



RULES AND REGULATIONS

Medical Staff

Providence St. Joseph Hospital

Eureka, California

December 22, 2021

ST. JOSEPH HOSPITAL, EUREKA
MEDICAL STAFF RULES AND REGULATIONS
December 2021

PREAMBLE

In accordance with the Medical Staff Bylaws, the Medical Staff has initiated and adopted these General Rules and Regulations. Adherence to these General Rules and Regulations is required of all practitioners holding clinical privileges at St. Joseph Hospital, including medical staff members, those holding temporary privileges and where applicable allied health professionals holding clinical privileges or working under a job description.

A. ADMISSION AND DISCHARGE OF PATIENTS

1. The Hospital shall allow a Medical Staff member in good standing, with appropriate privileges, to admit patients requiring care for which the hospital has adequate facilities.
2. All physicians and oral surgeons who have met established criteria, admitting patients to the Hospital shall be governed by the official admitting policy of the Hospital. Podiatrists and dentists with clinical privileges may, with the concurrence of an appropriate member of the Medical Staff, initiate the procedure of admitting a patient. This co-admitting physician member shall assume responsibility for the overall medical aspects of the patient's care throughout the hospital stay, including the medical history and physical examination and discharge summary. Patients admitted to the Hospital for podiatric and dental care must be given the same basic medical appraisal as patients admitted for other services.
3. The patient's attending physician shall be responsible for the overall medical care and treatment of each patient in the Hospital, for the promptness, legibility, and accuracy of the medical record, and for transmitting reports of the condition of the patient to any referring practitioner. Whenever any of these responsibilities are transferred to another Medical Staff member, a note documenting the transfer of the responsibility shall be entered on the order sheet of the medical record.
4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, the reason shall be recorded as soon as possible. Emergencies are defined as patients who have serious medical problems and may suffer death, serious injury, or permanent disability if they are not admitted and provided immediate treatment.
5. Practitioners admitting emergency cases shall be prepared to justify to the appropriate Quality Review Committee of the Medical Staff that the said emergency admission was warranted given the information available at that time. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

When a patient requires admission to the hospital for emergency medical treatment, the attending physician shall, whenever possible, contact the Admitting Department and determine whether there is an available bed. Any patient admitted through the Emergency Department shall be seen and evaluated by their attending physician either immediately prior to or within twelve (12) hours of admission except as otherwise required in these rules and regulations or medical staff policy and procedure.

6. An emergency admission of a patient who does not have a private practitioner must be authorized by the emergency physician on duty. A member of the Medical Staff on call will be assigned primary responsibility for the patient.

Questions regarding the admission (or discharge) of a patient to a Critical Care Unit shall be resolved by the attending physician consulting with the Medical Director of the Critical Care Unit and when necessary the President of Medical Staff.

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

All patients admitted to Telemetry shall be seen within eight (8) hours of admission.

7. When practitioners plan to be unavailable to cover their patients' hospital and emergency needs, arrangements must be made with another Hospital-privileged practitioner whose name shall be provided to the Hospital. In case of failure to name such associate, or when he/she is unavailable, the Administrator of the hospital, Chief of Staff, or Chairperson of the Department concerned, shall have the authority to arrange for the assumption of responsibility for care by another member of the Medical Staff.
8. When the hospital's Chief Executive Officer or administrator on call, after consulting with the President of the Medical Staff, determines that bed space is not available, he or she may limit admissions to emergency cases. In such an event, patients will be admitted using the following order of priority:
 - a. First Priority—Emergency Admissions. Patients who have serious medical problems and may suffer death, serious injury, or permanent disability if they are not admitted and provided treatment within four (4) hours.
 - b. Second Priority—Urgent Admissions. Patients who have serious medical problems who may suffer substantial injury to their health if they are not admitted and provided treatment within twenty-four (24) hours.
 - c. Third Priority—Preoperative Admissions. Patients who are already scheduled for surgery.
 - d. Fourth Priority—Routine Admissions. Patients who will be admitted on an elective basis to any service.

