# ST JOSEPH HOSPITAL CLINICAL RULES

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## RULE 1 ADMISSION OF PATIENTS

1.1 General

1.1.1 The Hospital shall accept patients for diagnostic and therapeutic care, except burn cases for whom suitable isolation cannot be maintained or adequate care given. The Hospital retains the right to decline to accept patients whose physical condition would pose a danger to staff or other patients, or for whom adequate care cannot be provided in the Hospital.

1.1.2 The Department Chair may contact the Attending Practitioner when questions arise as to whether a patient should be admitted, retained, or transferred.

1.1.3 Care shall be rendered in emergency situations based solely on the medical need of the patient and the ability of the Medical Staff to provide said care with the equipment, facilities and staff available. Every patient presenting to the Emergency Department for care must be medically screened and must be offered stabilizing medical treatment, regardless of the insurance or payment status of the patient for this visit. Private patients sent to the Emergency Department by their physicians must be screened and/or treated by either the private physician or by an Emergency Department physician.

1.1.4 Patients presenting to the Hospital who may be in active labor will be taken immediately to the Labor and Delivery Unit for medical screening and stabilizing treatment. Patients in active labor will not be transferred to another treating facility. Medical screening and stabilization treatment of patients in active labor will take place without regard for the insurance or payment status of the patient for this delivery.

1.1.5 Patients presenting to the Emergency Department with a psychiatric complaint will receive medical screening and appropriate medical and psychiatric stabilization treatment, up to and including an appropriate admission to the Behavioral Health Unit or transfer to a facility capable of treating the patient, without regard for the insurance or payment status of the patient. A patient with a psychiatric condition is stabilized when (a) the patient has been assessed by the treating physician and found to have no underlying organic basis for the presenting psychiatric symptoms that requires emergency care; (b) initial treatment has been provided as indicated; (c) the patient has been treated sufficiently to be medically stable for transfer to the Behavioral Health Unit with proper transfer precautions taken with patients who remain a threat to themselves or others at time of admission to the Behavioral Health Unit. Stabilization does not require resolution of an emergency psychiatric condition; rather, a patient must be sufficiently evaluated and treated so the patient does not pose a risk of immediate danger to himself/herself or others upon release.

1.1.6 Medical Screening Examinations: Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations within applicable Hospital policies and procedures and privileging are defined as:

1.1.6.1 members of the Medical Staff with clinical privileges to evaluate, diagnose and treat patients or history and physical privileges;

1.1.6.2 Residents and Fellows in formal approved training programs in the Hospital per approved training protocols and affiliation agreements; and

1.1.6.3 appropriately credentialed Advanced Practice Providers acting in accordance with Hospital policy and procedure and clinical privileges.

1.1.6.4 In Labor and Delivery: The Medical Staff of St. Joseph Hospital has adopted a standardized procedure to enable medical screening exams by registered nurses in Labor and Delivery. STP-935 ensures a uniform process for nursing to perform medical screening, examination and evaluation of the pregnant woman and her unborn child.

1.2 Procedure

1.2.1 Only Medical Staff members who have admitting privileges may admit patients to the Hospital. All Practitioners shall be governed by the Hospital's official admitting policy.

1.2.2 Medical Staff members may not admit, make entries in the medical record, perform procedures or otherwise provide medical care for themselves, an immediate relative or member of his/her household.

1.2.2.1 Immediate relative is defined from the Medicare Carriers Manual, section 2332 (husband and wife; natural or adoptive parent, child, and sibling; stepparent, step child, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild; and spouse or grandparent and grandchild).

1.2.3 Patients may be transferred out of the Emergency Department to another treating facility (e.g. hospital, nursing home, private physician office, etc.) only after medical screening and stabilization treatment. All such transfers from the Emergency Department will be governed by the Hospital's official transfer policy.

1.3 Responsibility

1.3.1 The admitting physician will be the patient's attending practitioner and shall be responsible for directing and supervising the patient's overall medical care, for completing or arranging for the completion of the medical history and physical examination within twenty-four hours after the patient is admitted or before surgery (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient's status to the patient, the referring Practitioner, if any, and to the patient's family.

1.3.2 Whenever these responsibilities are transferred to another Staff Member, a note covering the transfer of responsibility shall be entered in the medical record. It shall state the date responsibility is transferred. Alternatively, arrangements may be made in advance to designate that particular Staff Members shall have attending staff responsibility for patients depending upon their scheduled coverage time.

1.3.3 Any Medical Staff Member who cannot or will not assume all of the responsibilities of the Attending Practitioner shall admit patients only with another Medical Staff Member who can and will assume such responsibilities. (See also the Medical Staff Bylaws pertaining to podiatric and dental patient admissions).

1.4 Provisional Diagnosis

1.4.1 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been documented. In case of an emergency, such statement shall be recorded as soon as possible, no later than 24 hours after admission.

1.5 Patient Assessment

1.5.1 A Medical Staff member shall be responsible for each patient's medical care and treatment in the Hospital and for the initial medical assessment. The assessment shall provide information necessary to select the appropriate treatment and/or procedure and the optimal time; perform treatment and/or procedures safely and interpret findings of patient monitoring. Determining the appropriateness of care for each patient is based, in part, on a review of the patient's history; physical, emotional and functional status; diagnostic data, risks and benefits of the procedures; and the need to administer blood or blood components.

1.6 Psychiatric Precautions and Infection Admission Precautions

1.6.1 The Attending Practitioner, at the time the patient is admitted, shall inform the admitting staff and nursing staff if he or she suspects that the patient may be a danger to self or to others or has an infectious or contagious disease or condition. The Attending Practitioner shall recommend appropriate and approved precautionary measures to protect the patient and the staff, and shall document in the patient's record the reason for his or her suspicions, and the precautions taken to protect the patient and others.

1.6.2 In the event a patient presents at admission as a danger to him or herself or to others, the patient will be assessed for the appropriate level of protection (i.e. 1:1 by Security staff) if the patient's medical needs require admission to a general acute care service, or the availability of a secure room on the behavioral health unit after the patient is medical cleared for transfer will be arranged.

1.7 Emergency Admissions

1.7.1 When a patient who is not in the Emergency Department (or another part of the Hospital) requires admission to the Hospital for non-elective medical treatment, the Attending Practitioner shall, whenever possible, contact the Admitting Department and determine whether there is an available bed.

1.7.2 In all cases involving emergency admissions, the history and physical examination report must clearly justify the emergency admission.

1.7.3 Patients who require emergency admission and do not have an Attending Practitioner shall be assigned an Attending Practitioner in accordance with the "Call Panel" Rule.

1.8 Admission to Special Care Units

1.8.1 Practitioners admitting patients to the special care units shall abide by the special rules and regulations that apply to the care of patients in such units. (See the rules pertaining to the Special Care Units.)

1.8.2 Controversy regarding the discharge or admission of a patient to the critical care units shall be resolved by the attending physician consulting with the unit Medical Director.

1.9 Priority of Admissions and Transfers

1.9.1 When the Chief Executive Officer, after consulting with the Chief of Staff, determines that available bed space may be limited, admissions may be restricted to emergency cases. The attending physician will determine the state of the emergency. Patients will be admitted on the basis of the following order of priority:

1.9.1.1 First Priority - Emergency Admissions - i.e., patients who have serious medical problems and may suffer death, serious injury, or permanent disability if they are not admitted and provided treatment within four hours. The Chief of Staff, or designee, may require the attending physician to furnish, within twenty-four hours of the request, documentation of the need for the emergency admission. Failure to comply with such requests may be referred to the Medical Executive Committee for further action.

