responsible person wishes to authorize donation of specified organs, the appropriate authorization forms will be completed. The time of death will be determined by a practitioner or surgeon who attends the donor at death or, if none, the

practitioner or surgeon who certifies the death. The practitioner or surgeon who attends the donor at death, or determines the time of death will not participate in the procedures for removing or transplanting a part unless the document of gift designates a particular practitioner or surgeon pursuant to Minnesota Law. Notwithstanding, the foregoing policy may be superseded by the active involvement of a qualified organ procurement organization working with the Hospital and its Medical Staff.

10.10 Organ Removal. A surgeon who removes an organ from a donor cadaver in the surgical suite must make a note to this effect in the progress record.

MSP-11. RESUSCITATIVE GUIDELINES

11.1 Level of Resuscitation. Patients will have a code status ordered by a provider (Physician, NP, PA). An order indicating the level of resuscitation that a patient should undergo may only be written by the provider. The provider will discuss choice of resuscitative status with the patient and/or surrogate representative at time of hospital admission. Only three levels of resuscitation orders can be written:

(a) Full Code. Maximum resuscitation effort without reservation.

(b) Code With Specification. Based on patient and/or surrogate wishes, a provider's order may modify the code status to code with specification, or therapeutic effort with selected pre-determined measures which have been clearly defined in writing by the provider.

(c) No Code (DNR/DNI). Based on patient and/or surrogate wishes, a provider's order may modify the code status to no code. Discussions with the patient, and/or surrogate, are desirable. Patients with a no code status will be given the same level of care as any other patient, except for no resuscitation in the event of a cardiopulmonary arrest.

11.2 Code Modification Orders. The provider may modify the code status by written order, or in emergency circumstances, by verbal or telephone order. A resuscitation order may only be given over the telephone to a Licensed Nurse who is on duty. An order will be entered onto the patient's chart along with the date, name of provider and signature of the nurse. Verbal or telephone orders modifying a patient's code status will be signed by the provider within twenty-four (24) hours.

11.3 Progress Note. A provider's progress note will be written which supports the order to modify the code status. The provider's progress note supporting the modified code status should include:

(a) Prognosis. A description of the patient's prognosis;

(b) Consultation. Reference to any consultation which corroborates the change in the code status;

(c) Patient's &/or Surrogate's Wishes. Reference to the patient's &/or Surrogate's wishes or the existence of the patient's health care directive; a copy of which should be in the medical record; and

(d) Discussions. Reference to discussions of the patient's prognosis and the modified code status with the patient and/or surrogate.

11.4 Cardiopulmonary Arrest. If a patient experiences a cardiopulmonary arrest and no modification of the code status has been previously ordered, the Acute Care provider will be the captain of the resuscitation team unless the attending provider is present and wishes to direct the team.

11.5 Effect of Patient Transfer. Orders indicating the level of resuscitation that a patient should undergo will not be cancelled by transferring a patient from one medical service or nursing home to another or by the fact that a patient had an invasive procedure, such as surgery performed. However, the code status should be reviewed and specified on providers orders whenever the patient is transferred to or from the Special Care Unit (ICU/CCU) or surgery (please refer to Anesthesia Policy 3-93),. An order for resuscitation will be effective until it is rescinded or modified by the provider based upon patient and/or surrogate wishes.

11.6 Proper Rescission. Orders for resuscitation may only be rescinded when written on an order sheet by the provider.

MSP-12. HEALTH CARE DIRECTIVES

12.1 **Definition:** A Health Care Directive is a written instrument that includes one or more health care instructions, a health care power of attorney or both. A Health Care Directive shall be honored if the individual was competent when the Health Care Directive was executed and satisfies certain technical requirements. Minnesota law requires a written document that is dated, states the principal's name and signature, or the signature of an individual authorized by the principal to sign on the principal's behalf. The signature must also be verified by a notary public or witnessed by two persons other than the health care agent, alternate, or provider issuing direct care. A Health Care Directive becomes effective for a health care decision when the principal, in the determination of the attending physician, lacks decision making capacity to make the health care decision, or if other conditions for effectiveness otherwise specified by the principal have been satisfied. The physician shall continue to obtain the principal's informed consent when the principal has decision-making capacity unless other conditions for effectiveness are specified and satisfied. The agent and the provider (Physician, Nurse Practitioner (NP), or Physician Assistant(PA)) should concur in carrying out these wishes. Whether or not an individual has executed a Health Care Directive shall be fully documented by the provider in the patient's medical record.

12.2 **Validity:** Minnesota law currently uses the term "Health Care Directive" and the federal law uses "Advance Directive." Other terms and documents such as a living will, durable power of attorney, or a health care proxy may be used in other jurisdictions. Minnesota law recognizes Health Care Directives or similar documents executed by another jurisdiction subject to the following conditions. These documents must either comply with Minnesota's technical execution requirements or satisfy the laws of the jurisdiction in which it was executed. Provider questions concerning the validity of a Health Care Directive will be directed to the risk management staff, Ethics Committee, or Hospital legal counsel as designated by the CEO.

12.3 **Health Care Directives.** The patient has a right to formulate Health Care Directives and to have the Hospital and providers who provide care comply with these directives. The provider may not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed a Health Care Directive.

12.4 **Unstable Condition.** In the event that a patient is in an unstable medical condition prior to a potentially life threatening procedure, the provider must review and comply with the content of the Health Care Directive absent a Conscientious Objection.

12.5 **Conscientious Objections**. In cases where the provider cannot in his or her good conscience continue to care for a patient on the basis of the instructions contained in a Health Care Directive, he or she will consult the patient or surrogate to suggest selecting an alternative provider. In cases where an allied health provider cannot in good conscience assist with the treatment of a patient on the basis of the instructions contained in the Health

Care Directive, he or she will inform the provider of his or her desire to be removed from the case.

Approved 10/14/04 Patient Care Eval and 10/20/04 Medical Staff/cg

MSP-13. PATIENT COVERAGE

13.1 Regular Attendance by Rounding Practitioner. The rounding practitioner must attend his or her patient at the bedside on at least a daily basis, and more frequently as the patient's clinical status requires.

13.2 Basic Responsibilities. A member of the Medical Staff will be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of those portions of the medical record for which he or she is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, if any, and to relatives of the patient. Primary responsibility for these matters belongs to the admitting or responsible practitioner except when a transfer of responsibility is effected.

13.3 Transfer of Responsibility. When primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another Medical Staff member, a note covering the transfer responsibility and acceptance of the same must be entered on the orders and progress notes. (See also MSP-6.)

13.4 Alternate Coverage. Each practitioner must assure timely, adequate professional care for his or her patients in the Hospital by being available, or by designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this Hospital to care for the patient. Each member of the Medical Staff not present in the city or the immediate vicinity will name a member of the Medical Staff to attend patients in his absence.