Transfer Priorities. Priority shall be given for the transfer of patients in the following order:

- a. Emergency Department to an appropriate bed.
 - b. Critical Care Unit to a telemetry or general care area.
 - c. Temporary placement in an inappropriate area for that patient to an appropriate area.
9. All patients admitted to the hospital shall be seen by the attending physician or designee on a daily basis and a daily progress note shall be recorded in the medical record.

The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the Quality Steering Committee or otherwise upon request of the Department Chairperson. This documentation must contain:

- a. a written description of the reason for continued hospitalization - a simple recitation of the patient's initial diagnosis is not sufficient;
 - b. the estimated period of time the patient will need to remain in the Hospital;
 - c. plans for post-Hospital care.

This report or response must be submitted within 24 hours of receipt of such request.

10. Each patient admitted to the hospital shall have a medical staff member designated as the primary attending physician. In most instances the admitting physician is the primary attending physician. However, there may be circumstances when a patient is cared for by several physicians when it is appropriate for the admitting physician to delegate the responsibility of primary attending physician to another physician caring for the patient. Such delegation shall be made with the consent of the receiving physician and shall be made in writing in the physicians orders.

It is the responsibility of the primary attending physician to coordinate care when more than one physician is caring for the patient. The primary attending physician shall have the responsibility of communicating with the patient and their family the treatment plan and discussion of limitations of care when appropriate. The primary attending physician shall designate in the medical record the "Code Status" of the patient. The primary attending physician shall serve as focal point for coordinating care with the nursing staff. When the primary attending physician is not available the medical staff member covering for the primary attending physician will assume these responsibilities.

11. Patients shall be discharged only on a written or telephone order of the attending practitioner or his/her designee if he/she is unavailable.

The attending physician shall see that the record is complete, state the final diagnosis and sign the medical record. Appropriate discharge instructions for care will be given to the patient or family using current hospital format and a copy is to be retained in the medical record.

Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made on the patient's medical record. A minor not legally capable of contracting for the medical care in question shall be discharged only to the custody of his/her parent, legal guardian or custodian, unless such parent, guardian or custodian shall otherwise direct in writing. This shall not preclude minors legally capable of contracting for medical care from assuming responsibility for himself/herself upon discharge. The Health Facility Minor Release Report of the CAHHS Consent Manual must be completed whenever a minor is discharged to anyone except a parent, relative by blood or marriage, or legal guardian.

12. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee or the emergency room physician as soon as possible. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff or designee. Nurses may pronounce death pursuant to standardized procedures. Policies with respect to release of bodies shall conform to local law.

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

- a. Deaths in which an autopsy would explain unknown or unanticipated medical complications.
- b. Deaths in which the cause is not known with certainty on clinical grounds.
- c. Deaths in which an autopsy would allay concern of or reassure the public or family regarding the death.
- d. Cases of unusual academic interest.

An autopsy may be performed only if authorized in accordance with law. The persons who may consent to autopsies are identified in Chapter 10 of the CAHHS Consent Manual.

Except in coroner's cases, all autopsies shall be performed by the hospital pathologist or his or her designee. Communication between the attending physician and the pathologist prior to performance of an autopsy is essential and it is the responsibility of the pathologist to notify the attending physician when an autopsy will be performed and when indicated, a "limited" autopsy should be considered to focus efforts on organ system questions. Autopsies of suspected infectious etiology will be performed at the discretion of the pathologist in consultation with the attending physician. Provisional anatomic diagnoses shall be medically recorded on the medical record by the pathologist within forty-eight (48) hours after completion of the autopsy and the complete protocol should be made a part of the medical record within sixty (60) days.