1.9.1.2 Second Priority - Urgent Admissions - i.e., patients who have serious medical problems who may suffer substantial injury to their health if they are not admitted and provided treatment within twenty-four hours. The Chief of Staff shall review and prioritize urgent admissions if all of the urgent patients cannot be accommodated.

1.9.1.3 Third Priority - Preoperative Admissions - i.e., patients who are already scheduled for surgery. The Chief of Staff shall review and prioritize preoperative admissions if all of these patients cannot be accommodated.

1.9.1.4 Fourth Priority - Routine Admissions - i.e., patients who will be admitted on an elective basis to any service.

1.9.2 Transfer Priorities

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

1.9.2.1 Emergency Department to an appropriate bed.

1.9.2.2 Medical-Surgical Care area to a Critical Care unit.

1.9.2.3 Critical Care units to a General Medical-Surgical or Telemetry Care area.

1.9.2.4 Temporary placement in an inappropriate area for that patient to an appropriate area, within state licensing regulations.

## RULE 2 CASE MANAGEMENT

2.1 General

2.1.1 The Medical Staff must support the Hospital's Case Management and Utilization Management programs. Medical Staff Members must promptly respond to and cooperate with requests from the Hospital's Case Management and Utilization Management staff. It is unacceptable to ignore or be unresponsive to Case Management and/or Utilization Management Staff.

2.1.2 The providers must abide and document in accordance with the Centers for Medicare and Medicaid Services (CMS) regulatory requirements and recommendations. The providers are using standardized order sets and physician documentation templates as guidelines to ensure appropriate treatment and documentation.

2.2 Documentation of Medical Necessity

2.2.1 Each Attending Practitioner must document the need for the patient's admission, for the use of intensive resources (such as critical care beds), and for continued hospitalization in accordance with criteria approved by the Medical Staff Quality and Safety Committee.

2.2.2 The documentation shall include:

2.2.2.1 An adequate legible written record of the reason for admission, use of intensive resources, and continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.

2.2.2.2 The estimated period of time the patient will need to remain in the Hospital.

2.2.2.3 Plans for post-Hospital care.

2.3 Justification for Continued Hospitalization

2.3.1 Upon appropriate request, each Medical Staff member is required to report to the Medical Staff Quality and Safety Committee any information that will justify the patient's need for continued hospitalization for acute care.

2.3.2 This information will include the rationale for continued stay and estimates of additional days needed for treatment.

2.3.3 The Case Management Plan sets forth the procedures to be followed.

## RULE 3 CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

3.1 Policy

3.1.1 Patients have the right to participate actively in decisions regarding their medical care and to decide whether to authorize or refuse procedures recommended by their Practitioners. Practitioners must give patients the information they need to make their decisions. Accordingly, diagnostic and therapeutic procedures may be performed only when the patient, or his or her surrogate decision-maker, has been given information about the procedure and has given consent. When the recommended procedure is complex (i.e., involves risks or complications that are not commonly understood), "informed consent" must be secured. (See Section 3.2 below.) Decisions to discontinue life-sustaining treatment raise special concerns, which are discussed in the "Discontinuing Life-Sustaining Treatment" Rule.

3.1.2 Surgical, special diagnostic or therapeutic procedures require consent by the patient or his or her surrogate decision-maker. This Rule outlines the basic requirements. Further information and forms are provided in the Consent Manual prepared by the California Healthcare Association. The Consent Manual is available in Administration, Medical Records, and the Nursing Office. Questions may be directed to the risk manager.

3.2 Informed Consent Defined

3.2.1 Informed consent is a process whereby the patient, or his or her surrogate decision-maker, is given information that will enable him or her to reach a meaningful, informed decision regarding whether to give consent.

3.2.2 The information that must be provided includes a description of:

3.2.2.1 The nature of the recommended treatment.

3.2.2.2 Its expected benefits or effects, including likelihood of success.

3.2.2.3 The associated risks and possible complications including potential problems related to recuperation.

3.2.2.4 Any alternative procedures and their expected benefits or effects and associated risks and possible complications and the alternative of not providing any curative treatment.

3.2.2.5 Any independent economic interests a Practitioner may have that influence his or her treatment recommendations.

3.3 Who May Give Consent

Informed consent must be secured from competent patients. If a patient is incompetent by reason of age or condition, consent must be secured from a surrogate decision-maker (i.e., parents or guardians of minors who may not consent, conservators, agents appointed pursuant to an advance healthcare directive or a durable power of attorney for health care, a surrogate decision-maker designated by the patient, the patient's closest available relatives, or the court). (The persons who may give consent are identified in the CHA Consent Manual.)

3.4 Responsibility for Securing Informed Consent

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

3.4.2 Practitioners other than the patient's Attending Practitioner may have a duty to secure consent when they will provide specialized services at the request of or together with the patient's attending. (Examples include special diagnostic or therapeutic radiology, nephrology, gastroenterology, pulmonary or anesthesia services.)

3.4.3 If two or more Practitioners will provide specialized services, responsibility for providing information in order to secure consent is divided as follows:

3.4.3.1 The patient's Attending Practitioner who recommended the procedure shall explain why he or she has advised performance of the special procedure and describe any alternative procedures and their expected benefits and associated risks and the alternative of not providing any curative treatment.

3.4.3.2 The Practitioner who will provide the specialized service (e.g., the radiology study or anesthesia) shall describe the nature of the procedure and its risks and associated complications.

3.4.3.3 After both Practitioners have discussed the proposed procedure, the patient or the surrogate decision-maker shall be asked for consent.

3.4.3.4 The referring Practitioner must tell the specialist who should give consent when a patient is incompetent and help arrange contact with a suitable surrogate decision-maker.

3.4.4 When surgery or other procedures are performed on an outpatient basis or on the same day as admission, the Practitioner who will perform the procedure must either meet the patient (or surrogate decision-maker) prior to the procedure and discuss it or verify that another Practitioner has fully explained the procedure and secured consent.

3.5 Emergencies

3.5.1 Consent may be implied in an emergency. An emergency occurs when treatment is immediately necessary to prevent the patient's death, severe impairment or deterioration, or to alleviate severe pain, and the patient is incompetent to give consent, or there is insufficient time to secure consent from the patient, or his or her surrogate decision-maker.

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

3.5.3 In the case of an emergency (as defined above), treatment may proceed without the patient’s consent, if the patient or his or her legal representative is unable to give consent.

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

3.6 Particular Legal Requirements

3.6.1 Consent for blood transfusions, hysterectomies and other procedures that result in sterilization, use of investigational drugs or devices, participation in human experimentation, reuse of hemodialysis filters, treatment for breast or prostate cancer, use of psychotropic medications, electroconvulsive therapy, and involuntary commitment for psychiatric disorders must be secured in the manner specified in the laws applicable to these particular procedures. The laws are described in the CHA Consent Manual.

3.6.1.1 Psychotropic medications raise special concerns, even in general medical care units including the need for a Riese Hearing to administer psychotropic medications without the patient's consent for an involuntary psychiatric patient.