13.5 Participation in the On-Call Roster. Unless specifically exempted by the Medical Executive Committee for good cause or by an applicable Medical Staff Policy, each member of the Medical Staff agrees that when he or she is the designated practitioner on-call for emergencies and consultations, he or she will accept responsibility during the time specified by the published schedule for providing care to any patient in any unit of the Hospital referred to the service for which he or she is providing on-call coverage. Requests for inpatient emergent care coverage will be subject to retrospective review by the Medical Executive Committee. The director of each respective clinical service area will formulate an on-call roster for designation on the published schedule or designated practitioners on call. If there is a conflict with the published schedule, it is the Medical Staff member's responsibility to notify another staff member to cover their schedule. Also see MSP-14, dealing with Emergency Room coverage.

(a) General Provisions.

(i) Notice. The clinical service area must notify practitioners of their on-call status.

(ii) Accessible. The on-call practitioners must be accessible by phone or pager and are responsible for providing the appropriate phone or

pager numbers to the Emergency Room. The home phone/cell number must be made available to the Emergency Room.

(b) Response Time. The on-call practitioner must be available to respond to an emergency call. Under normal circumstances, response time will be within 30 minutes.If the on-call practitioner cannot respond in timely fashion, it is his or her responsibility to find another practitioner who will respond in his or her place. In any event, should the ER practitioner determine that the patient's interests need immediate attention, the practitioner may take any action to address the patient's needs. (See also MSP-15.)

(c) Sign Out. The on-call practitioner may sign out to another practitioner provided that:

(i) On Medical Staff. The substituting practitioner is on the Medical Staff of the Hospital;

(ii) Notice. The practitioner signing out must notify the Emergency Room of the name of the substituting practitioner prior to the onset of call; and

(iii) Take Responsibility. The substituting practitioner must know he is taking call and agree to adhere to normal call responsibilities.

(d) Emergency. For a patient who may have life or limb-threatening trauma or illness, the on-call practitioner will be assigned to treat the patient without regard to any personal physicians the patient may have.

(e) Physically Present. The on-call practitioner must physically attend the patient in the Hospital when requested to do so.

(f) Cannot Perform. If the on-call practitioner feels that he or she is not capable of performing the services or not available to perform the services required by a patient he or she must provide a replacement practitioner and so notify the Emergency Room within thirty 30 minutes.

(g) Actual Exam Before Discharge. No patient may be transferred or discharged from the Emergency Room except, after appropriate screening, by a practitioner who has actually examined the patient in the Emergency Room. (See also MSP-6.)

(h) On-Call Practitioner. If the patient is assigned to the on-call practitioner for outpatient follow-up, the practitioner must be willing to see the patient within reasonable proximity to the time specified by the referring

practitioner. After seeing the patient in the emergency room, the on-call practitioner must be willing to see the patient at least once without regard to financial or medical condition. After the first visit, the on-call practitioner may make whatever further referral he or she deemed appropriate.

(i) Failure. Failure to comply with the foregoing rules will be referred to the Chief of Staff for consideration with his or her recommendation forwarded to the MEC.

MSP-14. EMERGENCY ROOM COVERAGE

14.1 Assurance of Emergency Room Coverage. A viable system providing regular and total on-call practitioner coverage of patients in the emergency room will be in effect. Emergency care for the sick and injured will be provided in the emergency room by the Medical Staff on 24-hour service. Each clinical service area will assume responsibility for appropriate coverage as required by the emergency room and will be required to set up its own emergency room on-call list. A monthly emergency room on-call list by specialty/sub-specialty will be prospectively published. The practitioner on ER call, including specialty/sub-specialty call, is to respond to ER call when requested by the ER practitioner or by another primary or specialty practitioner attending the patient in the emergency room by return telephone call within 30 minutes. The obligation of the on-call practitioner to respond to the emergency room does not place an absolute obligation on the responding practitioner to accept a patient for admission. In the event of a discrepancy of opinion between the emergency room practitioner and the patient's Medical Staff practitioner (whether private or on call) as to advisability or necessity of patient admission, the patient will be retained in the emergency room by the emergency room practitioner under clinical surveillance and management, pending the earliest possible and reasonably timely arrival of, and evaluation by, the Medical Staff practitioner, who will then (a) decide whether to accept the patient for inpatient admission to his or her service or to release the patient from the emergency room, and (b) who will then complete the emergency room medical record, indicating the results of his or her assessment and the details of the disposition of the case by either (i) dictating an H & P or writing an admission note, and writing admission orders, or (ii) by recording post discharge instructions and issuing prescriptions, in either eventuality as indicated by the patient's clinical status and clinical potentials. The on-call list does not extend to Hospital inpatients (*i.e.,* patients who have been transferred from the Emergency Room to inpatient status). Copies of all call schedules will be available in the emergency room, in the CEO's office, in the Nursing office, and in the respective locations where such clinical services are to be provided. Call schedules will be prospectively published monthly by the appropriate departments or the affected sections and distributed prospectively to the members of the Medical Staff. Changes in published emergency room call schedules are to be prospective to the practitioner's date of call, and coordinated by the appropriate department.

14.2 Minimum Staffing Requirements. At all times, the emergency room will maintain the following minimum staffing requirements:

(a) Roster. A current roster of practitioners on call;

(b) Nurse. A registered nurse immediately available within the Hospital;

(c) Lab Technician. A laboratory technician on call; and

(d) Radiology Technician. A radiological technician on call.

(e) Respiratory Therapy. A respiratory therapist on call.

MSP-15. RESPONSE TIME

15.1 Setting Requirements. The Medical Executive Committee may from time-to-time, in consultation with the appropriate clinical service areas, establish primary on call response time requirements. In doing so, primary care, OB, surgeons, anesthetists must be in the physical presence of the patient at the hospital within 30 minutes of receiving call, responsible physicians must be in the physical presence of the patient at the hospital within 30 minutes of receiving call.

If the scheduled on-call physician is unable to respond due to circumstances beyond the physicians control, the relevant primary provider will determine whether to attempt to contact another specialist on the Medical Staff or arrange for a transfer pursuant to this policy.

Secondary Call: Definition – Secondary call is defined as when a physician is available by phone to support a mid level provider who is physically on-site.

When a physician is on secondary call with a mid-level hospitalist on-site, he or she will be immediately available by phone and physically present within 60 minutes if needed.

MSP-16. CRITICAL/SPECIAL CARE UNITS

16.1 In general, the following types of cases are eligible for admission to the Intensive Care Unit:

(a) Shock. All patients in shock or with impending shock or the possibility of impending shock.

(b) Hemorrhage. All cases of hemorrhage; i.e., hemorrhage in a medical case, pre-operative or post-operative hemorrhage.

