MEDICAL STAFF

RULES AND REGULATIONS

Lakeview Hospital
Stillwater, MN  55082

April 2016
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Definitions:
The term "Practitioner", unless otherwise expressly limited, means Physician or other person who has been granted clinical privileges by the Board. Physician means an appropriately licensed Medical Doctor, Doctor of Osteopathy, Dentist, or Podiatrist who has been admitted to membership on the medical staff.

EMR means Electronic Medical Record; the terms “written, “in writing” or “write” include electronic entry into the medical records when EMR entry is applicable.

ER or ED means Emergency Room or Department.

1. **ADMISSION OF PATIENTS:**

1.1 **Types of Patients**

The hospital accepts patients for care and treatment except for the following categories:

(a) Cases where we are unable to safely or adequately provide care due to lack of staffing, equipment, etc.

(b) In-patient admission of prisoners unless defined through contracted services.

(c) Patients requiring acute in-patient psychiatric or chemical dependency care. In the interest of patient safety Lakeview may admit and treat patients until such time space becomes available at a more appropriate facility.

Within these guidelines, patients are admitted without regard to race, sex, creed, age, color, sexual orientation, religion, ancestry, national origin marital status, disability, veteran status or on the basis of any other criterion protected under applicable non-discrimination laws.

1.2 **Admitting Prerogatives**

Only a member in good standing of the Active and Associate category of the medical staff with admitting privileges may admit patients to the hospital. ER privileged MDs may render care in the outpatient setting. The ER Physician has the ability to write admitting orders but the responsibility for patient care transfers to the on-call Physician or the Hospital Medicine Service when the patient leaves the ED and is admitted as an inpatient.

Limitations for Allied Health Professionals (AHP): Patients of AHPs may be admitted to the hospital provided an Active staff member is responsible for the medical care. The designation by the AHP of the responsible medical staff member must be completed prior to admission.
1.3 **Admitting Information**

Except in an emergency, a patient will not be admitted to the hospital until a provisional diagnosis or valid reason for admission is provided by the Practitioner requesting admission. The admitting Practitioner is also responsible for providing the following information concerning a patient to be admitted: any known source of communicable or significant infection; behavioral characteristics that would disturb or endanger others; need for protecting the patient from self-harm.

1.4 **Timely Visitation After Patient Admitted**

The attending Physician or his or her designee (i.e. another member of the staff in good standing with the requisite privileges to care for the patient) must see the patient within the time frames provided below or within any shorter time frame if the patient's condition requires it. If requested, the Physician should respond immediately. Nursing staff is encouraged to request immediate response when necessary:

(a) Patients designated as emergency cases and those admitted directly to or transferred into ICU/CCU as soon as possible, not to exceed four (4) hours or at the request of the ED Physician or nursing supervisor’s request for deterioration of a critical patient.

(b) Any patient admitted to the hospital will be seen within twelve (12) hours.

2. **RESPONSIBILITY FOR AND CONDUCT OF CARE**

2.1 **Generally**

A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of those portions of the medical record for which he or she is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring Practitioner, if any, and to relatives of the patient. Primary Physician responsibility for these matters belongs to the admitting Physician except when transfer of responsibility is effected.

The responsible Practitioner or his or her designee informs the patient (and when appropriate his or her family) about unanticipated outcomes of care, treatment and services.

Practitioners will adhere to all Lakeview Hospital policies and procedures regarding patient confidentiality.

2.2 **Transfer of Responsibility**

When primary responsibility for a patient's care is transferred from the admitting or current attending Physician to another medical staff member, other than routine coverage by the on-call Physician, (e.g. evenings, nights and weekends), a note covering the
transfer of responsibility must be entered on the order sheet or progress note or EMR documenting that the Physician discussed the transfer with the Physician assuming responsibility for the patient.

2.3 **Alternate Coverage**

Each Physician must assure timely, adequate professional care for his or her patients in the hospital by being available or designating a qualified alternate Physician with whom prior arrangements have been made and who has the requisite clinical privileges at this hospital to care for the patient. Each member of the medical staff who will be out of town or unavailable in case of emergency must indicate in writing the name of the Practitioner who will be assuming responsibility for the care of the patient during his or her absence, other than routine coverage by the on-call Physician, (e.g. evenings, nights and weekends).

In the absence of such designation, the President, the Chief of Staff, or department Chairperson has the authority to call any member of the Medical staff with the requisite clinical privileges.