3.6.1.2 Practitioners must secure informed consent for anti-psychotic medications, and document that the patient gave consent in writing. Preferably, the patient shall sign the form acknowledging informed consent was given, but a physician note documenting the discussion may suffice if the patient is not admitted to the licensed psychiatric unit.

3.6.2 Special requirements for consent also apply to discontinuing life-sustaining treatment. (See the "Discontinuing Life-Sustaining Treatment" Rule.)

3.6.3 The Attending Practitioner shall assure that consent for the special procedure is secured in the manner required by law, and that required forms, waiting periods, and certifications have been completed.

3.7 Documentation

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

3.7.1.1 Such documentation should describe any special or unique concerns of or related to the patient.

3.7.1.2 The documentation should indicate why a person was selected as a surrogate decision-maker for a patient who is incompetent.

3.7.2 The Practitioner's documentation for emergencies (see point 3.5 above), which may consist of a progress note or completion of the "Emergency Consent" form, must describe:

3.7.2.1 The nature of the emergency.

3.7.2.2 The reasons consent could not be secured from the patient or a surrogate decision-maker.

3.7.2.3 The probable result if treatment would have been delayed or not provided.

3.8 Verifying Consent

The Hospital staff is responsible for verifying that consent has been given.

3.9 Hospital Staff Role in Providing Information

Hospital staff may not provide patients or surrogate decision-makers with medical information to secure consent. If a patient or surrogate decision-maker expresses doubt or confusion about a procedure, the physician shall be contacted so he or she can provide the necessary information.

3.10 Consent by Telephone

3.10.1 Consent by telephone may be acceptable in certain situations. The risk manager should be contacted if there is a question about using the phone to discuss the case and secure consent.

3.10.2 When the telephone is used to obtain consent from a surrogate decision-maker, the information normally given to secure informed consent must be given. Thus, the condition of the patient and the proposed medical and/or surgical treatment must be explained. Inquiries concerning the procedure should be answered only by the Practitioner, or his or her designee.

3.10.3 When consent is obtained by telephone, a Hospital employee should join the conversation to listen and act as a witness. All persons joining the call must be informed that a Hospital employee will be listening to the discussion.

3.10.4 The Practitioner shall document the exact time, nature and any limitation of the consent in the medical record. The witness shall countersign and date this documentation.

3.10.5 The Practitioner should instruct the surrogate decision-maker immediately to send a facsimile, e-mail, or letter confirming the telephone consent. If possible, a copy of the consent form should be sent and returned (signed), by facsimile. At a minimum, the written documentation should name the person giving the consent, describe his or her relationship to the patient and confirm that consent was given for treatment. The facsimile, a hard copy of the e-mail, or the letter should be placed in the medical record.

3.11 Refusal of Treatment

3.11.1 A patient or the patient's surrogate decision-maker has the right to refuse treatment. If the patient is a minor who is not legally authorized to consent to treatment and his or her parent or guardian refuses consent, it may be desirable and possible to secure court authorization.

3.11.2 If a patient or the patient's surrogate decision-maker refuses treatment, the Attending Practitioner shall be contacted immediately and shall explain the reason for the treatment and the possible ill effects of refusal. The Attending Practitioner shall document a brief note in the patient's medical record regarding the initial refusal and whether the outcome was consent or continued refusal.

3.11.3 The Refusal of Treatment form should be presented to the patient or the surrogate decision-maker for signature. If the patient or surrogate decision-maker refuses to sign, the notation “refuses to sign” shall be made at the place for the signature.

3.11.4 If treatment is ultimately refused, an Incident Report or Quality Improvement form shall be completed and forwarded to Quality Review along with the appropriate Refusal of Treatment form.

3.11.5 See also the "Discharge of Patients" Rule, the section on leaving against medical advice, and the "Discontinuing Life-Sustaining Treatment" Rule.

## RULE 4 CONSULTATIONS

4.1 General

4.1.1 The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the seriousness of the illness and the resolution of any doubt regarding the diagnosis or treatment rests with the Practitioner responsible for the care of the patient. On the other hand, it is the duty of the organized Medical Staff, through the Department Chairmen and the Executive Committee, to see that those practitioners practicing in the Hospital do not fail to call consultants as needed and that consultants do not fail to respond to consults.

4.1.2 Any qualified Practitioner who has Privileges in this Hospital can be called for consultation within his or her area of expertise and within the limits of the Privileges that have been granted to him or her.

4.2 Requests for Consultations

Requests for consultation should be made by direct personal HIPAA compliant communication from the Attending Practitioner to the consulting Practitioner, with a required response. Hospital nurses or other employees are not to be used as intermediaries.

4.3 Patient Notice

The patient or the patient's surrogate decision-maker must be advised of the requested consultations and the name of the consulting physician by the attending physician

4.4 Recommended Consultations

Except in an emergency, consultation is recommended in the following instances:

4.4.1 High risk surgical patients.

4.4.2 Obscure diagnosis after completion of ordinary diagnostic procedures.

4.4.3 Substantial doubt concerning the choice of therapeutic measures to be used.

4.4.4 Need for specific skills the patient's physician does not have.

4.4.5 Patient exhibiting severe psychiatric symptoms or patients who are not exhibiting psychiatric symptoms but are on a 5150 72-hour hold and by law will require an assessment by a psychiatrist before they can be released from the hold and discharged from the Hospital.

4.4.6 Drug or chemical overdose or suspected or attempted suicide.

4.4.7 Pelvic surgery for a patient who is pregnant.

4.4.8 A request from the patient or his family.

4.4.9 Specific requirements from Department Rules.

4.4.10 Ethical dilemma consultation for cases in which there is an unresolved ethical dilemma or withdrawal and/or 'do not resuscitate' decisions are made involving an incompetent patient without a surrogate decision-maker.

4.5 Requested or Required Consultations

4.5.1 A consultation may be requested when the Department Chair or Chief of Staff determines that a patient will benefit from such consultation.

4.5.2 If a nurse has any reason to doubt or question the care provided any patient or believes that consultation is needed and has not been obtained, the nurse should discuss the issue(s) with the patient's attending physician first, and may call this to the attention of his or her supervisor, who in turn may refer the matter to the Department Chair. The Department Chair may then, in appropriate circumstances, request a consultation, after conferring with the patient's Attending Practitioner.

4.5.3 A Medical Staff Member may be required to have consultations on all or some of his or her cases. In such situations, the Member shall be responsible for informing the assigned consultants of each admission and for arranging for timely consultations.

4.6 Performance of and Reporting of Consultations

4.6.1 In an emergency, no more than one hour should lapse before a consultation is effected. In non-emergent cases, no more than 18 hours should lapse before a consultation is effected (reference Rule 9.2.1).

4.6.2 The consultation and specific diagnostic and therapeutic procedures will be done at the Hospital unless specific diagnostic or therapeutic facilities are not provided within the confines of the Hospital. Any outside sources used for inpatients must be approved by the Medical Staff and must meet accreditation standards.

4.6.3 An Attending Practitioner's responsibility for his or her patient does not end with a request for a consultation.

4.6.4 If a staff member is quoted in the patient's medical record as a consultant, a formal report of the opinion prepared by the consultant must be made a part of the patient's record and placed within 24 hours of consultation request.

4.6.5 A satisfactory consultation within 18 hours includes completing a pertinent history and physical examination and a review of pertinent portions of the record. When requesting a consultation, the attending physician is responsible for noting the consultation request in the medical record and supplying the consultant with all available and relevant information regarding the patient and the need for the consultation.