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

- a. Known or suspected homicide.
- b. Known or suspected suicide.
- c. Accident: Whether the primary cause or only contributory; whether the accident occurred immediately or at some remote time.
- d. Injury: Whether the primary cause or only contributory; whether the injury occurred immediately or at some remote time.
- e. Grounds to suspect that the death occurred in any degree from a criminal act of another.
- f. No physician in attendance. (No history of medical attendance.)
- g. Wherein the deceased has not been attended by a physician in the 20 days prior to death.
- h. Wherein the physician is unable to state the cause of death. (Must be genuinely unable and not merely unwilling.)
- i. Poisoning (food, chemical, drug, therapeutic agents).
- j. All deaths due to occupational disease or injury.
- k. All deaths in operating rooms or following surgery or a major medical procedure.
- l. All deaths where a patient has not fully recovered from an anesthetic, whether in surgery, recovery room, or elsewhere.
- m. All solitary deaths. (Unattended by physician, family member, or any other responsible person in the period preceding death.)
- n. All deaths in which the patient is comatose throughout the period of physician's attendance, whether in home or hospital.
- o. All deaths of unidentified persons.
- p. All deaths where the suspected cause of death is sudden infant death syndrome (SIDS).

- q. All deaths in prisons, jails, or of persons under the control of a law enforcement agent.
- r. All deaths of patients in state mental hospitals.
- s. All deaths where there is no known next of kin.
- t. All deaths caused by a known or suspected contagious disease constituting a public health hazard, to include AIDS.
- u. All deaths due to acute alcoholism or drug addiction.
- v. Any "observation" or "short stay" patient whose length of stay subsequently exceeds twenty-four hours automatically becomes an "(inpatient) admission"; physicians caring for such patients are responsible for abiding by the requirements for inpatient admissions delineated in these Rules and Regulations.

The Attending Physician, or his or her representative, is responsible for notifying the next of kin in all cases of death.

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

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

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

B. MEDICAL RECORDS

1. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Supervision of the patient's general health status while hospitalized shall include daily progress notes (this requirement shall be waived for patients at the skilled nursing level of care, so long as there is a physician of record).
2. Operative reports shall include:
 - a. primary surgeon and assistants and a description of their tasks,
 - b. pre- and post-operative diagnosis,
 - c. procedure performed,
 - d. type of anesthesia administered,
 - e. complications if any,
 - f. a detailed account of the findings and tissues removed or altered at surgery, as well as a description of the surgical technique, and
 - g. any prosthetic devices, grafts, tissues, transplants or devices implanted.

Operative reports shall be written or dictated immediately following surgery for outpatients, as well as inpatients, and the report promptly signed by the surgeon and made a part of the patient's current medical record.

A postoperative progress note is entered in the medical record immediately after surgery and prior to transfer to the next level of care.

The postoperative progress note shall contain the following elements:

- a. Date of surgery
- b. Pre and postop diagnosis
- c. Procedure performed
- d. Pertinent findings
- e. Estimated blood Loss
- f. Primary surgeon and assistants
- g. Specimens removed.

High-risk deliveries (including, but not limited to, cesarean sections, multiple deliveries, newborn fractures, shoulder dystocia, newborn lacerations and newborns with 5 minute apgars of six or less) require dictated operative reports. In addition to those, any instrumented vaginal delivery other than those with outlet forceps or outlet vacuum require a dictated delivery note.

3. Consultation entries shall show evidence of a review of the record by the consultant, pertinent findings, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation.
4. All entries in the patient's medical record shall be legible, accurate, dated, timed and signed by the responsible practitioner. Each entry that is made in the medical record shall be signed by the person making the entry, dated, and the time shall be noted. The date and time shall be the date and time that the entry is made, regardless of whether the contents of the note relate to a previous date or time.

In the event it is necessary to correct an entry in a medical record, the authorized person shall line out the incorrect data with a single line in ink, leaving the original writing legible. The person shall note the reason for the change, the date and time of striking, and sign the note. Appropriate cross-referencing shall be placed in the medical record when necessary to explain the correction. The correction shall never involve erasure or obliteration of the material that is corrected. In addition, all blanks left in dictated reports should be filled in by the dictating physician at the time the report is authenticated. Any cross-outs with or without re-entries in the report should be noted as error, dated, timed and initialed. No medical record entry shall be removed from the medical record.

5. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of all approved abbreviations will be kept on file in the Hospital Wide Policy and Procedure Manual. In order to avoid medical errors, the following abbreviations, acronyms, symbols, and dose designations may not be used in the medical record: U, u, IU, Q.D., QD, q.d., qd, -Q.O.D., QOD, q.o.d., qod, trailing zero (X.0 mg), lack of leading zero (.X mg), MS, MSO4, MgSO4, BIW, DPT, Dram, and Minim.
6. The Discharge Summary or final progress note should concisely recapitulate the reason for hospitalization, the significant findings and events of the patient's hospitalization, the patient's condition on discharge and recommendations and provisions for future care.

A discharge summary or clinical resume is required to be completed and authenticated within 14 days of the patient's discharge for all patient records that meet any of the following criteria:

A patient who expires (death summary)

A patient with a length of stay in excess of 24 hours except those who meet the criteria specified below.

A patient transferred to another hospital, to a different level of hospitalization or to residential care (transfer summary).

A final discharge progress note may be substituted for the discharge summary/clinical resume on all medical records for patients with problems of a minor nature (e.g., outpatient surgeries, observation status patients, etc.) who require less than a twenty-four (24) hour period of hospitalization and in cases of normal newborn infants and uncomplicated obstetrical deliveries. The final discharge note should document the condition of the patient on discharge, any specific instructions given to the patient and/or family as pertinent, follow-up care required and a final diagnosis.

Guidelines for determination of physician responsible for the discharge summary:

- a. The admitting physician will be expected to provide a discharge summary unless (a) he was covering for another physician and admitted the patient because of an "on call" situation and the patient's regular physician assumed care of the patient after coming back on call; or (b) the admitting physician handed the case over to another physician due to the complexity of the diagnosis.
- b. In cases where there are multiple partners and no obvious primary physician, the physician who discharged the patient will be responsible for the discharge summary.

Any cases involving discharge summaries that cannot be resolved between HIM personnel and physicians will be referred to the Chairperson of the appropriate department.

7. Written consent of the patient or legal representative is required for release of medical information to persons not otherwise authorized by law to receive this information.
8. Original medical records may be removed from the Hospital's custody only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without the permission of the Administrator or his/her designee. Unauthorized removal of medical records from the Hospital is grounds for corrective action in accord with the Medical Staff Bylaws.
9. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects shall be approved by the Administrator, the Institutional Review Committee and the Executive Committee before records can be studied. Such access shall also be afforded committees of the Medical Staff and to Medical Staff officers and other participants in the credentialing, peer review and quality assurance processes for authorized purposes. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
10. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is otherwise ordered filed by the Quality Steering Committee. The Committee Chairperson may authorize the Manager of Health Information Services to retire medical records under the following circumstances: when the physician is deceased, has moved from the area, has resigned from the Medical Staff, or is on an extended leave of absence. The Committee Chairperson must sign and date a cover letter for the medical record, stating the reason for retirement.
11. A practitioner's routine orders, when applicable to a given patient, will be reproduced in detail on the order sheet of the patient's record, dated, and signed by the practitioner. An order is considered to be in writing if dictated to a licensed nurse or other authorized person and signed by the attending practitioner.

The use of verbal medication orders is confined to telephone orders and circumstances where expeditious administration of medications would be best facilitated by verbal communication, e.g., Code Blue.

For verbal or telephone orders or for telephone reporting of critical test results, the individual giving the order or test result shall verify the complete order or test result by having the person receiving the information record and “read back” the complete order or test result to assure clear communication.

12. Prior to any specimen collection, medication administration, transfusion, or treatment, hospital staff and other practitioners (when appropriate) shall involve the patient and/or family in an identification and matching process of the patient to the proposed care. Two identifiers (the patient’s complete name and date of birth) shall be verified when:
 - a. Administering medications, blood, or blood components.
 - b. collecting blood samples and other specimens for clinical testing, and
 - c. providing other treatments or procedures.

