SUMMIT HEALTHCARE REGIONAL MEDICAL CENTER

Medical Staff Rules & Regulations

Version 01/2021

MEDICAL STAFF RULES AND REGULATIONS

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SECTION 1. ADMISSION AND DISCHARGE OF PATIENTS

1.1 General Admitting Policy

The hospital shall admit patients with all types of diseases, providing facilities are available for care of the patient and protection of the hospital personnel and visitors.

1.2 Admitting Privilege

Patients may be admitted to the hospital, to include swing beds, by members of the Active Medical Staff, approved Telemedicine Medical Staff, or approved Adjunct Professional Staff. Consulting Medical Staff members may admit inpatients for up to 24 hours provided the consulting physician is locally available for patient management through discharge. Stays longer than 24 hours will require transfer of care to an appropriate member of the Active Medical Staff or to another facility. All practitioners shall be governed by the official admitting policy of the hospital.

Consulting Medical Staff members who are employed by federally or state-operated health care institutions located within seventy-five (75) miles of the Medical Center, with the approval of the Medical Executive Committee and the Governing Board, may receive extended clinical privileges to provide clinical or surgical care at the Medical Center which is not available at such federally or state-operated health care institutions, but which can be provided at the Medical Center. Patients of these Consulting Medical Staff members may admit patients for these clinical or surgical procedures for periods of up to 96 hours provided the consulting physician is locally available for patient management through discharge. Patient stays longer than 96 hours will require transfer of care to an appropriate member of the Active Medical Staff or to another facility if necessary.

1.3 Dentist/Podiatrist Admissions

A dentist or podiatrist with clinical privileges may, with the concurrence of a member of the Active Medical Staff, initiate the procedure for admitting a patient. This concurring Medical Staff member shall assume responsibility for the overall aspects of the patient's care throughout the hospital stay, including the medical history and physical examination. Patients admitted to the hospital for dental or podiatric care must be given the same basic medical appraisal as patients admitted for other services.

1.4 General Responsibilities of Admitting Practitioner.

A member of the Medical Staff or Adjunct Professional Staff shall be responsible for the medical care and treatment of each patient in the hospital, for providing a clear and accurate system for identifying and determining the attending, treating, or on-call physician for his/her patients, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient.

1.5 Contact Preference, On-Call/On-Duty Requirements

1.5.1. All credentialed providers will be provided a document to reflect the respective provider’s contact preference and the order in which they are to be used.

1.5.2 Each provider will be required to provide at a minimum a primary and backup phone or paging number.

1.5.3 Each provider will be required to review, update if necessary, and return the Provider Contact Preference Form to Summit Healthcare's Medical Staff Services Department with his/her initial and reappointment application packet.

1.5.4 The Provider Contact Preference List will be updated and placed on the hospital intranet.

1.5.5 Each respective department manager or designee will be responsible for ensuring that a new list is printed regularly and made available for staff in their respective departments. The outdated list will be destroyed in a non-retrievable manner.

1.5.6 The on-call/on-duty provider will be required to respond to calls, texts, pages, or other communication methods as may be established in the future with in thirty (30) minutes in accordance with the Hospital's On Call Policy. Reasonable multiple attempts will be made by Hospital staff to contact the on-call/on-duty provider within the 30 minute time standard or more frequently as the situation dictates for emergencies.

1.5.6.1 Non-emergent messages may be sent via a HIPAA compliant electronic message (i.e. text message) and are expected to be addressed by the provider within a reasonable timeframe (not to exceed 5 hours).

1.5.7 The on-call/on-duty provider will be responsible for informing their respective office staff, answering or paging service if or when care or call responsibility has been transferred to another treating physician or provider.

1.5.8 A central log will be established in applicable hospital departments that documents time of call, number called, and time of response or no response.

1.5.9 If a clinical situation necessitates immediate intervention prior to the response to a call or other communication method during the thirty (30) minute time standard, either the Rapid Response Team or Emergency Physician will be requested to assess and manage the patient.

1.5.10 Failure of the on-call/on-duty provider to respond to an emergent call or other communication method within thirty (30) minutes will result in the completion of an occurrence / incident report.

1.5.10.1 The manager or designee for the department in which the occurrence/ incident report was initiated will review the call log and verify the Physician Contact Preference List was applied correctly.

1.5.10.2 If it is determined that hospital staff applied the Physician Contact Preference List incorrectly, the hospital's corrective action process will be initiated and an occurrence / incident report will be completed.

1.5.10.3 All occurrence / incident reports involving credentialed providers will be forwarded to the attention of the Performance Improvement Department for validation purposes.

1.5.10.4 All validated reports will be reviewed by the Leadership Council for trending and action.

1.5.11 Policy non-compliance will be defined as three (3) or greater occurrences with in a rolling two (2) year period.

1.5.12 Policy non-compliance will result in a Notice of Non-Compliance being forwarded to the attention of the respective physician and activation of the Medical Staff's Disruptive and Inappropriate Behaviors policy.

1.5.13 Prior to any notice of non-compliance being forwarded to the attention of the respective physician, or activation of the Medical Staff's Disruptive and Inappropriate Behaviors policy, hospital administration will confer with the Chief of Staff.

1.6 Patient Admissions and Observation Services

Active Medical Staff physicians or approved Adjunct Professional Staff shall admit/observe patients as follows:

a) Notice of Admission:
Except in emergency circumstances, the admitting practitioner shall first contact the receiving unit Administrative Shift Coordinator or designee of the intended admission/observation to ascertain the availability of a bed and assure appropriateness of the admission/observation.

b) Justification for Admission and Diagnosis:
Except in emergency circumstances, patients shall not be admitted to the hospital until a valid reason (criteria) for admission has been stated. In the case of an emergency, such statement is recorded as soon as possible.

All patient admissions must meet acute care or observation criteria at the time of the admission. The admitting practitioner shall provide appropriate documentation in the medical record to justify the patient's acute status.

c) Determination of Hospital Disposition Status:
Except in emergency circumstances, the admitting practitioner shall state/document the patient's admission status in the medical record with one of the following:

- **Admit to Inpatient** - For patients meeting inpatient admission criteria.

- **Place in Observation Services**- For patients meeting outpatient observation criteria.

d) Practitioners shall hospitalize patients according to criteria set forth by CMS /Medicare or other approved criteria (inpatient vs. observation) and the Medical Executive Committee (ICU vs. Med/Surg vs. OB.) (Rev 04/10)

e) Disposition status is to be authenticated within 24 hours. (Rev 07/11)

1.7 Continued Stay

Patients who require continued stay must meet acute care criteria daily. The practitioner shall provide appropriate documentation in the chart to justify the patient's continued acute status.

1.8 Emergency Admission Without PCP

A patient to be admitted on an emergency basis that does not have or is unable to designate a private practitioner will be assigned to an Active Medical Staff member with admitting privileges in the appropriate service to attend him.
(Rev. 11/09)

1.9 Practitioner Responsibility for Staff/Patient Safety

The admitting practitioner shall be held responsible for giving such information as he possesses which may be necessary to assure the protection of others whenever his patients might be a source of danger from any cause whatever and to assure protection of the patient from self-harm.

1.10 Precautions in the Suicidal Patient

For the protection of patients, the medical and nursing staff and the hospital, precautions to be taken in the care of the potentially suicidal patient include:

A. Any patient known or suspected to be suicidal in intent shall be admitted to the unit appropriate to the medical condition and suicide precautions followed.

B. Any patient known or suspected to be suicidal must be evaluated in accordance with Hospital policy within 24 hours of presentation and the documented in the medical record. Mental health assessment from another accredited facility may be utilized if the patient is presenting for medical clearance.

Rev. 04/2013

1.11 Triage

Triage situations, in any department of the hospital, require practitioners to actively collaborate with hospital personnel. During triage circumstances, the following applies:

a) The practitioner shall contact the receiving unit Charge Nurse or designee for admission requests to determine bed availability.
b) The practitioner shall assist in facilitating timely discharges and transfers as appropriate.
c) The Triage Officer (first call physician for the emergency department) shall assist as needed/requested.

d) Patients are admitted according to severity of illness. Emergency admissions receive priority followed by urgent admissions. Elective admissions (such as surgeries) may be rescheduled as deemed necessary. Circumstances may require patients to be transferred to another acute care facility if beds are not available.

