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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 patients who suffer from conditions that require services which the Hospital cannot provide. The Hospital shall provide emergency services as required by state and federal law.

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

1.2 PROCEDURE

A patient may be admitted to the Hospital only by Medical Staff Members who have admitting privileges. All Practitioners shall be governed by the Hospital’s official admitting policy.

1.3 RESPONSIBILITY

The patient’s Attending Practitioner shall be responsible for directing and supervising the patient’s overall medical care, which includes evaluating each patient daily. This may include utilization of appropriately credentialed and privileged Allied Health Professionals as consistent with State law, community standards of care, and hospital policies and procedures. The Attending Practitioner is responsible, for completing or arranging for the completion of the medical history and physical examination as required by the Rules, 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.

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

1.3.2 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 Rules pertaining to podiatric, dental and clinical psychologist patient admissions.)

1.4 PROVISIONAL DIAGNOSIS

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

1.5 PSYCHIATRIC PRECAUTIONS AND INFECTION ADMISSION PRECAUTIONS

1.5.1 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 note in the patient’s record the reason for his or her suspicions, and the precautions taken to protect the patient and others.

1.5.2 In the event the patient or others cannot be appropriately protected in the general acute care service, arrangements shall be made to transfer the patient to a unit or facility where his or her care can be appropriately managed. When indicated, individual nursing care shall be arranged in accordance with System policy.
1.5.3 The Attending Practitioner should also seek assistance from the appropriate medical specialist for any patient who suffers from an incapacitating emotional illness or substance abuse.

1.6 NON-ELECTIVE ADMISSIONS

1.6.1 When a patient who is not in the Emergency Room (or another part of the Hospital) requires admission to the Hospital for non-elective medical treatment, the Attending Practitioner shall contact the House Supervisor or their designee and determine whether there is an available bed.

1.6.2 In all cases involving emergency admissions, the Attending Practitioner must be able to demonstrate to the Medical Executive Committee and the Chief Executive Officer that the admission was due to a bona fide emergency. The history and physical examination report must clearly justify the emergency admission.

1.6.3 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 (General Medical Staff Rule 1.4).

1.7 CRITICAL CARE UNITS

1.7.1 Practitioners acknowledge the Hospital’s desire to reduce clinical variation and thus will assist in the advancement of clinical protocols. This will be done through compliance with the protocol or careful documentation should the protocol prove inappropriate for the patient.

1.7.2 Practitioner agrees to become familiar with the clinical and operational protocols of the Critical Care Unit, and shall abide by the Critical Care Unit’s Rules.

1.7.3 The resolution of issues regarding a patient’s discharge from or admission to the Critical Care Units shall be the responsibility of the Critical Care Medical Director (or his/her designee), following reasonable efforts to discuss these matters with the attending Practitioner. If necessary, these issues may be referred to the Chief Medical Officer to facilitate resolution of any differences between the Critical Care Medical Director and the attending Practitioner.

1.7.4 The Critical Care Medical Director has the right to review the care of and to write orders for any patient in the Critical Care Units as he or she deems appropriate. The Critical Care Medical Director shall make reasonable efforts to discuss these matters with the attending Practitioner; provided, however, that the Critical Care Medical Director’s orders shall take precedence over any conflicting order of the attending Practitioner.

1.7.5 ICU patients will be seen within an appropriate time frame that meets the needs of the patient.

1.8 TRAUMA SERVICE PATIENTS

1.8.1 Practitioners acknowledge the Hospital’s desire to reduce clinical variation and thus will assist in the advancement of clinical protocols and practice management guidelines. This will be done through compliance with the protocol or guideline or careful documentation should the protocol prove inappropriate for the patient.

1.8.2 Practitioner agrees to become familiar with the clinical and operational protocols and guidelines of the Trauma Service and shall abide by the Trauma Service’s rules, policies and guidelines.

1.8.3 The Trauma Service Medical Director has the right to review the care of and to write orders for any patient treated at EGSMC with a trauma related diagnosis as he or she deems appropriate. The Trauma Medical Director shall make reasonable efforts to discuss these matters with the attending Practitioner, provided, however, that the Trauma Medical Director’s orders shall take precedence over any conflicting order of the attending Practitioner.
1.9 PRIORITY OF ADMISSIONS AND TRANSFERS

1.9.1 When bed space is not available, admissions may be limited to emergency cases. Patients shall be admitted using the following order of priority or according to other applicable System or Hospital policies:

a. 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.

b. 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.

c. Third Priority -- Preoperative Admissions -- i.e., patients who are already scheduled for surgery.

d. 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 or according to other applicable System or Hospital policies:

a. Emergency admissions to an appropriate bed.

b. Critical care to a telemetry or general care area.

c. Temporary placement in an inappropriate area for that patient to an appropriate area.

The Chief Medical Officer may be consulted to help prioritize admissions and transfers.
RULE 2. CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

2.1 POLICY

2.1.1 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 authorized decision-maker, has been given information about the procedure and has given consent.

2.1.2 Any risk-prone medical, surgical, special diagnostic or therapeutic procedures require consent by the patient or his or her authorized decision-maker. This Rule outlines the basic requirements. Further information is provided in the Consent Manual prepared by the Colorado Hospital Association and applicable system or Hospital policies. The Consent Manual is available on the SCL Health – Front Range Intranet.

2.2 INFORMED CONSENT DEFINED

2.2.1 Informed consent is a process whereby the patient, or his or her authorized decision-maker, is given information which will enable him or her to reach a meaningful, informed decision regarding whether to give consent. Procedures that require informed consent include surgical procedures, administration of blood and blood products, procedures involving moderate or deep sedation, diagnostic procedures involving use of contrast medium, and such other procedures listed in Hospital’s Informed Consent Policy, as such is amended from time to time.