Containers used for blood and other specimens shall be labeled in the presence of the patient.

13. All Medical Staff/Practitioners practicing at St. Joseph Hospital-Eureka will give their best efforts to use the existing computerized physician order entry (CPOE) system and all future EMR changes adopted by St. Joseph Health. Failure to do so may trigger disciplinary action through the Professional Standards Committee and the Medical Executive Committee.
14. The medical staff acknowledges the important contribution timely completion of patient records makes to quality care. Each patient’s medical record shall be completed promptly and all entries authenticated or signed by each physician, dentist, or podiatrist providing care to the patient within two weeks following the patient’s discharge. Physicians will be notified of incomplete records by Health Information Management. A record is delinquent when it is incomplete fourteen (14) days after discharge.

A delinquent medical record list will be compiled by the Health Information Management (HIM) department once per week. The HIM department is authorized to automatically suspend any practitioner with delinquent records at the time of this report. Notice of automatic suspension shall be given by the Chief of Staff or the Director of Health Information Management to the practitioner and to appropriate departments of the Hospital. A suspended physician will not be permitted to admit, consult on, perform surgery on, write orders, or schedule new patients. Suspended physicians shall be allowed to continue caring for existing patients, as well as those scheduled for services before the physician became suspended. Should a suspended physician attempt to admit, schedule, or treat a patient, the hospital staff will notify the Administrator on Duty (AOD). If a physician accumulates 31 days of suspension within a calendar year, he/she shall be reported to the Medical Executive Committee, who will determine if it adversely affects quality patient care and should be reported to the Medical Board of California. Should the suspension remain in effect for two (2) months, the responsible practitioner shall be deemed to have resigned from the Medical Staff, and to have relinquished his/her privileges, in accord with the Medical Staff Bylaws.

Suspensions shall be excused for the period specified in the following cases:

- a. a physician who is newly assigned responsibility of an existing delinquent record. In such cases the physician will have an additional 72 hours after notification to complete his or her portion of the delinquent record.
- b. a physician who has been ill, on vacation, or otherwise unavailable to complete records up to 48 hours before the suspension would become effective. The

physician will have 72 hours after resuming his/her practice to complete his/her delinquent records.

- c. legitimate HIM record-processing issues including:
 - record(s) not available when physicians visit HIM to complete records
 - physicians being given less than seven days' notification of incomplete records prior to suspension
 - required dictation not being transcribed and ready for signature in a reasonable period of time (e.g. > 24 hours for a discharge summary).

The physician will have 72 hours from the time the records/documents in question become available before the suspension becomes effective.

In such instances the Director of Health Information Management must confirm the issue and a member of the hospital's Executive Management Team must authorize the excuse.

- 15. The staging information required to complete the American Joint Committee on Cancer staging form must be furnished by the responsible physician. If the physician fails to furnish the required staging information within 14 days of discharge, the physician will be suspended in accordance with Paragraph 14 above.

C. **GENERAL CONDUCT OF CARE**

- 1. Documentation of a general consent for treatment, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The nursing staff shall notify the attending practitioner whenever such consent has not been documented. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain and document consent before the patient is treated in the Hospital. An emergency shall be defined as a condition in which delay will endanger the patient's life or health. It is desirable to have another Medical Staff member verify in writing on the progress notes that an emergency exists.

Informed consents for specific surgical procedures or other unusual procedures or treatment shall be obtained by attending practitioners and documented in accordance with standard procedures.

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

The information that must be provided includes a description of:

- a. The nature of the recommended treatment.
- b. It's expected benefits or effects.
- c. The associated risks and possible complications.
- d. Any alternative procedures and their expected benefits or effects and associated risks and possible complications.
- e. Any independent economic interests a physician may have which may influence his or her treatment recommendations.
- f. Risks of not performing the procedure.