1.12 Transfers

a) When patients are discharged and sent to another licensed healthcare institution as an inpatient or resident without the intent of returning to the sending hospital, practitioners shall follow federal/state standards. The attending practitioner is responsible for:

i. ordering the patient transfer
ii. determining the patient's condition for transfer – stable versus unstable
iii. discussing the risks/benefits/ reasons of the transfer based upon the patient's medical condition and mode of transfer with the patient or patient's representative
iv. discussing the type of facility where the patient's continuing care needs will be best met
v. providing the receiving physician with report on the patient's condition (acute care transfers only)
vi. determining the level of care and mode the patient requires during transfer
vii. signing or countersigning the certification/consent
viii. documenting thoroughly

b) Transfer/Discharge Summary must be dictated and marked as STAT prior to the transfer of the patient.

c) When patients are transferred from one level of care to another within the hospital all previous physicians' orders are cancelled. (Rev 07/11; 11/09)

1.13 Transports – Sending and Receiving

When patients are sent to another health care institution for outpatient medical services with the intent of returning to the sending hospital, practitioners shall follow federal/state standards. The attending practitioner is responsible for:

a) SENDING: When patients are sent to other facilities for outpatient medical services not available at Summit Healthcare, practitioners shall follow federal/state standards. The attending practitioner is responsible for:
- ordering the patient transport
- discussing the risks/benefits/reasons of the transport based upon the patient's medical condition and mode of transfer with the patient or patient's representative
- determining the level of care the patient requires during transport
- signing or countersigning the certification/consent for transport
- documenting thoroughly

b) RECEIVING: When patients are received from another hospital for Summit Healthcare outpatient medical services practitioners shall follow federal/state standards. The attending practitioner is responsible for:
- ordering the patient transport

- determining the level of care and mode the patient requires during transport
- documenting thoroughly

1.14 Discharges

a) Discharge planning is initiated in a timely manner. Alternative levels of care and post-hospitalization needs are considered and discussed with the patient/family and discharge planning staff.

b) Patients shall be discharged only by order of the attending practitioner or designee and with patient instructions regarding diet, medication, activity, bathing, follow up and other special instructions as pertinent to the patient's status.

1.15 Death

In the event of a `hospital death, the deceased shall be pronounced dead by the attending practitioner, another practitioner on staff or two licensed registered nurses within a reasonable time. Policies with respect to release of dead bodies shall conform to local law.
Revised: 12/99, 4/02, 5/05, 9/05, 11/05

SECTION 2. MEDICAL RECORDS

2.1 General

a) The admitting practitioner shall be designated as the attending practitioner unless an order is written at any time during the hospitalization for another practitioner to assume care of the patient.

The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. All patient medical record entries must be dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. Its contents shall be pertinent and current.
Rev 09/2009

b) This record shall include: Identification data; complaint; appropriate consents; personal history; physical examination; admitting and final diagnosis; notes, documentation, records, reports, recordings, test results, assessments, including documentation of complications, hospital acquired infections, unfavorable reactions to drugs and anesthesia, patient reported allergies; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; and autopsy report when performed.

The medical record should contain sufficient information to:

- Justify admission;
- Justify continued hospitalization;
- Support the diagnosis
- Describe the patient's response to medications; and
- Describe the patient's response to services such as interventions, care treatments, etc.

c) A medical record is established and maintained for each patient who has been treated or evaluated at Summit Healthcare. The medical record, including electronic data and medical imaging are the property of Summit Healthcare Association.

d) Responsibility**:** The attending physician is responsible for each patient's medical record. The medical record must identify who has primary responsibility for the care of the patient. Whenever the responsibilities of the attending physician are transferred to another physician outside of his or her established call coverage, an order covering the transfer of responsibility will be entered into the patient's medical record. Transfers of primary responsibility of the patient are not effective until documented in the clinical information system by the transferring physician and accepted on the clinical information system by the accepting physician. All clinical entries in the patient's record must be accurately dated, timed and individually authenticated by the responsible physician.

e) Information from Outside Sources: Health record information obtained on request from an outside source is placed in the medical record and is available to the professional staff treating the patient. This information will contain the source facility name/address. Results of examination (Laboratory and X-Ray) performed prior to admission of the patient to Summit Healthcare and that are required for or directly related to the admission are made a part of the patient's hospital record. (Rev 11/09)

2.2 Clinical Entries

a) All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated.

b) Physician Assistants and nurse practitioners may enter orders including admission orders. Orders do not require counter-authentication by the physician.

c) Progress notes should be documented or dictate with a frequency that reflects appropriate attending involvement but at least every day. Exceptions may be given to an obstetrical patient that has a discharge order entered from the day before. Progress notes should describe no only the patient's condition, but also include response to therapy.

i. Gero-Psychiatry progress notes are keyed to problems (i.e., problem oriented), demonstrate medical necessity, severity of symptoms, reflect interventions and outcomes, changes in drug therapy, and dosages and address patient status in attaining treatment goals stated on the treatment plan. Progress notes are charted utilizing a behavioral format such as BIRP, DAR, PIP, SOAP, or others as appropriate.

A. Frequency of the attending physician's progress note is minimally five times per week. The physician note descriptively documents severity of symptoms/behaviors that support medical necessity for continued stay for level of care.

B. Frequency of clinician's individual therapy progress notes, family meeting, or discharge planning documentation is documented on the day of the intervention. Summary notes may be written on a weekly basis at a minimum.

d) Admitting Note – The responsible provider must see the patient and document an admitting note (that justifies admission and determines the plan of treatment) within 24 hours of admission.

2.3 Operative Reports

a) Operative reports include:

- Name and hospital identification number of the patient
- Date and times of the surgery
- Pre and post operative diagnoses
- Name of the specific surgical procedure(s) performed
- A description of techniques, findings, and tissues removed or altered

- Name(s) of the surgeon(s) and assistant or other practitioners who performed surgical tasks (even when performing those tasks under supervision)
- Type of anesthesia administered
- Complications, if any
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissue)
- Prosthetic devices, grafts, tissues, transplants, or devices implanted

b) Operative reports are written or dictated immediately following surgery but within24-hours post surgery.

c) Due to transcription delays, a written operative progress note is entered in the medical record immediately following surgery. The operative progress note contains the same elements as in 2.4a, in a summary format

2.4 Procedure Notes

a) Procedure notes shall be required to document any procedure performed in the hospital including but not limited to: closed reduction of fracture; epidural steroid injection; any endoscopy; central or arterial line placement, intubation, tracheotomy, etc. These notes shall be documented immediately following the procedure.

b) Procedures involving the use of local anesthesia shall require reports to be documented immediately following the procedure, and shall include the indication for the procedure, pertinent physical findings, and a description of the procedure performed.

2.5 Consultation Reports

a) Consultation reports shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

b) When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the medical record, be recorded prior to the operation. This includes cesarean sections.

2.6 Ambulatory Patient Records

Records for patients who receive ambulatory care on an ongoing basis should contain a summary list of known, significant diagnoses and known medications. The outpatient portion of the chart should also be available when a patient returns to the medical center for treatment.

Office encounter(s) closed with supporting documentation that reflects the patient encounter in the practice EMR within five (5) business days of the patient encounter. Coding and billing inquiries are to be completed within five (5) business days of posting.

2.7 Authentication (Rev. 07/11; 04/15/10)

a) All clinical entries and attestations in the patient's medical record are accurately dated, timed and authenticated by written or electronic signature or identifiable initials. Rev. 09/2009

b) Practitioner participating in the Electronic Signature program by signing the Physician Reports Agreement. This Agreement applies only to dictated reports meeting the requirements of the Agreement. After the finalized implementation of an Electronic Medical Record System, all providers are required to utilize the Electronic Signature system.

c) Counter-authentication (endorsement)

i. Physician Assistants/Nurse Practitioners (admitted patients) – History & Physical Reports, Operative/Procedural Notes, Consultations and Discharge Summaries must be counter-authenticated by the supervising/sponsoring physician. Each clinical event must be counter-authenticated within 48 hours.

ii. Physician Assistants/Nurse Practitioners (outpatient/Hospital Department clinics) – Counter-authentication is not required for orders written by a Physician Assistant/Nurse Practitioner. A monthly audit of not less than 10% of the Physician Assistant's charts shall be reviewed and signed off on by the Supervising/Sponsoring Physician.

iii. Residents/Fellows – Requirements for countersignatures will be established and monitored by specific training programs. Each clinical event must be documented as soon as possible after its occurrence. The Health Information Management Services Department does not monitor countersignatures by Residents/Fellows. Appropriate action will be taken by the specific training program.

iv. 1st & 2nd Year Medical Students – Access to view the patient chart only. May not document in the medical record.

v. 3rd & 4th Year Medical Students – Any and all documentation must be endorsed (countersigned, counter-authenticated) timely by the physician.

2.8 Abbreviations and Symbols

An official list of "DO NOT USE ABBREVIATIONS" will be maintained on the Hospital's Intranet system. There is a suggested list of abbreviations available on the Hospital Intranet system.
(Rev. 07/11)

2.9 Discharge Summary

a) Discharge summaries shall include: the reason for hospitalization; significant findings; procedures performed and treatment rendered; instructions on discharge regarding diet, medication, physical activity limitations and follow-up care, final diagnosis and~~,~~ condition on discharge stated in terms permitting specific measurable comparison and not in subjective terms such as "improved". (Rev. 02/10)

Discharge summaries for gero-psychiatry patients shall include: brief summary of present illness; psychiatric history; physical examination, laboratory data; consultations; summary of hospital course; Suicide Risk Assessment; discharge medications; condition upon discharge; final diagnosis; and disposition to include: residential disposition, follow-up treatment plan, and medications.

b) When applicable, a Death Summary must be completed on all patients.

c) For patient stays under 48 hours, the final progress notes may serve as the discharge summary and must contain the outcome of the hospitalization, the case disposition, and any provision for follow-up care. (Rev 07/11)

d) Discharge summaries should be completed at the time of patient discharge, but within 48 hours (including discharges from the Emergency Room) after discharge.