2.4 **Allied Health Professionals**

2.4.1 **Qualifications**

Allied Health Professionals (AHP) holding a license, certificate or other legal credential as required by state law, or when so required, certified by the appropriate accrediting agencies or professional societies, who:

(a) document their experience, background, training, ability and health status;

(b) are qualified to provide a needed service within the hospital;

(c) are under the supervision and sponsorship of a Physician member of the medical staff; and

(d) provide sufficient evidence that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency;

may be eligible to provide specified services within their scope of services in the hospital. Where appropriate, the Executive Committee of the medical staff may establish particular qualifications required of members of a specific category of AHP’s.

2.4.2 **Procedures for Specification of Service**

An application for specified services by an AHP shall be submitted and processed in the same manner as provided in the Medical Staff By-Laws for obtaining clinical privileges.
An AHP may be assigned to a medical staff committee appropriate to his or her professional training, shall attend committee meetings upon request, and shall be subject, in general, to the same terms and conditions as specified in the Bylaws, Rules and Regulations for Medical Staff privileges save and except that AHP's shall not have access to any of the policies and procedures provided in the Medical Staff Bylaws relating to hearings and review of reductions, suspensions, or terminations of clinical privileges.

2.4.3 Prerogatives

Unless otherwise expressly provided by resolution or written policy of the Governing Body, the prerogatives of an AHP shall be to:

(a) Provide specific patient care services under the supervision or direction of a Physician member of the Medical Staff as ordered by the attending Physician (except as otherwise expressly provided by resolution or written policy of the Executive Committee);

(b) Independent AHPs may perform the scope of services set forth in their individual scope of services. Dependent AHPs work under the direct supervision of a medical staff Physician and may perform the scope of services set forth in their individual scope of services. Dependent staff who are licensed Physician Assistants work under direct or indirect supervision of a medical staff Physician as set forth in their individual scope of services and designated in their Minnesota Board of Medical Practice Delegation Agreement. Independent and Dependent AHPs may perform only those duties as approved in their scope of services and allowed by Lakeview Hospital policies, Bylaws, Rules and Regulations and regulatory requirements.

(c) Except as otherwise expressly provided by resolution or written policy of the Executive Committee, or Section 6.6 of these Rules and Regulations, write orders which must be countersigned by the responsible Physician within the established timeframe for record completion and which must not be beyond the scope of the AHP's license, certificate or other legal credential or hospital granted services;

(d) Record progress notes or patient histories in addition to that required of the Physician;

(e) Consistent with their scope of service and applicable Lakeview Hospital Governing Body approved policies, AHP’s may be permitted to perform admission physical examinations or other procedures within their scope of service;

1) Co-signatures are not required for an History & Physical (H & P) by an Advanced Practice Nurse (APRN) or Licensed Physician Assistant (PA-C)
if the APRN or PA-C is acting within his or her individual scope of services and collaborative/delegation agreement.

(f) Prescribing: Only those AHPs who hold current DEA certificates and acting as allowed by MN State law, Lakeview Hospital policies, Bylaws, Rules and Regulations and other regulatory authorities may prescribe controlled substances.

(g) Serve on committees as appropriate;

(h) Attend meetings of the committee or subcommittee to which he or she is assigned; and

(i) Exercise such other prerogatives as shall, by resolution or written policy, be duly adopted by the Medical Staff or by any of its Committees and approved by the Executive Committee and the Board.

2.4.4 Responsibilities

Each AHP shall:

(a) Meet the basic responsibilities as are required for Medical Staff members as provided in the Medical Staff Bylaws;

(b) Exercise judgment within his or her area of professional competence for the care of each patient for whom he or she is providing services, or arrange a suitable alternative for such care, understanding that a member of the Active medical staff has ultimate responsibility for overall patient care and for the actions and conduct of the AHP which the Practitioner or group of Practitioners is sponsoring; and

(c) Participate as appropriate in monitoring and evaluation of patient care, in supervising initial appointees of his or her same profession during the focused evaluation period, and discharge such other staff functions as may be required from time to time.

2.4.5 Evaluation, Change in Status, Termination

(a) A Physician is identified to act as a sponsor for an AHP. A performance/competency evaluation is completed annually and submitted to the Executive Committee and Board. In addition, each medical staff committee chair and the Executive Committee shall periodically, at least every two years, review the AHP's performance and submit its evaluation(s), through the reappointment process, to the Credentialing Committee of the Board for approval. The sponsor’s annual evaluation(s) will be included with the reappointment packet for the applicable medical staff committee department chair’s review. The recommendation from the
Physician(s) sponsoring the AHP attests to the fact that the Physician(s) is continuing his or her sponsorship of said AHP.