Informed consent must be secured from competent patients who are able to give such consent. If a patient is incompetent by reason of psychiatric or medical condition then consent must be secured from a surrogate decision-maker. Surrogate decision-maker may include parents or guardians of minors who may not consent, conservators, attorneys-in-fact, the patient's closest available relatives, or the court. The persons who may give consent are identified in the CAHHS Consent Manual.

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

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

Hospital personnel shall verify that informed consent has been obtained from the patient by asking the patient to complete the General Authorization for and Consent to Surgery or Special Therapeutic or Diagnostic Procedures form.

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

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

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

Special consents must be obtained as required by law. Special consents shall be obtained for blood transfusions, HIV blood tests, elective sterilization procedures, hysterectomies, use of investigational drugs or devices, participation in human experimentation, reuse of hemodialysis filters, treatment for breast and prostate cancer, use of psychotropic medications and involuntary commitment for psychiatric disorders. Special consent must be secured by the attending physician in the manner specified in the law applicable to this particular procedure. When appropriate, hospital personnel shall verify that appropriate consent has been obtained. The laws related to special consents are described in the CAHHS Consent Manual.

The attending physician, or designee, shall assure that consent for the special procedure is secured in the manner required by law, and that required forms, waiting periods, and certifications have been completed.

The physicians involved in securing informed consent shall document in the patient's medical record, their discussions regarding the proposed procedure and whether they secured informed consent.

The physician's documentation related to an emergency situation shall be entered in a progress note and must describe:

- a. The nature of the emergency.
- b. The reasons consent could not be secured from the patient or a surrogate decision-maker.
- c. The probable result if treatment would have been delayed or not provided.

Hospital personnel may not provide patients or surrogate decision-makers with medical information regarding any proposed procedure except as noted above. If a patient or surrogate decision-maker expresses doubt or confusion about a procedure, the patient's attending physician or the physician who is responsible for securing consent shall be contacted and asked to provide the necessary information.

If the physician responsible for securing consent is not available, hospital personnel shall determine whether the patient's doubt or confusion warrants delaying the procedure until the physician is available to respond to the questions and concerns.

Hospital personnel are responsible for verifying that informed consent and other consents as may be required by law have been obtained. This verification will be done for all operations and other complex procedures for both inpatients and outpatients. Informed consent will be verified by asking the patient if they have given informed consent to their attending physician and asking the patient or surrogate decision-maker to sign the hospital's general consent form.

2. Verbal orders for medications must be dated, timed, and countersigned by the prescribing practitioner within 48 hours. If the prescribing physician is not able to authenticate his or her verbal order (e.g., the prescribing physician is off duty for the week-end or an extended period of time), it is acceptable for a covering physician to co-sign the verbal order of the prescribing physician. See section B.13. regarding verbal orders and read back requirements to assure clear communication of verbal orders.

Verbal orders for diagnostic tests shall be considered to be written if accepted by an appropriate person and then documented. An appropriate person is a person licensed to perform the test, the surgical secretary, or the receptionist-secretary in the Laboratory, X-ray, Radiation Therapy and Cardiopulmonary Departments. The appropriate person will acknowledge receipt of the verbal diagnostic order by writing on a chart provided by the Hospital and by indicating the name of the physician dictating the order per his/her own name.

The use of verbal medication orders is confined to telephone orders and circumstances where expeditious administration of medications would be best facilitated by verbal communication, e.g., Code Blue.

3. All medication orders must be reconciled by practitioners and hospital staff when a patient transition occurs between care settings. This includes, but is not limited to, the reconciliation of home medications with medications to be administered in the hospital, as well as upon discharge from the facility. All orders are automatically canceled when patients go to surgery. Each physician is expected to review all medications for all patients regularly to ensure discontinuation of all orders that are no longer needed.
4. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations, or FDA approved. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration. Drugs brought in by patients may not be used except under policies and procedures approved by the Medical Executive Committee.

