San Luis Valley
HEALTH
REGIONAL
MEDICAL
CENTER

Medical Staff
Rules and Regulations

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General Purpose and Use of Rules

A. Purpose.

These Rules and Regulations are intended to establish guidelines for the conduct of, and processes relating to, Practitioners who have applied for or been granted Medical Staff appointment and/or clinical privileges by the San Luis Valley Health Board of Trustees. Nothing in these Rules and Regulations is intended or shall be deemed to exercise control, supervision or direction over the provision of medical services in the Hospital by Practitioners who have been granted Medical Staff appointment and/or clinical privileges by the Board and/or temporary privileges as provided in these Rules and Regulations.

B. Additional Rules.

These Rules and Regulations are intended to inform Members of the Hospital's Medical Staff of the policies, procedures, protocols, rules, regulations, guidelines and requirements which apply to them. There may be additional policies, procedures, protocols, rules, regulations, guidelines and requirements which apply to such Medical Staff Members and it is each Medical Staff Member's sole responsibility to obtain, read, understand and abide by all bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Medical Staff.

C. Use.

These Rules and Regulations and all other bylaws, policies, procedures, protocols, rules, regulations, guidelines and requirements of the Hospital and/or its Medical Staff, which may apply to applicants and/or Members to the Hospital's Medical Staff are expressions of the current requirements of, and policies and procedures established by the Hospital relating to applicants and Members of its Medical Staff. THESE RULES AND REGULATIONS AND ALL OTHER BYLAWS, POLICIES, PROCEDURES, RULES, PROTOCOL, REGULATIONS, GUIDELINES AND REQUIREMENTS OF THE HOSPITAL AND/OR ITS MEDICAL STAFF DO NOT CONSTITUTE A CONTRACT OF ANY KIND, AS IS MORE FULLY EXPLAINED IN THE BYLAWS**.**

These Rules and Regulations and all other bylaws, policies, procedures, protocols, rules, regulations, guidelines and requirements of the Hospital and/or its Medical Staff shall be interpreted, applied and enforced within the sole discretion of the Hospital or those individuals delegated responsibility for interpretation, application or enforcement of same by Administration, the Board or under these Rules and Regulations or other bylaws, policies, procedures, protocols, rules, regulations, guidelines and requirements of the Hospital or its Medical Staff. These Rules and Regulations are not intended to delineate specific medical practice or standards, but only relate to policies, procedures, requirements, protocols and guidelines of the Hospital and its Medical Staff and functions of Staff Members.

D. Interpretation.

By submitting an application for appointment, reappointment or temporary privileges, every applicant and staff Member agrees that these Rules and Regulations and all other bylaws, policies, procedures, protocols, rules, regulations, guidelines and requirements of the Hospital and/or its Medical Staff are subject to the interpretation of the Hospital, through Administration and/or the Board, in its sole discretion, after consultation with the President.

I. ENABLING PROCEDURES

The Rules and Regulations have been created pursuant to and under the authority of the Medical Staff Bylaws of San Luis Valley Health Regional Medical Center. The Rules and Regulations outline the mechanisms that the Medical Staff will utilize to accomplish the functions outlined in the Medical Staff Bylaws. In the event of any conflict in the provisions between the Medical Staff Bylaws and the Rules and Regulations, the provisions of the Medical Staff Bylaws shall be controlling. Any definitions in the Medical Staff Bylaws shall apply to these Rules and Regulations.

II. APPROVAL AND MODIFICATION

As these Rules & Regulations are an appendix of the Medical Staff Bylaws, their adoption and amendments will be accomplished through the procedures outlined in Article VIII of the Bylaws.

III. GENERAL RULES

All diagnostic, treatment and patient care services performed at San Luis Valley Health Regional Medical Center shall be under the direction of a San Luis Valley Health Regional Medical Center Medical Staff member.

Except as provided otherwise in the Medical Staff Bylaws, in the event a Medical Staff officer is unavailable to perform an assigned function, the order of Medical Staff officer succession to perform the function is as follows: President, Vice-President, Immediate Past President; any member of the Medical Executive Committee.

IV. GENERAL CONDUCT OF CARE

A. Communication Between Medical Staff Members

To achieve optimum patient safety and to ensure continuity of care, all communications between Medical Staff members shall be done directly practitioner to practitioner, except in an emergency. This includes, but is not limited, to consultation requests, discussion of proposed orders/treatment plans, transfer of care from one practitioner to another practitioner, and patient updates.

B. Consultations

1. Except in emergent care situations, consultations shall be initiated by the practitioner requesting a consultation speaking directly with the consulting practitioner, via phone or in person, to make the request and provide pertinent patient information (to explain the reasons and level of urgency) Appropriate medical practice includes the proper and timely use of consultations. Judgment as to the seriousness of the illness and the resolution of significant doubt regarding the diagnosis or treatment rests with the practitioner responsible for the care of the patient. Consulting practitioners (not physician extenders) shall see patients within twenty-four (24) hours, or sooner if the patient's condition warrants, of the initial request unless otherwise requested, and appropriately document each visit in the medical records, to include their findings and recommendations. Consultants will then round on the patient every day thereafter at a minimum, until they have signed-off the case.

2. The attending practitioner should inform the patient or the authorized decision-maker that he has requested a consultation. Such notification may be forgone in emergencies.

3. In addition, the request for the consultation shall be documented in the orders and progress notes of the medical record. The requesting practitioner may also write an order for nursing staff to make a follow-up call to the attending practitioner once the consultant has seen the patient. The Medical

Staff, through the Medical Executive Committee, has oversight responsibility for assuring that consultants are utilized appropriately.

C. Reason to Doubt or Question Care Provided

1. If after speaking to the appropriate Medical Staff member, a nurse has reason to doubt or question the care provided to any patient and/or believes that appropriate consultation is needed and has not been obtained, the nurse may call this to the attention of their supervisor, who in turn may refer the matter to the appropriate Clinical Nursing Director. If warranted, the Director or his representative shall again attempt to bring these concerns to the attention of the Medical Staff member. Where circumstances are such as to justify such action, the Director may bring the matter to the attention of the Chief Medical Officer (CMO) or Chief Clinical Officer (CCO). The CMO or CCO will attempt to resolve the concerns.

2. If the patient or his legal representative wishes a change of Medical Staff member, he may request so. The attending Medical Staff member shall relinquish care of the patient as soon as an appropriate alternative Medical Staff member is assigned and available to assume care.

D. Informed Consents

1. Pursuant to Hospital policy, a general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. Informed consent is required for all operative and anesthesia/sedation procedures pursuant to the Informed Consent policy. The exception to initiating the general consent for treatment is in the case of emergency. In event of an emergency, documentation should include details of attempts to obtain informed consent and demonstrate the emergency nature of the patient's condition, including the ramifications to the patient's care and urgency of proceeding without consent.

2. In addition to obtaining the patient's general consent to treatment, a specific informed consent indicating that the patient is aware of the nature of and risks inherent in any special treatment or surgical procedure must be obtained prior to such treatment or procedure. Informed Consent is required for all major therapeutic and diagnostic procedures where disclosure of significant medical information will assist the patient in making an informed decision concerning the acceptance or refusal of that treatment.

3. It is proceduralist's responsibility to inform the patient of the nature and risks of treatments or procedures and to ensure that the signed informed consent is obtained from the patient. The informed consent process can be delegated by a physician to his physician extender, if the physician extender is appropriately privileged. The responsible practitioner has accountability to ensure that the informed consent process occurred. The presence of an appropriately executed consent form signed, dated and authenticated by the patient and the appropriate practitioner will serve as validation of this process.

4. An informed consent for emergent cases will be obtained from the patient, family member or the person with designated Durable Power of Attorney. If unable to obtain consent, the care will continue as appropriate. The need for and risk of blood transfusions and alternatives will be discussed and documented in the medical record in non-emergent cases. It will follow the criteria set and approved by the Medical Staff.

5. In severe emergencies, permission for the administration of blood or blood products is not required. If time and clinical condition allow, every effort will be made to obtain permission

from the patient, person with designated Durable Power of Attorney or from a family member. If possible, need for and risk of blood transfusion, as well as alternatives, will be discussed.