2.10 Confidentiality of Medical Records

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

b) Any practitioner involved in the care and treatment of a patient shall be allowed to review that patient's medical record at the hospital. Treating practitioner will receive copies of all dictated reports, reports of diagnostic studies, etc. Because of the patient-hospital privilege, the hospital does not have the authority to give the practitioner a copy of the patient's entire medical record without a signed authorization from the patient.

c) Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital.

d) Removal of medical records from the hospital is grounds for suspension of the practitioner for a period to be jointly determined by the Hospital Chief Executive Officer and the Medical Staff Executive Committee.

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

f) Free access to all medical records of all patients shall be afforded to members of the Medical Staff or Adjunct Professional Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Staff

Executive Committee before records can be studied. Subject to the Hospital Chief Executive Officer, former members of the Medical Staff or Adjunct Professional Staff may be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

g) Medical record access to confidential materials by authorized individuals is only permissible when access is sought for patient care, payment, peer review, risk management, approved research, or other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored. In addition, Summit Healthcare safeguards patients' records against unauthorized disclosure and/or use, loss, defacement, and tampering.

h) Passwords – All practitioners must maintain the confidentiality of passwords and may not disclose such passwords to anyone.

2.11 Physician Orders

a) All orders for treatment are in writing, justify medical necessity, are signed, dated, and timed by the attending practitioner when required. An order shall be considered to be in writing if dictated to authorized personnel and signed, dated and timed by the attending physician. Persons authorized to receive verbal or telephone orders are:

i. Registered Nurses (RN) or Licensed Practical Nurses (LPN)
ii. Registered Pharmacists
iii. Respiratory Therapists (for R.T.)
iv. Physical Therapists (for P.T.)
v. Registered Dietitian (for diet orders including tube feedings and TPN) or designee (for diet orders and nutrition supplements only).
vi. A.R.R.T. (For diagnostic imaging)
vii. C.N.M.T. (For nuclear medicine)
viii. M.T. (For lab procedures) (Rev. 09/2009)

b) A practitioner's protocols/pre-printed orders, when applicable to a given patient, shall be included in the patient's medical record and signed, dated, timed utilizing hospital standards, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided. All physician orders shall be timed, as with restraints. See 3.2a-h. (Rev 4/03; 09/2009; 02/2010)

c) Protocols/pre-printed orders are approved initially and reviewed bi-annually by the appropriate Medical Staff Department with final approval by the Medical Executive Committee. (Rev 02/10)

d) Verbal Orders - Verbal and telephone orders can be taken only from a physician, a Physician Assistant (PA) under a physician's direction, or a Registered Nurse, Nurse Practitioner or Licensed Practical Nurse under a physician's direction.

i.. Verbal orders should be used only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order or enter it into a computerized order entry system (if such system exists) without delaying of treatment. Verbal orders should be recorded directly onto an order sheet in the patient's medical record or entered into the computerized order entry system, if applicable. The content of verbal orders must be clearly communicated, and nationally accepted read-back verification practice to be implemented for every verbal order. Verbal and telephone orders shall be signed, dated and timed by the receiver of the verbal order, with the name of the physician, physician's assistant, or registered nurse dictating the order, per his or her own name. Whenever possible, the receiver of the order should write down the complete order or enter it into a computerized system, then read it back, and receive confirmation from the individual who gave the order.

The physician should sign, date and time such orders within 48 hours. A qualified licensed practitioner, such as a physician assistant (PA) or nurse practitioner (NP), may authenticate a physician's or other qualified license practitioner's verbal order only if the order is within his./her scope of practice and the patient is under his/her care.

If the ordering practitioner is unable to authenticate his or her verbal order (e.g., the ordering practitioner gives a verbal order which is written and transcribed, and then is "off duty" for the weekend or an extended period of time), it is acceptable for another practitioner who is responsible for the patient's care to authenticate the verbal order of the ordering practitioner, provided the ordering physician has written an order for another practitioner to assume care of the patient.. When a practitioner other than the ordering practitioner signs a verbal order, that practitioner assumes responsibility for the order as being complete, accurate and final. (Rev. 04/15/10)

Verbal orders are orders for medications, treatments, interventions or other patient care that are transmitted as oral, spoken communications, delivered either face-to-face or via telephone.
Rev. 09/2009

e) All practitioners' orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the person responsible for carrying out the order.

f) Standing orders and protocols may be formulated by individuals or Medical Staff committees and must be approved by the appropriate standing Committee and the Medical Executive Committee. All such orders and protocols shall be reviewed annually by the appropriate committee.

g) All medications on stop-order will be discontinued at the end of the stop-order period if they have not been reordered and if the attending physician has been notified.

h) When a patient goes to surgery or cardiac cath lab, all physician orders related to nursing and ancillary procedures (with exception of code status which is discontinued) are placed on hold for the duration of the perioperative period. Medication orders are kept active but are not acted upon. If the patient returns to the *same* level of care following surgery, orders (including medical orders) are continued unless the patient had general or neuraxial anesthesia. In that case, medication reconciliation must occur when post-operative orders are written. If the patient is transferred to a higher or lower level of care following surgery, medication reconciliation must also occur when post-operative orders are written. When the patient has sedation for a procedure outside the surgery department, all orders are continued and medication reconciliation is not required

When medication reconciliation contains complex medication orders, the surgeon may communicate with the attending for assistance.

Medication Reconciliation must occur:

- If patient has general or neuraxial anesthesia
- If patient is changing level of care following surgery (i.e. previously Med Surg patient but is returning to ICU)
- If patient is changing level of care within the hospital
- If a patient has general anesthesia for a radiological procedure. Medication reconciliation will be completed by the attending provider.

When in doubt, do a medication reconciliation.

i) The Medical Staff shall adhere to the Medical Center's policy for use of restraints for voluntary/involuntary immobilization of patients. Added 09/2009; Rev. 10/2014

j) In regards to attestation statements, the individual who authored a medical record entry is the only individual allowed to provide an attestation statement related to the same medical record entry. As such, a member of an ordering physician's call group or an ordering physician's partner may only provide an attestation statement if such member or partner authored the medical record entry related to the attestation statement.

k) Services in the Outpatient Setting – Outpatient Services in the hospital may be ordered (and patients may be referred for hospital outpatient services) in accordance with CMS Guidelines. The Hospital verifies that the referring practitioner who is responsible for the patient's care is appropriately licensed and acting within his/her scope of practice in accordance with Hospital policy regarding Sanction screening. Rev. 10/2014

l) Drug/Medication Orders

i. All medications on stop-order will be discontinued at the end of the specified time if they have not been re-ordered and after the physician has been notified.

ii. All controlled substances, II through V, are required to be re-ordered every three days (72 hours).

iii. All antibiotics are required to be re-ordered every seven (7) days.

iv. Drugs used shall be those that meet the standards of the United States Pharmacopeia/National Formulary. Exceptions to this rule shall be well justified and approved by the Pharmacy & Therapeutics Committee and the Medical Staff Executive Committee.

2.12 E.D. Medical Records

a) An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record if such exists. The record shall include:

i. Adequate patient identification;
ii. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
iii. Pertinent history of the injury or illness including place of occurrence and physical findings including the patient's vital signs and details relative to first aid or emergency care given prior to arrival at the hospital;
iv. Clinical observations, including results of treatment
v. Diagnostic impression
vi. Treatment given
vii. Condition of the patient on discharge or transfer; this shall be stated in terms permitting specific measurable comparison, not "improved", "good", etc.
viii. Final disposition including instructions given to patient or family regarding necessary follow up care. When relevant, the discharge summary should reflect instructions regarding medications, diet and physical activity.
ix. Whether the patient left against medical advice

b) Each patient's Emergency Department record shall be authenticated by the practitioner in attendance who is responsible for its clinical accuracy in accordance with these documents.

2.13 Intraoperative & Post Anesthesia/Sedation Record

a) An intraoperative anesthesia/sedation record will be maintained for each patient and include drugs/agents used, pertinent events during indications, maintenance of emergence from anesthesia/sedation, all other drugs, intravenous fluids and blood components given.

b) Documentation in the post anesthesia/sedation care unit includes the patient's level of consciousness upon entering and leaving the area, vital signs, and status of infusions, drains, tubes, catheters and surgical dressing (when used), unusual events or complications and management.

c) A post anesthesia/sedation evaluation for proper recovery of anesthesia/sedation must be completed and documented by an individual qualified to administer anesthesia/sedation within 48 hours after the procedure or prior to the patient being discharged or transferred from the post anesthesia/sedation care area regardless of type or location where anesthesia/sedation is performed.