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

Automatic stop order policies shall be effected as follows:

- | | | |
|----|------------------------|---------|
| a. | Antibiotics: | 7 days |
| b. | Narcotics: | 7 days |
| c. | All Other Medications: | 32 days |

The pharmacist shall notify the attending or ordering physician whenever an automatic stop note has been ordered by placing a notice in the medical record approximately two days prior to the automatic stop.

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

All medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field shall be labeled, even if there is only one medication being used.

Labels include the medication name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.

5. All practitioners shall comply with Medical Staff approved (WHO or CDC endorsed) hand hygiene guidelines and any:
 - a. evidence-based practices implemented by the hospital to prevent health care-associated infections due to multi-drug resistant organisms in the hospital,
 - b. evidence-based guidelines to prevent central line associated bloodstream infections,
 - c. best practices for preventing surgical site infections.
6. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise.
7. Qualified physicians who are not members of the Medical Staff may be called in consultation provided they have secured temporary privileges as provided in the Medical Staff Bylaws.
8. Except in emergency, consultation with a member of the Active, Courtesy or Provisional Medical Staff shall be required in all major cases involving:
 - a. cases in all services in which according to the judgment of the physician:
 - i. the diagnosis is obscure;
 - ii. there is doubt as to the best therapeutic measures to be utilized.
 - b. patient's needs exceed the privileges of the practitioner.
9. The Chief of Staff or designee or the chairperson of the pertinent department reserves the right to require consultation in appropriate individual situations, and this shall not necessarily constitute a restriction of privileges as described in the Medical Staff Bylaws.
 - a. Medical Staff member may be required by the Medical Executive Committee to have consultations on all or some of his or her cases. In such situations, the Medical Staff member shall be responsible for informing the assigned consultants of each admission and for arranging for timely consultation.
10. All members of the St. Joseph Hospital Medical Staff shall abide by the terms of the Notice of Privacy Practices prepared and distributed to Hospital patients as required by the Federal Patient Privacy Regulations.

D. **GENERAL RULES REGARDING SURGICAL CARE**

1. Except in emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation may be canceled by the Chief of Surgery or designee. In an emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.
2. A dentist who is a qualified oral-maxillofacial surgeon may be granted clinical privileges to admit a patient for oral-maxillofacial surgery, perform a full history and physical examination on the patient, care for the patient without the involvement of a physician member of the Medical Staff as long as no medical problem is identified, and discharge

the patient. In all other cases, the patient shall be the dual responsibility of the dentist and a physician member of the Medical Staff, as set forth below.

- a. The dentist's responsibility shall include:
 - i. a detailed dental history justifying hospital admission;
 - ii. a detailed description of the examination of the oral cavity and preoperative diagnosis;
 - iii. a complete operative report, describing the findings and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the Hospital pathologist for examination;
 - iv. progress notes as are pertinent to the oral condition;
 - v. clinical resume or summary statement;
 - vi. the dentist may write orders within the scope of his/her license as may be limited by his/her privileges or by the Medical Staff Bylaws or these Rules and Regulations.
 - b. The physician's responsibilities shall include:
 - i. medical history pertinent to the patient's general health;
 - ii. physical examination to determine the patient's condition prior to anesthesia and surgery;
 - iii. supervision of the patient's general health status while hospitalized.
 - c. The discharge orders and the discharge summaries shall be written by both the dentist and the physician.
 - d. The ultimate responsibility and authority over surgery and treatment shall reside with the co-admitting physician.
3. In keeping with the Medical Staff Bylaws, a patient admitted for podiatric care is a dual responsibility involving the podiatrist and physician member of the Medical Staff.
- a. The podiatrist's responsibilities shall include:
 - i. a detailed podiatric history justifying Hospital admission;
 - ii. a detailed description of the examination of the foot and preoperative diagnosis;
 - iii. a complete operative report, describing the findings and technique. All tissues shall be sent to the Hospital pathologist for examination;
 - iv. progress notes as are pertinent to the foot condition;
 - v. clinical resume or summary statement;
 - vi. the podiatrist may write orders within the scope of his/her license as may be limited by his/her privileges or by the Medical Staff Bylaws or these Rules and Regulations.
 - b. The physician's responsibilities shall include:

- i. the medical history pertinent to the patient's general health;
 - ii. physical examination to determine the patient's condition prior to anesthesia and surgery;
 - iii. supervision of the patient's general health status while hospitalized;
- c. The discharge order and discharge summary shall be written by both the podiatrist and the physician.
- d. The ultimate responsibility and authority over surgery and treatment shall reside with the co-admitting physician.
- 4. Any member of the Medical Staff enjoying the appropriate privileges may assist with surgical procedures at the discretion of the attending surgeon.
- 5. Documentation of informed consent shall be entered prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from the parents, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record. Should a second operation be required during the patient's stay in the Hospital, a second consent specifically worded should be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form.
- 6. In the medical record of each patient submitted to a general anesthetic, there shall be a "pre" and "post" anesthetic note written by the anesthesiologist. The pre-anesthetic note will include an anesthetic history and physical to include but not be limited to cardiorespiratory function, sensitivities and allergies and medications. The post-anesthetic examination should be made at a time when the patient is fully recovered from the anesthetic and can be evaluated for any anesthetic sequelae.
- 7. The surgical team must be gowned, scrubbed, and in the operating room and ready to begin the operation at the time scheduled, or face the possibility of forfeiting the time to the following case.
- 8. A "Universal Protocol" shall be followed prior to a procedure in an attempt to assure that all relevant documents and related information or equipment are:
 - a. Available prior to the start of the procedure.
 - b. Correctly identified, labeled, and matched to the patient's identifiers.
 - c. Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site.

All practitioners performing procedures are to remain familiar with, and abide by, the Medical Staff approved policy and procedure germane to the "Universal Protocol".

- 9. All tissues removed during the operation (with exception for those specific tissues determined from time to time to be inappropriate or unreasonable to examine in the discretion of the Medical Staff) shall be sent to the Hospital pathologist with a report indicating the pre- and post-operative diagnosis. The pathologist shall make such examinations as he/she may consider necessary to arrive at tissue diagnosis. All such pathological material is the property of the Hospital, and may be released to the patient upon written order of the attending physician after pathological examination is complete.

Pathology reports will be filed by diagnosis.

E. **EMERGENCY SERVICES**

1. The following practitioners are authorized to conduct a medical screening examination to determine if an emergency medical condition exists:
 - a. Emergency Department:
Physician members of the Medical Staff.
Nurse Practitioners and Physician Assistants of the Allied Health Professional Staff.
Registered Nurses who have completed the competency program and are operating under an approved Standardized Nursing Procedure.
 - b. Labor and Delivery:
Physician members of the Medical Staff.
Certified Nurse Midwives of the Allied Health Professional Staff.
Registered Nurses who have completed the competency program and are operating under an approved Standardized Nursing Procedure.
2. An appropriate medical record shall be kept for every patient receiving emergency service:
3. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.
4. The appropriate Medical Staff department or service shall develop a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community.
5. On call physician response time will be consistent with the patient's needs. In situations where medical intervention or emergency surgery may be required to stabilize the patient, in person response time will generally not exceed 30 minutes. In cases where the on-call physician is unavailable, department policy will be followed.

F. **MEDICAL STAFF**

1. **Professional Liability Insurance**

Each member of the Medical Staff shall carry professional liability insurance in an amount determined and through carrier(s) deemed acceptable by the Governing Body. Each member of the Medical Staff shall promptly report any lapses in coverage to the Administrator.

2. **Continuing Medical Education**

Consistent with state requirements, members of the Medical Staff shall submit, on an annual basis, a list of their activities in the field of continuing medical education as a requirement of Medical Staff reappointment. Activities will include attendance at local, regional, or national scientific meetings, post-graduate courses, journal clubs, television conferences, grand rounds, and other organized continuing education programs.

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