(b) Any complaints concerning the performance of any AHP shall be brought to the chair of the applicable medical staff committee and to the Executive Committee. Any such complaint shall be investigated by an ad hoc committee appointed by the Chief of Staff. The ad hoc committee shall be comprised of the President, an AHP, and a Physician. The ad hoc committee shall schedule a meeting to provide an opportunity for the AHP to present his or her position regarding the complaint and any other relevant information. The meeting shall not constitute a hearing, and the AHP may not have counsel or other witnesses present, unless authorized by the ad hoc committee. A written report of the investigation and recommendations relating to the further performance of functions by the AHP shall be made by the ad hoc committee to the Executive Committee. The Executive Committee shall review the report and conduct such further investigation as it deems necessary and submit its written report and recommendations relating to the AHP to the President or his or her designee.

(c) The Hospital Credentialing Committee shall make the final decision on an AHP's further performance of designated functions, after review of the recommendations of the Executive Committee and the President or his or her designee conduct and such other investigation as appears necessary.

Notification of the decision shall be communicated to the AHP in writing. There shall be no right of appeal from the action of the Hospital Credentialing Committee, nor shall an AHP have any right to any of the appeal provisions provided for in the Medical Staff Bylaws or any applicable Rules and Regulations.

(d) Any AHP employed or sponsored by a Physician or group of Physicians shall cease to be recognized under these Rules and Regulations when such employment sponsorship is terminated. When a Physician or group of Physicians terminates employment of an AHP, this decision shall be immediately communicated to the Executive Committee through the Medical Staff Office. The AHP may submit a new application if he or she is thereafter employed by another Active medical staff member.

(e) The AHP's privileges to provide services at the hospital are coterminous with the sponsoring Physician.

(f) AHP's are not eligible for hospital sponsored gratuities provided for the Medical Staff.

(g) It is understood that the performance of any patient care functions by the AHP does not substitute for the responsibilities of the attending Physician
to perform the required duties involved in the daily care of his or her hospitalized patient. The Physician maintains ultimate responsibility for the care of the patient.

2.5 **Emergency Medical Treatment and Labor Act (EMTALA)**

Lakeview Hospital will provide a medical screening exam, a process of examination and treatment necessary to determine whether an emergency medical condition exists. An appropriate screening shall be provided within the hospital’s capabilities, including all ancillary services routinely available, to any individual who comes to Lakeview and requests examination or treatment for a medical condition. The medical screening examination must be performed by a Physician or other qualified medical person as defined in the medical staff bylaws, rules and regulations or Governing Body approved policies.

A medical screening exam shall be provided to all persons who present with an urgent or emergent condition and request services, regardless of that person’s ability to pay. The medical screening exam must be appropriate to the medical complaints and sufficient to determine whether the person has an emergency medical condition.

Qualified medical personnel shall include only the following categories of persons when acting in their usual and customary settings and within the scope of their training and protocols: clinical psychologists, dentists, podiatrists, certified nurse midwives, nurse practitioners, registered nurses, and physician assistants.

If the patient has an emergency medical condition, or if a pregnant woman presents in labor, the hospital will treat or stabilize the patient. The patient will not be transferred to another facility unless the patient’s condition is stabilized or it is in the patient’s best interest to be transferred due to the hospital’s inability to provide the needed services or level of care and if the requirements for transfer outlined in the Medical Staff Bylaws Rules and Regulations and ER policies and procedures are met.

Pregnant women (greater than or equal to 20 weeks gestation) presenting with known or possible OB related conditions will be seen in the Women’s Health Unit by a Registered Nurse who has completed competencies to perform an OB Medical Screening exam and defined in orientation guidelines acting in consultation with the attending Physician/CNM.

3. **CONSULTATIONS**

3.1 **Responsibility**

The good conduct of medical practice includes the proper and timely use of consultation. The attending Practitioner is primarily responsible for calling a consultation from a qualified staff member when indicated. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending Practitioner.
3.2 Guidelines for Calling Consultations

Unless the attending Practitioner's expertise is in the area of the patient's problem, consultation with a qualified Physician is required in the following cases:

(a) When these Rules or the rules of any clinical unit, including any intensive or special care units, of the staff require it.

(b) When the patient is under two years of age.

(c) When the patient requires ICU/ED admission for mechanical ventilation.

(d) Problems of critical illness in which any significant question exists of appropriate procedure or therapy.