2.14 Special Studies: EEGs, EKGs, treadmill stress tests, echocardiograms, tissue, medical imaging, fetal monitor strips, and other special procedure reports will be interpreted and

documented within 48 hours (24 hours for medical imaging) of notice/communication to the physician or agent to inform the provider of the test completion. Rev. 05/2016

2.15 Amending Medical Record Entries

a) Electronic Documents (Structured, Text and Images) – Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error or omission through the Electronic Medical Record (EMR). The EMR will track all changes made to entries.

Once an entry has been authenticated and an error is found in the EMR will force the author to record his/her comments in the form of an electronic addendum in which the individual will document the erroneous information, authenticate the entry and the system will date and time stamp the entry.

If information is found to be recorded on the wrong patient, regardless of the status of the entry, the EMR will not allow deletion of any entries. The entry recorded in error must be documented as such by the author, and the author will re-enter the information on the correct patient.

b. Paper-Based Documents – Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error by drawing a single line through the erroneous entry, but not obliterating it, and initialing, dating, and timing the error.

Errors or omissions discovered at a later time shall be corrected by the individual with a new entry. The person making the change shall sign and note the date of the change and reason for the change. The new entry shall also stat who was notified of the change and the date of such notification. The individual must notify the HIM Department to permit a review of the erroneous documentation for recording in-error criteria within the EMR.

Any physician who discovers a possible error made by another individual should immediately upon discovery notify the supervisor of that clinical or ancillary area.

Upon confirmation of the error, the patient's attending physician and any other practitioners, nurses or other individuals who may have relied upon the original entry shall be notified as appropriate.

2.16 Timely Completion of Medical Records Documents – All medical records shall be completed within the timeframes defined below:

Documentation Requirement	Timeframe	Exclusions	Reference
Acute Care Criteria	Daily		R&R 1.5 & 1.6
Emergency Room Report	Documented within 24 hours of discharge/disposition from the ED		
Progress Note	Daily		CMS 482.24 (c)(1) [Authentication]
Progress Notes – Gero-Psychiatry	Minimally five times per week		CMS 482.61(d)
History & Physical (less than 30 days old)	Documented within 24 hours of admission or registration to inpatient or observation status, but prior to surgery or procedure requiring anesthesia services. Update to the H&P must be done no more than 24-hours after admission or registration but prior to surgery or procedure requiring anesthesia services	• Must be completed prior to surgery • No H&P needed for local anesthesia • OB's – may substitute prenatal record. If turns into surgical, need H&P prior to surgery	CMS 482.22 (c)(5) CMS 482.24
History & Physical (greater than 30 days)	Full H&P (not just an update) must be done within 24 hours of admission or registration to inpatient or observation status, but prior to surgery or procedure requiring anesthesia services		CMS 482.22 (c)(5)
Consultation Report	Documented within 24 hours of consultation		
Post-Op Progress Note	Documented immediately post op		
Provider Coding Query	1) Inpatient: Documented response no later than 7 days post notification to the provider 2) Ambulatory Clinic: Completed within 72 hours of posting		

Documentation Requirement	Timeframe	Exclusions	Reference
Operative Report	Immediately after the procedure but within 24 hours post surgery		
Intraoperative & Post Anesthesia/Sedation Record	Documented within 48 hours after the procedure but prior to patient being discharged/transferred from the post anesthesia/sedation care area		
Special Studies Report	Documented within 48 hours of the completion of the procedure.	Medical imaging reports within 24 hours of completion of procedure.	
Discharge Summary Report	Documented at the time of discharge/disposition but no later than 48 hours post discharge	Not required for normal vaginal deliveries and normal newborns	CMS 482.24 (c)(2)(viii)[Timing] CMS 482.24 (c)(2)(vii) [Authentication]
Discharge Progress Note / Post Procedure Note	Documented at the time of discharge/disposition and no later than 24 hours post discharge for all admissions less than 48 hours or for normal vaginal deliveries and normal newborns	Post-Op Note marked "Discharge Summary" may be used for stays less than 48 hours	
Death Summary	Documented at the time of death/disposition but no later than 48 hours post discharge		
Transfer Summary 1) EMTALA 2) All Others	Documented at the time of transfer but no later than 24 hours		
Signatures	Authentication of transcribed or scanned reports and progress notes within 7 days from the date of discharge		
Verbal Orders	Dated, time and authentication within 48 hours from order		CMS 482.24(c)(1)(iii) ARS 32-1601 (11)(12)(13)(14)(15) AZSBN Act R4-19-402.B
Disposition Orders	Authenticated within 24 hours of admission		

Documentation Requirement	Timeframe	Exclusions	Reference
Medical Record Completion	30-days of discharge *pending outstanding query (if applicable)*		CMS 482.24(c)(2)(viii)
Outpatient Clinic Records (Summit Healthcare Association only)	Office encounter closed within 5 business days of patient encounter		
All Clinical Entries	N/A. Must be signed, dated and timed (or by electronic means)		CMS 482.24(c)(1)
Gero-Psychiatry Certification	No later than the 12th day of hospitalization		CMS Publication 1004-04, Chapter 4, section 10.9
Gero-Psychiatry Recertification	As established by the Hospital's Utilization Review Committee, but no less frequently than every 30 days.		CMS Publication 1004-04, Chapter 4, section 10.9

2.17 Record Completion and Filing

a) The patient's medical record should be complete at time of discharge, including progress notes, final diagnosis, operative reports, procedure reports, and discharge summary. A medical record is considered complete if it contains sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment and services; document the course and results of care, treatment and services; and promote the continuity of care among providers. All incomplete medical records must be completed within 30 days of discharge or outpatient care, containing a final diagnosis per CMS CoP §482.24(c)(2)(viii).

b) Timely Completion of Medical Records**.** Documentation in the medical record is in accordance with timeliness requirements of the Center for Medicare and Medicaid Services Conditions of Participation (CMS CoP) and/or State Law. A delinquent record is defined as a medical record that is older than 30-days post discharge.
(Rev. 12/2010)

c) Medical Records Deficiencies - The Health Information Management (HIM) Department monitors timeliness of documentation and notifies the practitioner of incomplete/delinquent medical records via phone, fax mail or electronic notice. For Summit Healthcare Ambulatory clinics, notification will be indirectly sent to the respective office manager through a complied list of incomplete medical records and associate documents. If a vacation prevents the practitioner from completing his/her medical records the practitioner must notify the HIM Department in advance of the vacation; otherwise the temporary suspension will remain in effect until the delinquent documentation has been completed.

If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the practitioner or the practitioner's office must notify the HIM Department.

Exception: Request for deferment from temporary suspension may be granted by the Chief Medical Officer after consultation with the Chief of Staff (or designee) provided the practitioner notified the HIM Department him/her being out of town or ill prior to being placed on suspension. Unforeseen circumstances such as illness, injury, military duty or other personal issue will be reviewed by the Chief of Staff and/or the Hospital CEO. The practitioner will be given one week after his/her return to complete any delinquent records.

d) Medical Records Suspension/Sanctions If medical records are not completed within the timeframes indicated in this section, practitioners will be suspended 22 days from the date the deficiency is assigned (allocation date). This includes loss of privileges including but not limited to admitting, treating, consulting, surgical and anesthesia privileges in both the inpatient and ambulatory setting, if applicable. A practitioner whose privileges have been suspended under this section shall be allowed to continue to treat his/her patients who were in the Medical Center under their care prior to imposition of the temporary suspension of privileges for the day the suspension was implemented only. Request for deferment from temporary suspension may be granted by the Chief Medical Officer in conjunction with the Chief of Staff (or designee). Notice of temporary suspension will be sent to all appropriate Departments. Upon completion of the delinquent medical records, the practitioner's privileges will be reinstated. When a practitioner is temporarily suspended for a continuous period of 60 days, s/he may be deemed to have voluntarily resigned from the medical/allied health professional staff.

Temporary suspension shall become automatic permanent suspension following 60 cumulative days of temporary suspension. At that time, the practitioner's privileges will automatically move to permanent suspension for failure to complete medical records. Effected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if, all delinquent records have been completed. Thereafter, such practitioners shall have been deemed to have voluntarily resigned from the staff. In order to reinstate their staff privileges, the practitioner will be required to reapply for medical staff membership, including the application fee. Neither temporary nor permanent suspension of privileges or revocation of membership and privileges under this section entitles a practitioner to rights pursuant to the Fair Hearing Plan. Physicians may submit evidence demonstrating why the suspension/revocation is unwarranted to the Medical Executive Committee. Permanent suspensions will be reported to the applicable licensing/certification board and/or federal agency as required by law. Medical Records suspensions greater than 30 days are required to be reported to the National Practitioner Data Bank (NPDB). (Rev. 12/2010)

e) A medical record shall not be permanently filed until it is completed by the responsible practitioner except upon order of the Medical Staff Executive Committee.

