Bellevue Medical Center

Bellevue, NE

MEDICAL STAFF BYLAWS

Rules and Regulations

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MEDICAL STAFF RULES AND REGULATIONS

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ARTICLE I

INTRODUCTION

1.1 DEFINITIONS

"**ADVANCE DIRECTIVE**" means a document or documentation allowing a person to give directions about future medical care, or to designate another person(s) to make medical decisions if the individual loses decision-making capacity. Advance directives include a "Declaration" under the rights of the terminally ill act, a health care power of attorney, a Do-Not-Resuscitate Order evidencing patient consent and similar documents expressing the individual's preferences as specified under state law or in the Patient Self-determination Act.

"**APPOINTEE**" means any medical practitioner, osteopathic practitioner, dentist, or podiatrist holding a current license to practice within the scope of his or her license who is a member of the Medical Staff.

"**CLINICAL PRIVILEGES**" means the authorization granted to a practitioner to render patient care and includes unrestricted access to those hospital resources (including equipment, facilities, and hospital personnel) that are necessary to effectively exercise those privileges.

"**EMERGENCY**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

"**FAMILY**" means those persons who play a significant role in the individual's life. This may include persons who are not legally related to the individual.

"**HEALTH CARE AGENT**" means an individual designated in a health care power of attorney to make health care decisions on behalf of a person who is incapacitated.

"**INVASIVE PROCEDURE**" means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, implantations and interventional radiology procedures, and excluding venipuncture and intravenous therapy.

"**PATIENT**" means as any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the Hospital.

"**PHYSICIAN**" means an individual with a Doctor of Medicine or Doctor of Osteopathy degree as recognized by the Nebraska Board of Medicine and Surgery and who has a current valid licensed to practice medicine and surgery in Nebraska. This shall include active duty practitioners in the military licensed in another state and permitted to practice in Nebraska under state law.

"**PRACTITIONER**" means an appropriately licensed medical practitioner, osteopathic practitioner, dentist, podiatrist, or allied health professional that has been granted clinical privileges.

"**SURGEON**" refers to any practitioner performing an operation or invasive procedure on a patient, and is not limited to members of the Hospital service line involving Surgery.

"**UNABLE TO CONSENT**" means unable to appreciate the nature and implications of the patient's condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This definition does not include minors unless they are married or have been determined judicially or under hospital policy to be emancipated for purposes of consenting to health care.

Any definitions set forth in the Medical Staff Bylaws shall also apply to terms used in these Rules and Regulations.

1.2 APPLICABILITY

These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Managers, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges.

1.3 AMENDMENT

These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws Part I: Governance, Section 9.3.

1.4 ADOPTION

This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

ARTICLE II

ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

The hospital accepts short term patients for care and treatment provided suitable facilities are available.

a. **Admitting Privileges**: A patient may be admitted to the hospital only by a practitioner with admitting privileges. When a patient is admitted by a non-physician practitioner with privileges, a physician shall be responsible to assess and manage all medical conditions that may be present or arise.

b. **Admitting Diagnosis**: Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been written in the electronic health record. In the case of emergency, such statement will be recorded as soon as possible.

c. **Admission Procedure**: Admissions must be scheduled with the Hospital's Access Services Department. A bed will be assigned based upon the medical condition of the patient and the availability of hospital staff and services. Except in an emergency, the admitting practitioner or his designee shall contact the Hospital's Access Services Department to ascertain whether there is an available bed.

2.1.2 Admission Priority

The Admitting Registrar will admit patients on the basis of the following order of priorities:

a. **Emergency Admission**: Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. This patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient will be admitted immediately to the first appropriate bed available.

b. **Urgent Admissions**: Urgent admission patients meet the criteria for inpatient admission, however their condition is not life threatening. Urgent admission patients will be admitted as soon as an appropriate bed is available. Urgent admissions include admissions for observation as determined by Center for Medicare/Medicaid Services (CMS) criteria.

c. **Elective Admissions**: Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for his/her health's sake. These patients may be admitted on a first-come, first-serve basis. A waiting list will be kept and each patient will be admitted as soon as a bed becomes available.

2.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area. Patients in active labor will be admitted directly to the labor and delivery area.

2.2 UNASSIGNED EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department or to the Hospital with an emergency condition or in labor, the Hospital must provide for an appropriate medical screening examination within the capability of the hospital's Emergency Department, including ancillary services routinely available to the Emergency Department, to determine whether or not an emergency medical condition exists. Screening and immediate steps to stabilize patients shall be provided by assigned Emergency Department staff and practitioners on call to the Emergency Department and by other qualified practitioners approved by the board. In the case of patients presenting in labor, the medical screening exam will ordinarily be done in the labor and delivery area.

2.2.1 Definition of Unassigned Patient

Patients who present to the Emergency Department and require admission and/or treatment shall have a practitioner assigned by the Emergency Department practitioner if one or more of the following criteria are met:

a. The patient does not have a primary care practitioner or does not indicate a preference;

b. The patient's primary care practitioner does not have admitting privileges; or

c. The patient's injuries or condition fall outside the scope of the patient's primary care practitioner.

2.2.2 Unassigned Call Service

a. **Unassigned Call Schedule**: The Hospital is required to maintain a list of practitioners who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Each Medical Staff Hospital Service Line Chief, or his/her designee, shall provide the Emergency Department and the Medical Staff Services Office with a list of practitioners who are scheduled to take emergency call on a rotating basis. Emergency call shall be from 0700 to 0700 the following day unless a Hospital Service Line has chosen a different time range which has been approved by the MEC.

b. **Response Time**: It is the responsibility of the on-call practitioner to respond in an appropriate time frame. Appropriate time frame is defined as: (1) a call to the Emergency Department within thirty (30) minutes and/or (2) appearance in the Emergency Department within sixty (60) minutes unless otherwise specified by the Emergency Department practitioner.

   The Emergency Department practitioner should discuss the patient's condition and evaluation with the on-call practitioner to determine a plan of care. If the Emergency Department practitioner clearly states that the patient should be evaluated by the on-call practitioner in the Emergency Department, then it is the obligation of the on-call practitioner to do so. If the on-call practitioner does not respond to being called or paged, or to a clear request to evaluate the patient in the Emergency Department, then the practitioner's Hospital Service Line Chief shall be contacted. If the Hospital Service Line Chief is not available, the President of the Staff or his/her designee shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.

c. **Substitute Coverage**: It is the on-call practitioner's responsibility to arrange for coverage and notify Medical Staff Services if he/she is unavailable to take call when assigned. Failure to notify Medical Staff Services of alternate call coverage may result in the initiation of disciplinary action.

2.2.3 Patients Not Requiring Admission

In cases where the Emergency Department consults with the unassigned call practitioner and no admission is deemed necessary, the Emergency Department practitioner shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. It is the unassigned call practitioner's responsibility to provide a timely and appropriate follow-up evaluation for the patient following the Emergency Department visit.

2.2.4 Unassigned Patients Returning to the Hospital

Unassigned patients who return to the Emergency Department within fourteen (14) days of discharge from the Hospital will be referred to the practitioner, or his designated covering practitioner, who admitted the patient at the previous hospitalization. Unassigned patients who present to the Emergency Department more than 14 days after discharge will be referred to the practitioner taking unassigned call that day.