(e) When required by state law or federal law.

3.3 Qualification of Consultant

Any qualified practitioner may be called as a consultant regardless of his or her staff category assignment. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or sub-specialty board or by a comparable degree of competence based on equivalent training and extensive experience.

3.4 Documentation

(a) Consultation Request: Consultation is requested by admitting/attending Physician.

(b) Consultant's Report: The consultant must make and sign a report of his or her findings, opinions and recommendations that reflects an actual examination of the patient in the medical record immediately after completing the consultation. Such report shall become part of the patient's medical record.

(c) Attending Practitioner's Response to Consultant's Opinion:

In cases of elective consultation when the attending Practitioner elects not to follow the advice of the consultant, he or she shall either seek the opinion of a second consultant or record in the progress notes his or her reasons for electing not to follow the consultant's advice. In cases of required consultation when the attending Practitioner does not agree with the consultant, he or she shall either seek the opinion of a second consultant or refer the matter to the applicable Department Chairperson for final advice. If the attending Practitioner obtains the opinion of a second consultant and does not agree with it either, he or she shall again refer the matter to the applicable Department Chairperson.
4. **TRANSFER OF PATIENTS**

4.1 **Internal Transfer**

Internal patient transfer priorities are as follows:

(a) Emergency patient to an available and appropriate patient bed;

(b) From obstetric patient care area to general care area;

(c) From special care unit to any general care room;

(d) From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient;

(e) Or as required by specific departmental policies.

4.2 **Transfer to Another Facility**

**General:** A patient shall be transferred to another medical care facility only upon the order of the attending Practitioner, after a Physician examination, contact between the examining Physician and the Physician to whom the patient is being transferred, arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. A completed certificate of transfer and transfer order form with all pertinent medical information necessary to insure continuity of care must accompany the patient.

**Emergency or critically ill patient:** A transfer demanded by an emergency or critically ill patient or his or her family or significant other is not permitted until a Physician has explained to the patient or his or her family the seriousness of the condition and generally not until a Physician has determined that the condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form is to be executed. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record. A certificate of transfer and transfer order form and all pertinent medical information necessary to insure continuity of care must accompany the patient.

5. **DISCHARGE OF PATIENTS**

5.1 **Required Order**

A patient may be discharged only on the written order of the attending Practitioner or his or her physician assistant or nurse practitioner. The attending Practitioner is responsible for verifying documentation and attesting to principal diagnosis, secondary diagnosis, comorbidities, complications, principal procedures, therapies, meds, and additional procedures in the patient's medical record within 30 days of discharge. The Physician, or his or her designee, is responsible for seeing the patient on day of discharge unless other arrangements are predetermined with the patient and nursing staff.
5.2 Leaving Against Medical Advice

If a patient desires to leave the hospital against the advice of the attending Practitioner or without proper discharge, the attending Practitioner shall be notified and the patient will be requested to sign the appropriate release form, attested by the patient or his or her legal representative and witnessed by a competent third party. If a patient leaves the hospital against the advice of the attending Practitioner or without proper discharge, a notation of the incident must be made in the patient's medical record.

5.3 Discharge of Minor Patient

Any individual who cannot legally consent to his or her own care shall be discharged only to the custody of parents, legal guardian, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he or she shall so state in writing, and the statement must be made a part of the patient's medical record. Exceptions are addressed in Lakeview Hospital approved policies and/or state law.

6. ORDERS

6.1 General Requirements

All orders for diagnostic and therapeutic treatment, meds or diagnostic tests must be entered into the electronic medical record (EMR) or written clearly, legibly, completely, and signed, dated and timed by the Practitioner responsible for them. Orders which are illegible or improperly written or entered into the EMR in an improper manner will not be carried out until rewritten or understood by the nurse. When a test substance or medication is required as part of a diagnostic test, it will also require an order, in compliance with the Lakeview Hospital approved policy for specific requirements.

6.2 Preprinted/Physician Orders

All preprinted Physician orders shall be included in the patient’s record. Documentation requirements, as stated in 6.1, shall be followed. The attending Practitioner shall sign each preprinted Physician order.

All preprinted Physician orders must be reviewed at least every three years and revised as necessary.

6.3 Verbal and Telephone Orders

(a) Verbal orders are discouraged.