Revised: 8/93, 5/96, 8/96, 12/96, 5/9, 1/00, 2/00, 8/01, 3/02, 4/02, 7/02, 8/02, 1/07, 11/09; 07/11; 06/15

SECTION 3. GENERAL CONDUCT OF CARE

3.1 Consents

a) A Conditions of Admission form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. This shall serve as general consent for examinations, procedures and treatment rendered the patient under the general and special instructions of the physician.

b) An informed consent should be obtained by the physician from the patient or patient's legally authorized representative prior to the performance of any invasive procedure or procedure that puts the patient at risk for harm or adverse outcome and such consent should be documented in the patient's medical record. (see also 4.4,c)

c) Written, informed consent must be obtained by the physician before an HIV-related test can be ordered or performed. If the person is not competent to provide consent, consent must be provided by their legal representative (a protected person's parent or guardian or an individual holding a medical power of attorney).

EXCEPTIONS: See Laboratory Department's General Policy Manual; Section on HIV Testing, OR Arizona Consent Manual, Chapter 4.
Added 04/15/10

3.2 Investigational Drugs

a) Investigational drugs must be approved by the Pharmacy & Therapeutics Committee and the Medical Staff Executive Committee.

b) Use of investigational drugs shall be in accordance with approved pharmacy policy.

3.3 Consultations

a) It shall be the responsibility of the attending practitioner to request consultations when indicated. Except in an emergency, authorization for a consultant to examine a patient shall be provided by the attending practitioner as an order in the patient's medical record. The order shall indicate what responsibilities the consultant is to assume. Medical Staff members will extend professional courtesy to improve patient care by requesting a consultation with direct physician to physician communication, except in extreme extenuating circumstances (e.g. requesting physician is managing a code; requesting physician is in a complicated procedure which he/she cannot stop to make the personal phone call). It should be a rare instance when direct communication does not occur.
1) Consult;
2) Consult and assume care of patient. (Rev. 09/2014)

b) Consultations are recommended in the following instances:

i. When the patient is not a good risk for operation or treatment;
ii. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
iii. Where there is doubt as to the choice of therapeutic measures to be utilized;

iv. In unusually complicated situations where specific skills of other practitioners may be needed;
v. In cases in which the patient exhibits psychiatric symptoms;

c) The Specialty Call Schedule is to be utilized to identify which specialist is available for consults for the Emergency Department and inpatients. In addition to providing coverage to the Emergency Department, physicians on call per the Specialty Call Schedule must also be available for inpatient consults.

d) Consultations are to be completed within twenty-four (24) hours unless otherwise determined by the providers involved. Results of significant finding(s) should be communicated physician to physician.. Added 09/2009; Rev. 12/2010; Rev 09/2014

3.4 Reportable Deaths and Autopsies

a) According to Arizona law A.R.S. 11-593, the following types of deaths are reported to the nearest peace officer:
- Death when not under the current care of a physician for a potentially fatal illness or when an attending physician is unavailable to sign the death certificate;
- Death resulting from violence;
- Death occurring suddenly when in apparent good health;
- Death occurring in a prison;
- Death of a prisoner;
- Death occurring in a suspicious, unusual or unnatural manner;
- Death from a disease or accident believed to be related to the deceased's occupation or employment;
- Death believed to present a public health hazard;
- Death occurring during anesthetic or surgical procedure

If the death is reported, the family is contacted when possible. The autopsy is performed as determined by the medical examiner.

b) The following autopsy guideline criteria from the College of American pathologists assists physicians as to when to consider and autopsy:
- Unanticipated Death;
- Death occurring while patients is being treated under an experimental regime;
- Intraoperative or intraprocedural death;
- Death occurring within 48 hours after surgery or an invasive diagnostic procedure;
- Death incident to pregnancy or within 7 days following delivery;
- All deaths on the psychiatric service;
- Death where the cause is sufficiently obscure to delay completion of the death certificate;
- Death in infants/children with congenital malformations.

If the physician requests the autopsy, he/she obtains consent or refusal from the next of kin and documents such in the medical record.

c) Autopsies may be requested by the next of kin. If the family requests the autopsy, the physician is notified.

d) Autopsy reports are used as a source of clinical information when performing death chart reviews or other quality improvement activities. When appropriate, educational programs are designed to highlight findings that impact the quality and appropriateness of patient care.

Revised: 8/93, 2/95, 11/95, 8/96, 1/97, 6/99, 7/99, 4/02

3.5 Telemedicine Encounters for Non-Procedural Core Privileges

Telemedicine encounters are considered an extension of a provider's granted non-procedure privileges. Telemedicine encounters do not substitute for a physician's daily visit unless granted by the Governing Board for select specialties (i.e. Nephrology, Neonatology, etc.).

SECTION 4. RULES REGARDING SURGICAL CARE

4.1 Scheduling

A. Routine operating hours are 7:30 a.m. to 7:00 p.m., Monday through Friday (excluding holidays).

B. Elective scheduling is done by the O.R. Scheduler 7:00 a.m. to 7:00 p.m., Monday through Friday.

C. Emergency surgery may take priority over a regularly scheduled elective case and will be scheduled with the O.R. Scheduler. If time permits, the physician "bumping" the schedule with his emergency operation should notify the surgeon of the elective case. Only in dire emergencies will the O.R. Scheduler assume the responsibility of notifying the "elective" surgeon. The emergency patient should be seen by the surgeon prior to bumping an elective patient. Anesthesia will be notified of emergency surgery by O.R. personnel

D. Operating Room, anesthesia and PACU personnel are on-call evenings, weekends and holidays for emergency or urgent procedures only. The urgency of the procedure is to be determined and documented by the physician. Emergency or urgent surgery occurring outside the routine operating time will be scheduled by the Administrative Shift Coordinator or designee who will notify the on-call operating room and anesthesia personnel of pertinent information.

E. In cases of conflicting emergency or urgent surgery cases, priority will be determined by the surgeons and the anesthesia provider.

F. Anesthesia coverage is to be arranged by the surgeon.

G. Surgical assistance, if required, is to be arranged by the surgeon.

H. Pathology services needed during surgery are to be arranged by the surgeon and scheduled as early as possible in the day.

I. Radiology services for routine elective surgery are arranged by the O.R. Clerk. Emergency radiology services during surgery are arranged by O.R. personnel.

J. Information for scheduling surgery shall include:
1. Patient's name, age and sex
2. Surgeon and assistant
3. Diagnosis
4. Operative procedure planned
5. Special instrumentation/instructions
6. Anesthesia provider desired

K. Patients scheduled for surgery shall be admitted no later than one and one-half (1/2) hours prior to the posted time of surgery.

L. Cell saver services, if required, are to be arranged by the surgeon.

4.2 Major Surgery

A major surgery is any procedure involving an opening or entering into a sterile cavity (peritoneum, pleura, or pericardium), any major joint prosthetic implant, or any procedure having a significant risk of morbidity or mortality.

4.3 Surgery Requiring an Assistant

Surgery assistants will be required at the discretion of the surgeon.

An assistant must be a physician or other qualified credentialed individual who is granted privileges to first assist in surgery.

4.4 Surgical Consents

A. A surgical procedure shall be performed only on consent of the patient or the patient's legal representative. (see also 3.1,B)

B. Written consents are strongly preferred. Whenever a procedure involves significant risks, the need to administer blood or blood components, general anesthesia, or possible dispute concerning the patient's agreement, the physician must document in the medical record that the risks, consequences and alternatives have been explained to the patient, and that the patient understands and agrees to the procedure. When verbal consent is obtained, the physician must document in the medical record that the risks, consequences and alternatives have been explained to the patient, and that the patient understands and agrees to the procedure.

C. It is the responsibility of the operating physician to obtain informed consent from the patient. The physician or office personnel shall complete the proposed procedure, name of surgeon, date and time on the consent form. Hospital personnel may witness the patient's signature on the consent form.

D. The surgical consent form should be used in emergencies if the patient or the patient's legally authorized representative is able to sign. When a signature cannot be obtained, the "Physician's Certificate of Emergency and Necessity" form should be used.

4.5 Surgery Start Time

Start time is 7:30 a.m., Monday through Friday (except holidays). Surgeons should be in the O.R. suite and ready to commence surgery immediately prior to induction of anesthesia. Failure to begin surgery within a reasonable time after the scheduled start time may result in rescheduling of the procedure to a later time.

4.6 Routine Pre-operative Checks

Pre-operative checks by the O.R. staff shall include:

1. Patient identification & allergies
2. History and physical report
3. Laboratory reports
4. EKG report
5. Consents
6. Consultation reports, if indicated
7. Verification that pre-op meds were given

4.7 Pre-operative Orders

A. All pre-op orders shall be recorded on the physician's order sheet.

B. All previous physician's orders shall be canceled when a patient goes to surgery.

4.8 Pre-operative Laboratory Work

Pre-operative laboratory work shall be current as determined by the surgeon and the anesthesia provider. (See also Section 5.7).

4.9 Pre-operative Diagnosis

The surgeon shall record and sign a pre-operative diagnosis prior to surgery.