2.2.5 Guidelines for Hospital Service Line Policies on Unassigned Patient Call

Pursuant to the Medical Staff Bylaws, Hospital Service Lines may adopt rules, regulations, and policies that are binding on practitioners assigned to the Hospital Service Line. The following rules should be used in developing Hospital Service Line policies regarding unassigned patient emergency call obligations:

a. Practitioners with admitting privileges are expected to serve on the unassigned call roster regardless of their staff category.
b. Unassigned patient call duties shall ordinarily be apportioned equally among all eligible hospital service line members.
c. Unassigned call duties may be divided by division, specialty, or subspecialty.
d. Hospital service lines may establish policies for excusing members from service based on their age or length of service. These policies must be consistently applied, and shall not compromise the hospital service line's ability to fulfill the Hospital's EMTALA obligations.
e. Hospital Service Line rules and regulations concerning unassigned call must be approved by the Medical Executive Committee.

2.3 TRANSFERS

2.3.1 Transfers From Other Acute Care Facilities

Transfers from other acute care facilities must meet the following criteria:

a. The patient must be medically stable for transfer;

b. The patient's condition must meet medical necessity criteria for inpatient admission;

c. The patient must require, and Hospital must be able to provide, a higher level of care or a specific inpatient service not available at the transferring facility;

d. Responsibility for the patient must be accepted by a practitioner with admitting privileges at the Hospital; and

e. The transfer must be approved by the Hospital representative with authority for accepting transfers.

2.3.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. The attending practitioner will be notified of all transfers.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The admitting practitioner is responsible for providing the Hospital with necessary information to assure the protection of the patient from self harm and to assure the protection of others. Acute care admissions of suicidal patients will not be accepted except for those patients requiring medical stabilization. Once the patient's medical condition is stabilized, the patient will be evaluated and transferred to an appropriate outpatient or inpatient psychiatric facility.

2.5 PROMPT ASSESSMENT

New admissions must be personally examined and evaluated by the admitting practitioner or his/her designated covering practitioner as promptly as possible consistent with the patient's condition, but not to exceed twenty-four (24) hours after admission. Patients admitted to critical care units must be seen by the admitting practitioner or a critical care practitioner in consultation as soon as possible after admission but within twelve (12) hours. In all instances, patients must be seen as soon as possible in a time period dictated by the acuity of their illness.

2.6 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending practitioner or his or her designee who shall provide, or assist Hospital personnel in providing, documented discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. These instructions should include:

a. A list of all medications the patient is to take post-discharge;

b. Dietary instructions and modifications;

c. Medical equipment and supplies, if appropriate;

d. Instructions for pain management, if appropriate;

e. Any restrictions or modification of activity;

f. Follow up appointments and continuing care instructions;

g. Referrals to rehabilitation, physical therapy, and home health services; and

h. Recommended lifestyle changes, such as smoking cessation.

2.7 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the hospital against the advice of the attending practitioner, or without a discharge order, the following actions will occur:

a. The patient will be asked to remain in the hospital until the attending practitioner can be notified;

b. The patient will be asked to read and sign the Hospital's "Discharge Against Medical Advice" form; alternatively, a progress note outlining a general informed consent discussion with the patient and his/her response shall be documented;

c. The patient will be assisted in leaving the facility, and will be informed that he/she may not return directly to the patient care unit. If the patient chooses to return to the Hospital, such return will be treated as a new admission.

d. Documentation of the attending practitioner's notification, date, time, and mode of transfer will be made in the patient's record.

2.8 DISCHARGE AND READMISSION ON THE SAME DAY

If a patient is discharged and readmitted on the same day, the readmission will be considered a new admission.

2.9 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

2.10 THERAPEUTIC LEAVE OF ABSENCE

A patient receiving acute care services may not have a leave of absence.

ARTICLE III

ELECTRONIC HEALTH RECORDS

3.1 GENERAL REQUIREMENTS

The electronic health record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The electronic health record must contain information to justify admission or medical treatment, support the diagnosis, validate and document the course and results of treatment, and facilitate continuity of care. Only authorized individuals may have access to and make entries into the

electronic health record. The attending practitioner is responsible for the preparation of a complete and legible electronic health record for each patient. Its contents will be pertinent, current, and age-specific.

To facilitate consistency and continuity of patient care, the electronic health record shall include:

a. The patient's identification data and the name of any legally authorized representative;
b. the legal status of patients receiving mental health services;
c. emergency care provided to the patient prior to arrival, if any;
d. the record and findings of the patient's assessment, and the conclusions or impressions drawn from the medical history and physical examination;
e. the diagnosis or diagnostic impression;
f. the reason for admission or treatment;
g. the goals of treatment and the treatment plan;
h. evidence of known advance directives;
i. evidence of informed consent, when required;
j. documentation of any determination that a patient is unable to consent or is incompetent to consent;
k. diagnostic and therapeutic orders, if any;
l. all diagnostic and therapeutic procedures and test results relevant to the management of the patient's condition;
m. all operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
n. progress notes made by the Medical Staff and other authorized individuals, all reassessments and any revisions of the treatment plan, clinical observations, and the patient's response to care;
o. consultation reports;
p. every medication ordered or prescribed for an inpatient, every medication dispensed to an ambulatory patient or an inpatient on discharge, and every dose of medication administered and any adverse drug reaction;
q. all relevant diagnoses established during the course of care;
r. any referrals and communications made to external or internal care providers and to community agencies;
s. conclusions at termination of hospitalization;
t. discharge instructions to the patient and/or family as relevant;
u. autopsy findings, if applicable; and
v. a discharge summary or final progress note or transfer summary.

3.2 AUTHENTICATION

All clinical entries in the patient's electronic health record will be accurately dated, timed, and authenticated with the practitioner's legible signature and the practitioner identification number as a co-identifier; or by approved electronic means.

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the electronic health record shall be made in ink and shall be clear, complete, and legible. The clarity, completeness, and legibility of electronic health record documentation may be considered in evaluating the practitioner at the time of reappointment. Practitioners whose electronic health record entries are habitually unclear, incomplete, or illegible may be subject to one or more of the following conditions as determined by the Medical Executive Committee:

a. Required attendance at educational programs on documentation and penmanship as determined by the Medical Executive Committee;
b. A requirement that electronic health record entries be dictated or recorded by electronic means.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in handwritten documents. The use of abbreviations and symbols in the electronic health record must be consistent with the following rules:

Standard Abbreviations: Only standard symbols and abbreviations will be used. To be considered "standard," the symbol or abbreviation must be listed in the most recent edition of Stedman's Medical Dictionary. If a non-standard symbol or abbreviation is used, its full meaning must be explained on the same page.

Prohibited Abbreviations, Acronyms, and Symbols: The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in electronic health record entries or orders. This list specifically includes, but is not limited to, the following:

- 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.

Situations Where Abbreviations Are Not Allowed: Abbreviations, acronyms, and symbols may not be used in recording the final diagnoses and procedures on the face sheet of the electronic health record.