E. Imaging Studies

Any imaging studies may be read by the attending physician who may dictate or provide a written report, which will be included with the study and in the medical record. The study will also be over-read by radiologists who are members of the Medical Staff.

F. EKG Reading Panel

All members of the EKG panel will be appropriately privileged physicians. All EKG panel members will be subject to review of ongoing quality measurers. EKGs which are performed in the Emergency Department may be read by appropriately privileged Emergency Medicine physicians.

G. Universal Precautions

All elements of the Universal Precautions shall be followed for all applicable procedures, pursuant to the Hospital's Universal Precaution policy. A practitioner who fails to comply with this requirement may be subject to corrective action by the Medical Executive Committee.

H. Critical Tests and Critical Values Reporting

The Medical Staff has established a policy which defines those critical tests and diagnostic procedures, as well as critical values of certain tests and diagnostic procedures, which fall significantly outside the normal range and may indicate a life-threatening situation. These results will be reported to the ordering practitioner or covering provider in a timely manner as outlined with the policy. In order to have additional or alternative results reported immediately, the practitioner must delineate these instructions with the order itself.

I. Restraints

Restraints shall be employed only when alternative methods are not sufficient to protect the patient or others from injury, and only as allowed by applicable regulations and Hospital policy, to include specific requirements for time-limited orders and renewal of orders.

J. Outpatient Services

Outpatient diagnostic and therapeutic care shall include pathology, clinical laboratory services, imaging services, cardiology, pulmonology, neurology, gastroenterology, surgery, rehabilitation, physical therapy, speech/occupational therapy, infusion therapy, respiratory therapy and chemotherapy. Outpatient services shall be provided in accordance with Hospital and Medical Staff Policies.

K. On-Call Rosters

In support of the Hospital's basic plan for the delivery of emergency services, the Medical Staff shall adopt policies and a method of providing medical coverage in the emergency services that are acceptable to the Hospital. This shall be in accordance with the Hospital's plan for the delivery of such services, including on-call availability and the delineation of clinical privileges for all Medical Staff members who render emergency care. All Active Staff members may be subject to assignment to such rosters.

Active Staff members may be required to take reasonable rotations on emergent call rosters to which they have been assigned.

L. Response to Calls from the Hospital

The practitioner responsible for a patient will respond to STAT pages/calls as soon as they are received, and will respond to routine calls within twenty minutes. Practitioners who are on-call for the Emergency Department shall respond to calls as soon as the call is received, and will be expected to arrive within twenty (20) minutes of the call, when requested to come into the ED.

M. Coverage

Each Medical Staff member shall arrange coverage for each of their patients in the Hospital. The attending practitioner is responsible for informing the practitioner who will provide coverage about their schedule, and for assuring that that practitioner will be available and qualified to assume responsibility for the patients during the attending practitioner's absence. The attending practitioner is responsible to ensure that the "handoff of the patient" to the covering practitioner is comprehensive, and that the covering practitioner is aware of the status and condition of each patient. A failure to arrange appropriate coverage shall be grounds for corrective action by the Medical Executive Committee. In the event the attending practitioner's alternate is not available, the Chief Medical Officer or Administrator on Call shall be contacted and will arrange carefor the patient, until an appropriate Medical Staff member is appointed to assume responsibility.

V. ADMISSION OF PATIENTS (CLINICAL)

A. Unassigned Patients

Every unassigned patient admitted through the Emergency Department must be assigned to an appropriate Medical Staff member. The On-Call specialty roster will be utilized as deemed necessary by the Emergency Department physician to determine the most appropriate physician to be assigned as the attending physicians based upon the most immediate clinical care needed.

B. Attending Physician Assignments and Responsibilities

1. All patients who are admitted into the Emergency Department and/or Obstetrical Unit must be seen by a Medical Staff member within a reasonable period of time. This practitioner may be either the emergency medicine physician on duty, the hospitalist on duty, or the private physician of the patient.

2. The admitting physician will be considered the attending physician, unless otherwise designated by Medical Staff bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Medical Staff. All patients admitted to the Hospital must have written or appropriate telephone orders; and, must be seen by a physician (or a physician extender) within two (2) hours of admission, unless otherwise delineated for high acuity levels of care. Attending physician must ensure that the patient is rounded on by an appropriate physician or his designee at a minimum of every day thereafter, with the visit being documented in the progress notes. Those patients admitted under observation status will be cared for and the documentation completed per the observation admission policy.

3. A patient may be admitted to the Hospital only by an appropriately privileged Medical Staff member, unless otherwise designated by the Medical Staff Bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital. For patients admitted for podiatric or dental services, a medical physician member of the Medical Staff will be responsible for a patient with respect to any medical or psychiatric issues that are present upon admission or develop during hospitalization that are not within the scope of practice of a Podiatrist or Dentist.

4. A patient to be admitted on an emergency basis who does not have an attending physician shall be assigned a physician from the appropriate specialty (ie. hospitalists group, etc.). If the designated On-Call Physician (ie. emergency panel member) disagrees with the admission, he must examine the patient and document his decision in the record. If the On-Call physician does not wish to take care of a particular patient, it is his responsibility to find alternative care for the patient in accordance with these Rules and Regulations and other bylaws, policies, procedures, protocol, rules, regulations, guidelines and requirements of the Hospital and its Medical Staff. The Chief Medical Officer shall decide in case of disagreements.

5. A single physician member to the Medical Staff, or any Medical Staff member who is a member of such physician's group practice, who is also a member of the Medical Staff, shall be responsible, unless otherwise designated by the Medical Staff Bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Medical Staff, for directing and supervising the overall medical care and treatment of each patient admitted to the Hospital. This physician shall be responsible for the completeness and accuracy of the medical record, including an appropriate history and physical as required by the rules, for necessary special instructions, and for transmitting reports of the condition of the patient to the patient and/or relatives of the patient, and to the referring practitioner.

C. Transfer of Responsibilities of Attending Physician / Handoff Communications

Except in the case of a clerical error, whenever the responsibilities of the attending physician are transferred to another Medical Staff member, an order for the transfer of responsibility shall be entered on the order sheet of the medical record. It is the sole responsibility of the attending physician to notify the physician to whom he is transferring, or handing off care to, and to document that clinical conversation (hand-off communication) in the medical record, unless otherwise specified. The hand-off communication should include the patient's historical data and current condition, any recent or anticipated changes to their condition, and the current treatment plan. The communication must be interactive and allow for the receiving physician to verify the received information and have questions addressed.

D. Dual Responsibility of Podiatric and Dental Patients

1. The admission of a patient for podiatric or dental services shall be conducted in accordance with the requirements stated in the Medical Staff Bylaws and other policies, and requirements of the Hospital and its Medical Staff. The following applies to all patients admitted by dentists and those patients admitted by a medical physician instead of the podiatric surgeon.

2. The podiatrist's or dentist's responsibilities include the following.

   - Provide a detailed podiatric/dental history to support the hospital admission.
   - Provide a detailed description of the podiatric/dental examination, including when indicated, the initial and final diagnosis, surgery and prognosis.

- Provide a complete operative report, as well as an immediate written post procedure/progress note.
- Write orders for services and medications as they relate to the podiatric/dental care rendered.
- Write progress notes and final summary as they relate to the podiatric/dental care rendered.

3. The physician member of the Medical Staff, who provides medical care to the podiatric/dental patient in the Hospital, shall perform the functions put forth below.
   - Admit the patient.
   - Perform and document/dictate a medical history and physical examination.
   - Provide for and plan/direct the overall care of the patient's general health during the Hospital stay as appropriate.
   - Write orders for services and medications for the general care of the patient as appropriate.
   - Discharge the patient and complete the discharge summary.

E. Provisional/Admitting Diagnosis

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, such statement shall be recorded as soon as possible.

F. Priority of Admissions

When Hospital beds are limited, patients of Active Medical Staff members shall have priority of admission status; except, when failure to admit a patient will jeopardize that patient's life or health. Admissions shall be based solely on medical need and the ability to transfer patients to another health care facility. In case of doubt, questions of medical need shall be determined by the Department Chair, in their sole discretion. Priority of admissions shall follow this general guideline.