(c) Overdoses. All cases of drug overdosage where observation and intensive care is necessary.

(d) Concussion. All cases of concussion or possible concussion where vital signs and continuous care and observation are necessary.

(e) Myocardial Infarction. Myocardial infarction, suspected cases of myocardial infarction and those persons with symptoms suggesting acute ischemic heart disease.

(f) Eligibility. Examples of patients with conditions indicating eligibility for admission to a special care unit, such as ICU, are described in the hospital-wide plan of care.

16.2 Admissions Intensive Care Units.

(a) Who May Admit. Any practitioner on the Medical Staff with critical care privileges may admit a patient to the Intensive Care Unit if the patient requires intensive treatment, observation, or nursing care.

(b) Orders. Orders must accompany all patients admitted to the Intensive Care Unit.

(c) Consultations. All patients who require consultation when admitted to the Intensive Care Unit must be seen by the consultant or his or her designee within a timeframe established by the attending practitioner after discussion with the consultant.

(d) Admission from E.R. All persons admitted to the Intensive Care Unit from the Emergency Room because of a known or suspected acute cardiac event must have an intravenous line in place prior to admission.

16.3 Consultation and Participation. In accordance with the Medical Staff consultation policy, any practitioner who admits a patient to the Intensive Care Unit but does not have the

clinical privileges to treat the condition which caused the patient to be admitted to these units, is required to have mandatory consultation and participation by the appropriate specialist or sub-specialist. This will continue throughout the patient's stay in the unit. At the time of transfer from the unit, it will then be at the discretion of the attending practitioner whether or not further participation by the specialist or sub-specialist will continue.

16.4 Transfers and Discharges.

(a) Transfers. The transfer or discharge of a patient from the Intensive Care Unit requires a verbal, written or electronic order from the attending practitioner.

(b) At Capacity. When the unit is filled to capacity and bed space is required for an acutely ill new admission, the charge nurse will call the attending practitioner of those patients who may be candidates for transfer out of the unit. Patient may be transferred to another hospital.

MSP-17. THE LABORATORY AND X-RAY

17.1 Orders. All orders for radiology and laboratory services must include pertinent clinical information, such as a diagnosis or the reason for the service or test. Laboratory or tests not performed in the Hospital will be referred to approved reference laboratories.

17.2 Duplication, Etc. Outside pathology work which indicates a need for transfusions or transplants must be repeated at the Hospital. (See also MSP-2.24(c).) Surgeries indicated by outside biopsies or pap smears should not proceed until copies of the original slides have been reviewed by a member of the Pathology Service.

17.3 Tissues, Etc. Except as otherwise determined by Pathology, all tissues and foreign substances, including implants removed at an operation, must be delivered to the Hospital pathologist who will perform examinations as he may consider necessary to arrive at a pathological diagnosis. A written report of his or her findings will be included in the patient's medical record. Any removal of tissue or a foreign substance must be documented in the medical record.

17.4 Practitioner Exams. Practitioners may be required to submit to examinations as required by the Chief of Staff.

17.5 Diagnostic Imaging Studies.

(a) Rationale. The reason for an imaging study order and clinical information of a brief and pertinent nature must be written on the order sheet at the time the x-ray is ordered.

(b) Repetition. Imaging studies may be repeated without notification to the attending practitioner if technically inadequate unless the referring practitioner has indicated otherwise.

(c) Central Lines. A chest x-ray will be taken after the insertion of a central line, without the order of a practitioner.

(d) MRI Exams. An x-ray of the orbits will be taken prior to MRI exams, without requiring the order of a practitioner, if there is a history of intraocular metal foreign body or risk of such.

17.6 Outpatient Surgery. Lab work, x-rays, and/or an electrocardiogram will be ordered for any patient scheduled to undergo outpatient surgery at the discretion of the attending surgeon and/or CRNA.

17.7 Maintenance, Availability, Retention of Records.

(a) Records of Observations. Records of observations will be made concurrently with the performance of each step in the examination of specimens. The actual results of all control procedures will be recorded.

(b) Individual Performer. Records will identify the individual performing the examination. Such records as well as duplicate copies of laboratory reports will be retained in the laboratory area for a period of at least 1 year after the date the results are reported.

MSP-18. SURGERY

18.1 General Principles. Surgeons are to schedule operations, within their scope of practice, with the operating room and obtain a time for the operation. The surgeon must provide an order for the procedure that includes the identified critical elements on the preoperative order set.

18.2 Promptness. Surgeons, surgical assistants and CRNA must be in the operating room ready to commence surgery at the time scheduled and should commence operation at the time scheduled.

18.3 Scheduling. Surgical procedures will be scheduled in accordance with a policy maintained by the Surgical clinical service area.

18.4 General Preoperative Requirements. Except in an emergency, a surgical procedure may not be started unless the following requirement have been met:

(a) History and Physical. Report of history and physical examination written, or dictated. If dictated and not able to be transcribed a written H&P will be made available by admitting or ED physician. For H&P exams done greater than 24 hours prior to the procedure, the surgeon or anesthesia provider must review, update, and co-sign the H&P.

(b) Consent Forms. Signatures of both the patients and the responsible surgeon on the appropriate consent form to document that the practitioner has obtained the informed consent of the patient;

(c) Required Reports. Required preoperative diagnosis, laboratory findings, EKG and x-ray report (if required) are on the chart;

(d) Visit by Anesthesia Provider. A preoperative visit and evaluation by an anesthesia provider, is recorded; and anesthesia consent obtained.

(e) Medical Record. The surgeon has reviewed the patient's medical record immediately prior to surgery.

(f) Surgical Site Verification. The surgeon will verify the surgical site according to protocol.

(g) Time Out Protocol. Time Out procedure will be performed according to protocol.

If the circumstances prevent the recording of the complete history and physical examination, the surgeon must, before the operation proceeds, write an admission note giving the essential

findings to justify the diagnosis, the contemplated procedure, and a brief evaluation of the patient's condition.

18.5 Consultations and Medical Clearance.

(a) Consultations. Whenever consultations are required for elective surgery, they must be completed and recorded on the medical record prior to surgery in accordance with Medical Staff Policy. This policy applies whether the surgery is inpatient or ambulatory, same-day surgery.

(b) Medical Clearance.

(i) Medical Clearance Responsibility. All patients undergoing anesthesia will have a preoperative history and physical examination along with the appropriate diagnostic tests. The practitioner performing the history and physical examination in conjunction with the preoperative nurse educator and anesthesia provider will review the findings and determine whether or not the patient should be cleared for anesthesia and the surgical procedure. This preoperative history and physical examination will be conducted not more than thirty (30) days prior to the scheduled operation.