3.5 CORRECTION OF ERRORS

Electronic health records should not be improperly altered. When it is necessary to correct an error in the electronic health record these guidelines should be followed:

a. In the event an error is made in documentation, the original entry must not be obliterated, and the inaccurate information should still be accessible. Erroneous entries should not be removed, but marked as a correction with the date, time, and identification of the person noting the error. The contents of the records must not be otherwise edited, altered, or removed.

3.6 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.6.1 Time Limits

As outlined in the Medical Staff Bylaws Part I: Governance, Section 8.1, a medical history and appropriate physical examination shall be entered in the electronic health record no more than thirty (30) days before or twenty-four (24) hours after a hospital inpatient or observation admission. If an H&P Examination has been performed and documented within thirty (30) days of the patient's admission to the hospital, a legible copy of that H&P examination may be used in the patient's hospital electronic health record provided that an "Updated History and Physical Examination" is entered in the electronic health record no more than twenty-four (24) hours after admission or prior to surgery or any procedure requiring anesthesia or moderate sedation. Except in an emergency, a current medical history and appropriate physical examination shall be documented in the electronic health record prior to all invasive procedures performed in the hospital's surgical suites.

3.6.2 Who May Perform and Document the Admission History and Physical Exam

The History and Physical Examination shall be performed and recorded by a practitioner granted these privileges including doctor of medicine or osteopathy; Certified Nurse Midwife (CNM); or, for patients admitted only for oromaxillofacial surgery, by an oromaxillofacial surgeon. All or part of the H & P may be delegated to other practitioners in accordance with State law and hospital policy, but the MD/DO/CNM must sign the H & P and as applicable, the update note and assume full responsibility for the H & P. This means that a nurse practitioner, physician assistant or other practitioner meeting these criteria may perform the H & P and/or the update assessment and note as a delegated function if within the scope of their privileges at the Hospital.

3.6.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority as outlined in the Medical Staff Bylaws Part I Governance, Section 8.1.

3.6.4 Attending Practitioner is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the attending practitioner or his/her designee within the scope of their privileges at the Hospital.

3.7 PREOPERATIVE DOCUMENTATION

3.7.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the electronic health record prior to:

a. All invasive procedures performed in the Hospital's surgical suites; or
b. Certain procedures performed in the Hospital's interventional suites (e.g. angiography; angioplasty; vascular stenting; CT-guided biopsies and aspirations; myelography; pacemaker/defibrillation implantation; electrophysiologic studies; and ablations); or

c. Certain procedures performed in other treatment areas (e.g. bronchoscopy; gastrointestinal endoscopy; transesophageal echocardiography; therapeutic injections; central line insertions; and elective electrical cardioversion); or

d. Any other inpatient or outpatient procedure requiring moderate sedation or anesthesia services.

3.7.2 Procedure

a. **Inpatient/Observation Patient who Subsequently Requires Surgery**: This patient should already have an Admission History and Physical in the electronic health record. The surgeon should enter a pre-procedure progress note or consultation note documenting the provisional diagnosis, the indications for the procedure, and any changes in the patient's condition since the Admission History and Physical as also outlined in Article I, 8.1. If there are no changes in the patient's condition, this should be specifically noted.

b. **New Inpatient/Observation Patient Surgical Admission**: The attending practitioner must record an Admission History and Physical Examination as described in section 3.6. If the Admission History and Physical Examination is performed by a practitioner other than the surgeon (e.g., the patient's attending practitioner or a consulting practitioner), the surgeon should enter a pre-procedure progress note or consultation note documenting the provisional diagnosis, the indications for the procedure, and any changes in the patient's condition since the Admission History and Physical Examination. If there are no changes in the patient's condition, this should be specifically noted.

c. **Outpatient Surgery**: The surgeon should complete a History and Physical that may include an abbreviated physical examination focused appropriately to correspond to the planned procedure.

3.8 PROGRESS NOTES

The attending practitioner or his/her covering physician/CNM will record a progress note each day, and at the time of each patient encounter on all hospitalized patients within the scope of their privileges at the Hospital.

3.9 OPERATIVE REPORTS

Operative reports will be dictated immediately after surgery, procedure or delivery and the report promptly signed by the practitioner performing the surgery, procedure or delivery and made a part of the patient's current electronic health record. Operative notes (written or dictated) will include:

a. the name of the surgical procedure,

b. a detailed account of the findings at surgery,

c. the technical procedures used,

d. the tissues removed or altered,

e. estimated blood loss,

f. the post operative diagnosis, and

g. the name of the primary surgeon and any assistants.

3.10 CONSULTATION REPORTS

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The Consultation Report should be completed within the time frame specified by the practitioner ordering the consult and no later than 24 hours.

If the report is not in the electronic health record within the prescribed time, an explanatory note should be recorded in the electronic health record. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation.

3.11 OBSTETRICAL RECORD

The obstetrical record must include a medical history, including a complete prenatal record, and an appropriate physical examination. A copy of the practitioner's office prenatal record may serve as the history and physical for all labor admissions if it is legible and complete. If the office prenatal record is used as the history and physical examination, an Updated History and Physical Examination as described in subsection 3.6.5 will be recorded that includes pertinent additions to the history and any subsequent changes in the physical findings.

3.12 DISCHARGE SUMMARIES

The content of the electronic health record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries will be authenticated by the attending practitioner or his/her designee.

a. **Content**: A clinical summary will be dictated or documented upon the discharge or transfer of hospitalized patients including all deliveries. The discharge summary is the responsibility of the attending practitioner and will contain:
    1. Reason for hospitalization;
    2. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
    3. Condition of the patient at discharge;
    4. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
    5. Final diagnoses as outlined in these Rules & Regulations, Article III, Section 3.13, Final Diagnoses.

b. **Short-term Stays**: A discharge summary is not required for uncomplicated inpatient and observation hospital stays of less than twenty four (24) hours, other than deliveries, provided the discharging practitioner enters a final progress note or completes a discharge summary documenting:
    1. The condition of the patient at discharge; and
    2. Instructions given to the patient and family, including medications, referrals, and follow-up appointments.

c. **Deaths**: A clinical summary is required on all inpatients who have expired and will include:

1. Reason for admission;
2. Summary of hospital course; and
3. Final diagnoses as outlined in these Rules & Regulations, Article III, Section 3.13, Final Diagnoses..

d. **Timing**: A Discharge Summary must be entered in the electronic health record within fourteen (14) days of discharge, transfer, or death.

3.13 FINAL DIAGNOSES

The final diagnoses will be recorded in full in the discharge summary, without the use of symbols or abbreviations, dated and authenticated by the attending practitioner at the time of discharge, transfer, or death of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the practitioner will be required to document such in the patient's record. Once the pending diagnostic information has been received and a definitive diagnosis has been made, the practitioner will be required to document the diagnostic findings and final diagnosis in the patient's electronic health record. The final diagnoses shall include the following components:

a. **Principal Diagnosis**: The condition established after study to be chiefly responsible for occasioning the admission to the hospital for care. The principal diagnosis should be as specific as possible. A sign or symptom should not be used as the principal diagnosis if a more specific diagnosis is known or suspected.

b. **Other Diagnoses**: All conditions that exist at the time of admission or that develop subsequently that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode and that have no bearing on the current hospital stay are not to be reported.

c. **Principal Procedure**: A procedure performed for definitive treatment rather than diagnostic or exploratory purposes or that was necessary to treat a complication. The principal procedure is usually related to the principal diagnosis.

d. **Other Procedures**.

e. **Co-morbid Conditions**: Preexisting conditions that, because of their presence with a specific diagnosis, causes an increase in length of stay.

f. **Complications**: Conditions that arise during the hospital stay that prolong the length of stay.

g. **Abnormal Test Results**.

h. **Signs and Symptoms**.

i. **Any Suspected Conditions and what was done to investigate or evaluate them.**

j. **Discharge Status**: The disposition of the patient at discharge (for example: left against medical advice, discharged home, transferred to an acute care hospital, expired).