4.6.6 An opinion signed by the consultant must be included in the patient's medical record within 24 hours. When operative procedures are involved, consultations performed prior to surgery shall be documented before the operation, except in emergency cases. Consultations shall be prepared in accordance with the standards set forth in the rules regarding Medical Records.

4.6.7 Consulting providers must document in the medical record when their consultation services have been completed and communicate this directly with the attending physician.

## RULE 5 COVERAGE

5.1 General

5.1.1 Each Practitioner shall arrange coverage for each of his or her patients in the Hospital.

5.1.2 The person who will provide coverage must be a member of the Medical Staff and must be available for patients in the Hospital or who may present at the Emergency Department.

5.1.2.1 Physician Assistants and Nurse Practitioners may triage calls for the sponsoring physicians.

5.1.2.2 The responsible physician is required to be immediately available by phone and in person if necessary for emergency situations (emergency as perceived by the caller).

5.1.3 The Attending Practitioner is responsible for informing the Practitioner who will provide coverage about his or her schedule and for assuring that Practitioner will be available and qualified to assume responsibility for the patients during the Attending Practitioner's absence and is aware of the status and condition of each patient he or she is to cover.

5.2 Arranging Interim Coverage

If a Practitioner is unavailable and has no available coverage, the Department Chair or Chief of Staff must be contacted and may ask a qualified Department Member to provide coverage until the Practitioner can be reached.

## RULE 6 DEATHS

6.1 Pronouncement of Death

6.1.1 If a patient arrives at the Hospital dead or dies in the Hospital, a physician or Registered Nurse (RN) shall pronounce the patient dead within a reasonable time. The patient's remains may not be released until the physician/RN has made an authenticated entry of the pronouncement of death in the patient's medical record. Registered Nurses may pronounce death with a physician's order as they are educated to the process in orientation and the process is revisited occasionally through inservice.

6.1.2 If the patient has suffered "brain death" (i.e., the total and irreversible cessation of all functions of the entire brain, including the brain stem), death may be pronounced only after a second, independent physician has confirmed the "brain death" and both physicians have documented their findings supporting the determination of "brain death" in the patient's medical record.

6.1.3 The patient's family must be informed of the patient's death.

6.1.4 Medical treatment shall be continued only if the family contests the accuracy of the diagnosis.

6.1.5 Contested cases shall be referred to Administration for review before further action is taken.

6.2 Autopsies

6.2.1 Staff Members shall attempt to secure consent to meaningful autopsies for inpatients at St. Joseph Hospital.

6.2.2 The College of American Pathologists (CAP) suggests that an autopsy be conducted in all instances in which the cause of death is unclear. The following are general recommendations on when to consider an autopsy:

6.2.2.1 Deaths where there is no adequate clinical explanation.

6.2.2.2 Cancer patients in whom there is not prior tissue diagnosis or the source of the primary is unknown.

6.2.2.3 Patients dying of internal bleeding not identified as to source.

6.2.2.4 Deaths where there is no adequate clinical explanation.

6.2.2.5 Patients who have participated in clinical trials (protocols approved by the institutional review board)

6.2.2.6 Transplant patients.

6.2.2.7 Patients with infections of undetermined type and/or source.

6.2.2.8 All obstetric deaths.

6.2.2.9 All perinatal and pediatric deaths.

6.2.2.10 Deaths occurring at any age in which it is believed that an autopsy would disclose a known or suspected disease which also may have a bearing on survivors .

6.2.2.11 Patients with suspected environmental exposure or occupational exposure.

6.2.2.12 Death in which there is a known or suspected congenital malformation, genetic disease, syndrome or undefined metabolic disease.

6.2.3 An autopsy may be performed only if authorized in accordance with law. (The persons who may consent to autopsies are identified in the CHA Consent Manual.)

6.2.4 Except in coroner cases, all autopsies shall be performed by the Hospital pathologist or his or her designee. Provisional anatomic diagnoses shall be documented on the medical record by the pathologist within 24 hours (excepting weekends and holidays) after completion of the autopsy. The complete protocol should be made a part of the record within 60 days. Exceptions may be made when consultation on an autopsy precludes prompt completion.

6.2.5 Hospital Pathologists shall evaluate the risk and benefits of autopsies based on the Pathology Department Rules.

6.3 Coroner's Cases

6.3.1 A physician and surgeon shall immediately notify the coroner when he or she has knowledge of a death that occurred or has charge of a body in which death occurred under any of the following circumstances:

6.3.1.1 Without medical attendance, this includes all deaths outside of hospitals or skilled nursing facilities.

6.3.1.2 Wherein the deceased had not been attended by a physician in the 20 days prior to death.

6.3.1.3 The attending physician is unable to render a reasonable opinion as to the cause of death.

6.3.1.4 When homicide is known or suspected.

6.3.1.5 When suicide is known or suspected.

6.3.1.6 When a criminal action is involved or suspected to be involved in the death.

6.3.1.7 Related to, or following known or suspected self-induced or criminal abortion.

6.3.1.8 Associated with a known or alleged rape.

6.3.1.9 Known or suspected as resulting in whole or in part from an accident or injury, either old or recent.

6.3.1.10 When aspiration, starvation, exposure, drug addition or acute alcoholism is the known or suspected cause.

6.3.1.11 When poisoning is known or suspected.

6.3.1.12 When occupational disease or hazards are the known or suspected cause.

6.3.1.13 When a contagious disease is the known or suspected cause.

6.3.1.14 When death occurred while in-custody of a law enforcement agency or while in prison.

6.3.1.15 All deaths of State Hospital patients.

6.3.1.16 All Sudden Infant Death Syndrome (SIDS) deaths.

6.3.1.17 Deaths during or related to surgery or surgical procedures, or following a surgery or surgical procedure if the deceased did not awake from the anesthetic.

6.3.2 The coroner also asks for reports of deaths due to drug addiction, pneumoconiosis and therapeutic misadventures as well as deaths during or within 24 hours after operations.

6.4 Notifying the Next of Kin

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

6.5 Disposition of Remains and Contributions of Anatomical Gifts

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

6.5.2 The patient's attending physician, or hospital staff acting at his direction, shall be responsible for asking the patient or the patient's legal representative whether they wish to make an anatomical gift and for informing them regarding the procedure for making such gifts.

6.5.3 If the patient or his or her family indicates that the patient has or will contribute anatomical gifts, consent shall be secured in accordance with the relevant law, which is described in the CHA Consent Manual.

6.6 Death Certificate

The Attending Practitioner or other physician last in attendance is responsible for signing the death certificate or ensuring its completion. The attending physician may designate another physician who have access to the patient's medical record to complete the death certificate provided the designated physician acts in consultation with the attending physician.

## RULE 7 DISCHARGE OF PATIENTS

7.1 General

7.1.1 Patients shall be discharged only on the order of the Attending Practitioner, or his or her designee, or by a Hospital Staff member acting pursuant to an approved standardized procedure.

7.1.2 The attending practitioner should make every attempt to discharge the patient by 11:00 a.m. on the day of discharge.

7.1.3 The Attending Practitioner should inform the Nursing Service of possible discharges as early as possible and enlist the aid of the Case Manager when appropriate.