(b) Telephone orders will be accepted only from the responsible Practitioner or his or her designee and when it is not practical for the order to be given in writing or entered into the EMR.
Telephone and verbal orders may be taken by a Practitioner, registered nurse, or licensed practical nurse, except that the following personnel may take telephone orders for medication, treatment, and/or procedures within their respective areas of practice which they will prepare, deliver or perform: registered pharmacist; respiratory therapist; physical, occupational or speech therapist; laboratory technician; radiology technician; registered dietician; CRNA; social worker; paramedic; or other disciplines, as defined by the State of Minnesota Statutes or Rules and Regulations.

6.4 Documentation of Verbal, Telephone, and Preprinted Physician Orders

All verbal and telephone orders shall be transcribed in the proper place in the medical record, shall include the date, time, name and signature of the person transcribing the order and the name of the Practitioner. Staff are required to “read back” verbal or telephone orders. If staff fails to “read back” the order, the Physician will be responsible to request a “read back”. Documentation of the verbal order read back or telephone order read back is encouraged. For inpatients, the Practitioner or his or her qualified counterpart will be required to countersign the verbal order or telephone order within forty-eight (48) hours. The purpose of the countersignature is to insure the order is properly transcribed.

6.5 Orders for Outpatient Ancillary Services

If services are scheduled via the telephone, an order must be entered in the EMR or written; a signed Physician order must follow prior to or at the time of service. The written or electronic order shall include an appropriate diagnosis, sign or symptom, procedure or service to be performed and a Physician signature.

6.6 Orders by Allied Health Professionals

Any Allied Health Professional (AHP) may write orders only to the extent specified in the position description developed for that category of AHP's and consistent with the scope of services individually defined for him or her. Except as otherwise expressly provided by resolution or written policy of the Executive Committee, or as noted in 6.6 (a) of these Rules and Regulations, any authorized order by an AHP must be countersigned by the responsible supervising Practitioner as soon as possible after the order is written.

(a) Co-signatures are not required for an order by an Advanced Practice Nurse (APRN) or Licensed Physician Assistant (PA-C) if the APRN or PA-C is acting within his or her individual scope of services and collaborative/delegation agreement.

6.7 Automatic Cancellation of Orders

All previous orders are automatically discontinued when the patient goes to surgery except for minor local anesthesia cases. The attending Practitioner must reinstate all or
some of the orders, write new orders, or refer to another Practitioner for a decision on whether or not to reinstitute all or particular orders. Blanket reinstatement is prohibited; all orders must be rewritten.

6.8 **Stop Orders**

6.8.1 **Drugs/Treatments Covered and Maximum Duration**

When feasible and in order to assure that the proper and complete therapeutic regimen intended by the prescribing Practitioner is carried out, the exact total dosage or total period of time for the drugs or treatment listed shall be specified. When that has not been done, a stop order will be placed automatically after six months, unless a specific terminal date has been indicated.

6.8.2 **Exceptions**

Exceptions to the stop order rule are made under the following conditions:

(a) The last effective order indicated an exact number of doses to be administered;

(b) The last effective order specifies an exact period of time for the medication; or

(c) The prescribing Practitioner re-orders the medication or treatment.

6.8.3 **Notification of Stop**

The applicable unit/department notifies the Practitioner within 12-36 hours before an order is automatically stopped.

6.9 **Blood Transfusions and Intravenous Infusions**

Blood transfusions and intravenous infusions must be started by the attending Practitioner, a CRNA, or by a registered nurse, licensed practical nurse, or paramedic who has the requisite training. The Practitioner's order must specifically state the rate of IV infusion.

6.10 **Special Orders**

6.10.1 **Patient's Own Drugs and Self-Administration**

Drugs brought into the hospital by a patient may not be administered unless the drugs have been identified and there is a written order from the attending Practitioner to administer the drugs. Self-administration of medications by a patient is permitted on a specific written order by the authorized prescribing Practitioner and in accordance with established hospital policy.
6.10.2 **DNAR/DNAI Orders**

An oral order ordinarily for "DNAR/DNAI" is not acceptable. The order must be written by the attending Physician on the order sheet or entered into the EMR by the attending Physician after consultation with the patient/family and must be documented in the patient record. Other documentation, including any consents/authorizations, and any notices required shall be accomplished in accordance with the hospital's "DNAR/DNAI" policy.

6.10.3 **Restraints**

There are two types of restraints as defined by the Joint Commission standards and CMS Conditions of Participation; those appropriate for restraint for non-violent or non-self-destructive behavior and those appropriate for behavioral or self destructive behavior reasons. Reasons for non-violent or non-self-destructive behavior restraints include confusion and disorientation. Behavioral or self destructive behavior reasons include aggressive or threatening behavior. Guidelines are available through Lakeview Hospital policies and procedures. Electronic restraint order sets must be used and followed.