(ii) Definition, Etc. Medical clearance is an opinion of a practitioner regarding the patient's ability to withstand the proposed operation or procedure. It may also include recommendations. Medical clearance may appear as a statement within the history and physical examination or consultation, or it may appear as a separate statement. Whichever form is acceptable to the requesting surgeon or anesthesia provider, it must be dated and signed by the practitioner giving the medical clearance. Medical clearance contained within a consultation or as a separate statement does not replace the need for a history and physical examination.

18.6 Patient Visit. The anesthesia provider must visit the patient prior to surgery. The purpose of this visit is to examine the patient, explain the proposed anesthesia and obtain the patient's consent for anesthesia.

18.7 Informing Surgeon. The CRNA, or an otherwise qualified practitioner, must discuss the anesthesia plan with the involved surgeon prior to surgery.

18.8 Informed Consent. In accordance with Medical Staff Policy, no operation will be performed unless written informed consent has been obtained except in the case of an emergency where the operation is necessary to save the patient's life or preserve function. The patient, or the person acting on behalf of the patient, must know who, among the Medical Staff members is

attending the patient, is the operating surgeon and must consent to the specific operation. The surgeon is responsible for communicating to the Nursing Staff the terminology to be used on the surgical consent form. (See also MSP-5.) Both the surgeon and patient (or the person acting on behalf of the patient) must sign the consent form.

18.9 Qualified Assistant. Surgical residents or externs from recognized training programs may assist in surgery. The surgeon is responsible to arrange for or request an assistant in those procedures that an assistant is deemed necessary. A second provider, surgical resident, physician assistants, externs from recognized schools, surgical technologists, and registered nurses may assist in surgery. All must have established competency in sterile technique.

18.10 Infections. All infections must be reported to the Infection Prevention Nurse who will investigate the case, and make a report to the Infection Prevention Committee.

18.11 Patient Care. The primary surgeon will see all patients preoperatively, review the history and physical examination, assess the patient for any changes in physical status and co-sign (this may be delegated by the surgeon in some instances to the anesthesia provider or a physician assistant) the history and physical examination. The surgeon will also verify the surgical site according to protocol. The primary surgeon is responsible for writing the preoperative and postoperative orders, progress notes regarding the patient's condition and a discharge summary.

18.12 Postoperative Report. The practitioner performing the operation must write or dictate immediately following a procedure an operative report which fully describes the operation. This report will include the name of the practitioner who performed the procedure and his or her assistants, the procedure performed, description of the procedure, the findings of the procedure, estimated blood loss, any specimens and the postoperative diagnosis. The operative report should be dictated immediately following the procedure. Along with dictated operative report, the practitioner must provide a postoperative note, which will be immediately available to the next point of care. This note must include the following: preoperative and postoperative diagnosis, the procedure, estimated blood loss, any specimens, and any complications.

18.13 Surgical Specimens. Specimens removed at surgery will be sent to Pathology for appropriate examination, according to Hospital protocol. The Hospital pathologist will make a pathological diagnosis and sign his or her report which will be made part of the patient's medical record.

18.14 Accountability for objects. All objects will be accounted for according to Hospital protocol. If a sponge or any other foreign body cannot be accounted for when the count is made after a procedure, an x-ray must be taken to rule out the possibility of a foreign body having been left unintentionally in the patient. The costs for the additional x-ray will be assumed by the Hospital.

18.15 Scheduling Surgical Procedures.

(a) Scheduling. All surgical cases must be scheduled with the surgery scheduling office in accordance with Hospital policies.

(b) Preoperative Orders. The surgeon is responsible for providing signed preoperative orders to the surgery scheduling office; these orders may arrive electronically, by fax or personal delivery. These orders will appear on a form acceptable to Hospital protocol. Unless urgent, surgery will not be scheduled and preoperative testing will not be started in the absence of an order. Verbal orders can be taken by an authorized individual according to hospital protocol.

(c) Preoperative Testing. The preoperative orders will be managed by the preoperative nurse educator who will assure the appropriate tests are ordered according to Hospital protocol. The results of all preoperative tests will be reviewed by the preoperative nurse educator prior to the day of surgery and any abnormal results reported to the appropriate individuals.

(d) Needed Documentation. All required documents requiring signatures, such as history and physical examinations, consultations, consents and medical clearance, and all laboratory work and diagnostic testing must be in the preadmission center by the day before the scheduled surgery or procedure.

(e) Medical Records. The chart of the elective outpatient surgery patient must include:

(1) History and Physical. Within 30 days prior to the date of the elective surgery (available electronically or in printed form);

(2) Operation Report. Report of operation must be dictated along with a written note before the patient goes to the next point of care;

(3) Anesthesia Records. Anesthesia records, including pre-anesthesia assessment, anesthesia consent and intraoperative record;

(4) Orders. Preoperative and postoperative orders must be present;

(5) Discharge Instructions. Discharge instructions form, signed by the patient indicating receipt of the appropriate discharge instructions;

(6) Inpatient Records. Inpatient records, in the event the patient is admitted to the Hospital including an admission note stating the

reason for the admission, the plan of treatment, and other usual records.

(f) Cancellation of Surgery. The anesthesia provider is authorized to cancel any scheduled surgery procedure if, in his or her professional judgment, the risk to the patient makes the procedure inappropriate.

(g) Surgical Care Review. Surgical procedure will be reviewed and evaluated on a routine basis.

18.17 Physician Available. When the operating/anesthesia team consists entirely of non-physicians, there must be a physician immediately available in case of an emergency, such as cardiac standstill or cardiac arrhythmia.

MSP 19. PROFESSIONAL LIABILITY INSURANCE

19.1 Policy. The Governing Body, upon a recommendation from the Medical Executive Committee, establishes the professional liability insurance requirements for members of the Medical Staff.

19.2 Failure to Comply. Failure to comply with this requirement will result in automatic suspension as provided in the Medical Staff Bylaws.

MSP-20. EDUCATION/TRAINING

20.1 Continuing Medical Education. As a precondition to continued Medical Staff Membership, practitioners must fully participate in, and with the requirements of, the continuing medical education requirements established by the State of Minnesota.

20.2 Clinical Privilege Criteria. Each individual with delineated clinical privileges is expected to participate in continuing educational activities that relate, in part, to privileges granted. To obtain and maintain clinical privileges at the Hospital, a practitioner must fully satisfy all educational training requirements for granted or requested clinical privileges as such are established from time-to-time by the Governing Body of the Hospital.

20.3 Teaching Responsibilities. Upon the reasonable request of his or her Medical Director, or according to policy established by the Medical Executive Committee, each member of the Medical Staff will, without compensation, aid, participate in or teach approved educational programs for medical students, interns, resident physicians, resident dentists, physicians, dentists, nurses and other personnel.