- First Priority: emergency admissions (i.e. patients who have serious medical problems and may suffer death, serious injury, or permanent disability if not admitted and provided treatment within four hours).
- Second Priority – urgent admissions (i.e. patients who have serious medical problems who may suffer substantial injury to their health if not admitted and provided treatment within twenty-four hours).
- Third Priority – preoperative admissions (i.e. patients who are previously scheduled for surgery).

G. Patient Transfers

Transfer priorities shall be as follows: urgent and emergency transfers shall take precedence over routine transfers. The attending physician is responsible for obtaining an Accepting Physician, by speaking directly with the Accepting Physician via phone, prior to arrangements being made for the transfer. Care of patients transferring to another hospital for discharge to a lower level of care, or from acute care to acute care, due to payor issues (ie. Kaiser/VA) will be coordinated through the attending physician and Case Management staff. Transfers shall be made in accordance with Hospital policy, and state and federal law.

H. Utilization Review

Each Medical Staff member is required to report the necessity for continued hospitalization for a patient, including an estimate of the number of additional days of stay and the reasons therefore. Patients that remain in the hospital but do not meet medical criteria for continued hospitalization will be reviewed by the Utilization Review Committee and will be reported to the Clinical Excellence Committee. When necessary, the Chief Medical Officer will assist with coordination for disposition for patients that do not meet continued stay criteria. The attending practitioner is required to document the need for continued hospitalization and planned treatments. This documentation shall contain an adequate written record of the reason for continued hospitalization (a reconfirmation of the patient's diagnosis is not sufficient), the estimated period of time the patient will need to remain in the Hospital, and the plan for post-hospital care.

I. Suicidal Precautions

The admitting practitioner shall provide such information known to them as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others, whenever his patient might be a source of danger. When appropriate, documentation of a Mental Health Hold will be completed and signed by the physician caring for the patient, and the Hold will be appropriately managed according to hospital policy. For the protection of patients, the Medical Staff, hospital personnel and the Hospital, precautions to be taken in the care of the potentially suicidal patient include:

- The patient shall be referred, if possible, to another institution where suitable facilities are available, if there are no appropriate accommodations in the Hospital.
- Any patient known to have suicidal intentions shall have prior to discharge, a face-to-face consultation by a mental health provider who are members of the Medical Staff and the nursing staff shall be notified verbally and by a note on the order sheet.

VI. DISCHARGE OF PATIENTS

A. Discharge

Patients shall be discharged only by order of the attending practitioner or his designated alternate physician, and only after the patient has been examined by that practitioner. The attending physician must coordinate care with all other consulting practitioners and services to ensure the patient is appropriate for discharge and that discharge needs are met (ie. consultants, pharmacy, respiratory, home health, case management, etc.).

B. Against Medical Advice

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 in the patient's medical record and the patient will be asked to sign an acknowledgment form indicating that he understands he is leaving against medical advice. If the patient refuses to sign the acknowledgment form, appropriate documentation regarding same shall be made in the medical record. The attending physician shall be notified of the patient's intent to leave and shall attempt to discuss the risks of leaving the hospital with the patient.

C. Refusal to Leave

Administration, along with the Case Management staff and the Nursing Director, shall be contacted for assistance whenever a patient refuses to leave the hospital. When a patient or their family initiates a Medicare Appeal to discharge, Case Management staff will assist with the HINN 12 (Noncovered Continued Stay) process.

D. Death

1. In the event of a patient's death, the deceased shall be pronounced dead by a physician, preferably the attending physician, within a reasonable period of time after the death has been discovered. If the patient has suffered "brain death" (i.e. the total and irreversible cessation of all functions of the entire brain, including the brain stem), death may be pronounced only in accordance with Hospital policy regarding brain deaths.

2. Requests for any other Medical Staff Member to pronounce a patient dead must be made directly by the attending physician. The attending physician shall also provide this physician with background information surrounding the patient's death, which would be helpful in dealing with the family and friends.

3. The attending practitioner or other physician last in attendance is responsible for signing the death certificate or ensuring its completion. The physician who pronounced the death must write a death summary in the medical record.

4. The attending physician or designee is responsible for notifying the next of kin in all cases of death.

5. If the attending physician is unavailable to sign the CMO will make arrangements for signature on the death certificate.

E. Coroner's Cases and Autopsies

1. All deaths which occur in the Hospital shall be reported to the Coroner as required by applicable law or as directed by the Coroner's Office. Refer to the Hospitals autopsy policy.

F. Disposition of Remains and Contributions of Anatomical Gifts

1. The patient's remains shall be disposed of in accordance with the instructions of the patient, the patient's legal representative or their next of kin. The order, in which the next of kin shall be consulted, is set forth in the Colorado Hospital Association's Consent Manual.

2. If the patient or their family indicates that the patient has or will contribute anatomical gifts, consent shall be secured in accordance with the applicable state laws and pursuant to the Hospital's Organ and tissue Procurement policy. The patient's physician shall comply with the Hospital protocol for identifying potential organ and tissue donors; and, whenever possible, shall confer with the patient or family about donations.

VII. HIGH ACUITY LEVELS OF CARE

1. Practitioners admitting patients to the intensive care unit shall write and accept orders in accordance to ICU protocols..

2. All patients admitted to a high acuity care level shall be seen by the attending physician (not a physician extender) within one (1) hour of admission to the ICU. The attending physician or his designee must round on the patient at a minimum of daily, as further defined by the Hospital's policies.

3. Hospitalists or surgeons shall round on each patient admitted to the ICU to determine if care is appropriate, pursuant to Hospital policy. Consulting physicians (not physician extenders) shall see patients daily, at a minimum.

4. Questions regarding the discharge or admission of a patient to the high acuity care level shall be resolved by the attending practitioner, consulting with the Hospitalist or CMO.

VIII. SURGICAL CASES

1. Surgical procedures shall be scheduled with the surgical supervisor. The history and physical and provisional diagnosis shall be recorded in writing or dictated before any surgical procedure, except when such delay would constitute a hazard to the patient's life. The practitioner must certify that such a situation exists. Failure to complete the chart, except as herein stated, shall place in effect the same rule as being late for a surgical start time and the same rule shall apply. Appropriate laboratory work, as ascertained by the attending Medical Staff Member, shall be obtained and recorded prior to any elective procedure.

2. Practitioners shall be on time for scheduled surgical procedures, by arriving in the surgical area at least ten minutes prior to the scheduled start time. After a fifteen-minute delay, the case may be reassigned to another time to follow all other previously scheduled cases.

3. Practitioners canceling a previously scheduled case will not be permitted to substitute another case in that time period, without the express consent of the surgical supervisor.

4. No unauthorized personnel will be allowed in the operating room. Authorized personnel may observe a surgical case, pursuant to Medical Staff policy.

5. Practitioners providing both moderate sedation and/or major anesthetic will be required to make a pre-operative and post-operative note on the chart, as to the patient's condition and any pertinent findings. No flammable anesthetizing agent shall be used in any location of the Hospital.

6. Emergency treatments/procedures will be expedited as much as possible. In general, such cases shall follow the elective cases previously scheduled for the day. When the seriousness of the case justifies the need, it will take precedence over all elective cases. If two practitioners cannot agree on the re-scheduling of a case, the problem will be presented to the CMO, who will determine a suitable plan.

7. Assessment of Emergent/Non-emergent operative and other anesthesia/sedation procedures: In order to insure appropriate assessment and care is performed for both emergent and non-emergent operative and other anesthesia/sedation procedures, the following will be accomplished.

- An assessment will be performed by the physician to determine the provisional diagnosis to insure appropriate procedure for the patient, optimal time for the procedure, and a baseline for interpreting findings while monitoring the patient.

- Operative and other anesthesia/sedation procedures will be determined emergent or non-emergent by the physician. An emergent operation or other invasive/sedation procedure (emergency) is defined as a procedure which is necessary to prevent imminent loss of life or limb.

- All assessments for non-emergent cases will abide by the definition set forth in these Rules and Regulations and as established in hospital policies for the safe delivery of anesthesia. Routine pre-operative screening tests, such as laboratory tests, will not be required. Each patient is assessed individually based upon the clinical presentation, history and physical examination.