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

a. The nature of the proposed care, treatment, services, medications, interventions or procedures.

b. The potential benefits, risks, or side effects, including potential problems related to recuperation.

c. The likelihood of achieving care, treatment and service goals.

d. Reasonable alternatives to the proposed care, treatment and service.

e. The relevant risks, benefits and side effects related to alternatives, including the possible result of not receiving care, treatment and services.

f. When indicated, any limits on the confidentiality of information learned from or about the patient.

2.3 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 an authorized decision-maker (i.e., parents or guardians of minors who may not consent, conservators, attorneys-in-fact, the patient’s closest available relatives, or the court). (The persons who may give consent are identified in the Hospital’s Policy on Consents and in the Consent Manual.)

2.4 RESPONSIBILITY FOR SECURING INFORMED CONSENT

2.4.1 The patient’s Attending Practitioner or his or her designee is responsible for giving the patient, or his or her authorized decision-maker, the requisite information and securing consent or assuring this has happened, to include obtaining the patient’s or the patient’s authorized decision maker’s signature.

2.4.2 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 Practitioner.
The consent process is shared when two or more Practitioners will provide specialized services. In this Hospital, responsibility is divided as follows:

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.

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

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

2.4.3 Consent shall be obtained and documented in writing prior to surgery or other procedures.

2.4.4 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 authorized decision-maker) prior to the procedure and discuss it or verify that another Practitioner has fully explained the procedure and secured consent.

2.5 EMERGENCIES

2.5.1 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 authorized decision-maker.

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

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

2.6 PARTICULAR LEGAL REQUIREMENTS FOR CONSENT

2.6.1 Consent for HIV blood tests, hysterectomies, use of investigational medications or devices, participation in human experimentation, 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 Consent Manual.

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

2.6.3 Special requirements for consent also apply to discontinuing life-sustaining treatment. (See the “Discontinuing Life-Sustaining Treatment” Rule.)
2.7 DOCUMENTATION OF CONSENTS

2.7.1 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.

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

b. The documentation should indicate why a person was selected as an authorized decision-maker for a patient who is incompetent.

c. The Practitioner’s documentation for emergencies (see Rule 2.5 above), which should be entered in a progress note, must describe:

1. The nature of the emergency.

2. The reasons consent could not be secured from the patient or an authorized decision-maker.

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

2.8 HOSPITAL STAFF ROLE IN PROVIDING INFORMATION

2.8.1 Hospital staff may not provide patients or authorized decision-makers with medical information regarding any proposed procedure. If a patient or authorized decision-maker expresses doubt or confusion about a procedure, the patient’s Attending Practitioner or the Practitioner who is responsible for securing consent shall be contacted and asked to provide the necessary information.

2.8.2 The Hospital staff is responsible for verifying that consent has been given. This will be done for all procedures including major invasive procedures, for inpatients and outpatients. This is done one of four ways:

a. Asking the patient, or an authorized decision-maker, to sign the general consent form. The Hospital staff member acts as a witness to the signature only.

b. Verifying that any special forms that are required for HIV blood tests, hysterectomies, investigational medications, investigational devices, human experimentation, electroconvulsive shock therapy, antipsychotic medications or involuntary commitment have been signed, as required by law.

c. Verifying that the patient, or an authorized decision-maker, has signed an informed consent form which contains not only the general provisions set forth in the standard consent form, but also medical information regarding the procedure, and that this form is included in the patient’s medical record.

d. Verifying that the “emergency exception” applies.

2.9 CONSENT BY TELEPHONE

2.9.1 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.

2.9.2 When the telephone is used to obtain consent from an authorized decision-maker, the information normally given to secure informed consent must be given. Inquiries concerning the procedure should be answered only by the Practitioner, or his or her designee.
2.9.3 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.

2.9.4 The Practitioner shall note the exact time, nature and any limitation of the consent in the medical record. The witness shall authenticate and date this note.

2.9.5 The documentation should name the person giving the consent, describe his or her relationship to the patient and confirm that consent was given for treatment. As soon as possible the decision-maker will confirm his or her consent via a facsimile, electronic transmission, letter, or signature on the consent form. This confirmation will be placed in the medical record.

2.10 REFUSAL OF TREATMENT

2.10.1 A patient or the patient’s authorized 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.

2.10.2 If a patient or the patient’s authorized 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 enter a brief note in the patient’s chart regarding the initial refusal and whether the outcome was consent or continued refusal.

2.10.3 See also the “Discharge of Patients” Rule, the section on leaving against medical advice, and the “Discontinuing Life-Sustaining Treatment” Rule.
RULE 3. CONSULTATIONS

3.1 GENERAL

3.1.1 Appropriate 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. The Medical Staff, through its Department Leaders and the Medical Executive Committee, has oversight responsibility for assuring that consultants are called as needed.

3.1.2 Any qualified Practitioner with clinical privileges in this Hospital can be called for consultation within his or her area of expertise and within the limits of clinical privileges which have been granted to him or her.

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

3.1.4 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.

3.2 REQUESTS FOR CONSULTATIONS

3.2.1 Requests for consultation should be made by direct personal communication from the Attending Practitioner to the consulting Practitioner. The Attending Practitioner must document the consultation request.

3.2.2 The Attending Practitioner should tell the patient or the authorized decision-maker that he or she has requested a consultation and secure the patient or the authorized decision-maker’s verbal authorization for the consultation. Such authorization can be forgone in emergencies.