6.11 **Formulary and Investigational Drugs**

**Formulary:** The hospital formulary lists drugs available for ordering from stock. Each member of the medical staff assents to the use of the formulary as approved by the Medical Staff. All drugs and medications administered to patients, with the exception of drugs for bona fide clinical investigations, shall be those listed in the latest edition: American Hospital Formulary Service; Facts and Comparisons; or LexiComp.

**Investigational Drugs:** Use of investigational drugs must be in full accordance with all Regulations of the Food and Drug Administration and must be approved by the Institutional Review Board. Investigational drugs shall be used only under the direct supervision of the principal investigator or as delineated by a Lakeview Hospital Governing Board approved policy. The principal investigator shall be responsible for receiving all necessary consents and completing all necessary forms.

7. **MEDICAL RECORDS**

7.1 **Required Content**

The attending Practitioner and other medical staff members as applicable, shall be responsible for the preparation of a complete and legible medical record for each patient. The medical record, a combination of paper and electronic documents, shall be pertinent, accurate, legible, timely and current. The record shall include:

(1) The patient’s name, address, date of birth, and the name of any legally authorized representative;
(2) Emergency care provided to the patient prior to arrival, if any;
(3) The record and findings of the patient’s assessment;
(4) Conclusions or impressions drawn from the medical history and physical examination;
(5) The diagnosis or diagnostic impression;
(6) The reasons for admission or treatment;
(7) The goals of treatment and the treatment plan;
(8) Evidence of known advance directives;
(9) Evidence of informed consent, when required by hospital policy;
(10) Diagnostic and therapeutic orders, if any;
(11) All diagnostic and therapeutic procedures and test results;
(12) Test results relevant to the management of the patient’s condition;
(13) All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
(14) Progress notes made by the medical staff and other authorized individuals;
(15) All reassessments and any revisions of the treatment plan;
(16) Clinical observations;
(17) The patient’s response to care;
(18) Consultation reports;
(19) Every medication ordered or prescribed for an inpatient;
(20) Every medication dispensed to an ambulatory patient or an inpatient on discharge;
(21) Every dose of medication administered and any adverse drug reaction;
(22) All relevant diagnoses established during the course of care;
(23) Any referrals and communications made to external or internal care providers and to community agencies;
(24) Conclusions at termination of hospitalization;
(25) Discharge instructions to the patient and family;

(26) Clinical resumes and discharge summaries, or a final progress note or transfer summary;

(27) Patient’s language and communication needs;

(28) Records of communication with patient regarding their care treatment and services (phone calls, emails, etc.); and

(29) Patient generated information.

7.2 **History and Physical Examination (H & P)**

7.2.1 **General**

An H & P must meet the requirements set forth in the Medical Staff Bylaws Article VI, Section 7, History and Physical Examination.

7.3 **Preoperative Documentation**

7.3.1 **Laboratory Tests**

Appropriate advance lab tests must be performed within seven days prior to admission for any surgery and the results in the chart prior to the induction of anesthesia.

7.3.2 **Preoperative Anesthesia Evaluation**

The anesthesiologist must conduct and document in the record a pre-anesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient status classification, and orders for pre-op medication.

Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before pre-operative medications have been administered. Reassessment will be made prior to intubation.

7.4 **Progress Notes**

7.4.1 **Generally**

Pertinent progress notes must be recorded at the time of observation on a daily basis and must be sufficient to permit continuity of care and transferability of the patient.
7.5 Operative, Special Procedure and Tissue Reports

7.5.1 Operative and Special Procedure Reports

Operative and special procedure reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the post-operative diagnosis, and the name of the primary performing Practitioner and any assistants. If the report is not written in the record immediately after the procedure but instead the completed report is dictated, the Practitioner must enter an operative progress note in the medical record immediately after the procedure providing sufficient and pertinent information for use by any Practitioner who is required to attend the patient.

The complete report must be written or dictated immediately following the procedure, filed in the medical record as soon after the procedure as possible, and promptly signed by the primary performing Practitioner.

7.5.2 Tissue Examination and Reports

All tissues, foreign bodies, artifacts and prostheses removed during a procedure, except those specifically excluded by hospital policy shall be properly labeled, packaged in preservative as designated, identified as to patient, and source in the operating room or suite at the time of removal, and sent to the pathologist. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. An authenticated report of a pathologist's examination shall be made a part of the medical record.