3.14 DIAGNOSTIC REPORTS

Diagnostic reports (including but not limited to EEGs, EKGs, echocardiograms, stress tests, Doppler studies) must be read by the practitioner scheduled to provide the interpretation service within 24 hours. Failure to provide prompt interpretation of diagnostic tests may result in removal from the reading list.

3.15 ALLIED HEALTH PROFESSIONALS

Allied Health Professionals (AHPs) may make entries and initiate orders consistent with the scope of their privileges granted at the Hospital and the terms of any supervision or collaboration agreement between the

AHP and the supervising or collaborating practitioner. If required, the supervising or collaborating practitioner will review and authenticate the orders of an AHP.

3.16 AUTHENTICATION OF OUTSIDE RECORDS

It is the duty of the attending practitioner to authenticate any patient information obtained from sources outside of the Hospital (such as the practitioner's office records, diagnostic test results, prenatal records, etc.). Only the attending practitioner, after performing a review, can append patient information received from outside sources.

3.17 ACCESS AND CONFIDENTIALITY

A patient's electronic health record is the property of the Hospital. The record will be made available to any member of the Medical Staff attending the patient and to others in accordance with hospital policy. Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

a. **Access to Old Records**: In case of readmission of a patient, all previous records will be made available to the admitting practitioner, whether the patient was attended by the same practitioner or by another practitioner.

b. **Access for Medical Research**: Access to the electronic health records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with Hospital policy and the goal of preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of an internal or external Institutional Review Board used by the Hospital for this purpose. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.

c. **Access for Former Members**: Former members of the Medical Staff will be permitted access to information from the electronic health records of their patients covering all periods during which they attended such patients in the Hospital for permitted uses.

3.18 ELECTRONIC HEALTH RECORD COMPLETION

A electronic health record will not be retired until it is completed by the responsible practitioner or is ordered retired by the Medical Executive Committee.

3.18.1 Requirements for Timely Completion of Electronic health records

Electronic health records must be completed in accordance with the following standards:

a. The patient receives an Admission History and Physical Examination no more than thirty (30) days prior to or within twenty four (24) hours after admission. For a medical history and physical examination that was completed within thirty (30) days prior to inpatient admission, an update documenting any changes in the patient's condition is completed within twenty four (24) hours after inpatient admission or prior to surgery, whichever comes first.

b. A Preoperative History and Physical Examination, Focused Preoperative History and Physical Examination , or Updated documentation note to the History and Physical Examination must be present prior to the surgery or procedure requiring moderate sedation or anesthesia services;

c. An Admission Prenatal Record must be entered in the electronic health record by the attending practitioner or designated covering practitioner within 24 hours of an obstetrical admission

d. An Operative Report must be entered in the electronic health record by the performing practitioner immediately following the surgery or procedure ;

e. An Inpatient Progress Note must be recorded and authenticated by the attending physician/CNM or designated covering physician/CNM at the time of each encounter, and on a daily basis ;

f. An Emergency Department Record must be completed by the responsible practitioner within 24 hours of the encounter;

g. A Consultation Note must be completed by the consulting practitioner within 24 hours of the consult request;

h. A Diagnostic Report must be completed by the interpreting practitioner within 24 hours of the test or procedure;

i. A Discharge Summary must be entered in the electronic health record by the attending practitioner or his/her designee within 14 days of an inpatient or observation discharge, transfer, or death; and

~~j.~~ The Inpatient or Observation Electronic health record must be completed within thirty (30) days of discharge, including the authentication of all progress notes, consultation notes, operative reports, verbal and written orders, final diagnoses, and discharge summary.

3.18.2 General Rules Regarding Completion of Electronic health records

Timely record completion is essential for safe, quality patient care. It enables communication among healthcare practitioners, appropriate and timely reimbursement and supports the legal requirements of the facility.

a. Responsibility
    1. Completion of electronic health record documentation is the responsibility of the attending physician and other healthcare providers designated at the time the assessment is made or service provided.
    2. A practitioner shall not complete a electronic health record on a patient unfamiliar to him/her in order to complete a record that was the responsibility of another practitioner, unless directed by the Hospital Service Line Chief. A practitioner may authenticate a electronic health record document or entry on a patient unfamiliar to him/her to complete the responsibility of another provider when:
        - The practitioners share clinical responsibilities
        - The document or entry appears to be clinically valid
        - The document or entry is assigned to the correct practitioner

b. Overdue Records

    Reports not completed within the time frames below will be declared overdue.
    1. Discharge summaries not dictated within 48 hours (two (2) working days) of discharge;
    2. Operative reports not dictated immediately following an operation/procedure;
    3. History and physicals (H&Ps) not completed within 24 hours of admission;
    4. Pre-operative history and physicals not completed prior to surgery;
    5. Pre-anesthesia evaluation not completed within 48 hours prior to any procedure requiring anesthesia services or services provided by the department of anesthesiology;
    6. Post-anesthesia evaluation not completed within 48 hours after any procedure requiring anesthesia services or services provided by the department of anesthesiology;
    7. Electronic orders not electronically signed within 48 hours of the order;
    8. Electronic signatures of documents not completed within fifteen (15) days of discharge;

9. Cancer staging forms not completed within 30 days of diagnosis of cases for which a staging scheme exists.

c. Notification of Overdue H&P and Discharge Summary Dictation
    1. The responsible practitioner will be notified in writing of incomplete electronic health record documentation at 7 days post discharge for H&Ps, Discharge Summaries, and other documents that are the provider's responsibility.
    2. If the responsible practitioner has not completed records within one week of impending suspension, the President of the Medical Staff will contact the practitioner with the date of the impending suspension and notice of contact will be placed in practitioner's trending file. Electronic health records will notify the Hospital Service Line Chief of impending suspension.
    3. If the electronic health records are not completed within 30 days of discharge or timeframe given by the President of the Medical Staff, the responsible practitioner will be placed on suspension for failure to complete delinquent electronic health records. Access Services and appropriate clinical areas will be informed of those individuals whose clinical privileges are suspended and notice will be placed in the practitioner's trending file.
    4. If the responsible practitioner has not completed records within 40 days of discharge, written notification of impending voluntary relinquishment of privileges will be communicated by certified mail.
    5. The responsible practitioner and Hospital Service Line Chief will receive written notification via certified mail when voluntary relinquishment of privileges is reached with notice placed in the practitioner's trending file.