- When appropriate, an assessment of emergent procedures shall abide by these Rules and Regulations. However, the appropriate level of assessment, including history and physical, pre-operative laboratory testing, and other screening diagnostics will be established by clinical appropriateness given the time constraints.

- An informed consent for non-emergent cases will be obtained by the physician for any procedure as stated in these Rules and Regulations.

- An informed consent for emergent cases will be obtained from the patient, family member or the person with designated Durable Power of Attorney. If unable to obtain consent, the care will continue as appropriate. The need for and risk of blood transfusions and alternatives will be discussed and documented in the medical record in non-emergent cases. It will follow the criteria set and approved by the Medical Staff.

- In severe emergencies, permission for the administration of blood or blood products is not required. If time and clinical condition allow, every effort will be made to obtain permission from the patient, person with designated Durable Power of Attorney or from a family member. If possible, need for and risk of blood transfusion, as well as alternatives, will be discussed.

IX. PATHOLOGY

Tissue removed in the operating room shall be sent to the Hospital pathologist for evaluation and/or documentation even if the material just requires a gross description. The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include:

- Cataracts
- Tissue scrapings and filings
- Foreskin of newborns
- Placentas from normal deliveries
- Therapeutic radioactive sources, the removal of which may be guided by radiation safety
- Foreign bodies that for legal reasons are given directly in the chain of custody to law enforcement representative

The pathologist shall examine tissue as necessary to arrive of tissue diagnosis. The authenticated report shall be made a part of the patient's medical record. Each specimen shall be accompanied by necessary information including the pre-operative diagnosis, description of tissue and brief pertinent clinical data which the surgeon will complete or cause to be completed.

X. ORDERS

1. There must be an order from an appropriate practitioner responsible for each patient's care for patient status, either as an inpatient or outpatient, all medications, biologicals, therapeutic diets, restraint, isolation, radiological and diagnostic tests/procedures, and physical, occupational, speech and respiratory services. All orders shall be entered via Computerized Physician Order Entry (CPOE), or via verbal/telephone, or in writing, when necessary, in accordance with Hospital policies and procedures, or except as noted, in the following section. Applicable Hospital policies would include when electronic means of ordering is unavailable and the definition of "downtime" for CPOE, as well as those areas of patient care that are designated as "out of scope for CPOE". Further details regarding order sets, content and documentation of orders is delineated in Section XII of this policy.

2. Only physicians and certain types of non-physician practitioners, working within their licensure, scope of practice and privileges granted, are allowed to give orders for care. They are as follows:
   - Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine);
   - Clinical Psychologist;
   - Certified Clinical Nurse Specialist, Nurse Practitioner, Certified Registered Nurse Anesthetist or Certified Nurse Midwife, in accordance with policy and privileges granted to individuals;
   - Physician Assistant, in accordance with policy and privileges granted to individuals; and,
   - Residents, in accordance with policy.

3. Standing orders/protocols designed to protect critical patients from treatment delays or gaps in medical care may be initiated without the practitioner's prior approval when applied in a very limited and focused manner. Initiation of standing orders and protocols without the practitioner's prior approval or order require authentication by the practitioner responsible for patient care. Inpatient and outpatient staff initiating such standing orders and protocols will immediately notify the patient's practitioner to obtain a telephone order (TO). ED Guidelines/protocols may be initiated without prior approval or practitioner notification. These orders will be authenticated by the ED practitioner responsible for the care of the patient or the supervising ED practitioner when the patient is not yet assigned to a physician.

4. Written Orders - When appropriate pursuant to Hospital policy, an order may be hand written in the medical record or given in written form to a registered nurse, registered/certified respiratory therapists, certified physical/occupational/speech therapists, licensed pharmacist, registered dietitian, nutrition attendant, radiology technician or medical imaging clerical staff, laboratory technician or laboratory clerical staff, social workers or case managers, or a credentialed Allied Health Staff member with specified privileges, and signed by the person whom receives it. All such written orders must be signed, dated and timed by the practitioner giving the order. All written orders must be entered/transcribed immediately.

   Written orders must be written clearly, legibly and completely, to include date, time and signature. Orders which are illegible, improperly written or ambiguous will not be carried out until rewritten or understood by the caregiver responsible to carry out the orders. Orders with illegible signatures which are not accompanied by a printed name will not be carried out until the practitioner is properly identified.

5. Verbal/Telephone Orders - When appropriate pursuant to Hospital policy, verbal orders (by telephone or in person) may be necessary. The following exceptions may apply, pursuant to Hospital policy: unavailable access to a computer, Emergency orders for care such as a Code

Blue, preoperative orders when patient is coming from outpatient setting, and when a practitioner is performing a procedure. All verbal orders should be entered via CPOE, but if necessary, they must be written by the receiver, then read back for clarification and documented in the medical record. Both the orders and the read-back must be documented in the medical record. Verbal orders may be given orally to a registered nurse, licensed pharmacist, physician assistant, nurse practitioner, respiratory therapist (for respiratory therapy medications, and/or treatment only), and/or treatment only), physical therapist (for medications used in the physical medicine and rehabilitation environment, PT/OT/ST evaluation and treatment and vending equipment only), or occupational therapist (for OT/PT/ST evaluation and treatment and vending equipment only), speech therapist (for ST/OT/PT evaluation and treatment and diet recommendations only), dietician or nutrition attendant (for dietary orders only), radiology technician or medical imaging clerical staff (for radiology studies or procedures only), laboratory technician or laboratory clerical staff (for laboratory tests only), or social workers and case managers (for admission status, therapy evaluations and dietary/pharmacy consults only).

Verbal orders and read-backs must be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order and the date, time and signature of the person receiving the order.

Telephone orders may be given orally to a registered nurse, licensed pharmacist, physician assistant, nurse practitioner, respiratory therapist (for respiratory therapy medications, and/or treatment only), cardiovascular invasive specialist (for cardiovascular therapy medications, and/or treatment only), physical therapist (for medications used in the physical medicine and rehabilitation environment, PT/OT/ST evaluation and treatment and vending equipment only), or occupational therapist (for OT/PT/ST evaluation and treatment and vending equipment only), speech therapist (for ST/OT/PT evaluation and treatment and diet recommendations only), dietician or nutrition attendant (for dietary orders only), radiology technician or medical imaging clerical staff (for radiology studies or procedures only), laboratory technician or laboratory clerical staff (for laboratory tests only), or social workers and case managers (for admission status, therapy evaluations and dietary/pharmacy consults only).

Telephone orders must be entered/transcribed immediately by the person taking the telephone order, noting the name of the person giving the telephone order and the signature of the person receiving the order, with the date and time. After the order has been recorded, the person taking the order must read the order back to the person giving the order and must be verified verbally by the person giving the order. The read-back of the order must be documented in the medical record. No telephone order shall be fulfilled if this process is not followed.

All verbal and telephone orders which have documented evidence of read back and verification by the individual receiving the verbal/telephone order are to be authenticated (dated, timed and signed) electronically within thirty days after the date of the patient's discharge. If there is no evidence of documented read back and verification, the telephone or verbal order must be signed electronically with in forty-eight hours of the order being given.

6. Do Not Resuscitate ("DNR") Orders and Discontinuing Life-Sustaining Treatment - Decisions to withhold or withdraw medical care must be handled carefully. The effect upon the patient, and the patient's family, friends, significant others, and members of the health care team should be kept in mind. All decisions to withhold or withdraw medical care, particularly as it affects end of life decision-making, shall be done in accordance with the Hospital's Consent policy and Withdraw of Care guidelines. It is the responsibility of the attending physician to have the withholding/ withdrawing care conversation with the patient and/or the patient's family, along with any other disciplines the physician requests to be in attendance.

7. All previous orders, with the exception of rehabilitation services orders, are canceled when a Patient is transferred to a different level of care (ie. operating rooms, surgical unit, ICU, etc.) and all such orders must be renewed or re-written upon admission to the new level of care. All previous PT/OT/ST orders will remain in effect and be continued despite a patient's transfer to another level of care. Such PT/OT/ST orders will only be cancelled by an order from the practitioner.