7.5.3 Pre-Procedure Review of External Histo-Pathologic Diagnosis

When a patient enters this hospital to undergo a definitive therapeutic procedure based on histo-pathologic diagnosis made elsewhere, the attending Practitioner must present diagnostic slides and reports to this hospital's pathology staff for review and confirmation of the diagnosis. The pathologist will accept the responsibility of notifying the attending Practitioner regarding the findings of the review.

7.6 Obstetrical Record

The current obstetrical record must include a complete prenatal record. The prenatal record may be a durable, legible copy of the attending Practitioners office or clinic record transferred to the hospital before admission. If no prenatal care was provided, a complete history and physical will be required. The prenatal record must be reviewed and updated within 24 hours of admission.
All obstetrical patients undergoing surgery must have a history and physical examination recorded as required by Lakeview Medical Staff Bylaws, Rules and Regulations, policies and applicable regulatory authorities.

7.7 **Entries at Conclusion of Hospitalization**

7.7.1 **Face Sheet/Discharge Summary**

The principal diagnosis, any secondary diagnoses, comorbidities, complications, principal procedure and any additional procedures must be recorded in full by the attending Practitioner and must be recorded within 30 days of discharge.

The following definitions are applicable to the terms used herein:

(a) **Principal Diagnosis:** The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

(b) **Secondary Diagnosis (if applicable):** A diagnosis, other than the principal diagnosis, that describes a condition for which a patient received treatment or which the attending Practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.

(c) **Comorbidities (if applicable):** A condition that coexisted at time of admission that would affect the management or treatment of the patient and/or increase the length of stay.

(d) **Complications (if applicable):** An additional diagnosis that describes a condition arising after the beginning of hospital observation and treatment and modifying the course of the patient's illness of the medical care required, and/or is thought to increase the length of stay by at least one day.

(e) **Principal Procedure (if applicable):** The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.

(f) **Additional Procedures (if applicable):** Any other procedures, other than principal procedure, pertinent to the individual stay.

7.7.2 **Discharge Summary**

The discharge summary concisely recapitulates

- the reason for hospitalization
- the significant findings
– the procedures performed and treatment rendered
– the condition of the patient on discharge
– specific instructions given to the patient and/or family relating to physical activity, medication, diet, and follow-up care as appropriate.

The discharge summary, unless thoroughly legible or recorded in the EMR and complete, must be dictated.

The condition of the patient at discharge is stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology such as “improved”.

A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature, including normal vaginal deliveries, who require less than a 48 hour period of hospitalization. The final progress note includes:

– condition at discharge.
– discharge instructions given to patient and/or family relating to follow-up care requirements.

In the event of death, a summation statement is added to the record either as a final progress note or as a separate resume. The final note must indicate: the reason for admission, the findings and course in the hospital, and events leading to death. When an autopsy is performed, provisional anatomical diagnoses are recorded in the medical record within three days, and a complete protocol is made part of the record within 60 days, unless exceptions for special studies are established by the medical staff.

7.8 Authentication

All clinical entries in the patient's record must be accurately dated, timed, and individually authenticated. Authentication means to establish authorship by written signature. Computerized signatures may be used as specified in Lakeview Hospital approved policy and permitted by regulatory requirements.

7.9 Use of Symbols and Abbreviations

A listing of unacceptable abbreviations will be reviewed and approved by the medical staff and be available on-line via Compliance 360. Lakeview Hospital’s Intranet.

7.10 Filing

No medical record shall be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible Practitioner to complete the record, the Executive
Committee shall consider the circumstances and may enter such reasons in the record and order it filed.

7.11 Ownership and Removal of Records

All original patient medical records, including images, pathological specimens and slides, are the property of the hospital and may be removed only in accordance with a court order, subpoena or statute, or with the permission of the President or his or her designee. Except in cases of emergency, copies of records, images, slides, etc. may be released for follow-up patient care only upon presentation of appropriate authorization and fees for duplication. Unauthorized removal of a medical record or any such portion thereof from the hospital is grounds for such disciplinary action, including immediate and permanent revocation of staff appointment and clinical privileges, as determined by the appropriate authorities of the Medical Staff and Board.

7.12 Access to Records

7.12.1 By Patient

A patient may, upon written request to Health Information Services, have access to all information contained in his or her medical record, unless prior to the request, access is specifically restricted by the attending Practitioner for medical reasons or is prohibited by law. Any Practitioner objecting to patient access must document in the patient’s medical record the medical reasons for the objection.