7.1.4 Discharge planning is defined as any activity or set of activities which facilitate the transition of the patient from one environment to another. The complexity of discharge plans varies and may be describe by four levels of outcome:

7.1.4.1 Patient and family understanding of the diagnosis, anticipated level of functioning, discharge medications, and anticipated medical follow-up;

7.1.4.2 Specialized instructions or training so that the patient or family can provide post-hospital care;

7.1.4.3 Coordination of community support systems which enable the patient to return home;

7.1.4.4 Relocation of the patient and coordination of support systems or transfer to another health care facility.

7.1.5 The discharge summary must be completed within 14 days after the patient's discharge.

7.2 Leaving Against Medical Advice (AMA)

7.2.1 If a patient indicates that he or she will leave the Hospital without a discharge order from the Attending Practitioner, the nursing staff shall attempt to arrange for the patient or the patient’s surrogate decision-maker to discuss his or her plan with the Attending Practitioner before the patient leaves. If the patient is on a psychiatric hold (5150 or 5250) the patient can not be released AMA from any unit in the Hospital or from the ED without the hold being released by a staff psychiatrist after a face-to-face evaluation.

7.2.2 Whenever possible, the Attending Practitioner shall discuss with the patient or the patient’s surrogate decision-maker the implications of leaving the Hospital against medical advice.

7.2.3 The patient who insists on leaving AMA shall be asked to sign (or have the surrogate decision-maker sign) the form “Leaving Against Medical Advice.” If the patient or the patient’s surrogate decision-maker refuses to sign the form, or cannot be located, the nursing staff shall document in the patient's record the facts surrounding the patient's departure.

7.3 Refusal to Leave

The Administration shall be contacted for assistance whenever a patient refuses to leave the Hospital.

## RULE 8 DISCONTINUING LIFE-SUSTAINING TREATMENT

8.1 General

8.1.1 Decisions to withhold or withdraw medical care must be handled carefully. The effect upon the patient, and the patient's family, friends, significant others, and members of the health care team should be kept in mind.

8.1.2 The decisions are to be made by the patient or his or her surrogate decision-maker, in consultation with the patient's inpatient or outpatient treating physician or Nurse Practitioner. The inpatient or outpatient treating physician or Nurse Practitioner is responsible for providing medical information/recommendations about when medical care should be withheld or withdrawn.

8.2 Guidelines for Decisions

8.2.1 Whether life-sustaining care should be continued or started depends upon whether the treatment is “proportionate” or “disproportionate.” This framework applies to all patient conditions and all possible treatments or interventions.

8.2.2 Whether a treatment is proportionate or disproportionate depends on an assessment of the treatment's expected benefits versus the burdens it may cause. The unique facts of each case must be considered. The relevant considerations include:

8.2.2.1 How long the treatment is likely to extend life and whether it can improve the patient's prognosis for recovery.

8.2.2.2 What the nature of the patient's additional life may be, and specifically what are the possibilities of a return to a cognitive life and of a remission of symptoms enabling a return towards a normal, functioning integrated existence.

8.2.2.3 What is the degree of intrusiveness, risk, and discomfort associated with the treatment.

8.2.3 There is no legal distinction between withholding or withdrawing medical care. Clinical conditions and perspectives may change and it may become proper to withdraw care that was previously initiated. Always time should be taken to confirm the medical diagnosis and prognosis and for review prior to making the irrevocable decisions to terminate life-sustaining treatment.

8.2.4 All medical treatment may be withheld or withdrawn, except any medical procedure deemed necessary to alleviate pain. Further guidance is provided in the Hospital policy for special considerations pertaining to artificial feeding, irreversible comas, persistent vegetative states and cardiopulmonary resuscitation.

8.2.5 No Cardiopulmonary Resuscitation Orders [to stop the otherwise automatic initiation of cardiopulmonary resuscitation (CPR)] may be proper when the patient has an underlying incurable medical condition, does not have any reasonably conceivable possibility of recovering or long term survival, and there is no medical justification or purpose which would be achieved by applying cardiopulmonary resuscitation should the natural course of a patient's medical condition cause vital functions to fail. CPR may also be found disproportionate if the patient has a serious, life-threatening illness.

8.3 Procedure for Issuing Orders

8.3.1 Who Must Be Consulted

8.3.1.1 The treating inpatient or outpatient treating physician or Nurse Practitioner and consulting physician (if any) shall be responsible for determining the patient's prognoses and diagnoses. The physicians or Nurse Practitioner must identify, to the extent possible, the patient's clinical and physiological/ neurological diagnosis, the expected course of the patient's condition, and the risks and possible complications of treatments that can be provided, as well as their potential benefits.

8.3.1.2 The inpatient or outpatient treating physician/Nurse Practitioner is responsible for providing this information to the patient, or the patient's surrogate decision-maker, to enable him or her to evaluate a treatment's benefits and burdens. Confirmation of a treating physician's determinations is not required, although a physician or Nurse Practitioner may choose to secure a second opinion or to consult with the Medical Director of the Critical Care Unit.

8.3.1.3 With children, almost always the parents or another proper surrogate decision-maker must make the decision. The patient may decide, however, if he or she is competent, (i.e., 18 years or older or a minor otherwise entitled to make decisions, and able to understand the decision). The Hospital policy provides further guidance regarding who may make the decisions when questions or disputes arise.

8.3.1.4 Unless the patient has directed otherwise, the patient's immediate family and significant others shall be consulted, and their wishes should be given very great weight in arriving at the decision. The patient's desires, if known, should guide the decisions.

8.3.1.5 Orders to withhold or withdraw CPR and other forms of life-sustaining treatment when there are no surrogate decision-makers who can act on behalf of the patient may be proper in some cases. The patient's Attending Practitioner may consult with the Ethics Committee, an ethicist or the Hospital's risk manager about the proposed order, at his or her discretion.

8.3.2 Issuing the Order

All orders to withhold or withdraw life-sustaining treatment must be entered or written and signed by a physician or Nurse Practitioner on the DNAR/physician order set in the patient’s medical record. The physician or Nurse Practitioner also must orally inform the nursing staff that such an order has been given to assure that the order is known and understood at the time it is documented.

8.3.3 Do Not Attempt Resuscitate (DNAR) Orders

Cardiopulmonary resuscitation (CPR) will be initiated when cardiac or respiratory arrest is recognized, unless a No-CPR or DNAR Order is given. No resuscitative measures will be taken if the physician or Nurse Practitioner documented into the medical record “No-CPR,” “No Code” or “Do Not Resuscitate.”

8.3.4 Reviewing Other Treatments

The physician or Nurse Practitioner should assess whether to continue other treatments the patient is receiving, such as routine laboratory testing, antibiotics, use of a ventilator and other treatments. It can be proper to discontinue some, but not all life-sustaining medical treatment.

8.3.5 Documentation

The orders to withhold or withdraw life-sustaining treatment must be supported by complete documentation in the MD DNAR documentation form/progress notes of all the circumstances surrounding the decision. The notes should summarize the medical situation and the patient's diagnosis and prognosis; the outcome of any consultations with other physicians; if the patient has capacity to make decisions, an Advanced Directive and identify who are the decision-makers and document who the physician or Nurse Practitioner has consulted (the patient or the surrogate) and describe the information they were given and state their decision.

8.3.6 Maintaining Comfort

Every necessary procedure should be performed to relieve the patient's suffering and to maintain the patient's comfort, hygiene and intrinsic human dignity.