4.10 Verification of Surgical Privileges

Verification of privileges to perform scheduled procedures shall be the responsibility of the Assistant Director of Nursing for the O.R. or a designee.

4.11 Tissue Requiring Pathological Examination

A. It shall be the responsibility of the surgeon to see that all specimens removed during surgery, which require pathological examination, are sent to the pathologist.

B. Tissue removed at surgery will be sent to pathology in accordance with the hospital's policy as approved by the Medical Staff. (Rev 8/07; 02/10)

C. The ordering physician and pathologist shall determine which tissue specimens require a gross and/or microscopic examination in an effort to establish a definitive diagnosis. (Rev. 02/10)

4.12 Dental and Podiatric Surgery

Dental and podiatric surgery is under the general supervision of the physician advisor of the Surgery Department.

4.13 Surgical Equipment

Verification of the physical presence of all equipment necessary for a given procedure, prior to the onset of anesthesia, is a primary responsibility of the operating surgeon. Ordering equipment will not substitute for verifying its arrival in the operating room.

4.14 Surgical Deaths

Deaths occurring in the surgical department are automatically classified as coroner's cases pursuant to A.R.S. 11-596.

4.15 Recovery Room

A. Routine recovery room hours are 8:00 a.m. to 10:00 p.m., Monday through Friday (except holidays).

B. After routine hours, recovery will be accomplished by the on-call P.A.C.U. nurse.

C. Patients are discharged from PACU by a Licensed Independent Practitioner or according to criteria developed and approved by the Medical Staff.

4.16 Supervision of Non-Physician First Assistants and Certified Surgical Technicians with Suturing Privileges

Non-physician First Assistants (Registered Nurse First Assistant (RNFA), Physician Assistant (PA), Certified Surgical Technologist First Assistant (CSTFA), etc.) and Certified Surgical Technologists with suturing privileges are considered dependent Allied Health Practitioners (AHP), as defined in the Medical Staff Bylaws, and will be credentialed through the Medical Staff process as delineated in the Medical Staff Bylaws and accompanying documents. The Surgery Department Chairman shall act as the sponsoring physician for these AHPs and the operating surgeon shall act as the AHP's supervisor during the procedure. The operating surgeon agrees to assume responsibility for supervision and monitoring of the AHP's practice during the surgical procedure. A dependent AHP may not perform a task during a surgical procedure unless:

1. It is within the AHP's scope of practice;
2. It is delineated within the AHP's scope of privileges on the AHP's privilege checklist; and
3. If applicable, has been appropriately delegated by the AHP's supervising physician in accordance with applicable law.

The AHP is not authorized to independently perform a surgical procedure or to perform organ transplants. (Added 04/24/2014)

Revised:10/93, 6/95, 1/97, 2/97, 5/98, 3/00, 10/06

SECTION 5. RULES REGARDING ANESTHESIA CARE

5.1 Anesthesia Coverage
Continuous anesthesia coverage will be provided for surgical and obstetrical services.

5.2 Pre-Anesthesia Evaluation
Every patient will have a pre-anesthesia evaluation done by a licensed anesthesia provider. Except in emergencies, this evaluation should be recorded before pre-operative medication is administered and should include choice of anesthesia, the contemplated procedures, the patient's previous drug history, other anesthetic experiences, and any potential anesthesia problems.

Immediately preceding the administration of conscious sedation drugs, a re-evaluation is documented.

5.3 Pre-Induction*
Equipment and Supplies Check*
Anesthesia Record*
Post-Op Responsibility*

*Refer to Anesthesia Department Policy/Procedure Manual

5.4 Anesthesia Agents Permitted in Hospital
Only non-flammable anesthetic agents shall be permitted for use in the hospital.

5.5 Anesthesia Agents Permitted in Delivery Room
Anesthetic agents permitted to be used in the delivery room are narcotics, tranquilizers, and local anesthetic agents via any route deemed appropriate by the anesthesia provider.

5.6 General Anesthesia in Delivery
General anesthesia may be administered in the delivery room by anesthesia staff, only when all O.R. suites are occupied, and providing appropriate staff, equipment and monitors are available.

5.7 Pre-Operative Guidelines for Anesthesia Services
Preoperative guidelines for Anesthesia Services are as follows:

A. Elective outpatient cases should be scheduled by 1300 when possible.
B. All pediatric and diabetic patients should be done in early morning when possible.
C. When a surgeon schedules multiple cases during the day, priority should be given to pediatric patients, diabetics, and outpatients in that order.

5.8 Conscious Sedation
Prior to conscious sedation procedures, a pre-sedation assessment is completed by the credentialed physician, CRNA, or licensed independent provider. Immediately preceding the administration of conscious sedation drugs, a re-evaluation assessment is documented, At a minimum the assessment components include the following:

- pre-existing cardiac or pulmonary disease

- previous experience with sedation/analgesia
- physical evaluation to include cardiac and respiratory status
- oral airway evaluation
- anesthesia/sedation plan
- ASA classification

D. Preoperative routine laboratory screening for otherwise healthy patients in various age categories is as follows:

AGE	
Under 50	HB or HCT Only if indicated
Over 50	EKG (excl. Outpatient procedures under local IV sedation unless indicated)

Other labs if indicated per patient's medical history/condition.

E. The referring physician may obtain any lab considered necessary, allowing sufficient time for results to be considered pre-operatively. Often patients not in the "healthy" category will require additional preoperative laboratory workup; this will be at the discretion of the referring physician or the anesthesia provider.

F. Routine use of CBC and UA will be at the physician's discretion.

G. Preoperative laboratory values are acceptable for 14 days. EKGs are acceptable for six (6) months.

Revised: 8/96, 8/98, 2/00, 6/00, 4/02

SECTION 6. RULES REGARDING OBSTETRIC/NEWBORN CARE

6.1 Standard of Care

A. All physicians will provide obstetric and newborn care within the limits of their approved delineation of privileges. Patients requiring care the physician is not privileged to provide will require consultation and/or referral.

B. Responsibility for obtaining required consultations is that of the attending physician or nurse midwife.

C. Practitioners must have current certification in neonatal resuscitation in order to be granted the privilege of attending the newborn at high risk deliveries.

6.2 Maternal/Neonatal Transport

A. Infants needing specialty care and/or services not available at Summit Healthcare will be transferred to an appropriate facility as soon as possible.

B. Federal law places strict requirements on transfers of women in labor by hospital that receive Medicare funding. The following procedures must be followed:

1) Determining whether a patient has an emergency medical condition. The statutory definition is as follows: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention can reasonably be expected to result in placing the health of the individual in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The health of the fetus must also be considered in determining whether an emergency medical condition exists.

2) Special determination of emergency medical condition of a pregnant woman. The statutory definition also makes specific reference to pregnant women. It provides that an emergency medical condition exists if a pregnant woman is having contractions and (a) there is inadequate time to effect a safe transfer to another hospital before delivery; or (b) transfer may pose a threat to the health or safety of the woman or the unborn child. An emergency medical condition does not exist unless the woman meets one of the two above criteria in addition to having contractions.

3) Pregnant women meeting the criteria for an emergency medical condition. If it is determined that a pregnant woman is having contractions and meets either of the two other criteria for an emergency medical condition noted above, the physician may either provide treatment to stabilize her condition - which means delivering the fetus and placenta - or may effect her transfer to another medical facility in accordance with specific procedures as outlined below.

4) Procedures to follow for transferring a pregnant woman to another medical facility. The patient may request a transfer in writing after being informed of the hospital's obligations under the law and of the risks of a transfer. A patient may also be transferred to another medical facility without having

requested a transfer provided that the following conditions are met: A physician must certify in writing that based upon the information available at the time of the transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweighs the increased risk of the transfer poses to the individual's medical condition and that of the unborn child. If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person may sign the certification described above after consultation with a physician who authorizes the transfer provided that the physician later countersigns the certification.

Receiving hospital: The receiving hospital must have space and qualified personnel to treat the patient and must have agreed to accept the transfer. The law provides that specialized facilities, such as neonatal intensive care units cannot refuse to accept patients if space is available.

Transferring hospital: The medical records from the transferring hospital must be sent with the patient and the transfer must be made using qualified personnel and transportation equipment. It is important to note that the medical records must include the informed written consent or certification required by the statute (as discussed above) and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

Hospitals are prohibited from penalizing physicians who, in complying with the law, refuse to transfer patients.

6.3 Labor Rules

A. Induction/augmentation with oxytocin will be administered according to approved OB Department policy #10.2.

B. Prior to initiation of induction of labor, it is recommended that any physician who does not have cesarean section privileges document in the patient's medical record the name of a physician who has agreed to provide coverage should a cesarean section become necessary and the time that physician was contacted.