7.12.2 For Statistical Purposes and Required Activities

Patient medical records shall also be made available to authorized hospital personnel, medical staff members or others with an official, hospital-approved interest.

Use of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification, and confidential personal information extraneous to the purposes for which the data is sought shall not be used.

7.12.3 On Readmission

In the case of readmission of a patient, all previous records shall be available for use of the current attending Practitioner.

7.12.4 To Former Medical Staff Members

Subject to the discretion of the President former members of the medical staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the hospital.
7.12.5 **Patient Consent Required Under Other Circumstances**

Written consent of the patient or his or her legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section 7.12 or by law to receive this information.

7.13 **Delinquent Records**

All medical records must be completed within 30 days of discharge or corrective action shall be taken.

8. **CONSENTS**

8.1 **Informed Consent:**

8.1.1 **Requirement**

The performing Practitioner is responsible to inform and obtain the patient or his or her legal representative's informed consent for all procedures and treatments. The signature of a patient or his or her legal representative is required for the following procedures:

(a) Anesthesia

(b) Surgical and other invasive and special procedures

(c) Blood and blood products*

(d) Use of experimental drugs

(e) Organ donation*

(f) Chemotherapy

(g) Autopsy*

(h) Photography*

(i) Observing of a procedure or treatment in progress by an individual who is not a member of the treatment team, except for educational purposes as specified on the general admission form.*

* Hospital-specific forms are available.

8.1.2 **Documentation Required**

The informed consent must be documented in patient's medical records or on a form appended to the record and must include at least the following information:
The Practitioner must certify in writing and/or via entry into the EMR that the risks, complications, benefits, and alternatives have been explained with sufficiency and in terms that a patient would reasonably consider material to the decision whether or not to undergo the procedure or treatment and that the patient consents to the proposed procedure/treatment.

8.1.3 Emergencies

If circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in Section 8.2.1 without first obtaining informed consent as required therein, such circumstances must be explained in the patient's medical record. Two Physicians shall document the medical advisability of proceeding without informed consent.

9. HOSPITAL DEATHS AND AUTOPSIES

9.1 Hospital Deaths

9.1.1 Pronouncement

In the event of a hospital death, the deceased shall be pronounced dead by the attending Physician or his or her designee within a reasonable period of time.

9.1.2 Reportable Deaths

Reporting of deaths to the Medical Examiners Office shall be carried out when required by and in conformance with local law. See hospital specific policy for criteria for Medical Examiner referral. All hospital deaths are also reported to the organ procurement agency.

9.1.3 Death Certificate

The death certificate must be signed by the attending Physician, his or her associate, or another Physician, unless the death is a Medical Examiners case in which event the death certificate may be issued only by the Medical Examiner. When a reported case is declared "No Jurisdiction" or "Jurisdiction Terminated" by the Medical Examiner, the attending Physician issues the death certificate.

9.1.4 Release of the Body

The body may not be released until an entry has been made and signed in the deceased medical record by a Physician member of the medical staff, or his or her designee. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel or to police officers, except upon the receipt of an "Order to Release Body" form issued by the Medical Examiner. All other policies with respect to the release of dead bodies shall conform to local law.
9.2 **Autopsies**

It is the responsibility of every member of the medical staff to secure autopsies whenever indicated. Established criteria has been written when an autopsy needs to be performed. Proper consent for an autopsy shall be in accordance with applicable state law. All autopsies shall be performed by a hospital pathologist. The provisional anatomical diagnoses must be recorded on the medical record within 72 hours; and the complete protocol shall be part of the medical record within 60 days. These rules do not apply to cases which according to law must be referred to the Medical Examiner's Office.

10. **INFECTION CONTROL**

10.1 **General Authority**

The Infection & Prevention Control Committee has the authority to institute any appropriate control measure or study when there is reasonably felt to be a danger to patients or personnel from an infectious source.

11. **AMENDMENT**

These General Rules and Regulations of the Medical Staff may be amended or repealed, in whole or in part, by one of the following mechanisms:

(a) a resolution of the Executive Committee recommended to and adopted by the board

(b) action by the board on its own initiative

(c) updating is needed to comply with accreditation and regulatory standards.

12. **ADOPTION**

12.1 **Medical Staff**

These General Rules and Regulations were adopted and recommended to the Medical Staff by the Executive Committee on March 15, 2016.

12.2 **Governing Board**

These General Rules and Regulations were approved and adopted on behalf of the Governing Body by resolution of the Medical Staff on April 22, 2016, after considering the Executive Committee's recommendations.