d. Notification of Overdue Order Signatures
    1. Interactive alerts will be provided to the ordering practitioner at the time of the electronic record use on each occasion when they have electronic orders not signed within 1 day.
    2. The responsible practitioner will be notified in writing of incomplete electronic health record documentation at 7 days following order origination for electronic order signatures.
    3. If the responsible practitioner has not completed signatures within 14 days of impending suspension, the President of the Medical Staff will contact the practitioner with date of impending suspension and notice of contact will be placed in practitioner's trending file. Electronic health records will notify the Hospital Service Line Chief of impending suspension.
    4. If the signatures are not completed within 14 days of order origination or timeframe given by the President of the Medical Staff, the responsible practitioner will be placed on suspension for failure to complete delinquent electronic health records. Access Services and appropriate clinical areas will be informed of those individuals whose clinical privileges are suspended and notice will be placed in the practitioner's trending file.
    5. If the responsible practitioner has not signed the orders within 21 days of order origination, written notification of impending voluntary relinquishment of privileges will be communicated by certified mail.
    6. The responsible practitioner and Hospital Service Line Chief will receive written notification via certified mail when voluntary relinquishment of privileges is reached with notice placed in the practitioner's trending file.

e. Notification of Overdue Operative Report Dictation and Anesthesia Notes

1. The responsible practitioner will be notified in writing of incomplete electronic health record documentation at 5 days post surgery for Operative Reports and Anesthesia notes.
2. If the responsible practitioner has not completed records within 7 days of impending suspension, the President of the Medical Staff will contact the practitioner with date of impending suspension and notice of contact will be placed in practitioner's trending file. Electronic health records will notify the Hospital Service Line Chief of impending suspension.
3. If the electronic health records are not completed within 14 days of surgery or timeframe given by the President of the Medical Staff, the responsible practitioner will be placed on suspension for failure to complete delinquent electronic health records. Access Services and appropriate clinical areas will be informed of those individuals whose clinical privileges are suspended and notice will be placed in the practitioner's trending file.
4. If the responsible practitioner has not completed records within 21 days of surgery, written notification of impending voluntary relinquishment of privileges will be communicated by certified mail.
5. The responsible practitioner and Hospital Service Line Chief will receive written notification via certified mail when voluntary relinquishment of privileges is reached with notice placed in the practitioner's trending file.

f. Delinquent Records
   1. All overdue records of discharged inpatients, observation patients and ambulatory surgery patients will be declared delinquent if not complete within 30 days following discharge, or at 14 days post surgery for Operative Reports and Anesthesia notes.
   2. Suspension of all privileges which occurred as indicated in Section C, D, & E above will stand.
   3. The number of delinquent electronic health records will be reported monthly to the Medical Executive Committee or its designee.

g. Electronic health record Suspension
   Practitioners will be placed on electronic health record suspension under the following conditions:
   1. The practitioner will be suspended for failure to complete delinquent electronic health records within 30 days of discharge, or at 14 days post surgery for Operative Reports and Anesthesia notes.
   2. The practitioner on electronic health record suspension will be precluded from scheduling new surgical procedures or from admitting new patients or seeing new patients in consultation; however care of previously admitted patients or scheduled surgical procedures will be allowed.
   3. Failure to complete electronic health records within 45 days of discharge or 30 days post surgery for Operative Reports and Anesthesia notes will result in automatic relinquishment of privileges and medical staff membership (as applicable).

h. Reinstatement of Medical Staff Privileges
   1. Once delinquent records are completed, the practitioner must ask the President of the Medical Staff to reinstate his/her full privileges.
   2. Any subsequent suspensions within a rolling twelve month period will require the practitioner to attend the Medical Executive Committee to discuss potential reinstatement of privileges.

3.19 ELECTRONIC RECORDS AND SIGNATURES

"Electronic signature" means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

3.20 ELECTRONIC HEALTH RECORD FORMS

a. **Required-use Forms**: The Medical Executive Committee may adopt and require the use of specific forms in the electronic health record. Prior to adoption, these forms should be reviewed by the Health Information Management Director.

b. **Periodic Review**: Electronic health record forms shall be periodically reviewed.

ARTICLE IV

STANDARDS OF PRACTICE

4.1 ATTENDING PRACTITIONER

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending practitioner who is an appointee of the Medical Staff with admitting privileges. The attending practitioner will be responsible for:

a. the medical care and treatment of each patient in the Hospital;

b. making daily rounds;

c. the prompt, complete, and accurate preparation of the electronic health record;

d. necessary special instructions regarding the care of the patient; and

e. transmitting reports of the condition of the patient.

4.1.2 Identification of Attending Practitioner

At all times during a patient's hospitalization, the identity of the attending practitioner shall be clearly documented in the electronic health record.

4.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending practitioner are transferred to another Medical Staff appointee, there shall be a practitioner-to-practitioner conversation. The electronic health record shall document that conversation and the transfer of responsibility shall be entered as an electronic order, by the attending practitioner.

4.2 COVERAGE AND CALL SCHEDULES

Each practitioner shall provide the Medical Staff Services Office with a list of designated Medical Staff appointees (usually the members of his/her group practice who are members of the same clinical hospital service line and have equivalent clinical and procedure privileges) who shall be responsible for the care of his/her patients in the Hospital when the practitioner is not available. Each practitioner is responsible for providing the Medical Staff Services Office with a current and correct on-call schedule. Exceptions may be made only by petition to the Medical Executive Committee.

4.3 RESPONDING TO CALLS AND PAGES

Practitioners are expected to respond promptly to calls within thirty (30) minutes from the Hospital's patient care staff regarding their patient.

4.4 ORDERS

4.4.1 General Principles

a. All orders for treatment will be documented in the electronic health record.

b. Orders must be clear and unambiguous.

c. All orders must be given by a practitioner who is privileged to do so.

d. Vague or "blanket" orders (such as "continue home medication" or "resume previous orders") will not be accepted.

e. Instructions should be documented in plain English. Prohibited abbreviations may not be used.

Electronic orders are required for requesting treatment and services. Types of electronic orders may include:

a. Admission, discharge, and transfer orders including medication reconciliation
b. Orders for tests and services
a. Medication orders
b. Consultation orders
c. Nursing and care orders

Procedures and administration:
All orders will be electronically prepared and recorded after user access is authenticated by entry of identity and password.

The EHR will time stamp and verify order content against EHR master tables. Certain users may Pend orders for review and authentication by licensed personnel who have appropriate privileges. Orders must be authenticated (signed electronically) and submitted with valid order status and class. Order status determines the management of order instances when released during the order processing cycle. Normal status orders are active upon authentication. Standing and future orders have one or more actions that may be initiated upon manual release by authorized staff or by system automation. Certain order classes such as medication orders may require verification prior to activation. Orders may be placed on hold for purposes of administrative or patient care. Written orders submitted by personnel not authorized for order entry will be entered electronically by authorized personnel for electronic order management and transmission. Source documentation of written orders received from extramural sources will be maintained as scanned documents integrated into the EHR.

f. Orders may be received and executed only by an authorized individual.