C. Prostingel for cervical ripening, augmentation/induction will be used only in accordance with approved protocols.

D. Visitors will be permitted during labor with the patient's consent and physician and/or nursing staff approval.

6.4 Delivery Rules

A. Vaginal deliveries will be performed in the delivery room or in labor room #2. Alternative sites for delivery will be:

1. Labor room #1
2. Post partum rooms 2 and/or 3
3. Available post partum beds
4. On a gurney in the labor/delivery hall

B. Elective cesarean sections, sterilizations, and D & C's will be performed in the surgical suite.

C. Emergency cesarean section may be performed in the delivery room only when all O.R. suites are occupied and appropriate surgical staff is available.

D. Anesthetic agents permitted for use in the delivery room are:

1. Narcotics
2. Tranquilizers
3. Local anesthetic agents

E. General anesthetics for high risk mothers should be administered by hospital approved anesthesia personnel.

F. Significant others may be permitted to observe delivery at the discretion of the attending physician and nursing staff.

G. In addition to the delivering physician or surgical team, a physician qualified in neonatal resuscitation should be present for the following delivery situations:

1. Gestational age less than 36 weeks
2. Multiple gestations
3. Intrauterine growth retardation (present or suspected)
4. Thick meconium
5. Maternal complications:
   a. Placenta abruption
   b. Hemorrhage, ie; as with placenta previa
   c. Cesarean section for diabetes mellitus of mother
   d. Eclampsia

6.5 Recovery

A. All hospital performed vaginal deliveries will be recovered in the OB Department as their condition permits.

B. The responsibility for post-anesthetic care rests with anesthesia provider.

6.6 Newborn Rules

A. Oxygen and/or other respiratory therapy must be ordered by the attending physician. Oxygen orders shall be stated in percent (%), not liters/minute.

REVISED: 10/95, 5/98

SECTION 7. RULES REGARDING EMERGENCY SERVICES

7.1 Types of Services

A. Emergency services will be rendered any patient presenting at the Emergency Department.

B. Every patient will be assessed by a physician and will receive appropriate emergency treatment.

C. Circumstances under which definitive care will not be rendered will be determined by the attending Emergency Department physician but will include:
1. Severe and extensive burns
2. Neurosurgical cases
3. Severe eye injuries
4. Massive trauma requiring reconstructive surgery
5. Neonates requiring intensive care

D. Outpatient services provided in the Emergency Department include the following:

1. Throat culture
2. Urinalysis
3. Vital signs
4. Medication administration

Patients requiring hospital admission will not be classified as outpatients.

E. Procedures not permitted to be performed in the Emergency Department include:
1. Those requiring general, major regional or spinal anesthesia
2. Elective dilatation and curettage
3. Elective incision and drainage of peritonsillar abscess
4. Colonoscopy and endoscopy (except in emergency situation, i.e. actively bleeding)

F. Anesthesia that IS permitted for use in the Emergency Department includes:
1. Topical anesthesia
2. Local anesthesia
3. Bier block anesthesia
4. Emergent rapid sequence intubation

G. Anesthesia that IS NOT permitted for use in the Emergency Department includes:
1. General anesthesia
2. Spinal anesthesia
3. Major regional blocks, i.e. axillary block

7.2 Physician Staffing

A. All physicians providing Emergency Department coverage must be Medical Staff members

B. A physician will be on duty 24 hours a day

C. E.R. patients requiring admission must be admitted by a member of the Active Medical Staff.

D. Specialist referral and/or consultations will be arranged by the attending Emergency department physician or the patient's local private physician (if he/she is a member of the Medical Staff). In the event the patient has no local private physician, the "on-call" physician will arrange referrals and/or consultations.

D. Medical direction of the Emergency Department will be provided by the Emergency Department Medical Director.

7.3 Observation

The E.D. has no observation beds. Patients requiring prolonged observation will be admitted to Outpatient Observation status. (Exception: see Hospital Triage Policy)

7.4 Direct Admits

Patients transported to the hospital by ambulance for direct admission will be screened by the Emergency Department Physician.

7.5 Transfers from the Emergency Department

A. Ability to pay for services shall not be a determining factor in the decision to transfer.

B. If the specialty or level of care required cannot be provided in this hospital, arrangements will be made to refer the patient elsewhere for definitive care.

C. Patients must be stable at time of transfer unless expected benefits outweigh increased risks.

D. Patients may be transferred only upon order of the attending physician or at the request if the patient or patient's family.

E. Documentation of patient transfer must conform with COBRA regulations.

The referring physician is responsible for the patient until the patient is turned over to the Air Ambulance crew for transfer. At such time, the Base Hospital for the Air Ambulance and that Medical Director will be responsible for all orders and directives until the patient reaches the receiving facility.

For purposes of ground transports originating out of Summit Healthcare E.D. and transported by a ground ambulance whose Medical Control is based at Summit Healthcare, the referring physician is responsible for the patient during transport until such time as care is turned over to the receiving hospital.

Reviewed and approved, ER/CC Committee 4/2/91
Revised 10/95, 7/98

SECTION 8. RULES REGARDING SPECIAL CARE UNITS

8.1 Services

The Intensive Care Unit of Summit Healthcare Regional Medical Center provides services to predominately adult patients that require intensive treatment, intensive monitoring, and intensive nursing care. During times of high utilization and scarce beds, patients requiring intensive treatment have priority over monitoring and terminally ill patients. Telemetry monitoring is also provided in the ICU.

8.2 Admission & Transfer Eligibility

It is the responsibility of the attending physician and/or his representative to request ICU admission and to promptly transfer patients meeting discharge criteria.

8.3 Eligibility

Eligibility for ICU admission and discharge is also based upon the reversibility of the clinical problem as well as the likely benefits of ICU treatment and expectation for recovery.

8.4 Patient Priority

A. Priority 3 patients: Critically ill, unstable patients in need of intensive treatment such as ventilator support, continuous vasoactive drug infusion, etc. Examples of such admissions are:

1. Respiratory failure
2. Multiple systems injuries
3. Frank gastrointestinal bleeding
4. Acute/chronic life threatening dysrhythmia

B. Priority 2 patients: Patients who, at the time of admission, are not critically ill but whose condition requires the technologic monitoring services of the ICU. These patients would benefit from intensive monitoring (e.g., peripheral or pulmonary arterial lines) and are at risk for needing immediate intensive treatment. Examples of such admissions are:

1. Acute or underlying heart, lung, or renal disease in patients with severe medical illness or who have undergone surgery.

2. Suicide attempt and/or overdose with potential for self-injurious behavior.

C. Priority 1 patients: Critically ill, unstable patients whose previous state of health, underlying disease, or acute illness, either alone or in combination, severely reduces the likelihood of recovery and benefit from ICU treatment. Examples of such admissions are:

1. End-stage metastatic malignancy
2. End-stage heart or lung disease complicated by severe, acute illness.

Priority 1 patients receive intensive therapy to relieve acute complications, but therapeutic efforts might stop short of other measures such as intubation or cardiopulmonary resuscitation.

8.5 Patients Who Do Not Meet Routine Admission Criteria

A. Patients who have confirmed clinical and laboratory evidence of brain death, except those suitable for organ donation.

B. Competent patients who refuse life-supporting therapy including chemotherapy.

C. Patients with irreversible coma.

D. Patients who do not require frequent or continuous monitoring for unstable or potentially unstable illness.

8.6 Transfers

1. Transfers to another facility may be required if the patient has the need for specialties or services not offered at Summit Healthcare, or by request of the patient or family members.

2. Patients eligible for transfer from ICU to another unit in the hospital are those who no longer require the intensive care services. Cardiac monitoring may be continued off the unit via telemetry monitoring. (For specific transfer criteria, see ICU policy #1.1)

3. When a patient goes to surgery or cardiac cath lab, all physician orders related to nursing and ancillary procedures (with exception of code status which is discontinued) are placed on hold for the duration of the perioperative period. Medication orders are kept active but are not acted upon. If the patient returns to the *same* level of care following surgery, orders (including medical orders) are continued unless the patient had general or neuraxial anesthesia. In that case, medication reconciliation must occur when post-operative orders are written. If the patient is transferred to a higher or lower level of care following surgery, medication reconciliation must also occur when post-operative orders are written. When the patient has sedation for a procedure outside the surgery department, all orders are continued and medication reconciliation is not required

   When medication reconciliation contains complex medication orders, the surgeon may communicate with the attending for assistance.

   Medication Reconciliation must occur:

   - If patient has general or neuraxial anesthesia
   - If patient is changing level of care following surgery (i.e. previously Med Surg patient but is returning to ICU)
   - If patient is changing level of care within the hospital
   - If a patient has general anesthesia for a radiological procedure. Medication reconciliation will be completed by the attending provider.

When in doubt, do a medication reconciliation.
(Rev. 11/09; 10/2014)

8.7 Discharges

Discharge from the ICU should be considered an unusual event. Discharge is acceptable for those patients in which a diagnostic work-up has shown no evidence of acute disease that requires further hospitalization. These patients must meet adapted ISDA discharge screening criteria specific for their diagnosis, as determined by the patient's physician. (For specific discharge criteria, see ICU policy #1.1)

8.8 Standing Orders and Protocols

Standing orders and/or protocols for use in ICU will be approved by the Medical/Critical Care Committee and the Medical Executive Committee. When used, they must be signed, dated and timed by the physician initiating the orders. Rev. 09/2009

8.9 Medical Standards

A. Medical staff members admitting patients into special care units will have the appropriate credentialed privileges to care for their patients or they will consult with a physician with the appropriate privileges. If a patient is in need of specialized medical services and there is no physician with the appropriate skills/privileges available on staff, the patient will be referred/transferred to a physician with the appropriate skills/privileges.