8.4 Dispute Resolution

If a dispute arises concerning the issuance of an order to withhold or withdraw treatment, the matter may be referred to the Ethics Resource Team for review. Until the dispute is resolved, life-sustaining treatment should be provided and disputed DNAR Orders, if any, suspended. Any concerned person involved in the patient’s care may request an Ethics consult. (More complete guidance is provided in the Hospital Policy Ethics: Access to Consultation and Resolution of Dilemmas RI-009.)

## RULE 9 MEDICAL RECORDS

9.1 General

9.1.1 The patient's hospital medical record serves a multitude of purposes, including those relating to primary patient care, continuity of patient care, quality improvement, medical research, and business documentation. Medical Records must be maintained for all patients who receive treatment at the Hospital, including inpatients, outpatients, and emergency patients.

9.1.2 Although the primary purpose of the medical record is to serve the interests of the individual patient, it also serves as the basis for quality improvement and utilization review activities. In addition, it may be used in connection with legal investigations, and thus serves a medico-legal function.

9.1.3 Medical Records must be maintained for all patients who receive treatment at the Hospital, including inpatients, outpatients, and emergency patients.

9.1.4 Use of the electronic medical record system is the standard of practice at St. Joseph Hospital. All members of the Medical Staff who care for patients in the hospital are required to receive training on the electronic medical record system and demonstrate a basic competency in order to receive login information and passwords. This will include mandatory training updates as new functionality is added to the system. Physicians who have not been trained on the system will not be allowed to practice at the institution until this training is complete. A signed agreement to use the electronic medical record system will be included in the credentialing process for new physicians, as well as those applying for reappointment. These agreements will be renewed biennially. Practitioners who fail to comply with the requirement to utilize the electronic medical record will be subject to disciplinary action which may include suspension of Medical Staff privileges and membership.

9.2 Responsibility for the Record

The patient's Attending Practitioner and each Practitioner involved in the care of the patient shall be responsible for preparing a complete and legible medical record for each patient.

9.3 Completion of the Record

9.3.1 Timely Completion

9.3.1.1 Entries should be made as soon as possible after clinical events occur, to ensure accuracy and to provide information relevant to the patient's continuing care. Verbal orders must be countersigned by the Practitioner who issued the order or a covering Practitioner within the same time periods established in the Medical Staff Rules. (See the "Orders" Rule.)

9.3.1.2 Medical records must be completed promptly and all reports must be authenticated, by a Practitioner within 14 days following the inpatient patient's discharge or completion of an outpatient service.

9.3.1.3 If a patient's record remains incomplete 14 days after discharge, it will be considered delinquent. Any Practitioner who fails to complete his or her medical records may be automatically suspended after the notices have been given as described in the Corrective Action Rule on automatic suspensions for failure to complete medical records.

9.3.1.4 A medical record shall not be permanently filed until it is completed by the responsible Attending Practitioner or is ordered filed by the Quality Enhancement Committee Chair or his or her designee. The Quality & Safety Committee of the Medical Staff Chair or his or her designee may authorize the Director of Medical Records to retire charts under the following circumstances: when the Practitioner is deceased; has moved from the area; has resigned from the Medical Staff; or is on an extended leave of absence. The Chair or his or her designee must sign and date a cover letter for the chart, stating the reason for retirement.

9.3.1.5 Practitioners rendering care to Hospital patients shall come to the Medical Records area to complete the records at timely intervals to maintain records to satisfy the Hospital licensure requirements. The Medical Records Administrator shall maintain a current and daily updated list of incomplete medical records for each member's of the Medical Staff and make those records promptly available for completion to each practitioner upon reasonable request.

9.3.2 Authentication

The author of each entry made in the medical record shall be identified. History and physical examination reports, operative reports, consultation reports (excluding routine pathology and radiology reports), and discharge summaries must be authenticated. Authentication may be completed by a signature, signature sent by fax or signature affixed by computer key. When the document is authenticated, the date and time of the authentication shall be noted. Electronic signatures will be accepted only when the Practitioner has placed a signed statement in Medical Records confirming he or she is the only person who has possession of or access to the password for the electronic signature and will use it.

9.3.3 Correction of the Medical Record

If an entry in a paper medical record must be corrected, the person shall line out the incorrect data with a single line in ink, leaving the original writing legible. The person shall note the reason for the change, the date of striking, and sign the note. Appropriate cross-referencing shall be placed in the record when necessary to explain the correction. The correction shall never involve erasure or obliteration of the material that is corrected. In addition, the dictating Practitioner must fill in all blanks left in dictated reports at the time the report is authenticated. Any cross-outs with or without reentries in the report should be noted as "error," dated, and initialed.

9.3.4 Dating and Timing of Entries

Each entry that is made in the medical record shall be dated and timed. The date and time (if any) shall be the date and time that the entry is made, regardless of whether the contents of the note relate to a previous date or time.

9.4 Contents

9.4.1 General

Each medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among healthcare providers. Medical Records shall be organized to allow a subsequent treating Practitioner or other health care provider to understand the patient's history and to provide effective care. The contents of the record must be legible in order to be useful. The medical record must be accurate; consequently, only those who are familiar with the patient's case will be allowed to make entries in the record.

9.4.2 Inpatient Medical Records

The inpatient medical record shall include the following elements:

9.4.2.1 Identification Sheets

The identification sheets (“face sheets”) shall include patient identifying and demographic information. When a patient is transferred to a different service or Practitioner, the face sheet and patient identification card shall be updated.

9.4.2.2 Admitting Note

An admitting note must be documented in the progress notes on admission. The only exceptions are when the Practitioner already has a history and physical examination report in the medical record prior to surgery. The Admitting Note shall include an initial diagnostic impression (i.e., a concise statement of the complaints which led the patient to consult with the Practitioner), and a provisional diagnosis (i.e., the impression reflecting the examining Practitioner's evaluation of the patient's condition based upon the physical findings and history).

9.4.2.3 History and Physical Examination Report

9.4.2.3.1 The H&P shall consist of a chief complaint, history of present illness, allergies and medications, relevant social and family history, past medical history, physical examination, and assessment and plan appropriate to the patient’s age and condition.

9.4.2.3.2 When a physician delegates a H&P to another member of the medical staff or a non-staff physician, the attending physician must still have a pre-operative or pre-procedure note on the chart outlining the pertinent history, examination, studies, and justification for planned surgery or procedure.

9.4.2.3.3 If a complete H&P was performed within 30 calendar days prior to the patient's admission to the Hospital, a reasonably durable, legible copy of the report may be used in the patient's medical record in lieu of the admission H&P, and he or she updates the information within 24 hours of admission.

9.4.2.4 Consultation Reports

Consultation requests should be documented in the chart. Consultants should provide a written opinion that they authenticate, including findings on physical examination of the patient or of other data and information. (See also the "Consultations" Rule.)

9.4.2.5 Orders/CPOE Order Sets

Medication treatments and physician orders shall be entered on the order sheet/CPOE (see also “Orders” rule)

9.4.2.6 Progress Notes

Progress notes shall be documented at least daily, and more often when warranted by the patient's condition. The progress notes shall give a chronological picture of the patient's progress, and be sufficient to permit continuity of care and transferability. The progress note shall delineate the course and results of treatment.
Progress notes for patients admitted to the Rush Center or Family Recovery Services need not be documented daily but should be entered as frequently as needed to document the patient's condition and comply with those units’ Policies and Procedures.