4.4.2 Verbal Orders

Verbal orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner enter it in a computer. Verbal orders must comply with the following criteria:

a. Verbal orders shall be signed by the person who received the order and shall list both the ordering practitioner's name and the name of the person transcribing the order.

b. The following individuals are authorized to accept and transcribe verbal orders for patients under their care and within their respective discipline:

1. Advance Practice RN (APRN)
2. Certified Registered Nurse Anesthetist (CRNA)
3. Clinical Dietitian
4. Licensed Practical Nurse (LPN)
5. Medical Technologist
6. Occupational Therapist
7. Perfusionist
8. Physical Therapist
9. Practitioner Assistant (PA)
10. Registered Nurse (RN)
11. Registered Pharmacist
12. Registered Radiology Technologist
13. Respiratory Therapist
14. Social Worker
15. Speech Therapist.

c. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal orders, like documented orders, should be conveyed in plain English without the use of prohibited abbreviations.

d. The order must be read back to the prescribing practitioner by the authorized person receiving the order.

e. All verbal orders must be signed by the ordering practitioner or another practitioner involved in the patient's care within 48 hours unless State law specifies a different (either shorter or longer) time frame.

f. Electronic orders are preferred over verbal orders. A practitioner with access to the electronic ordering system shall be expected to enter orders electronically;

g. The following orders may not be given verbally:
   1. Orders for cancer chemotherapy;
   2. A do-not-resuscitate order, except as allowed in hospital policy;
   3. An order to withhold or withdraw life support.

4.4.3 Telephone Orders
Orders dictated over the telephone must comply with the requirements of verbal orders as described in subsection 4.4.2 above.

4.4.4 Facsimile Orders
Orders transmitted by facsimile shall be considered properly authenticated and executable provided that:

a. The facsimile is legible and received as it was originally transmitted by facsimile or computer;

b. The order is legible, clear, and complete;

c. The identity of the patient is clearly documented;

d. The facsimile contains the name of the ordering practitioner, his address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law;

e. The original order, as transmitted, is signed; dated and timed; contains an assigned numerical co-identifier; and

f. The facsimile, if received without signature, shall be considered a verbal order and handled as per Rules & Regulations Article IV, Section 4.4.2: Verbal Orders.

4.4.5 Electronic Orders
The Medical Executive Committee shall develop and maintain policies regarding the use of electronic orders and computerized order entry consistent with federal and state law.

4.4.6 Illegible, Unclear, and Incomplete Orders
A practitioner's handwritten orders shall be made in ink and written clearly, legibly, and completely. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly written (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual will contact the practitioner, request a verbal order for clarification, read back the order, and document the clarification in the electronic health record. This verbal order must be signed by the ordering practitioner as described in Subsection 4.4.2.

4.4.7 Cancellation of Orders Following Surgery or Transfer
All previous orders are canceled when the patient:

a. goes to surgery,

b. is transferred to a critical care area,

c. is transferred to a general medical unit from a critical care area, or

d. is transferred to, and readmitted from, another hospital or health care facility. New orders shall be specifically documented following surgery or the aforementioned transfers. Instructions to "resume previous orders" will not be accepted.

4.4.8 Printed Order Forms
Printed order forms containing medications, whether required-use order forms or practitioner created order forms, shall be approved and reviewed as outlined in these Rules & Regulations, Article III, Section 3.2.0, Electronic health record Forms.

4.4.9 Range and Conditional Orders
The ordering practitioner is responsible for evaluating the patient's status and reviewing all existing therapies before ordering, modifying, or discontinuing a particular therapy. The practitioner should evaluate the patient's response to therapy by monitoring clinical signs, symptoms, and relevant laboratory data, and by periodically reevaluating the need for continuing therapy. This responsibility should not be delegated by

the use of “range” or “conditional” orders (i.e., orders which instruct nurses to start, stop, modify, or adjust treatment based on certain parameters) that depend on the evaluation and judgment of nurses or other patient care providers.

Nothing in this section shall prohibit the appropriate use of Medical Staff-approved, evidence-based, clinical practice guidelines.

4.4.11 Drugs and Medications

a. **Hospital Formulary**: To assure the availability of quality pharmaceuticals at a reasonable cost, practitioners shall comply with the formulary system established by the Medical Executive Committee upon the recommendation of the Pharmacy Director. Any practitioner may submit a request for addition of a drug to the Hospital formulary prior to its need. These requests shall be submitted to the Pharmacy Director. Drug will be added to, or removed from, the formulary based on evidenced-based criteria.

b. **Substitution**: Medication orders written for trade-name drugs may be dispensed as the formulary generic drug unless the practitioner specifically writes “Do Not Substitute” on the patient order sheet. The Medical Executive Committee shall adopt policies concerning automatic therapeutic substitution upon the recommendation of the Pharmacy Director.

c. **Approved Drugs**: Only drugs and medications listed in the latest edition of United States Pharmacopeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations may be administered to patients in the Hospital, the only exception being drugs for bona fide clinical investigation in the course of studies approved by the Institutional review Board (IRB).

d. **Investigational Drugs**: Investigational drugs shall be used in full accordance with the guidelines established by the Hospital’s Institutional Review Board, and shall comply with all regulations of the US Food and Drug Administration and Drug Enforcement Administration.

e. **Controlled Substances**: Only practitioners holding a currently valid DEA (Drug Enforcement Agency) Controlled Substances Registration Certificate may document orders for narcotics or drugs classified in the DEA Controlled Substances Category.

f. **Definition of a Complete Order**: All medication orders shall include the drug name, the metric mass or concentration, the dosage form, the route of administration, the schedule of administration, and if appropriate, the date and time of discontinuation. If appropriate, a dilution and rate of administration should be specified. All medication orders that are incomplete will be called to the attention of the ordering practitioner for clarification prior to being dispensed.

g. **Nomenclature**: When ordering medications, standard nomenclature must be employed, using the United States Adopted Names-approved generic name, the official name, or the trademarked name (if a specific product is required). Prohibited abbreviated names and symbols should not be used.

h. **Dosing Formats**: SI (metric system) units must be used in medication orders except for therapies that use standard units (such as insulin and vitamins). Exact dosage strengths (such as milligrams) shall be used, rather than dosage form units (such as “vials” or “ampules”).

i. **Hold Orders**: Instructions to “hold” a medication should be specific and must include the name of the medication to hold and the number of doses to hold. If it is uncertain that a medication will be resumed, a “stop” or “discontinue” order should be given.

j. PRN Orders: “PRN” or “as needed” orders must be qualified by listing the indication for the medication.

l. Medication Errors: The Medical Executive Committee shall adopt policies and procedures to minimize drug errors following the recommendation of the Pharmacy Director. Drug administration errors, adverse drug reactions, and incompatibilities shall be immediately reported to the attending practitioner, and, if appropriate, to the hospital-wide quality assurance program.

m. Automatic Stop Orders: Drugs and biologicals not specifically prescribed as to time or number of doses must automatically be stopped after a reasonable time that is established by the Medical Executive Committee upon the recommendation of the Pharmacy Director, the Medication Management Committee, and the Medical Staff Performance Improvement and Patient Safety Committee.

4.4.12 "Stat" Orders

"Stat" or "now" orders should only be used when the practitioner expects hospital personnel to discontinue all other tasks so that they may execute the order as soon as possible. "Stat" and "now" orders should be reserved for true emergency situations, and should not be used for the convenience of the practitioner. Inappropriate use of "stat" and "now" orders may be grounds for corrective action.