20.4 Practicing. Upon the reasonable request of his or her Medical Director, each member of the Medical Staff will observe or proctor, under the terms of the Medical Staff Bylaws and without compensation, provisional members of the Medical Staff assigned to their services or sections to evaluate clinical competence and adherence to the bylaws and policies of the Medical Staff and Hospital.

MSP-21. SEXUAL HARASSMENT

21.1 General Principle. No individual will be subjected to unwelcome sexual advances, requests for sexual favors or other sexually oriented conduct, be it verbal or physical, from a Medical Staff member. Behavior by a Medical Staff member that will not be tolerated includes, without limitation, derogatory or suggestive comments and slurs or gestures which are personally offensive, adversely affect morale or interfere with work effectiveness.

21.2 Unacceptable Behavior. Unacceptable behavior, constituting sexual harassment, includes, but is not limited to:

(a) Offensive Flirtations. Repeated, offensive, sexual flirtations.

(b) Propositions. Sexual advances or propositions.

(c) Verbal Abuse. Continued or repeated verbal abuse of a sexual nature.

(d) Comments on Appearance. Graphic or degrading verbal comments about an individual or an individual's appearance.

(e) Objects and Pictures. The display of sexually suggestive objects or pictures.

(f) Physical Contact, Etc. Any offensive or abusive physical contact or gesture.

(g) Quid Pro Quo. Conduct which implies or threatens that an individual's "cooperation" of a sexual nature (or a refusal of same) will affect the individual's employment, assignment, compensation, advancement, career development, contract or professional standing.

21.3 Procedure for Handling of Complaints. Complaints of sexual harassment against a Medical Staff member must be made in writing. The complaint must include the following:

(a) Time. The date and time of the incident(s).

(b) Subject. The name of the subject of the harassment.

(c) Description. A factual, objective description of the conduct.

(d) Intervening Action. Any action taken, including date, time, place, action and names(s) of those intervening.

(e) Witnesses. The names of any potential witnesses.

21.4 Who May File A Report. A report of sexual harassment against a Medical Staff member may be filed by any individual, irrespective of whether he or she is an employee, volunteer, patient or another Medical Staff member and will be submitted to the Chief of Staff.

21.5 Notifications. The Chief of Staff will immediately notify the CEO of the report.

21.6 Complainant Interviews. The Chief of Staff and the appropriate Medical Director of the Medical Staff will interview the individual who filed the report, and when possible, others who may have knowledge of the incident.

21.7 Practitioner Interview. If, after the initial interviewing process is completed, the Chief of Staff and the appropriate Medical Director determine that the report of sexual harassment is credible, the Chief of Staff will notify by letter, and schedule a meeting with, the Medical Staff member involved. At that meeting, the Medical Staff member will be advised of the nature of the complaint(s). The Chief of Staff will protect the identity of the complainant if, in the judgment of the Chief of Staff, it is necessary and appropriate.

(a) Opportunity to Respond. The Medical Staff member will be given an opportunity to respond to the allegations.

(b) Conclusion. If, at the conclusion of the investigation, it is believed that the alleged misconduct did in fact occur, the Medical Staff member will be informed that:

(i) Nature of Conduct. The conduct may violate federal law and will not be tolerated by the Hospital;

(ii) Cessation of Conduct. The offending behavior must cease immediately and, if appropriate, an apology must be offered to the individual(s) involved;

(iii) Effect of Continued Behavior. Further incidents of a similar nature will result in the Medical Staff member's not being permitted to enter the Hospital and the initiation of disciplinary action under the Medical Staff Bylaws.

21.8 Documentation. The meeting will be documented.

21.9 Letter of Reprimand. After the meeting and a finding against the Medical Staff member, the Chief of Staff will send a formal letter of reprimand to the Medical Staff member. The letter will confirm the Hospital's position that, if sexual harassment again occurs, the Medical Staff member will not be allowed to enter the Hospital and disciplinary procedures will be initiated under the Medical Staff Bylaws. A copy of the letter will be placed in the Medical Staff member's credentials file. Notwithstanding, after any such finding or letter of reprimand,

the accused Medical Staff member may request procedural due process under the Medical Staff Bylaws in regard to the appropriateness of the finding.

21.10 CEO Notification. The CEO will be fully apprised of the situation. Specifically, the CEO will receive copies of the reports filed, the documentation of the meeting with the Medical Staff member, a copy of the letter of reprimand, and (if necessary) a brief explanation of the federal law prohibiting such conduct. It is ultimately the responsibility of the CEO to keep the Hospital environment free from sexual harassment.

MSP-22. DISRUPTIVE PRACTITIONER

22.1 Definition. Unacceptable, disruptive behavior includes, but is not limited to, the following:

(a) Abuse of Another. Verbal, written, psychological or physical abuse of another person, which includes either unwarranted or unfair professional criticism or any criticism presented in an uncivil manner.

(b) Misrepresentations. Lying, cheating, stealing, knowingly making false accusations, altering or falsifying patient records or Hospital documents.

(c) Sale of Controlled Substances. Selling or unlawful possession of controlled substances on the premises of the Hospital.

(d) Juvenile Behavior. Unwarranted, obstinate or juvenile behavior that unnecessarily distracts another person from his or her job or wastes time.

(e) Inappropriate Comments, Etc. Irrelevant or inappropriate written comments or drawings on patient records or other Hospital documents.

(f) Refusing to Discharge Obligations. Refusing to accept or properly discharge Medical Staff or Hospital assignments or obligations; or refusing to abide by Hospital or Medical Staff bylaws or policies.

(g) Unwarranted Requirements. Placing peculiar or personal requirements or burdens on another person that are unwarranted or unnecessary.

(h) Intimidation. Inappropriate comments or criticism which intimidate, demean or belittle another person.

(i) Fighting/Weapons. Fighting (fisticuffs or otherwise) or bringing a weapon or explosive device of any kind (whether lawfully owned or not) onto the premises of the Hospital.

(j) Public Criticism. Behavior outside of accepted channels that publicly criticizes the Hospital's or a Medical Staff member's quality of care.

(k) Knowing Waste. Wasting Hospital resources by knowingly and persistently ordering or performing unnecessary tests or procedures.

(l) Personal Gain. Using Hospital property or plans for unauthorized personal gain.

22.2 Reporting. Any individual may confidentially report disruptive behavior to the Chief of Staff or the Medical Executive Committee, who will immediately notify the CEO. The Chief of Staff or designee may meet with the practitioner on a one-to-one basis. The Chief of staff will determine if this reported behavior needs to go on for further investigation. The involved practitioner may ask to come to the Medical Staff Meeting for follow-up. This report must be in writing and will objectively describe:

(a) Time and Place. The date, time and place of the incident.

(b) Parties. The incident and the parties involved.