3.3 RECOMMENDED CONSULTATIONS

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

3.3.1 When the patient is not a good risk for an operation or treatment.

3.3.2 Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.

3.3.3 Where there is doubt as to the choice of therapeutic measures to be used.

3.3.4 In unusually complicated situations where specific skills of other Practitioners may be needed.

3.3.5 In instances where the patient exhibits severe psychiatric symptoms.

3.3.6 In the case of medication or chemical overdose or suspected suicide risk or attempted suicide.

3.3.7 When pelvic surgery is contemplated in the presence of a confirmed pregnancy.

3.3.8 When requested by the patient or an authorized decision-maker.

3.3.9 When required by the Medical Staff Rules or Hospital policies.
3.4 REQUESTED OR REQUIRED CONSULTATIONS

3.4.1 A consultation may be requested when the Chief Medical Officer, or a Department Chair or Medical Staff President determines that a patient will benefit from such consultation.

3.4.2 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, he or she may call this to the attention of the Attending Physician or his or her supervisor, who in turn may refer the matter to the Medical Director, if applicable, Department Chair, or Chief Medical Officer. The Medical Director, if applicable, Department Chair, or Chief Medical Officer may then, in appropriate circumstances, request a consultation, after conferring with the patient’s Attending Practitioner.

3.5 PERFORMANCE OF AND REPORTING OF CONSULTATIONS

3.5.1 A satisfactory consultation includes examination of the patient and the record. The Attending Practitioner is responsible for supplying the consultant with all available and relevant information regarding the patient and the need for the consultation.

3.5.2 The consultant’s opinion must be entered into the patient’s electronic record by the consultant. A limited statement, such as “I concur,” is not sufficient. When operative procedures are involved, consultations performed before surgery shall be reported before the operation, except in emergency cases. Consultation reports shall be prepared in accordance with the Medical Records Rule.
RULE 4. COVERAGE

4.1 GENERAL

4.1.1 Each Practitioner shall arrange coverage for each of his or her patients in the Hospital. The Attending Practitioner is responsible for informing the Practitioner who will provide coverage about his or her schedule and for assuring that 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. If the covering Practitioner does not have the privilege(s) to address a specific patient care need, the covering Practitioner is responsible for arranging for another qualified Practitioner with the appropriate privileges to assume that portion of the care. Practitioners with affiliate status who are only granted limited privileges in the hospital, do not need to provide 24 hour coverage.

4.1.2 In the event the Attending Practitioner’s alternate is not available, the Department Chair must be contacted, and assume responsibility for caring for the patient or appoint an appropriate Medical Staff Member who will assume responsibility until the Attending Practitioner can be reached.
RULE 5. DEATHS

5.1 PRONOUNCEMENT OF DEATH

5.1.1 The pronouncement of death will be done by a Physician or Registered Nurse using approved medical standards and Colorado State Law, “Determination of Death”, Colorado Revised Statutes, 12-36-135. The RN may perform the pronouncement after providing required information to the physician. The patient’s remains may not be released until the physician has made an authenticated entry of the pronouncement of death in the patient’s medical record.

5.1.2 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 in accordance with the Hospital Administrative Policy governing “brain death.” (In brief summary, a second, independent physician must confirm the “brain death” and both physicians must document their findings in the patient’s record. The patient’s family must be informed of the patient’s death. If the family objects to terminating treatment or contests the accuracy of the diagnosis, Hospital Administration shall be consulted before treatment is discontinued.)

5.2 AUTOPSIES

5.2.1 It shall be the duty of all Medical Staff Members to attempt to secure consent to meaningful autopsies. Autopsies should be encouraged in the situations identified by the American College of Pathology:

a. Deaths in which an autopsy would explain unknown or unanticipated medical complications.

b. Deaths in which the cause is not known with certainty on clinical grounds.

c. Deaths in which an autopsy would allay concerns of or reassure the public or family regarding the death.

d. Unexplained or unexpected deaths from dental, medical or surgical procedures.

e. Deaths of patients participating in clinical investigations.

f. Deaths that are reported to the coroner but not accepted by the coroner, such as deaths of persons on arrival at the hospital, deaths within twenty-four hours after admission, or deaths of patients who were or might have been injured while hospitalized.

g. Deaths resulting from high risk, infectious, and contagious diseases.

h. Obstetric deaths.

i. Neonatal and pediatric deaths.

j. Deaths whenever an autopsy might reveal information that could affect survivors or recipients of transplant organs.

k. Deaths known or suspected to arise from environmental or occupational hazards.

5.2.2 An autopsy is a consultation. It requires consent and requires the concurrence of the Hospital’s pathologist that it would offer meaningful information. An autopsy may be performed only if authorized in accordance with law. (The persons who may consent to autopsies are identified in the Hospital policy on autopsies and in the Consent Manual.)
5.2.3 Except in coroner cases, all autopsies shall be performed by the Hospital pathologist or his designee. Provisional anatomic diagnoses shall be recorded on the medical record by the pathologist within 48 hours after completion of the autopsy and the complete protocol should be made a part of the record within 30 days.

5.3 CORONER'S CASES

The law requires deaths to be reported to the coroner in certain circumstances, as outlined in the Hospital’s policy on reporting to the Coroner and in the Consent Manual.

5.4 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.

5.5 DISPOSITION OF REMAINS AND CONTRIBUTIONS OF ANATOMICAL GIFTS

5.5.1 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 Consent Manual.