XI. DRUGS AND MEDICATIONS

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 AMA Drug Evaluations.

A. Formulary Drugs

1. The formulary system is the accepted method whereby the Pharmacy and Therapeutics Committee evaluates, selects from among the numerous medicinal agents available and approves those drugs that are considered most useful in patient care. Under the formulary system, Medical Staff members agree that in each instance in which they prescribe a drug by proprietary (brand) name, they are expressly authorizing the pharmacist to dispense, and the appropriate caregiver to administer, the same drug under its "therapeutic equivalent", irrespective of whether it is or is not the same brand referred to in the prescription or order. If for any medical reason, a Practitioner wants a patient to receive a specific brand name of drug, they must specifically indicate by writing on the Physician's Order form or the Outpatient Prescription blank, the words "Dispense as Written or Prescribed Brand Only or DAW or PBO". Only then will the pharmacist dispense that particular brand. All "Dispense as Written" orders are subject to evaluation by the Pharmacy and Therapeutics Committee.

2. Those drugs that have been reviewed and approved by the Pharmacy and Therapeutics Committee are designated formulary drugs. It is the responsibility of the Pharmacy Department to maintain a safe and therapeutically efficacious supply of each formulary drug. The brand stocked in the Pharmacy will be dispensed for prescription orders for any brand unless otherwise indicated by the prescribing Practitioner.

3. Requests for additions to or deletions from the formulary shall be submitted on a Formulary Drug Request form, available from the Pharmacy Department, to the Director of Pharmacy for presentation to the Pharmacy and Therapeutics Committee. These requests are researched and evaluated by the Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee is composed of an inter-disciplinary team, including pharmacists and Medical Staff members. All drugs are admitted to the formulary on a non-proprietary name basis. No drug of unknown or undisclosed composition shall be administered.

4. When a non-formulary drug is requested from the Pharmacy Department, the pharmacists will inform the prescribing Practitioner of those formulary drugs which are pharmacologically similar. If the Practitioner has a medical reason for using the non-formulary drug, the Pharmacy will obtain the medication for that particular patient, or allow the patient to use their own medication after it has been evaluated by a pharmacist pursuant to the Medication Formulary System policy. Since non-formulary drugs are not stocked within the Pharmacy, there may be a time delay in obtaining the medication up to twenty-four (24) hours.

5. Certain medications may be interchanged with a therapeutically equivalent product as determined and approved by the Pharmacy and Therapeutics Committee. Such interchanges will be communicated to the Medical Staff prior to implementation. The interchanges will be automatic pursuant to the Medication Formulary Systems policy.

B. Procurement of Medications

1. All medications shall be procured from the Hospital Pharmacy. If the medication ordered is not stocked by the Hospital Pharmacy, it will be substituted or obtained pursuant to the Medication Formulary System policy.

2. All medications brought to the Hospital will be turned over to the nurses in charge of the patient's care for safekeeping. These medications are not to be used, unless the medication is a bulk item such as eye drops and inhalers, or if the medication is a Non-Formulary drug and a suitable Formulary substitution cannot be made. These medications may only be administered to the patient if the medication is clearly identified by a Hospital pharmacist and specifically ordered by a Medical Staff Member who has the privileges to prescribe. The order must specify the name, dosage, frequency, and route of administration of each medication. "May use own medication" or "Take home medications" are not acceptable orders. The patient's medications will not be self-administered pursuant to Hospital policy. Once the patient's home medications are accurately recorded, they shall be either sent home with a family member or secured in the Pharmacy vault.

C. Stop Order Policy on Drugs and Medications

1. Automatic stop orders shall be implemented pursuant to the Hospital's Automatic Stop Order practices for Medications policy.

2. Discontinuance of a medication because of the Stop Order policy will be brought to the attention of the attending physician, starting four (1) day before the stop date, whenever appropriate to allow an opportunity to renew or discontinue the order.

D. Review of Medication Orders

Each Medical Staff member is expected to review all medications for each patient to insure current appropriateness of orders and discontinuation of orders that are no longer needed. Orders for medications must be issued by the Medical Staff member:

- upon admission
- when patients return from surgery or other operative/invasive or anesthesia/sedation procedures;
- when medication is to be resumed after an automatic stop order has been implemented;
- when patients are transferred to or from a different level of care; and/or,
- upon discharge.

E. Special Orders

Non-FDA Approved Pharmaceutical/Products - All formulary pharmaceuticals currently used for the treatment of patients are FDA approved products and/or Pharmacy & Therapeutics Committee approved supplements, which meet many required criteria including but not limited to: efficacy, safety and toxicity, bioequivalence, risks for adverse reactions, propensity to induce errors, and cost, etc. It is acknowledged that the use of non-traditional products (e.g., herbal remedies, extracts, certain vitamin components) which do not have FDA approval is controversial. Because these non-FDA approved products do not meet the above standards within the primary literature, in general, their use is not supported without factual documentation, and are not available from the Hospital's Pharmacy. However, should the patient request to utilize these products for their own use, the attending Practitioner may support this practice by writing an order in the patient's chart requesting the patient utilize their personal supply. The order shall be written in

compliance with the Use of Herbal or Homeopathic Medications and Supplements policy and the Medication Formulary Services policy.

XII. MEDICAL RECORDS

A. General Guidelines

1. The patient's hospital medical record serves a multitude of purposes, including patient care, continuity of patient care, medical research, and business and medical legal documentation. Although the primary purpose of the record is to serve the interests of the individual patient, it also serves as the basis for quality improvement and utilization review activities.

2. Records must be maintained for all patients who receive treatment at the Hospital, including inpatients, outpatients, and patients admitted to the Emergency Department. Each member of the medical staff is expected to maintain adequate current documentation within the medical record for the care they are providing to each patient. Its content shall be pertinent and current. Each Patient's medical record shall be legibly signed, dated and timed by the Practitioner in attendance who is responsible for its clinical accuracy.

3. The original medical record shall be maintained by the Hospital as required by Colorado law. Certified copies shall be released only pursuant to a valid authorization for release or court order or as otherwise required by state statute or subpoena. All records are the property of the Hospital and shall be maintained in the HIM department. 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. All medical records must be signed out of the HIM department. Unauthorized removal of charts from the Hospital may be grounds for corrective action by the Medical Executive Committee and/or legal action. Medical Staff members agree to comply with all requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and with the Hospital's policies with regard to the privacy and security of patients' protected health information.

4. Access to medical records of patients shall be afforded to Members of the Medical Staff for bona fide medical study and research as long as the confidentiality of personal information concerning the individual Patient is preserved. Present and former Members of the Medical Staff shall be permitted reasonable access to information from the medical records of their Patients for continuity of care purposes. Written consent of the patient or legal representative is required for release of medical information to that individual or to persons not_otherwise authorized to receive this information except as otherwise required by applicable law.

B. General Contents

Each patient record shall include, if applicable:

- Identification data
- Date and time of admission
- Admission status and level of care
- Chief complaint/symptoms
- Personal history family medical histories, including food/medication allergies

- History of present illness, including care provided prior to arrival if any.
- Physical examination, including inventory of body systems
- Conclusions or impressions drawn from the medical history and physical exam including admitting diagnosis.
- Reasons for admission or treatment, including any pertinent emergency or pre-admission care
- Goals of treatment and treatment plans, including evidence of Advance Directive
- Progress notes stating medical or surgical treatment and patient's response to care.
- Special reports, such as consultations, clinical laboratory and radiology services, EEG, EKG, anesthesia and others
- Provisional diagnosis, medical or surgical treatment
- Diagnostic and therapeutic orders
- Evidence of appropriate informed consent(s)
- Pre- and post- anesthesia notes, including pre-induction assessment, pre- and post-sedation notes
- Operative/anesthesia/sedation procedure report handwritten immediately post-op
- Operative/anesthesia/sedation procedure report- dictated
- Pathological findings
- All relevant final principal and secondary diagnoses, complications and procedures performed are written without use of symbols and abbreviations.
- Condition on discharge
- Discharge instructions to the patient and family
- Medications ordered and administered
- Discharge summaries, final note or transfer summary
- Autopsy report, when performed

C. Responsibility for the Record

The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current. This record shall include the general contents delineated in Section XII-B.