(c) Effects. The apparent effect of the incident on patient care, Hospital operations or individuals.

22.3 Medical Executive Committee Options. The Medical Executive Committee may elect to take no action, place a description of the incident in the practitioner's file, require a corrective action plan (or agreement) or initiate disciplinary procedures under the Medical Staff Bylaws. If the Medical Executive Committee takes no action, it will briefly and objectively note its reasons in its committee minutes.

22.4 Report in Practitioner's File. If the Medical Executive Committee considers placing a report in the practitioner's file, it will not do so without first notifying by letter and interviewing the practitioner. If, after this interview, the Medical Executive Committee decides to place a description of the reported incident in the practitioner's file, the practitioner also will be allowed to separately include a brief, written rebuttal in his or her file.

22.5 Disciplinary Action. After a single incident or a series of incidents, the Medical Executive Committee may initiate disciplinary action under the Medical Staff Bylaws.

22.6 Summary Suspension. The foregoing does not preclude the use of summary suspension and any other disciplinary procedure provided for in the Medical Staff Bylaws.

MSP-23. IMPAIRED PRACTITIONER

23.1 Definition. A member of the Medical Staff will be considered "impaired" for the purposes of this policy if he or she is unable to practice, under his or her license, with reasonable skill and safety because of an illness or disability including, without limitation, emotional or mental disorders, physical disabilities or the abuse of alcohol or drugs.

23.2 Procedure. If an individual working in the Hospital has a reasonable suspicion that a Medical Staff member is impaired, the following steps should be taken:

(a) Written Report. A written report should be given to the Medical Executive Committee. The report will include a description of the incidents and circumstances that led to the belief that the practitioner is impaired. The report must be factual. The individual making the report does not need to provide conclusive proof of the impairment.

(b) Investigation. If, after interviewing the individual who filed the report, the Medical Executive Committee believes there is enough information to warrant an investigation, it will direct that an investigation be initiated and a report made to it by:

(i) Committee. A standing or ad hoc committee of the Medical Staff;

(ii) Consultant. An outside consultant; or

(iii) Others. Another individual or individuals appropriate under the circumstances.

(c) Notification to Practitioner. The suspected practitioner will be notified by letter and interviewed as part of the investigation.

(d) Options. If, in the opinion of the Medical Executive Committee, a problem exists and depending upon the severity of the problem and the nature of the impairment, it has the following options:

(i) Rehabilitation Program. Require the practitioner to undertake a rehabilitation program and a rehabilitation consent agreement as a condition of continued appointment and clinical privileges;

(ii) Practice Restrictions. Recommend appropriate restrictions on the practitioner's clinical practice;

(iii) Referral to Committee. Refer the matter to a standing or ad hoc committee of the Medical Staff; or

(iv) Summarily Suspend. Recommend summary suspension of the practitioner's clinical privileges (subject to due process rights) until rehabilitation has been accomplished, if the practitioner does not agree to discontinue practice voluntarily.

(e) Reportable Conduct. If the matter cannot be handled internally or jeopardizes the safety of the practitioner or others, the Medical Executive Committee will obtain the advice of Hospital counsel to determine whether any conduct must be reported to law enforcement authorities or other governmental agencies and whether further steps must be taken.

(f) Disposition of Report. The initial report and a description of the actions taken by the Medical Executive Committee will be included in the practitioner's personnel file. If the investigation reveals that there is no merit to the initial report, the report will be destroyed. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report will be included in a confidential portion of the practitioner's personnel file and the practitioner's activities and practice will be monitored until it can be established that there is, or is not, an impairment problem.

(g) Status Report. The Medical Executive Committee should inform the individual who filed the report that follow-up action was taken.

(h) Confidentiality. Throughout this process, all parties will treat the initial report and investigation as confidential and will not engage in any discussions of this matter with anyone other than the individuals described in this policy.

23.3 Rehabilitation. At the request of the Medical Executive Committee, the Hospital will assist the practitioner in finding an acceptable rehabilitation or diversion program and may require the practitioner to enter into a rehabilitation consent agreement. A practitioner's clinical and admitting privileges will not be reinstated until it is established, to the Hospital's satisfaction, that the practitioner has successfully completed a program acceptable to the Hospital, has satisfied all of the terms of his or her rehabilitation consent agreement and is competent to exercise clinical privileges in the Hospital.

23.4 Reinstatement.

(a) Successful Rehabilitation. Upon sufficient proof that an impaired practitioner has successfully completed a rehabilitation program, has satisfied all of the terms of his or her rehabilitation consent agreement and appears competent to exercise clinical privileges at the Hospital, the Hospital, after consultation with the Medical Executive Committee, may consider the reinstatement of the practitioner's clinical privileges.

(b) Patient Care is Primary. In considering an impaired practitioner for such reinstatement, the Hospital and its Medical Staff must consider patient care interests as paramount.

(c) Clinical Director's Letter. The Medical Executive Committee must first obtain a letter from the clinical director of the rehabilitation program where the practitioner was treated (if appropriate) or from his personal physician; and the practitioner must authorize the release of this information. That letter (as appropriate) must state:

(i) Participation. Whether the practitioner did or is participating in the program;

(ii) Compliance. Whether the practitioner is or was in compliance with all of the terms of the program;

(iii) Attendance. Whether the practitioner attends AA or similar follow up meetings regularly (if appropriate);

(iv) Monitoring. To what extent the practitioner's behavior and conduct are monitored;

(v) Opinion. Whether, in the opinion of the treating practitioner, the practitioner is rehabilitated;

(vi) After Care Program. Whether an after care program was recommended to, and is being attended by, the practitioner and, if so, a description of the after care program; and

(vii) Rehabilitated and Competent. Whether, in the opinion of the treating practitioner, the practitioner is capable of resuming his or her professional practice and providing continuous, competent care to patients.

(d) Practitioner Release. The practitioner must inform the Hospital of the name and address of his or her personal physician or the clinic director, and must authorize that physician to provide the Hospital with information regarding his or her condition and treatment. The Hospital has the right to require an opinion from other clinical consultants of its choice.

(e) Nature of Condition. From the practitioner's personal physician the Hospital needs to know the precise nature of the practitioner's condition, and the course of treatment as well as the answers to the questions posed above.

(f) Additional Precautions. Assuming all of the information received indicates that the practitioner is rehabilitated and capable of resuming care of patients, the Hospital must take the following additional precautions when restoring clinical and admitting privileges:

(i) Satisfactory Evidence. If there is a rehabilitation consent agreement, the practitioner must provide the Medical Executive Committee with satisfactory evidence, in its sole discretion, that all terms of the rehabilitation consent agreement have been satisfied.