4.5 CONSULTATION

a. Any qualified practitioner with clinical privileges may be requested for consultation within his/her area of expertise. The attending practitioner is responsible for obtaining consultation. Consultation should be requested when: (i) the patient presents a significant co-morbidity or risk factor outside of the usual area of practice of the attending practitioner or requesting practitioner; (ii) the patient's capacity to give informed consent or participate in health care decision making is unclear; (iii) to determine and document that a patient is in a persistent vegetative state or a terminal condition for purposes of applying an advanced directive; (iv) the patient exhibits severe psychiatric symptoms; (v) when required by the Medical Staff Bylaws or these Rules and Regulations or by Hospital policy; and (vi) in other cases where the attending practitioner or treating practitioner believes consultation is indicated.

b. The request for consultation should specify:

1. the reason for the consultation;

2. the urgency of the consultation (urgent—within 4 hours; today—before midnight; or routine—within 24 hours); and

3. whether the attending practitioner requests the consulting practitioner to only render an opinion, provide treatment in his or her area of specialty, or assume the role of attending practitioner. If the practitioner is requesting another practitioner to assume the role of attending physician, then the procedure outlined in these Rules & Regulations, Article IV, Section 4.1.3, "Transferring Attending Responsibilities" shall be followed.

b. If a nurse has any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to attending practitioner and/or a group associate. If unresolved, the nurse should contact Director of Nursing, or designee, who may then contact the practitioner's Hospital Service Line Chief. All practitioners should be receptive to obtaining consultation when requested by patients, their families, and hospital personnel.

4.6 CRITICAL CARE UNITS

4.6.1 Critical Care Unit Privileges

The privilege to admit patients to, and manage patients in, critical care units shall be specifically delineated. Decisions regarding the validity of admissions to, or discharge from, a critical care unit will be made through consultation with the medical director of the unit and with the patient's attending practitioner.

4.6.2 Prompt Evaluation of Critical Care Patients
Each patient admitted or transferred to a critical care unit shall be examined by the attending practitioner or a critical care practitioner in consultation as soon as possible after admission or transfer but within twelve (12) hours. In all instances, patients must be seen as soon as possible in a time period dictated by the acuity of their illness.

4.6.3 Critical Care Services
Certain services and procedures may be provided to patients only in critical care units. The Medical Executive Committee shall establish policies that specify which services may be provided only in a critical care unit.

4.7 DEATH IN HOSPITAL

4.7.1 Pronouncing and Certifying the Cause of Death
In the event of a hospital death, the deceased will be pronounced by the attending practitioner or his/her designee and within a reasonable time all consistent with Nebraska state law. The body will not be released until an entry has been made and signed in the electronic health record of the deceased by the attending practitioner or another practitioner designated by the attending practitioner. The attending practitioner or his/her designee is responsible for certifying the cause of death, and completing the Death Certificate in a timely manner.

4.7.2 Organ Procurement
When death is imminent, practitioners should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.

4.8 AUTOPSY
It is the duty of the attending practitioner to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medico-legal or educational interest and for securing permission on a form approved by the Hospital. The Pathology Service shall notify the Medical Staff Quality Committee (MSQC) and the attending practitioner if a patient is referred for an autopsy. The MSQC and the attending practitioner shall also be notified by Pathology Service that the autopsy has been completed. The anatomic diagnosis and the complete autopsy report shall be made a part of the electronic health record immediately upon availability from the consultant performing the autopsy.

4.9 INFECTION CONTROL
Practitioners have an important role in the prevention of hospital acquired infection. All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties. An essential part of this program incorporates patient infection prevention measures as well as systems of barrier precautions. Universal Precautions are to be used by practitioners for contact with blood, moist body substances, and non-intact skin of all patients, regardless of the patient’s diagnosis.

4.10 CLINICAL PRACTICE GUIDELINES
Clinical practice guidelines provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Clinical practice guidelines assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. Clinical practice guidelines can also be used in designing clinical processes, or checking the design of existing processes.

The Medical Executive Committee may adopt evidenced-based clinical practice guidelines upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

The Medical Executive Committee shall consider such sources as the Agency for Health Care Policy and Research, professional medical societies and practitioner organizations, professional health care organizations, and local organizations. Guidelines shall be adapted to the community, the needs of the patient population, and the resources of the Hospital. Clinical practice guidelines so adopted must anticipate and capture variance.

ARTICLE V

INFORMED CONSENT

5.1.1 Responsibility for Obtaining Informed Consent

The practitioner responsible for performing a procedure or course of treatment for which informed consent is required shall be responsible to assure that the patient or patient's decision maker has been fully informed and has given consent. Except in an emergency, the informed consent shall be required for any invasive procedure; the administration of anesthesia or moderate sedation; the administration of blood or blood products; the initiation of a regimen of cancer chemotherapy; or the performance of any procedure or implementation of any plan of care carrying risk to the patient and not described and consented to in the general consent obtained by the Hospital at registration. The informed consent must be documented in writing and dated, timed and signed by or on behalf of the patient. It shall be included in the patient's electronic health record prior to the treatment for which it is given.

5.1.2 Content

The documentation of informed consent should include, as applicable:

a. the name of the Hospital and the name of the practitioner or other practitioner who will perform the procedure or treatment;

b. the name of the specific procedure or other type of treatment for which consent is being given;

c. a statement that the procedure or treatment, including (i) the anticipated benefits; (ii) the material risks; (iii) the known side effects; (iv) and any significant alternatives to the procedure or treatment, were all explained to the patient or party giving consent;

d. if applicable and not specifically addressed in a general consent for care, a statement that medical residents or practitioners other than the operating practitioner will be performing or participating in the procedure;

e. the name and signature of the individual who conducted the informed consent discussion with the patient or patient's decision maker.

5.1.3 Who May Consent

Hospital policy shall be followed as to who may consent and under what circumstances.

5.1.4 Refusal to Consent

The patient, or when appropriate the substitute decision maker, has a right to refuse treatment(s) or procedure(s). Patient refusal shall be so documented in the patient's electronic health record.

5.1.5 Forms and Procedures

Approved forms and methods of documenting informed consent and procedures for obtaining informed consent are set forth in Hospital policy.

ARTICLE VI

SURGICAL CARE

6.1 SURGICAL PRIVILEGES

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Services Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

6.2 SURGICAL POLICY AND PROCEDURE MANUAL

All practitioners shall comply with the Hospital's policies and procedures regarding surgical procedures. This shall include, but not be limited to, the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 ANESTHESIA

Moderate or deep sedation and anesthesia may only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The anesthesiologist/anesthetist will maintain a complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition for each patient receiving moderate or deep sedation and anesthesia.

6.4 ASSISTING SURGEON

There will be a list of procedures developed by the Procedural/Surgical Hospital service line, and approved by the MEC, listing which procedures shall have a qualified assisting practitioner present and scrubbed unless the patient's life is in jeopardy and a qualified practitioner is not immediately available.