5.5.2 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 Consent Manual. The patient’s physician shall comply with the Hospital protocol for identifying potential organ and tissue donors, and, whenever possible, confer with the patient or family about donations.

5.6 DEATH CERTIFICATE

The Attending Physician or other physician last in attendance is responsible for signing the death certificate or ensuring its completion within a reasonable time.
RULE 6. DISASTER ASSIGNMENTS

6.1 GENERAL

6.1.1 The organizational structure used to manage all emergencies is the Hospital Emergency Incident Command System (HEICS).

6.1.2 There shall be a plan for the care of mass casualties at the time of a major disaster, based upon the Hospital’s capabilities in conjunction with other emergency facilities in the community. The plan shall be developed by an Emergency Management Planning Committee. Disaster privileges may be granted when the emergency management plan has been activated (a Plan D has been called) and the organization is unable to handle the immediate patient needs.

6.1.3 All Practitioners shall be assigned to posts, either in the Hospital, an auxiliary hospital, or a mobile casualty station in the event of a mass disaster. The Practitioner shall be responsible for reporting to his or her assigned station and performing the assigned duties unless the Medical Staff Director (HEICS) changes the assignment.

6.1.4 If patients are evacuated from one section of the Hospital to another, or from the Hospital premises, necessitating transfer of disaster privileged staff for their care, the Emergency Incident Commander (HEICS) after conferring with the Medical Staff Director (HEICS), will arrange for the transfers with the Planning Section Chief (HEICS).

6.1.5 In a state of emergency, Practitioners or Allied Health Professionals who volunteer to assist the Hospital will be privileged on an emergency basis, in accordance with the Disaster Privileging Rule in the Credentialing and Privileging Rules.
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.

7.1.2 Minors shall be discharged only to their parents or legal guardians or a person designated in writing by the parent or legal guardian.

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

7.1.4 The Practitioner discharging the patient must complete and authenticate the discharge summary within 30 days after the patient's discharge.

7.2 LEAVING AGAINST MEDICAL ADVICE

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 to discuss his or her plan with the Attending Practitioner before the patient leaves.

7.2.2 Whenever possible, the Attending Practitioner shall discuss with the patient the implications of leaving the Hospital against medical advice.

7.2.3 The patient who insists on leaving against medical advice shall be asked to sign the form documenting the decision. If the patient 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

7.3.1 The Administration shall be contacted for assistance whenever a patient refuses to leave the Hospital.
RULE 8. DISCONTINUING LIFE-SUSTAINING TREATMENT

WITHHOLDING AND WITHDRAWING MEDICAL CARE, ISSUING NO CARDIOPULMONARY RESUSCITATION CODE ORDERS

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 authorized decision-maker, after consulting with the patient’s physician. The physician is responsible for providing advice 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:

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

b. What the possibilities are for a return to a cognitive life and for a remission of symptoms enabling a return towards a normal, functioning integrated existence.

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

8.2.3 There is no legal distinction between withholding and withdrawing medical care. Clinical conditions and perspectives may change and it may become proper to withdraw care that was previously initiated. Time should be taken to confirm the medical diagnosis and prognosis 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; but such decisions should usually be reserved to the patient rather than authorized decision-makers.
8.3 PROCEDURE FOR ISSUING ORDERS

8.3.1 Who Must Be Consulted

a. The treating physician and consulting physicians (if any) shall be responsible for determining the patient's prognoses and diagnoses. The physicians 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.

b. The primary attending physician is responsible for providing this information to the patient, or the patient's authorized 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 may choose to secure a second opinion or consultation.

c. With minors, the parents or another proper authorized decision-maker must make the decision. The Hospital policy provides further guidance regarding who may make the decisions when questions or disputes arise.

d. In all cases, 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.

e. Orders to withhold or withdraw CPR and other forms of life-sustaining treatment when there are no authorized decision-makers who can act on behalf of the patient may be proper in some cases. The patient's physician must notify the Hospital Administration of the proposed order, and consult with any designated persons or entity, such as the Ethics Committee and/or Risk Management Department.

8.3.2 Issuing the Order

All orders to withhold or withdraw life-sustaining treatment must be entered into the patient's electronic record and authenticated by a physician. The physician should assure that the nursing staff has been informed that such an order has been given.

8.3.3 Verbal Orders

Oral telephone orders will be accepted only if the physician is familiar with the patient and the medical record already includes documentation supporting the order.

8.3.4 No-CPR Orders

a. Cardiopulmonary resuscitation (CPR) will be initiated when cardiac or respiratory arrest is recognized, unless a No-CPR Order is given. No resuscitative measures will be taken if the physician writes “No-CPR,” “No Code,” “Do Not Attempt Resuscitation” (DNAR), or “Do Not Resuscitate” (DNR). If a physician wants specific medications administered and/or procedures performed notwithstanding a No-CPR order, he or she must specifically describe what medications are to be used and/or what procedures are to be performed.

b. A “partial no-CPR,” “partial do not resuscitate order,” or partial COR may be written or electronically transmitted but must include any inclusions and/or exclusions that have been discussed with the patient/family.
8.3.5 Reviewing Other Treatments

The physician 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.

8.3.6 Documentation

The orders to withhold or withdraw life-sustaining treatment must be supported by complete documentation in the 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; identify who are the decision-makers and describe the information they were given and state their decision.

8.3.7 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 Administration and/or the Ethics Committee Chair or his or her designee for review. Until the dispute is resolved, life-sustaining treatment should be provided and disputed No-CPR orders, if any, suspended.
RULE 9. MEDICATIONS

9.1 GENERAL

9.1.1 All medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or the American Medical Association Drug Evaluations or newly approved medications that are not listed but have been approved by the Medication Safety Committee. Non-formulary medications are to be used only in accordance with the EGSMC Hospital Drug Formulary System Policy, as such is amended from time to time.