(ii) Clinical Coverage. The practitioner must identify a similarly licensed and experienced practitioner who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability;

(iii) Continuing Treatment. The practitioner will be required to obtain periodic reports for the Hospital from his or her primary care physician -- for a period of time specified by the Medical Executive Committee -- stating that the practitioner is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired.

(g) Monitoring Clinical Performance. The practitioner's exercise of clinical privileges in the Hospital will be monitored by the appropriate Medical Director, by a member of the service appointed by the appropriate Medical Director or by a practitioner designated by the Medical Executive Committee. The nature of that monitoring will be determined by the Credentials Committee after its review of all of the circumstances.

(h) Random Tests. The practitioner must agree to submit to random and periodic alcohol or drug screening tests (if appropriate to the impairment) at the request of the Medical Executive Committee.

(i) Requests for Information. All requests for information concerning the impaired practitioner will be forwarded to the Medical Executive Committee for response.

MSP- 24. MEDICAL STAFF PEER REVIEW POLICY

24.1 Purpose: To ensure that the hospital, through the activities of its medical staff, assesses the Ongoing Professional Practice Evaluation of individuals granted clinical privileges and uses the results of such assessments to improve care and, when necessary, performs Focused Professional Practice Evaluation.

24.2 Goals:

(a) Monitor and evaluate the ongoing professional practice of individual practitioners with clinical privileges;
(b) Create a culture with a positive approach to peer review by recognizing practitioner excellence as well as identifying improvement opportunities;
(c) Perform focused professional practice evaluation when potential practitioner improvement opportunities are identified;
(d) Promote efficient use of practitioner and quality staff resources;
(e) Provide accurate and timely performance data for practitioner feedback, Ongoing and Focused Professional Practice Evaluation and reappointment;
(f) Support medical staff educational goals to improve patient care;
(g) Provide a link with the hospital performance improvement structure to assure responsiveness to system improvement opportunities identified by the medical staff;
(h) Assure that the process for peer review is clearly defined, fair, defensible, timely and useful.

24.3 Definitions:

(a) Peer Review

The evaluation of an individual practitioner's professional performance for all relevant competency categories using multiple sources of data and the identification of opportunities to improve care. During this process, the practitioner is not considered to be "under investigation" for the purposes of reporting requirements under the Healthcare Quality Improvement Act.

The data sources may include case reviews and aggregate data based on review, rule and rate indicators in comparison with generally recognized standards, benchmarks or norms. The data may be objective or perception-based as appropriate for the competency under evaluation.

The medical staff has determined that for purposes of defining its expectations of performance and measuring and providing feedback for the Joint Commission General Competencies, it will use the ACPE/ Practitioner Performance Dimension Framework outlined below:

- **Technical Quality**
- **Service Quality**
- **Relationships**
- **Citizenship**
- **Patient Safety/Patient Rights**
- **Resource Use**

A table describing the relationship this framework and The Joint Commission competencies is provided in Attachment A.

(b) Peer
An individual practicing in the same profession who has the expertise to evaluate the subject matter under review. The level of subject matter expertise required will be determined what "practicing in the same profession" means on a case-by-case basis.

(c) Practitioner
A Medical Staff member (MD, DO, DPM, dentist, and oral surgeon) or an Allied Health Practitioner (AHP)

(d) Peer Review Body
The committee designated by the Medical Executive Committee to conduct the review of individual practitioner performance for the Medical Staff. The peer review body will be the Medical Staff Quality Committee (MSQC) as described in the MSQC Charter (Attachment B) unless otherwise designated for specific circumstances by the MEC. Members of the peer review body may render judgments of practitioner performance based on information provided by individual reviewers with appropriate subject matter expertise.

(e) Ongoing Professional Practice Evaluation (OPPE)
The routine monitoring and evaluation of current competency for practitioners with granted privileges.

(f) Focused Professional Practice Evaluation (FPPE)
The confirmation of current competency based on:

- concerns from OPPE (i.e. focused review) or
- new medical staff members or new privileges, (e.g. proctoring)

(g) Conflict of Interest
A member of the medical staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the practitioner is the provider under review or a first degree relative or spouse. Potential

conflicts of interest would result if the practitioner was: 1) directly involved in the patient's care but not related to the issues under review or 2) a direct competitor, partner or key referral source, or 3) involved in a perceived personal conflict with the practitioner under review.

24.4 Peer Review Procedures

(a) Information Management

1. All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.
2. The involved practitioner will receive provider-specific feedback on a routine basis.
3. The medical staff will use the provider-specific peer review results in making its recommendations to the hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.
4. Any written documents that the medical staff determines should be retained related to provider-specific peer review information will be kept by the hospital in a secure, locked file.
   - Provider-specific peer review information may include aggregate performance data for all of the general competencies measured for that practitioner or any written correspondence with the practitioner deemed necessary regarding commendations, improvement opportunities, or corrective action.
   - Aggregate peer review data will be retained for six years after the most recent reappointment of the provider. Information related to formal investigations and corrective actions will be retained for six years unless there is reoccurrence of the issue.
5. Only the final determinations of the MSQC, any subsequent actions or recommendations and correspondences between the committee and the practitioner are considered part of an individual provider's quality file. Any written or electronic documents related to the review process other than the final committee decisions shall be considered working notes of the committee and shall be destroyed by policy after the committee decision has been made. Working notes include potential issues identified by hospital staff, preliminary case rating, questions and notes and the practitioner reviewers and requests for information from the involved practitioners and any written responses to the committee.
6. Peer review information in a practitioners quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities. The Quality/Risk Director will assure that only authorized individuals have access to

individual provider quality files and that the files are reviewed under the supervision of the Quality Risk Director for the following individuals:

- The specific provider who may see documents sent to or by him/her; other documents will be summarized in writing;
- Members of the MEC and , credentials committee during committee meetings
- The specialty medical director at the request of the Chief of Staff, MEC or Credentials Committee chair, or the chairs of these committees for the purpose of conducting committee business
- Medical staff services professionals, Quality/Risk Director and quality staff supporting the peer review process;
- Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g. state/federal regulatory bodies;
- Individuals with a legitimate purpose for access as determined by the hospital Board of Trustees;
- The CEO or medical staff Chief of Staff for purposes of any potential professional review action as defined by the medical staff bylaws.

7. No copies of peer review documents will be created and distributed unless authorized by medical staff policy or bylaws, the MEC, the Board or by mutual agreement between the Chief of Staff and the CEO.

(b) Circumstances requiring Internal Peer Review (IPR): IPR is conducted by the medical staff using it own members as the evaluation source of practitioner performance. It is performed as an OPPE and reported to the appropriate committee for review and action. The procedures for conducting IPR for an individual case and for aggregate performance measures are described in Attachments B and C.

(c) Conflict of Interest Procedure: It is the obligation of the reviewer to disclose to the peer review committee the potential conflict. It is the responsibility of the peer review body to determine on a case by case basis if a relative conflict is substantial enough to prevent the individual from participating.