B. When a physician asks another physician to "cover" or "take call" for him, that physician must have the appropriate privileges/skills to care for his patients.

C. All patients entering or leaving the ICU will have met the criteria outlined in the ICU Admission/Discharge/Transfer Criteria. (Refer to ICU Policy, #1.1).

D. All patients in ICU will be seen by their admitting physician within twelve (12) hours of admission. Initial evaluation in the office, ER, or Cath Lab is counted as a visit. Patient must be seen earlier as circumstances dictate. (Rev 10/07)

E. Responsibility for obtaining consultation is that of the attending physician. Requests for a physician consult will be arranged from physician to physician and documented in the physician orders. Nursing personnel will assist with obtaining non-physician consults.(See also 2.6 & 3.5)

F. Each ICU patient will be seen at least once each 24 hours by the admitting and/or consulting physician.

G. The patients in ICU will be under the care of an attending physician who has appropriate privileges to monitor the care being provided to them. The Emergency Department physician will respond to emergencies within the Intensive Care Unit and the patient’s attending physician, or an appropriate on call physician covering, will respond promptly to the unit to take over the care of the patient.

Revised: 11/95, 5/98, 3/00

SECTION 9. RULES REGARDING OUTPATIENT CLINICS

9.1 Narcotics in Clinics

Narcotics will not be stocked in Summit Healthcare outpatient clinics with the exception of walk-in clinics or a clinic with a medication point of care service.
Placard to be displayed in clinics indicating no narcotics onsite except as noted above.

9.2 Emergency Care Services in Off-Campus Locations

Summit Healthcare off-campus locations do not provide emergency services. Outpatient clinics will maintain basic preparedness for an emergency which may include AEDs. All staff shall be trained in BLS, at a minimum, and ACLS is optional for providers.

9.2.1 Appraisal of Persons with Emergencies. During clinic operation hours, qualified personnel will conduct an assessment of the patient to determine if an emergency exists.

9.2.2 Referral When Appropriate. If qualified personnel determines the patient's needs exceeds the outpatient clinic's capabilities, *9-1-1* will be called to arrange for appropriate transfer to Summit Healthcare's emergency department. Basic CPR and first aid will be given until appropriate emergency personnel arrive.

9.2.3 Initial Treatment. Outpatient clinics are expected to provide treatment and stabilization consistent with the complexity of services, the type and qualifications of clinical staff, and the resources available at that location.

SECTION 10 – RULES REGARDING GERO-PSYCHIATRY UNIT

10.1 Admissions.

All appropriate persons are admitted to the Gero-Psychaitric Program ("Program") regardless of race, color, creed, and/or economic status. A patient is admitted to the program only by written order of a psychiatrist or licensed physician.

10.1.1 Any psychiatrist on the Medical Staff may admit patients to the Program. Other physicians on the staff may refer patients to a psychiatrist for admission to the Program, and may follow their patient in consultation with the psychiatrist during the hospitalization on the unit.

10.1.2 Patients becoming acutely agitated within the general hospital who meet admission criteria will have first priority for bed space in the Program.

10.1.3 In an emergency situation where the patient would be difficult to treat on the medical-surgical areas, the gero-psychiatry staff and the attending physician will make the decision where to place the patient.

10.1.4 Patients presenting through the Emergency Department who are judged by the Emergency Department physician to be medically stable may be admitted in consultation with the psychiatrist to the Program if admission criteria is met.

10.2 Discharge.

Discharge from any hospital unit and admission to the psychiatric unit will be by order of the attending physician in consultation with the psychiatrist to the Program if admission criteria is met. Prior to patient discharge, the attending Psychiatrist will complete and transmit to the unit:

10.2.1 Discharge order

10.2.2 Discharge instruction form or transfer form

10.2.3 Psychiatrist discharge note.

10.3 Gero-Psychiatrist Responsibilities.

A Psychiatrist appropriately licensed/authorized pursuant to A.R.S. 36-3606 A-D and credentialed by the Medical Staff will assess, diagnose, and treat patients face to face. This face to face interaction may be done via interactive telecommunications technology and equipment. The Psychiatrist will participate in individual interdisciplinary treatment planning meetings, program performance improvement initiatives, and Medical Staff peer review. The Psychiatrist may provide the following specific psychiatric services:

- Psychiatric diagnostic interview examination;
- Individual psycho therapy
- Pharmacological management;
- Neurobehavioral status exams

10.3.1 The attending Psychiatrist will conduct an initial comprehensive psychiatric examination within regulatory standard timeframes and document the examination in the patient's medical record.

10.3.2 The attending Psychiatrist will conduct daily follow-up assessments. A progress note for each session will be documented in the medical record.

10.3.2 The attending Psychiatrist will attend and participate in interdisciplinary treatment team meetings and management meetings. Immediately following the meeting sessions, the attending Psychiatrist will submit progress notes for placement in the patient's medical record.

10.3.3 Following individual patient sessions, the attending Psychiatrist will place new orders, physician certification or recertification, if applicable, and updated treatment plans or reviews in the patient's medical record.

10.4 Distant site Psychiatrists.

For encounters conducted via interactive telecommunications technology, the distant site Psychiatrist will be credentialed in accordance with the Summit Healthcare Medical Staff Bylaws, Rules and Regulations, and Practitioner Procedural Policy.

10.4.1 The distant site Psychiatrist will ensure secure medical record storage in accordance with patient confidentiality laws.

10.4.2 The distant site Psychiatrist will safely destroy any unnecessary medical record information.

10.5 Physician Certification and Recertification for inpatient hospital services.

At the time of admission, or as soon thereafter as reasonable and practical, the admitting physician or a Medical Staff members with knowledge of the case must certify the medical necessity for inpatient gero-psychiatric hospital services. Only a physician may complete the certification or recertification. Recertification is required no later than the 12th day of hospitalization. Subsequent recertifications must be made at intervals established by the Hospital's utilization review committee (on a case-by case basis, if it so chooses), but no less frequently than every 30 days.

10.5.1 The required physician's statement for certification should certify that the inpatient psychiatric hospital admission was medically necessary for either:

10.5.1.1 Treatment which could reasonably be expected to improve the patient's condition; or,

10.5.1.2 Diagnostic study.

10.5.2 The physician recertification should state that:

10.5.2.1 The inpatient psychiatric hospital services furnished since the previous certification or re-certification were, and continue to be, medically

necessary for, either, treatment which could reasonably be expected to improve the patient's condition or diagnostic study;

10.5.2.2 The patient continues to need, on a daily basis, active inpatient psychiatric treatment furnished directly by or requiring the supervision of Inpatient Psychiatric Facility (IPF) personnel; and

10.5.2.3 The hospital records indicate that the services furnished were intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

10.5.3 The period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving active treatment as defined in 10.5.2.1 and 10.5.2.2. If the patient remains in the hospital but the period of "active treatment" ends, Program payment can no longer be made even though the patient has not yet exhausted his benefits. When the period of "active treatment" ends, the physician is to indicate the ending date in making his/her recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his/her recertification, the date on which it resumed.

10.5.4 The provider may adopt any method that permits verification of all IPFs requirements to continue treatment (e.g. entered on provider generated forms, in progress notes, or in the related patient medical record). The certification or recertification document must include:

10.5.4.1 An adequate written record of the reason for continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study, or special or unusual services for cost outlier cases for hospitals under a Prospective Payment System (PPS);

10.5.4.2 The estimated period of time the patient will need to remain in the hospital and, for cost outlier cases, the period of time for which the special or unusual services will be required; and

10.5.4.3 Any plans for post-hospital care.

10.6 Psychiatric Evaluation.

Each gero-psychiatric patient must receive a psychiatric evaluation, initiated upon the written physician order that must:

10.6.1 Be completed within 60 hours of admission;
10.6.2 Include a medical history;
10.6.3 Contain a record of mental status
10.6.4 Note the onset of illness and the circumstances leading to admission;
10.6.5 Describe attitudes and behavior;
10.6.6 Estimate intellectual functioning, member functioning, and orientation; and

10.6.7 Include an inventory of the patient's assets in descriptive, not interpretative fashion.

ADOPTION

This Medical Staff Rules and Regulations is adopted and made effective upon approval of the Governing Board, superseding and replacing any and all other Medical Staff Rules and Regulations, rules, regulations, policies, manuals or Medical Center policies pertaining the subject matter thereof.

Adopted by the Medical Staff on: ***June 15, 2021***
Dated

Approved by the Governing Board on: ***June 24, 2021***
Dated