9.4.2.7 Operative Reports

The operative reports shall include the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, estimated blood loss, and post-operative diagnosis.
All operative reports must be dictated immediately following surgery. The surgeon shall also enter a post-operative note that includes at least the minimum comparable operative report information in the progress notes immediately following surgery. (“Immediately following surgery” means upon completion of surgery, before the patient is transferred to the next level of care, for example, the post anesthesia unit.) The surgeon shall authenticate the post-operative note and dictated report.

9.4.2.8 Cancer Staging

All newly diagnosed cancer malignancies must be staged according to the Tumor, Nodes and Metastases (TNM) scheme of the American Joint Committee on Cancer. The managing or treating physician is responsible for the cancer staging and for completing the Hospital’s cancer staging form.

9.4.2.9 Nursing and Ancillary Notes

Notes and reports from the nursing, ancillary and support staff and services involved in the patient's care shall be included in the patient record.

9.4.2.10 Outside Tests Results

Records of any laboratory, radiographic, or other diagnostic reports from outside laboratories or other facilities which include results pertinent to the patient's current hospitalization shall be included in the medical record.

9.4.2.11 Obstetric Records

Obstetrical records shall include prenatal information. A durable legible original or reproduction of the office prenatal record is acceptable.

9.4.2.12 Consent Forms. (See the "Consent for Medical and Surgical Procedures" Rule.)

9.4.2.13 Restraints.

Restraints shall be used only when alternative methods are not sufficient to protect the patient or others from injury. A Practitioner's order must be obtained for each use of restraints. The order may be given electronically, in writing, or verbally. It must be time-limited and should include the reason for restraint and the type of restraint to be used. If nursing services staff initiate the restraints, an order for the restraints must be obtained electronically, in writing or verbally as soon as possible. Any verbal orders given for restraints must be countersigned by the Practitioner (or his or her covering Practitioner) on the next visit. Restraints used for behavior management are subject to stricter review, as provided in the Hospital policy. The time within which the patient’s physician must see the patient is established in the Hospital policy. The maximum time restraints may be continuously used is established by hospital policy, as are the requirements for periodic observation of the patient, including a maximum time between observations.

9.4.2.14 Discharge Summary

The discharge summary shall briefly recapitulate the significant findings and events of the patient's hospitalization, describe his or her condition on discharge, justify the patient's admission and the treatment provided, and identify the recommendations and arrangements for follow-up care, including discharge medications, dietary and activities advice. The discharge summary shall be documented by the responsible Practitioner or his or her designee and authenticated by the responsible Practitioner within 14 days after the patient's discharge. If the patient was hospitalized for less than 48 hours for minor ailments, a short form discharge summary may be used.

9.4.2.15 Final Diagnosis

The discharge summary shall include a final diagnosis. It shall be recorded in full without the use of symbols or abbreviations.

9.4.3 Outpatient Records

Each outpatient record (including outpatient surgery records) shall include the following elements:

9.4.3.1 Identification sheet.

9.4.3.2 A record of the patient's medical history, (including, for pediatric patients, immunization record, screening tests, allergy records, and a neonatal history) and a physical examination report. The History and Physical Examination report is required only for outpatients who will have procedures and surgery done while under anesthesia (general or local) excluding radiologic procedures under straight local anesthesia. The H and P is also required for radiation oncology services.

9.4.3.3 For patients receiving continuing ambulatory care services, a summary of known significant diagnoses, conditions, procedures, drug allergies, and medications.

9.4.3.4 Consultation reports.

9.4.3.5 Clinical notes, including the dates of visits.

9.4.3.6 A record of treatment and instructions, including notation of any prescriptions written, diet instructions, if applicable, and self-care instructions.

9.4.3.7 Reports of all ancillary services, including laboratory tests, pathology reports, if tissue or body fluid was removed, and X-ray examinations.

9.4.3.8 If an operation was performed, an operative report must meet the requirements of paragraph 9.4.2.7.

9.4.3.9 Referral information from other providers.

9.4.3.10 Consent forms. (See the "Consent for Medical and Surgical Procedures" Rule.)

9.4.4 Emergency Records

A record shall be kept for each patient receiving emergency services, which shall be incorporated in the patient's Hospital and outpatient record and shall include at least the following information:

9.4.4.1 Adequate patient identification.

9.4.4.2 Information concerning the patient's time of arrival, means of arrival, and by whom transported.

9.4.4.3 Pertinent history of the injury or illness, including details regarding first aid or emergency care given the patient prior to his or her arrival at the Hospital.

9.4.4.4 A description of significant clinical, laboratory and radiology findings.

9.4.4.5 Diagnosis.

9.4.4.6 A description of the treatment provided.

9.4.4.7 The condition of the patient upon discharge or transfer.

9.4.4.8 Final disposition, including instructions given to the patient and/or his or her family, relative to follow-up care.

9.4.4.9 The signature of the Practitioner in attendance who is responsible for the patient's treatment and for the clinical accuracy of the record.

9.5 Availability of Records

9.5.1 Medical Records shall be maintained safely by the Hospital. Each Practitioner shall respect the confidentiality of physician-patient communications, information obtained in the course of diagnosing and treating patients, and in medical records.

9.5.2 Medical Records may be removed from the Hospital only in accordance with a court order, subpoena, patient authorization or other authorization as allowed by California and federal law, including the laws the provide special protection for records pertaining to treatment for mental illness and alcohol or drug abuse. All medical records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer.

9.5.3 Patients requesting access to their own medical records shall be referred to their attending Practitioner and to the Medical Records Administrator, who will grant the patient access, through a copy, inspection, or a summary, in accordance with the state and federal laws governing patients' access to records.

9.5.4 Unauthorized removal of charts from the Hospital is grounds for corrective action against the Practitioner.

9.5.5 Medical Records may be reviewed by Medical Staff officers and committees which are responsible for carrying out quality improvement and peer review functions so long as all disclosures comply with state and federal laws.

9.5.6 All forms to be incorporated in the medical record require the approval of the Quality & Safety Committee of the Medical Staff.

## RULE 10 MEDICATIONS

10.1 General

10.1.1 The medical staff will abide by the hospital policies & procedures that govern medication and medication therapy if previously approved by the hospital, Pharmacy & Therapeutics Committee and the MEC.

10.1.2 The Medical Staff has granted authority upon receipt of a physician order authority for pharmacists to follow a drug regimen or order routine drug therapy-related laboratory tests for a patient in accordance with the medical staff approved protocol, policies and/or procedures by the hospital Pharmacy & Therapeutics and MEC

## RULE 11 ORDERS

11.1 Treatment Orders

All orders for treatment shall be authenticated.

11.2 Verbal/Telephone Orders

Telephone orders are allowed only when the ordering provider is speaking directly to the patient care provider. Telephone orders are not to be given by proxy.

11.2.1 A verbal/telephone order shall be considered to be in writing if the Practitioner dictates the order to a registered nurse, licensed vocational nurse, licensed pharmacist, respiratory care Practitioner, or a duly authorized person functioning within his or her sphere of competence and the order is then signed by the responsible Practitioner.

11.2.2 Persons authorized to accept verbal/telephone orders for drugs and medications are registered nurses, licensed vocational nurses licensed pharmacists, respiratory therapists, physical therapists, licensed dietitians, and physicians' assistants within their scope of practice, licensure and sphere of competence.