- When a potential conflict is identified, the MSQC chair will be informed in advance and make the determination if a substantial conflict exists.
- When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions other than to provide specific information requested as described in the Peer Review Process (Attachment C).

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the MSQC or the MEC will replace, appoint or determine who will participate in the process so that bias does not interfere in the decision-making process.

(d) External Peer Review (EPR): Either the MSQC, MEC or the Board of Directors will make determinations on the need for EPR. No practitioner can require the hospital to obtain EPR if it is not deemed appropriate by the determining bodies indicated above.

(1) Circumstances for EPR may include but are not limited to the following:

- Lack of internal expertise: when no one on the medical staff has adequate expertise in the specialty under review; including new procedures or technology or the only practitioners on the medical staff with that expertise are determined to have a significant conflict of interest
- Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees.
- Legal concerns: when the medical staff needs confirmation of internal findings or an expert witness for potential litigation or fair hearing
- Credibility: when or if the medical staff or board needs to verify the overall credibility of the IPR process typically as an audit of IPR findings.
- Benchmarking: when an organization is concerned about the care provided by its physicians relative to best practices and wishes to better define its expectations and as future quality monitoring to determine whether improvement has been achieved.
- Lack of internal resources: when the medical staff has the expertise but lacks sufficient time to perform EPR.
- In addition, the MEC or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

The authorizing body will define the whether the results will be considered definitive regarding the quality and appropriateness of care once the report is received. This will be based on the nature of the review, the expertise of the reviewer, and the issues under review.

Once the results of EPR are obtained, the report will be reviewed by the body that authorized the EPR and any designees as it sees fit within 30 days of receipt to determine if any improvement opportunities are present. If improvement opportunities exist, they will be handled through the same mechanism as IPR unless the issue is already being addressed in the corrective action process.

The authorizing body will prospectively determine the nature of the involvement for the practitioner under review. Unless otherwise determined, as with IPR, the practitioner will not be made aware that EPR is being obtained unless there are issues with care identified. If issues are identified, the practitioner will be given a copy of the report and an opportunity to provide input regarding its findings in the same timeframes as for IPR prior to the committee's final decision.

(e) Participants in the review process: Participants in the review process will be selected according to the medical staff policies and procedures as described in Attachments B and C. All participants will sign a statement of confidentiality prior participating in peer review activities. MSQC members will sign the statement on appointment. Reviewers who are not committee members will sign a statement for each requested review. Invited guests will sign the statement for at least the first meeting attended for that year.

(f) Performance Measurement and OPPE

1. Individual Case Review
   Peer review will be conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the Quality Management staff and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability. The timelines for this process are described in Attachment B. The rating system for determining results of individual case reviews is described in the Case Review Rating Form (Attachment D).

2. Rate and Rule Indicator Data Evaluation
   The evaluation of aggregate practitioner performance measures via either rate or rule indicators will be conducted on an ongoing basis by the MSQC or its designee is described in Attachment B.

3. Selection of Practitioner Performance Measures
   Measures of practitioner performance will be selected to reflect the six General Competencies and will utilize multiple sources of data described in the Medical Staff Indicator List in Attachment E. For indicators based on incident reports, the incidents will be validated through the Incident Validation Policy in Attachment F.

4. Practitioner Performance Feedback and OPPE
   The best approach to improve practitioner performance is to provide practitioners their own data on the general competencies on a regular basis though a Practitioner Feedback Report (PFR) which can also be used by

medical staff leaders for systematic evaluation and follow-up for OPPE. The use of PFR and OPPE procedure are as follows:

- Once established, the PFR will be distributed semi-annually to practitioners with significant clinical activity. The PFR data will be confidential to the individual practitioner and appropriate medical staff leaders (i.e. Specialty medical directors, Credentials Committee, Medical Staff Quality Committee, and Medical Staff Officers).
- The PFR may contain indicators for feedback purposes only that will not be used in reappointment decisions (e.g. LOS). The MEC will determine which indicators are used for reappointment decisions.
- When indicators are added to the PFR over time, the medical staff should have sufficient lead time prior to the use of any new indicators in credentialing and privileging decisions.
- The PFR is a starting point for identifying improvement opportunities and not considered definitive until further evaluation, including FPPE if appropriate, is used to understand differences in performance relative to expectations and discussed with the practitioner involved.
- Specialty medical directors will review the semi-annual PFRs and discuss with the practitioner those indicators rated Needs Follow-up for :
  - any single indicator has two sequential report periods in the Needs Follow-up category
  - three or more indicators in a single report period in the Needs Follow-up category.
- After follow-up, the specialty medical director will document conclusions or the need for further analysis for each indicator that was discussed with the practitioner.
- The MSQC will follow-up with the specialty medical director if they have not received communication from them regarding areas that Need Follow-up within 30 days of the reports being distributed.
- At time of reappointment, the Credentials Committee will review the past two years of PFR data and document their interpretation of any indicator that shows Needs Follow-up..

5. Thresholds for Focused Professional Practice Evaluation
   If the results of Ongoing Professional Practice Evaluation indicate a potential issue with practitioner performance, the MSQC may initiate FPPE. The thresholds for FPPE are described in the acceptable targets for the medical staff indicators in Attachment E. However, a single egregious case may initiate a focused review by the MSQC.

(g) Oversight and Reporting
The oversight of the peer review process is described in the MSQC charter (Attachment B).

(h) Statutory Authority

This policy is based on statutory authority. All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled consistent with the following language:

"Statement of confidentiality"

Data, records, documents, and knowledge, including but not limited to minutes and case review materials, collected for or by individuals or committees assigned peer review functions are confidential, not public records, shall be used by the committee and committee members only in the exercise of proper functions of the committee, and are not available for court subpoena.

MSP 25

Medical Staff Certification Requirements

Advanced Cardiac Life Support Certification (ACLS)
ACLS Certification is required upon initial appointment and reappoint of all member who:

- Provide call, admissions, rounding, **or care in outlying clinics**
- Exceptions: Orthopaedics and General Surgeons
- Members who have privileges for Moderate Sedation

Advanced Trauma Life Support (ATLS), Comprehensive Advanced Life Support (CALS) or comparable certification
Either ATLS, CALS or comparable certification is required **in addition to ACLS** (other than those exempted above) upon appointment or reappointment to the medical staff for:

- All members who provide coverage to the Emergency Department (no grace period will be granted)
- Nurse Practitioners (Mid-levels) who provide coverage in the **hospital**
- A six month grace period may be granted for initial appointments to obtain ATLS or CALS
- A six month grace period may be granted for renewing certifications for ATLS or CALS
- The Chief of Staff will review and approve comparable certification in advance of appointment