9.1.2 Medications for bona fide clinical investigations are exceptions. Investigational medications may be used only if the physician complies with the policy governing use of investigational medications and secures Institutional Review Board approval. All uses must be in compliance with the Federal Protection of Human Subjects regulations. Investigational medications must be dispensed by the Hospital pharmacy according to established procedure for handling investigational medications.

9.1.3 A documented diagnosis, condition or indication for use is required for each medication that is ordered.

9.2 REVIEW OF MEDICATION ORDERS

9.2.1 Each Practitioner is expected to review all medications for all patients to ensure discontinuation on all orders that are no longer needed.

9.2.2 Medications must be reconciled at admission, transfer, return from surgery and discharge.

9.2.3 Medications must be reconciled and reordered when:
   a. Patients return from surgery.
   b. Medication is to be resumed after an automatic stop order or hold has been employed.
   c. When patients are transferred in-house see the Policy on the Transfer of Patients In-house.

9.3 PROCUREMENT OF MEDICATIONS

9.3.1 All medications shall be procured from the Hospital pharmacy or according to applicable policies.

9.3.2 All medications brought to the Hospital by patients will be turned over for safekeeping to the nurses in charge of the patient’s care and may be administered to the patient only if the medications are clearly identified by a Hospital pharmacist and specifically ordered.

9.3.3 Under no circumstances may controlled substances be brought into the Hospital by the Practitioner or the patient for administration to the patient at any time.

9.4 SUBSTITUTION OF GENERIC MEDICATIONS

The Pharmacy may generically substitute for medications prescribed by a practitioner unless the practitioner clearly writes after the order for a trade (proprietary) medication “do not substitute” or “dispense as written.” The Medication Safety Committee may develop policies and procedures relating to the therapeutic substitution of medications.

9.5 MEDICATION ORDERS

Medication orders must be given as provided in the Rule on “Orders.”
MEDICATIONS PRESCRIBED FOR RELEASE TO PATIENTS ON DISCHARGE

9.6.1 Each medication prescribed to be dispensed to a patient on discharge shall be recorded in the medical record.

9.6.2 Whenever discharge medications are ordered, the nurse, pharmacist or other qualified person shall review with the patient (or if the patient is incompetent, a competent caregiver) the use and storage of each medication, the precautions and relevant warnings, and the importance of compliance with directions.

9.6.3 When pre-printed medication information sheets are given to the patient or family, the medical record should so indicate.
RULE 10. MEDICAL RECORDS

10.1 GENERAL

10.1.1 The patient’s hospital medical record serves a multitude of purposes, including those relating to primary patient care, continuity of patient care, performance improvement, medical research, and business documentation. Although the primary purpose of the record is to serve the interests of the individual patient, it also serves as the basis for performance improvement and utilization review activities. In addition, it may be used in connection with lawsuits, and thus serves a medico-legal function.

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

10.1.3 Any documentation entry that may be dictated, may be electronically entered in the medical record instead of being dictated, subject to the authentication and other requirements for electronic records under applicable EGSMC policies and state and federal law.

10.2 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.

10.3 COMPLETION OF THE RECORD

10.3.1 Timely Completion

a. 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 authenticated by the Practitioner who issued the order or a covering Practitioner as required by the Rules. (See the “Orders” and “Medication Orders” Rules and the Completion of Medical Record Policy.)

b. Medical records must be completed promptly and authenticated or signed by a Practitioner within 30 days following the patient’s discharge.

c. If a patient’s record remains incomplete 16 days after discharge, the Health Information Management Department shall notify the Practitioner by phone, mail, facsimile, and/or electronic transmission that the record remains incomplete and that he or she has only 14 days to complete it. If the records remain incomplete 14 days after the notice was sent by the Health Information Management Department, the Practitioner shall be sent a letter indicating that all of the Practitioner’s privileges shall be suspended and the automatic suspension procedure set forth in the Rules shall be followed. Any additional overdue records will be added to the list of records for completion before the Practitioner can be removed from suspension. When the Practitioner completes all incomplete records, the Practitioner shall be advised of the reinstatement of his or her privileges and the appropriate Hospital Department notified. (See Suspension Policy)

d. Three suspensions in a consecutive 12 month period for a failure to complete medical records shall result in automatic termination of membership, as provided in the Medical Staff Rules.

e. A medical record shall not be permanently filed until it is completed by the responsible Attending Practitioner or is ordered filed by the Performance Excellence Committee Chair. The Performance Excellence Committee Chair may authorize the Director of Health Information Management Department 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 Performance Excellence Committee Chair must sign and date a cover letter for the chart, stating the reason for retirement.
10.3.2 Use of Signature Stamp or Computer Key

Medical records may be authenticated by a signature stamp or computer key in lieu of a Practitioner’s signature, only when that Practitioner has placed a signed statement in the Health Information Management Department to the effect that he or she is the only person who has possession of or access to the stamp or key and will use it and promise not to disclose it.

10.3.3 Correction of the Medical Record

In the event it is necessary to correct a written entry in a medical record, the person shall line out the incorrect data with a single line, leaving the original writing legible. The person (or computer entry) shall note the date of correction and authenticate the entry. Appropriate cross-referencing shall be placed in the record when necessary to explain the correction. The correction shall never involve erasure or obliteration of the material that is corrected. In addition, all blanks left in dictated reports must be filled in by the dictating Practitioner at the time the report is authenticated. Any cross-outs with or without reentries in the report should be noted as “error,” dated, and initialed.