6.5 TISSUE SPECIMENS

A list of specimens that must be sent to Pathology will be developed by the appropriate Hospital Service Line Chiefs with consultation and recommendations from Pathology. The operator may send any additional specimens as deemed appropriate. The Hospital pathologist will make such examination as may be considered necessary to obtain a tissue diagnosis. The pathologist's report will be made a part of the patient's electronic health record.

6.6 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE

6.6.1 Policy

The practitioner/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID wrist band with information contained on it consistent with Hospital policy.

6.6.2 Surgical Verification

A surgical verification checklist will be utilized by the designated health care providers and by the registered nurse for all applicable surgical procedures and shall include the following documentation:

a. Verification of the patient, correct site, and procedure in the preoperative or pre-assessment area.

b. A notation that the site was verified by the practitioner/surgeon and marked when applicable, prior to entering the operating room or starting the procedure.

c. Correlation and verification of the patient, procedure, and site with (as applicable):

   1. A review of the practitioner's informed consent documentation;
   2. A review of the surgery or procedure listed on the surgical schedule;
   3. A review of the History and Physical Examination and other preoperative documentation ;
   4. A review of the practitioner's progress or consultation notes; and/or
   5. Correlation with imaging studies or reports thereof.

6.6.3 Verification with Patient or Responsible Party

The practitioner performing the procedure or surgery will confirm the correct procedure or site with the patient or responsible adult prior to starting the procedure or entering the surgical suite.

6.6.4 Site-Marking

a. **Procedure**: Each procedure or surgical intervention involving right/left distinction, multiple structures (such as fingers or toes), or multiple levels (such as the spine) will be marked by the practitioner/surgeon in the practitioner's office or in the hospital's preoperative assessment area with an indelible skin marker utilizing "YES" as the identifier on the appropriate site. When multiple sites involving laterality, multiple structures or levels are involved the identification, marking and verification steps will be repeated for each site individually.

b. **Exceptions**: Site-marking is not required for:

   1. those procedures through or immediately adjacent to a natural body orifice (e.g., gastrointestinal endoscopy, tonsillectomy, hemorrhoidectomy, or procedures on the genitalia);
   2. situations in which marking the site would be technically impossible or impractical, including mid-line sternotomy for open-heart surgery, Cesarean section, laparotomy and laparoscopy, and interventional procedures for which the site of insertion is not predetermined, such as cardiac catheterization procedures;
   3. routine minor procedures such as venipuncture, peripheral intravenous line placement, or insertion of a nasogastric tube or a Foley catheter; and
   4. a life or limb-threatening emergency as proclaimed by the practitioner/surgeon.

6.6.5 Time-out

a. **Procedure**: There will be a "time-out" to obtain verbal verification of patient identification, surgical site, intended procedure, patient position, and availability of needed equipment or implant(s) in the Operating or Procedure Room by each member of the surgical team (practitioner/surgeon, anesthesia provider, nurses, and surgical technicians) prior to incision or the start of the procedure. Any discrepancy from this procedure requires reverification of the patient, site, and procedure by the practitioner/surgeon.

b. **Exceptions**: The above requirements for time-out may be waived in a life or limb-threatening emergency as proclaimed by the practitioner/surgeon.

ARTICLE VII

RULES OF CONDUCT

7.1 GENERAL

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital, as described in the Bellevue Medical Center Medical Staff Code of Conduct and consistent with Hospital policy. Disruptive behavior by a practitioner will be dealt with according to Hospital policy and the procedures defined in the Medical Staff Bylaws.

7.2 DISRUPTIVE BEHAVIOR

Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. Examples of disruptive behavior include, but are not limited to:

a. outbursts of rage or violent behavior;

b. physical or verbal attacks or assaults;

c. impertinent and inappropriate comments (or illustrations) made in patient electronic health records or other official documents that impugn the quality of care in the Hospital, or attacking particular Medical Staff members, patients, nurses, non-clinical personnel, or Hospital policies;

d. refusal to accept Medical Staff assignments and unassigned call responsibilities, or to do so in a disruptive manner including repeated refusal to respond to calls;

e. sexual harassment;

f. poor hygiene;

g. stealing;

h. throwing instruments, equipment or patient charts or records; and

i. harassment or insulting comments directed at any individual (e.g., against another Medical Staff appointee, resident practitioner, medical student, nursing student, hospital employee, visitor, or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, marital status, sex, or sexual orientation;

j. retaliation against individuals for making reports, providing information or participating in hospital and medical staff quality monitoring, performance improvement, peer review or similar functions.

7.3 SEXUAL HARASSMENT

a. “Sexual harassment” is unwelcomed verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments, or slurs), physical harassment (such as unwelcomed touching, assault, or interference with movement or work), or visual harassment (such as display of derogatory cartoons, drawings, or posters). Sexual harassment includes unwelcomed advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature. Sexual harassment shall be treated as disruptive behavior.

7.4 PHYSICAL EXAMINATION GUIDELINES

In order to prevent misunderstandings and protect practitioners and their patients from allegations of sexual misconduct, the following guidelines for performing physical examinations shall be followed by all practitioners:

a. **Patient Dignity**: Maintaining patient dignity should be foremost in the practitioner's mind when undertaking a physical examination. The patient should be assured of adequate auditory and visual privacy and should never be asked to disrobe in the practitioner's presence.

b. **Location and Equipment:** Physical examination shall be conducted in a safe, clean and well-maintained location, with appropriate equipment for the examination and treatment. Gowns, sheets, and/or other appropriate apparel shall be made available to protect patient dignity and decrease embarrassment to the patient while promoting a thorough and professional examination.

c. **Chaperones**: A third party shall be readily available at all times during a physical examination, and it is required that the third party be actually present when the practitioner performs an examination of the sexual and reproductive organs or rectum. This precaution is essential regardless of the sex of the practitioner and the patient.

d. **Consent for Examination**: The practitioner should individualize his/her approach to physical examinations so that the patient's apprehension, fear, and embarrassment are diminished as much as possible. An explanation for the necessity of a complete physical examination, the components of that examination, and the purpose of disrobing may be necessary in order to minimize the patient's apprehension and possible misunderstanding.

e. **Procedures Requiring Disrobing**: The practitioner and his/her assistants shall exercise the same degree of professionalism and caution when performing diagnostic procedures (i.e., electrocardiograms, electromyograms, endoscopic procedures, and radiological studies, etc.) as well as surgical procedures and post-surgical follow-up examinations when the patient is in varying stages of consciousness.

f. **Handling Inappropriate Patient Behavior**: The practitioner should be alert to suggestive or flirtatious behavior or mannerisms on the part of the patient, and should not put him or herself in a compromising position.

g. **Allegations of Exploitation**: The practitioner shall not exploit the practitioner-patient relationship for sexual or any other purposes.

7.5 REPORTING IMPAIRED PRACTITIONERS

Reports and self referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall be directed to the individual's Hospital Service Line Chief, the President of the Medical Staff, the Chief Medical Officer or the Hospital Administrator. These reports will be handled in a manner consistent with the directives of the Nebraska Board of Medicine and Surgery.

7.6 SMOKING POLICY

Medical Staff appointees and other individuals exercising clinical privileges shall be in compliance with the Hospital policy on smoking.