D. History & Physical Requirements

1. The attending practitioner is responsible for the History and Physical. However, a document performed by any privileged provider can be used as an H&P, so long as it contains all of the required elements including timeliness, legibility and accuracy requirements. This includes consultations and pre-anesthesia assessments, but does not include NURSING documentation.

2. H&Ps may only be completed and documented by a physician or other qualified licensed individual in accordance with state law and privileges granted.
    - A specific history and physical noting the podiatric details is required by the podiatrist prior to podiatric procedures.
    - Other qualified individuals such as licensed practitioners (ie Advance Practice Registered Nurses and Physician Assistants) may also conduct H&P's, if privileged to do so and countersigned by the supervising physician.
    - H&P's prepared by physicians without appropriate privileges or qualified LIPs who does not practice in the hospital, but are acting within their scope of practice, will be acceptable if co-signed by a member of the medical staff within required timeframes described below.
    - H&Ps compiled and prepared for a privileged practitioner by their non-privileged office staff is only acceptable if completed under the direction of the practitioner and if the data used in compiling the information was documented within thirty days before admission or registration. The non-privileged staff may assemble and organize documentation performed by the privileged practitioner, including prior the H&P (if not outdated), test results and interpretations. The physical examination may never be delegated to non-privileged office staff.

3. Inpatient and Observation status admissions must have an authenticated H&P placed in the medical record within twenty-four hours of admission or registration, but prior to operative and other high risk procedures and procedures requiring anesthesia or deep/moderate sedation. This includes weekend and holidays. If the required timeframes are not achievable due to delays in transcription, handwritten short-form H&P may be used to supplement the H&P. If the H&P is not in the medical record prior to operative and other high risk procedures and procedures requiring anesthesia or deep/moderate sedation, the procedure may be cancelled.

4. Outpatient and ambulatory patient H&Ps must be completed prior to operative and other high risk procedures and procedures requiring anesthesia or deep/moderate sedation. A handwritten short-form H&P is acceptable.

5. When the H&P is conducted within thirty days before admission or registration, an update must be completed, authenticated and in the medical record according to the required timeframes. The update must include a re-examination of the patient. If upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he may indicate in the patient's medical record that "the H&P was reviewed, the patient examined and no changes have occurred in the patient's condition". If the licensed practitioner finds that the H&P done prior to admission is incomplete, inaccurate of otherwise unacceptable, the practitioner reviewing may disregard the existing H&P and conduct a new history and physical examination.

6. If an emergency, a brief history and appropriate physical findings and pre-operative/pre-procedure diagnosis should be recorded in the medical record prior to operative and other high risk procedures and procedures requiring anesthesia or deep/moderate sedation

7. The content of the H&P should be pertinent and relevant, and it should provide sufficient information necessary to provide care and services required to address the patient's conditions and needs. It may vary by setting or level of care, treatment or services. The components to be included in the H&P are noted below. For outpatient procedures, it is permissible to have a focused rather than a complete H&P.

History and Physical Components that are pertinent, include:	Short Form H&P components that are pertinent but not limited to Moderate/Conscious sedation include:
Patient Name Chief Complaint / Admission Diagnosis Details of present illness/condition Relevant history, including: Previous surgery Medications Allergies Review of systems Pertinent family history Physical exam relevant to medical condition or procedure and including heart and lungs (Heart and lung may be done by surgeon, proceduralist and/ or CRNA) Impression and/or risk assessment Procedure / Plan of action	Patient name and date of admission Admission diagnosis Details of illness Procedure/plan Patient history/pertinent family history Current medications Allergies Physical exam relevant to medical condition or procedure and including heart and lungs (Heart and lung may be done by surgeon, proceduralist and/ or CRNA) Diagnostic test results, if applicable Moderate/Conscious Sedation Risk Classification, if applicable

8. Several other documents that may serve as an H&P are as follows, providing required minimal content is included. A legible copy of the Obstetrician's prenatal record is acceptable for Labor and Delivery, but they must be updated within twenty-four hours of admission or registration, and prior to operative and other high risk procedures and procedures requiring anesthesia or deep/moderate sedation. The newborn assessment as performed after delivery may serve as the H&P. A consult report at the direction of the physician may be a substitute document for an H&P if all elements are included.

E. Pre-Anesthesia or Deep Sedation Assessment

1. A pre-anesthesia or deep sedation evaluation must be performed for each patient who receives general, regional or monitored anesthesia care. Anesthetic agents for which there is no antidote for reversal (i.e. Propofol, Ketamine and Etomidate) will be, at a minimum, included in the category of Monitored Anesthesia Care. The evaluation must be performed by practitioner qualified and privileged to administer general or regional anesthesia, MAC or Deep sedation (a qualified anesthesiologist; a doctor of medicine or osteopathy (other than an anesthesiologist); or, a dentist/oral surgeon or podiatrist who is qualified to administer anesthesia under State law). The Pre-anesthesia and Pre-deep sedation evaluation may not be delegated to practitioners who are not privileged to administer anesthesia/deep-sedation.

2. The pre-anesthesia or pre-deep sedation evaluation must be performed within 48 hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. The delivery of the first dose of medication(s) for the purpose of inducing anesthesia or deep sedation marks the end of the 48 hour timeframe.

3. Some elements contributing to the pre-anesthesia, pre-deep sedation evaluation may be performed prior to the 48-hour timeframe. However, under no circumstances may these elements be performed more than thirty days prior to surgery or a procedure requiring anesthesia or deep sedation services. Review of these elements must be conducted, and any appropriate updates documented, within the 48-hour timeframe.

4. Elements that must be performed within the 48-hour timeframe:
   - Review of the medical history, including anesthesia, drug and allergy history; and
   - Interview, if possible given the patient's condition, and examination of the patient.

5. Elements that may be reviewed and updated as necessary within 48 hours, but which may also have been performed during or within thirty days prior to the 48-hour time period, in preparation for the procedure:
   - Review of medical history including anesthesia, drug and allergy history;
   - Interview and examination of the patient;
   - Notation of Airway and ASA classification of risk;
   - Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);
   - Additional pre-anesthesia data or information, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation); and,
   - Development of the plan for the patient's anesthesia care, and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia.

6. If the practitioner performing the procedures is also administering anesthesia and an H&P was completed that covers all above required components of documentation (ie. ED practitioner performing short procedure involving deep sedation), the H&P may serve as the pre-sedation assessment. The anesthesia record should reflect that the H&P is to be referred to for patient's information.

7. Immediate anesthesia or deep sedation re-evaluation prior to induction -- An anesthesia or deep sedation re-evaluation of the patient must occur immediately before administering deep sedation or just prior to induction of anesthesia. This may not be delegated to practitioners who are not privileged to administer anesthesia or deep sedation. The immediate re-evaluation should occur no more than 5 minutes prior to administration of first dose of anesthesia/deep sedation. Minimum components of the immediate re-evaluation must include HR, BP, SaO2 and respiratory rate.

8. Anesthesia/Deep Sedation record -- There must be an intraoperative anesthesia or deep sedation record or report for each patient who receives general, regional or monitored anesthesia (which includes deep sedation).
   The intraoperative or intra-procedural anesthesia record, at a minimum, includes the following.
   - Name and hospital identification number of the patient
   - Name(s) of practitioner who administered anesthesia Name, dosage, route and time of administration of drugs and anesthesia agents
   - Technique(s) used and patient position(s), including the insertion/use of any intravascular or airway devices
   - Name and amounts of IV fluids, including blood or blood products, if applicable
   - Vital signs documented every 5 minutes and oxygenation ventilation every 15 minutes
   - Pain
   - ETCO2
   - Immediate re-evaluation
   - Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient response to treatment

9. Post-Anesthesia or Post-Deep Sedation Evaluation -- A post-anesthesia, post-deep sedation evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. The evaluation is required any time general, regional, monitored anesthesia or deep-sedation has been administered to the patient. For patient receiving moderation sedation, a post-anesthesia evaluation is not required. The evaluation must be completed and documented by any practitioner who is qualified and privileged to administer anesthesia and deep sedation. This need not be the same practitioner who administered the anesthesia or deep sedation to the patient. The calculation of the 48-hour timeframe begins at the point the patient is moved into the designated recovery area. Accepted standards of anesthesia care indicate that the evaluation should not begin until the patient is sufficiently recovered from the acute administration of the anesthesia or deep sedation so as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks, etc. While the evaluation should begin in the PACU/ICU or other designated recovery location, it may be completed after the patient is moved to another inpatient location, or for same day surgeries after the patient is discharged, so long as it is completed within 48 hours.