10.3.4 Authentication, Dating and Timing of Entries

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

10.4 CONTENTS

10.4.1 General

Each record shall contain sufficient detail and be organized in a manner which will enable 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. (See Completion of Medical Record policy for additional detail.)

10.4.2 Inpatient Records

The inpatient record shall include the following elements:

a. Identification Information

The identification information in the record shall include the patient’s name, address, identification number, age, sex, marital status, religion, date of admission, date of discharge, name, address and telephone number of a person responsible for the patient, initial diagnostic impression, discharge or final diagnosis, other diagnoses, complications, procedures and consultants. The principal diagnosis must be recorded on discharge. This is defined as the condition established, after study, to be chiefly responsible for occasioning the patient’s admission. When a patient is transferred to a different service or Practitioner, the information shall be updated.

b. Admitting Note

An admitting note must be entered in the progress notes on admission. The only exceptions are when the Practitioner already has a dictated history and physical examination report on the chart. 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 the date and onset and duration of each), and a provisional diagnosis (i.e., the impression (diagnosis) reflecting the examining Practitioner’s evaluation of the patient’s condition based upon the physical findings and history).
c. History and Physical Examination Report

1. A history and physical examination ("H&P") shall be performed and dictated, or electronically entered by a Practitioner with appropriate Privileges (or by an AHP with appropriate Privileges, provided the H&P is signed by a Practitioner with appropriate Privileges) and shall include all pertinent positive and negative findings. The H&P shall be completed within 24 hours after the patient’s admission, unless the patient will be taken to surgery before that time, in which case the H&P report must be placed in the patient’s chart before the patient is taken to surgery. The content of the H&P report is governed by the Medical Records Completion Policy, as such is amended from time to time.

2. If a complete H&P was performed by a Practitioner with appropriate Privileges up to 30 calendar days prior to the patient’s admission to the Hospital (including an H&P from the patient’s prior admission to the Hospital), a reasonably durable, legible copy of the H&P report may be used in the patient’s medical record in lieu of an admission H&P report, provided a Practitioner with appropriate Privileges performs a physical assessment and updates the H&P report in writing (regardless of whether there have been any changes to the patient’s status) at the time of admission, unless the patient will be taken to surgery before that time, in which case the H&P report and the updates must be placed in the patient’s chart before the patient is taken to surgery.

3. An H&P performed by someone who does not have appropriate privileges is allowed providing a Practitioner with appropriate Privileges reviews the history and physical examination document, conducts a second assessment to confirm the information and findings, updates any information and findings as necessary (including any summary of the patient’s condition and course of care during the interim period) and the current physical/psychosocial status; and signs and dates the information as an attestation to it being current.

4. The H&P report shall be prepared by the patient’s Attending Practitioner, unless he or she either delegates this responsibility to another Practitioner or Allied Health Professional with Privileges to perform H&Ps, or he or she is required by the Medical Staff Bylaws or Rules to delegate or share this responsibility with another Practitioner. (See specifically the General Medical Staff Rules pertaining to the completion of H&P reports when a podiatrist or dentist is the co-admitting Practitioner.)

d. Consultation Reports

Consultation requests must be entered into the patient’s record. Consultation reports must be entered into the patient’s record by the consultant, including findings on physical examination of the patient or of other data and information. (See also the “Consultations” Rule.)

e. Orders

Medication, treatment, and diet orders shall be entered on the record. (See also the “Orders” and “Medication Orders” Rules.)

f. Progress Notes

Progress notes shall be entered at least daily, and more often when warranted by the patient’s condition, except that progress notes may be entered every 7 days for patients in a transitional care unit. The progress notes shall give a chronological picture of the patient’s progress, describe the patient’s response to medications and services such as interventions, care, and treatments and be sufficient to permit continuity of care and transferability.
g. Operative/Procedure Reports

1. The operative/procedure reports shall include the name of the primary surgeon and assistants, findings, procedures performed and a description of the procedure, estimated blood loss, as indicated, specimens removed, and post operative diagnosis.

2. All operative/procedure reports must be dictated or electronically entered immediately following surgery. If there is a transcription delay, the surgeon or his or her designee shall also enter a post-operative note in the progress notes immediately following surgery. The post-operative/post procedure note shall include the name of the primary surgeon and assistants, findings, procedures performed and a description of the procedure, estimated blood loss, as indicated, specimens removed, and post operative diagnosis.

3. Separate anesthesia notes shall be entered in the record for pre-operative, intra-operative and post-operative documentation. The documentation shall provide information relative to the choice of anesthesia for the procedure and any unusual risks that were anticipated or arose. The anesthesia post-op note/post anesthesia note may be completed and documented by an individual qualified to administer anesthesia. The post anesthesia note will be completed within 48 hours after surgery.

h. 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.

i. Discharge Summary

The discharge summary shall state the final diagnosis, 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 dictated or electronically entered by the responsible Practitioner and completed within 30 days after the patient's discharge. If the patient was hospitalized for less than 48 hours for minor ailments or for an uncomplicated obstetrical delivery that resulted in a normal newborn, an abbreviated clinical resume format or final progress note may be used.

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

k. Restraints.

Restraints shall be used only when alternative methods are not sufficient to protect the patient or other from injury. The use of restraints shall be in accordance with established policy.

l. Cancer Staging

All newly diagnosed cancer malignancies, for which a staging scheme exists, must be staged in accordance with the latest edition of the American Joint Committee on Cancer (AJCC) Cancer staging Manual. The managing or treating physician is responsible for assigning the AJCC cancer staging and for completing, signing, and dating the Hospital’s staging form.