11.2.3 All verbal or telephone orders shall be dated, timed and authenticated by the person receiving the order, with the name of the practitioner noted.

11.2.3.1 Verbal or telephone orders must be authenticated within 48 hours after the order was given. The order must be documented by the prescriber or any other like practitioner directly involved in the patient's care.

11.2.3.2 Verbal or telephone orders for restraints shall be signed by the practitioner who issued the order on the practitioner's next visit to the Hospital within the time limits set by the Hospital policy on restraints and/or the law.

11.2.3.3 If orders are not authenticated in a timely fashion as required by regulatory agencies, the practitioner shall be given notice that further infractions may result in corrective action.

11.2.3.4 If such orders are not signed in a timely fashion as required by regulatory agencies, practitioner may be subject to a fine of $100. The Chief of Staff may waive such fine for cause. Further infractions may be referred to the Department Chair for further corrective action.

11.2.4 Do Not Attempt Resuscitation (DNAR) orders and other orders to withhold or withdraw life-sustaining treatment may be given as verbal or telephone orders only if two authorized persons authenticate the order. The order must be authenticated by the responsible practitioner within 24 hours.

11.2.5 The indication or reason for ordering a diagnostic test shall be included as part of the order under the following circumstances:

11.2.5.1 The test requires clinical interpretation since the results are not self-evident

11.2.5.2 The individual interpreting the test results is not the same individual who ordered the test.

11.2.5.3 The reason or indication is necessary to interpret the test appropriately.

11.3 Legibility, Compliance, and Clarity

11.3.1 All orders must comply with applicable statutory and regulatory requirements

11.3.2 Orders may not utilize disallowed abbreviations, as determined by the MEC

11.3.3 PRN orders for medication may not indicate a dosage range, but must stipulate a specific dose for a given situation or symptom.

11.3.4 Orders must be written in a legible manner. An entry is defined as illegible if two staff members together cannot decipher with clear comfort what the handwriting is intended to convey.

11.3.5 Renew, repeat, and continued orders without further explanation are inappropriate and may not be used.

11.3.6 If orders are found which are not legible, or include disallowed abbreviations or dosage ranges, the following process will be invoked:

11.3.6.1 On the initial occasion, the practitioner shall be given notice and requested to cease such usage.

11.3.6.2 Both individual and aggregate data on physician compliance will be forwarded in a timely manner to the appropriate departmental Quality Enhancement Committee for appropriate action.

11.3.6.3 If unacceptable orders continue to be used by the practitioner, he/she shall be given notice that further infractions will be forwarded to the Department Chair and may be the basis for corrective action.

11.3.6.4 If such usage is found on subsequent occasions, with the concurrence of the Chief of Staff, the practitioner will be given notice that his/her clinical privileges have been automatically suspended and is required to pay a fee of $100 in order to be reinstated.

11.3.6.5 Such fee may be waived with cause by the Chief of Staff

11.4 Cancellation of Orders on Transfer; Automatic Stop Orders

11.4.1 All previous orders are canceled when a patient goes to surgery, when a patient leaves the Labor and Delivery area or when the patient is admitted to or discharged from a critical care Unit.

11.4.2 Daily x-ray, EKGs and laboratory study orders and respiratory therapy orders must be reviewed and reordered at least every three days, unless otherwise stipulated in the order.

11.4.3 Physical therapy orders must be reviewed and reordered at least every seven days.

11.4.4 An initial order for restraints cannot exceed 24 hours (with lesser time frames if restraints are used for behavior management, and depending upon the patient's age.) The use of restraints must be reviewed and reordered following the standards and within the time limits set forth in the Hospital's policy. (For further information, consult Hospital's Restraint Policy.)

11.5 Standing orders

Standing Orders may be used for specified patients when authorized by a person licensed and given privileges to issue the orders. A copy of an order set for a specific patient must be dated, promptly signed by the Practitioner, and included in the patient's medical record. Standing Orders must:

11.5.1 Specify the circumstances under which the orders are to be carried out.

11.5.2 Specify the medical conditions to which the standing orders are intended to apply.

11.5.3 Be specific as to the orders that are to be carried out, including all of the relevant information that usually is given in the order.

11.5.4 Be initially approved by the appropriate Department Committee, the Pharmacy and Therapeutics Committee, the Quality Enhancement Committee, and the Executive Committee and be reviewed at least annually or whenever any changes are made in the order set.

## RULE 12 OUTPATIENT SERVICES

12.1 Services

Outpatient services shall include behavioral health, cardiology, chemotherapy, clinical laboratory services, gastroenterology, neurology, pathology, physical therapy, pulmonary function, radiation oncology, radiology, rehabilitation, respiratory therapy, surgery, and vascular.

12.2 Registration of Outpatients

Patients referred for outpatient services must be registered to the Hospital's outpatient service. A record shall be created in accordance with the "Medical Records" Rules.

12.3 Non-Verbal Orders

Patients shall receive outpatient Infusion therapy at the CCPT upon the non-verbal order of a Medical Staff member or non-Medical staff member. For the non-Medical Staff member the following are required:

- Current California license
- Attestation that practitioner is acting within his/her scope of practice by completing the following ( an affirmative answer to either or both will suffice):
- In the past 12 months I have delivered the above noted drug(s) or product
- I have the current training and expertise to deliver the above noted drug(s) or product

12.4 Outpatient Surgery

12.4.1 Eligible Cases

Any surgical procedure may be performed on an outpatient basis, provided the patient may be safely cared for on an outpatient basis.

12.4.2 Anesthesia

All types of anesthesia may be used for patients undergoing outpatient surgery.

12.4.3 Pre-Op Evaluation

Each patient shall be evaluated pre-operatively by the surgeon, who shall be responsible for determining what surgical intervention is necessary and for securing the patient's informed consent for the surgery. In addition, if anesthesia other than a local anesthesia will be used and administered by an anesthesiologist, the anesthesiologist shall be responsible for evaluating the patient preoperatively, using the same standards as apply when surgery is performed on an inpatient basis. A short form H&P may be used by the surgeon, although a full H&P is preferred. For eye laser procedures a short form H&P can be the physician’s office notes documenting pathology being treated.

12.4.4 Informed Consent

Prior to the performance of surgery on an outpatient basis, the surgeon shall be responsible for assuring that an informed consent is secured for the procedure or that it is an emergency situation and that the emergency circumstances are documented in the record. (See the “Consent" Rule.)

12.4.5 Specimens

All anatomical parts, tissues and foreign objects that are removed during surgery (except those exempted from review in the Surgery or Pathology Department Rules) shall be submitted to the Hospital pathologist for examination. The pathologist shall prepare a report on the findings from an examination of the specimen and a copy of the report shall be entered in the patient's medical record.

12.4.6 Pre-Op Instructions

Patients admitted for outpatient surgery should be given pre-operative instructions that address:

12.4.6.1 Any restrictions on food and drug ingestion prior to surgery;

12.4.6.2 Any special preparations the patient should make;

12.4.6.3 Any post-operative instructions; and

12.4.6.4 The statement that admission to the hospital may be required in the event of unforeseen circumstances.

12.5 Discharge

Each patient shall be examined by a physician immediately prior or on arrival in the recovery room. Patients may be discharged by registered nurses utilizing discharge criteria that have been approved as a “Standardized Procedure” by the Interdisciplinary Practice Committee and the Executive Committee.