   For those patients who are unable to participate in the post anesthesia/post deep sedation evaluation (e.g., post-operative sedation, mechanical ventilation, etc.), a post-anesthesia/post-deep sedation evaluation should be completed and documented within 48 hours with notation that the patient was unable to participate. This documentation should include the reason for the patient's inability to participate as well as expectations for recovery time, if applicable. For those patients who require long-acting regional anesthesia to ensure optimum medical care of the patient, whose acute effects will last beyond the 48-hour timeframe, a post-anesthesia evaluation must still be completed and documented within 48 hours. However, there should be a notation that the patient is otherwise able to participate in the evaluation, but full recovery from regional anesthesia has not occurred and is not expected within the stipulated timeframe for the completion of the evaluation.

   The elements of an adequate post-anesthesia/ post-deep sedation evaluation should be clearly documented and conform to current standards of anesthesia care, which include the following.
   - Respiratory function, including respiratory rate, airway patency and oxygen saturation
   - Cardiovascular function, including pulse rate and blood pressure
   - Temperature
   - Pain
   - Nausea and vomiting
   - Post-operative hydration
   - LOC/mental status
   - Unusual events or complication

10. Moderate Sedation -- Moderate sedation may be administered after any of the following provided appropriate privileges have been granted.
    - A anesthesiologist
    - A doctor of medicine or osteopathy (other than an anesthesiologist)
    - A dentist, oral surgeon or podiatrist who is qualified to administer anesthesia under State law
    - A certified registered nurse anesthetist (CRNA) A Registered Nurse, Registered Cardiac Interventional Specialists, or Cardiovascular Technologists who holds current ACLS certification and has been medically delegated by their supervising physician.

11. Pre- Moderate Sedation Assessment -- A pre-moderate sedation assessment must be performed by a qualified person, who is privileged to perform moderate sedation. This would include any of the following practitioners.
    - A anesthesiologist

- A doctor of medicine or osteopathy (other than an anesthesiologist)
- A dentist, oral surgeon or podiatrist who is qualified to administer anesthesia under State law
- A certified registered nurse anesthetist (CRNA) who is under the medical direction of an anesthesiologist

A pre-sedation assessment must be performed no more than 48 hours before the planned procedure. The pre-sedation assessment should be performed by the qualified person who is going to be administering the moderate sedation. A pre-sedation assessment includes the following, at a minimum.

- Airway assessment
- ASA classification
- Drug and allergy history
- Pertinent history and physical examination
- Plan for sedation

12. Immediate Pre-Moderate Sedation Re-evaluation -- The patient must be re-evaluated immediately before administering moderation sedation. This Immediate Re-evaluation should occur no more than five minutes prior to administration of sedation. The person administering the sedation may perform the Immediate Re-evaluation or delegate it to another qualified person. Minimum components of the Immediate Reevaluation must include the following.
    - HR
    - BP
    - SaO2
    - ETCO2
13. Moderate Sedation Monitoring -- The qualified provider administering the sedation should monitor the patient. The minimum components of intra-procedural monitoring shall include the following.
    - Level of consciousness
    - Respirations (frequency & adequacy)
    - O_2 saturations
    - Blood pressure
    - ECG
    - ETCO2

    Any complications, adverse reactions, or problems occurring during moderate sedation, including time and description of symptoms, vital signs, treatments rendered, and patient response to treatment should also be documented.

14. Post Moderate Sedation Documentation --There is no requirement for a post-moderate sedation assessment. Recovery and achievement of the discharge criteria may be performed by a Registered Nurse, Cardiac Interventional Specialist or Cardiovascular Technologist who holds current ACLS certification and has been medically delegated by their supervising and privileged physician.

F. Discharge Summary / Transfer Summary / Death Summary

1. The admitting physician or another covering physician knowledgeable about the patient's condition during the hospitalization is responsible for the preparation of a discharge summary for all patients hospitalized over twenty-four hours and all deaths, regardless of the length of stay. Other qualified individuals such as licensed practitioners (i.e. Advance Practice Registered

Nurses and Physician Assistants) may write the discharge summary when privileged to do so and when delegated to do so by the patient's physician.

2. A final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case and provisions for follow up care but only when a patient has been hospitalized for less than twenty-four hours.

3. The discharge summary must be completed promptly after discharge but no later than forty-eight (48) hours after discharge. Components of documentation that must be included in the Discharge Summaries include the following.
   - Reason for hospitalization --final diagnosis and secondary diagnoses
   - Procedures performed
   - Outcome of care, treatment and services provided
   - Condition and disposition of the patient at discharge
   - Provisions for follow-up care
   - Information provided to the patient and family
   - Content of the discharge summary shall reflect the hospital course and be sufficient to justify the diagnosis and treatment

4. When the patient is transferred within the same facility/organization, from one level of care to another level of care, or the caregivers change, a transfer summary may be substituted for the discharge summary. A transfer summary briefly describes the patient's condition at time of transfer and the reason for transfer. When practitioners remain the same, a progress note may suffice.

5. In the event of death, a death summary is required. This summation shall include the following.
   - Reason for admission
   - Findings and course in the hospital
   - Event leading to death
   - Time and date of death

G. **Immediate Postoperative Note versus Complete Operative Report** (Comprehensive Report and Immediate Post-Op Note)

1. A complete operative/procedure REPORT is required for all patients regardless of whether an operative NOTE has been written. If the REPORT is entered into the medical record electronically, is immediately available, and contains the minimal required elements, an immediate post-op NOTE is not required. The operative/procedure REPORT shall contain at least the following:
   - Name of the LIP(s) who performed the procedure
   - Name of all assistants
   - Name of the procedure performed
   - Description of the procedure
   - Findings of the procedure
   - Estimated blood loss or notation of no blood loss
   - Name of specimen(s) removed
   - Post-operative diagnosis

2. When a complete operative/procedure REPORT cannot be entered immediately into the patient's medical record after a procedure, a hand written or postoperative **NOTE** may be entered in the

medical record following completion of the procedure before the patient is transferred to the next level of care. At a minimum the Operative NOTE must include:

- Name of the LIP(s) who performed the procedure
- Name of all assistants
- Name of procedures performed
- Description of each procedure's finding
- Estimated blood loss or notation of no blood loss
- Name of specimen(s) removed
- Post-operative diagnosis

3. If the practitioner performing the operation or high risk procedure accompanies the patient from the OR/procedure suite to the next unit or area of care, the Note may be written in the new unit or area of care.

4. If a post-operative NOTE was written immediately after the procedure, the practitioner must enter/dictate the complete operative REPORT within twenty-four hours.

H. Orders for Care

1. There must be an order placed in the medical record from the practitioner or practitioners responsible for each patient's care for patient status, either as an inpatient or outpatient, all medications, biologicals, therapeutic diets, restraint, seclusion, radiological and diagnostic tests/procedures, and physical, occupational, speech and respiratory services.

2. Orders must be legible, complete, dated, timed, and authenticated in either electronic or written form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. The requirements for dating and timing do not apply to orders or prescriptions that are generated outside of the hospital until they are presented to the hospital at the time of service. Once the hospital begins processing such an order or prescription, it is responsible for ensuring that the implementation of the order or prescription by the hospital is promptly dated, and timed in the patient's medical record.

3. When a practitioner must use a preprinted order set sheet, the following requirements must be met:
   - Last page: Sign, date, and time the last page of the orders, with the last page also identifying the total number of pages in the order set.
   - Pages with Internal Selections: Sign or initial any other (internal) pages of the order set where selections or changes have been made.
   - The practitioner should initial/sign the top or bottom of the pertinent page(s);and
   - The practitioner should also initial each place in the preprinted order set where changes, such as additions, deletions, or strike-outs of components that do not apply, have been made.
   - It is not necessary to initial every preprinted box that is checked to indicate selection of an order option, so long as there are no changes made to the option(s) selected.