10.4.3 Outpatient Records

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

a. Identification sheet. (See Clinical Rule 10.4.2(a) above.)
b. A record of the patient’s medical history to include all clinically pertinent positive and negative findings, including for pediatric patients immunization records, screening tests, and allergy records. (See Completion of Medical Record Policy.)

c. A physical examination report. (See Completion of Medical Record Policy.)

d. Consultation reports. (See Clinical Rule 10.4.2(d) above.)

e. Clinical notes, including the dates of visits.

f. A record of treatment and instructions, including notation of any prescriptions, diet instructions, if applicable, self-care instructions and follow-up care.

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

h. If an operation/procedure was performed, the operative/procedure reports shall include the name of the primary surgeon and assistants, findings, procedures performed and a description of the procedure, estimated blood loss, as indicated, specimens removed, and post operative diagnosis. The operative/procedure report must be dictated immediately following surgery. (See Clinical Rule 10.4.2(g).)

i. Referral information from other providers.

j. Consent forms. (See the “Consent for Medical and Surgical Procedures” Rule.)

10.4.4 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:

a. Adequate patient identification.

b. Information concerning the patient’s arrival, means of arrival, and by whom transported.

c. 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.

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

e. Diagnosis.

f. A description of the treatment provided.

g. The condition of the patient upon discharge or transfer.

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

i. The signature of the Practitioner in attendance who is responsible for the patient’s treatment and for the clinical accuracy of the record.
10.5 AVAILABILITY OF RECORDS

10.5.1 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.

10.5.2 Records may be removed and/or copies released from the Hospital only in accordance with a court order, subpoena, patient authorization or other authorization as allowed by Colorado and federal law. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer or his or her designee.

10.5.3 Charts stored off-premises will be purged on an as-needed basis by Hospital personnel and maintained by a professional storage service to assure confidentiality and security of the records.
RULE 11. ORDERS

11.1 GENERAL

11.1.1 All orders shall be given in writing.

11.2 VERBAL ORDERS

11.2.1 Orders may be given orally to a registered nurse, licensed pharmacist, physician assistant, respiratory therapist (for respiratory therapy medication and/or treatment), physical therapist or occupational therapist (for physical therapy/occupational therapy medications, occupational therapy/occupational therapy medications, and/or speech therapy), speech therapist (for physical therapy, occupational therapy, speech therapy, and/or diet orders), dietitian (for dietary orders), radiology technician or imaging clerical staff (for radiology studies or procedures), laboratory technician or laboratory clerical staff (for laboratory test), licensed practical nurse (LPN), or case manager for discharge planning orders.

11.2.2 Verbal orders must be recorded promptly in the patient’s medical record, noting the name of the person giving the verbal order and the authentication by the individual receiving the order. As verification, the complete verbal order will be read back to the prescriber by the person receiving the order and verbally confirmed by the prescriber. Documentation that the verbal or telephone order was read back and verified will be documented in the record by the individual receiving the order.

11.2.3 The responsible Practitioner shall authenticate the verbal order as soon as possible. All verbal orders must be authenticated within 30 days after the date of the patient’s discharge. Countersignatures must be dated and timed. (See Completion of Medical Record Policy.) For the purposes of this Rule, Practitioners practicing in formal and informal group practices may be deemed co-prescribers for purposes of reviewing and authenticating each other’s orders. A Practitioner who has assumed responsibility for the patient from the Practitioner who issued the order may authenticate the verbal order if it appears proper. If there is any question about the order (e.g., why it was given or whether it was accurately noted), the responsible person should refer the matter back to the Practitioner who issued the order, who shall clarify the order and authenticate the order within the required time.

11.2.4 No-CPR orders and other orders to withhold or withdraw life-sustaining treatment may not be given as verbal orders, except as noted in Rule 8.3.3 in the “Discontinuing Life-Sustaining Treatment” Rule, and must be entered into the patient’s record by the responsible Practitioner.

11.2.5 Verbal orders should be used infrequently.

11.2.6 Chemotherapy cannot be ordered using a verbal or telephone order.

11.3 CONTENTS OF MEDICATION ORDERS

Each medication order shall include the name of the medication (either brand or generic name), the dosage and frequency of administration, the route of administration and the date and signature of the prescriber. Additional information is required for the following types or orders:

PRN order. An indication for use is required.

Hold order. A duration of hold and parameters for the hold must be specified. Hold orders without specific parameters will be discontinued.

Automatic stop order. See medication/situation specific procedures.

Resume orders. Blanket reinstatement of previous orders for medications is not allowed. A new medication order is required.
Titrating/taper orders. Specific parameters for titration are required.

Range order. See range order policy for specific requirements.

Compounded medications. If no recipe is established in the pharmacy, orders for compounded medications should include the active ingredients and their amounts.

Investigational medications. See investigational medication policy.

Herbal Products Orders. Orders for herbal products must include the same information as required for any medication order.

Look-alike or sound-alike names. See look-alike/sound-alike policy.

Medication-related devices. See policies related to each device.

11.4 CLINICAL PROTOCOLS

11.4.1 Clinical Protocols, standing orders or order sets for treatment and medications may be used for specified patients when authorized by a person who has privileges to issue the order. A copy of clinical protocol for a specific patient must be dated, timed and authenticated by the ordering Practitioner responsible for the patient’s care as soon as possible, and included in the patient’s medical record. These clinical protocols must:

a. Specify the circumstances under which the medication is to be administered and/or treatment provided.

b. Specify the types of medical conditions to which the standing orders are intended to apply.

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

d. Be specific as to the medication, dosage, route and frequency of administration, when medications are used.

11.4.2 Clinical protocols, standing orders or order sets (pre-printed or electronic) may be used if they are:

a. Reviewed and approved by a designated representative or committee of (i) the Medical Staff, (ii) the Nursing Staff, and (iii) the Pharmacy leadership.

b. Consistent with nationally recognized and evidence based guidelines.

c. Periodically reviewed under Section 11.4.2(a) above, to determine the continuing usefulness and safety of the protocols and orders.

11.5 CLARITY OF ORDERS

The Practitioner’s orders must be entered clearly and completely. Dangerous abbreviations are to be avoided. Orders which are unclear, or incomplete will not be carried out until reentered or clarified by the Practitioner for those who are expected to carry out the order. Practitioners whose orders are unclear or incomplete may be subject to peer review processes in accordance with the Peer Review, Hearing and Appeal Rules.

11.6 CANCELLATION OF ORDERS ON TRANSFER

All previous orders are canceled when a patient goes to surgery or when patients are transferred in
RULE 12. OUTPATIENT SERVICES

12.1 SERVICES

Outpatient diagnostic and therapeutic care shall include pathology, clinical laboratory services, radiology, cardiology, pulmonary function, neurology, gastroenterology, surgery, rehabilitation, physical therapy, respiratory therapy, and chemotherapy.

12.2 ADMISSION OF OUTPATIENTS

Patients referred for outpatient services must be admitted to the Hospital’s outpatient service. A record shall be created in accordance with the “Medical Records” Rules.

12.3 ORDERS

Patients shall receive outpatient therapy only upon the orders entered into the patient’s record or verbal orders of and pursuant to the continuing supervision of a Medical Staff Member.

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

12.4.2 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.

12.4.3 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.)

12.4.4 Specimens

All anatomical parts, tissues, foreign objects, and implanted objects that are removed during surgery (except those exempted from review) 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 filed in the patient’s medical record.

12.5 DISCHARGE

Each patient shall be examined by a Practitioner prior to discharge from the Hospital or discharged by staff acting pursuant to criteria established for discharge set forth in Hospital policies.
RULE 13. RESEARCH

13.1 ENCOURAGEMENT FOR RESEARCH

Practitioners who desire to conduct clinical research should be encouraged to conduct reasonable research projects utilizing patient records and other data sources.

13.2 APPROVAL

All research undertaken by Medical Staff Members or others involving Hospital patients must be approved by the Department Chair and, when appropriate, the Institutional Review Board. All research must be conducted in accordance with the Rules and policies governing research, approved by the Institutional Review Board and Medical Executive Committee.

13.3 USE OF HOSPITAL NAME

A Medical Staff Member may use or allow the use of the Hospital’s name in published works only with the permission of the Medical Executive Committee. However, Members may identify themselves as Members of the Medical Staff within the limits of accepted professional ethics and practices.
RULE 14. UTILIZATION MANAGEMENT

14.1 GENERAL

Each Attending Practitioner must document the need for his or her patient's admission and for continued hospitalization.

14.2 DOCUMENTATION FOR UTILIZATION MANAGEMENT

Documentation for Utilization Management shall include:

14.2.1 An adequate record of the reason for admission and continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.

14.2.2 Plans for post-Hospital care.

14.3 JUSTIFICATION FOR CONTINUED HOSPITALIZATION

Upon appropriate request, each Medical Staff Member is required to report the necessity for continued hospitalization for any patient, including an estimate of the number of additional days of stay and the reasons therefore.
RULE 15. MEDICAL EDUCATION

15.1 PATIENT PARTICIPATION

All patients shall be available for teaching purposes unless the patient or an authorized decision-maker objects or there is a specific contraindication, and the patient’s attending Practitioner issues a specific order indicating that the patient shall not be involved in any medical education activities.

15.2 SUPERVISION OF MEDICAL STUDENTS, RESIDENTS AND FELLOWS

Medical students participating in training programs shall be supervised by Medical Staff Members and act in accordance with any agreement that may govern their training and the Hospital’s policy governing students, as such are amended from time to time. If residents and fellows participating in training programs are permitted to have clinical experiences at the Hospital, they shall be supervised by Medical Staff Members and act in accordance with any agreements that may govern their training and the Hospital’s policies governing residents and fellows, as such are adopted and amended from time to time.

15.3 RECORD KEEPING OF MEDICAL STUDENTS, RESIDENTS, AND FELLOWS

15.3.1 General

Residents, fellows and medical students shall be responsible for completing records pertaining to the clinical services if any that they may provide while participating in a residency, fellowship, and medical student training rotation at the Hospital.

15.3.2 Authentication

The attending or supervising Practitioner shall review and then authenticate the following reports prepared by a resident:

a. History and Physical Examination Report
b. Operative Reports
c. Discharge Summaries

15.3.3 Designation on Operative Reports

a. Residents and fellows who act as an assistant surgeon shall be designated in the operative report as the “assisting surgeon,” and the primary operating surgeon shall be designated as the “primary operating surgeon” in the operative report.

b. Medical Students who observe surgery shall be designated as observers. Medical Students who assist with simple procedures during surgery shall be designated in the operative report as the “assisting medical student,” and the primary operating surgeon shall be designated as such.
Approved by:
Medical Executive Committee on October 20, 2014.

Signed: [Signature]
Medical Staff President


Signed: [Signature]
SCL Health – Front Range, Inc. Corporate Secretary