4. In the case of a pre-established electronic order sets, the same principles above apply. The practitioner should ensure that all such entries are dated, timed and authenticated, with the exception that pages with internal changes would not need to be initialed or signed if they are part of an integrated single electronic document.

5. When telephone or verbal orders are issued, they must be authenticated by the responsible or designated practitioner as follows: within thirty days if the order has been read-back and verified, or, within 48 hours.

6. Verbal orders (by telephone or in person) should be used infrequently and accepted only by an RN or, in specialized departments, by registered or otherwise certified personnel. Medical staff shall use the Hospital's current EMR system for CPOE (computerized physician order entry) to enter orders. The following exceptions may apply: unavailable access to a computer, Emergency orders for care such as a Code Blue, preoperative orders, and when a physician is performing surgery.

7. Orders for the use of physical restraints must be documented for non-behavioral health purposes including order for use, results of patient monitoring, reassessment and unanticipated changes in patient's condition. Orders for the use of restraints or seclusion for behavioral health purposes including each episode of restraint and/or seclusion, must be documented pursuant to appropriate policy.

I. Medical Record Entries

All medical record entries must be legible, dated, timed and authenticated. Authentication of medical record entries may include written signatures and electronic authorizations. Rubber stamps used to date and time stamp or assist with identification of the author are acceptable only when accompanied by a written signature.

Inappropriate use of electronic passwords or pins violates the Security policy and Medical Staff policies. Medical staff members may be subject to corrective action by the Medical Executive Committee for such infractions. The H&P, ED notes, operative reports, consultations, and final summaries, written or dictated by physician office personnel, must be authenticated by the attending/supervising physician, dentist, or podiatrist. The responsible medical staff member's own pertinent observations and significant physical findings should be added wherever necessary.

J. Informed Consents

1. The health record must contain evidence of the patient's informed consent for any procedure or treatment for which it is appropriate. This information should include the:
   - Name of the patient.
   - Name of hospital.
   - Name(s) of the individual(s) who will perform surgical tasks, procedure or treatment
   - Names of surgeons and other practitioners who will perform significant surgical tasks (even when performing those tasks under supervision).
   - A description of the specific significant surgical tasks, procedure or treatment and indications for the proposed surgery, procedure or treatment
   - A description of the specific significant surgical tasks, procedure or treatment that will be conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues).
   - Material risks, benefits and likelihood of success for the patient related to the procedure or treatment and anesthesia, including the likelihood of each
   - Alternatives to the procedure or treatment and their risks, benefits and side effect
   - Probable consequences of declining recommended or alternative therapies
   - The circumstances under which information must be reported to appropriate entities, such as the department of health or Centers for Disease Control.

2. Informed consent forms signed by the patient for recurring procedures or for a series of treatments shall be valid for thirty days, so long as the first procedure or treatment is conducted within thirty days of obtaining informed consent. Any consent obtained prior to thirty days from the time of the intended procedure shall be considered invalid, unless facts warrant its validity.

K. Progress Notes

Progress notes shall be written or entered electronically for every patient daily by the attending physician or designee. Each entry must be legible, dated, timed and signed. Pertinent progress notes shall be recorded at the time of observation sufficient to present continuity of care and easy transfer. Each of the patient's clinical problems should be clearly identified in the progress notes and correlated with the specific orders, as well as results of tests and treatment. Progress notes should include, but not be limited to, the following.

- Findings of assessments and reassessments
- Continued medical necessity for hospitalization
- Conclusions or impressions drawn from the patient's physical examination and results of diagnostic and therapeutic tests and procedures including laboratory test results
- Observations relevant to care, treatment, and services
- The patient's response to care, treatment, and services
- Treatment goals, plan of care, and revisions to the plan of care

L. Consultations

Requests for consultations shall be documented in the medical record. Consultation notes 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 record. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations.

M. Same Day Surgery with Extended Recovery

The medical records of any outpatient/same-day surgery patient, who receive anesthesia, must contain the following, if applicable.

- History and physical examination, diagnostic test results, anesthesia, drug and allergy information and preoperative diagnosis
- Pre-sedation or pre-anesthesia assessment, including anesthesia risk
- Consent for procedure and anesthesia
- Re-evaluation of patient status documented immediately before moderate or deep sedation use and before anesthesia induction
- Peri-operative documentation including unusual events, physiologic readings, treatments and responses to treatments
- Documented assessment of post-operative status on admission to and discharge from post-anesthesia recovery area

- Each entry must be legible, dated, timed and signed or electronically submitted.

N. Emergency Department Records

A record shall be kept for each patient receiving emergency services in the Emergency Department, which shall be incorporated in the patient's Hospital and/or outpatient record. Emergency Department records on all patients seen by a staff appointee shall be completed before the staff appointee leaves the hospital premises. This record shall include the following information, at a minimum:

- Adequate patient identification
- Information concerning the patient's arrival
- Pertinent history of the injury or illness, including details regarding first aid or emergency care given the patient prior to his or her arrival at the Hospital
- Description of significant clinical, laboratory, and radiology findings
- Provisional diagnosis
- Description of the treatment provided
- Condition of the patient upon discharge or transfer
- Final disposition, including instructions given to the patient and/or his or her family, relative to follow-up care
- Signature of the practitioner in attendance who is responsible of the patient's treatment and for the clinical accuracy of the record
- All entries must be dated, timed and signed or electronically submitted. The date of service may not serve as the date or time that the entry was authenticated

O. Correction of the Medical Record

In the event it is necessary to correct an entry in a medical record, the person shall line out the incorrect data with a single line, leaving the original writing legible. The person (or computer) shall note the date of correction and authenticate the entry. Appropriate cross-referencing shall be placed in the record when necessary to explain the correction. The correction shall never involve erasure or obliteration of the material that is corrected. In addition, all blanks left in dictated reports must be filled in by the dictating practitioner at the time the report is authenticated. All electronic corrections of the medical record are to be completed in accordance with the Medical Record Corrections policy.

P. Legibility

Practitioners' documentation, which is handwritten, must be legible and complete.

Q. Symbols and Abbreviations

Symbols and abbreviations may be used only when they have been recommended by the appropriate entity and approved by the Medical Executive Committee. A list of approved abbreviations is available and the source document is Medical Abbreviations: Conveniences at the Expense of Communications and Safety, current edition, author Neil M. Davis. Additional acceptable abbreviations are the standardized mnemonics used in the Hospital's current EMR system's dictionaries.

R. Record Completion

1. A patient's medical record shall be as complete as possible at the time of discharge, including progress notes, final diagnosis and dictated clinical resume. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be made available for completion electronically by the Health Information Management Department. The record must be completed within thirty days after discharge.

2. The appropriate physician shall be responsible for the completion of the medical record for each patient within thirty days following discharge regardless of patient type. A complete medical record is defined as one that has all entries, dictation and authentication (dated, timed and signed) completed. For the purpose of chart completion, a practitioner's signature shall be handwritten or electronic. No record is to be filed in the permanent file until completed and properly authenticated.

3. A record is considered "complete" when the contents required by the Medical Staff's Rules and Regulations are assembled and authenticated, and all final diagnoses and complications are recorded. In the event a medical record remains incomplete by reason of death, resignation or inability of a medical staff member to complete the record, the Administrative Retirement of a Medical Record policy will be followed.

4. Medical Staff members, who do not complete medical records on a timely basis and after notice of delinquency, may be subject to corrective action pursuant to Medical Staff policy.

S. Confidentiality of Medical Records/Medical Information

A practitioner's access to patient information is limited to necessary use in the treatment of patients, scientific study, or peer review activities. Medical Staff members are required to maintain the confidentiality of patient information and abide by all applicable local, state and federal laws related to confidentiality and security of patient information. Practitioners may only access their own medical records, or those records of family and friends upon completion of the proper authorization process. Improper use or disclosure of patient information may be grounds for corrective action by the Medical Executive Committee.

Adopted: July 29, 2015
Amended: